Hospice Business Plan

Spree Hospice | Berlin

DOCUMENT GUIDE

Contents

Proposed Berlin adult inpatient hospice | 3 October 2026 | Model 1.0

A decision document for prospective founders and funders. Financial forecasts are conditional planning assumptions. No authorisation, quoted supplier terms or committed funding is claimed.

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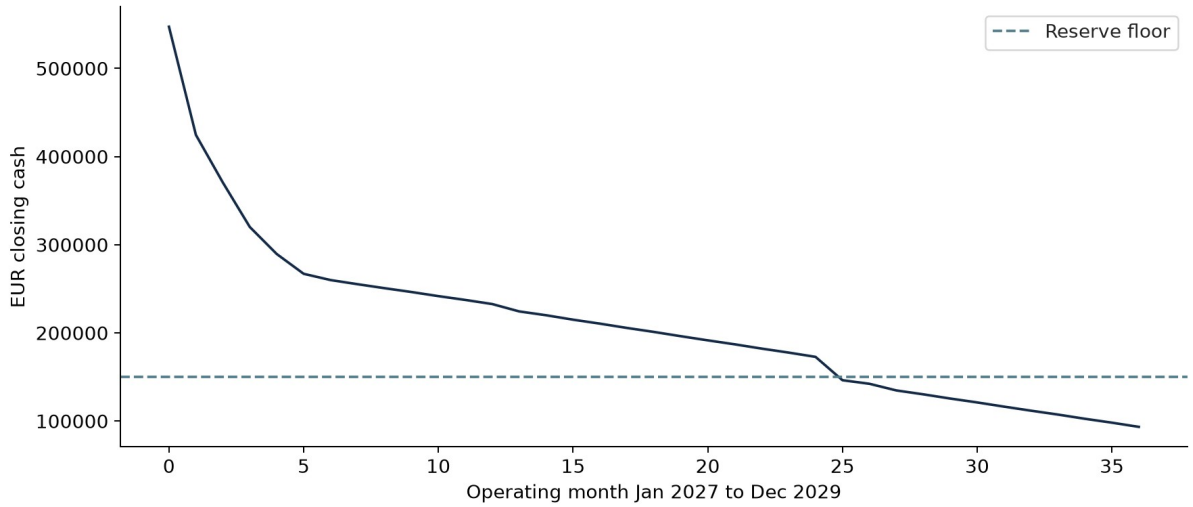
01 / OVERVIEW

Executive summary

Spree Hospice is a proposed eight-bed adult inpatient hospice in Berlin, organised as a charitable gGmbH subject to incorporation, tax recognition and commissioning. It would support eligible adults whose palliative needs cannot be met at home and who do not require hospital treatment. The decision is whether to finance regulated care readiness and a conditional launch, rather than assume a profitable business already exists. No appointed founder credentials, lease, licence, tariff, admissions, donor promises or finance is claimed.

The plan funds qualified staff and owner governance. Base and Downside donation income is zero. Insurance revenue is only the agreed eligible care value multiplied by the statutory 95% funding share, including nursing-insurance offsets. The operator must obtain the remaining 5% through donations; residents are not charged this shortfall [S 1 S 2]. Clinical staffing, the individual patient approval and the operating contract must all be validated before opening.

Base forecasts EUR 1,320,699 revenue and negative EUR 155,910 EBITDA in 2027; minimum company cash is EUR 93,441 and its reserve funding gap is EUR 56,559. Proposed sponsor equity EUR 1,000,000 and debt EUR 250,000 remain uncommitted. Downside minimum cash is negative EUR 1,827,744; reaching the EUR 150,000 reserve needs an additional EUR 1,977,744 beyond those sources. Upside requires its uncommitted donor and tariff assumptions. Base 2027 unfunded donor requirement is EUR 69,510.



Conditional Base company cash EUR January 2027 to December 2029. Financing is proposed; donations are not secured.

02 / OVERVIEW

Business details

The working entity is Spree Hospice gGmbH, subject to name checks, incorporation and charitable recognition. It is a proposed eight-place adult inpatient service in Berlin using EUR and January 2027 to December 2029 monthly forecasts. It excludes children's hospice, hospital beds, ambulatory SAPV operations, outpatient nurse visits, assisted dying and property development.

The model assumes qualifying hospice contracts exist before trading. Their absence is an opening stop condition, not authority to admit or invoice patients. Physicians and pharmacies retain their lawful professional responsibilities and distinct reimbursement routes. No separate prescription, physician or SAPV revenue is added to the hospice's care claim. Recognised care value is conservatively capped by a planning eligible-cost budget; this monthly ceiling is a modelling choice rather than a statutory settlement formula.

Field	Proposed scope
Entity	Charitable gGmbH subject to incorporation and recognition
Care	Adult inpatient palliative nursing and accompaniment
Places	Eight single rooms, premises approval required
Period	January 2027 to December 2029 EUR
Unsecured	Staff appointments premises commissioning tariff finance and donations

03 / STRATEGY

Business concept and objectives

Develop an eight-room service that combines qualified continuous nursing, psychosocial support, family access and carefully documented eligibility. The aim is dignified care and financial continuity, with surplus reinvested in the charitable purpose. The owner cannot substitute commercial occupancy goals for appropriate admissions.

The first decision gates are a clinical concept approved with regional contract partners, a viable premises assessment, qualified appointments and a funded cash stress case. Obtain referral and collection evidence before expansion. Beds beyond eight require a fresh staffing and commissioning assessment; the national reference does not authorise a linear staffing extrapolation [S 3].

Gate	Evidence required
Clinical	Qualified lead, detailed rota, medical cooperation and safe scope
Premises	LAGeSo process, accessibility fire and hygiene approvals
Commissioning	Signed §39a care and daily-rate agreement
Finance	Unrestricted capital debt terms donor strategy and liquidity stress

04 / STRATEGY

Business model canvas

Eligible residents receive inpatient palliative nursing and accompaniment without a hospice copayment. Statutory insurers pay the agreed eligible claim after approval, with care-insurance benefits offset rather than added. Donors support the operator’s remaining funding share. Residents, referrers, insurers and donors have different needs and must not be treated as one purchasing customer [S 1 S 2].

Qualified nursing, psychosocial, management, administration and premises staff are paid. The model includes no volunteer replacement of core roles. External doctors, pharmacies, legal advisers and training providers require documented arrangements. Revenues are reimbursement and explicitly conditional donations; secured gifts and public grants are not assumed.



Nine-block proposed hospice canvas. Care claims, resident needs and uncommitted donor support are distinguished.

05 / STRATEGY

SWOT and longer term goals

Proposed strengths are an eight-room family-scale concept, funded qualified staffing and explicit eligibility safeguards. Weaknesses are no commissioned tariff, appointees, premises or referral history and substantial payroll during empty periods. The business carries liquidity risk even if residents and families value the service.

Opportunities include an evidenced unmet local care need and stronger referral coordination. Threats include recruitment difficulty, delayed claim approval, premises costs, donor shortfalls and clinical incidents. Years four and five require renewed cash, staffing and contract evidence. An additional site is not forecast and should never be financed from assumed admission growth.



Proposed capabilities and unverified opportunities; no claimed care track record.

06 / STRATEGY

TOWS strategy matrix

Use the small setting to validate family access, referral communication and safe handovers after commissioning. The clinical lead records care quality and the owner monitors approvals, donor coverage and collections. Clinical outcomes and resident preferences require lawful, consent-aware evaluation rather than promotional claims.

Obtain cash headroom before recruitment commitments and refuse opening without safe daily coverage. Build a named backup roster and professional medical agreements. If the tariff or demand cannot cover paid service costs, reduce or defer the launch only after a new clinical assessment; do not silently reduce qualified care to balance the model.



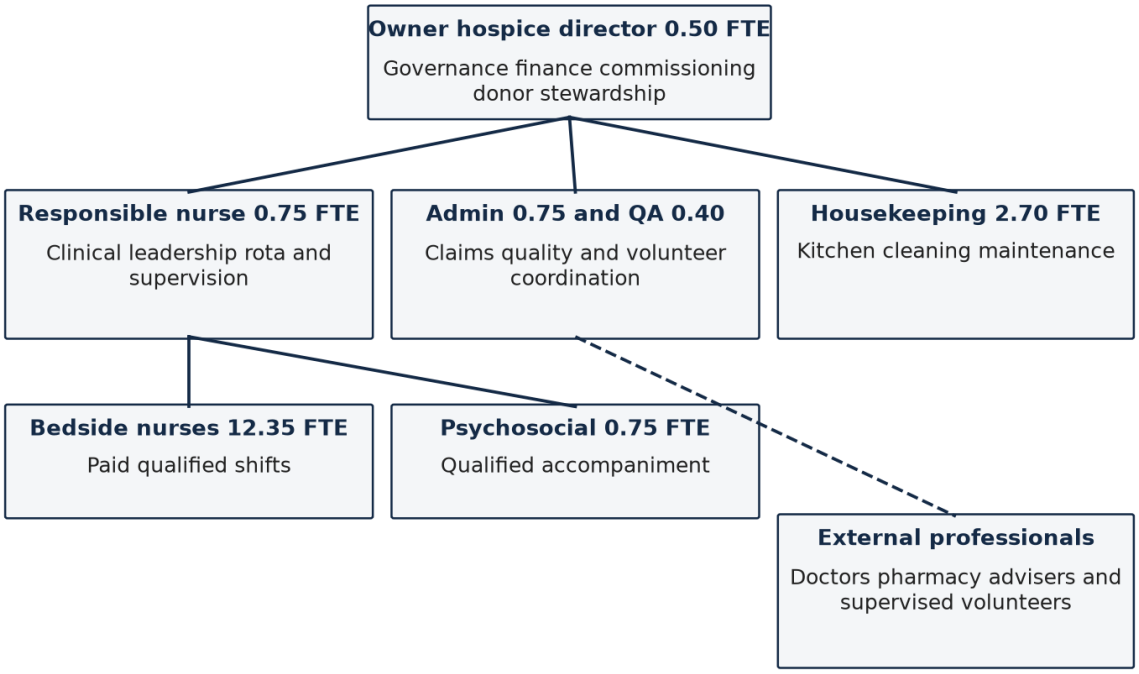
Named actions link clinical readiness, tariff evidence and liquidity to the proposed leadership roles.

07 / PEOPLE

Owner and management

The paid owner hospice director is planned at 0.50 full-time equivalent and manages purpose governance, finance, donor relationships and commissioning. A separate responsible nurse lead at 0.75 FTE owns clinical leadership, supervision and the daily rota. The owner is not described as a nurse and contributes no bedside hours in the capacity model.

Qualified bedside nursing is 12.35 FTE, separately funded from the responsible nurse. Psychosocial support is 0.75 FTE, administration 0.75, quality and volunteer coordination 0.40, and housekeeping/kitchen/maintenance 2.70. These eight-bed reference categories are regional contract negotiation inputs, not proof of a licence [S 3].



Solid internal reporting lines; dashed external professional cooperation. Nursing management is separate from bedside FTE.

08 / PEOPLE

Owner and key personnel profiles

No biographies, registration numbers or clinical qualifications are invented. Appoint a hospice director with demonstrated governance and commissioning capability. The responsible nurse needs the qualifications, experience and leadership development required by the applicable framework and local agreement. Every bedside nurse must satisfy the agreed professional and palliative-care requirements [S 3].

Verify references, registration recognition where relevant, working-time arrangements and training. Psychosocial staff need suitable professional experience; administration needs reliable claim and privacy controls. Medical cooperation, out-of-hours escalation and pharmacy access must be agreed with appropriate external professionals before admissions.

Role	Appointment evidence
Director owner	Charitable governance budgets donor stewardship and contracts
Responsible nurse	Verified qualifications clinical leadership and approved rota
Bedside nurses	Recognised qualifications palliative competence and safe handovers
Psychosocial and QA	Relevant qualifications supervision safeguarding and bereavement scope

09 / MARKET

Target customers

Eligible adult residents have advanced illness and need inpatient palliative nursing that cannot appropriately be supplied at home, while hospital treatment is unnecessary. Admissions require medical evidence and individual insurer approval; not every older resident, hospital discharge or terminal diagnosis qualifies [S 1 S 2].

Families need clear communication and access, referrers need a reliable eligibility route, insurers need complete claims and donors need transparent purpose and spending. Respect resident wishes, cultural needs and privacy. No survey, waiting list, referral partnership or promised admission is asserted.

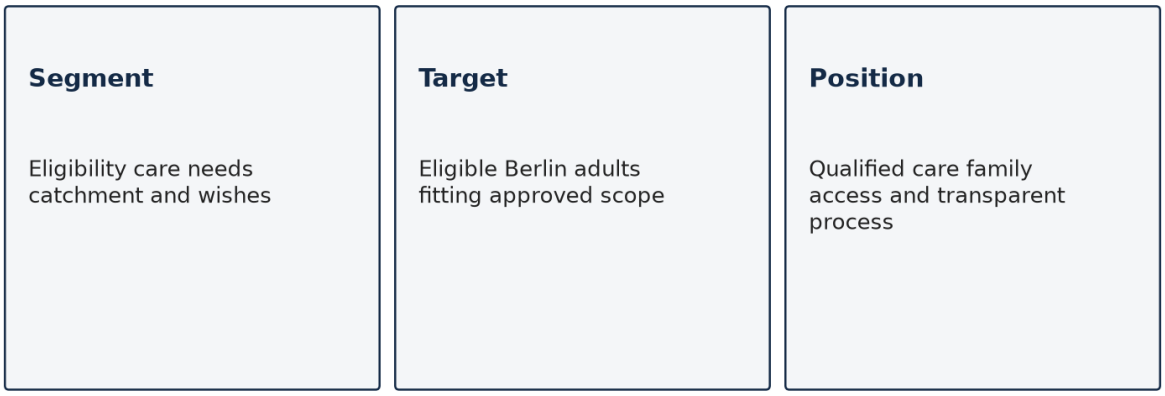
Participant	Need and qualification
Resident	Appropriate inpatient hospice eligibility and informed preferences
Family	Access communication psychosocial support consent boundaries
Referrer	Clinical evidence care continuity and available staffed beds
Insurer and donor	Correct claim approval and transparent charitable finances

10 / STRATEGY

Segmentation targeting and positioning

Segment by care eligibility, clinical needs, geography, home-support limitations and resident preferences. Target adults within a proposed Berlin referral catchment whose needs fit the commissioned service and daily skill mix. The initial offer excludes children, hospital-intensity treatment and a separately billed ambulatory service.

Position the proposed hospice around qualified care continuity, understandable admission information and family access. No claim of better clinical outcomes, shortest waiting times or lowest costs is supported. Validate the catchment with qualified referrers and actual eligible admissions after authorisation.



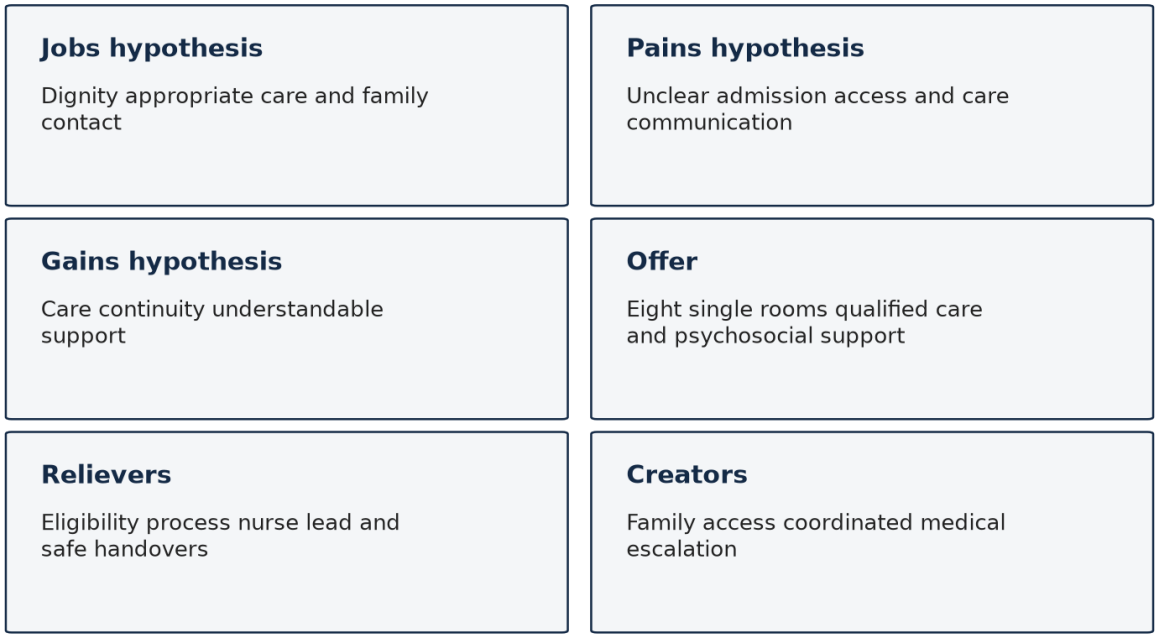
Eligibility and care fit govern targeting. No unsupported outcome or competitor score is shown.

11 / STRATEGY

Value proposition canvas

Residents need symptom-oriented nursing, dignity, familiar contact and a place that matches their care needs. Families may face uncertainty over admission, communication and practical support. These are service design hypotheses, not quoted interviews or measured satisfaction findings.

The proposed offer is a private room, funded qualified shifts, a clinical lead, psychosocial accompaniment and a clear referral process. The hospice does not promise cure, a particular survival time or guaranteed relief. Care plans, escalation and professional medical cooperation require clinical approval and individual assessment.



Jobs pains and gains are proposed hypotheses. Clinical promises require professional assessment.

12 / MARKET

Market size and trends

TAM is eligible adult inpatient hospice bed-days and associated commissioned care spending in Berlin during 2027 to 2029. SAM is the portion suitable for the proposed catchment, clinical scope and referral pathway. Neither narrowly defined total has been established from the reviewed primary sources; no death count or elderly population is multiplied by an invented conversion rate.

SOM requires approved eligible admissions and funded staffed capacity. Eight beds provide at most 2,920 physical days in 2027 and 2,928 in leap-year 2028, before occupancy and room-turnover constraints. That supply ceiling is not market share. The national framework's typical small facility character provides context but does not demonstrate local unmet demand [S 2 S 3].



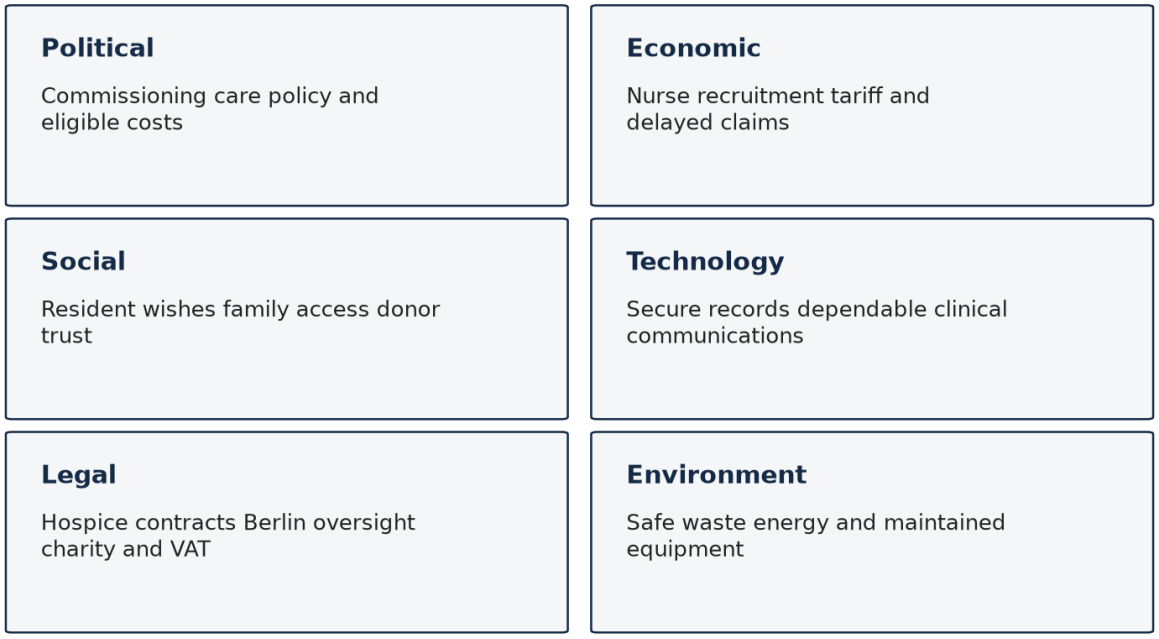
Berlin 2027–2029 TAM/SAM unquantified. Eight-bed supply ceiling and conditional admissions are not validated share.

13 / STRATEGY

PESTLE analysis

Political exposure centres on commissioning and care policy. Economic exposure includes staffing, premises costs and insurer collection delays. Social responsibilities include resident preferences, cultural access, family communication and transparent fundraising. No donation tax receipt or public support is assumed before the relevant status is confirmed.

Technology concerns secure clinical records and reliable communications. Legal duties include §39 a contracts, Berlin oversight, qualifying health VAT treatment and charitable-purpose governance [S 1 S 4 S 5 S 7]. Environmental decisions concern safe waste handling, energy use and durable equipment; infection-control requirements take precedence over reuse.



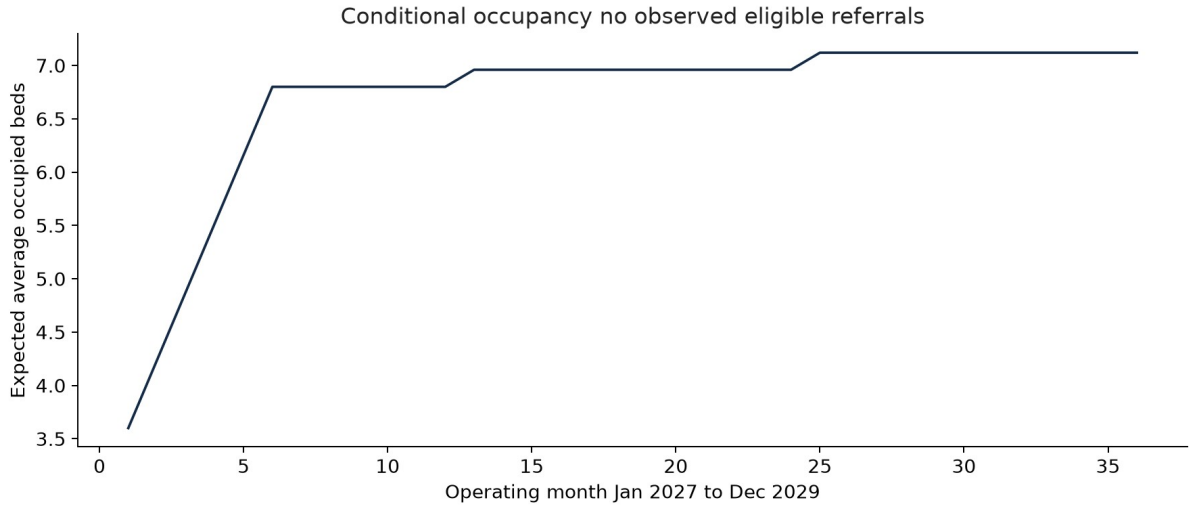
Six aligned panels connect local care requirements to operating responses.

14 / MARKET

Local demand and evidence

Berlin’s official information describes inpatient hospice as part of the city’s care system and identifies commissioning and eligibility processes [S 10]. Lazarus publishes an actual local inpatient service [S 9]. These facts demonstrate service context and an alternative, rather than prove that Spree Hospice can fill eight beds.

Obtain dated referral interviews, appropriate unmet-need evidence and eligibility/approval timing before recruitment. After authorisation, record admissions, occupied days, refusals by reason and collections without sharing identifiable resident data. Forecast occupancy is an unvalidated assumption; no insurer, hospital or family has committed to this plan.



Conditional forecast occupied beds only. No observed demand, waiting list or secured referrals is claimed.

15 / MARKET

Competitors and positioning

Lazarus Hospiz Berlin publicly describes an existing inpatient hospice [S 9]. It is a real service alternative with its own clinical and charitable arrangements, not a vendor quoted for the proposed site. Reviewed public information does not support a like-for-like fee comparison, waiting-time ranking or quality score.

Other alternatives depend on assessed need: home-based palliative support, hospital care when clinically required and other commissioned hospices. Referral continuity and resident preference matter more than an invented competitor chart. Compare actual scope, eligibility and available qualified capacity with professionals before making a placement claim.

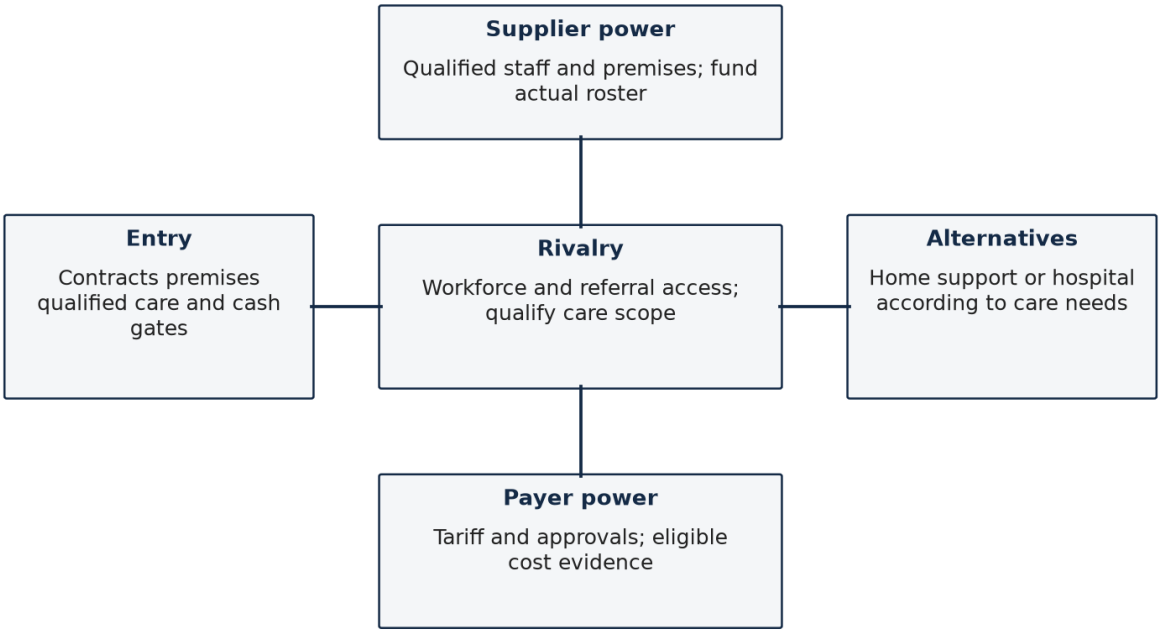
Alternative	Evidence and implication
Lazarus Hospice Berlin	Published local service; no comparative rating inferred
Other commissioned hospices	Eligibility and actual available places must be checked
Home palliative support	Appropriate when needs can be met at home
Hospital	Separate route when hospital treatment is needed

16 / STRATEGY

Porter five forces

Rivalry concerns qualified workforce, commissioning and appropriate referral access; admissions are not ordinary retail sales. Insurers hold substantial negotiating and claim-approval power. Nurses, suitable premises and specialist partners constrain supply. The response is a funded roster, realistic eligible-cost tariff and complete clinical documentation.

Entry requires regulatory, contractual and professional readiness rather than only a building. Home support and hospital services are alternatives according to care need, not interchangeable substitutes selected on price. The diagram is a reasoned assessment, not a quantitative competition study.



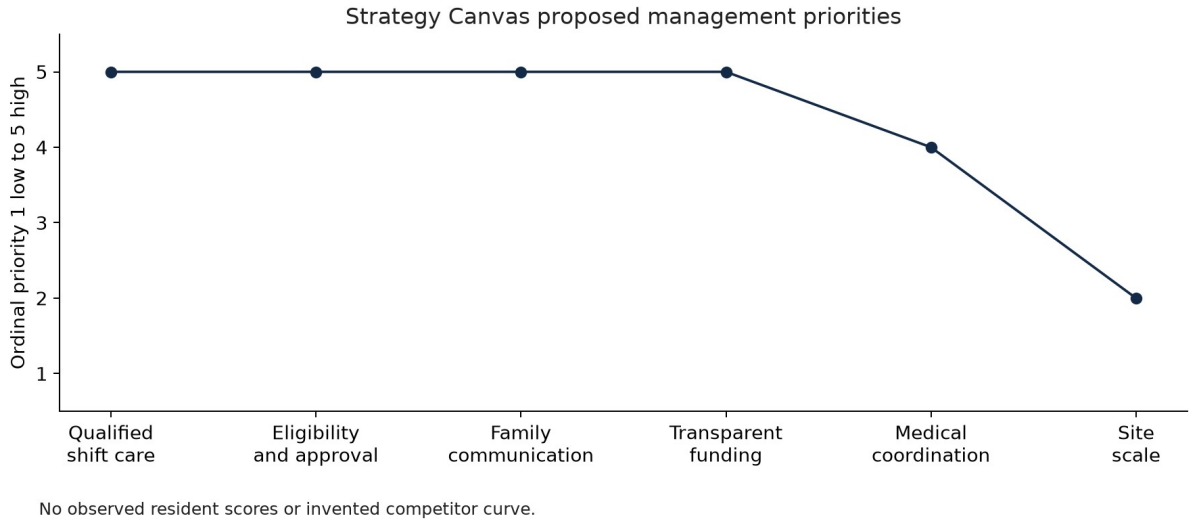
Rivalry is central. Four surrounding forces reflect care commissioning, workforce and clinically appropriate alternatives.

17 / STRATEGY

Strategy canvas

Management proposes high priority for qualified shift continuity, care eligibility, family communication and transparent finances. The eight-bed setting limits scale and requires dependable external medical cooperation. Priorities reflect the proposed operating concept, not resident survey scores.

The canvas uses internal ordinal priorities and contains no invented competitor curve. Validate these choices through clinical review, lawful resident/family feedback, documented handovers and referral decisions. Never interpret an attractive diagram as evidence of safer care.



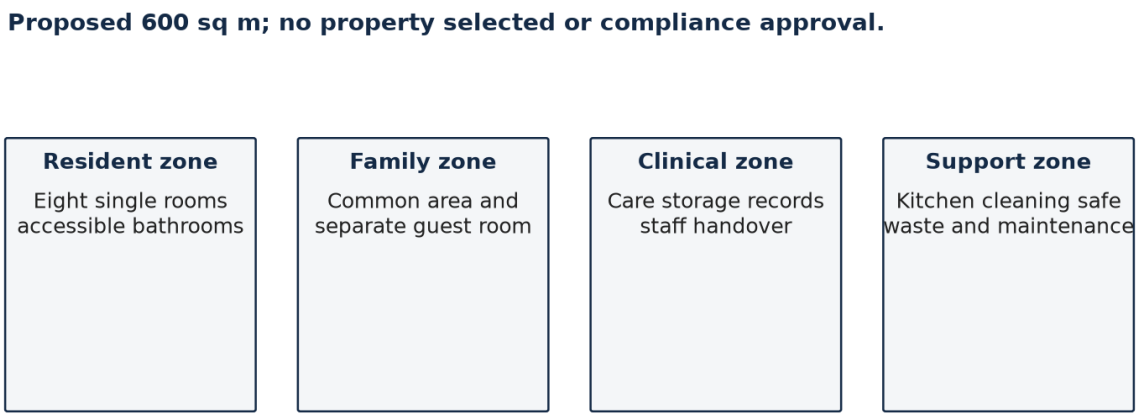
Ordinal management priorities 1 low to 5 high. No measured clinical ranking or fabricated competitor rating.

18 / OPERATIONS

Location and premises

Plan approximately 600 square metres in Berlin with eight private resident rooms, suitable bathrooms, family and common spaces, a separate guest room, clinical storage and staff facilities. The current Berlin building register requires single rooms with space for a trusted person to stay overnight and at least one separate guest room [S 14]; the exact site and current detailed building requirements must be assessed with competent professionals and LAGeSo [S 4].

Rent is an unquoted EUR 12,000 monthly with EUR 36,000 refundable deposit. No building is selected and no lease is signed. Check permitted use, accessibility, evacuation, fire protection, hygiene, medical storage and reliable utilities before commitment. The diagram shows proposed zones and is not an architectural or licensing approval.



Indicative 600 square metre zoning with eight single rooms and guest space. Exact building compliance unresolved.

19 / OPERATIONS

Equipment and resource plan

Initial supplier budgets are EUR 300,000 net fitout and EUR 100,000 net equipment. Assuming 19% unrecoverable input VAT gives capitalised gross costs EUR 357,000 and EUR 119,000. No supplier quote is asserted. The model depreciates fitout over 120 months and equipment over 60, capped at original cost even with fractional life inputs.

Equipment scope includes care beds, lifts, furniture, suitable clinical equipment, records systems and secure communications. A further EUR 15,000 net equipment allowance is planned in month 25. Validate specifications, infection control, servicing and emergency access with the clinical lead; no unapproved device or clinical protocol is prescribed.

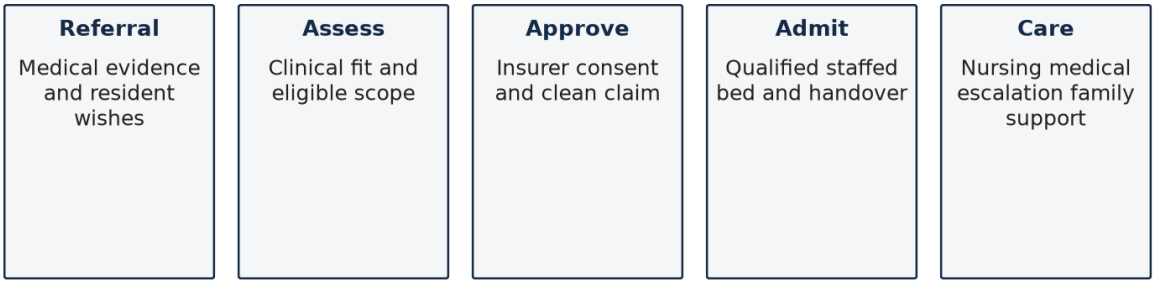
Category	Net supplier EUR	Gross capitalised EUR
Fitout	300,000	357,000
Equipment	100,000	119,000
Initial total	400,000	476,000
Month 25 additional equipment	15,000	17,850

20 / OPERATIONS

Care and service strategy

The launch scope is adult inpatient hospice care under qualifying §39 a contracts. Referrals need appropriate medical evidence, resident preferences, care-fit assessment and payer approval. The clinical lead checks staffing and available space before admission. The plan offers nursing and accompaniment, not curative hospital treatment or an unlicensed medical service [S 1 S 3].

Doctors and pharmacies operate through their lawful care and payment arrangements. A gross EUR 1,000 monthly coordination allowance is included within overhead, but no free physician availability or secured retainer is claimed. Agree out-of-hours escalation, medicines processes, family access and bereavement boundaries before opening. Volunteers are recruited and supervised for appropriate accompaniment, never as a replacement for paid professionals.



Referral eligibility consent approval staffed-bed check admission care handover. No admission without clinical readiness.

21 / MARKET

Competitor price comparison

Residents have no hospice copayment for the eligible inpatient stay. The planned EUR 650 daily eligible need rate is an unquoted commissioning assumption, not a retail fee or competitor price. Statutory coverage applies to agreed eligible costs, with care-insurance amounts offset; the operator's remaining share requires donations [S 1 S 2].

A tariff assessment must use the proposed staffing, premises and eligible-cost schedule and be agreed with regional contract partners. No public competitor reimbursement rate is inferred from donations or service descriptions. Charges for unrelated services, if ever proposed, require a separate legal, tax and accounting review.

Item	Proposed treatment	Evidence
Resident hospice copayment	Zero for eligible stay	S2, eligibility and agreement required
Eligible need rate	EUR 650 daily Base	Unquoted negotiated assumption
Insurer share	95% eligible value	S1 inclusive care-insurance offset
Operator share	5% donor-funded	No Base/Downside donation promises

22 / SALES

Brand and resident experience

Spree Hospice is a working name requiring checks. The intended experience is understandable admission information, respectful communication, family access and coordinated care. Materials must make eligibility and contact pathways clear without claiming available places, clinical outcomes or endorsement before the service exists.

Seek consent for any story, photograph or public testimony and protect health information. Staff should record concerns and escalate them through the clinical lead and appropriate external routes. Donor communication reports aggregate activities and financial use, never treats residents as marketing assets.

23 / SALES

Referral channels and process

Appropriate channels are clinician referrals, hospital discharge teams, local palliative networks and understandable public information. No referral agreement is secured. Each inquiry proceeds through medical evidence, care-fit review, resident preference, insurer approval and current staffed-bed availability.

Administration records approvals and claim completeness; the nurse lead approves clinical suitability. The owner monitors anonymised referral conversion and collection delay without pressuring admissions. No referral commission, paid lead marketplace or occupancy guarantee is included.

Step	Responsible role
Inquiry and information	Administration
Clinical eligibility and preferences	Responsible nurse with external physician
Insurer approval and claim setup	Administration
Daily staffed capacity confirmation	Responsible nurse
Admission and care handover	Qualified bedside nursing

24 / SALES

Launch marketing

The gross preparation budget includes EUR 4,000 for accessible referral materials and a restrained information website or printed guide; this plan does not authorise website modification. Ongoing information and donor communication use EUR 250 monthly within the gross overhead budget. These are planning allowances, not purchased media or supplier bids.

Prioritise clear scope, contact information and approved referral processes. Do not advertise clinical claims, immediate vacancies or tax-deductible gifts without evidence. Measure professional engagement and appropriate inquiries; donations and admissions remain zero until actually secured or approved.

Budget item	Gross EUR
One-off preparation materials	4,000
Monthly information and donor communication	250

25 / SALES

Continuity and ongoing referrals

Continuity means clear professional handovers, family communication and appropriate onward coordination. Hospice residents are not a repeat-purchase cohort; retention metrics must not imply that longer stays are a sales objective. Average stay is a planning input rather than a clinical target.

Maintain reliable referrer contact and timely claims while respecting residents' wishes. Donor stewardship reports purpose and use of funds and must not promise clinical results. Record the unfunded 5% requirement separately from bank cash, and revise fundraising or the opening decision when evidence is insufficient.

26 / OPERATIONS

Daily operations and suppliers

The proposed bedside roster has two qualified nurses on each eight-hour shift and a further four qualified relief hours distributed across shifts for breaks and handovers, totalling 52 qualified hours per day. The model's net annual hours include paid leave, holidays, sickness and training. Average coverage is only a planning gate; actual daily skill mix, breaks, shift handovers and absences need an approved roster and named relief arrangements [S 3].

Paid housekeeping staff cover kitchens, cleaning and maintenance; gross food and care consumables are EUR 25 per occupied bed-day. Confirm catering, waste, equipment maintenance, pharmacy and external medical contracts. If safe staffing cannot be supplied, close admissions and escalate; volunteers never fill a professional staffing shortfall.

27 / OPERATIONS

Sustainability practices

Choose repairable equipment, appropriate servicing and energy-efficient premises when they meet clinical requirements. Plan safe waste segregation and supplier collections with qualified advice. Infection prevention and resident safety control any reuse decision; the plan makes no quantified environmental saving claim.

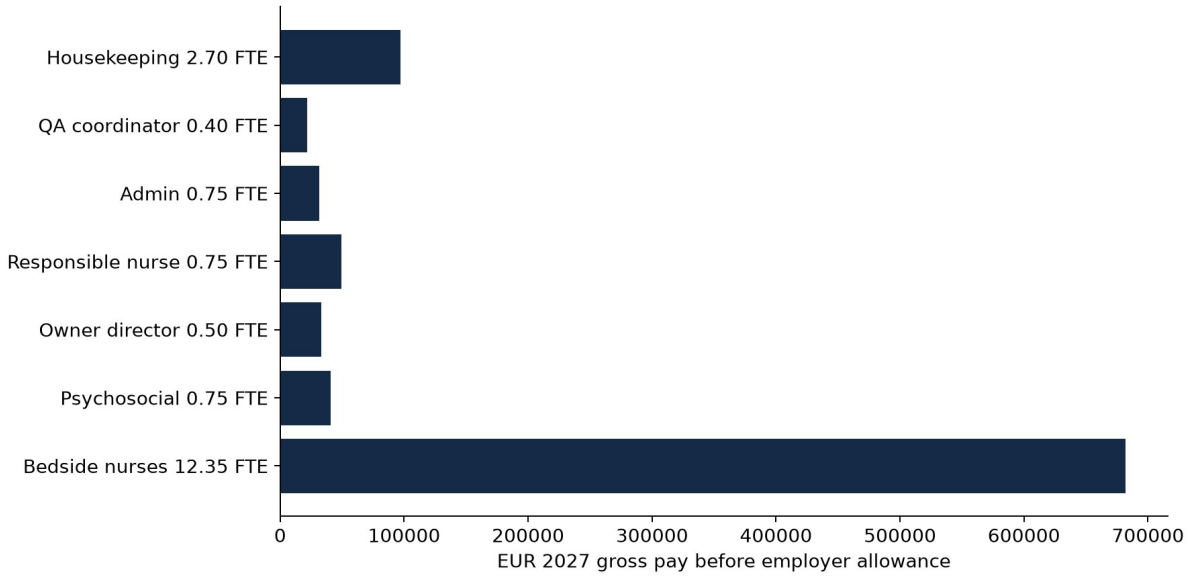
Track utility consumption, equipment service records and waste invoices. Include these costs in operating budgets and evaluate actual supplier bids. A small footprint does not justify omitting accessible rooms, cooling, reliable communications or emergency arrangements.

28 / PEOPLE

Staffing and training

The paid staff plan uses the national eight-bed orientation: bedside nurses 12.35 FTE, psychosocial 0.75, owner director 0.50, responsible nurse 0.75, administration 0.75, quality/volunteer coordination 0.40 and housekeeping 2.70, totalling 18.20 FTE [S 3]. Full FTE gross monthly pay assumptions are EUR 4,600, 4,500, 5,500, 5,500, 3,500, 4,500 and 3,000 respectively, with a 25% employer and shift-cost allowance.

Base payroll is EUR 99,481 monthly before annual inflation. The owner earns EUR 2,750 gross at 0.50 FTE and is never free labour. Training, clinical supervision, recognised qualifications and safe scheduling are launch requirements. The 1,554 net annual hours already include absence; no second absence deduction is applied.



2027 gross pay by funded role before employer allowance. FTE and responsibilities match the workbook.

29 / PEOPLE

Staff skills and fair work

Recruit qualified people for the agreed role and care scope. Verify recognition, experience and palliative training as required, rather than invent names or credentials. Use lawful working hours, paid training, breaks, supervision and a documented backup roster. The clinical lead must assess actual shift coverage rather than rely only on annual-average hours.

Track vacancies, overtime, sickness and training without exposing personal data in donor reports. Model changes in paid FTE and available hours are financial stress assumptions, not permission to relax agreed professional standards. External professionals remain responsible for their own lawful services.

Area	Required evidence
Qualified care	Verified appointments and agreed palliative competencies
Rota	Daily shift breaks leave relief and escalation arrangements
Fair pay	Contracts employer costs tariff terms and premiums
Training	Paid induction supervision and refresh records

30 / OPERATIONS

Legal and insurance requirements

Opening requires the applicable Berlin oversight and premises procedures plus qualifying hospice contracts, agreed clinical scope and appointments. The official Berlin legal register publishes the WTG in force since 28 February 2026 with hospice facilities in scope [S 13]. LAGeSo publishes current hospice staffing forms; these are reporting tools rather than an issued authorisation [S 15]. Specific building requirements remain a site approval gate [S 14]. Seek professional advice on current notifications, approvals, fire protection, hygiene, professional responsibilities and health-data obligations before taking a lease or admissions.

Qualifying hospice care can be VAT exempt under §4(14)(b)(gg); associated purchase VAT is generally excluded from deduction under §15 [S 5 S 6]. Charitable tax recognition and purpose-operation treatment are separate gates [S 7 S 8]. Budget insurance within overhead but obtain actual professional, employer, property and interruption quotations. No licence, charitable notice or insurance cover is claimed.

Gate	Owner
Commissioning and eligibility	Director and responsible nurse
Premises and daily care standards	Responsible nurse with qualified advisers
VAT and charitable purpose	Director with tax adviser
Insurance data and contracts	Director with legal insurance and privacy specialists

31 / OPERATIONS

Opening roadmap

The model assumes launch in January 2027 only after readiness and funding gates pass. Before opening, assess premises, agree the clinical concept and tariff, appoint qualified leads, secure proposed financing and validate donor strategy. Preparation includes a full paid-team induction month plus two additional months for the director and responsible nurse; it does not assume free setup work.

Do not sign an irreversible lease before the premises/contract assessment. Complete the actual rota, equipment checks, referral and claim processes, medical cooperation and training before admissions. If any gate fails, defer opening and refresh cash costs; the workbook does not simulate an unfunded delay automatically.

Phase	Evidence
Before commitments	Site/clinical concept commissioning advice and funding
Before full recruitment	Approved pay budget appointable leads and tariff pathway
Paid induction	Rota equipment records medical escalation and training
Before first admission	All legal care approvals finance and insured readiness

32 / RISK

Risks and management actions

The largest exposures are clinical staffing, unagreed daily reimbursement, slower admissions and insurer collection delay. Safe care needs an actual rota and qualified appointments, while recurring payroll continues when rooms are empty. A nominal bank balance does not satisfy the operator’s donor-funding obligation.

Monitor clinical incidents, approved claim rates, occupied days, donor coverage, collections and unrestricted cash. Escalate unsafe coverage immediately and pause admissions. If Downside threatens the reserve, secure lawful finance or defer the launch after clinical reassessment. No emergency grant, asset sale, reimbursement appeal or insurance recovery is automatically added.

Risk	Action and accountable role
Staff shortage	Nurse lead activates named relief or closes admissions
Tariff and approvals	Director obtains signed terms; admin checks clean claims
Unfunded5% and liquidity	Director validates donors and stress finance before opening
Premises incident	Clinical lead follows approved evacuation and continuity plan

33 / EVIDENCE

Research and evidence

Research uses primary legislation, the GKV funding page, the adult hospice agreement and Berlin care guidance. The current eight-bed staffing orientation is read from the agreement effective January 2025, including separate bedside and nursing-management categories [S 3 S 11]. It is not a substitute for regional contracts or daily clinical approval.

Evidence reviewed establishes context, funding mechanics and planning responsibilities. It does not establish an available building, supplier price, market size, credentials, referral orders or donations. Planning assumptions are separately identified in Inputs, with source URLs beside the driver table. All sources were accessed for this production on 3 October 2026.

S1 statutory hospice reimbursement https://www.gesetze-im-internet.de/sgb_5/__39a.html

S2 GKV funding and eligibility https://www.gkv-spitzenverband.de/krankenversicherung/hospiz_und_palliativversorgung/stat_hospizleistung/stat_hospiz/stat_hospizversorgung.jsp

S3 adult hospice framework effective 2025 https://www.gkv-spitzenverband.de/media/dokumente/krankenversicherung_1/hospiz_palliativversorgung/2024-11-18_Rahmenvereinbarung_39a_Abs1_Satz_4__SGB_V_stat_Hospizversorgung_Erw.pdf

S4 Berlin premises staffing and oversight https://www.berlin.de/sen/pflege/grundlagen/rechtliche-grundlagen/landesrecht/artikel.1402653.php

S5 health VAT exemption qualifying hospice contracts https://www.gesetze-im-internet.de/ustg_1980/__4.html

S6 exempt-output input VAT exclusion https://www.gesetze-im-internet.de/ustg_1980/__15.html

S7 charitable purpose operation https://www.gesetze-im-internet.de/ao_1977/__66.html

S8 corporation charitable exemption conditional https://www.gesetze-im-internet.de/kstg_1977/__5.html

S9 actual local service alternative https://www.lazarushospiz.de/stationaeres-hospiz/

S10 Berlin hospice commissioning https://www.berlin.de/sen/pflege/service/vertraege/hospiz-versorgung/

S11 primary signatory copy framework2025 https://www.dhpv.de/files/public/themen/2024-11-18_Rahmenvereinbarung_39a_Abs1_Satz_4__SGB_V_stat_Hospizversorgung_Erw.pdf

S12 charitable trade-tax exemption conditional https://www.gesetze-im-internet.de/gewstg/__3.html

S13 current Berlin WTG effective2026 https://sozialrecht.berlin.de/kategorie/rechtsvorschriften/rv-wtg-2026-1615056.html

S14 Berlin hospice building rules https://sozialrecht.berlin.de/kategorie/rechtsvorschriften/rv-wtg-bauv-573419.html

S15 LAGeSo current hospice reporting forms https://www.berlin.de/lageso/soziales/heimaufsicht/downloads/

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Quotes and assumptions

No supplier quotes or signed commercial terms are supplied. The daily need rate, occupancy, stay duration, room turnaround, salaries, employer allowance, rent, consumables, equipment, collection delay and finance are hypothetical planning inputs. Future escalation rates are not contractual entitlements.

Obtain dated property, clinical staffing, equipment, catering, insurance and medical-cooperation bids plus actual regional tariff advice. Validate charitable recognition and health VAT treatment with advisers. Base and Downside donations remain zero; Upside full coverage is a conditional fundraising sensitivity rather than a donor commitment.

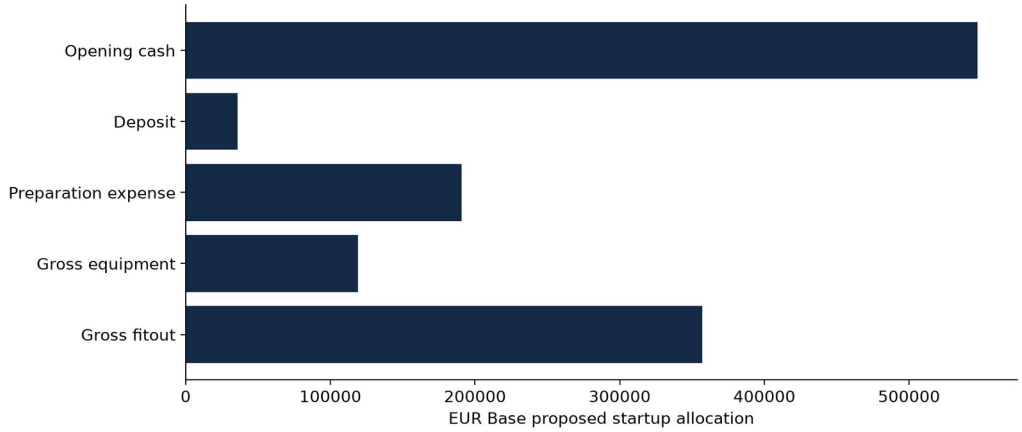
Unresolved item	Next evidence
Daily tariff and eligible costs	Regional contract negotiation and written eligible-cost budget
People and premises	Appointable qualified roster compliant site and dated bids
Demand and collections	Eligible referral evidence approval and clean-claim timings
Finance and donations	Sponsor lender and donor commitments with lawful restrictions

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Startup costs and funding

Proposed unrestricted sponsor equity is EUR 1,000,000 and term debt EUR 250,000. Initial gross capital assets are EUR 476,000, preparation expense EUR 190,669 and refundable deposit EUR 36,000. Remaining opening cash is EUR 547,331. No funds are secured.

Unrecoverable VAT is capitalised with equipment and fitout, not a receivable. Gross preparation includes paid staff, rent and supplier budgets. Sponsor equity is not care revenue, donation income or a balancing plug. Donor funds require separate restrictions and receipts.



Base funding allocation EUR. Proposed equity and debt are uncommitted.

Startup allocation	EUR
Proposed equity	1,000,000
Proposed term debt	250,000
Initial gross capital assets	476,000
Preparation expense	190,669
Refundable deposit	36,000
Opening cash	**547,331**

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Itemized startup costs

Capital asset prices are unquoted net supplier budgets; associated unrecoverable VAT is included in gross capitalised cost. Preparation includes all staff paid for induction plus additional director and nurse-lead preparation, preopening rent and gross supplier allowances. It is expensed into opening retained earnings.

The deposit remains a refundable asset. Opening cash is proposed finance less actual modelled uses; it is not another source. Equipment useful lives are planning assumptions subject to lease term and professional accounting review.

Startup use	EUR
Net fitout	300,000
Unrecoverable fitout VAT	57,000
Net clinical equipment	100,000
Unrecoverable equipment VAT	19,000
Full paid team induction	99,481
Additional director and nurse lead preparation	17,188
Preopening rent	36,000
Other gross preparation	38,000
Total preparation expense	**190,669**
Refundable deposit	36,000
Opening cash	**547,331**

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Owner personal survival budget

The owner is paid EUR 2,750 gross monthly for the 0.50 FTE director role in Base 2027, already included in company payroll. Estimated 65% retention gives EUR 1,788 net against EUR 2,500 living expenses, leaving negative EUR 713 monthly surplus. This is a household planning estimate, not a tax calculation.

No dividend or unspecified outside income fills a deficit. The owner needs separate household savings or a revised sustainable plan, while the company still needs its own reserve and donor funding. A charitable gGmbH does not imply distributable profits.

Household estimate	Monthly EUR
Owner gross pay	2,750
Estimated net pay	1,788
Housing	1,400
Essentials	700
Transport	200
Buffer	200
Estimated surplus	**(713)**

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Financing terms and security

Proposed Base debt is EUR 250,000 at 7.0% annual interest, with 6 initial principal-grace months and equal principal over 84 months thereafter. Interest is charged on opening monthly balance and principal is capped at outstanding debt. Closing debt remains EUR 160,714 in 2029.

No lender offer, collateral valuation, guarantee or sponsor commitment exists. Confirm charitable covenants, asset restrictions, security and solvency with advisers. Negative cash requires new lawful funding or a revised launch. No overdraft or default permission is implied.

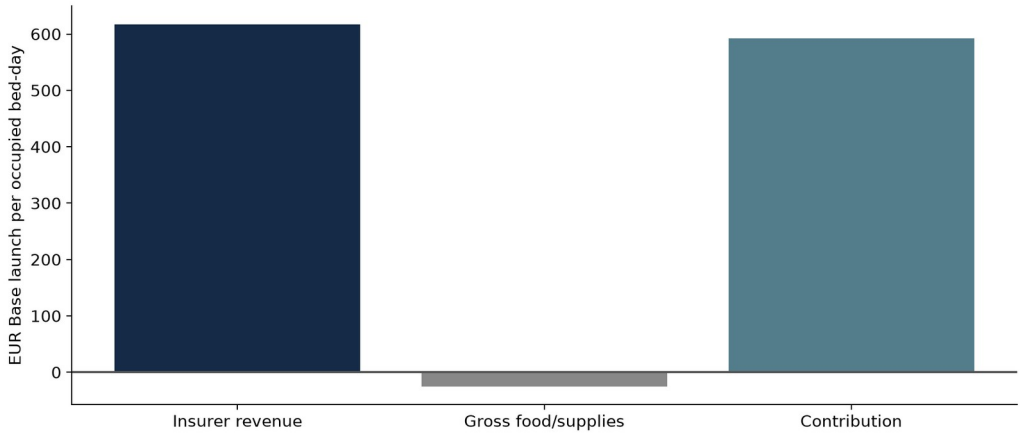
Term	Base assumption
Opening debt	EUR 250,000
Interest	7.0% on opening balance
Principal grace	6 months
Repayment	84 monthly equal principal payments
2029 closing debt	EUR 160,714

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Pricing and care economics

The Base launch negotiated eligible need rate is EUR 650 per occupied bed-day. Statutory coverage produces EUR 618 care revenue per day; the remaining EUR 33 is the operator's donation requirement, not a resident charge. Base and Downside assume no such donations. Gross meals and care supplies are EUR 25 per day, leaving EUR 593 contribution before payroll, rent and other costs.

The tariff must be agreed against eligible costs and cannot exceed applicable rules. The model caps care value at the lesser of occupied-day tariff value and a planning share of care operating cost plus depreciation and interest. This is a conservative monthly budgeting choice, not the statutory payment formula. Eligibility of management, fundraising/marketing, medical coordination, depreciation and interest must be agreed; no book expense is automatically legally eligible. No separate Pflegeversicherung claim or drug/doctor reimbursement is added. Occupancy, annual tariff increases and donor coverage are conditional; revenue follows approved occupied care days, while collections follow the model's claim lag.



Base launch bed-day economics EUR. No resident copayment or extra nursing-insurance revenue.

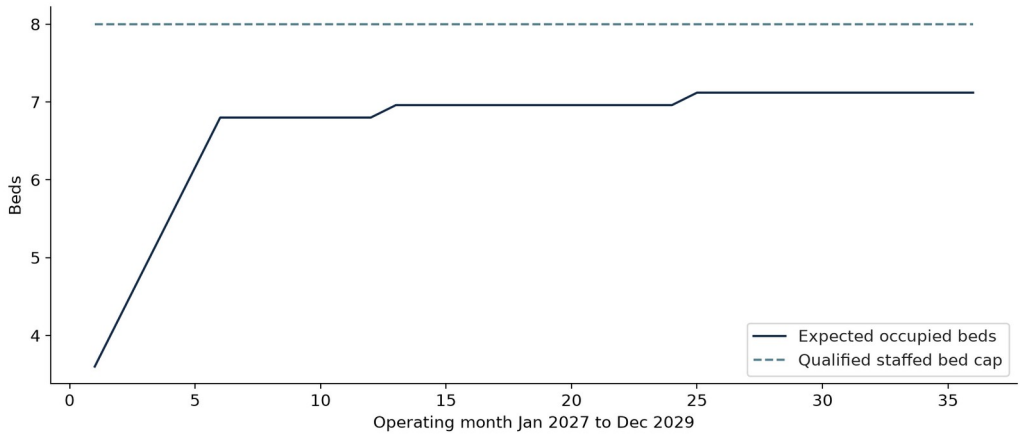
Launch unit economics	EUR per occupied day
Eligible need rate	650
Insurance reimbursement	618
Operator donor requirement	33
Gross food and supplies	25
Contribution before fixed costs	593

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Revenue forecast and capacity

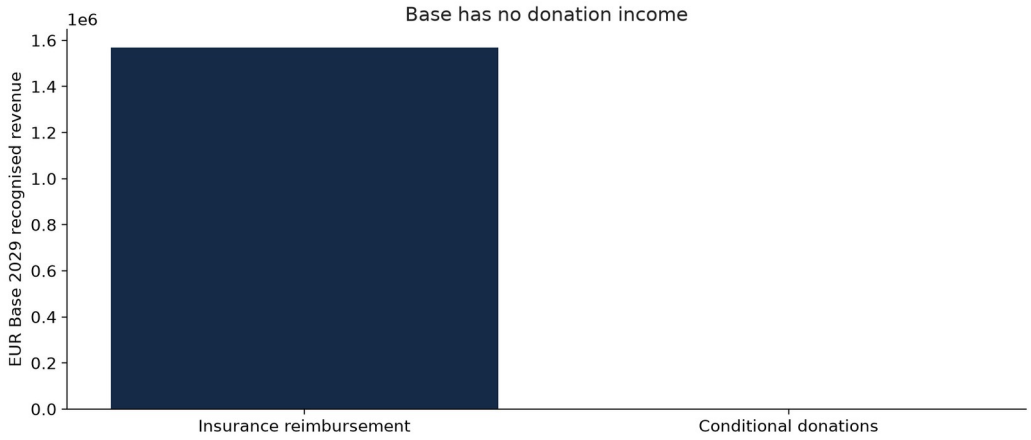
Base occupied days are 2,193.4, 2,547.4 and 2,598.8; revenue is EUR 1,320,699, EUR 1,524,396 and EUR 1,567,892. Demand ramps from 45% to 85% over six months, then 87% and 89% in later years. These are unvalidated demand assumptions, not promised admissions.

Base uses actual calendar days including leap-year 2028. Calendar controls may be reduced for a planned partial-month closure, retaining full monthly payroll; they cannot exceed actual days. Beds are bounded by qualified bedside, psychosocial and housekeeping hours, with positive funded director, nursing lead, administration and quality coordination; the proposed minimum qualified shift coverage can close admissions. Stay duration and room turnaround cap achievable occupancy. Expected stays are steady-flow equivalents, not a patient cohort forecast or clinical target. Daily actual rota approval remains mandatory.

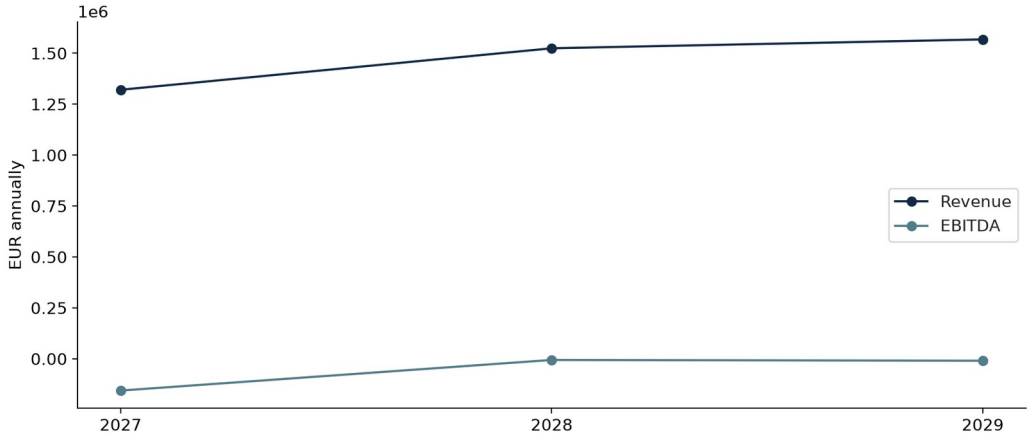


Occupied days and qualified staffed supply ceiling. Capacity is not proof of demand.

Metric	2027	2028	2029
Occupied bed days	2,193	2,547	2,599
Insurance revenue	1,320,699	1,524,396	1,567,892
Conditional donations	–	–	–
Revenue	**1,320,699**	**1,524,396**	**1,567,892**



Base 2029 insurance reimbursement and conditional donor income EUR.



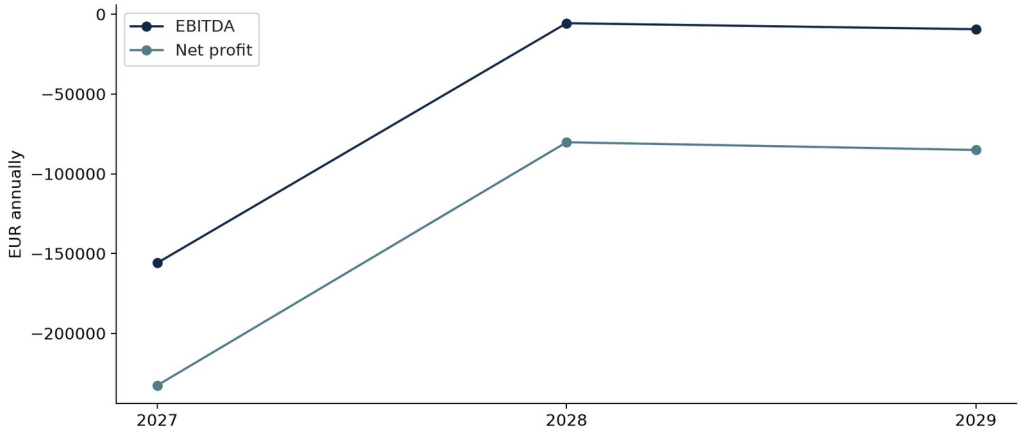
Base annual revenue and EBITDA EUR 2027 to 2029 model 1.0.

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Costs and projected profit

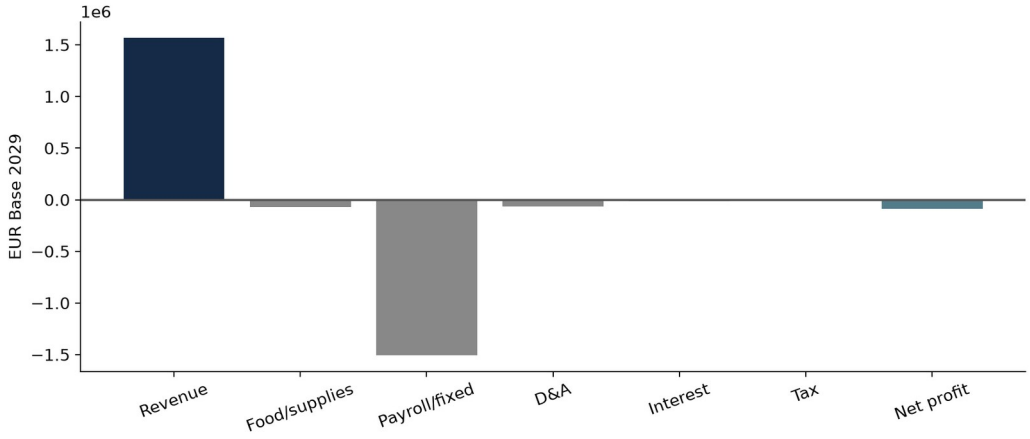
Base 2027 paid payroll is EUR 1,193,775 including employer/shift costs. Full staffing continues when rooms are empty. Gross consumables follow occupied days; rent and other overhead continue monthly and inflate under planning assumptions. No volunteer capacity substitutes for wages and no startup VAT credit reduces cash cost.

Base 2027 EBITDA is negative EUR 155,910 and net profit negative EUR 232,650. Depreciation is capped at capitalised gross cost; interest follows debt. The zero tax budget requires recognised charitable purpose operation and excludes unrelated trading. Revoke that assumption or add taxable operations only with a refreshed professional tax model.



Base annual EBITDA and net profit EUR from the same verified model.

Annual costs EUR	2027	2028	2029
Gross food and care supplies	54,834	65,595	68,927
Payroll and fixed overhead	1,421,775	1,464,428	1,508,361
EBITDA	**(155,910)**	**(5,627)**	**(9,396)**
Depreciation	59,500	59,500	63,070
Interest	17,240	15,104	12,604
Tax budget provision paid	–	–	–
Net profit	**(232,650)**	**(80,231)**	**(85,070)**



Base 2029 profit bridge EUR from verified monthly statements model 1.0.

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Profit and loss forecast

The P&L recognises eligible approved bed-day reimbursement and explicit conditional donations separately in the care build. Food/supplies, all paid roles and fixed costs are deducted before EBITDA. Preparation expense is already in opening retained earnings and is not charged again in these operating years.

Depreciation uses gross assets including unrecoverable VAT. Zero tax is conditional on recognised purpose-operation treatment; it is not a blanket exemption for every gGmbH activity. No grants, medicine resale, physician billing, property revaluation or volunteer labour value is booked.

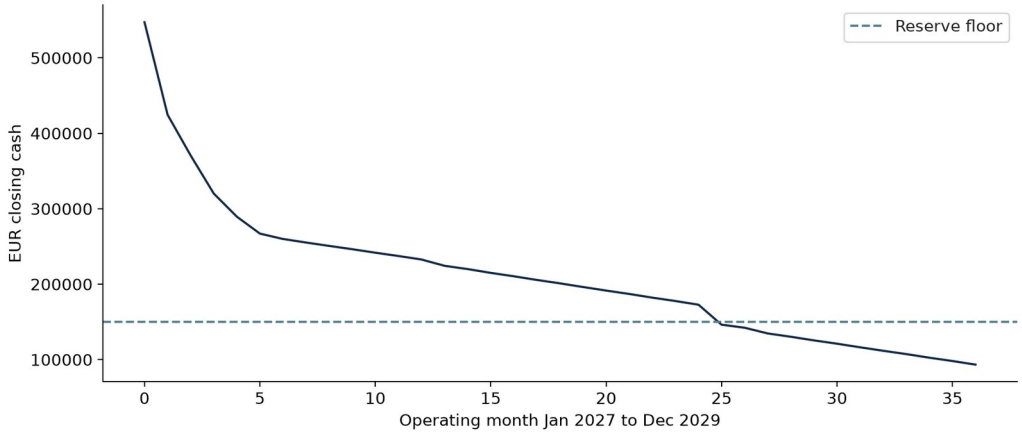
EUR	2027	2028	2029
Revenue	**1,320,699**	**1,524,396**	**1,567,892**
Gross food and care supplies	54,834	65,595	68,927
Gross contribution	1,265,865	1,458,801	1,498,965
Payroll and fixed overhead	1,421,775	1,464,428	1,508,361
EBITDA	**(155,910)**	**(5,627)**	**(9,396)**
Depreciation	59,500	59,500	63,070
Interest	17,240	15,104	12,604
Profit before tax	**(232,650)**	**(80,231)**	**(85,070)**
Tax budget provision paid	–	–	–
Net profit	**(232,650)**	**(80,231)**	**(85,070)**

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Cash flow and financial position

Base opening cash is EUR 547,331. Care claims are collected after 1 whole month, while payroll and gross operating expenses are paid in the service month. Donation income, when conditionally assumed in Upside, is received immediately; no donor receivable or pledge is booked. Minimum Basecash is EUR 93,441 and reserve gap EUR 56,559.

The cash bridge starts with net profit, adds depreciation and deducts the change in actual uncollected care claims. Gross capital spending and principal are separate. Negative cash is shown without an overdraft plug. Do not interpret uncommitted funding or a positive bank balance as fulfilment of the operator's 5% donation obligation.



Base monthly company cash includes all gross costs and claim delay; no VAT refund assumed.

EUR	2027	2028	2029
Operating cash flow	**(296,727)**	**(24,182)**	**(25,846)**
Gross capital spending	–	–	17,850
Principal repayment	17,857	35,714	35,714
Net cash change	(314,584)	(59,896)	(79,410)
Closing cash	**232,747**	**172,851**	**93,441**

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Cash flow forecast months one to six

These Base monthly values follow the actual linked operating statements. Care claims follow the whole-month collection lag. Opening cash rolls forward through operating cash, gross equipment spending and principal repayment to closing cash.

No donations are assumed in Base, no VAT recovery is booked and no financing plug hides a shortfall. Rebuild captured comparisons and refresh this document after changing any driver.

EUR	M1	M2	M3	M4	M5	M6
Opening cash	**547,331**	**424,602**	**370,607**	**320,195**	**289,531**	**267,075**
Operating cash flow	**(122,730)**	**(53,995)**	**(50,412)**	**(30,664)**	**(22,456)**	**(7,122)**
Gross capital spending	–	–	–	–	–	–
Principal repayment	–	–	–	–	–	–
Closing cash	**424,602**	**370,607**	**320,195**	**289,531**	**267,075**	**259,954**

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Cash flow forecast months seven to twelve

These Base monthly values follow the actual linked operating statements. Care claims follow the whole-month collection lag. Opening cash rolls forward through operating cash, gross equipment spending and principal repayment to closing cash.

No donations are assumed in Base, no VAT recovery is booked and no financing plug hides a shortfall. Rebuild captured comparisons and refresh this document after changing any driver.

EUR	M7	M8	M9	M10	M11	M12
Opening cash	**259,954**	**255,266**	**250,757**	**246,419**	**241,750**	**237,414**
Operating cash flow	**(1,712)**	**(1,533)**	**(1,362)**	**(1,692)**	**(1,360)**	**(1,691)**
Gross capital spending	–	–	–	–	–	–
Principal repayment	2,976	2,976	2,976	2,976	2,976	2,976
Closing cash	**255,266**	**250,757**	**246,419**	**241,750**	**237,414**	**232,747**

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Financial position summary

The balance sheet carries unrestricted company cash, uncollected care claims, the refundable lease deposit and net owned capital assets. It includes term debt, paid equity and retained earnings beginning after preparation expense. No donation pledge, subsidy promise, intangible clinical goodwill or property value is inserted.

Every monthly balance sheet, debt and cash roll-forward reconciles within EUR 0.01. Negative cash remains visible and signals that the plan is not financeable without intervention. The model does not establish charitable distributability or legal solvency.

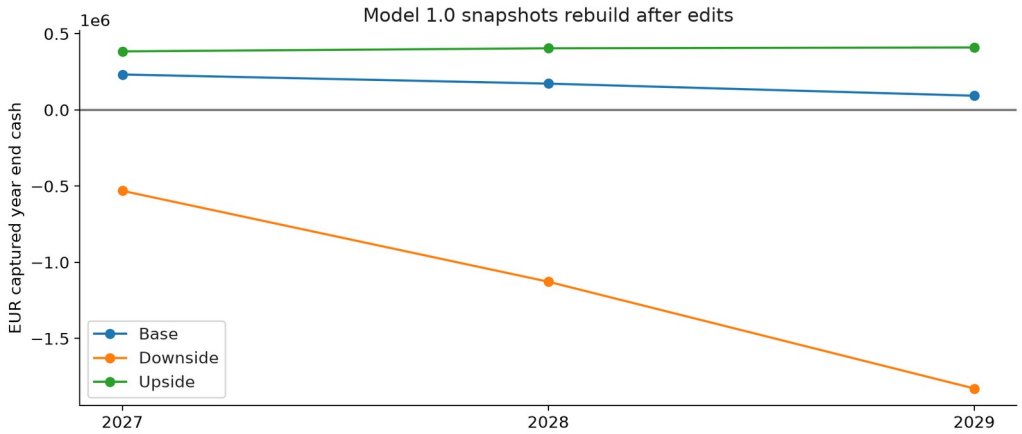
EUR	2027	2028	2029
Closing cash	**232,747**	**172,851**	**93,441**
Claims receivables	123,577	127,027	130,873
Refundable deposit	36,000	36,000	36,000
Net capitalised assets	416,500	357,000	311,780
Total assets	**808,824**	**692,878**	**572,094**
Term debt	232,143	196,429	160,714
Total liabilities	**232,143**	**196,429**	**160,714**
Paid equity	1,000,000	1,000,000	1,000,000
Retained earnings	(423,319)	(503,550)	(588,620)
Total equity	**576,681**	**496,450**	**411,380**
Liabilities and equity	**808,824**	**692,878**	**572,094**

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Break even and scenarios

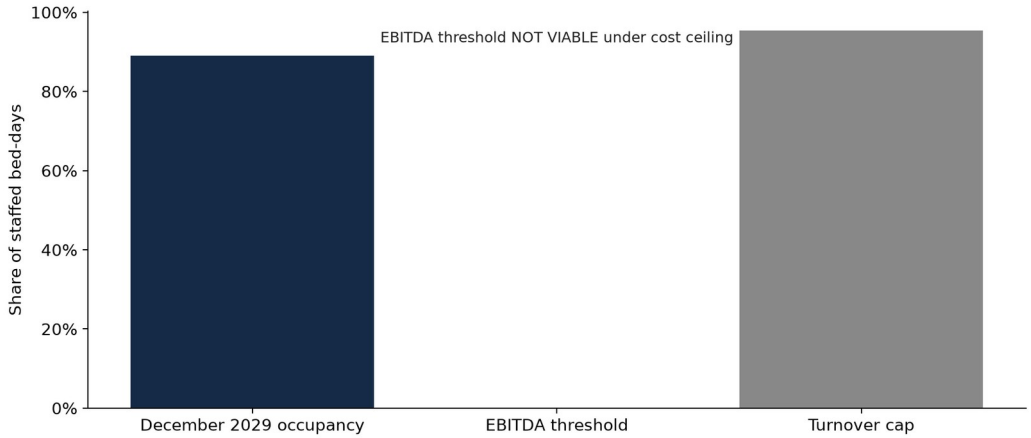
Base December 2029 EBITDA threshold occupancy is NOT VIABLE, with qualified staffed capacity 8 beds. This threshold excludes interest, tax, equipment and principal. A nonpositive bed-day contribution, closed staffed capacity or an eligible-cost ceiling that prevents the nominal threshold returns NOT VIABLE. Turnover and care eligibility still limit feasible occupancy.

Downside minimum cash is negative EUR 1,827,744 and the additional reserve funding gap is EUR 1,977,744 beyond proposed opening equity/debt. Upside changes occupancy tariff wages costs and assumes donor coverage of the remaining 5%, all uncommitted. Cases and Word are captured snapshots; edits to every driver, inactive case or calendar flag STALE CAPTURE. Rebuild before using comparisons.



Captured annual company cash EUR. Upside donation income is conditional and unsecured.

Case	2029 revenue	2029 EBITDA	Minimum cash	Reserve gap
Base	1,567,892	(9,396)	93,441	56,559
Downside	1,081,860	(620,914)	(1,827,744)	1,977,744
Upside	1,717,733	73,874	358,474	–



Base December 2029 EBITDA threshold and proposed occupancy share; excludes debt service.

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Model guide and completion

Use Inputs selector 1 Base,2 Downside or 3 Upside. Blue inputs drive Care, Staffing, Costs, AssetsDebt, Statements and Summary. Care revenue is bounded by finite staffed beds, actual calendar, demand and room turnover. Recognised care value is capped using the unvalidated planning eligible-cost share; actual regional cost allowability and settlement can differ. Claims are collected with a whole-month lag; no input VAT recovery is forecast for exempt care. Gross assets depreciate only to their original cost.

Cases and Word are captured snapshots. Every relevant driver and calendar change, including inactive case edits, flags STALE CAPTURE. Rebuild retained build_model.mjs and refresh Word. The US hospice reference inspired patient-days, care workforce and receivables; Medicare payment tiers, aggregate cap,USD and DCF were deliberately replaced by a Berlin charitable operator model. Clinical rota commissioning tax status and finance remain opening gates.