Hospital Business Plan

Madrid Elective Hospital

DOCUMENT GUIDE

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Madrid private elective hospital feasibility and proposed finance

All approvals, staffing appointments, premises, commercial rates and finance are unconfirmed. Read the scope and conditions before relying on the forecast.

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01 / OPERATIONS

Executive summary

Planning basis

A proposed private elective hospital in Madrid offers 24 overnight beds, two theatres and four consulting rooms. Adult low complexity surgery and related consultations are the planned scope. There is no emergency department, ICU, maternity, paediatric or oncology service. Case selection and escalation protocols require a credentialed clinical director. No site, company registration, credentials, approvals, payer contract, demand evidence or finance commitment has been supplied.

Action and model consequence

The decision is whether to fund site and clinical feasibility work before entering an unconditional lease. All major costs and tariffs are planning assumptions. The forecast includes fully paid preparation, owner governance and clinical teams. The downside must remain visible when funding sufficiency is assessed. The model is an economic planning tool and does not certify safe staffing or clinical suitability.

Captured model 1.0 on 2026-10-03. Base first year revenue EUR5,514,720, EBITDA EUR(3,789,921), and ending cash EUR7,953,345. Initial cash EUR13,590,000. Downside minimum cash EUR(8,439,479) requires additional unfunded cash EUR8,439,479 to reach zero and EUR11,439,479 to meet policy. All proposed finance remains uncommitted.

02 / OPERATIONS

Business details

Planning basis

Madrid Elective Hospital is a working name for a proposed Spanish sociedad limitada. The city is Madrid, Spain; the site and district remain unselected. Forecast currency is euros. Calendar years 2027 to 2029 include preparation from January and hypothetical first activity in July 2027 in Base. Downside opens in October. There is no established operating history or existing customer book.

Action and model consequence

An owner CEO will be accountable for finance, appointments, premises, supplier contracts and board reporting. A separately paid clinical director controls privileges, protocols and admission criteria. The proposed equity and debt are uncommitted. An address, tax number, company register entry, beneficial ownership, directors and hospital licence will be recorded only after independent confirmation.

03 / OPERATIONS

Business concept and objectives

Planning basis

The hospital would combine planned admission, surgery, recovery and short inpatient stays in one controlled pathway. The package includes surgical and anaesthesia labour, theatre use, ordinary bed care and routine related consumables. Consultations are separate encounters and exclude followups already paid in a package. Outsourced imaging and laboratory support will be contracted; no CT or MRI revenue or equipment is assumed.

Action and model consequence

The first objective is to establish a licensable, clinically feasible 24 bed design and a safe paid roster. The second is to validate net prices and real referrals against the model break even requirement. Expansion, additional beds and high acuity services are excluded until the first facility has demonstrated quality, reliable collections and cash resilience. Proposed targets are tests, not observed outcomes.

04 / OPERATIONS

Business model canvas

Planning basis

Customers are eligible adult elective patients and private insurers accepting the defined package. The proposed value is a coordinated scheduled pathway with transparent scope and followup. Channels are direct enquiries, insurer directories and ethical specialist referral relationships. Revenue is admission packages plus separate consultation fees. No public concession, capitated population or secured payer volume is assumed.

Action and model consequence

Key resources are licensed premises, paid clinical staff, functioning equipment and medical records. Key activities are assessment, selection, surgery, nursing, billing and safety review. Partners are accredited external diagnostics, receiving hospitals, transfer providers and suppliers. Costs are salaries, employer charges, rent, clinical inputs, capital, insurance and administration. Every partner commitment is still subject to contracting.

Business model canvas

Partners Paid diagnostics, transfer and receiving hospital, suppliers. Agreements unconfirmed.	**Activities** Assessment, safe elective surgery, 24 hour ward care, records and billing.	**Resources** Licensed 24 beds, two theatres, paid staff and finite clinical equipment.
Value Coordinated scheduled care with written package scope and discharge plan.	**Relationships** Consent, clinical continuity, clear financial obligations and complaints route.	**Channels** Direct enquiries and future payer listings; no committed referrals.
Customers Clinically eligible adult elective patients and accepted private payers.	**Costs** Full paid teams, rent, gross clinical inputs, capital, insurance and maintenance.	**Revenue** Admission package and separate consultations; no duplicate followup fees.

Planning framework generated from retained narrative. No measured competitor or demand scores.

05 / OPERATIONS

SWOT and longer term goals

Planning basis

Proposed strengths are a limited elective scope and a single accountable clinical pathway. These are design choices rather than demonstrated quality. Weaknesses are an unknown site, no proven referral base, large fixed payroll and dependence on scarce clinical hires. The opportunity is to test whether patients and payers value the offer at sustainable net prices. Competition, licensing delay and complication costs are threats.

Action and model consequence

By year three the facility should either demonstrate sustained safe performance and collection discipline or revise the offer. Additional theatres, beds or clinical complexity require new licensing, capital and paid staffing. The forecast has no speculative expansion value. The board should avoid rewarding occupancy alone where the clinical director requires fewer admissions for safe care.

Provisional SWOT

Strengths	Weaknesses
Focused elective scope; separately paid clinical governance. Design choices only.	Unknown site, no validated demand, fixed payroll and scarce recruitment.
Opportunities	**Threats**
Test a coordinated package with eligible patients and private payers.	Licence delay, wage pressure, complications, rejected tariffs and slow collections.

Planning framework generated from retained narrative. No measured competitor or demand scores.

06 / OPERATIONS

TOWS strategy matrix

Planning basis

Use the focused scope to negotiate package definitions before making price claims. Pair governance investment with explicit emergency transfer criteria to reduce the risk of accepting unsuitable cases. Address the absent referral book by obtaining nonbinding payer discussions and documented prospective clinician referral interviews; these are validation work, not committed demand.

Action and model consequence

Respond to fixed cost exposure with staged decisions before an unconditional lease, rather than assuming nurses and doctors can work unpaid. Test opening delay, reduced tariffs, longer stays and increased clinical cost together in Downside. Owner and clinical director will review the findings before site commitment. Contracted transfer and receiving arrangements remain a launch requirement.

TOWS actions

Strengths with opportunity

Clinical director validates permitted case matrix before payer discussions.

Strengths against threat

Defined scope and paid transfer prevent unsupported high acuity growth.

Weakness with opportunity

Test referrals and net fees before unconditional premises commitments.

Weakness against threat

Maintain full pay and stress delayed opening; do not borrow automatically.

Planning framework generated from retained narrative. No measured competitor or demand scores.

07 / OPERATIONS

Owner and management

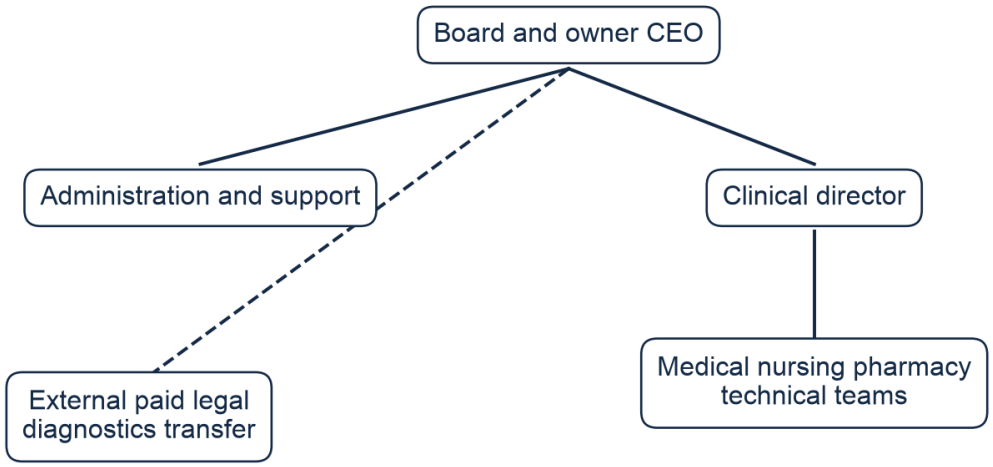
Planning basis

The owner CEO receives full gross pay of EUR 140000 annually in every case before escalation, plus the employer cost allowance. No clinical capacity is credited to that role. The clinical director is separately paid EUR 150000 and controls admissions, credentialing, clinical audits and escalation. The proposed pharmacy lead is also separately paid. Actual appointments and ownership percentages are unknown.

Action and model consequence

The CEO oversees administration, support and procurement. The clinical director oversees specialists, anaesthetists, resident physicians, ward nurses and theatre recovery teams. External legal, accounting, privacy, diagnostics and transfer support are paid services with contractual deliverables. The board must define authority to suspend admissions even when this harms revenue. No founder credentials are invented.

Proposed organization Full paid governance and external support



Planning framework generated from retained narrative. No measured competitor or demand scores.

08 / OPERATIONS

Owner and key personnel profiles

Planning basis

Required profiles include hospital governance, cash management, clinical leadership, elective surgical expertise, anaesthesia, resident ward care, nursing leadership, pharmacy and sterile processing. Individual names, qualifications, registrations, employment history and references have not been provided. Recruitment criteria should be confirmed with the clinical director and regional licensing advisor.

Action and model consequence

Verify professional registration, privileges, competence, indemnity, fit for duty, background checks and lawful work eligibility before appointment. Record actual paid availability and shift restrictions. Employer salary assumptions are recruitment budgets, not evidence that candidates exist at those rates. The owner may not provide medical care without independently verified qualifications and privileges.

09 / OPERATIONS

Target customers

Planning basis

The primary hypothesis is eligible adults in Madrid who need low complexity elective inpatient surgery and have verified private funding or insurer coverage. A secondary segment is adults requiring related specialist consultation. Inclusion depends on clinician assessment, procedure suitability and a safe discharge plan, not ability to pay alone. Complex and urgent conditions are excluded.

Action and model consequence

Purchase occasions are a planned assessment and a later elective admission where clinically indicated. The plan does not convert public waiting lists into private paying demand. Catchment travel times, patient willingness to pay, insurer approval and referral habits require fieldwork. Billing staff must confirm package coverage and patient obligations before scheduling.

10 / OPERATIONS

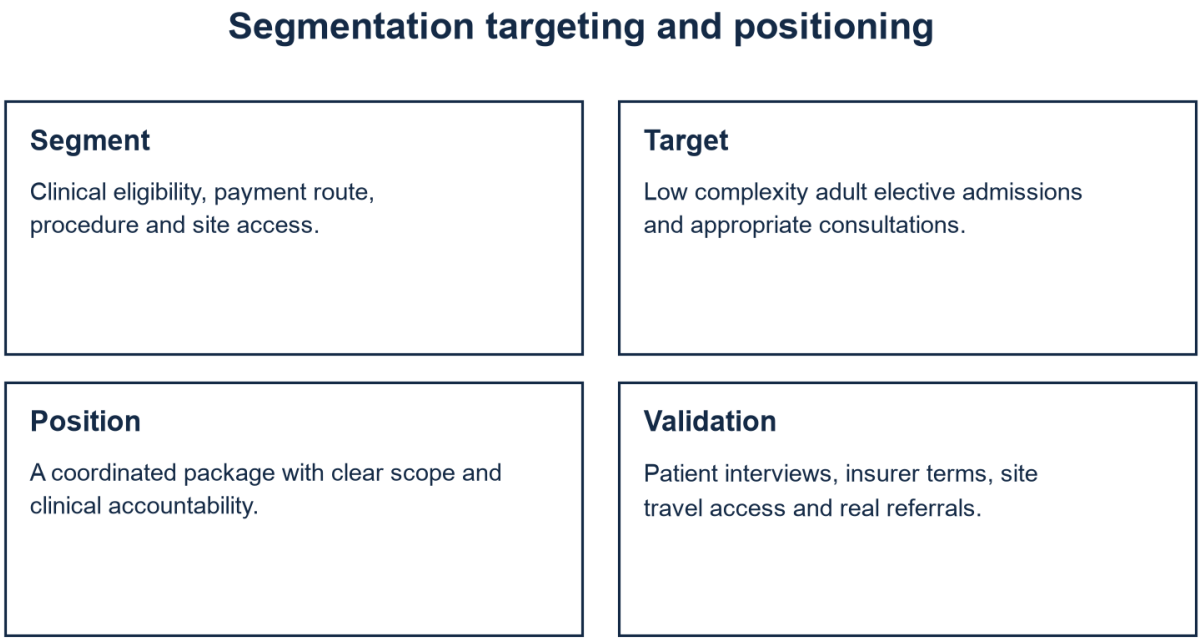
Segmentation targeting and positioning

Planning basis

Segment prospective patients by clinical eligibility, payment route, procedure pathway and travel access. Prioritise low complexity elective cases with a short anticipated stay and clearly priced package. Separate consultations from packaged aftercare. Insured and self paying patients may face different authorization and collection processes but are not assigned invented market shares.

Action and model consequence

The positioning hypothesis is a coordinated, clearly scoped scheduled care pathway with responsive communication. It must be demonstrated through verified outcomes, appropriate consent and reliable followup. Validation should compare coverage, booking steps and package exclusions against real alternatives. No superior clinical outcomes or faster access are claimed before evidence exists.



Planning framework generated from retained narrative. No measured competitor or demand scores.

11 / OPERATIONS

Value proposition canvas

Planning basis

The customer profile has three explicit facets. Jobs are understanding clinical suitability, arranging payment and recovering around work and family responsibilities. Pains may include unclear exclusions, disconnected records and uncertain discharge contact. Gains may include a clear pathway, predictable package scope and knowing whom to contact. These are interview hypotheses; no measured customer preference or clinical outcome is claimed.

Action and model consequence

The proposed value map has three corresponding facets. Products and services are the admission package, separately billed consultations, assessment and discharge pathway. Pain relievers are written inclusions, coordinated records and a documented escalation/contact route. Gain creators are explained scheduling, discharge criteria and continuity information. These promises rely on the fully paid 98 FTE team including clinical governance, gross IT capital and recurring support, and paid external transfer and diagnostic budgets. All remain conditional on verified appointments, contracts, licences and actual capacity. Test patient comprehension before offering them.

Value Proposition Canvas Proposed service fit

Jobs	Pains	Gains
Understand suitability, arrange payment and recover around work and family obligations.	Unclear exclusions, disconnected records and uncertain discharge contact.	Clear care pathway, explained scope and a known contact route.
Products and services	**Pain relievers**	**Gain creators**
Admission package, separate consultations, assessment and discharge. Fully paid clinical team.	Written inclusions, coordinated records and escalation route. IT and paid external support budgets.	Scheduling explanation, discharge criteria and continuity information. Paid governance and transfer budgets.

Planning framework generated from retained narrative. No measured competitor or demand scores.

12 / OPERATIONS

Market size and trends

Planning basis

TAM is annual Madrid region spending on clinically eligible private elective surgery and related consultations, excluding nonclinical services and public care. SAM is the portion accessible to the chosen Madrid site under the authorized offer and payer contracts. No defensible buyer count, spend estimate or catchment has been obtained. TAM and SAM are therefore unavailable, not zero.

Action and model consequence

The model provides a capacity constrained forecast of admissions and consultations; this is an obtainable sales hypothesis and cannot establish market share. Use one common calendar year and qualifying clinical service euro basis when evidence becomes available. Validate payer tariffs and demand independently before assigning a share. Population alone is insufficient to determine the spending pool.

Market scope and sizing status

TAM Madrid region

Annual eligible private elective surgery and related consultation spend. Amount unavailable.

SAM chosen Madrid site

Licensed scope, practical access and accepted payer contracts. Amount unavailable.

SOM forecast

Capacity constrained planning revenue in euros for 2027 to 2029; no validated market share.

Method required

Buyer counts, annual spend, catchment, clinical eligibility and tariffs on one common basis.

Planning framework generated from retained narrative. No measured competitor or demand scores.

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PESTLE analysis

Planning basis

Madrid regional approval is the main political and legal gate. Economic exposure comes from fixed salaries, rent, financing and unagreed tariffs. Social exposure includes trust, informed choice and discharge support. Technology requires reliable medical records, sterile equipment and paid maintenance. Environmental obligations include controlled clinical waste and energy intensive facilities.

Action and model consequence

The response is to keep authorization, clinical roster, transfer and funding gates editable and separate. The board should challenge longer preparation, reduced productivity and higher input cost in Downside. Source R 1 describes prior authorizations, R 2 provides the national framework, R 5 informs employer cost context and R 6 covers patient records. These sources do not establish demand or prices.

Madrid hospital PESTLE

Political

Regional clinical unit authorization before opening. R1 R2.

Economic

Fixed payroll, unquoted capital and unagreed net payer tariffs.

Social

Trust, informed choice, eligibility and discharge support. Hypotheses.

Technology

Records, sterilisation, equipment uptime and paid finite renewals.

Legal

Licensing, consent, employment, pharmacy and conditional VAT. R1 R3 R6.

Environmental

Clinical waste and energy intensive premises; budgets need quotes.

Planning framework generated from retained narrative. No measured competitor or demand scores.

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Local demand and evidence

Planning basis

No patient interviews, payer letters, physician referral logs, local observations or waiting list conversion studies have been supplied. The starting monthly requests and ramp in the workbook are explicit planning hypotheses. Capacity charts show forecast supply constraints and must not be labelled as observed local demand.

Action and model consequence

Before signing a lease, commission interviews with eligible patients and potential payers, record dates and recruitment method, and review referral routes without inducements. Use anonymous aggregate information and obtain privacy review. The outcome should confirm or reject prices, procedure mix, access and likely bookings. Positive expressions of interest are not recognized revenue or finance commitments.

Demand evidence and forecast status

Available evidence

Official regulatory sources and template references; no prospective patient observations.

Unavailable evidence

Payer tariffs, referral logs, interviews, bookings, competitor prices and site study.

Request hypothesis

Base 90 admissions at opening plus 4 monthly;800 requested consultations plus 25 monthly.

Supply constraint

Actual dates, 24 beds, 2 theatres and separate paid specialist hours cap delivered encounters.

Planning framework generated from retained narrative. No measured competitor or demand scores.

15 / OPERATIONS

Competitors and positioning

Planning basis

Alternatives include established private hospitals, specialist outpatient providers and public care. The official Madrid register can establish authorization and scope but does not establish comparative prices, outcomes or patient preference. The plan deliberately has no invented competitor rating, tariff comparison or claimed shortage. The site has not been selected, so a local catchment comparison is incomplete.

Action and model consequence

Create a dated comparison after site selection using official provider disclosures and written payer information. Compare authorized procedure scope, package inclusions, booking process and travel access. The hospital should compete through a defined pathway that it can safely deliver and finance. No volume premium is attributed to branding alone.

16 / OPERATIONS

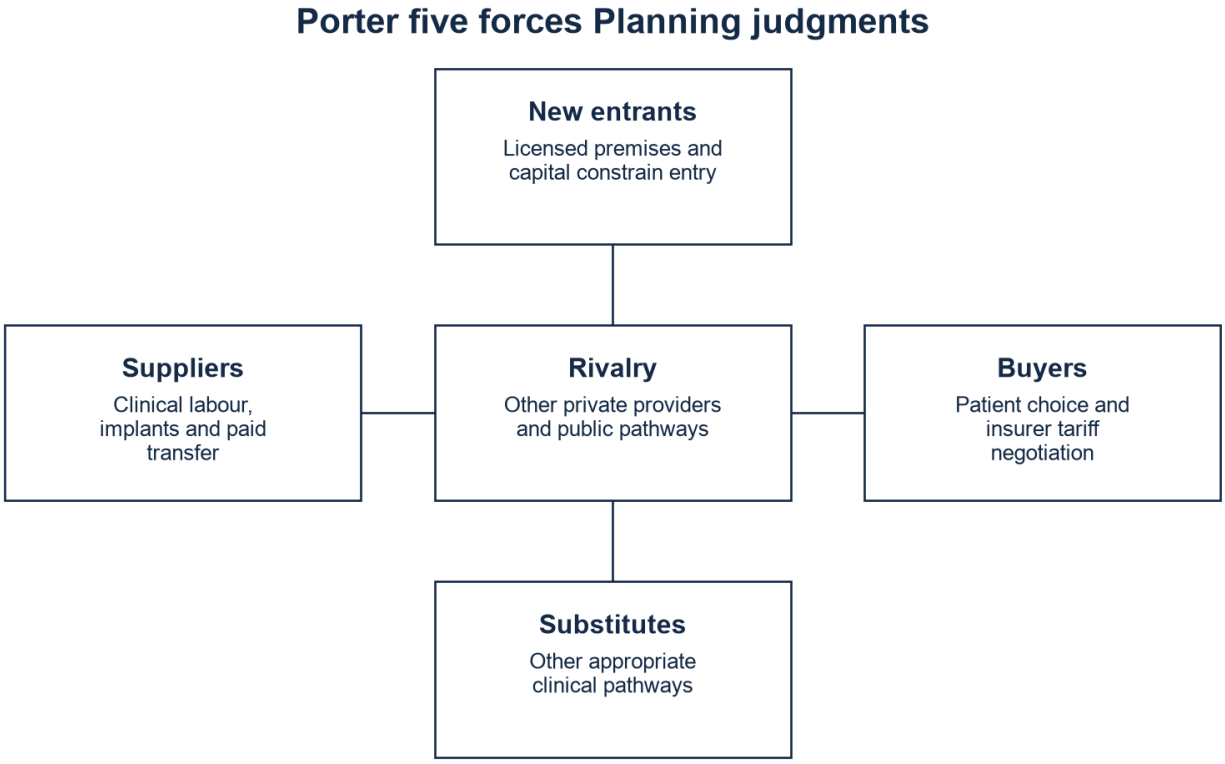
Porter five forces

Planning basis

Rivalry and substitutes are provisionally high because patients and payers can choose other private providers or public pathways. Payer bargaining is potentially high where a concentrated insurer negotiates tariff and coverage. Clinical labour supplier power is high for a new hospital recruiting scarce specialists. Entry is constrained by licensed premises, clinical staff and major capital. These are analytical judgments, not measured market scores.

Action and model consequence

Respond by validating net contracts and collections rather than gross list charges. Keep direct clinical inputs and full wages explicit. Limit the launch scope, contract critical transfers and diversify payer exposure only with evidence. The model combines lower prices, higher costs, longer stay and delayed opening in Downside to test these pressures.



Planning framework generated from retained narrative. No measured competitor or demand scores.

17 / OPERATIONS

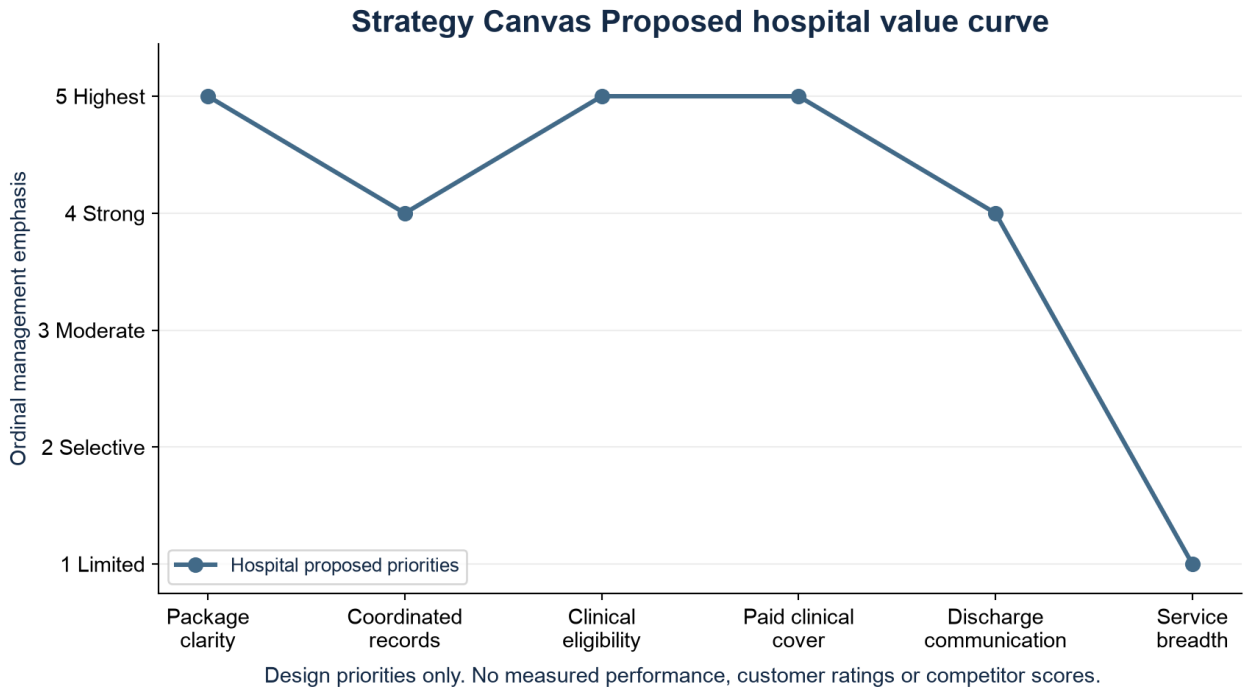
Strategy canvas

Planning basis

The value curve shows only the hospital's proposed design priorities on an ordinal scale from 1 (limited emphasis) to 5 (highest emphasis). Package clarity, clinical eligibility and paid clinical cover rank 5; coordinated records and discharge communication rank 4; service breadth ranks 1 because the funded concept deliberately restricts care to low complexity adult elective pathways. The ranks express relative management emphasis, not measured performance, spending proportions, clinical quality or patient preference. No competitor is rated.

Action and model consequence

The curve is tied to the funded assumptions: separately paid clinical governance and full team payroll support clinical cover and eligibility; IT capital and recurring support fund records; paid external support and transfer budgets support the discharge/escalation pathway. Full pay applies in preparation, and activity remains constrained by licensing, asset and paid-hour gates. An ordinal rank cannot relax any safety or authorization requirement. Validate the choices with patients and actual commercial/clinical evidence before making comparative claims. No premium price or superior outcome is assumed.



Planning framework generated from retained narrative. No measured competitor or demand scores.

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Location and premises

Planning basis

The planning footprint is a leased refurbished hospital building of approximately 3000 square metres in Madrid with 24 beds, two theatres, recovery, sterile processing, pharmacy, consultation rooms and separate patient/staff/service flows. This is an unquoted specification, not an available site. Monthly gross rent is EUR 70000 in Base and a EUR 300000 refundable deposit remains held throughout the forecast.

Action and model consequence

Commission a licensability, fire, accessibility, infection prevention, medical gas, ventilation, power resilience and waste assessment before accepting the lease. Obtain landlord permissions and define fitout ownership, break rights, reinstatement and service obligations. Site approval must match the actual clinical offer. No premises value is treated as owned collateral.

19 / OPERATIONS

Equipment and resource plan

Planning basis

Original installed fitout is budgeted at EUR 10 m, clinical equipment EUR 3 m and IT equipment EUR 0.5 m in Base, all unquoted gross costs paid before forecast. There is no CT, MRI or ICU equipment revenue assumption. Routine diagnostic support is outsourced within direct case cost or the standby retainer. No intangible is created from recruitment, design or launch payroll.

Action and model consequence

Assets have finite zero residual lives: 180 months fitout, 84 clinical equipment and 36 IT. One explicit paid renewal cohort for each is available at original expiry, with a finite renewal life. No perpetual free replacement exists. If an original or funded replacement is unavailable, the asset gate prevents activity. Shortened lives and zero renewals are meaningful model tests.

20 / OPERATIONS

Clinical service strategy

Planning basis

The clinical offer replaces the template menu: low complexity adult elective surgical admissions and related specialist consultations. The clinical director must define permitted procedures, comorbidity exclusions, anaesthetic criteria and expected stay before any marketing. A tariff includes ordinary care, surgery and anaesthesia; consultations already included as followup cannot also be billed as separate visits.

Action and model consequence

Complex surgery, emergency admission, ICU, maternity, paediatrics and oncology are excluded. External imaging does not generate a separate fee in this model. Case escalation beyond scope requires paid transfer and a receiving hospital agreement. The model uses an average case, so the real procedure matrix and high cost implants must be costed before booking.

21 / OPERATIONS

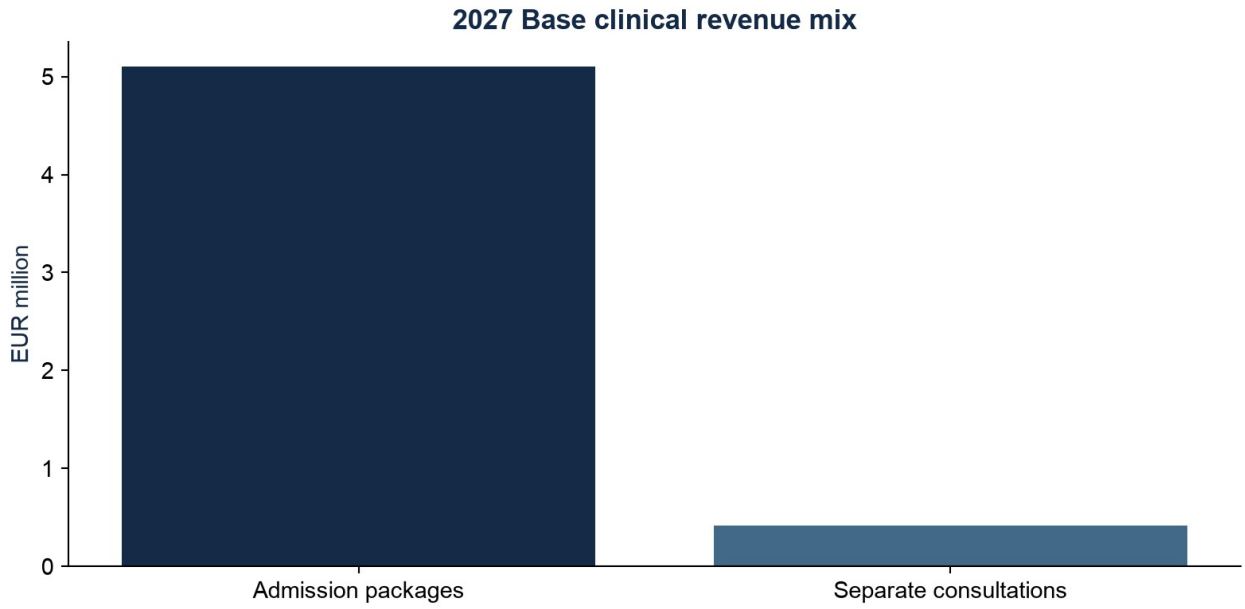
Pricing and encounter economics

Planning basis

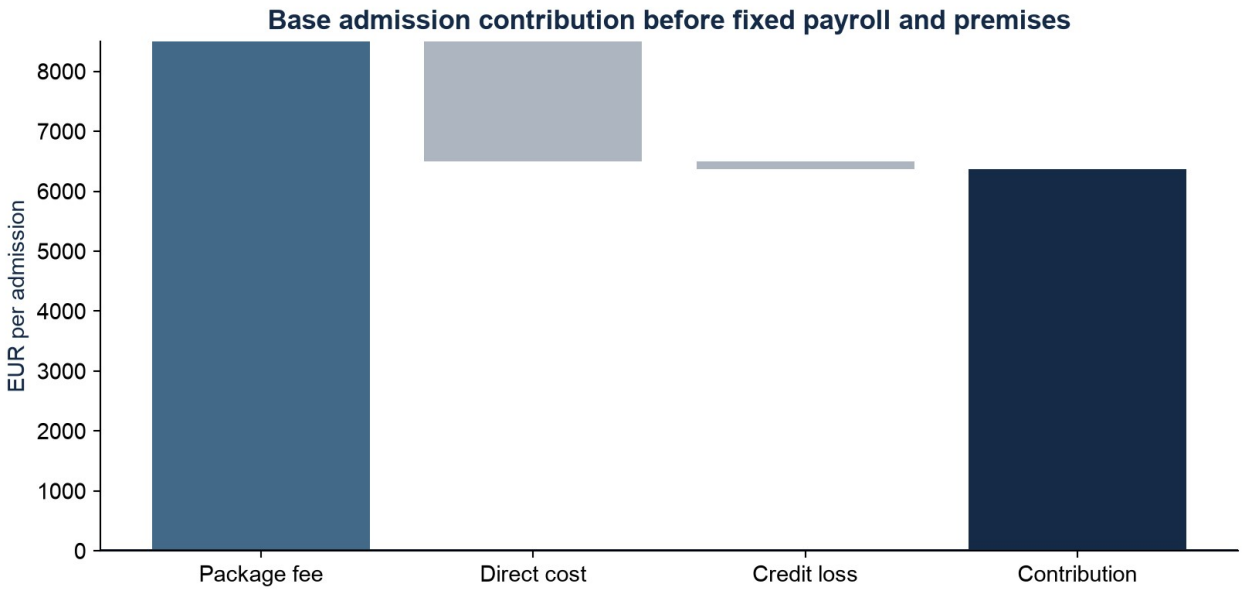
Base admission package EUR 8500 and consultation EUR 160 are net clinical fee assumptions with no payer quotation. Direct gross costs are EUR 2000 per admission and EUR 25 per consultation before escalation. Package revenue includes employed surgical and anaesthesia work, which remains separately expensed in payroll. There is no doctor fee pass through or duplicate bed day charge.

Action and model consequence

Qualifying clinical VAT exemption is assumed conditionally under R 3. A tax advisor must confirm private establishment and price communication conditions; nonclinical/cosmetic sales are excluded. Costs and capex include irrecoverable input VAT. Expected credit loss is an operating expense and is excluded from collected receivables. Break even must cover fixed clinical, owner, premises and governance costs.



Captured numerical forecast from model 1.0 checked 2026-10-03 EUR.



Captured Base model 1.0 2026-10-03 Numerical units shown on figure.

22 / OPERATIONS

Comparable tariff evidence

Planning basis

No valid competitor tariff or insurer reimbursement schedule has been collected. The quoted-looking workbook prices are planning inputs only. A hospital list charge is not a net contracted collection, and package inclusions can differ sharply. Do not present these assumptions as a low price or premium against a named competitor.

Action and model consequence

Obtain written scope matched comparisons for permitted procedures and consultations, including surgeon, anaesthesia, implants, bed days, tests, complications and followup. Record source date and exclusions. Payer discussions should establish authorization, denial rules and payment timing. Until then, Downside tests lower fees with longer stay and higher purchased clinical inputs.

23 / OPERATIONS

Brand and customer experience

Planning basis

The working name is a descriptive placeholder. Proposed experience standards are clear clinical suitability information, written financial obligations, understandable consent, documented discharge advice and an accessible complaints route. Marketing will not promise cure, comparative quality or access times without evidence. Licensed identity and register number must be verified before public clinical promotion.

Action and model consequence

The administrative team handles enquiries and invoices while clinical decisions remain with credentialed professionals. No salesperson can override an exclusion or discharge decision. Retention means continuity and appropriate followup, not unnecessary repeat procedures. Patient privacy and vulnerable decision making require staff training and a clear escalation route.

24 / OPERATIONS

Sales channels and process

Planning basis

Direct enquiries, future insurer listings and lawful clinician relationships are proposed channels; none carries committed demand. An enquiry becomes a consultation only after identity, clinical suitability and funding checks. An admission requires clinician approval, appropriate consent, approved package and scheduled capacity. The model has no patient deposit liability and no public service contract.

Action and model consequence

Revenue is recognized for delivered encounters; collections occur partly current month and partly next month. The assumed credit loss reduces cash and receivables through expense. Administration must track denials, documentation and aging separately from clinical records. Referrals may not be bought through undisclosed inducements. Patient safety can reduce admissions even when demand exceeds capacity.

25 / OPERATIONS

Launch marketing

Planning basis

Base marketing is EUR 8000 monthly throughout preparation and service, plus setup work already included in preforecast expense. The budget is unquoted. Proposed work includes accessible patient information, a scope accurate website, enquiry handling and insurer credentialing materials. No paid referral fees or clinical claims based on invented outcomes are planned.

Action and model consequence

Before launch, the owner and clinical director review wording against the licensed units and medical advertising requirements. Monitor qualified enquiries, assessed eligibility, scheduled encounters and collection; do not confuse enquiries with admissions. The budget does not guarantee bookings. Downside decreases marketing but also delays opening and reduces tariff, creating a combined adverse case.

26 / OPERATIONS

Retention and ongoing sales

Planning basis

The priority is clinically appropriate continuity, clear followup and discharge coordination. Routine followup covered by the admission package is not additional consultation revenue. Subsequent independent encounters require a documented clinical need and a separate billing basis. No assumed repeat surgery rate, loyalty discount or guaranteed insurer renewal drives the forecast.

Action and model consequence

Review complaints, cancellations, patient information comprehension and collection disputes. Contact policies must respect consent and privacy, with clinical records accessible only to appropriate staff. Ask payers about package quality and billing accuracy. Monthly request growth remains a hypothesis until actual eligible referrals and collections support a revised forecast.

27 / OPERATIONS

Daily operations and suppliers

Planning basis

Before elective lists, confirm case suitability, staff roster, theatre function, sterile stock and receiving arrangements. During 24 hour ward operation, nursing and resident doctors need paid breaks, leave and escalation cover. The model uses productive annual hours and a baseline of two registered nurses plus one resident doctor around the clock; this is a planning check, not a certified safe ratio.

Action and model consequence

Paid external services cover transfer standby, pharmacy relief and diagnostic availability within explicit budgets. Direct clinical inputs include case specific supplies, implants and routine outsourced tests. Supplier credit applies only to direct clinical cost; rent, wages and routine services are paid monthly. Track batch traceability, controlled medicines, sterile processing and backup suppliers. Actual shift-by-shift overlap needs clinical approval.

28 / OPERATIONS

Sustainability practices

Planning basis

Separate clinical waste and ordinary waste under specialist contractor instructions, maintain medicines and sharps controls, and record waste volumes. No unsupported recycling rate or savings benefit is assumed. Ventilation, sterile processes and medical gases take priority over energy reduction where clinical safety requires them. Utilities remain a substantial explicit monthly cost.

Action and model consequence

Assess procurement packaging, reusable instruments within validated reprocessing, water and HVAC performance after commissioning. Costs of compliant waste services form part of direct clinical and service budgets and require quotations. No carbon credit income or green financing is assumed. Environmental claims should be backed by measured site data and a defined reporting boundary.

29 / OPERATIONS

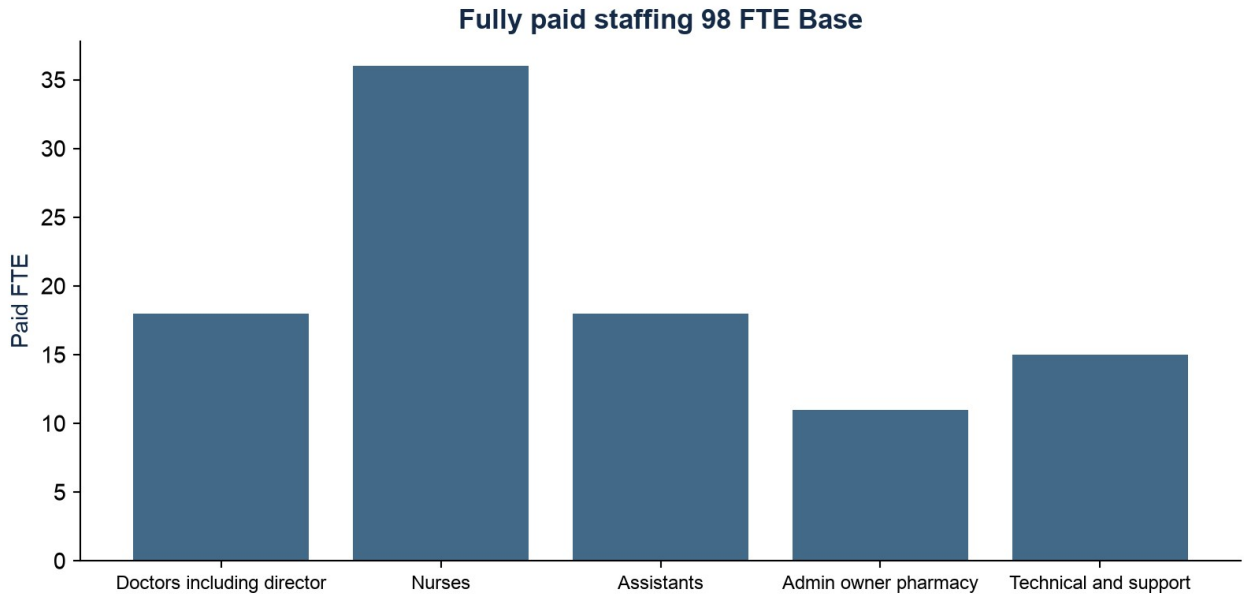
Staffing and training

Planning basis

The paid team includes owner CEO, clinical director, pharmacy lead, 6 surgical specialists, 3 anaesthetists, 8 resident physicians, 24 ward nurses, 12 theatre/recovery nurses, 18 assistants, 9 administrative staff, 3 technical staff and 12 support staff. Every role is fully paid through preparation. The total is 98 FTE; there is no volunteer clinical cover. Salary budgets, contract patterns and candidates are unverified.

Action and model consequence

Annual 1800 paid hours per employee and 80% productive availability in Base leave a planning buffer for leave, training and sickness. Specialist productive hours split 30% consultations and 70% theatre, preventing double counting. Ward nursing hours cap bed-day support; residents must cover all calendar hours. Theatre staffing, anaesthesia and physical slots separately constrain admissions. Credentialing, simulation and emergency drills precede launch.



Captured numerical forecast from model 1.0 checked 2026-10-03 EUR.

30 / OPERATIONS

Staff skills and fair work

Planning basis

Core skills are clinical assessment, infection prevention, safe medication, sterile processing, records, billing and respectful communication. Qualifications and privileges must be verified rather than assumed from the salary line. Shift work, oncall, annual leave and working-time compliance require a real roster. Employee consultation and applicable collective agreement review should occur before contracts are issued.

Action and model consequence

The 34% employer and benefits allowance is a conservative planning load, not an exact statutory contribution calculation. R 5 gives contribution context; ceilings, solidarity charges, contract classification and occupational risk premiums vary. Paid training and relief cannot be treated as free capacity. The clinical director must confirm the available-hour buffers are sufficient for the actual procedure mix and nights.

31 / OPERATIONS

Legal and insurance requirements

Planning basis

Regional installation and functioning authorization must cover the exact clinical units before activity; pharmacy arrangements require additional documentation (R 1, R 2). The owner must verify premises, company, tax and employment registrations. Consent and clinical records obligations follow R 6; privacy review, lawful record retention and access controls require qualified advice. No approval is represented as complete.

Action and model consequence

Insurer acceptance must match elective scope, transfer, staff privileges and exclusions. Malpractice, employer, property, cyber and business interruption budgets require quotations. Medical VAT exemption must be established under R 3 before relying on the net fee basis. A denied authorization or inadequate roster should switch the relevant forecast gate to zero while costs and debt obligations remain visible.

Requirement	Evidence and status
Clinical units and pharmacy	R1 R2 Not approved
Consent clinical records privacy	R6 Procedures and counsel pending
Clinical employer property cyber cover	No policy or quote
VAT and payroll classification	R3 R5 Advisor confirmation pending

32 / OPERATIONS

Opening roadmap

Planning basis

January 2027 begins fully paid preparation in the planning model. Site assessment, licensing advice and financing diligence precede unconditional property commitments. Recruit management and clinical teams, complete fitout, validate records and sterile processes, negotiate transfer and payer terms, and complete commissioning. No opening schedule is an administrative guarantee.

Action and model consequence

Base service starts July 2027 only if all four editable gates and asset/clinical capacity tests are met. Downside starts October. The gate defaults of 1 mean a hypothetical readiness case, not actual approvals. Failure stops all clinical revenue while paid teams, rent, maintenance, debt service and taxes continue. The board must fund delay or change the proposal before commitments are made.

33 / OPERATIONS

Risks and management actions

Planning basis

The largest risks are unvalidated tariffs/referrals, unsafe or unavailable staffing, licensing delay, complication/transfer exposure, gross capital cost overruns and slow payer collections. A clinically unsuitable patient must be refused or redirected even when this reduces cash. A forecast that depends on unpaid owner or night cover is unacceptable.

Action and model consequence

Assign clinical eligibility and quality to the clinical director; assign cash, contracts and premises to the owner CEO. Review actual roster capacity, payer denials, costs and liquidity monthly. Downside combines adverse changes; isolated input tests examine each major mechanism. Negative cash is an unfunded financing requirement, not an automatic overdraft. Reserve shortage must be discussed before opening.

34 / OPERATIONS

Research and evidence

Planning basis

Research is limited to official Spanish and Madrid regulatory sources checked 3 October 2026. It establishes authorization and tax/employment context, not site feasibility, customer demand, comparative outcomes, actual wages or tariffs. The Sources register records URLs and interpretation. The retained research folder separates assumptions from facts and contains no invented supplier quotation.

Action and model consequence

Actual approved blank Word template and accepted Common Cup pilot were inspected. The hospital workbook reference was inspected in openpyxl and its design notes reviewed. Capacity, labour, working capital, asset and debt schedules inspired the rebuilt model; US Medicare, Medicaid, 340 B and municipal bond assumptions were excluded. This is a rebuilt Spain forecast, not an imported hospital template.

R 1 Madrid authorization procedure https://sede.comunidad.madrid/autorizaciones-licencias-permisos-carnes/autorizacion-centros-sanitarios Checked 2026-10-03. Prior installation and functioning authorization; offered clinical units determine classification; pharmacy units require additional documentation; no approval held.

R 2 National healthcare centre authorization framework https://www.boe.es/buscar/act.php?id=BOE-A-2003-19572 Checked 2026-10-03. National classification and authorization framework; specialist elective inpatient offer needs regional confirmation.

R 3 Spanish VAT Law consolidated https://www.boe.es/buscar/act.php?id=BOE-A-1992-28740 Checked 2026-10-03. Article 20 medical/hospital exemptions subject to applicable conditions; assume qualifying clinical services only, adviser must establish price communication and exemption; no cosmetic/nonclinical taxable income.

R 4 Spanish corporation tax rates https://sede.agenciatributaria.gob.es/Sede/impuesto-sobre-sociedades/que-base-imponible-se-determina-sociedades/tipo-impositivo.html Checked 2026-10-03. Rates vary by company and period. Conservative 25% positive monthly PBT cash provision omits relief and special rates, not filed liability.

R 5 Social Security contribution overview https://www.seg-social.es/wps/portal/wss/internet/Trabajadores/CotizacionRecaudacionTrabajadores/10721/10957/583?changeLanguage=es Checked 2026-10-03. Employer common contingency 23.60% plus other contributions; model 34% gross salary total allowance deliberately conservative and unverified for specific salary/contract mix.

R 6 Patient autonomy and clinical records law https://www.boe.es/buscar/act.php?id=BOE-A-2002-22188 Checked 2026-10-03. Information, consent and clinical records obligations inform paid clinical governance and record controls.

R 7 Madrid authorized centre register https://www.comunidad.madrid/salud/registro-centros-servicios-establecimientos-sanitarios Checked 2026-10-03. Use official register to validate competing scope and eventual own registration. No competitor price/quality ranking inferred.

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Quotes and assumptions

Planning basis

No supplier, landlord, lender, insurer or payroll quotation is available. Obtain written costs for the licensable building, fitout, theatres, sterile processing, clinical IT, insurance, transfer, diagnostics and recruitment. Quotes must specify tax, payment dates, installation, maintenance, warranty and replacement needs. The model deliberately treats capital and purchased costs as gross with no input VAT recovery.

Action and model consequence

Validate admission package scope against actual case costs and credentials before booking. If quotes or roster costs change, update the dated case inputs and refresh the linked workbook, results and Word financial section together. Any static printed figure is a captured version and becomes stale after inputs change. Do not use the package as a financing commitment or certified staffing plan.

36 / FINANCE

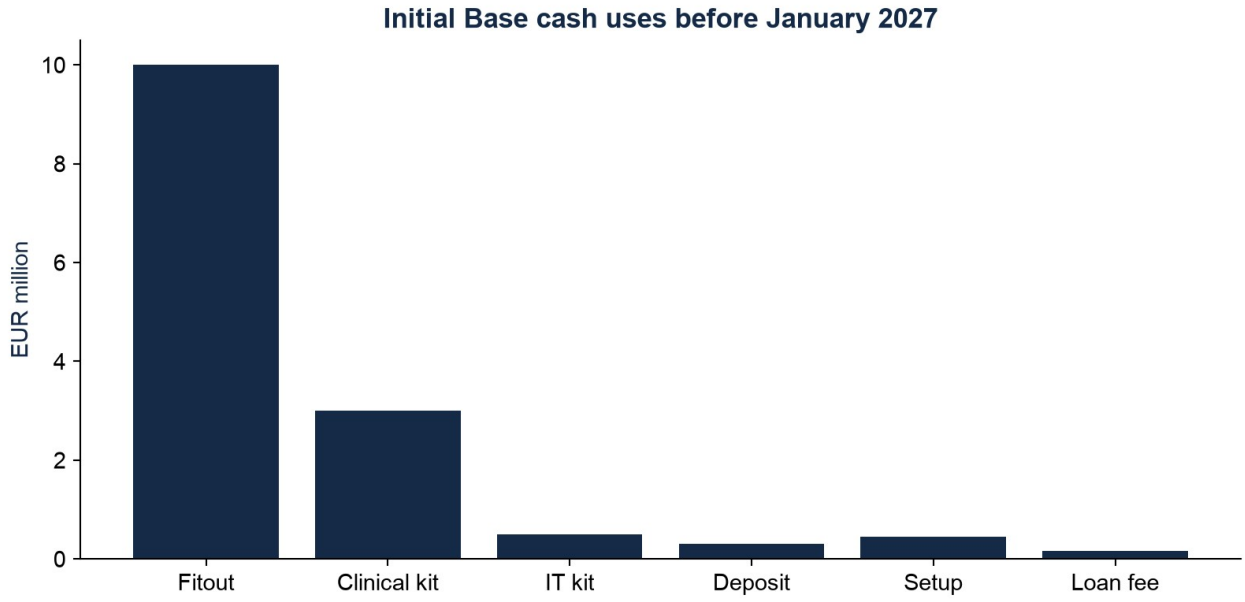
Startup costs and funding

Planning basis

Proposed financing is fixed EUR 20 m equity and EUR 8 m debt drawn before the forecast. Neither is approved. Initial fitout, equipment, IT, deposit, setup and financing fee are paid before January 2027. There is no balancing cash injection. Preparation payroll, rent and services then consume monthly cash until service begins.

Action and model consequence

Assess startup uses together with the lowest monthly cash through December 2029, not only day-one cost. The unrestricted reserve policy is EUR 3 m, a liquidity target rather than an expense. A policy shortfall and a negative cash gap are separate findings. No security valuation, personal guarantee or leasehold value is treated as available cash.



Captured numerical forecast from model 1.0 checked 2026-10-03 EUR.

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Itemized startup costs

Planning basis

Original gross fitout EUR 10 m, clinical equipment EUR 3 m, IT equipment EUR 0.5 m and refundable premises deposit EUR 0.3 m are planning inputs. Setup design/legal/recruitment expense EUR 0.45 m and debt arrangement fee 2% of EUR 8 m are separately expensed. Initial assets are installed and available in January 2027; depreciation starts then during preparation.

Action and model consequence

The initial cash uses exclude monthly preparation costs, which are in P&L and cash flow. No paid preparation wage is capitalized to improve profits. Depreciation has zero residual and finite lives. Quotes may change the timing, in which case a construction/payment schedule is required before commitment. No claim is made that the building can actually be procured at these budgets.

Initial cash use EUR	Base
Fitout	10,000,000
Clinical equipment	3,000,000
IT equipment	500,000
Deposit	300,000
Setup expense	450,000
Loan fee	160,000
Total initial uses	14,410,000

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Owner personal survival budget

Planning basis

The owner household planning budget is EUR 6500 monthly: housing 2500, bills and food 1300, transport 700, dependents 1000, other and savings 1000. No reliable other income is assumed. The owner CEO gross salary EUR 140000 annually is included in company payroll in every case. Personal expenditure does not also enter company operating expense.

Action and model consequence

An illustrative 65% takehome proxy yields personal cash availability; it is not a Spanish personal tax filing or actual household profile. The model compares that proxy with the household requirement. Employer charges remain company expense. Confirm the owner household and actual tax treatment privately before setting salary. Owner governance contributes no clinical hours and is never substituted for paid medical staff.

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Financing terms and security

Planning basis

The illustrative loan is EUR 8 m, 6.5% annual interest in Base, 120 equal monthly principal repayments and 2% initial arrangement expense. It is drawn before January 2027 with no grace period. Interest uses opening debt, principal is capped at outstanding balance and payment stops at zero. Downside increases interest. No lender offer or covenant term has been supplied.

Action and model consequence

A lender may seek security over owned clinical equipment or shares and guarantees, but none is offered or valued here. The building is leased and cannot be pledged as owned real estate. Legal ownership, existing charges and collateral appraisals need evidence. Extra funds required by an adverse case remain unfunded; debt is not resized to hide the gap.

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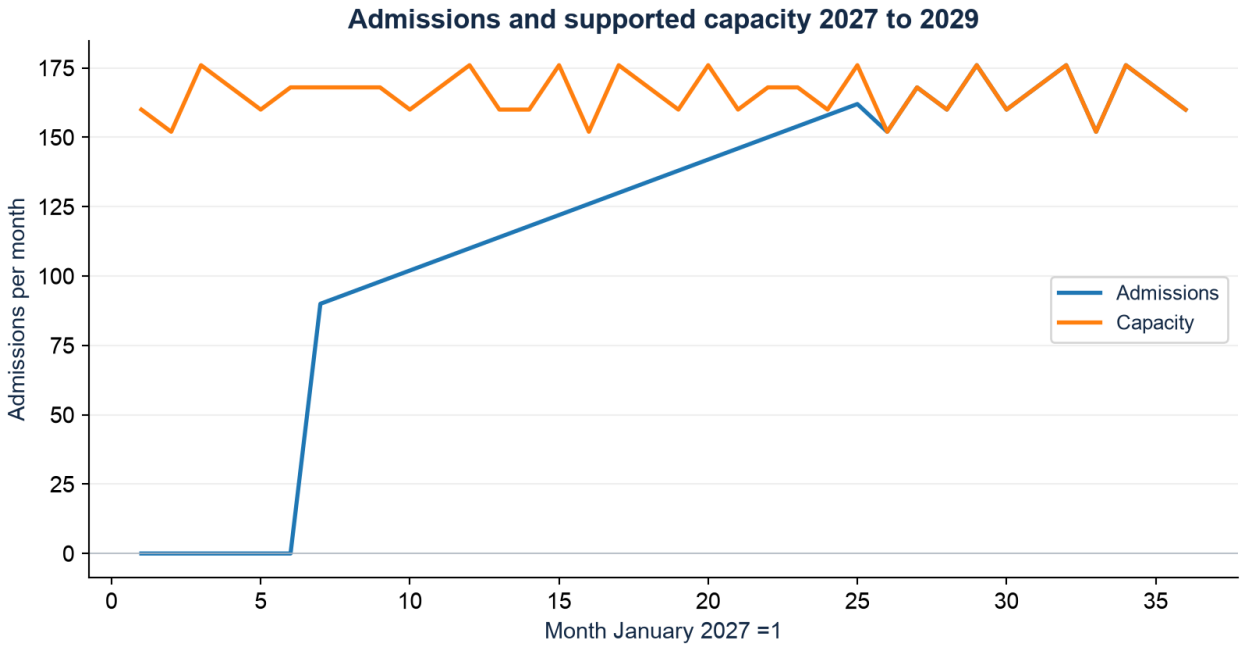
Revenue forecast and capacity

Planning basis

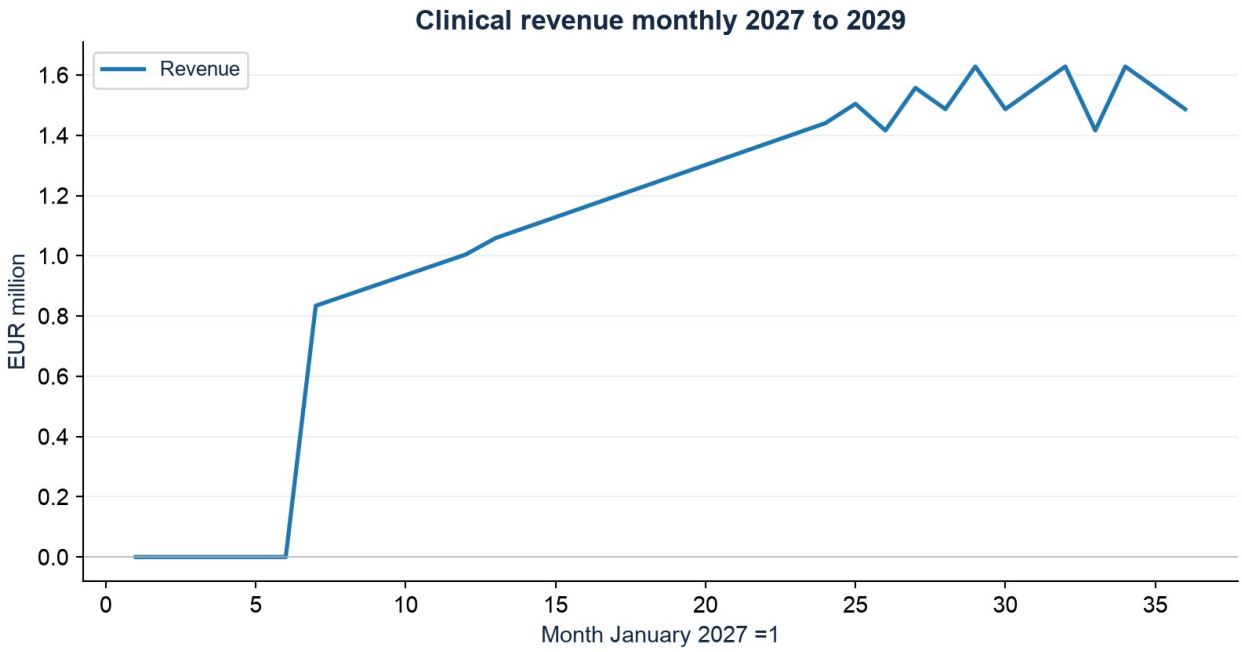
Admissions are the minimum of requested cases, bed days divided by stay, available ward nursing hours divided by care hours and stay, physical theatre slots, paid specialist theatre hours, anaesthesia hours and theatre nurse hours. Volumes are rounded down. Calendar bed days include leap-year February 2028. Weekday theatre days use actual dates with an evenly allocated shutdown allowance.

Action and model consequence

Consultations have their own room and paid specialist-hour limits. The 30% consultation allocation removes those same specialist hours from surgery. No ward patient-day fee is added to an admission package. A baseline 24 hour paid resident and two-nurse cover check blocks activity if insufficient. All gates remain hypothetical until real rostering and approvals confirm feasibility.



Captured numerical forecast from model 1.0 checked 2026-10-03 EUR.



Captured Base model 1.0 2026-10-03 Numerical units shown on figure.

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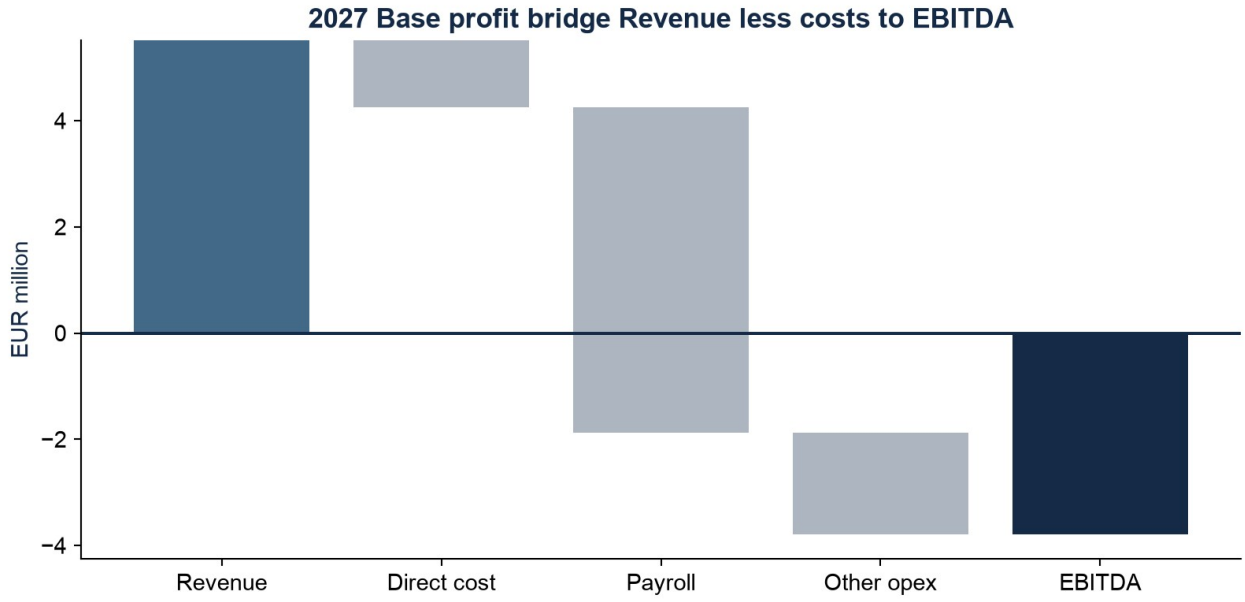
Costs and projected profit

Planning basis

Direct clinical costs vary by delivered admissions and consultations. Full paid salaries, owner governance, employer load, rent, utilities, insurance, external support, maintenance, IT and marketing apply in preparation and service. Salaries and costs escalate annually. Expected credit loss is explicit. It is neither a cash payment nor an invoice collected later.

Action and model consequence

EBITDA deducts payroll and recurring costs. Depreciation, interest and positive-profit cash-tax reserve lead to net profit. Tax is a conservative 25% monthly positive-PBT reserve without loss relief or special rates, not a statutory Spanish filed liability. Principal and capex affect cash and balance sheet separately, preventing double deduction. No draw or dividend is assumed.



Captured numerical forecast from model 1.0 checked 2026-10-03 EUR.

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Profit and loss forecast

Planning basis

The linked forecast uses euros and calendar years 2027, 2028 and 2029. Year one includes six paid preparation months in Base; revenue starts only when assumed gates and clinical capacity permit. Output fees are conditional qualifying clinical VAT-exempt fees, with gross irrecoverable costs.

Action and model consequence

Annual P&L sums monthly activity, not year-end snapshots. Retained earnings include preforecast setup and arrangement expense as an opening loss and accumulate monthly after reserve-tax profit. No loss is capitalized. The forecast remains sensitive to admission mix and procedure complexity, which require costed clinical evidence beyond this average-case model.

Base EUR	2027	2028	2029
Clinical revenue	5,514,720	14,995,469	18,355,195
Direct clinical costs	1,264,800	3,495,408	4,334,413
Contribution	4,249,920	11,500,061	14,020,782
Full payroll including owner	6,121,120	6,304,754	6,493,896
Other operating costs incl credit loss	1,918,721	2,116,012	2,223,140
EBITDA	(3,789,921)	3,079,295	5,303,745
Depreciation	1,261,905	1,261,905	1,261,905
Interest	496,167	444,167	392,167
Profit before cash tax reserve	(5,547,992)	1,373,224	3,649,674
Cash tax reserve	–	351,791	912,418
Net profit after reserve	(5,547,992)	1,021,433	2,737,255

Displayed subtotal rounding residuals EUR (2027, 2028, 2029): contribution 0, 0, 0; EBITDA 0, 0, -1; profit before reserve 1, 1, 1; net profit 0, 0, -1. Add each residual to its rounded components. Underlying calculations retain precision.

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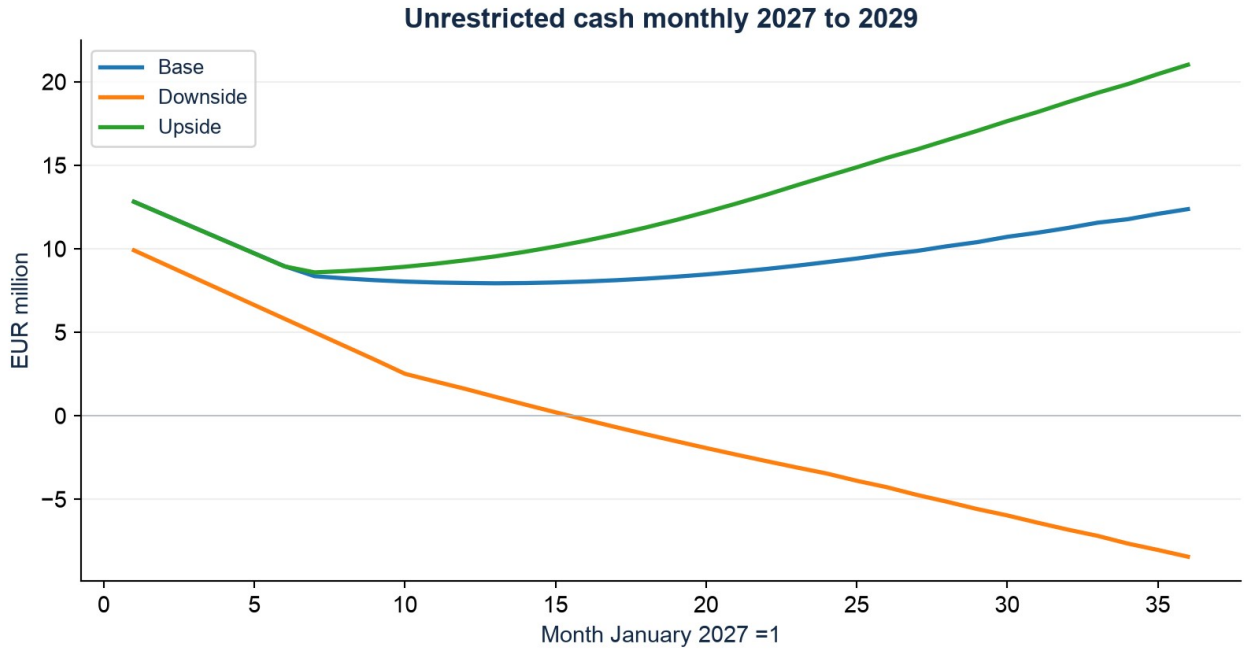
Cash flow and financial position

Planning basis

Clinical collections include current-month eligible invoices and previous-month receivables after expected credit loss. Direct supplier payments include current costs and prior payables. Other costs, wages, interest and tax reserve are paid in month. There are no customer deposit liabilities, inventory balances, tax receivables or unmodelled overdrafts.

Action and model consequence

The balance sheet links unrestricted cash, receivables, deposit and finite net assets to payables, debt, fixed contributed equity and retained earnings. Negative cash is shown explicitly but means the proposed financing is insufficient; it is not a legally arranged borrowing facility. The accounting differences must remain zero while funding warnings can be adverse.



Captured numerical forecast from model 1.0 checked 2026-10-03 EUR.

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Cash flow forecast months one to six

Planning basis

January to June 2027 are fully paid Base preparation months. The opening cash comes from fixed proposed funding less initial capital, deposit, setup and arrangement expense. There is no service income during these six months. Wage, employer, occupancy, clinical-support, interest and principal obligations remain payable.

Action and model consequence

The closing cash of each month becomes the next opening balance. Salary expenses are not capitalized or deferred. This view should be interpreted alongside remaining launch conditions and the full 36 month workbook. Delaying the first service month increases paid idle time and can impair the reserve or produce a negative cash requirement.

Base EUR	Jan 27	Feb 27	Mar 27	Apr 27	May 27	Jun 27
Opening cash	13,590,000	12,816,907	12,044,174	11,271,803	10,499,793	9,728,144
Clinical cash collections	–	–	–	–	–	–
Direct supplier payments	–	–	–	–	–	–
Payroll including owner	(510,093)	(510,093)	(510,093)	(510,093)	(510,093)	(510,093)
Recurring cash opex	(153,000)	(153,000)	(153,000)	(153,000)	(153,000)	(153,000)
Interest	(43,333)	(42,972)	(42,611)	(42,250)	(41,889)	(41,528)
Cash tax reserve	–	–	–	–	–	–
Operating cash flow	(706,427)	(706,066)	(705,704)	(705,343)	(704,982)	(704,621)
Capital renewals	–	–	–	–	–	–
Principal repaid	(66,667)	(66,667)	(66,667)	(66,667)	(66,667)	(66,667)
Net cash change	(773,093)	(772,732)	(772,371)	(772,010)	(771,649)	(771,288)
Closing cash	12,816,907	12,044,174	11,271,803	10,499,793	9,728,144	8,956,857

Outflows in parentheses. Displayed rounding residuals EUR in month order: operating cash -1, -1, 0, 0, 0, 0; net change 1, 1, 0, 0, 0, 0; closing cash 0, -1, 0, 0, 0, 1. Add residual to rounded components. Underlying cash roll difference is zero.

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Cash flow forecast months seven to twelve

Planning basis

July to December 2027 are first service months in Base if gates pass. Requests are capped by physical and paid clinical capacity. Collections lag recognized fees, while clinical costs and payroll must be paid. The model does not assume all booked procedures convert or all invoices are immediately received.

Action and model consequence

December closing cash is a stock and is not summed for the annual cash balance. The companion model continues monthly through December 2029. Downside begins service later and carries higher cost, longer stay and lower price. Loan principal is distinct from interest, and asset renewal is distinct from maintenance.

Base EUR	Jul 27	Aug 27	Sep 27	Oct 27	Nov 27	Dec 27
Opening cash	8,956,857	8,359,013	8,226,177	8,119,192	8,038,059	7,982,776
Clinical cash collections	287,563	833,330	866,820	900,310	933,800	967,290
Direct supplier payments	(114,480)	(195,600)	(203,600)	(211,600)	(219,600)	(227,600)
Payroll including owner	(510,093)	(510,093)	(510,093)	(510,093)	(510,093)	(510,093)
Recurring cash opex	(153,000)	(153,000)	(153,000)	(153,000)	(153,000)	(153,000)
Interest	(41,167)	(40,806)	(40,444)	(40,083)	(39,722)	(39,361)
Cash tax reserve	–	–	–	–	–	–
Operating cash flow	(531,177)	(66,169)	(40,318)	(14,467)	11,384	37,235
Capital renewals	–	–	–	–	–	–
Principal repaid	(66,667)	(66,667)	(66,667)	(66,667)	(66,667)	(66,667)
Net cash change	(597,844)	(132,836)	(106,985)	(81,134)	(55,283)	(29,431)
Closing cash	8,359,013	8,226,177	8,119,192	8,038,059	7,982,776	7,953,345

Outflows in parentheses. Displayed rounding residuals EUR in month order: operating cash 0, 0, -1, -1, -1, -1; net change 0, 0, 0, 0, 0, 1; closing cash 0, 0, 0, 1, 0, 0. Add residual to rounded components. Underlying cash roll difference is zero.

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Financial position summary

Planning basis

Year-end balances use December stocks. Assets comprise unrestricted cash, net surviving receivables, refund-held deposit and net finite capital cohorts. Liabilities are direct supplier payables and the loan. Paid share capital is fixed at the proposed contribution; retained earnings equal opening expense loss plus accumulated profits. No plug balances the sheet.

Action and model consequence

A balance sheet reconciliation is an accounting control, not confirmation that negative cash is financeable or that assets can be sold at book value. Historical gross asset cost and accumulated depreciation remain inspectable. A renewal is cash capex and a new finite cohort. Once both original and renewal service lives expire, no further funded capacity is assumed.

Base EUR	2027	2028	2029
Cash	7,953,345	9,199,700	12,374,829
Receivables	642,888	922,192	951,960
Held refundable deposit	300,000	300,000	300,000
Net fixed assets	12,238,095	10,976,190	9,714,286
Total assets	21,134,328	21,398,083	23,341,074
Supplier payables	92,320	134,642	140,378
Debt	7,200,000	6,400,000	5,600,000
Total liabilities	7,292,320	6,534,642	5,740,378
Paid share capital	20,000,000	20,000,000	20,000,000
Retained earnings	(6,157,992)	(5,136,559)	(2,399,304)
Liabilities plus equity	21,134,328	21,398,083	23,341,074
Balance difference	0	0	0

Displayed rounding residuals EUR (2027, 2028, 2029): total assets 0, 1, -1; total liabilities 0, 0, 0; assets less liabilities and equity 0, 0, 0. Add residual to rounded components. Underlying balance difference is zero.

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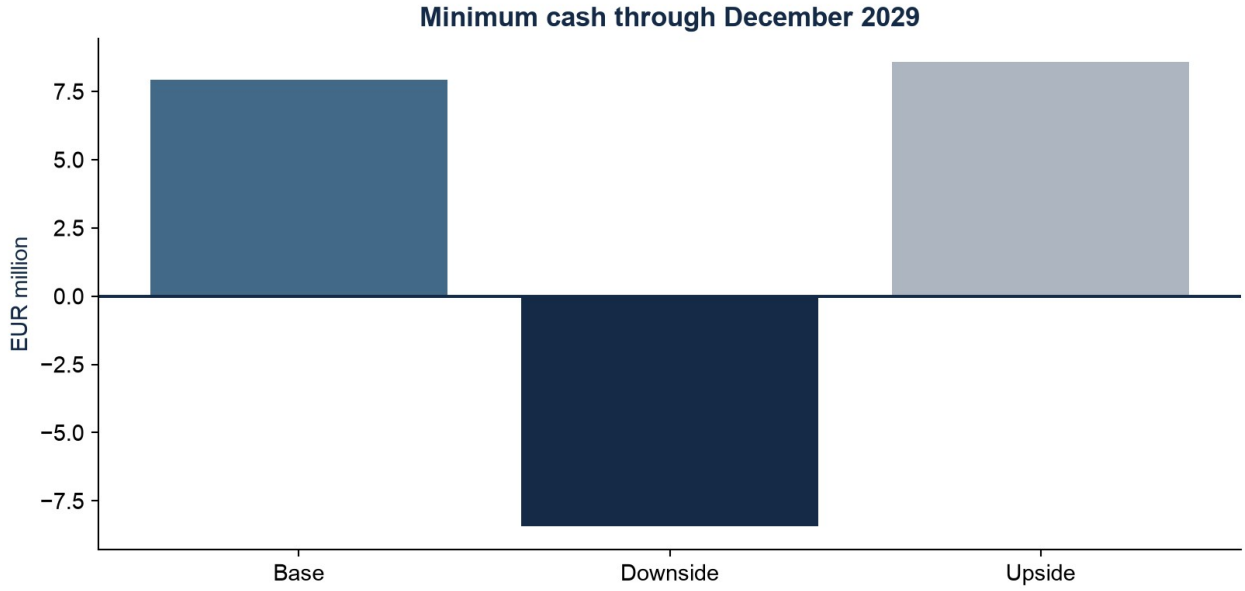
Break even and scenarios

Planning basis

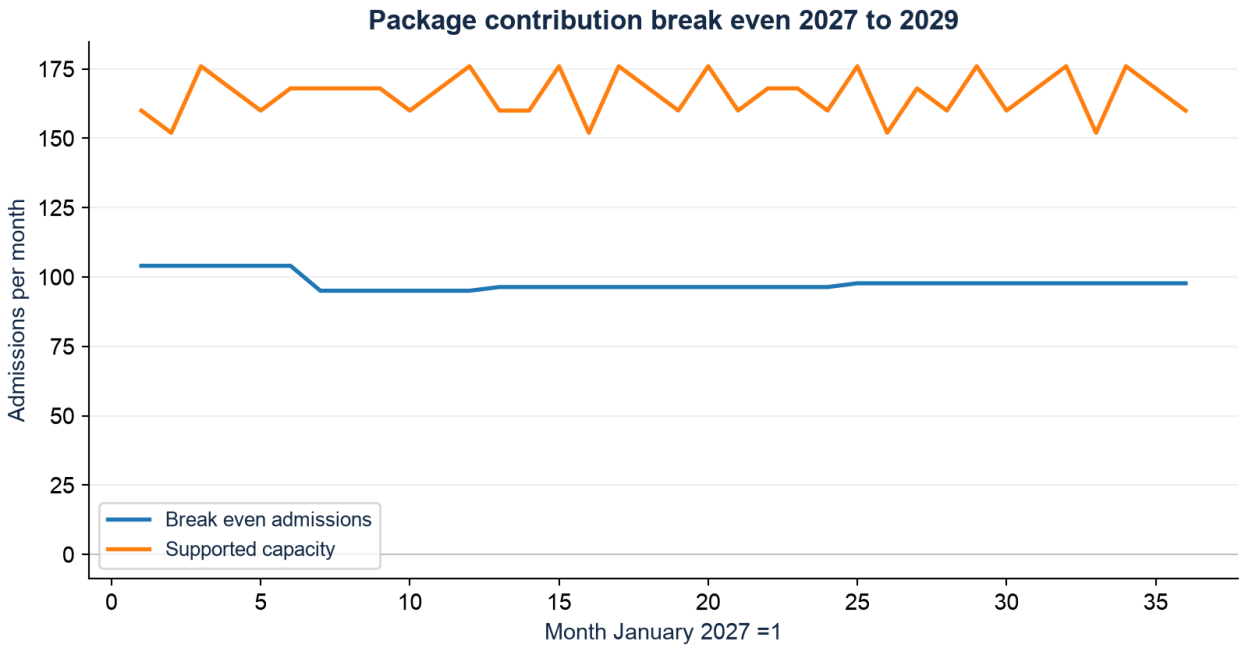
Monthly package break even admits enough cases to cover fixed payroll and recurring costs after separate consultation contribution. It is a contribution test before depreciation, interest, tax reserve and principal, and may exceed physical or paid capacity. It is not proof that demand exists. Confirm that feasible bookings support total cash obligations before launch.

Action and model consequence

Base, Downside and Upside each have editable dated drivers and a complete linked monthly build. Downside changes launch, demand, tariffs, stay, productive time, costs, capital and interest together. Comparisons recalculate live in Excel. Printed Word snapshots record version and capture date and require refresh whenever workbook inputs change. Missing or invalid inputs should expose errors rather than plausible healthy zero output.



Captured numerical forecast from model 1.0 checked 2026-10-03 EUR.



Captured Base model 1.0 2026-10-03 Numerical units shown on figure.

Captured case EUR	Base	Downside	Upside
Minimum cash	7,932,731	(8,439,479)	8,587,713
Reserve policy gap	–	11,439,479	–

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Model guide and completion

Planning basis

Edit blue numeric cells for Base, Downside and Upside on Inputs and choose 1, 2 or 3 in D 5. Each case sheet retains its own driver column; Summary selects the case while Annual displays all three. Save changes and import them with the retained build_model.mjs --import-inputs path.xlsx workflow. Persisted inputs.json is authoritative for repeated builds, and defaults initialize only when it is absent.

Action and model consequence

All printed financial tables and charts are captured from the validated model-results.json. Refresh results, visuals, Word and native TOC together after edits. The retained QA includes saved-sheet/chart views, independent arithmetic and cache-cleared meaningful native input tests. Outstanding commercial and clinical gates remain conditions, not completed actions. Final delivery is for feasibility discussion and financing review, with no fabricated approvals.