



GOOD CARE **UGANDA FOUNDATION**

IMPLEMENTATION PLAN TO ESTABLISH GOOD CARE INTERNATIONAL
UNIVERSITY TEACHING HOSPITAL IN UGANDA.



April, 2018

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Open hearts. Open minds. Open hearts

PROPOSAL SUMMARY

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PROJECT TITLE	Good Care International University Teaching Hospital
TARGET AREAS	Africa, Uganda as a Centre
ADVISORY TEAM	Governing/ Executive Body
DURATION OF THE PROJECT	10-30 YEARS
COMMENCING OF THE PROJECT	2018
FUNDING SOURCE	BGK BANK POLAND
COST OF THE PROJECT	110 MILLION USD

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INTRODUCTION

Organization Profile

Good Care Uganda Foundation (GCUF) is a not-for-profit non-governmental organization. It was established in 2000 as Community Based Organisation and is legally incorporated and registered under the laws of the Government of Uganda (GOU). Good Care Uganda Foundation partners with organizations to help meet basic needs of the population in Uganda with a focus on communities which are home to some of the world's most economically vulnerable persons. This work includes providing education, food security and nutrition, medical care, socio-economic empowerment, psycho-social support and capacity building. We are passionate about creating positive change in our communities.

Good care International University Teaching Hospital;

The dynamics of health care demand and supply in developing countries in recent years have led to a growing need for private health care facilities. As a result of various demographic and epidemiological changes, the public sector has been overwhelmed by the demand for health care services, particularly services delivered by hospitals. This has forced changes in government policies that in turn have led to significant increases in private sector participation in health care provision.

Increasing life expectancy and slowing population growth in many countries are bringing a greater burden of chronic and degenerative diseases such as cardiovascular diseases and cancer. Along with other non-communicable conditions such as road crash injuries, these diseases of aging account for a rising share of health care demand. They often require comprehensive health interventions. Thus, the graying of the population has increased the demand for hospital care in terms of the volume of admissions, average length of stay, and complexity of treatments.

The concept of Goodcare international university teaching hospital is premised on this background to counteract the ravaging health situation particularly in sub-Saharan Africa. With serious physician shortfalls and inadequate facilities for medical doctors to train and practice in Africa and Uganda in particular, this concept comes with a remedial solution to the already existing health care problems. In Uganda alone, staffing levels are low by all standards: An estimated number of 2,919 physicians working in the country translates into 1: 8,373 people if spread throughout the country. Furthermore, the government expenditure on treatment abroad annually is startlingly costly; every year Uganda government spends at least \$2.2m (about shs5.8b) on treatment of mostly public servants abroad. The entire country including private patients the estimated amount spent is \$76m (about shs204b).

Good care in partnership with our funders in Poland is set to implement the establishment of a state-of-the-art international teaching hospital. The hospital will offer teaching capabilities and much more sophisticated and broader range of medical services to top government officials, foreign expatriates and tourists as well as higher and low-income local population. The hospital will as well develop innovations in research and will improve the quality and availability of health care in Uganda and Africa. **It also will give special attention to the needs of the medically underserved Regions in Africa.**

BACKGROUND

Demographic and Epidemiological Changes

Low- and middle-income countries represent 84 percent of the world's population and 93 percent of the disease burden, but only 18 percent of global health spending. Despite significant improvements in general health indicators, vastly advanced medical technologies, and increasing expenditures on health, serious challenges remain in the quest for universal and high-quality health care. Improvement in health indicators appears to have slowed in the 1990s, and at the present pace most regions did not meet the health-related Millennium Development Goals by 2015.

There has been a significant decrease in the share of communicable diseases. However, changes in mortality and morbidity are distributed unevenly throughout low-and middle-income countries. Although the means to control common communicable diseases are available and infection rates of tuberculosis, malaria, cholera, and measles have declined, these diseases remain a major burden to the poorest countries - many in Africa - and to rural and poor populations in several middle-income countries. Special emphasis needs to be placed on the emergence of the HIV/AIDS epidemic, which has brought increased pressure on often fragile health systems. In some high-prevalence environments, more than half of hospital admissions are related to HIV/AIDS¹.

The overlap of the epidemiological transition and the emergence of new threats such as HIV/AIDS exacerbates the pressures on national health systems at a time when public resources in many countries are increasingly stretched. Given the multiple demands on limited public funds, in several countries it appears that reliance on the public sector alone to address health challenges may not be a viable or sustainable option in the long term.

Expanding Role of the Private Sector

Given the capacity constraints of the public sector in meeting health care demand, many governments are beginning to turn to the private sector and for reliance on market instruments to enhance the efficiency and quality of health care provision². One of the earliest areas of private sector participation (in the public sector) was the subcontracting of auxiliary services such as laundry and cleaning. This was followed by subcontracting of more clinically oriented services and departments, such as radiology and pharmacy³.

More recently, health care reforms in various countries have sought to increase the role of the private sector as the provider (although not necessarily the financier) of comprehensive care, to complement the activities of the public sector. The general argument is that these reforms can retain equity in the financing of health care yet promote efficiency by introducing and encouraging competition. High-performing health systems are typically characterized by mixed delivery of services, with private providers playing an integral role.

¹ In Uganda, for instance, 54.3 percent of hospital admissions are due to HIV/AIDS-related illnesses. U.S. Agency for International Development, Bureau for Global Health, HIV/AIDS Country Profile: Uganda (Washington, DC: USAID, 2004), http://www.synergyaids.com/Summaries_PDF/UgandaprofileFeb2004FINAL.pdf.

² Until the twentieth century, most people paid independent health providers directly for their services. Thus, in most countries, private provision predates the development of publicly funded health care services.

³ International Finance Corporation, Investing in Private Health Care: Strategic Directions for IFC (Washington, DC: IFC, 2003).

Table 1.1. Private Health Expenditure as a Share of Total Health Expenditure, 2002

Region	Percentage of total
Low-income	72.2
Middle-income	50.6
Lower-middle-income	54.6
Upper-middle-income	42.4
Low- and middle-income	53.8
East Asia and Pacific	62.2
Europe and Central Asia	34.4
Latin America and Caribbean	52.2
Middle East and North Africa	42.9
South Asia	76
Sub-Saharan Africa	59.5
High-income	36.7

Source: World Bank, *World Development Indicators 2005* (Washington, DC: World Bank, 2005).

Today, the private sector increasingly serves as a partner with public health systems, particularly in the provision of clinical health care. In many low-income countries over 50 percent of health care provision and financing is now private (table 1.1). The increase in private sector participation in health care services, especially in developing countries where public sector capacity is constrained, makes Goodcare international teaching hospital a viable and a timely project.

Overview of Health Care Facilities in Uganda

Uganda's healthcare expenditure amounted to \$25 per capita as of 2006. This is slightly higher than other countries in Sub-Saharan Africa (\$24), though lower than the average for all low-income countries (\$27). At the same time, it should be noted that Uganda spends a higher share of its GNI to healthcare, 7.2%, compared to 4.8% and 4.6% for sub-Saharan Africa and low-income countries respectively (WDI & WHO data).

The sources of healthcare expenditures are composed of three primary sources. Out-of-pocket expenses accounted for the largest share, with 37.9%, followed by the government with 33.6%, and external sources with 28.5% (World Bank, 2010). The Ugandan healthcare delivery system is composed of seven levels. Health Centers, categorized into levels I to IV, cover geographic areas ranging from villages to counties, with varying level of population coverage (1,000 for level I to 100,000 for level IV). Their roles also differ, from Health Center I focusing on prevention and health education to Health Center IV, which cover prevention, cure, rehabilitation, and emergency surgeries. The next level is District Health Services, which typically cover population of 500,000. Regional Referral Hospitals typically cover 2M people, providing select specialty care and outreach services, in addition to the functions provided by the institutions previously mentioned. National Referral Hospitals, which cover 27M people, provides comprehensive specialty care, research and training, in addition to other roles (Markle, 2007).

Access to Care

Despite record investment over the past five years, the government expenditure on health has steadily increased from \$3.46 per capita in 1995 to almost \$9 per capita in 2006 (Keane, Kennan, Massimiliano, Massa, & Dirk, 2010), Uganda's healthcare performance is still ranked as one of

the worst in the world. In 2009, Uganda ranked 186th out of 191 nations by the WHO in terms of health care performance (Sisay, 2009).

In terms of health facilities, the Uganda Ministry of Health reported 3,237 health facilities in 2006, with 71% public, 21% private-not-for-profit, and 9% private-for-profit (Okwero, Tandon, Sparkes, McLaughlin, & Hoogeveen, March 2010). Within these health facilities, there are 1.1 hospital beds per 1,000 people in 2006, 5.5 nurses per 10,000 people in 2004, and 1.17 physicians per 10,000 people in 2005 (World Development Indicators (WDI) & Global Development Finance (GDF)). In terms of physical access to these health facilities, 75.4% of respondents to a World Bank survey reported living within 5 km of a health facility or hospital in 1999, compared to 82.5% in 2006 (Okwero, Tandon, Sparkes, McLaughlin, & Hoogeveen, March 2010).

In terms of services availability, as of 2007, over two thirds of health facilities provide a basic package of health services, 88% provide immunization, 71% provide antenatal care, 80% provide family planning, 98% provide STI services and curative care for children (Kaijuka, et al., 2007). Among the general population, in 2008 48% has access to improved sanitation – 38% of urban population vs. 49% of rural population. 67% of the population has access to improved water source – 91% of urban population vs. 64% of rural population (World Development Indicators (WDI) & Global Development Finance (GDF)).

In terms of utilization, Uganda eliminated user fees at state health facilities in 2001, resulting in an 80% increase in the number of visits (The Elimination of User Fees in Uganda: Impact on Utilization and Catastrophic Health Expenditures, 2005). Today, 42% of the births in Uganda are attended by skilled health personnel vs. regional average of 47%, its antenatal care coverage is 94% vs. regional average of 73%, and 68% of Ugandan 1-year-olds receive measles immunization vs. regional average of 73%. Uganda's contraceptive prevalence is 24% vs. regional average of the same, its antiretroviral therapy coverage among people with advanced HIV infection is 33% vs. regional average of 44% (Department of Health Statistics and Informatics of the Information, 2010).

Health Equity

In Uganda, there exists considerable inequity in health outcomes across regions and socio-economic classes. Whereas some districts such as Kapchorwa and Bukwa have life expectancy rates exceeding 60 years, the national average is about 51 years and there are some districts such as Kitgum where the figure is less than 30 (Okwero, Tandon, Sparkes, McLaughlin, & Hoogeveen, March 2010). There are similar variations in infant and child mortality rates; in 2010, the under-5 mortality rate for the rural population is 147 deaths per 1,000 live births, as compared to 115 among urban population, 172 among the poorest 20%, and 108 among the wealthiest 20% (Uganda: Health Profile, 2010).

Overall, however, the government of Uganda has adopted a pro-poor attitude towards health spending. According to estimates by the World Bank, through utilization of various public health facilities, the poorest 20% of the population captures 24% of government spending while the wealthiest 20% receives about 16.6% (Okwero, Tandon, Sparkes, McLaughlin, & Hoogeveen, March 2010). And as already discussed in the previous section, Uganda's elimination of user fees at state health facilities in 2001 has resulted in an 80% increase in visits; over half of the increase came from the poorest 20% of the population (Department of Health Statistics and Informatics of the Information, 2010). While the non-poor's utilization of public facilities did not change significantly, utilization among the poor increased substantially after the abolition of fees, but catastrophic expenditure did not fall. One possible explanation is that "frequent unavailability of drugs at government facilities after 2001 forced patients to purchase from private pharmacies,

with the extra payments for pharmaceuticals offsetting the reduction in payments for consultations” (The Elimination of User Fees in Uganda: Impact on Utilization and Catastrophic Health Expenditures, 2005).

Disease Burden

According to WHO's estimates in 2011, the communicable, maternal, perinatal and nutritional conditions account for 70 % of the mortality causes, see Figure 1.

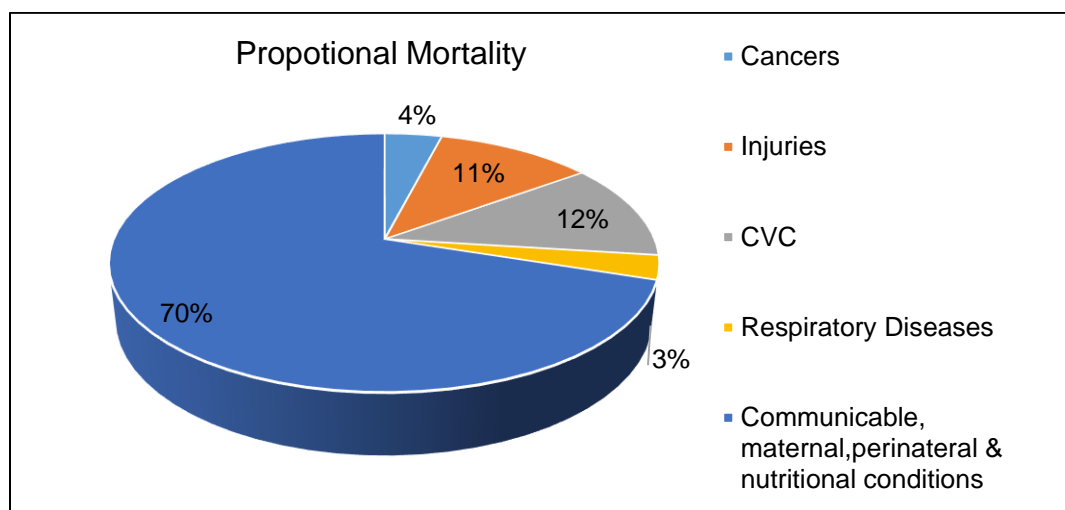


Figure 1. Proportional mortality as % of total deaths, all ages. WHO (2011) NCD Country Profiles Uganda 2011

Non-communicable diseases, account for 25 %. The infectious diseases in Uganda, which includes malaria, tuberculosis (TB) and HIV/AIDS, account for 54 % of the total burden of disease (MoH 2010a). Except HIV/AIDS, the indicators of the prevalence of infectious diseases are improving. This is the area where the donor-funded programmes are focused and where health education, public resources and policies are directed. Government implements national programmes, funded by donors, and results are followed up in WHO's reports on Malaria, TB and HIV/AIDS. Research programmes exist in cooperation with foreign institutions. However, continued innovation, improvement and new partnerships are still needed in the area, in particular in awareness-raising and prevention, management in health care system and supply chains, for smart and affordable supplies and equipment, and for human resources both in numbers and in training.

Infection Control is generally a problem in the health care facilities in Uganda. The Ministry of Health regards Infection Control to be important and the Health Sector Strategy and Investment Plan ensures that the issue is addressed in 2012/2013. Infection control standards will be developed, disseminated and implemented in all hospitals and Health Centre IVs.

Summary of the Health Sector in Uganda

- 44% of all health facilities are privately owned and the private sector provide for more than 50 % of the output, i.e. the services delivered.
- Primary care provided by public facilities is decentralized to district level which implies that decisions regarding General Hospitals and Health Centers are taken locally.
- Public health care is underfinanced and government contribution to health is low while out-of-pocket-spending is high.

- Private insurances contribute with less than 1% of the Total Health Expenditure, but the number of Ugandans with private insurances is increasing with a growing formal labour market.
- 60% of the imported medicines and supplies are procured through the private sector, donor's procurement agencies or directly by Ministry of Health. 40% is procured by the governmental National Medical Stores.
- Resources and human resources within health care are concentrated to the Central region. More than 70% of the medical doctors, dentists and pharmacists work in the Central region, while only hosting 27% of the population.
- Private sector is also concentrated to the Central region. 70% of the private health facilities are located there. Primary care facilities in the rural area are mainly publicly owned or by private-not-for-profit providers.

As most low-income countries, Uganda faces a heavy disease burden due to poverty. The critical health determinants constitute strong risk factors in Uganda. The fertility rate is among the highest in the world, 32.5 % of the population lives without proper latrines, discrimination against women is rife, the average schooling rate is 4.7 years for adults, and urbanization is rapid with growing slums. 39 % of the population in the rural areas lives further than 2 kilometers from a water source. However, in partnership with other nations, international organizations and public and private stakeholders, Uganda will seek to accelerate progress toward a world safe and secure from infectious disease threats and to promote global health security as an international security priority. The focus is on; preventing epidemics, detecting biological threats early, and rapidly responding to disease outbreaks, whether naturally occurring, intentionally produced, or accidentally caused.

In this regard, Goodcare Uganda Foundation recognizes the right of everyone to enjoy the highest attainable standard of physical and mental health. Irrespective of where one lives, gender, age or socio-economic status being healthy and having access to quality and effective health care services is of fundamental importance for all people, while at the same time healthy populations are essential for the advancement of human development, well-being and economic growth.

PROJECT DESCRIPTION AND MISSION STATEMENT

Project Description

Goodcare runs as a not-for-profit organisation which is passionate about creating positive impact in communities. In partnership with the funders from the government of Poland, Good care intends to establish a state-of-the-art international teaching hospital in Uganda to provide Africans and Ugandans in particular with health care and higher education of world-class quality.

Goodcare was motivated to establish a state-of-the-art international teaching hospital by the inherent need to put an end to foreign medical tourism trips that cost Uganda billions of shillings annually. As noted in the introduction, every year Uganda government spends at least \$2.2M (about Shs5.8b) on treatment of mostly public servants abroad. The entire country including private patients the estimated amount spent is \$76M (about Shs204b) However, the figures seem to be more than what is estimated according to unconfirmed reports that indicate that the government spends at least \$150m (about SHS400b) on treatment of mostly top government

officials abroad annually⁴. Poor sanitation alone costs Uganda 389 billion Ugandan Shillings each year, equivalent to US\$111 million, according to a desk study carried out by The Water and Sanitation Program (WSP). This sum is the equivalent of US\$5.5 per person in Uganda per year or 1.1% of the national GDP.

Therefore, Good care believes that it is only healthy Ugandans who can contribute to the growth of the economy, a resource that would be much more scarce without the proper medical facilities available to those in need.

Good care looks forward to providing a range of treatments and services that are currently unavailable in Uganda, and to training and retaining health care leaders who raise quality standards within Uganda's health sector and Africa in general. The hospital will be a Centre of excellence in provision of medical services and training not only in Uganda but in Africa and will bring knowledge and competence of sophisticated science on an on-going basis as a whole. This will be achieved through collaborative arrangements with re-known universities across the world i.e USA, Poland, Japan, Europe (Germany & Poland) and Asian Countries. These arrangements will involve lecturer and student exchange programs which will greatly enrich teaching and research components to international standards. This will result into acquisition of modern technology treatment facility equipment.

This diagnostic equipment will keep patients within Uganda including those with non-communicable diseases (NCDs) particularly; cardiovascular (heart) diseases, diabetes, cancers and chronic obstructive pulmonary diseases which according to the ministry of health are becoming increasingly important as causes of morbidity (illness) and mortality (death) in the Ugandan population. This will reduce the government expenditure on treatment abroad annually hence saving for economic development in the country. Goodcare's vision for the international teaching hospital in Uganda include:

A first phase to be completed in 2021: The ultimate vision is for the international teaching Hospital to grow toward 1000 beds in phases of development over time. The first phase of construction will be completed in 2021 with the establishment of a tertiary hospital of approximately 250 beds costing more than US\$ 150 million.

Provision of advanced care: As an international standard teaching hospital, the Hospital will provide advanced forms of care. It will include specialties in cardiology and cardiothoracic surgery, cancer, women and child health, stem cell and regenerative medicine, neurology and minimally invasive surgery, and have the latest in state-of-the-art medical equipment such as MRI and CT scanners and nuclear medicine. It will ensure that Ugandans have access to world-class care when they need it and where they need it. No longer will Ugandans need to leave the country to receive high quality health care. This will be of enormous economic and social benefit to patients and to Uganda. In addition to treating Ugandans, the hospital is expected to attract patients from across the region.

The education of a new breed of health care providers and leaders: The teaching hospital will use the facility to educate doctors, nurses, midwives and allied health professionals who are equipped not only to provide excellent care but to lead and transform health care institutions and systems to make them work more effectively. A Postgraduate Medical Education programme will train specialist doctors in a range of fields – including internal medicine, surgery, paediatrics and

⁴ <http://www.monitor.co.ug/SpecialReports/Shs204b-spent-abroad-because-Uganda-cannot-treat-her-own/688342-2512228-159od38/index.html>.

obstetrics and gynaecology – helping to alleviate the severe shortage of such specialists in Uganda.

Retaining and returning Ugandan health professionals: By providing a working environment and training programmes that meet the highest international standards, the Hospital will attract Ugandan health professionals working abroad back to Uganda, while retaining new graduates who might otherwise leave for advanced education or for work outside the country.

A research programme: Research will address a range of issues, including the growth of non-communicable diseases such as cardiovascular disease, cancer and diabetes, the need to improve maternal and child health, and the social and economic determinants of health.

In addition to establishing the Hospital, Goodcare plans to add to four Medical Centres in Uganda by building a dozen more over time across the country where patients can access basic care and receive referrals to the main Hospital. This will connect patients within and beyond Kampala to the main Hospital and make it easier for them to access its services.

Mission Statement

Goodcare international teaching hospital's mission is ...

“... to bring health care of international standards within the reach of every individual. We are committed to the achievement and maintenance of excellence in education, research and health care for the benefit of humanity.”

PROJECT MANAGEMENT

As Good care international university teaching hospital project moves forward, the project concept and mission statement will be tested, improved, and refined through the prefeasibility and feasibility studies.

The hospital will be planned, designed, and constructed by IDS BUD S.A. The company has a long term vast experience in large scale projects inside and outside Poland including several modern Hospitals under PPP model of operation. IDS BUD S.A, already signed a letter of Intent on undertaking the construction of the proposed Teaching Hospital under the suggested model (BOT) in partnership with Good Care Uganda Foundation and Ministry of Health.

Advantageously, IDS BUD S.A will undertake feasibility studies that are focused on design. These will include; works to be developed within the project detailing how each component will be delivered, specific requirements to be observed by the designer, available land surveys and design stages. Further to the design feasibility studies, a geotechnical survey will be carried out by IDS BUD S.A with careful analysis of the structural parameters of the terrain, as selection of a favorable site depends upon a particular structural element possessed by the rock. Land survey, Hydro - geological studies and a thorough environmental and social impact assessment will be part of the studies undertaken by the construction company. Other activities require for IDS BUD S.A are; Architectural Plans, Civil and Structural designs, Electrical and Plumbing designs and Landscape designs.

Medical equipment will be bought, and the hospital staffed. This will be supplied by ALVARO company which has over 25 years in production and supply of medical equipment especially theater complexes. The company has supplied to many African companies including some in

Uganda and is ready to cooperate towards supplying world class equipment to the proposed International University Teaching Hospital.

The hospital will utilize the production and medicine research laboratories at all levels deemed fit for the corporation. Pharmaceutical Research Institute is a medical innovation and research company based in Poland whose scope of business includes implementing research in the field of pharmaceutical studies and API production in the scale ranging from several dozen grams to several hundred kilograms. The institute has already indicated its cooperation by signing a Letter of Intent with Good Care Uganda Foundation which will pave way for Uganda Government policy to be supported by the institute. This process of implementation is illustrated in figure 2.

The top tier of the figure lays out the stages that will take place: project concept and mission statement, prefeasibility analysis, feasibility analysis, hospital planning and design, hospital construction, and hospital opening. The arrow behind the stages indicates that they will occur largely in sequence, although with different levels of iteration and considerable overlap. Medical equipment is placed parallel to the sequence because activities related to medical equipment are less sequential and will take place during four of the stages: the feasibility analysis, the hospital planning and design, hospital construction, and hospital opening. The greatest attention to medical equipment will come during the hospital planning/design and construction phases.

Shown at the bottom of figure 2 are the major supporting functions: financial management, human resources management, and marketing. These supporting functions are essential to successful completion of the stages shown in the top part of the figure, though their complexity and intensity will vary depending on each stage of the process. The supporting functions will continue to be critically important to the hospital's operation after its opening.

In the middle of the figure, a large arrow illustrates the planning and management functions that continue throughout the implementation of the project and are critical to its success. The central person who will perform this role is the project director, who will provide leadership, guidance, and oversight to everyone involved in the project. The project director with complete understanding of the vision and mission of the hospital will set the priorities, standards, and key policies for the project. He will represent the project and the project team in dealings with government agencies, architects, banks, and contractors and will take the lead role in conducting negotiations

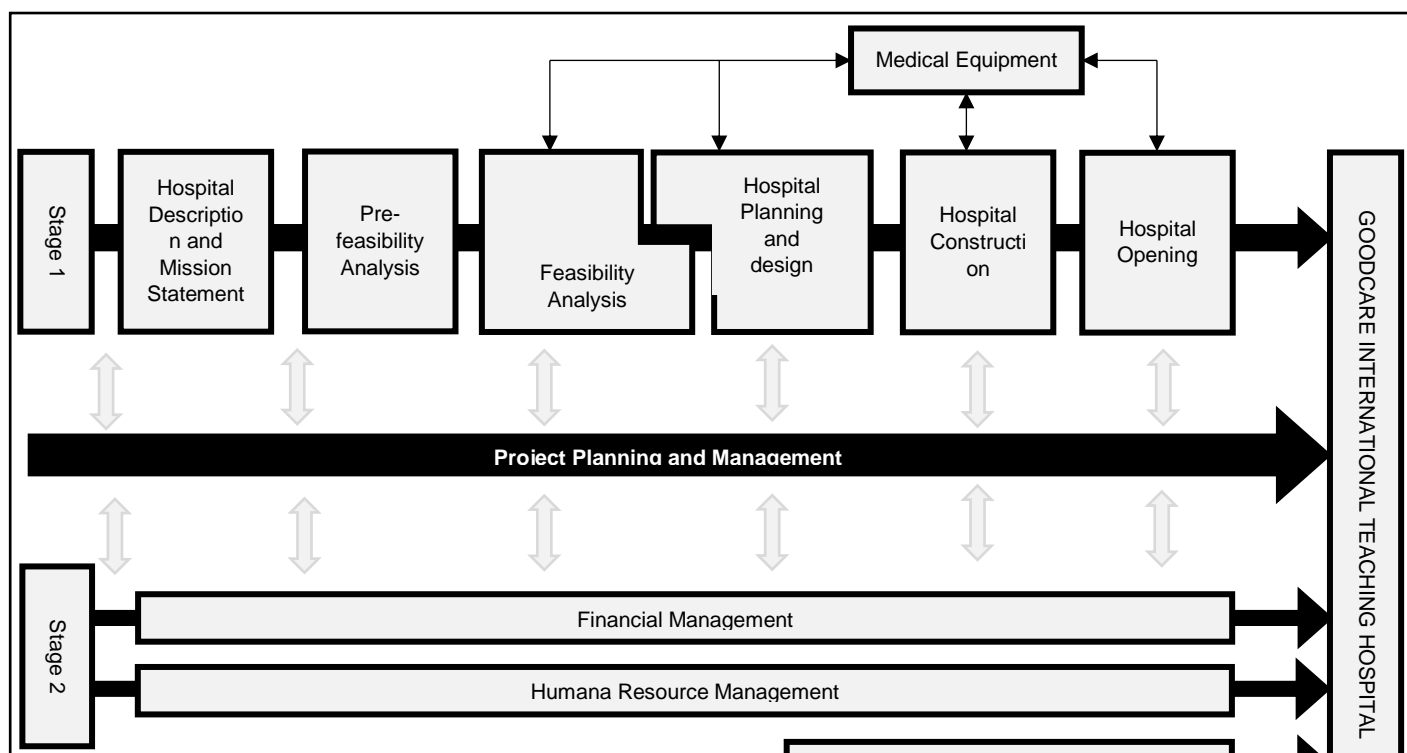


Figure 2: Project Management: Establishing Goodcare International teaching hospital

Goodcare and the partners from Poland who have conceived the idea of developing Goodcare international teaching hospital will agree on who will manage the project successfully. As the project initiators, Goodcare and the Polish partners will provide the initial equity financing and thus will be called the project's owners

PRE-FEASIBILITY ANALYSIS

Market Demographic Analysis

Health care services in Uganda are delivered by both public sector (government) and private entities that include private-not-for-profit (PNFP) and private-for-profit (PFP) organisations as well as complementary health service providers such as the traditional medicine providers. The public health facilities make up 55% of the total health care facilities in Uganda, while PNFP and PFP make up 16% and 29%, respectively. Nearly all (90%) of the private-for-profit facilities are located in one district – Kampala district which also hosts Uganda's capital city.

In Uganda's health service delivery structure, the national level stewardship functions are performed by the Ministry of Health (MoH). In the public sector, health services are delivered through the national referral hospitals, regional referral hospitals and district health services. The national referral hospitals are autonomous and have a target population of 10 million people. They provide referral services for the regional and general hospitals across the country. National referral hospitals are expected to offer highly specialised medical and surgical services, advanced diagnostic services, advanced research and training for medical doctors, nurses and paramedical officers such as orthopaedic officers and laboratory technologists.

Regional hospitals are located in each of the 14 health zones and have a target population of 2 million people. They provide referral services and supportive supervision to the district level hospitals within each health zone. Services expected at the regional hospitals include 34 specialised medical and surgical care, basic research, and training of nurses and paramedical officers. The district-level health service includes the district health management team, general hospitals and an array of primary care facilities (also known as health centres (HCs)). The district health service is under a District Health Officer who is appointed by and accountable to the district local government. Because the decentralized system of governance adopted in 1995 devolved most functions and powers to districts, the district health services are administratively independent of regional hospitals and report directly to the MoH. A general hospital in Uganda has a target population of 500,000 people. It is expected to provide preventive and general medical and surgical services, with limited specialist services.

Uganda has three levels of primary care facilities: level II (lower-level primary care facility), III (mid-level primary care facility) and IV (higher-level primary care facility) all focusing mainly on prevention and treatment of infectious illnesses. A level II primary care facility is the lowest level

of formal health care delivery. It is mostly staffed by nurse aides and qualified nurses. A level III primary care facility has provisions for basic laboratory services, maternity care, and inpatient care (often for onward referral). It is usually staffed by nurse aides, qualified nurses and clinical officers (physician assistants). A level IV primary care facility is the level immediately below a district hospital and has a target population of 100,000 people. It has provisions for an operating theatre, in-patient and laboratory services, and is a referral facility for 20-30 level II and III primary care facilities under its jurisdiction. A level IV primary care facility is staffed by nurse aides, qualified nurses, clinical officers and doctors, although the majority does not have doctors.

Uganda is in the process of creating a community hospital which is a level between a general hospital and a level IV primary care facility. A community hospital is expected to provide services similar to those provided at general hospitals but closer to the communities.

The organisational structure of the private health services in Uganda is not as elaborate as that of the public sector. Their level or amount of services they provide is also often not as clear as it is in the public sector. Private-not-for-profit health facilities (often faith-based) work very closely with the public sector and are heavily subsidized by the government. Although they are autonomous, they are often supervised by and report to the district health services.

Uganda's Population

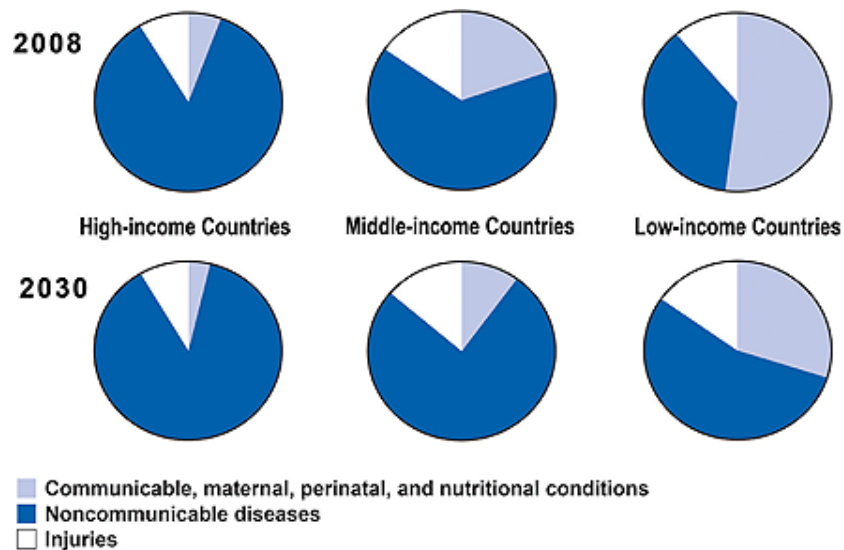
According to population and housing census (UBOS 2014), Uganda had close to 35 million people. The population in the districts ranged from 53,406 to 2,007,700; with a median of 243,876. On average, a district in Uganda had 308,467 people.

Global Disease Burden

The transition from high to low mortality and fertility that accompanied socioeconomic development has also meant a shift in the leading causes of disease and death. Demographers and epidemiologists describe this shift as part of an “epidemiologic transition” characterized by the waning of infectious and acute diseases and the emerging importance of chronic and degenerative diseases. High death rates from infectious diseases are commonly associated with the poverty, poor diets, and limited infrastructure found in developing countries. Although many developing countries still experience high child mortality from infectious and parasitic diseases, one of the major epidemiologic trends of the current century is the rise of chronic and degenerative diseases in countries throughout the world— regardless of income level.

Evidence from the multicountry Global Burden of Disease project and other international epidemiologic research shows that health problems associated with wealthy and aged populations affect a wide and expanding swath of world population. Over the next 10 to 15 years, people in every world region will suffer more death and disability from such non-communicable diseases as heart disease, cancer, and diabetes than from infectious and parasitic diseases. The myth that non-communicable diseases affect mainly affluent and aged populations was dispelled by the project, which combines information about mortality and morbidity from every world region to assess the total health burden from specific diseases. The burden is measured by estimating the loss of healthy years of life due to a specific cause based on detailed epidemiological information. In 2008, non-communicable diseases accounted for an estimated 86 percent of the burden of disease in high-income countries, 65 percent in middle-income countries, and a surprising 37 percent in low-income countries.

Figure 3. The Increasing Burden of Chronic Non-communicable Diseases: 2008 and 2030



By 2030, noncommunicable diseases are projected to account for more than one-half of the disease burden in low-income countries and more than three-fourths in middle-income countries. Infectious and parasitic diseases will account for 30 percent and 10 percent, respectively, in low- and middle-income countries (Figure 3). Among the 60-and-over population, noncommunicable diseases already account for more than 87 percent of the burden in low-, middle-, and high-income countries.

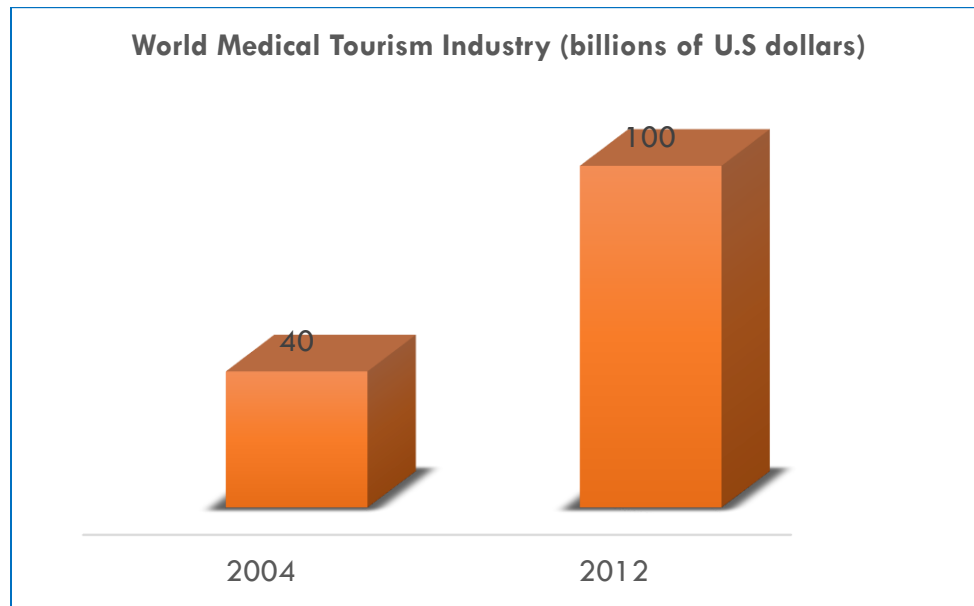
But the continuing health threats from communicable diseases for older people cannot be dismissed, either. Older people account for a growing share of the infectious disease burden in low-income countries. Infectious disease programs, including those for HIV/AIDS, often neglect older people and ignore the potential effects of population aging. Yet, antiretroviral therapy is enabling more people with HIV/AIDS to survive to older ages. And, there is growing evidence that older people are particularly susceptible to infectious diseases for a variety of reasons, including immunosenescence (the progressive deterioration of immune function with age) and frailty. Older people already suffering from one chronic or infectious disease are especially vulnerable to additional infectious diseases. For example, type 2 diabetes and tuberculosis are well-known “comorbid risk factors” that have serious health consequences for older people.

Global and Regional Competitor Analysis

Global competition is emerging in the health care industry. Wealthy patients from developing countries have long traveled to developed countries for high quality medical care. Now, growing numbers of patients from developed countries are traveling for medical reasons to regions once characterized as “third world.” Many of these “medical tourists” are not wealthy, but are seeking high quality medical care at affordable prices. To meet the demand, entrepreneurs are building technologically advanced facilities outside Africa, using foreign and domestic capital. They are hiring physicians, technicians and nurses trained to global standards, and where qualified personnel are not available locally, they are recruiting expatriates.

Medical tourism is growing and diversifying. Estimates vary, but McKinsey & Company and the Confederation of Indian Industry put gross medical tourism revenues at more than \$40 billion

worldwide in 2004⁵. Others estimate the worldwide revenue at about \$60 billion in 2006⁶. McKinsey & Company projects the total will rise to \$100 billion by 2012⁷.



Source: McKinsey & Company and the Confederation of Indian Industry.

Hospital Service Competitor and Demand

Goodcare underscores the fact that Internationally-known hospitals, such as Bumrungrad in Thailand and Apollo in India, report revenue growth of about 20 percent to 25 percent annually⁸. McKinsey & Company estimates that Indian medical tourism alone will grow to \$2.3 billion by 2012⁹. Singapore hopes to treat 1 million foreign patients that year.⁶ Reports on the number of patients traveling abroad for health care over the past few years are scattered, but all tell the same story. In 2005:

- Approximately 250,000 foreign patients sought care in Singapore, and 500,000 traveled to India for medical care¹⁰.
- Thailand treated as many as 1 million foreign patients¹¹.
- The foreign patients treated in these countries included some of the 500,000 Americans who traveled abroad for medical treatment that year¹².

⁵ McKinsey & Company and the Confederation of Indian Industry, cited in Laura Moser, "The Medical Tourist," *Slate*, December 6, 2005, and Bruce Stokes, "Bedside India," *National Journal*, May 5, 2007.

⁶ See Dudley Althaus, "More Americans Seeking Foreign Health Care Services," *Houston Chronicle*, September 4, 2007.

⁷ McKinsey & Company and the Confederation of Indian Industry, cited in Laura Moser, "The Medical Tourist," and Bruce Stokes, "Bedside India."

⁸ Mark Roth, "\$12 for a Half Day of Massage for Back Pain," *Pittsburgh Post-Gazette*, September 10, 2006.

⁹ McKinsey and the Confederation of Indian Industry, Press Trust of India, 2005.

¹⁰ "Medical Tourism Growing Worldwide," *U Daily* (University of Delaware), July 25, 2005. Available at <http://www.udel.edu/PR/UDaily/2005/mar/tourism072505.html>. Accessed May 22, 2016.

¹¹ Malathy Iyer, "India Out to Heal the World," *Times of India*, October 26, 2016

¹² Jessica Fraser, "Employers Increasingly Tapping Medical Tourism for Cost Savings," *News Target*, November 6, 2016.

Residents of countries with national health insurance, including Canada and the United Kingdom, often travel to other countries, including the United States, because they lack timely access to elective procedures due to rationing. In Canada, physicians cannot privately treat their fellow Canadians if those treatments are covered by the government health plan (Medicare). Also, national health systems sometimes deny treatment to particular patients (for example, because of age or physical condition), and some treatments may not be available to any patients (for example, because of cost)¹³.

However, for most medical tourists, including those from the United States, the reason for travel is financial. The effect of financial incentives on Americans' willingness to travel for medical care is shown by a recent nationwide survey.

- Almost no one would travel a great distance to save \$200 or less.
- Fewer than 10 percent would travel to save \$500 to \$1,000.
- About one-quarter of uninsured people, but only 10 percent of those with health insurance, would travel abroad for care if the savings amounted to \$1,000 to \$2,400.
- For savings exceeding \$10,000 about 38 percent of the uninsured and one-quarter of those with insurance would travel abroad for care¹⁴.

Some American medical tourists are seeking lower prices for treatments not covered by insurance (such as cosmetic surgery and weight loss surgery). Uninsured patients paying the cost out of their own pocket travel because American hospitals often charge cash-paying, uninsured individuals inflated "list" prices, which can be much higher than government or private insurers have to pay¹⁵.

Also, a small but growing number of insurers are creating health plans that encourage enrollees to shop for better prices among approved vendors in other countries and allow them to share in the savings. There are "Medical tourists include residents of countries with national health insurance, where health care is rationed." For example, if a procedure cost \$4,000 less in another country, a patient required to pay 20 percent of the cost (through a copayment) would save \$800 out of pocket.

MARKET OVERVIEW

South Africa

The global healthcare market is facing both challenges and opportunities. Spend is forecast to grow by 5.2% per annum to US\$9.3 trillion by 2018¹⁶, with growing populations and rising incomes increasing demand for healthcare services, whilst increasing longevity and chronic diseases are creating pressure on funding.

Cost is the biggest healthcare issue facing most countries as they try to align supply to demand. Targeted therapies, personalized medicine, genetic-based medicine, medical devices and other

¹³ Who Can Have Fertility Treatment?" BBC Health, undated. Available at http://www.bbc.co.uk/health/fertility/features_who-can.shtml. Accessed April 30, 2016. Also see "Cost of Fertility Treatment," 2006. Available at http://www.gettingpregnant.co.uk/cost_information.html. Accessed April 30, 2016

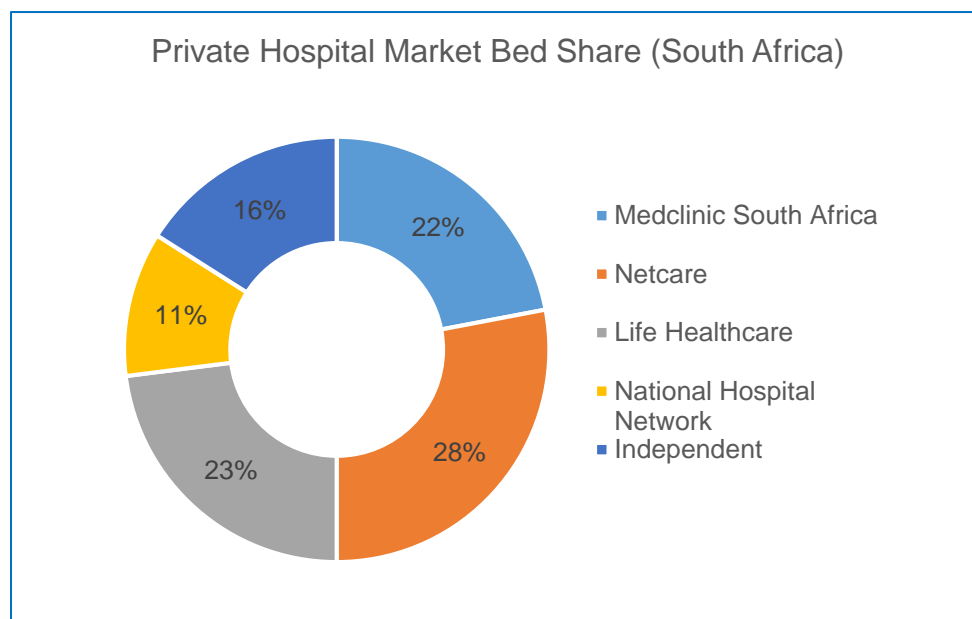
¹⁴ Arnold Milstein and Mark Smith, "Will the Surgical World Become Flat?" Health Affairs, Vol. 26, No. 1, January/February 2007, pages 137-41

¹⁵ Arnold Milstein and Mark Smith, "America's New Refugees — Seeking Affordable Surgery Offshore," New England Journal of Medicine, Vol. 355, No. 16, October 19, 2006

¹⁶ Source: Deloitte 2015 Global healthcare outlook report

technology advances are delivering significant advances in patient care but driving up costs at the same time. Healthcare providers are scaling up to address these opportunities and challenges, with consolidation becoming a key feature of the market to ensure access to technology and attract resources in an increasingly competitive market for highly qualified staff – especially doctors and nurses.

The global healthcare regulatory landscape is complex and evolving. The primary driver is patient health and safety, with government scrutiny varying widely from country to country. Patients are becoming more cost conscious and involved in healthcare decisions, with concerns about data security rising.



Private health expenditure covers approximately 16.3% of the national population, representing around 4.2% of GDP. Around 8,785,048 people were insured by medical schemes in 2015¹⁷.

Switzerland

In 2014 the Swiss healthcare market comprised 289 registered hospitals with about 1.4 million hospital visits and an average length of stay of nine days. About 40% of hospitals are in the private sector, providing about one-fifth of hospital services and employing approximately 20 000 people. Switzerland spends around 11% of its GDP on healthcare costs, lying at second place in the ranking of OECD countries, with costs of healthcare rising to CHF71 billion in 2014. Approximately 32% of this is funded by the private sector.

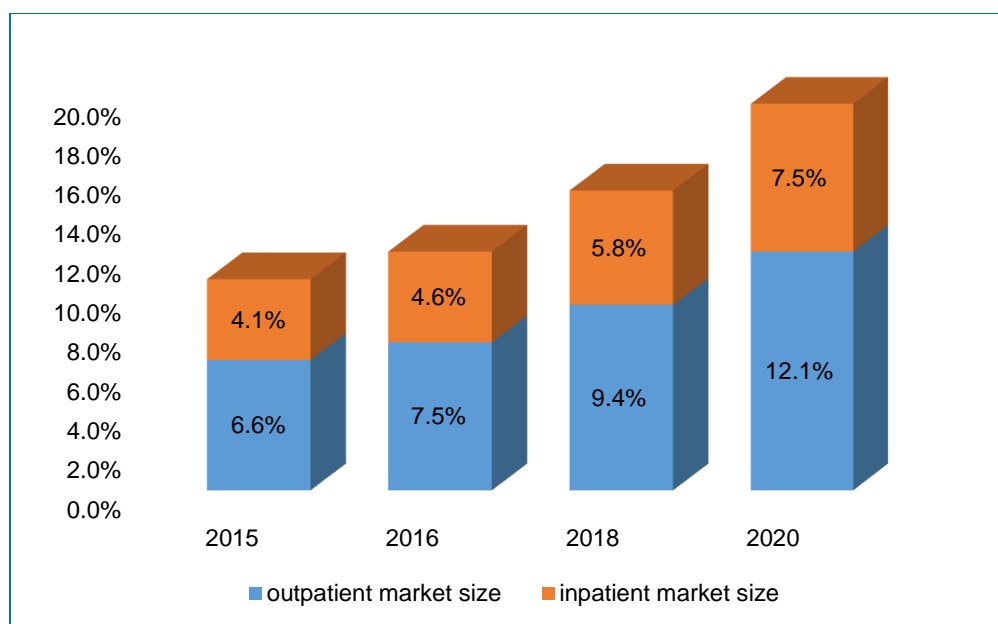
SWOT Analysis

UAE

The market for private healthcare in the UAE reached US\$10.7bn in 2015, with predicted growth rates of 12.7% CAGR to 2020 and the number of beds forecast to rise from 12 007 to 13 881 over the same period.

Healthcare Market Size Forecast (UAE)

¹⁷ Source: Council for Medical Schemes Quarterly Report for the period ending 30 September 2015



Estimated health worker deficit by region and income

The actions required to have a fit-for-purpose and fit-to-practise health workforce in the 21st century amount collectively to a paradigm shift across several dimensions of HRH governance, financing, education, deployment and management. Applying a labour market framework to the health workforce discourse helps to understand the interconnectedness of these elements and to identify relevant policy levers.

Region	Demand based gap			Needs-based gap (3 .45/1000 threshold)		
	2012	2030	AEGR in supply	2012	2030	AEGR in supply
Europe & Central Asia	1,628,263	4,485,682	2.37%	0	0	NA
Latin America & Caribbean	629,735	2,240,624	6.01%	249,842	427,429	3.12%
Middle East & North Africa	311,899	1,814,130	5.05%	268,459	439,869	3.93%
North America	672,192	3,713,399	3.51%	0	0	NA
South Asia	398,190	3,432,044	3.87%	2,291,638	3,481,713	3.91%
Sub-Saharan Africa	466,113	2,356,154	6.68%	2,103,770	3,757,522	10.21%
Income						
Lower middle	2 251,233	10,658,754	5.63%	3,091,924	5,013,848	4.20%
Upper middle	9,929,267	24,871,142	8.52%	1,044,690	1,583,102	1.51%
High	2,243,762	8,723,184	2.97%	54,965	89,536	3.37%
World	14,612,068	45,371,281	5.64%	6,400,362	10,124,528	3.86%

Medical Staff and Workforce Availability

In May 2016, the sixty-ninth World Health Assembly (69th WHA) endorsed the Global Strategy on Human Resources for Health: Workforce 2030, and adopted a resolution (WHA69.19) in support of its implementation. The GSHRH has an overall goal of improving health and socioeconomic development outcomes by ensuring universal accessibility, acceptability and quality of the health workforce through adequate investments and the implementation of effective policies at national, regional and global levels. The vision is to accelerate progress towards universal health coverage and the UN Sustainable Development Goals. To achieve this, the GSHRH presents four objectives: 1) optimize the existing workforce; 2) anticipate future workforce requirements; 3) strengthen individual and institutional capacity; and 4) strengthen the data, evidence and knowledge.

The GSHRH resolution (WHA69.19) urges Member States to consolidate a core set of HRH data with annual reporting to the Global Health Observatory, as well as progressive implementation of NHWA to support national policy and planning and the GSHRH's monitoring and accountability framework. The aim of NHWA is to create a harmonized, integrated approach for annual and timely collection of health workforce information, improve the information architecture and interoperability, and define core indicators in support of workforce policy and planning and global monitoring. The concept was first presented at the Measurement and Accountability for Results in Health Summit (June 2015) and was identified as one of the priority action areas for strengthening country data and accountability systems. It was endorsed as part of the Roadmap for Health Measurement and Accountability and is currently part of the Health Data Collaborative – an initiative which aims for improved partner collaboration and joint action aligned around country health priorities. The implementation of NHWA is a progressive agenda in the period 2016 – 2030 and beyond.

THE FUNDING STRUCTURE.

(Finance Bi-lateral cooperation between the Governments of Uganda and Poland).

BGK BANK, KUKI Insurance and the Ministry of Trade in Poland.

The project will be funded by BGK Bank in cooperation with KUKI Insurance to open a Credit line for Uganda Government starting with Good Care International Teaching University Hospital in Uganda.

BGK bank as the only state development bank in Poland has a long history of financing projects on a basis of Build Operate and Transfer under the Financing principle of up to 85% from the funders and 15% from Uganda government.

The implementation of the funding process entails the initialization of a bi-lateral relationship between the Government of Uganda and the Government of Poland.

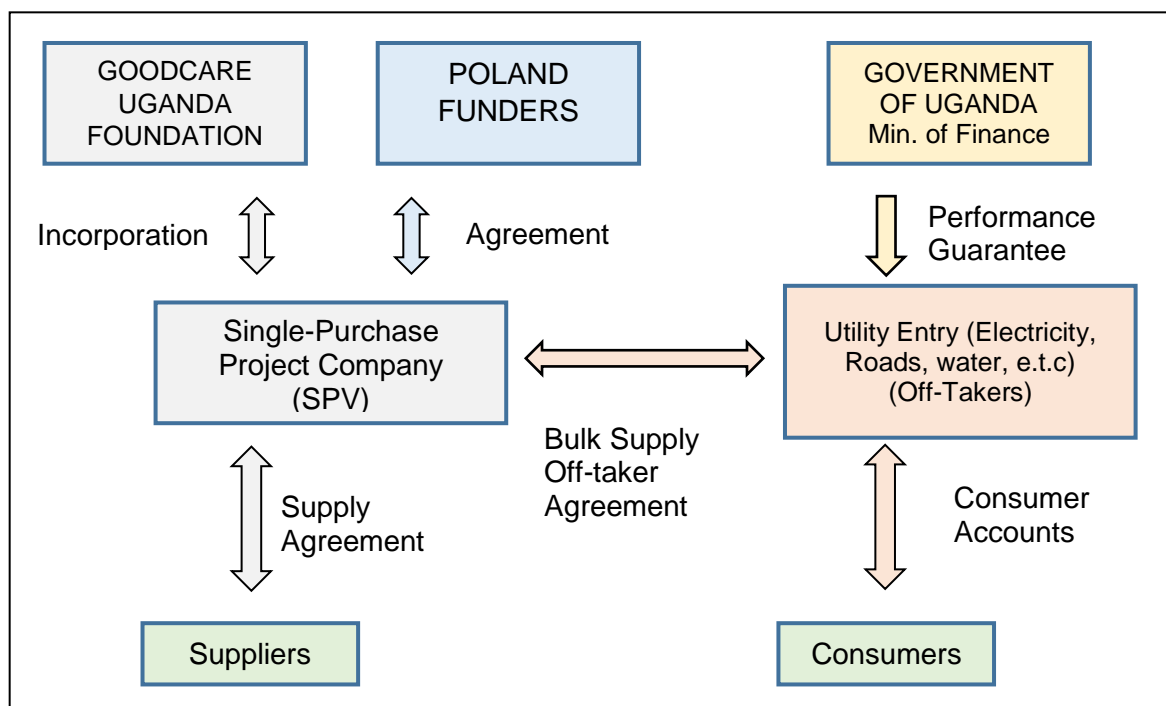
The benefactor Ministry of Health of Uganda shall formally request the Ministry of Finance of Uganda to cogitate issuing an official letter to BGK Bank and KUKI confirming the interest in a bi-lateral financial cooperation supported by the Ministry Trade of Poland (where Polish companies (IDS-BUD, ALVARO and the Pharmaceutical Research Institute are involved).

Sharply followed by the internal analysis process carried on by BGK and KUKI concerning the limit for financing/insuring for Uganda State Treasury.

At an advanced level, the two parties shall be involved in the Signing of a Memorandum of Understanding (“the MoU”) establishing basic terms and conditions which shall be implemented in each future facility agreement.

The government of Uganda, Good care Uganda Foundation and the Polish Funders will join to establish a special purpose vehicle (SPV) company to work on the design, construction, operations and maintenance of Good care international teaching hospital for a specified government-granted concession for a period of around 13 years (3 years’ construction plus 10 years’ operation), after which the facility would be handed back to Good care Uganda Foundation. The initial investment is intended to be recovered through revenues from the services provided during the concession period, which will be determined to sufficiently pay off the debt incurred and earn an acceptable profit from the hospital cash flows.

Build-Operate-Transfer (BOT).



The estimated total capital cost (including equipment) is US\$110 million. The financing plan of Good care international teaching hospital will take three to five years to firmly establish its reputation and start generating positive cash flow. For this reason, the total cost of establishing the hospital will be financed with long-term funds from the Polish funders and will not place large payback burdens on the hospital soon after its opening. The financing plan consists of long-term equity. The financing plan, will largely be discussed with various potential financial partners, the availability of financing and its conditions so as to gain a reasonable sense of whether Good care will be able to obtain the financing necessary for the hospital.

Regulatory Requirements

World Health Organizations' Guidelines in the Planning and Design of A Hospital and Other Health Facilities

Goodcare international teaching hospital will adhere to WHO guidelines for planning and designing a hospital as indicated. A hospital and other health facilities shall be planned and designed to observe appropriate architectural practices, to meet prescribed functional programs, and to conform to applicable codes as part of normal professional practice. References shall be made to the following:

Environment:

A hospital and other health facilities shall be so located that it is readily accessible to the community and reasonably free from undue noise, smoke, dust, foulodor, flood, and shall not be located adjacent to railroads, freight yards, children's playgrounds, airports, industrial plants, disposal plants.

Occupancy:

A building designed for other purpose shall not be converted into a hospital. The location of a hospital shall comply with all local zoning ordinances.

Safety:

A hospital and other health facilities shall provide and maintain a safe environment for patients, personnel and public. The building shall be of such construction so that no hazards to the life and safety of patients, personnel and public exist. It shall be capable of withstanding weight and elements to which they may be subjected.

Exit:

Exits shall be restricted to the following types: door leading directly outside the building, interior stair, ramp, and exterior stair. A minimum of two (2) exits, remote from each other, shall be provided for each floor of the building. Exits shall terminate directly at an open space to the outside of the building.

Security:

A hospital and other health facilities shall ensure the security of person and property within the facility.

Patient Movement:

Spaces shall be wide enough for free movement of patients, whether they are on beds, stretchers, or wheelchairs. Circulation routes for transferring patients from one area to another shall be available and free at all times. Corridors for access by patient and equipment shall have a minimum width of 2.44 meters.

Corridors in areas not commonly used for bed, stretcher and equipment transport may be reduced in width to 1.83 meters. A ramp or elevator shall be provided for ancillary, clinical and nursing areas located on the upper floor. A ramp shall be provided as access to the entrance of the hospital not on the same level of the site.

Lighting:

All areas in a hospital and other health facilities shall be provided with sufficient illumination to promote comfort, healing and recovery of patients and to enable personnel in the performance of work.

Ventilation:

Adequate ventilation shall be provided to ensure comfort of patients, personnel and public.

Auditory and Visual Privacy:

A hospital and other health facilities shall observe acceptable sound level and adequate visual seclusion to achieve the acoustical and privacy requirements in designated areas allowing the unhampered conduct of activities.

Water Supply:

A hospital and other health facilities shall use an approved public water supply system whenever available. The water supply shall be potable, safe for drinking and adequate, and shall be brought into the building free of cross connections.

Waste Disposal:

Liquid waste shall be discharged into an approved public sewerage system whenever available, and solid waste shall be collected, treated and disposed of in accordance with applicable codes, laws or ordinances.

Sanitation:

Utilities for the maintenance of sanitary system, including approved water supply and sewerage system, shall be provided through the buildings and premises to ensure a clean and healthy environment.

Maintenance:

There shall be an effective building maintenance program in place. The buildings and equipment shall be kept in a state of good repair. Proper maintenance shall be provided to prevent untimely breakdown of buildings and equipment.

Material Specification:

Floors, walls and ceilings shall be of sturdy materials that shall allow durability, ease of cleaning and fire resistance.

Segregation:

Wards shall observe segregation of sexes. Separate toilet shall be maintained for patients and personnel, male and female, with a ratio of one (1) toilet for every eight (8) patients or personnel.

Fire Protection:

There shall be measures for detecting fire such as fire alarms in walls, peepholes in doors or smoke detectors in ceilings. There shall be devices for quenching fire such as fire extinguishers or fire hoses that are easily visible and accessible in strategic areas.

Signage

There shall be an effective graphic system composed of a number of individual visual aids and devices arranged to provide information, orientation, direction, identification, prohibition, warning and official notice considered essential to the optimum operation of a hospital and other health facilities.

Parking.

A hospital and other health facilities shall provide a minimum of one (1) parking space for every twenty-five (25) beds.

Zoning

The different areas of a hospital shall be grouped according to zones as follows:

- Outer Zone – areas that are immediately accessible to the public: emergency service, outpatient service, and administrative service. They shall be located near the entrance of the hospital.
- Second Zone – areas that receive workload from the outer zone: laboratory, pharmacy, and radiology. They shall be located near the outer zone.
- Inner Zone – areas that provide nursing care and management of patients: nursing service. They shall be located in private areas but accessible to guests.
- Deep Zone – areas that require asepsis to perform the prescribed services: surgical service, delivery service, nursery, and intensive care. They shall be segregated from the public areas but accessible to the outer, second and inner zones.
- Service Zone – areas that provide support to hospital activities: dietary service, housekeeping service, maintenance and motorpool service, and mortuary. They shall be located in areas away from normal traffic.

Function:

The different areas of a hospital shall be functionally related with each other.

- The emergency service shall be located in the ground floor to ensure immediate access. A separate entrance to the emergency room shall be provided.
- The administrative service, particularly admitting office and business office, shall be located near the main entrance of the hospital. Offices for hospital management can be located in private areas.
- The surgical service shall be located and arranged to prevent non-related traffic.
- The operating room shall be as remote as practicable from the entrance to provide asepsis. The dressing room shall be located to avoid exposure to dirty areas after changing to surgical garments. The nurse station shall be located to permit visual observation of patient movement.
- The delivery service shall be located and arranged to prevent non-related traffic.
- The delivery room shall be as remote as practicable from the entrance to provide asepsis.
- The dressing room shall be located to avoid exposure to dirty areas after changing to surgical garments. The nurse station shall be located to permit visual observation of patient movement.
- The nursery shall be separate but immediately accessible from the delivery room.
- The nursing service shall be segregated from public areas.
- The nurse station shall be located to permit visual observation of patients. Nurse stations shall be provided in all inpatient units of the hospital with a ratio of at least one (1) nurse station for every thirty-five (35) beds. Rooms and wards shall be of sufficient size to allow for work flow and patient movement.
- Toilets shall be immediately accessible from rooms and wards.
- The dietary service shall be away from morgue with at least 25-meter distance.

Space:

Adequate area shall be provided for the people, activity, furniture, equipment and utility.

Local Regulatory Requirements

Goodcare understands that MoH coordinates the drafting of bills to promote and regulate health services and that the government of Uganda has put in place policy analysis units to support sectors in this area. Goodcare international hospital will adhere to the regulatory frameworks enshrined in various bills such as the Pharmacy Profession and Practice Bill, Uganda Medicines Control Authority Bill, Food and Nutrition Bill, Food and Drug Act, National Health Insurance

Bill and the Traditional and Complementary Medicines Bill of which some are at different stages of development.

Goodcare International Teaching Hospital SWOT Analysis

The hospitals' responsibility is to implement change that is beneficial to the patient, staff, and the community. The primary areas driving change in quality healthcare include quality improvement, customer satisfaction, improvement of working conditions, and diversification of the healthcare workforce.

INTERNAL	Strengths	Weaknesses
	<ul style="list-style-type: none"> Outstanding Medical Staff Strong Commitment Excellent Hospital Facility Advanced health care High level of organizational efficiency Research programmes High tech equipment 	<ul style="list-style-type: none"> Structural inertia High transaction costs
EXTERNAL	Opportunities	Threats
	<ul style="list-style-type: none"> Growing metropolitan community Increased managed care business Technological developments Insurance industry picking up 	<ul style="list-style-type: none"> Highly regulated industry Ethical pressure Economic crisis Fluctuation of raw materials

FEASIBILITY ANALYSIS

The 1000-bed Goodcare international teaching hospital will be constructed by Polish companies using 80% of the local labor. The hospital will be located in the central region of Uganda in close proximity to numerous prominent private and public institutions. The location of Goodcare international hospital will afford a very central locale with access to a significant population base.

Goodcare seeks to use the hospital in establishing a regionally competitive specialist international teaching hospital, delivering a wide scope of healthcare services not currently available in Uganda. The scope of services will include specialties in cardiology and cardiothoracic surgery, cancer, women and child health, stem cell and regenerative medicine, neurology and minimally invasive surgery, and have the latest in state-of-the-art medical equipment such as MRI and CT scanners and nuclear medicine. It will ensure that Ugandans have access to world-class care when they need it and where they need it.

The feasibility study considered the commercial viability of the private sector operating Goodcare international hospital and concluded that the hospital can deliver a reasonable profit margin.

Service Structure

The table below shows the types of services that will be delivered in Goodcare hospital.

Medicine	# Bed	Surgery	# Bed
Cardiology	65	Cardiothoracic Surgery	80

Respiratory	35	Vascular Surgery	40
Neurology	45	Orthopedics	85
Nephrology	40	Neurosurgery	35
Gastro-intestinal Medicine	60	Urology	35
Endocrinology	15	Dental / Oral and Maxillofacial	40
Oncology – chemotherapy	60	ENT	40
Oncology – radiotherapy	60	Plastic and Reconstructive Surgery	40
Rehabilitation / Geriatrics: Orthopaedics (Combined with Stroke)	60	Intensive Care Unit	35
Coronary Care Unit	50	Gastro-intestinal Surgery & Other Surgery	80
Total	490	Total	510

Market analysis

As part of the feasibility study, we reviewed the existing services available both in Uganda and East Africa. Our research conducted through a household survey suggests that patients are willing to consider healthcare within Uganda provided the quality is assured. The key finding is that there are no comparably high-quality services of international standards currently offered in Uganda, and 17% of all respondents had traveled abroad for tertiary care services (rising to 40% in some middle-income brackets). Taken alongside the epidemiological analysis, this supports the case that demand is sufficient for an additional 1000-bed care hospital with international standards in Uganda.

A 600-household survey captured attitudes toward Uganda's private health sector. Findings included a high utilization – over 98% - of private medical care across all income levels surveyed. Of those households surveyed, 17% had sought medical treatment abroad. A report compiled from a ministerial retreat which was convened by the Prime Minister's Office in December 2011 to assess the government's performance in the previous year, revealed that the government spends at least \$150m (about SHS400B) on treatment of mostly top government officials abroad annually. The key factors such as regular misdiagnosis and a lack of quality facilities currently available in Uganda are responsible for this medical tourism abroad.

Available epidemiological data were analyzed to establish whether sufficient burden of disease exists to support additional beds providing the proposed scope of services. Uganda suffers from very poor health indicators, common across the services envisaged for the Goodcare international teaching hospital. The disease incidence data clearly show demand for services will be more than sufficient to support Goodcare international teaching hospital.

Site Assessment

The site will be fully assessed to grant an opinion on the facility's suitability to serve in its intended capacity as an international teaching hospital. An expert was commissioned to fully document the extent of remediation work required as well as its suitability from a medical planning perspective. As per the MoH requirements, the following assets are included in the site assessment: Goodcare international teaching Hospital, Transformer/Switch Room and Stock Room.

Significant remediation work is required to bring the building to international standards. The site and building survey estimated the total work at 235 billion shilling (US\$ 67.2). In addition, the

medical planning assessments showed the hospital would need to be structurally remediated to deliver the intended services. The cost of this work is estimated at 350 million shilling (US\$ 10m) and also suggests the building's capacity be limited to 1000 beds, meeting international norms regarding beds per square meter.

Key remediation activities were undertaken and are identified within the detailed assessment. The "specification of the preliminary design" agreed with the Polish government is contained in the full site and building report.

There will likely be a number of alternative approaches to each remediation and the precise approach taken by any prospective bidder to deliver international healthcare services will depend on their service delivery model. In the financial analysis we compare the cost scenarios of remediation versus new build, allowing the MoH to make an informed investment decision for making the site operational.

These findings do not fundamentally affect the feasibility of a PPP partner to operate Goodcare international teaching hospital, but rather provide inputs into the financial model determining the financial feasibility.

Accreditation

Options for international accreditation were included. Accreditation aims at achieving the best standards with the available resources, placing emphasis on overall performance and patient safety. Hence the quality of the management team and the quality control is pivotal. The goal of accreditation can be reached within 3-5 years, but it is important to consider the high cost and the effect on service demand due to affordability.

Financial Model Assumptions

The financial model incorporated the following key assumptions:

- Full financial sustainability is maintained
- No burden on public funds for operational costs
- Achieving international standards of operations
- Full professional staffing to accommodate capacity projections and utilization
- Adequate level of equipment and maintenance
- Full cost recovery from patients

Organization and Management Structure and Staffing

Goodcare International Hospital will be comprised of three elements that will be effectively integrated to ensure optimal patient care, these are; a well-functioning governing body, and both highly trained and competent medical staff and hospital staff members.

Governing Body

The Board of Trustees or Board of Directors will be the executive body that governs hospital organization. Members will be carefully selected from the community. Although members often have a business or health background, a wide range of skills and talent will be sought to fulfill the requirements of the Board. The Board will be responsible for the establishment of the hospital's by-laws and policies, enforcement of the Public Hospitals Act, according to the Regulations 729 and 965 concerning the management of a hospital. In a nutshell, the Board will be ethically, financially and legally responsible for 'everything' in the day-to-day operations of a hospital.

The Board will organize itself into a variety of committees, including those that encompass financial activities, community relations, planning, quality assurance and personnel. It will also be

responsible for organizing medical, dental and midwife staff hospital privileges and duties. Board By-Laws provide details on the organization of the hospital management and administration, an occupational health and safety program, a health surveillance program, avenues for staff participation, organ and tissue donation policies and procedures and a fiscal advisory committee which offers recommendations on monies allocated to the operation of the hospital including staffing. Information regarding the Goodcare International Teaching Hospital Administrative By-Law can be found here.

Hospital Administration

The organizational structure of Goodcare International Teaching Hospital will generally consist of several layers. The Hospital Administrator or President is at the top of the hierarchy (directly under the Board) followed by a second level of department managers often designated as Vice-Presidents and a third level of managers referred as Directors or Coordinators of various departments throughout the hospital.

The Hospital Administrator, also referred to as the Hospital Director, Executive Director, President, or Chief Executive Officer (CEO), will be responsible for creating a vision and mission statement for the hospital and its day to day management. The Administrator also will ensure that a budget is in place, maintains medical staff relations, reports to the Board of Trustees and carries out the directives set out by the Board of Trustees. The Administrator will ultimately be responsible for the staffing and operations of the hospital.

Second level managers will typically include a minimum of three, including a COO, a CFO and a Director of Nursing who report directly to the Administrator. The Chief Operating Officer (COO) will instead be referred to as the Vice-President of Operations or Assistant Executive Director of Operations. The COO will be responsible for daily the operations of the hospital. The Chief Financial Officer (CFO) will be referred to as the Vice-President of Finance or the Assistant Executive Director of Finance. The CFO will be responsible for the financial management of hospital funds. The Director of Nursing (DON) will instead be given the title Associate Director of Nursing, Vice-President of Nursing, or Assistant Executive Director of Nursing. This person will be in charge of supervising all patient care in the hospital

Staffing

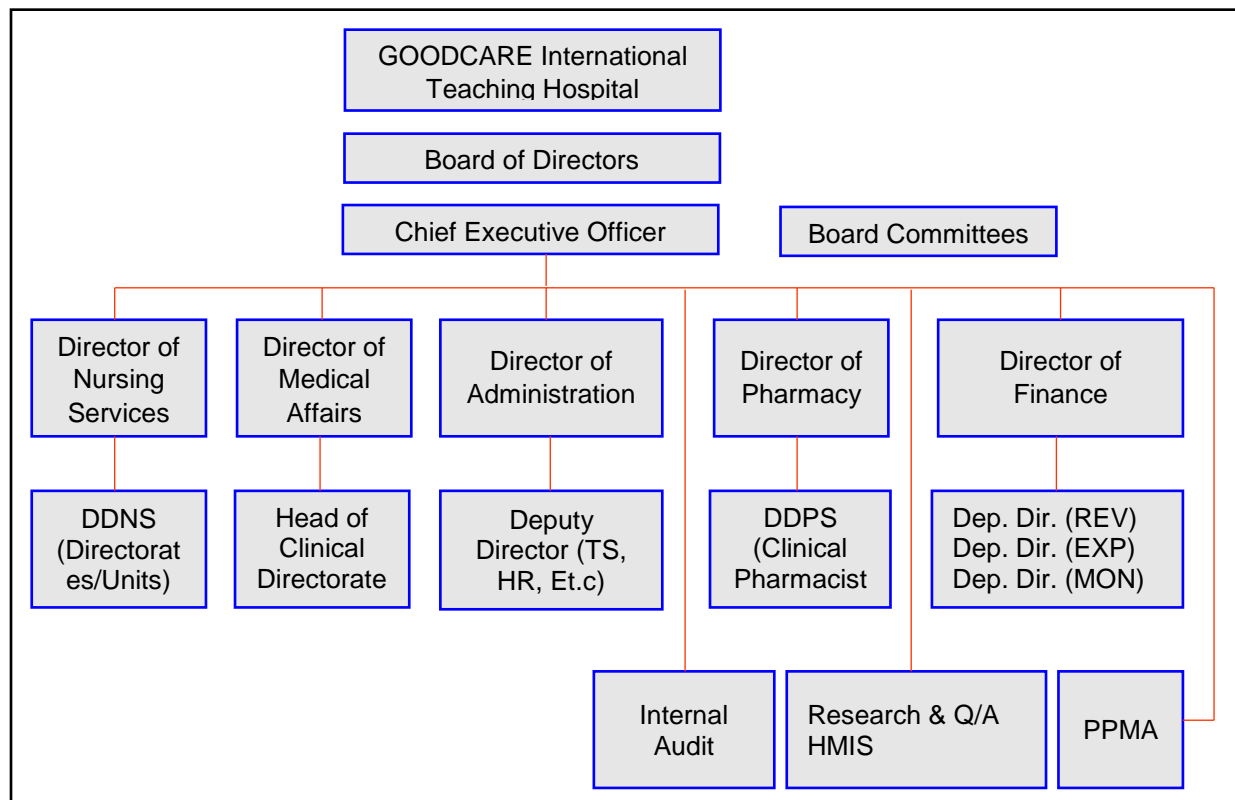
Medical Staff Overview

The medical staff includes physicians (General Practitioners), dentists, psychologists, psychiatrists, podiatrists and specialty/sub-specialty physicians (e.g. Cardiologists). New medical staff are appointed by the Board of Trustees upon recommendation by the Medical Advisory Committee (MAC). The medical staff are organized into departments (e.g. internal medicine, surgery, family practice, obstetrics and gynecology, pediatrics). Clinical departments have a department head who oversees functioning of its department.

Staffing Formula (Standard Value of Nursing Care)

#	Cases/Patients	NCH/pt/day	Prof. to Non-Prof Ratio
1	Surgery	3.4	60:40
2	General Ward	3.5	60:40

3	Pediatric	4.6	70:30
4	Pathologic Nursery	2.8	55:45
5	Medical	3.4	60:40
6	OB	3	60:40
7	ICU/ER/RR	6	70:30
8	CCU	6	80:20



Clinical Department: Functions

The clinical departments of a hospital are responsible for establishing the standards of practice for their specialty, as well as providing continuing education, monitoring individual physicians' performance, and providing a forum for the exchange of ideas and new techniques. The medical staff have a unique relationship with hospital in that most are not hospital employees but rather they are in private practice and therefore self-employed. The medical staff may be faculty members at a school of medicine (e.g. Western University). Those who are employees tend to be the Emergency Room doctors, Pathologists, Radiologists and physicians in charge of Infection Control.

Medical Staff: Organizational Structure

The medical staff are directly linked to the hospital organization. An elected Chief of (Medical) Staff serves as a liaison to hospital Administrator. The Administrator and Chief of Staff work together to resolve issues, achieve mutual goals and most importantly to provide optimal patient care.

Medical Staff: Designations

Members of the medical staff are given various titles dependent upon their education, hospital privileges and duties. For instance, Honorary Staff are physicians who have provided an exemplary or long-standing service to the hospital. However, they do not have attendance or voting privileges at committee (e.g. MAC) meetings. Consulting Staff do have attendance and voting privileges at committee meetings. They are also specialists (e.g. Surgeons) who are in good standing within their field. Active Staff comprise the main body of physicians in a hospital and are responsible for committee work and the administrative duties on behalf of the medical staff. Active Staff attend and treat their private patients as well as patients in clinics at the hospital. They have committee attendance and voting privileges. Associate Staff are newly appointed physicians for a set period of time. Their status will be changed to Active once their commitment to patient care is proven. Courtesy Staff are physicians, typically Family Practitioners, who are given the opportunity to attend to their own patients who have been hospitalized. They are able to attend committee meetings but may not vote or hold office. Residents are physicians who are completing post-graduate training (3-4 years) in a specific field of medicine (e.g. oncology, neurology, dermatology).

Medical and Surgical Departments

Medical and surgical departments are categorized into specialty departments. Larger hospitals may subdivide departments to ensure that adequate representation and chain of command will happen. The number of divisions depends upon the services provided at the hospital. Typically, each division or department has a department head and each sub-division has a chief or chair of service who is responsible to the department head. Medical departments include the following: Internal Medicine, Psychiatry, Neurology, Dermatology, Cardiology, Geriatrics, Endocrinology, Pulmonary Diseases, Rheumatology, Gastroenterology and Immunology/ Allergy. Surgical departments include: General Surgery, Neurologic Surgery, Ophthalmology, Urology, Orthopedic Surgery, Obstetrics and Gynecology, Plastic Surgery and Proctology. (Make sure you are familiar with the meaning of each of the above. e.g. the dermatology department deals with issues relating to the skin; orthopedic surgery deals with conditions relating to the bones and muscles)

Hospital Staff (Support Services)

Many other departments and support staff are required to keep a hospital running smoothly from day to day. They include:

- The Accounting department which is responsible for payables, receivables, payroll and materials management.
- Cardiopulmonary support services including Electrocardiogram, Holter Monitoring, Nuclear Cardiology and Echocardiography
- Pulmonary services including respiratory therapy and pulmonary function
- Neurology services such as performing Electroencephalography (EEG)
- Dietary services involving diet counseling and Total Parenteral Nutrition (TPN) consultation
- Educational Services for new employees and volunteers
- Health Records that are compiled and maintained for access by medical staff and patients or their families
- Diagnostic imaging including Radiography, Nuclear medicine and Ultrasound
- Chiropractic services
- Perfusionist services
- Laboratory services including Hematology, Pathology and Cytology
- Mental Health services such as an outpatient clinic

- Rehabilitation services such as a Sports Medicine Clinic, Physiotherapy, Occupational therapy and Speech and Audiology
- Renal Dialysis including Hemodialysis and Peritoneal dialysis
- Central Service Department which provides non-pharmaceutical supplies for nursing and specialized units (often called Supply, Porter and Distribution or SPD)
- Social Work which includes discharge planning, crisis intervention for Emergency Room patients and counseling services
- Volunteer services which organizes volunteers to conduct fundraising activities, provide in-patient library service and to staff the gift shop

Implementation Stages

Phase	Activities	Comments
I. Identification		
Identify Hospital Infrastructure Needs	Human Resource and Staffing Bed Capacity Safety Requirements and targets Centers of Excellence Use rates – Science & Technology Machine Utilization Targets Transportation Ambulance services Utilities	
Understand the Application Procedures	Application procedures for funding from BJK Bank - Poland	The eligibility criteria required by Good care for funding has been evaluated.
Analyze the Available resources	Land for the Hospital Project Geographical Access Hospital Market Share Hospital site planning (outside and inside the hospital) – Feasibility and suitability Zoning Analysis – current space, building space and future development space End-user involvement to include preferences and local requirements	
Analyze the context and community needs	Healthcare Access Health Disparities and Resource Deserts	

	<p>Infrastructure - Unifying Prevention Efforts and Maximizing Resources Behavioral Health</p> <p>Projected Inpatient Volume Utilization rates Quality of care and Treatment Required Beds Outpatient specialist care</p>	
Draw up the substantiation note		
Draw up the expertise report		
Initial Budget Development		
Assess the socio-economic impact of project development	<p>Employment Goods and services Poverty reduction – increased incomes Saving lives with “24/7” emergency care Offering hope and healing through compassionate, high-quality care. Offer preventive care Screenings, and Education</p>	<p>The hospital will hire people from the community at all skill levels. It will also offer career ladders and training programs that enable members of the community to attain new levels of education and improve their incomes and lives. The economy and community will benefit from the opportunities the hospital will offer to employees to build their skills, achieve a better standard of living, and follow their dreams.</p>
Assess the project sustainability	<p>The hospital will generate revenue through Students tuitions Grants applications and operational research Provision of super specialized services and patient management</p>	<p>The hospital will strive to attract about 10,000 students Health research will attract over 60 grants worth over 100 million USDs within the first five years</p>

		Over 10,000 patients both from Uganda and foreign countries in the first five years
Site identification	Land and site issues have been settled and finalized with the Uganda Investment Authority, with Land acquired in Mbarara (Western Uganda). The site is free from encumbrances The process of delineating boundaries is ongoing.	
Site Assessment	Assessment has been done for suitability to serve in its intended capacity as an international teaching hospital. An expert will be commissioned to fully document the extent of remediation work required as well as its suitability from a medical planning perspective. The site and building survey total work in dollars and the cost of structural remediation to deliver the intended services will be established at the end of phase 1.	
II. Design		
Contract the Feasibility study	Work that is required for feasibility study focused on Design include; Brief description of the existing situation Works to be developed within project Minimal description of each work	The service provider for this activity is yet to be secured upon completion of the first phase.

	<p>Specific requirements to be observed by the designer</p> <p>Available land surveys and</p> <p>Design stages.</p>	
Feasibility Study Development	<p>Four areas designated for feasibility study are;</p> <p>Geotechnical survey - careful analysis of the structural parameters of the terrain, as selection of a favorable site depends upon a particular structural element possessed by the rock.</p> <p>Land survey - Topographical features have also a primary importance in the construction of any engineering</p> <p>Hydro - geological study - intended to provide the designer solutions to deal with water identified underground, accumulation of rain waters</p> <p>Environmental and social impact assessment. The environmental impact assessment represents a specific procedure required by environmental authorities as a basis for providing the environmental permit.</p>	<p>This will also depend on subsequent completion of other phases as one phase feeds into the other one</p>
Feasibility Study Approval	<p>Environmental Impact Assessment</p> <p>Individual wastewater treatment system</p> <p>Acquisition of land</p>	

	Hazardous or toxic materials Impacts on forests and/or protected areas Handling / management of medical waste Traffic and Pedestrian Safety	
Designing of the hospital	Architectural Plans Civil and Structural designs Electrical and Plumbing designs Landscape designs	
Building and Construction		
Equipment and Fittings	Tax exemptions on equipment Audit and approvals Size and space verifications IT and automation compatibility assessments	
III. Appraisal		
Administrative Appraisal	Identify national & local legislation & permits that apply to project activity Urban planning certificate Permits	
Eligibility Appraisal	Land Use Approval – Strategic Plan and Needs Assessment	
Technical and Economic Appraisal	Written parts: General issues related to project promoter; General description of the project with reference to location, topography and geological features, main works, access ways etc; Technical reports for each category of works (electricity networks, water supply, sewerage, access ways, platforms, buildings etc); Technical specifications for each	

	works category; Bill of quantities for each works category and the summary; Execution time schedule. Drawings: General layout, Main topographical drawings, Drawings with project objects, Cross – sections for buildings, Architectural drawings, Structural drawings, Installation drawings, Drawings for equipment to be procured within project (positioning, flows, cinematic charts etc).	
IV. Funding		
Pre-contracting - site visit	Critical success factor Adequate funding – Complete or phased implementation Planned and timely cash flow – To match progress and Payment, Capital contribution and Infrastructure contribution	
Preparation and submission of technical design		
Contract signing		
Budget Approval		
V. Implementation		
Public Procurement of Constructions		
Payments		
Construction works	Authorization of Construction – Building permits	A construction manager will select the architect/engineer. The construction manager is part of the project delivery team and advises the hospital on construction systems and

		techniques that may be incorporated in the design. They may also provide each of the cost estimates prior to the start of construction as well as manage the project delivery schedule.
Equipment and Installations	<p>Critical success factor</p> <p>Important to include the cost and availability of consumables and fuel during commissioning and acceptance phase</p> <p>Important to have competent personnel from both the vendor and end-user to ensure successful testing and commissioning of major equipment</p> <p>Important to have reliable electricity supply during the testing of major or sensitive equipment</p> <p>Important to make provision for proper storage of major and sensitive equipment pending T&C and taking over</p> <p>Important to define and sort out third-party rights, responsibility and licensing especially with regards to ICT</p>	
VI. Commissioning		
	<p>A process to ensure building's systems operate as per intent of the design scope</p> <p>Functional Testing – building system operate & function as designed</p> <p>A systematic and documented process</p>	<p>Contractor</p> <p>Consultants</p> <p>Owner/User – verification</p> <p>P&D, Engineering Div, Users, Support services provider</p>

	building systems perform interactively to design intent and user needs	Five project phases Facility program phase Design phase Construction phase Acceptance phase Post-acceptance phase
VI. Operation and Maintenance	HR & Management	
VII. Evaluation		

Expected Project Timelines

[illegible]

Investment Costs

#	BLOCK	FUNCTIONALITY	LEVELS	Number of Blocks		SQM	Cost per SQM (USD)	Amount
1	A	General Hospital + parking	6	4	930	16600	400	6,640,000.00
2	B	Children's Hospital (shall be far from General Hospital)	5	2	800	5500	500	2,750,000.00
3	C	Cancer Ward	5	2	600	6000	500	3,000,000.00
4	D	Tuberculosis care Center (shall be far from other institution)	5	2	400	12500	400	5,000,000.00
5	E	Specialty Wards i.e. Dental, ENT, medical, surgical that includes orthopedic, neurology, GIT, ophthalmology, urology e.tc.	5	10	300	11500	400	4,600,000.00
6	F	Heart Institute	5	2	700	6500	400	2,600,000.00
7	G	Leisure Room Block i.e. Banking areas, cafeteria, restaurants, lounges, recreation areas	2	1	1100	8500	500	4,250,000.00
8	H	Admin Block i.e. , Laboratories, block for hospital and University separate	6	4	1280	19500	340	6,630,000.00
9	I	Staff Estates near campus & Guest residences at city, e.g. for Visiting professors, volunteers)	5	12	300	14400	400	5,760,000.00
10	J	Students Dormitories (prohibited for rooms sharing, shall have a single room, single apartment and single rooms in a shared flat)	5	5	600	15000	440	6,600,000.00
11	K	Lecture rooms	5	5	500	11000	500	5,500,000.00
13	L	Infrastructure (roads, water, drainage, Gas, electricity, ICT, Emergency landing ground shall be near first class clinical Center)	1	4	1	42000	300	12,600,000.00
14	M	Emergency Power Supply-	1	1	2	950	1400	1,330,000.00
15	N	First aid center (at city center)	2	2	1	2100	400	840,000.00
16	O	Nursing and Medical Assistance Centre	2	2	1	5000	200	1,000,000.00
17	P	First class clinical center	2	2	800	2100	200	420,000.00
		Sub-total						69,520,000.00
18	Q	Other services	1					872,028.00
19	R	Administrative works	2					1,744,056.00
20	S	Consultancy Team and design fees	1					872,028.00
21	T	Furnishing and Machinery	4					3,488,112.00
		Sub-total						6,976,224.00

22	U	Specialized laboratories i.e. Anatomic pathology, Clinical Microbiology, Clinical Chemistry, Hematology and X- ray department	3	1				1,000,000.00
23	V	Oxygen plant	1	1				850,000.00
24	W	Incinerator	1					1,000,000.00
25	X	Central stores	4	2				900,000.00
26	Y	Production department for IV fluids, distilled sterile water, laboratory reagents	2	2				900,000.00
27	Z	Blood transfusion department and special ambulance for blood collection	2	1				950,000.00
28	AA	Central Pharmacy	2	1				1,000,000.00
29	AB	Workshop for University and Hospital e.g. Motor vehicle	1	1				1,000,000.00
30	AC	Research center for GCITH and Administration Block	6	2				750,000.00
31	AD	Training and Technical	1	1	120			500,000.00
32	AE	Medicine package	30	1	2			1,100,000.00
33	AF	Marketing & Advertisement	1	1	1	130	2000	260,000.00
34	AG	Min Super market center with storage facilities, Ware house & one Transportation vehicle	1	1	1	9500	400	3,800,000.00
35	AH	Sports Academy Center & sports irrigation (shall be far from other centers)	3	2		11000	250	2,750,000.00
36	AI	Senior care estate	3	2		10000	400	900,000.00
		Sub-total	1					31,612,448.00
37	AJ	Vehicles for Heads of Departments, Heads of Units, Administrative work transportation, medical waste, including special 6 busses for on Campus and off Campus students and Communities.	30	2				1,300,000.00
38	AK	Ambulances with equipment	10	1				1,160,976.00
		Sub-total						2,460,976.00
39		Grand Total						110,569,648.00

The feasibility study revealed that;

- The hospital will be built without major problems and within the overall budget and time frame.
- The hospital will operate without serious worry of disruption (for example, power shortages, lack of necessary personnel, floods, social unrest, nearby construction or serious pollution).
- The hospital will generate enough cash to pay for all its operating expenses, increases in working capital, and capital expenditures required for proper upkeep

of its facilities; service its debts; and pay dividends and other obligations associated with share capital.

- The base case financial projections are realistic and reasonable enough to allow a high level of confidence that the estimated cash flows can be generated as expected.
- The hospital will operate without serious concern about environmental or health hazards and/or worker safety issues.
- A sufficient amount of funds will be sourced in time and on terms and conditions that the hospital's cash flow can afford.

MARKETING

As increasing patient volume becomes tantamount to staying financially viable, marketing Goodcare international teaching hospital developed a robust marketing plan to market its services to potential referring physicians and patients. Four steps will be followed to create an attractive marketing campaign for a set of service lines.

Market research.

Before deciding how to market the hospital, information about what other teaching hospitals in the region and at continental level and audience profiling will be necessary. We will need to discover 95 percent of the market in our particular service line, so that the expectations for growth will be mitigated against what we will get out of the market.

Prioritizing marketing goals.

Once we have conducted market research, we will take a systematic approach to marketing as opposed to a reactive approach. We will engage in a campaign to promote based on empirical studies.

Figuring out the budget.

Once we've decided which service lines we will use for the campaign, we will tweak our service line decision somewhat depending on finances.

Creating a tactical plan.

Once the strategic plan is in place detailing the service lines that we will target, we will create a tactical plan to figure out the "nuts and bolts" of the campaign.

PROJECT FINANCIAL ANALYSIS

Revenue Generation

Students Category	Forecasted Number of Students	Tuition fees per student (USD)	Amount (USD)	Cost per student	Total Cost
Local	6,000	800.00	4,800,000.00	430.00	2,580,000.00
International	4,000	1,230.00	4,920,000.00	570.00	2,280,000.00
Total	10,000		9,720,000.00		4,860,000.00

S/No	Revenue Source	Amount (USD)
1	Student(University) Tuitions Fee Generation	3,650,000.00
3	Grants Applications and Operational Research	4,789,000.00
4	Provision of Super Specialized Services and Patient Management	6,590,000.00
5	Targeting Local and International Companies for Medical Care to Employees	4,390,000.00
6	Affiliations with Ten International Universities	2,700,000.00
7	Manage New Innovative Service Lines to Increase Market Share	1,907,000.00
8	Dormitories Fee Fair Rent Generation	1,800,000.00
9	Residential Compound Rent Generation	580,000.00
10	Sports Academy Center Income Generation	440,000.00
11	Min Supermarket Fee Rent Generation	310,000.00
12	Monthly Health Care Income Generation (From Insurance Company)	1,000,000.00
13	Transportation (Daily Buses) Fee Generation	330,000.00
14	Monthly Clinical Care Fee Generation	1,530,000.00
15	Monthly Extra Energy Produced Income Generation	198,000.00
16	Staff Estate Monthly Fee Generation	670,000.00
17	Parking Fee Income Generation	120,000.00
18	Fee for International Patient Income Generation	760,000.00
19	Registration Entrance for General Hospital	110,000.00
20	Senior Care Fee Income Generated (Source GOV)	390,000.00
	Total	32,264,000.00

Annual Operating Expenses

Category	Annual Operating Expenses (USD)	
	Hospital	University
In-patients	589,000.00	-
Out-patients	288,000.00	-
Salaries	980,000.00	650,000.00
Utilities	23,000.00	20,000.00
Equipment	58,000.00	32,000.00
Staff development and training	103,000.00	100,000.00

Sponsorships	376,000.00	440,000.00
Charity Expenses	39,000.00	87,000.00
Insurance	287,000.00	168,000.00
Exchange Programs	211,300.00	430,000.00
Others	870,000.00	667,000.00
Total	3,824,300.00	2,594,000.00

Expected Annual Revenue Generation

S/No	Revenue Source	Amount (USD)
1	Student(University) Tuitions Fee Generation	3,650,000.00
3	Grants Applications and Operational Research	4,789,000.00
4	Provision of Super Specialized Services and Patient Management	6,590,000.00
5	Targeting Local and International Companies for Medical Care to Employees	4,390,000.00
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Cash Flow Projections

CASH FLOW PROJECTIONS

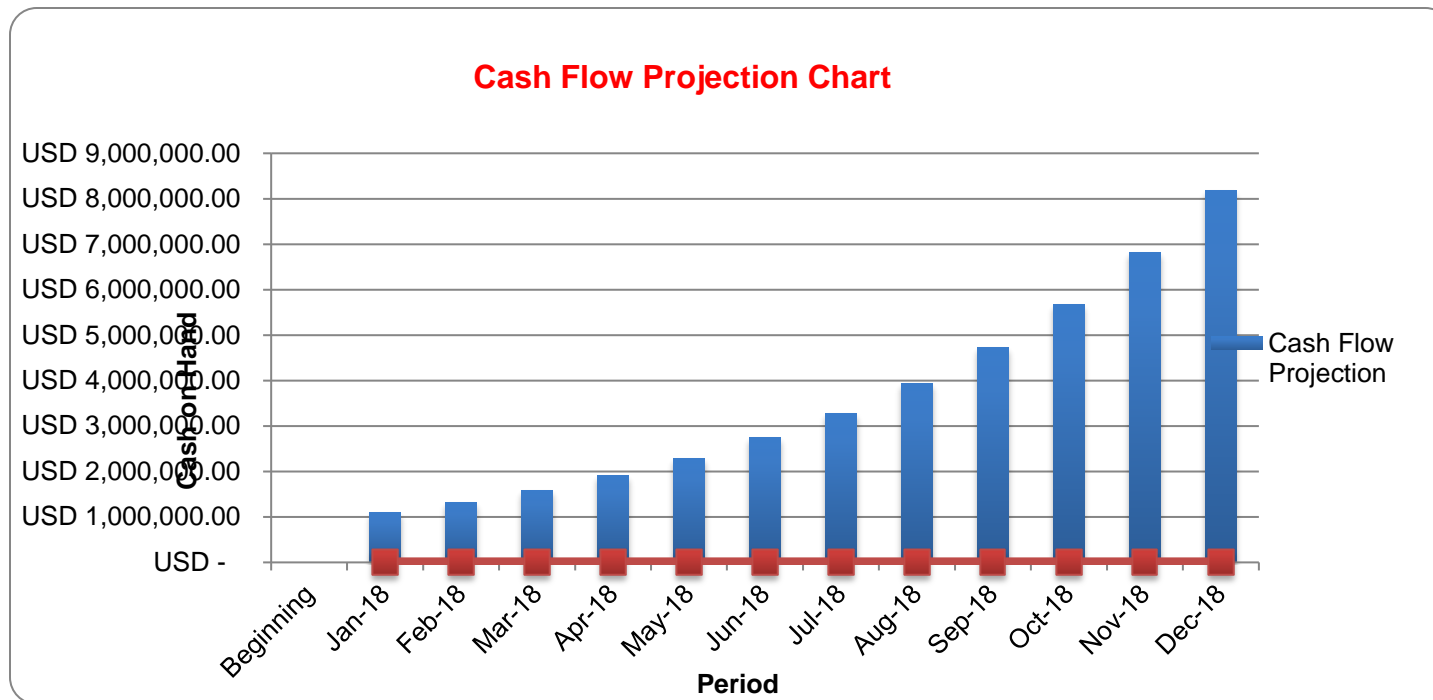
Starting date	Jan-18
Cash balance alert minimum	

	Beginning	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Total
Cash on hand (beginning of month)	USD 36,500,000.00	USD -	USD 1,100,000.00	USD 1,320,000.00	USD 1,584,000.00	USD 1,900,800.00	USD 2,280,960.00	USD 2,737,152.00	USD 3,284,582.40	USD 3,941,498.88	USD 4,729,798.66	USD 5,675,758.39	USD 6,810,910.06	

Expected RECEIPTS														
Student (University) fee generation	USD 3,650,000.00	USD 4,380,000.00	USD 5,256,000.00	USD 6,307,200.00	USD 7,568,640.00	USD 9,082,368.00	USD 10,898,841.60	USD 13,078,609.92	USD 15,694,331.90	USD 18,833,198.28	USD 22,599,837.94	USD 27,119,805.53	USD 144,468,833.18	
Grants applications and operational research	USD 4,789,000.00	USD 5,746,800.00	USD 6,896,160.00	USD 8,275,392.00	USD 9,930,470.40	USD 11,916,564.48	USD 14,299,877.38	USD 17,159,852.85	USD 20,591,823.42	USD 24,710,188.11	USD 29,652,225.73	USD 35,582,670.87	USD 189,551,025.23	
Provisional of super-specialized services and patient management	USD 6,590,000.00	USD 7,908,000.00	USD 9,489,600.00	USD 11,387,520.00	USD 13,665,024.00	USD 16,398,028.80	USD 19,677,634.56	USD 23,613,161.47	USD 28,335,793.77	USD 34,002,952.52	USD 40,803,543.02	USD 48,964,251.63	USD 260,835,509.77	
Targeting local and international companies for medical care to employees	USD 4,390,000.00	USD 5,268,000.00	USD 6,321,600.00	USD 7,585,920.00	USD 9,103,104.00	USD 10,923,724.80	USD 13,108,469.76	USD 15,730,163.71	USD 18,876,196.45	USD 22,651,435.75	USD 27,181,722.89	USD 32,618,067.47	USD 173,758,404.84	
Affiliation with ten international Universities	USD 2,700,000.00	USD 3,240,000.00	USD 3,888,000.00	USD 4,665,600.00	USD 5,598,720.00	USD 6,718,464.00	USD 8,062,156.80	USD 9,674,588.16	USD 11,609,505.79	USD 13,931,406.95	USD 16,717,688.34	USD 20,061,226.01	USD 106,867,356.05	
manage new innovative service lines to increase Market share	USD 1,907,000.00	USD 2,288,400.00	USD 2,746,080.00	USD 3,295,296.00	USD 3,954,355.20	USD 4,745,226.24	USD 5,694,271.49	USD 6,833,125.79	USD 8,199,750.94	USD 9,839,701.13	USD 11,807,641.36	USD 14,169,169.63	USD 75,480,017.77	
dormitories fee fair rent generation	USD 1,800,000.00	USD 2,160,000.00	USD 2,592,000.00	USD 3,110,400.00	USD 3,732,480.00	USD 4,478,976.00	USD 5,374,771.20	USD 6,449,725.44	USD 7,739,670.53	USD 9,287,604.63	USD 11,145,125.56	USD 13,374,150.67	USD 71,244,904.03	
residential compound rent generation	USD 580,000.00	USD 696,000.00	USD 835,200.00	USD 1,002,240.00	USD 1,202,688.00	USD 1,443,225.60	USD 1,731,870.72	USD 2,078,244.86	USD 2,493,893.84	USD 2,992,672.60	USD 3,591,207.12	USD 4,309,448.55	USD 22,956,691.30	
sports academy center income generation	USD 440,000.00	USD 528,000.00	USD 633,600.00	USD 760,320.00	USD 912,384.00	USD 1,094,860.80	USD 1,313,832.96	USD 1,576,599.55	USD 1,891,919.46	USD 2,270,303.35	USD 2,724,364.03	USD 3,269,236.83	USD 17,415,420.99	
min supermarket fee rent generation	USD 310,000.00	USD 372,000.00	USD 446,400.00	USD 535,680.00	USD 642,816.00	USD 771,379.20	USD 925,655.04	USD 1,110,786.05	USD 1,332,943.26	USD 1,599,531.91	USD 1,919,438.29	USD 2,303,325.95	USD 12,269,955.69	
monthly health care income generation (from insurance company)	USD 1,000,000.00	USD 1,200,000.00	USD 1,440,000.00	USD 1,728,000.00	USD 2,073,600.00	USD 2,488,320.00	USD 2,985,984.00	USD 3,583,180.80	USD 4,299,816.96	USD 5,159,780.35	USD 6,191,736.42	USD 7,430,083.71	USD 39,580,502.24	
Transportation (daily buses) fee generation	USD 330,000.00	USD 396,000.00	USD 475,200.00	USD 570,240.00	USD 684,288.00	USD 821,145.60	USD 985,374.72	USD 1,182,449.66	USD 1,418,939.60	USD 1,702,727.52	USD 2,043,273.02	USD 2,451,927.62	USD 13,061,565.74	
monthly clinical care fee generation	USD 1,530,000.00	USD 1,836,000.00	USD 2,203,200.00	USD 2,643,840.00	USD 3,172,608.00	USD 3,807,129.60	USD 4,568,555.52	USD 5,482,266.62	USD 6,578,719.95	USD 7,894,463.94	USD 9,473,356.73	USD 11,368,028.07	USD 60,558,168.43	
monthly extra energy produced income generation	USD 198,000.00	USD 237,600.00	USD 285,120.00	USD 342,144.00	USD 410,572.80	USD 492,687.36	USD 591,224.83	USD 709,469.80	USD 851,363.76	USD 1,021,636.51	USD 1,225,963.81	USD 1,471,156.57	USD 7,836,939.44	
staff estate monthly fee generation	USD 670,000.00	USD 804,000.00	USD 964,800.00	USD 1,157,760.00	USD 1,389,312.00	USD 1,667,174.40	USD 2,000,609.28	USD 2,400,731.14	USD 2,880,877.36	USD 3,457,052.84	USD 4,148,463.40	USD 4,978,156.08	USD 26,518,936.50	
parking fee income generation	USD 120,000.00	USD 144,000.00	USD 172,800.00	USD 207,360.00	USD 248,832.00	USD 298,598.40	USD 358,318.08	USD 429,981.70	USD 515,978.04	USD 619,173.64	USD 743,008.37	USD 891,610.04	USD 4,749,660.27	
fee for international patient income generation	USD 760,000.00	USD 912,000.00	USD 1,094,400.00	USD 1,313,280.00	USD 1,575,936.00	USD 1,891,123.20	USD 2,269,347.84	USD 2,723,217.41	USD 3,267,860.89	USD 3,921,433.07	USD 4,705,719.68	USD 5,646,863.62	USD 30,081,181.70	
registration entrance for general hospital	USD 110,000.00	USD 132,000.00	USD 158,400.00	USD 190,080.00	USD 228,096.00	USD 273,715.20	USD 328,458.24	USD 394,149.89	USD 472,979.87	USD 567,575.84	USD 681,091.01	USD 817,309.21	USD 4,353,855.25	
senior care fee income generated (source (GOV))	USD 390,000.00	USD 468,000.00	USD 561,600.00	USD 673,920.00	USD 808,704.00	USD 970,444.80	USD 1,164,533.76	USD 1,397,440.51	USD 1,676,928.61	USD 2,012,314.34	USD 2,414,777.20	USD 2,897,732.65	USD 15,436,395.87	
TOTAL CASH RECEIPTS	USD 32,264,000.00	USD 27,223,200.00	USD 32,667,840.00	USD 39,201,408.00	USD 47,041,689.60	USD 56,450,027.52	USD 67,740,033.02	USD 81,288,039.63	USD 97,545,647.55	USD 117,054,777.07	USD 140,465,732.48	USD 168,558,878.97	USD 1,277,025,324.31	
Total cash available	36,500,000	32,264,000.00	28,323,200.00	33,987,840.00	40,785,408.00	48,942,489.60	58,730,987.52	70,477,185.02	84,572,622.03	101,487,146.43	121,784,575.72	146,141,490.87		

CASH PAID OUT														
general hospital +parking	USD 6,640,000.00	USD 7,968,000	USD 9,561,600	USD 11,473,920	USD 13,768,704	USD 16,522,445	USD 19,826,934	USD 23,792,321	USD 28,550,785	USD 34,260,942	USD 41,113,130	USD 49,335,756	USD 262,814,53	
children's hospital (shall be far from general hospital)	USD 2,750,000.00	USD 3,300,000	USD 3,960,000	USD 4,752,000	USD 5,702,400	USD 6,842,880	USD 8,211,456	USD 9,853,747	USD 11,824,497	USD 14,189,396	USD 17,027,275	USD 20,432,730	USD 108,846,38	
cancer ward	USD 3,000,000.00	USD 3,600,000	USD 4,320,000	USD 5,184,000	USD 6,220,800	USD 7,464,960	USD 8,957,952	USD 10,749,542	USD 12,899,451	USD 15,479,341	USD 18,575,209	USD 22,290,251	USD 118,741,50	
tuberculosis care center (shall be far from other institution)	USD 5,000,000.00	USD 6,000,000	USD 7,200,000	USD 8,640,000	USD 10,368,000	USD 12,441,600	USD 14,929,920	USD 17,915,904	USD 21,499,085	USD 25,798,902	USD 30,958,682	USD 37,150,419	USD 197,902,51	
specialty wards i.e. Dental, ENT, medical, surgical that includes orthopedic,neurology,GIT,ophthalmology,urology e.t.c	USD 4,600,000.00	USD 5,520,000	USD 6,624,000	USD 7,948,800	USD 9,538,560	USD 11,446,272	USD 13,735,526	USD 16,482,632	USD 19,779,158	USD 23,734,990	USD 28,481,988	USD 34,178,385	USD 182,070,31	
heart institute	USD 2,600,000.00	USD 3,120,000	USD 3,744,000	USD 4,492,800	USD 5,391,360	USD 6,469,632	USD 7,763,558	USD 9,316,270	USD 11,179,524	USD 13,415,429	USD 16,098,515	USD 19,318,218	USD 102,909,30	
leisure room block i.e. Banking areas, cafeteria, restrutants,lounges,recreation areas	USD 4,250,000.00	USD 5,100,000	USD 6,120,000	USD 7,344,000	USD 8,812,800	USD 10,575,360	USD 12,690,432	USD 15,228,518	USD 18,274,222	USD 21,929,066	USD 26,314,880	USD 31,577,856	USD 168,217,13	
admin block i.e.laboratories , block for hospital and university separate	USD 6,630,000.00	USD 7,956,000	USD 9,547,200	USD 11,456,640	USD 13,747,968	USD 16,497,562	USD 19,797,074	USD 23,756,489	USD 28,507,786	USD 34,209,344	USD 41,051,212	USD 49,261,455	USD 262,418,73	
staff estates near campus and guest residences at city, e.g. for visiting professors,volunteers)	USD 5,760,000.00	USD 6,912,000	USD 8,294,400	USD 9,953,280	USD 11,943,936	USD 14,332,723	USD 17,199,268	USD 20,639,121	USD 24,766,946	USD 29,720,335	USD 35,664,402	USD 42,797,282	USD 227,983,69	
students dormitories (prohibited for rooms sharing,shall have a single room,single apartment and single rooms in a shared flat	USD 6,600,000.00	USD 7,920,000	USD 9,504,000	USD 11,404,800	USD 13,685,760	USD 16,422,912	USD 19,707,494	USD 23,648,993	USD 28,378,792	USD 34,054,550	USD 40,865,460	USD 49,038,552	USD 261,231,31	

lecture rooms	USD	5,500,000.00	6,600,000	7,920,000	9,504,000	11,404,800	13,685,760	16,422,912	19,707,494	23,648,993	28,378,792	34,054,550	40,865,460	217,692.76
infrastructure(roads, water,drainage, gas,electricity,ICT,emergency landing ground shall be near first class clinical center)	USD	12,600,000.00	15,120,000	18,144,000	21,772,800	26,127,360	31,352,832	37,623,398	45,148,078	54,177,694	65,013,232	78,015,879	93,619,055	498,714.32
emergency power supply-2MW	USD	1,330,000.00	1,596,000	1,915,200	2,298,240	2,757,888	3,309,466	3,971,359	4,765,630	5,718,757	6,862,508	8,235,009	9,882,011	52,642.06
First aid center (at city center)	USD	840,000.00	1,008,000	1,209,600	1,451,520	1,741,824	2,090,189	2,508,227	3,009,872	3,611,846	4,334,215	5,201,059	6,241,270	33,247.62
Nursing and medical assistance center	USD	1,000,000.00	1,200,000	1,440,000	1,728,000	2,073,600	2,488,320	2,985,984	3,583,181	4,299,817	5,159,780	6,191,736	7,430,084	39,580.50
First class clinical center	USD	420,000.00	504,000	604,800	725,760	870,912	1,045,094	1,254,113	1,504,936	1,805,923	2,167,108	2,600,529	3,120,635	16,623.81
Sub-total	USD	69,520,000.00	83,424,000	100,108,800	120,130,560	144,156,672	172,988,006	207,585,608	249,102,729	298,923,275	358,707,930	430,449,516	516,539,419	2,751,636.51
Other services	USD	872,028.00	1,046,434	1,255,720	1,506,864	1,808,237	2,169,885	2,603,862	3,124,634	3,749,561	4,499,473	5,399,368	6,479,241	34,515.30
Administrative works	USD	1,744,056.00	2,092,867	2,511,441	3,013,729	3,616,475	4,339,769	5,207,723	6,249,268	7,499,122	8,998,946	10,798,735	12,958,482	69,030.61
Consultancy team and design fees	USD	872,028.00	1,046,434	1,255,720	1,506,864	1,808,237	2,169,885	2,603,862	3,124,634	3,749,561	4,499,473	5,399,368	6,479,241	34,515.30
furnishing and machinery	USD	3,488,112.00	4,185,734	5,022,881	6,027,458	7,232,949	8,679,539	10,415,447	12,498,536	14,998,243	17,997,892	21,597,470	25,916,964	138,061.22
Sub-total	USD	6,976,224.00	8,371,469	10,045,763	12,054,915	14,465,898	17,359,078	20,830,893	24,997,072	29,996,486	35,995,784	43,194,940	51,833,928	276,122.45
specialized laboratories i.e. Anatomic pathology,clinical microbiology,clinical chemistry,hematology and Xray department	USD	1,000,000.00	1,200,000	1,440,000	1,728,000	2,073,600	2,488,320	2,985,984	3,583,181	4,299,817	5,159,780	6,191,736	7,430,084	39,580.50
oxygen plant	USD	850,000.00	1,020,000	1,224,000	1,468,800	1,762,560	2,115,072	2,538,086	3,045,704	3,654,844	4,385,813	5,262,976	6,315,571	33,643.42
incinerator	USD	1,000,000.00	1,200,000	1,440,000	1,728,000	2,073,600	2,488,320	2,985,984	3,583,181	4,299,817	5,159,780	6,191,736	7,430,084	39,580.50
central stores	USD	900,000.00	1,080,000	1,296,000	1,555,200	1,866,240	2,239,488	2,687,386	3,224,863	3,869,835	4,643,802	5,572,563	6,687,075	35,622.45
production department for IV fluids, distilled sterile water,laboratory reagents	USD	900,000.00	1,080,000	1,296,000	1,555,200	1,866,240	2,239,488	2,687,386	3,224,863	3,869,835	4,643,802	5,572,563	6,687,075	35,622.45
Blood transfusion department and specila ambulance for blood collection	USD	950,000.00	1,140,000	1,368,000	1,641,600	1,969,920	2,363,904	2,836,685	3,404,022	4,084,826	4,901,791	5,882,150	7,058,580	37,601.47
Central pharmacy	USD	1,000,000.00	1,200,000	1,440,000	1,728,000	2,073,600	2,488,320	2,985,984	3,583,181	4,299,817	5,159,780	6,191,736	7,430,084	39,580.50
Workshop for university and hospital e.g.Motorvehicle	USD	1,000,000.00	1,200,000	1,440,000	1,728,000	2,073,600	2,488,320	2,985,984	3,583,181	4,299,817	5,159,780	6,191,736	7,430,084	39,580.50
Research center for GCITH and Administration block	USD	750,000.00	900,000	1,080,000	1,296,000	1,555,200	1,866,240	2,239,488	2,687,386	3,224,863	3,869,835	4,643,802	5,572,563	29,685.37
Training and Technical support	USD	500,000.00	600,000	720,000	864,000	1,036,800	1,244,160	1,492,992	1,791,590	2,149,908	2,579,890	3,095,868	3,715,042	19,790.25
medicine package	USD	1,100,000.00	1,320,000	1,584,000	1,900,800	2,280,960	2,737,152	3,284,582	3,941,499	4,729,799	5,675,758	6,810,910	8,173,092	43,538.55
Marketing and advertisment	USD	260,000.00	312,000	374,400	449,280	539,136	646,963	776,356	931,627	1,117,952	1,341,543	1,609,851	1,931,822	10,290.93
min supermarket center with storage facilities, warehouse and one transportation vehicle	USD	3,800,000.00	4,560,000	5,472,000	6,566,400	7,879,680	9,455,616	11,346,739	13,616,087	16,339,304	19,607,165	23,528,598	28,234,318	150,405.90
sports academy center and sports irrigation (shall be far from other centers)	USD	2,750,000.00	3,300,000	3,960,000	4,752,000	5,702,400	6,842,880	8,211,456	9,853,747	11,824,497	14,189,396	17,027,275	20,432,730	108,846.38
senior care estate	USD	900,000.00	1,080,000	1,296,000	1,555,200	1,866,240	2,239,488	2,687,386	3,224,863	3,869,835	4,643,802	5,572,563	6,687,075	35,622.45
Sub-total			0	0	0	0	0	0	0	0	0	0	0	
vehicles for heads of departments, heads of units,administrative work transportation,medical waste,including special 6 buses for on campus and off campus students and communities	USD	1,300,000.00	1,560,000	1,872,000	2,246,400	2,695,680	3,234,816	3,881,779	4,658,135	5,589,762	6,707,714	8,049,257	9,659,109	51,454.65
Ambulances with equipment	USD	1,160,976.00	1,393,171	1,671,805	2,006,167	2,407,400	2,888,880	3,466,656	4,159,987	4,991,984	5,990,381	7,188,457	8,626,149	45,952.01
Sub-total	USD	2,460,976.00	2,953,171	3,543,805	4,252,567	5,103,080	6,123,696	7,348,435	8,818,122	10,581,746	12,698,096	15,237,715	18,285,258	97,406.66
			0	0	0	0	0	0	0	0	0	0	0	
Grand total			0	0	0	0	0	0	0	0	0	0	0	
	USD	175,574,400.00	210,689,280	252,827,136	303,392,563	364,071,076	436,885,291	524,262,349	629,114,819	754,937,783	905,925,339	1,087,110,407	1,304,532,489	6,949,322.93



5-YEAR FINANCIAL PLAN

FORECASTED REVENUE

	Number of Studnets	Tution per student	Annual revenue per product
Local students	6000	USD 800.00	USD 4,800,000.00
International Students	40000	USD 1,000.00	USD 40,000,000.00

TOTAL OF FORECASTED REVENUE 44,800,000.00

COST OF GOODS SOLD

	Expected gross margin	Annual cost per student
Local students	30%	530.00
International Students	25%	670.00

TOATL COST OF GOODS SOLD		1,200.00
ANNUAL MAINTENANCE, REPAIR AND OVERHAUL		
Factor (%) on capital equipment	<input type="text" value="15%"/>	
ASSET DEPRECIATION		
Number of Years	<input type="text" value="5"/>	
TAX		
Annual Tax Rate	<input type="text" value="30%"/>	
INFLATION		
Annual Inflation Rate	<input type="text" value="2%"/>	
PRODUCT PRICE INCREASE		
Annual Price Increase	<input type="text" value="2%"/>	

PROFIT AND LOSS PROJECTION

PROFIT AND LOSS ASSUMPTION					
	2018	2019	2020	2021	2022
Annual cumulative price (revenue) increase	0.00%	2.00%	4.00%	6.00%	8.00%
Annual cumulative inflation (expense) increase	0.00%	2.00%	4.00%	6.00%	8.00%

INCOME					
	Year 1	Year 2	Year 3	Year 4	Year 5
Tuition fee per student					
Local Students	USD 4,800,000.00	USD 4,896,000.00	USD 5,091,840.00	USD 5,397,350.40	USD 5,829,138.43
International Students	USD 4,000,000.00	USD 4,080,000.00	USD 4,243,200.00	USD 4,497,792.00	USD 4,857,615.36
Total revenue	USD 8,800,000.00	USD 8,976,000.00	USD 9,335,040.00	USD 9,895,142.40	USD 10,686,753.79
Cost of Sales					
Local Students	USD 530.00	USD 540.60	USD 562.22	USD 595.96	USD 643.63
International Students	USD 670.00	USD 683.40	USD 710.74	USD 753.38	USD 813.65
Cost of goods sold	USD 1,200.00	USD 1,224.00	USD 1,272.96	USD 1,349.34	USD 1,457.28
Gross Profit	USD 8,798,800.00	USD 8,974,776.00	USD 9,333,767.04	USD 9,893,793.06	USD 10,685,296.51

Non-Operation Income					
Student (University) fee generation	USD 3,650,000.00	USD 3,723,000.00	USD 3,797,460.00	USD 3,873,409.20	USD 3,950,877.38
Grants applications and operational research	USD 4,789,000.00	USD 4,884,780.00	USD 4,982,475.60	USD 5,082,125.11	USD 5,183,767.61

Provisional of super-specialized services and patient management	USD 6,590,000.00	USD 6,721,800.00	USD 6,856,236.00	USD 6,993,360.72	USD 7,133,227.93
Targeting local and international companies for medical care to employees	USD 4,390,000.00	USD 4,477,800.00	USD 4,567,356.00	USD 4,658,703.12	USD 4,751,877.18
Affiliation with ten international Universities	USD 2,700,000.00	USD 2,754,000.00	USD 2,809,080.00	USD 2,865,261.60	USD 2,922,566.83
Manage new innovative service lines to increase Market share	USD 1,907,000.00	USD 1,945,140.00	USD 1,984,042.80	USD 2,023,723.66	USD 2,064,198.13
Dormitories fee fair rent generation	USD 1,800,000.00	USD 1,836,000.00	USD 1,872,720.00	USD 1,910,174.40	USD 1,948,377.89
Residential compound rent generation	USD 580,000.00	USD 591,600.00	USD 603,432.00	USD 615,500.64	USD 627,810.65
Sports academy center income generation	USD 440,000.00	USD 448,800.00	USD 457,776.00	USD 466,931.52	USD 476,270.15
Min supermarket fee rent generation	USD 310,000.00	USD 316,200.00	USD 322,524.00	USD 328,974.48	USD 335,553.97
Monthly health care income generation (from insurance company)	USD 1,000,000.00	USD 1,020,000.00	USD 1,040,400.00	USD 1,061,208.00	USD 1,082,432.16
Transportation (daily buses) fee generation	USD 330,000.00	USD 336,600.00	USD 343,332.00	USD 350,198.64	USD 357,202.61
Monthly clinical care fee generation	USD 1,530,000.00	USD 1,560,600.00	USD 1,591,812.00	USD 1,623,648.24	USD 1,656,121.20
Monthly extra energy produced income generation	USD 198,000.00	USD 201,960.00	USD 205,999.20	USD 210,119.18	USD 214,321.57
Staff estate monthly fee generation	USD 670,000.00	USD 683,400.00	USD 697,068.00	USD 711,009.36	USD 725,229.55
Parking fee income generation	USD 120,000.00	USD 122,400.00	USD 124,848.00	USD 127,344.96	USD 129,891.86
Fee for international patient income generation	USD 760,000.00	USD 775,200.00	USD 790,704.00	USD 806,518.08	USD 822,648.44
Registration entrance for general hospital	USD 110,000.00	USD 112,200.00	USD 114,444.00	USD 116,732.88	USD 119,067.54
Senior care fee income generated (source (GOV)	USD 390,000.00	USD 397,800.00	USD 405,756.00	USD 413,871.12	USD 422,148.54
Total Non-Operation Income	32,264,000.00	32,909,280.00	33,567,465.60	34,238,814.91	34,923,591.21

TOTAL INCOME	41,062,800.00	41,884,056.00	42,901,232.64	44,132,607.97	45,608,887.72
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EXPENDITURES					
Operating expenses					

In-patients	USD 589,000.00	USD 600,780.00	USD 624,811.20	USD 662,299.87	USD 715,283.86
Out-patients	USD 288,000.00	USD 293,760.00	USD 305,510.40	USD 323,841.02	USD 349,748.31
Salaries	USD 1,630,000.00	USD 1,662,600.00	USD 1,729,104.00	USD 1,832,850.24	USD 1,979,478.26
Utilities	USD 43,000.00	USD 43,860.00	USD 45,614.40	USD 48,351.26	USD 52,219.37
Equipment	USD 90,000.00	USD 91,800.00	USD 95,472.00	USD 101,200.32	USD 109,296.35
Staff development and training	USD 203,000.00	USD 207,060.00	USD 215,342.40	USD 228,262.94	USD 246,523.98
Sponsorships	USD 816,000.00	USD 832,320.00	USD 865,612.80	USD 917,549.57	USD 990,953.53
Charity Expenses	USD 126,000.00	USD 128,520.00	USD 133,660.80	USD 141,680.45	USD 153,014.88
Insurance	USD 455,000.00	USD 464,100.00	USD 482,664.00	USD 511,623.84	USD 552,553.75
Exchange Programs	USD 641,300.00	USD 654,126.00	USD 680,291.04	USD 721,108.50	USD 778,797.18
Others	USD 153,700.00	USD 156,774.00	USD 163,044.96	USD 172,827.66	USD 186,653.87
Total operating expenses	USD 5,035,000.00	USD 5,135,700.00	USD 5,341,128.00	USD 5,661,595.68	USD 6,114,523.33

Non-Recurring Expenses					
Unexpected Expenses	-	-		-	-
Other expenses	-	-	-	-	-
Total Non-Recurring Expenses	-	-	-	-	-

TOTAL EXPENSES	5,035,000.00	5,135,700.00	5,341,128.00	5,661,595.68	6,114,523.33
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TAXES					
Income Tax	10,808,340.00	11,024,506.80	11,268,031.39	11,541,303.69	11,848,309.31
Other Tax (specify)	-	-	-	-	-
TOTAL TAXES	10,808,340.00	11,024,506.80	11,268,031.39	11,541,303.69	11,848,309.31
NET PROFIT	25,219,460.00	25,723,849.20	26,292,073.25	26,929,708.61	27,646,055.07

BALANCE SHEET PROJECTION

ASSETS

Current Assets	Initial balance	Year 1	Year 2	Year 3	Year 4	Year 5
Cash and short-term investments	USD 50,000.00	USD 50,000.00	USD 50,000.00	USD 50,000.00	USD 50,000.00	USD 50,000.00
Accounts receivable	USD 3,000.00	USD 3,000.00	USD 3,000.00	USD 3,000.00	USD 3,000.00	USD 3,000.00
Total inventory	USD 25,000.00	USD 25,000.00	USD 25,000.00	USD 25,000.00	USD 25,000.00	USD 25,000.00
Other current assets	USD 5,000.00	USD 5,000.00	USD 5,000.00	USD 5,000.00	USD 5,000.00	USD 5,000.00
Total current assets	USD 83,000.00	USD 83,000.00	USD 83,000.00	USD 83,000.00	USD 83,000.00	USD 83,000.00

Property and Equipment	Initial balance	Year 1	Year 2	Year 3	Year 4	Year 5
General hospital +parking	USD 69,520,000.00	USD 69,520,000.00	USD 69,520,000.00	USD 69,520,000.00	USD 69,520,000.00	USD 69,520,000.00
Land	USD 10,000.00	USD 10,000.00	USD 10,000.00	USD 10,000.00	USD 10,000.00	USD 10,000.00
Capital improvements	USD 1,766,000.00	USD 1,766,000.00	USD 1,766,000.00	USD 1,766,000.00	USD 1,766,000.00	USD 1,766,000.00
Machinery and equipment	USD 10,000.00	USD 10,000.00	USD 10,000.00	USD 10,000.00	USD 10,000.00	USD 10,000.00
Less Accumulated depreciation expense		USD 288,000.00	USD 581,760.00	USD 887,270.40	USD 1,211,111.42	USD 1,560,859.73
Total Property and Equipment	USD 71,306,000.00	USD 71,018,000.00	USD 70,724,240.00	USD 70,418,729.60	USD 70,094,888.58	USD 69,745,140.27

LIABILITIES

Current Liabilities	Initial balance	Year 1	Year 2	Year 3	Year 4	Year 5

Accounts payable	USD 2,000.00	USD 2,000.00	USD 2,000.00	USD 2,000.00	USD 2,000.00	USD 2,000.00
Accrued expenses	USD -	USD -	USD -	USD -	USD -	USD -
Notes payable/short-term debt	USD -	USD -	USD -	USD -	USD -	USD -
Capital leases	USD -	USD -	USD -	USD -	USD -	USD -
Other current liabilities	USD 100.00	USD 100.00	USD 100.00	USD 100.00	USD 100.00	USD 100.00
Total Current Liabilities	USD 2,100.00	USD 2,100.00	USD 2,100.00	USD 2,100.00	USD 2,100.00	USD 2,100.00

Debt	Initial balance	Year 1	Year 2	Year 3	Year 4	Year 5
Long-term debt/loan	USD 10,000.00	USD 10,000.00	USD 10,000.00	USD 10,000.00	USD 10,000.00	USD 10,000.00
Other long-term debt	USD 100,000.00	USD 200,000.00	USD 150,000.00	USD 175,000.00	USD 225,000.00	USD 150,000.00
Total Debt	USD 112,100.00	USD 212,100.00	USD 162,100.00	USD 187,100.00	USD 237,100.00	USD 162,100.00

EQUITY

	Initial balance	Year 1	Year 2	Year 3	Year 4	Year 5
Owner's equity (common)	50,000.00	50,000.00	50,000.00	50,000.00	50,000.00	50,000.00
Paid-in capital	250,000.00	250,000.00	250,000.00	250,000.00	250,000.00	250,000.00
Retained earnings	-	25,219,460.00	50,943,309.20	77,235,382.45	104,165,091.05	131,811,146.12
TOTAL EQUITY	300,000.00	25,519,460.00	51,243,309.20	77,535,382.45	104,465,091.05	132,111,146.12
TOTAL LIABILITIES AND EQUITY	300,000.00	25,519,460.00	51,243,309.20	77,535,382.45	104,465,091.05	132,111,146.12

BREAKEVEN ANALYSIS

AMOUNTS SHOWN IN US DOLLARS

SALES

SALES PRICE PER UNIT	USD	8,000.00
Expected number of students PER PERIOD (UNIT)	USD	1,000.00
TOTAL SALES	USD	32,264,000.00

VARIABLE COSTS

COMMISSION PER UNIT	USD	1,000,000.00
Nursing Equipments PER UNIT	USD	6,630,000.00
LECTURE FACILITIES PER UNIT	USD	4,250,000.00
Clinical SUPPLIES PER UNIT	USD	2,460,976.00
OTHER VARIABLE COSTS PER UNIT	USD	1,000,000.00
VARIABLE COSTS PER UNIT	USD	15,340,976.00
TOTAL VARIABLE COSTS	USD	11,056,964.00

UNIT CONTRIBUTION MARGIN	USD	-
GROSS MARGIN	USD	21,207,036.00

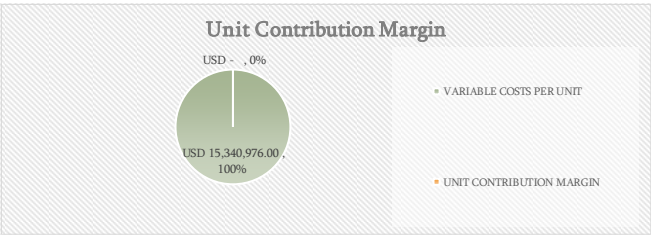
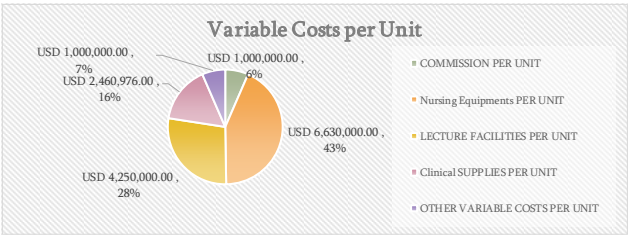
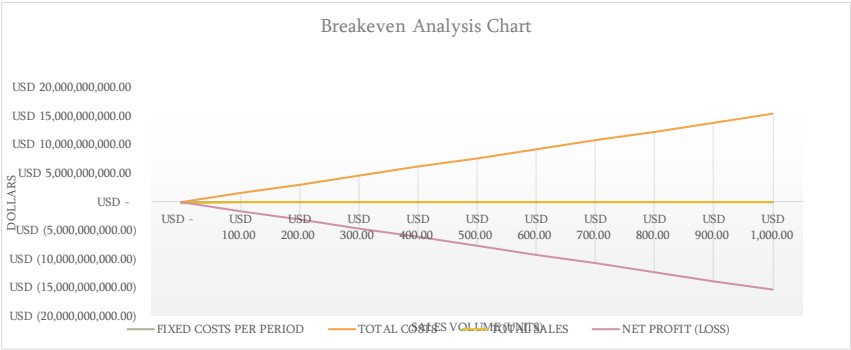
FIXED COSTS PER PERIOD

ADMINISTRATIVE COSTS	USD	6,976,224.00
INSURANCE	USD	500.00
OTHER FIXED COSTS	USD	3,488,112.00
TOTAL FIXED COSTS PER PERIOD	USD	10,464,836.00

NET PROFIT (LOSS)	USD	10,742,200.00
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RESULTS

BREAKEVEN POINT (UNITS):	-
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SALES VOLUME ANALYSIS:

SALES VOLUME PER PERIOD (UNITS)	USD	-	USD	100.00	USD	200.00	USD	300.00	USD	400.00	USD	500.00	USD	600.00	USD	700.00	USD	800.00	USD	900.00	USD	1,000.00
SALES PRICE PER UNIT	USD	8,000.00	USD	8,000.00	USD	8,000.00	USD	8,000.00	USD	8,000.00	USD	8,000.00	USD	8,000.00	USD	8,000.00	USD	8,000.00	USD	8,000.00	USD	8,000.00
FIXED COSTS PER PERIOD	USD	10,464,836.00	USD	10,464,836.00	USD	10,464,836.00	USD	10,464,836.00	USD	10,464,836.00	USD	10,464,836.00	USD	10,464,836.00	USD	10,464,836.00	USD	10,464,836.00	USD	10,464,836.00	USD	10,464,836.00
VARIABLE COSTS	USD	-	USD	1,534,097,600.00	USD	3,068,195,200.00	USD	4,602,292,800.00	USD	6,136,390,400.00	USD	7,670,488,000.00	USD	9,204,585,600.00	USD	10,738,683,200.00	USD	12,272,780,800.00	USD	13,806,878,400.00	USD	15,340,976,000.00
TOTAL COSTS	USD	10,464,836.00	USD	1,544,562,436.00	USD	3,078,660,036.00	USD	4,612,757,636.00	USD	6,146,855,236.00	USD	7,680,952,836.00	USD	9,215,050,436.00	USD	10,749,148,036.00	USD	12,283,245,636.00	USD	13,817,343,236.00	USD	15,351,440,836.00
TOTAL SALES	USD	-	USD	800,000.00	USD	1,600,000.00	USD	2,400,000.00	USD	3,200,000.00	USD	4,000,000.00	USD	4,800,000.00	USD	5,600,000.00	USD	6,400,000.00	USD	7,200,000.00	USD	8,000,000.00
NET PROFIT (LOSS)	USD	(10,464,836.00)	USD	(1,543,762,436.00)	USD	(3,077,060,036.00)	USD	(4,610,357,636.00)	USD	(6,143,655,236.00)	USD	(7,676,952,836.00)	USD	(9,210,250,436.00)	USD	(10,743,548,036.00)	USD	(12,276,845,636.00)	USD	(13,810,143,236.00)	USD	(15,343,440,836.00)