Open Source Healthcare Campus Feasibility Report

Transforming American Healthcare Through Productive Endowments

Preliminary concept and financial analysis | October 22 2026 | United States

1 Executive assessment

An Open Source Healthcare Campus is feasible as a community governed outpatient care and teaching organization supported by earned clinical revenue, philanthropy, and productive assets. It could demonstrate a replicable alternative to fragmented care. A campus cannot, on its own, reproduce the purchasing power, universal coverage, or prices of a national health system. Its strongest contribution would be to publish a tested operating model that other communities can adopt.

The recommended first institution is a teaching primary care campus with integrated behavioral health, rehabilitation, nutrition, basic diagnostics, a rigorous evaluation program, and contracted hospital and specialty access. Build medical education through existing accredited institutions. Develop open medical hardware through a separately funded research program. An independent hospital and a new degree granting medical school are later decisions with separate capital requirements.

The financial conclusion is conditional. A $20 million endowment drawing 4% supplies $800,000 annually, only 4% of a $20 million operating requirement. Funding that entire requirement from a financial endowment would need $500 million at 4%, before startup capital. Productive enterprises can reduce the required subsidy, but revenue is not profit and business assets do not provide guaranteed distributions.

In the moderate planning case, a mature campus generates $13.5 million of net clinical collections, $2 million in enterprise distributions, $0.8 million in endowment support, $2 million in grants, and $0.5 million in shared savings. Against $20 million in annual cash requirements, it still has a $1.2 million gap. Excluding grants, its gap is $3.2 million. The ambitious case produces a surplus, but requires higher patient revenue, profitable enterprises, and contract execution that have not been demonstrated.

Recommendation: fund a six month feasibility and partnership phase, then a leased clinic pilot. Approve expansion only after independent evidence of safe care, equitable access, adequate collections, and enterprise cash generation. Frame the eventual proposal to Lucy McBride and others as an invitation to co-design and test this model. Do not promise that free comprehensive healthcare has already been financially solved.

2 Scope and evidence standard

This is a desk feasibility study, not a local market study, actuarial certification, legal opinion, equipment validation, or investment underwriting. The user's Ecology Campus financial statements, land plan, enterprise results, target state, payer contracts, and donor commitments were not supplied. No prior campus economics are assumed. All campus financial figures are explicit planning assumptions in 2026 dollars, not quotations or actual results.

The working interpretation of the goal is $20 million in annual campus cash requirements. Three other meanings must remain distinct: a $20 million initial capitalization, a $20 million financial endowment, and $20 million in enterprise sales. None independently establishes a $20 million annual healthcare operation.

Sources emphasize CMS national expenditure accounts, OECD comparisons, regulators, original research, and organizations' own descriptions. National spending uses 2024 actuals, rather than labeling projections as actual spending. International data use their own reporting periods and purchasing power adjustments. Published organizational successes establish plausibility, not causal proof that their results will transfer. Source identifiers in brackets map to the linked source register in Section 15. Public roles were checked for this study; willingness to collaborate was not established.

3 Where US healthcare money goes

CMS reports 2024 national spending of approximately $5.3 trillion, $15,474 per person, and 18.0% of GDP. The underlying CMS authored expenditure article gives $5,278.6 billion, used below for arithmetic. Hospital and physician services together account for about 52% of spending. [S1, S2]

Destination in 2024	Billions of dollars	Share calculated
Hospital care	1,634.7	31.0%
Physician and clinical services	1,109.7	21.0%
Retail prescription drugs	467.0	8.8%
Other health residential and personal care	320.5	6.1%
Nursing facilities and continuing care communities	219.9	4.2%
Dental services	189.2	3.6%
Other professional services	184.9	3.5%
Home health	169.4	3.2%
Other nondurable medical products	128.7	2.4%
Durable medical equipment	86.4	1.6%
Remaining national expenditure categories	768.2	14.6%
Total	5,278.6	100.0%

Sources: [S1–S3]. Shares and residual are calculated; rounding affects displayed totals. The residual includes government administration, net cost of health insurance, public health, investment, and other categories outside the listed services. It is not a measure of waste. Retail drug spending excludes drugs already included in hospital and other service bills. Equipment used by hospitals is embedded in hospital spending; the retail equipment row does not represent all medical technology.

Financing is a separate view of the same dollars. Private health insurance paid $1,644.6 billion; Medicare $1,118.0 billion; Medicaid $931.7 billion; and patients paid $556.6 billion out of pocket. Together these are $4,250.9 billion, leaving $1,027.7 billion in other financing categories. Do not add insurance payments to the service table: that would count the same care twice. [S1]

Several popular diagnoses of the problem are incomplete. Insurance overhead is only part of administration: clinicians and hospitals also employ billing, authorization, and documentation staff. Hospital revenue pays nurses, buildings, standby capacity, teaching, drugs, and other inputs as well as margins. Physician service revenue is not physician take home pay. A revenue reduction can remove unnecessary expenditure, but it can also destabilize necessary services unless costs and financing change together.

Recent growth and international spending levels answer different questions. CMS attributes much of 2023–2024 growth to use and intensity of care, alongside price increases. That does not negate longstanding US price differences. Reducing today's unnecessary care and bargaining down a hospital price are separate interventions. [S3]

4 Structural inefficiencies and quantified opportunity

National evidence

Shrank and colleagues' 2019 review estimated $760–935 billion in annual waste, about one quarter of then current spending, but identified $191–286 billion in potential savings from studied interventions. Those are historical estimates in 2019 dollars, not a current recoverable cash pool. Their domains are shown below. [S4]

Waste domain	Estimated annual billions in 2019 dollars	Campus response
Administrative complexity	265.6	Fewer contract variants and standardized workflows
Pricing failure	230.7–240.5	Bundled purchasing and competitive referral contracts
Failure of care delivery	102.4–165.7	Reliable preventive and chronic care
Overtreatment and low value care	75.7–101.2	Indication based testing and prescribing
Fraud and abuse	58.5–83.9	Procurement controls and billing audit
Failure of care coordination	27.2–78.2	Shared care plans and closed referrals

The study did not identify intervention studies for the administrative complexity category. Its full waste estimate therefore cannot be treated as demonstrated savings. Domains can also interact in local implementation. Staff time released is not cash saved unless staffing, purchased capacity, or spending changes.

RAND found commercial hospital prices averaged 254% of Medicare rates in its 2022 study population. A hypothetical reduction from 254% to 180% of Medicare is a 29.1% reduction in that payment, not a 74% reduction. This is arithmetic illustrating negotiating scope, not an estimate that every hospital can safely operate at 180%. Case mix, rural standby costs, market power, contract access, and commercial payer mix matter. [S5]

CMS's 2024 Shared Savings Program results provide a more grounded US demonstration: $4.1 billion in ACO performance payments and $2.5 billion retained by Medicare relative to program benchmarks. Benchmarks are not randomized counterfactuals. A campus should join an experienced network before bearing large population risk. [S6]

Why these costs persist

Fragmented purchasing gives individual patients and small employers little negotiating power against concentrated hospital and specialist markets. Even a transparent posted price does not guarantee that a patient can access an alternative provider or change an insurer's contract. The campus needs contracted referral prices and transport access as well as a public price list.

Fee for service rewards billable activity, while communication, navigation, and prevention can be poorly supported. Moving appropriate care into teams may improve capacity, but simply adding wellness visits to the same billing system can increase total spending. Payment contracts must fund useful coordination and discourage unnecessary volume without encouraging undertreatment.

Administrative friction grows when benefits, networks, authorizations, quality reporting, and billing rules differ across payers. Simplify the number of contract designs and measure claim rework, authorization labor, and collection delays. Preserve necessary safety, privacy, and anti-fraud controls; eliminating those would create risk rather than efficiency.

Workforce scarcity and fragmented clinical records compound these problems. Repeated tests, incomplete handoffs, and preventable deterioration can arise when no team owns the whole care plan. Training more professionals helps

over time, but a new campus can initially draw scarce workers away from neighboring providers. Measure regional workforce effects and fund retention and training rather than assume a larger building creates capacity.

Drug costs require separate work on appropriate prescribing, generics and biosimilars, procurement, and access to effective high cost medicines. A campus cannot remove patents or reproduce national purchasing power. Likewise, reducing medical student tuition may improve career choice and financial access but is not itself a large short term national healthcare savings strategy.

An illustrative local savings test

For underwriting, audit actual claims and administrative accounts. The example below assumes $100 million in annual attributed total spending. It is not a national estimate or a forecast for 15,000 campus patients. Assign every dollar to one mutually exclusive bucket; put price reductions only on services remaining after avoided utilization. This classification prevents price and utilization savings from being counted on the same avoided service.

Disjoint spending bucket in millions	Baseline	Conservative reduction	Moderate reduction	Ambitious reduction
Retained services eligible for lower negotiated prices	25	10%	20%	30%
Potentially avoidable acute episodes	20	2%	5%	10%
Low value testing and procedures	10	5%	10%	15%
Drugs eligible for substitution or purchasing change	10	3%	8%	12%
Administrative operations	5	5%	15%	25%
Other necessary spending	30	0%	0%	0%
Gross reduction in millions	100	3.95	8.55	13.45
Incremental implementation cost in millions	—	2.00	3.00	4.00
Net reduction in millions	—	1.95	5.55	9.45

These percentages are hypotheses for testing, not measured intervention effects. The implementation cost is incremental to the baseline and includes added care management, analytics, and contracting. Add any new campus subsidy or duplicate infrastructure not already included before claiming system savings. Cost effective preventive care can improve health while increasing near term spending. Food and housing benefits must be evaluated on outcomes as well as medical claims.

Separate four beneficiaries of savings: patients, employers or insurers, government, and the campus. A lower patient bill does not automatically improve the campus margin. If a payer captures savings, campus revenue requires an explicit care management payment, capitation arrangement, or shared savings agreement. The operating model below includes only assumed campus receipts, not this illustrative total savings pool.

For scale only, 1%, 3%, and 5% of 2024 national expenditure equal approximately $53 billion, $158 billion, and $264 billion. These are mathematical reference points, not achievable national projections. National transformation would require coverage reform, standardized payment, stronger price competition or rate policy, workforce investment, and replicated delivery changes.

5 International models and what transfers

OECD's 2025 comparison estimates US spending at over $14,880 per person in purchasing power adjusted dollars for 2024, roughly 2.5 times the OECD average. Its US country note reports life expectancy of 78.4 years, below the OECD average by 2.7 years. These use different definitions and periods from CMS dollars. The gap is a signal to investigate, not proof that healthcare organization alone determines life expectancy. Violence, poverty, substance use, and population risks also matter. [S7, S8]

Model	Financing and delivery	Transferable design	Limits for a US campus
England NHS	Tax financed universal system with most core care free at use	Defined benefit package and community care coordination	Campus lacks tax authority; constrained budgets can create waits
Germany	Statutory social insurance alongside private coverage and negotiated payment	Common benefits and organized purchasing	Multi payer simplification needs policy and collective agreements
Netherlands	Compulsory regulated insurance with public financing and private insurers	Risk pooling and primary care coordination	Adverse selection requires systemwide protections
Taiwan	National health insurance with centralized financing	Administrative consistency and common payment rules	A campus cannot create a single national payer
Singapore	Subsidies plus MediSave MediShield Life and MediFund	A protected assistance fund layered onto insurance	Savings accounts alone do not explain affordability; public support matters
Aravind India	High volume eye care with paying and subsidized services	Standard processes and transparent cross subsidy	A narrow specialty and different input costs limit transfer

Sources: [S9–S14]. These are institutional comparisons, not claims that one financing label guarantees superior care. Useful features can be combined locally: continuity, standardized pathways, published prices, and a protected charity fund. Coverage, purchasing power, and national fee schedules cannot simply be replicated inside a campus.

Aravind reports that about half its patients receive free or heavily subsidized services while the organization remains financially self-sustaining. Its example supports testing cross subsidy in a well defined service line. It does not establish that agriculture can finance comprehensive US healthcare or that all services should use high throughput workflows. [S14]

6 Successful American alternatives

Alternative	Evidence or established feature	Application and caution
HRSA health centers	Established national primary care access infrastructure and sliding fee requirements	Partner with an existing center; designation and public funding are conditional
Southcentral Foundation Nuka	Alaska Native owned relationship based care with integrated services	Community governance and continuity are central; respect tribal ownership and context
Physician led ACOs	CMS reports benchmark savings and performance payments	Use existing risk and claims infrastructure; savings can reverse

Alternative	Evidence or established feature	Application and caution
Direct primary care	Subscription primary care with reduced billing complexity	Useful for defined services; does not replace hospital insurance
Surgery Center of Oklahoma	Published bundles combining facility surgeon and anesthesia fees with stated exceptions	Contract referrals and compare complete episodes; not all patients are ASC candidates
VA Whole Health	An established whole person approach inside conventional healthcare	Learn from implementation; do not assume all complementary services save money
NYU Grossman Long Island	Tuition scholarships supported by major philanthropy	Scholarships are feasible; tuition free does not mean education is costless

Sources: [S6, S15–S21]. HRSA's current impact page reports more than 32.7 million patients in 2025. Its sliding fee framework provides a useful access design, with full discounts or nominal charges at or below 100% of federal poverty guidelines and partial discounts through 200%, subject to program requirements. An FQHC look alike is not the same as a grant funded health center. Do not assume grant awards, enhanced payment, 340B access, or malpractice protection before eligibility is established. [S15, S16]

Nuka's ownership and relationship model is relevant, but published before and after utilization improvements cannot be imported as a campus savings forecast. The direct primary care actuarial report likewise describes context dependent employer economics, not guaranteed population savings. DPC enrollment may attract a different patient mix and smaller clinician panels. [S17, S18]

NYU Long Island's $200 million gift illustrates the capital scale associated with sustaining tuition scholarships at an existing medical institution. The campus should initially fund student years at accredited schools and supervised community rotations. It should not assume online curriculum removes faculty, clinical supervision, student services, or accreditation expenses. [S21]

7 Campus clinical and educational design

Population and services

Serve a geographically defined community, prioritizing people who lack reliable primary care, while maintaining a mixed payer base. Moderate scale is 15,000 active patients, with 12 physicians and 6 advanced practice clinicians working in multidisciplinary teams. A planning assumption of 1,100 patients per primary care clinician gives nominal capacity of 19,800; teaching time, clinical complexity, and vacancies reduce usable capacity.

At 2.8 primary care encounters per patient annually, this panel requires 42,000 encounters. Eighteen clinicians providing 12 encounters per day over 220 days supply 47,520 slots, about 88% utilized. This leaves limited headroom for absence and training; verify visit length, acuity, asynchronous workload, and supervision in the pilot. Behavioral health, therapy, and diagnostic activity require separate capacity planning and are not free additions to these slots.

Start with longitudinal primary care, vaccinations, guideline indicated screening, chronic disease treatment, medication reconciliation, behavioral health, rehabilitation, nutrition support, care navigation, and basic approved point of care testing. Use specialist e-consults and negotiated external referrals. Provide a defined urgent assessment service only within staffing and licensing capacity. Publish hours, coverage arrangements, services included, prices, and exclusions in plain language.

Hospital admissions, trauma, intensive care, childbirth, emergency surgery, oncology, and dialysis remain with partner providers. A campus membership is not comprehensive health insurance. Help eligible patients enroll in coverage and establish a funded referral assistance process for uninsured patients. Budget a finite assistance fund rather than imply that all external care will be free.

Evidence based integrative care

Integrative care means coordinated treatment of physical health, mental health, function, and relevant social needs. Include evidence supported nutrition counseling, activity, tobacco treatment, sleep interventions, psychotherapy, and rehabilitation alongside medication and other indicated conventional treatment. Use condition specific guidance and patient preferences.

Adjunctive acupuncture may be offered for selected pain conditions after evidence review. NCCIH describes evidence varying by indication and identifies safety risks, so it should have credentialed practitioners, consent, infection controls, time limited treatment goals, and documented reassessment. Evidence for pain relief does not validate unrelated claims about immunity or disease reversal. [S22]

Establish an independent formulary and evidence committee. Exclude routine unvalidated laboratory panels, detoxification claims, unsupported cancer treatments, and incentives to sell supplements. Review supplement interactions through pharmacy staff. Do not delay indicated diagnostics or treatment while trying complementary care. Stop ineffective adjunctive therapy. Patients must be able to decline research or complementary services without losing ordinary care.

Affordable and free education

Publish an openly licensed curriculum in clinical reasoning, prevention, communication, health systems, evidence appraisal, biomedical maintenance, and campus enterprise economics. Free access to learning material is an immediate deliverable. It confers no license to practice.

Partner with community colleges and existing nursing, allied health, PA, and medical schools for supervised placements. Moderate budget includes 10 concurrent student years of $50,000 tuition support, plus $400,000 for teaching and preceptor support and $350,000 for stipends or training operations. These are proposed allowances; $50,000 may not cover actual tuition or living costs. Ten newly admitted students each year across four medical school years would eventually require 40 scholarships, or $2 million annually at the same tuition rate.

Use NHSC scholarships and loan repayment where eligible, recognizing competitive awards and service obligations. A residency track should be sponsored with an existing ACGME accredited institution before attempting an independent program. A new MD program requires LCME accreditation; DO education has a separate accreditor. Online access and open source materials do not waive degree authority, clinical placement, or licensure requirements. [S23–S25]

8 Open source diagnostics and imaging

Open source should first improve transparency, interoperability, repair knowledge, and research reproducibility. Clinical deployment needs a responsible organization that controls versions, verifies performance, funds maintenance, and carries liability. An open license is not a clinical authorization.

Layer	Initial use	Required gate before broader use
Open clinical protocols and procurement specifications	Publish with evidence dates and change history	Clinical review and scheduled updates
OpenEMR or comparable supported EHR	Evaluate a certified supported configuration	Security assessment interfaces backups and workflow acceptance
Research image analysis such as 3D Slicer	Education and approved research	Validate intended use and determine regulatory obligations
Commercial approved or cleared testing and ultrasound	Clinical service within authorized use	Credentialing quality assurance CLIA scope and referral escalation

Layer	Initial use	Required gate before broader use
Open microscopes electronics and phantoms	Teaching and bench work	Verification and research approvals as applicable
OSI² ONE low field MRI	Engineering collaboration and research	Defined indication regulatory strategy safety and diagnostic validation

OpenEMR's current project documentation describes active certification for version 8; confirm the installed configuration, dependencies, and certification requirements during procurement. Certification does not substitute for operational security or complete every reporting obligation. 3D Slicer itself states that it is intended for research and has no FDA clearance or approval; products built using it may have their own authorizations. [S26, S27]

OSI² ONE's project page lists estimated materials of €25,000–60,000, a 50 mT field, and a head or extremity bore. These are not a US installed clinical system quote. Engineering labor, quality systems, facility preparation, maintenance, radiologist interpretation, insurance, software validation, and regulatory work remain additional. No US marketing authorization for the proposed campus configuration was verified in this study. Assume research only until that is resolved. Low field MRI is not automatically interchangeable with conventional MRI for every indication. [S28]

Create a separate $250,000–500,000 scoping study only after a clinical partner defines an unmet need and comparator. Start with phantoms and bench testing. Human device studies require an IRB and the applicable investigational device pathway; significant risk studies generally require an FDA approved IDE as well. Select a diagnostic task, prespecify accuracy and failure criteria, compare with the accepted reference, and plan how incidental findings are managed. An engineering demonstration is not evidence of equivalent clinical outcomes. [S29]

Do not rely on speculative device savings in the initial campus operating budget. Initial imaging access should use negotiated external providers and appropriately authorized equipment. Compare cost per completed clinically useful study, including staff time and repeat imaging, rather than component cost alone.

9 Productive endowment and governance

Use a mission nonprofit for education, charitable care, and stewardship, with a legally appropriate clinical practice entity under state law. Put unrelated commercial activities in separately accounted entities where counsel advises. A community board should include patient representatives, clinical expertise, finance, public health, and independent safety oversight. Clinical decisions must remain independent of donors and enterprise sales targets.

The productive endowment should have two clearly identified parts: a liquid investment fund with a disciplined spending policy, and productive enterprises distributing genuine free cash after operating costs, maintenance, taxes, debt service, and reinvestment. Neither land appreciation nor uncollected invoices can pay clinicians. Do not count the same asset both as liquid endowment and as a business investment.

Prioritize contracted demand over speculative production. Candidate enterprises include workforce housing, external commercial space, energy sales, professional training, EHR implementation, and biomedical maintenance services within legal scope. Farming, food processing, and teaching kitchens can support the ecological mission, but low and volatile margins make them weak foundations for essential payroll. Verify each enterprise as a business, including customers, management, working capital, market prices, and downside losses.

Moderate enterprise portfolio in millions	Capital	External sales	Operating costs	Renewal reserve	Tax and debt cash	Distribution
Housing and leased real estate	20.0	2.40	1.20	0.30	0.10	0.80
Energy sold to external customers	5.0	0.65	0.15	0.10	0.05	0.35

Moderate enterprise portfolio in millions	Capital	External sales	Operating costs	Renewal reserve	Tax and debt cash	Distribution
Training and implementation services	5.0	2.50	1.60	0.20	0.15	0.55
Farm and food operations	4.0	1.20	1.05	0.10	0.00	0.05
External commercial workspace	6.0	1.20	0.65	0.20	0.10	0.25
Total	40.0	7.95	4.65	0.90	0.40	2.00

All figures are underwriting placeholders. The $2 million distribution is a 5% cash yield on $40 million of enterprise capital, not a forecast or guaranteed return. Capital is assumed primarily donated equity; tax and debt allowances need entity level modeling. If debt funds these assets, replace allowances with actual amortization and covenant requirements before accepting any distribution estimate.

Only external sales are shown. Internal rent or electricity charges move money within the organization and must be eliminated on consolidation. Energy savings on campus may lower expense, but cannot also be counted as external enterprise income. Staff housing subsidies belong in compensation or program expense. Enterprise workers receive ordinary wages; free student labor is not a financial assumption.

Maintain separate clinical, education, research, enterprise, and endowment accounts with consolidated reporting. Publish annual audited financials, unit costs, service exclusions, evidence reviews, and deidentified outcomes. Release curricula and designs with licenses appropriate to their content. Patient data remain protected; open governance does not mean public medical records.

IRS guidance makes clear that using business profits for charity alone does not make a regularly conducted unrelated business tax exempt. Related party leases, debt financed income, private benefit, donor restrictions, and nonprofit investment rules need qualified review. Budget after tax cash, not gross business revenue. [S30]

10 Preliminary financial model

Basis and annual campus requirement

The workbook uses a single operating forecast driven by a case selector. Select 1 Conservative, 2 Moderate, or 3 Ambitious and inspect the same five year build. The report compares the resulting mature cases. Figures below are millions of 2026 dollars. Endowment support is a spending policy allowance against initial capital, not a modeled investment cash flow or a verified preservation of principal. Investment returns and asset values require a separate schedule. No uncommitted fundraising is included beyond the explicitly assumed grant receipts.

The $20 million target is annual campus cash required, including a $1 million replacement reserve, but excluding enterprise operating expenses already deducted before enterprise distributions. It is not a GAAP income statement: depreciation, capital grants, enterprise gross expenses, and investment accounting require a later consolidated financial model. Debt principal and interest for the campus itself are assumed zero because capital is equity funded.

Mature moderate cash requirement	Millions
12 physicians at $300,000 loaded annual cost	3.60
6 advanced practice clinicians at $180,000	1.08
14 nurses at $110,000	1.54

Mature moderate cash requirement	Millions
20 assistants and community health workers at $65,000	1.30
10 behavioral therapy nutrition and pharmacy staff at $120,000	1.20
10 faculty administration and leadership at $135,000	1.35
8 technology and facilities staff at $100,000	0.80
Total personnel for 80 FTE	10.87
Clinical supplies outsourced testing and purchased services	2.03
Occupancy utilities and maintenance	1.50
Information systems and security	0.85
Insurance malpractice compliance and legal	0.75
Scholarships preceptor support and training	1.25
External referral assistance	0.50
Evaluation and open knowledge publication	0.40
Capital replacement reserve	1.00
Operating contingency	0.85
Total annual requirement	20.00

Loaded compensation includes benefits and payroll burden. Recruiting costs and regional compensation can materially exceed these allowances. This budget does not finance a full hospital, medical school, or major device approval program. Clinical services and purchased testing must be defined carefully before accepting the $2.03 million allowance. High cost drugs and external hospital bills are outside the offered package except for the limited assistance fund.

Mature scenarios at the same annual scale

Annual measure	Conservative	Moderate	Ambitious
Active patients	10,000	15,000	18,000
Net collected clinical dollars per patient	800	900	1,000
Clinical collections in millions	8.00	13.50	18.00
Enterprise capital in millions	15.00	40.00	60.00
Net enterprise cash yield	5.0%	5.0%	5.0%
Enterprise distribution in millions	0.75	2.00	3.00

Annual measure	Conservative	Moderate	Ambitious
Liquid endowment in millions	20.00	20.00	20.00
Endowment draw	3.0%	4.0%	4.0%
Endowment support in millions	0.60	0.80	0.80
Recurring grants in millions	1.50	2.00	1.50
Shared savings receipts in millions	0.00	0.50	1.20
Total available in millions	10.85	18.80	24.50
Annual campus cash requirement	20.00	20.00	20.00
Annual surplus or deficit	(9.15)	(1.20)	4.50
Surplus or deficit excluding grants	(10.65)	(3.20)	3.00

These are execution scenarios, not probabilities. Holding the same $20 million requirement makes the revenue risk visible. The conservative case is an underperforming full campus, not a recommended lean pilot. The ambitious case assumes the budget can serve 18,000 patients without added cost. At 2.8 encounters each, that means 50,400 encounters, exceeding the baseline 47,520 slots. It requires at least 13 encounters per clinician day at the same staffing, fewer encounters where clinically appropriate, or added staff and expense. Capacity, payer mix, and service scope must prove this before surplus is credible.

Net collections per patient represent an annual blended receipt after discounts, denials, and bad debt for a defined package. This is not a proposed insurance premium or an average national reimbursement rate. Membership, fee for service, and payer care management payments must be assigned to distinct covered services to avoid double billing. Shared savings are separately paid for verified contractual performance and excluded from routine collection yield. Charity care contributes no fictitious revenue.

Suppose 20% of the moderate panel pays nothing and generates no insurer collections. The remaining 12,000 patients must generate $1,125 each to achieve $13.5 million. If insured low income patients generate payer collections, free care at point of use is easier to sustain. These are financing choices to validate, not grounds for excluding complex or uninsured patients.

Capital and five year runway

An illustrative full moderate capitalization includes $25 million for campus land, facilities, equipment, and project contingency; $40 million for productive businesses; $20 million for the liquid endowment; $10 million of untouched minimum operating liquidity; and $1.5 million in preopening costs. The subtotal is $96.5 million before ramp losses. Local quotes, environmental review, and enterprise diligence could change this substantially.

Relative operating year	Year 1	Year 2	Year 3	Year 4	Year 5
Clinical collections	3.00	6.30	9.90	12.15	13.50
Enterprise distribution	0.00	0.30	0.80	1.50	2.00
Endowment support	0.80	0.80	0.80	0.80	0.80

Relative operating year	Year 1	Year 2	Year 3	Year 4	Year 5
Grants	1.00	1.50	2.00	2.00	2.00
Shared savings	0.00	0.00	0.10	0.30	0.50
Total receipts	4.80	8.90	13.60	16.75	18.80
Campus cash requirement	6.00	10.00	14.00	18.00	20.00
Annual surplus or deficit	(1.20)	(1.10)	(0.40)	(1.25)	(1.20)

The moderate case needs another $5.15 million to fund modeled ramp deficits while preserving $10 million in liquidity: approximately $101.65 million total committed resources. The $5.15 million is spent over the ramp; the $10 million is a remaining reserve, not additional revenue. An unresolved $1.2 million recurring deficit remains after Year 5. Raising the startup amount alone does not resolve that structural gap.

This is a constant dollar annual cash model, not a construction draw schedule or monthly liquidity forecast. Enterprise capital is assumed available before its distributions; grant and payer cash timing is simplified. Before financing, build monthly construction and working capital schedules and stress receivables, payroll timing, debt, taxes, and inflation separately. Do not treat annual break even as proof of monthly solvency.

Conditions for sustainability

At moderate assumptions, grant independent receipts total $16.8 million. Break even requires another $3.2 million, equivalent to $213.33 more annual net collections per active patient, an additional $80 million liquid endowment at 4%, or $64 million more productive assets at a truly distributable 5% yield. These are alternatives, not simultaneous requirements. With $2 million recurring grants retained, the remaining $1.2 million equals another $80 per patient.

Annual cash impacts relative to the moderate case are straightforward: a 10% clinical collection shortfall costs $1.35 million; a 50% enterprise distribution decline costs $1 million; losing all grants costs $2 million; losing shared savings costs $0.5 million; and a 10% payroll increase costs $1.087 million. Together these turn the $1.2 million deficit into a $7.137 million annual deficit before mitigation. These shocks can occur together during a recession or reimbursement disruption.

Four percent is a spending assumption, not a guaranteed investment return. To preserve purchasing power, returns must cover distributions, inflation, and fees over time. A 25% endowment market decline would reduce a simple 4% draw from $0.8 million to $0.6 million if calculated directly on the lower asset value. Smooth spending rules can stabilize payroll temporarily but increase pressure on principal. Require an investment policy, diversification, liquidity limits, and an independent investment committee.

If $20 million is the entire initial capital ceiling, use a smaller leased pilot and existing educational partners. An illustrative allocation is $3.5 million leasehold improvements, $1 million equipment, $1 million data and legal setup, $0.5 million launch and recruitment, $5 million contracted enterprise assets, $4 million liquid endowment, and $5 million cash. At 5% and 4%, the two asset pools provide only $0.41 million annually. A $3 million pilot would need at least $2.59 million other annual receipts. Do not spend this capital on a full campus before proving that revenue.

11 Regulatory accreditation and clinical safety barriers

The state is not yet selected. The following is a diligence map; it does not conclude that any particular ownership, subscription, construction, or device arrangement is lawful. Retain healthcare counsel and regulatory specialists during site selection.

Barrier	Required action and accountable lead
Practice ownership and professional scope	Counsel maps state corporate practice fee splitting scope and telehealth rules; medical director controls clinical decisions
Facility and service licensing	Operations and counsel identify clinic imaging pharmacy laboratory and ambulatory surgery approvals; assess certificate of need if relevant
Patient billing and payment	Revenue lead validates payer enrollment Medicaid rules Medicare participation or opt out rules and subscription limits
Federal fraud and abuse	Counsel reviews referral compensation related entities free services scholarships and inducement concerns
Lab quality	Laboratory director determines CLIA certificate and test complexity plus any state requirements
Devices and software	Regulatory lead determines classification intended use marketing pathway quality system and reporting duties
Privacy and cybersecurity	Privacy and security officers implement HIPAA obligations vendor agreements access controls audit backup and incident response
Education	Academic partner verifies affiliation supervision degree and accreditation responsibilities and student protections
Research	Independent IRB and research lead distinguish quality improvement from research and establish consent and oversight
Buildings and enterprises	Project lead validates zoning accessibility fire safety environment food safety housing and utility requirements

Federal fraud and abuse review must address Anti-Kickback, Stark where applicable, false claims, and beneficiary inducement rules. A nonprofit structure does not remove those duties. Avoid routine blanket copay waivers without a compliant policy. A financially independent clinical evidence committee should review services even when an affiliated enterprise could profit from a referral. [S31]

CLIA applies to human laboratory testing for diagnosis, prevention, treatment, or health assessment, including settings outside a conventional lab. Waived status depends on the test and use, not on the campus's nonprofit status. Modified tests can change obligations. [S32]

FDA's Quality Management System Regulation became effective February 2, 2026 and incorporates ISO 13485:2016 by reference with FDA requirements. Determine whether each campus activity is device manufacturing, servicing, or remanufacturing. Open hardware files and local fabrication do not remove applicable requirements. Use appropriate electrical, electromagnetic, radiation, and MRI safety standards with qualified engineering review. [S33, S34]

For accredited education, negotiate institutional ownership of curriculum, assessment, clinical supervision, student support, and liability. Only ACGME accredited sponsoring institutions may apply for new residency programs. Do not advertise an accredited degree, guaranteed residency, or license eligibility before the relevant approvals and agreements exist. [S24, S25]

HIPAA covered entities and business associates require appropriate safeguards and agreements. Implement role based access, multifactor authentication, encrypted backups, tested restoration, vendor review, and breach response. Obtain expert deidentification review before publishing datasets; rare diagnoses and small rural populations make reidentification possible. Review other applicable confidentiality and state privacy obligations. [S35]

Clinical safety requires more than an advisory board. Hire an accountable medical director; credential and privilege staff; verify licenses; carry malpractice and general liability insurance; define emergency transfer and after hours coverage; track tests and referrals to completion; audit prescribing; and operate an accessible complaint and incident reporting process. Do not expand diagnostics without reliable specialist interpretation and escalation.

Before opening, simulate critical test results, deterioration, medication errors, infection control failures, equipment downtime, cyber incidents, and transfers. Before adding each service, confirm staff competence, facility suitability, operating procedures, insurance, and backup arrangements. Serious unexplained safety events trigger an immediate service review and pause where warranted.

12 Potential collaborators and the role of each

All entries are prospects for consideration, not endorsements, affiliations, commitments, or evidence of availability. No outreach has been sent. Resolve the two ambiguous identities before preparing a personalized proposal or contacting anyone.

Prospect	Verified basis for relevance	Proposed first contribution
Dr Lucy McBride	Her public biography identifies internal medicine primary care and work connecting mental and physical health	Review patient experience clinical philosophy and a humane primary care pilot
Dr Jane Kim identity to confirm	VA lists Jane Kim MD MPH in preventive medicine leadership; several other clinicians share the name	If this is the intended person invite a prevention and implementation review subject to institutional rules
Lucas Winter identity to confirm	Likely intended imaging collaborator is Lukas Winter whom PTB identifies as OSI² founder	Confirm spelling and identity then review the imaging research and safety plan
Southcentral Foundation Nuka learning team	Established relationship based care and learning programs	Paid learning visit and governance consultation with respect for tribal knowledge
Local HRSA health center leadership	Existing access infrastructure and public program experience	Operating partnership and referral network before duplicating infrastructure
OpenEMR Foundation and qualified support vendors	Open source EHR and certification documentation	Costed implementation interoperability and security proposal
Thomas Bodenheimer or UCSF primary care implementation network	Published work on teams access and primary care redesign	Team workflow critique and evaluation partner suggestions
Stacy Tessler Lindau and CommunityRx researchers	University of Chicago research on connecting patients to community resources	Design measurable social care referral and resource navigation pilot
NYU Grossman Long Island education leadership or a regional medical school	Established tuition scholarship and primary care education model	Scholarship and clinical placement partnership design
Surgery Center of Oklahoma or regional transparent price ASCs	Published episode bundles	Referral pricing and selection criteria learning exchange
Aravind LAICO education and operations teams	Documented cross subsidy and standardized eye care	Compare unit economics and quality controls for one replicable service

Prospect	Verified basis for relevance	Proposed first contribution
Independent health economist and community patient board	Needed expertise rather than identified commitments	Register evaluation and audit savings and equitable access

Sources: [S17, S19, S21, S26, S36–S40]. Lucy McBride's public work supports relevance to whole person primary care; it does not establish agreement with this campus concept or capacity to lead it. Jane Kim at VA is a verified candidate, not a confirmed match to the user's intended Dr. Kim. An integrative medicine page names a DULA alumna with the same name; do not merge those credentials or infer she is an MD. Obtain the intended person's affiliation and preferred public profile before tailoring any proposal.

For the imaging lead, PTB's Lukas Winter and his published open MRI work are a strong topical match. The user's spelling Lucas remains unresolved. An institutional conversation would also need to address IP, publications, device liability, funding, cross border collaboration, and conflicts. Do not position any prospect as a founder before they accept that role. [S38, S41] The separate DULA name match is recorded only to explain the Jane Kim ambiguity, not to validate treatment or publication claims. [S42]

The most consequential collaborators are local operating partners: an accredited school, a hospital willing to accept transfers and referrals, a health center or physician group, a payer or self insured employer, patient representatives, and an enterprise operator with audited cash flow. A prominent advisory group cannot substitute for those contracts.

13 Prioritized implementation roadmap

Timeframes are relative to a funded project start and may overlap. Budgets are stage planning allowances, not approved commitments; pilot spending is an alternative early route, not an amount to add blindly to the full capitalization model.

Priority and timing	Deliverable	Lead role	Spending gate
P0 first 30 days	Define $20m goal service package intended collaborators and community	Founder and clinical adviser	No land acquisition or equipment build
P1 months 1 to 3	Shortlist three regions and secure claims and community needs data	Project director health economist community board	Fund $150k to $250k diligence tranche
P1 months 2 to 6	Legal structure payer and referral terms school affiliation enterprise underwriting	Counsel medical director CFO	Complete total $300k to $500k feasibility budget before launch decision
P2 months 6 to 18	Open leased primary care pilot with external specialty and imaging access	Licensed operating partner	Commit 24 months operating liquidity and all required approvals
P2 months 12 to 30	Evaluate safety access collections staffing and independent enterprise cash	Independent evaluator CFO board	Expand only with acceptable quality and funded subsidy gap
P3 months 24 to 48	Expand toward 10k to 15k panel add scholarships and selected diagnostics	Campus executive and academic partner	Signed contracts and capital fully funded by stage
P4 years 4 to 7	Approach $20m scale publish replication kit and contract outcomes	Board and operating partners	Rolling 12 month cash adequacy and no unresolved safety failures

Priority and timing	Deliverable	Lead role	Spending gate
P5 after demonstrated operations	Consider residency sponsorship advanced imaging or degree program	Separate academic and regulatory teams	Separate business case and accreditation capital

The first six months

Authorize a $300,000–500,000 feasibility phase in tranches. A proposed $400,000 allocation is $90,000 clinical and community design, $80,000 claims and actuarial analysis, $70,000 legal and accreditation diligence, $60,000 enterprise underwriting, $50,000 site and facility analysis, and $50,000 project management and contingency. This is a proposed use of funds, not a vendor quote.

By day 30, write the benefit package and exclusions and confirm whether the capital ceiling is $20 million or the annual operating target is $20 million. Verify the intended Jane Kim and Winter identities. Convene a compensated patient advisory group and recruit a medical director with operating responsibility.

By day 90, compare three markets using unmet primary care need, payer mix, clinician recruitment, school proximity, hospital access, travel burden, affordable buildings, and state regulatory feasibility. Avoid cheap remote land that increases transport costs and loses access to clinical training or emergency services. Obtain 24 months of appropriately protected baseline claims where possible and assess payer data completeness.

By month 6, produce signed or counsel reviewed draft terms for referral access, school affiliation, payer collection assumptions, enterprise customers, facility lease, and liability coverage. Prepare a monthly 24 month cash forecast and downside funding plan. Obtain independent review of every enterprise distribution assumption. Decide whether to launch, resize, or stop.

Measurable gates

Proposed operating gates, to be ratified by clinical and community governance, include funded staffing before accepting patients, no unassigned critical test follow up, documented urgent transfer coverage, and closure of material safety findings. These are operating requirements, not claims of clinical accreditation.

Track appointment delay, continuity, patient reported function and experience, guideline appropriate screening, chronic disease outcomes, medication safety, referral completion, and hospital and ED use. Stratify access and outcomes by payer, income, race and ethnicity where lawfully and appropriately collected, disability, geography, and complexity. Audit panel exclusion and disenrollment to detect selection against costly patients.

Evaluate total allowed spending and patient out of pocket spending, not only campus bills. Use a prespecified matched comparison or phased rollout, adjust for case mix and regression to the mean, and report uncertainty. Claims lag and small samples can make short term savings estimates unreliable. Include evaluation and campus subsidy costs when reporting net societal savings.

For financial expansion, require collections consistent with contracts, a funded 24 month downside plan, and separate verification of enterprise cash after reserves. Before describing the mature model as self sustaining, require at least 12 months of grant independent recurring receipts covering operating cash and replacement needs, alongside a credible forward budget and six months minimum liquidity. A grant supported model can still be valuable; label it accurately.

14 Feasibility decision and proposal implications

The model's strongest near term proposition is better access and continuity with transparent economics, subsidized education, and openly shared methods. Its ecological enterprises can support mission and resilience, but they add

management complexity and capital demands. Their financial performance must be demonstrated independently from the quality of clinical care.

Proceed with partnership and pilot design. Defer a new medical school, hospital construction, and reliance on unapproved diagnostic hardware. The moderate full campus case is not yet financially self sustaining. Close its $3.2 million grant independent gap through validated payer receipts, a smaller service package, more endowed support, or profitable assets before expansion.

The later proposal to Lucy McBride, the intended Jane Kim, Winter, and other collaborators should ask for specific paid review or co-design contributions. Lead with a testable question: can a community governed teaching clinic improve health and access at a lower total cost, while publishing its methods and supporting a defined share of care and education through productive assets? Include the proposed six month scope, honest financial gap, clinical independence, and the decision each collaborator would help resolve.

The evidence supports a serious experiment and a possible replication network. It does not support guaranteeing national transformation, free comprehensive care, or perpetual enterprise profits before the first operating data exist.

15 Linked source register

Accessed October 22 2026. Publication and data years differ. Organizational pages establish described activities and credentials; they do not establish causal impact or willingness to participate. Campus budgets, scenarios, thresholds, and roadmap dates are original planning assumptions unless explicitly attributed above.

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[S18] Society of Actuaries. Direct Primary Care Evaluating a New Model of Delivery and Financing. 2020. https://www.soa.org/globalassets/assets/files/resources/research-report/2020/direct-primary-care-eval-model.pdf

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