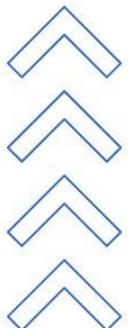


CH



# Modeling of **CODES HEALTH**



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**Start - Up Since 2024**

This Codes Health model is built primarily on assumptions and limited publicly available information gathered from various sources, which have not been independently confirmed. The figures are illustrative for academic use. In the PDF version, only the base-case income statement is presented due to format constraints in this document.



# INDEX

**About CodesHealth**



**Revenue Assumption**



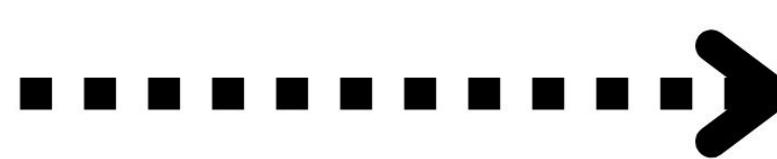
**Cost Assumption**



**Income Statement ; Cash Flow Runway**



**Conclusion**



Codes Health is a next-generation digital health company focused on transforming how healthcare services are delivered, managed, and experienced. The company operates at the intersection of healthcare and technology, building scalable digital infrastructure that enhances accessibility, improves operational efficiency, and supports data-driven decision-making. By integrating smart digital tools into healthcare systems, Codes Health aims to simplify patient care workflows and enable more responsive, efficient service delivery.

The company is positioned as an early-stage growth startup operating in the rapidly expanding digital health sector. Based on benchmarking against comparable startups and available industry performance indicators, we estimated that Codes Health generated approximately \$300,000 in revenue in 2025. This estimate serves as the foundation for our forward-looking financial projections and reflects a realistic early traction phase typical of emerging health technology firms.

For modeling purposes, Codes Health is assumed to have secured approximately \$500,000 in seed-level funding, consistent with capital raised by startups at a similar development stage. This funding is projected to support platform development, infrastructure scaling, talent acquisition, and early market expansion. The assumed funding structure reflects a common startup growth trajectory where early investment enables rapid product refinement and customer acquisition.

Our financial model is constructed using best-case, base-case, and worst-case scenarios to capture uncertainty inherent in startup growth. Revenue assumptions are driven by user adoption rates, pricing benchmarks, and scalable service expansion. Cost assumptions incorporate a blend of fixed operational infrastructure and variable expenses that increase with growth. This structured scenario approach allows for realistic performance evaluation under multiple market conditions.

Codes Health is modeled as a high-potential digital health venture positioned to benefit from increasing global demand for technology-enabled healthcare solutions. While the financial figures used in this model are hypothetical and created strictly for analytical and educational purposes, the modeling framework follows industry-standard startup financial planning practices. The exercise demonstrates how structured assumptions, funding strategy, and operational scaling interact to shape the financial trajectory of an early-stage health technology company.

Through this model, Codes Health represents a practical simulation of how innovation-driven healthcare startups can scale responsibly while balancing growth, cost discipline, and long-term sustainability.

		For Providers	For Lawyers	
Trusted Investor Backing		<p><b>Pin - Point Past Providers</b></p> <p>When Codes Health refers to "pinpointing past providers," it means accurately identifying every healthcare provider or institution that has previously treated a patient. In high- and administrative cases, missing even one provider can result in incomplete medical histories, delayed documentation, or weakened case outcomes. Codes Health uses structured data collection and verification processes to map a patient's treatment journey and ensure no relevant provider is overlooked. This creates a complete healthcare timeline, allowing records to be requested efficiently and confidently. By eliminating uncertainty, the platform improves accuracy, reduces delays, and ensures decisions are based on full medical visibility.</p>	<p><b>Missing Record Review</b></p> <p>Missing record review refers to the process of identifying gaps or incomplete sections within a patient's medical documentation. In healthcare and legal workflows, incomplete records can lead to delays, compliance issues, or incorrect decisions. Codes Health uses structured verification tools to systematically scan collected documentation and flag missing reports, treatment periods, or provider information. This allows legal teams to quickly identify gaps and address them before case preparation begins. By detecting issues early, the platform prevents last-minute complications and strengthens documentation reliability. The result is a more accurate, organized, and dependable medical record system that supports confident decision-making.</p>	Practices
pathlight ventures		<p><b>Gather Medical Records</b></p> <p>Gathering medical records refers to the accurate collection and consolidation of patient documentation from multiple healthcare providers into a single organized system. Traditionally, this process is slow and fragmented, requiring manual consolidation across hospitals, clinics, and administrative offices. Codes Health streamlines record retrieval through automated request workflows and standardized digital processing. The platform ensures documents are collected efficiently, verified for accuracy, and formatted for easy review. By centralizing records, Codes Health reduces administrative delays and eliminates inconsistencies. This creates a reliable medical archive that supports legal review, insurance processing, and healthcare decision-making with speed, clarity, and confidence.</p>	<p><b>Automated Follow Ups</b></p> <p>Automated follow-ups refer to the systematic tracking and management of outstanding record requests and documentation tasks without manual intervention. In traditional workflows, staff must repeatedly contact providers to check request status, which is time-consuming and prone to delays. Codes Health replaces this process with automated reminders and progress monitoring that continuously follow up until records are received. This ensures no request is forgotten or stalled. By maintaining constant communication in the background, the platform accelerates turnaround times and reduces administrative workload. Automated follow-ups create a dependable workflow where documentation moves toward efficiency without requiring constant human oversight.</p>	Personal Injury
GENERAL CATALYST		<p>Codes Health delivers healthcare providers a modern digital framework that streamlines medical record management, external documentation requests, and compliance workflows. Hospitals, clinics, and healthcare organizations operate under increasing administrative pressure as record-sharing demands grow alongside regulatory complexity. Providers must maintain accuracy, protect patient privacy, and respond efficiently to legal and insurance requests — all while prioritizing patient care. Codes Health acts as a digital extension of provider infrastructure, reducing administrative strain and improving operational clarity.</p> <p>The platform enables providers to structure patient records into standardized digital formats that are easy to retrieve, verify, and transfer. This eliminates the inefficiencies of fragmented record systems and manual document handling. Automated request intake ensures that records are processed proactively through consistent workflows rather than ad hoc staff intervention. This reduces human error and ensures documentation integrity.</p> <p>One of the most significant benefits for providers is time savings. Administrative staff traditionally spend extensive hours locating files, verifying patient authorization, and coordinating document delivery. Codes Health automates large portions of this workflow, allowing healthcare teams to redirect energy toward clinical responsibilities. Faster processing also improves external relationships with legal professionals, insurers, and regulatory bodies by delivering predictable response timelines.</p> <p>Compliance and security are central pillars of the platform. Healthcare providers operate in a heavily regulated environment where improper data handling can result in severe legal and financial consequences. Codes Health incorporates secure encryption, access controls, and audit tracking to ensure every document exchange meets privacy standards. By embedding compliance into daily operations, the platform reduces institutional risk and strengthens trust.</p> <p>Workflow transparency is another core advantage. Providers gain visibility into request status, outstanding documentation, and follow-up requirements through centralized dashboards. This tracking system prevents lost records and communication breakdowns while enabling proactive issue resolution. Missing or incomplete documentation can be identified early, minimizing downstream complications.</p> <p>Codes Health also supports scalability. Whether serving small clinics or large hospital networks, the platform adapts to growing record volumes without sacrificing performance. This scalability allows providers to modernize infrastructure without disruptive operational transitions. As healthcare systems increasingly digitize, Codes Health becomes a long-term administrative partner capable of evolving alongside institutional needs.</p> <p>By modernizing record management and documentation workflows, Codes Health improves productivity, reduces operational friction, and strengthens compliance. Providers benefit from faster information exchange, lower administrative burden, and enhanced data security. The result is a more efficient healthcare environment where organizations can maintain regulatory excellence while focusing on their primary mission: delivering high-quality patient care.</p>	<p>Codes Health provides legal professionals with a comprehensive, technology-driven infrastructure designed to simplify the management of medical documentation — one of the most complex and resource-intensive components of healthcare-related legal cases. Attorneys handling personal injury litigation, malpractice claims, insurance disputes, disability cases, and workers' compensation rely heavily on complete and accurate medical records. However, retrieving, verifying, organizing, and interpreting these records is traditionally slow, fragmented, and prone to administrative bottlenecks. Codes Health transforms this process into a structured digital workflow that prioritizes speed, clarity, and reliability.</p> <p>The platform enables legal teams to systematically identify all relevant healthcare providers connected to a case. Through automated provider discovery tools, lawyers can ensure that no critical medical source is overlooked. Once providers are identified, Codes Health tracks and manages the retrieval process through secure, standardized channels. Instead of navigating multiple hospital systems, law firms, or insurance documentation formats, attorneys receive organized digital files that are uniform, searchable, and immediately usable.</p> <p>A key advantage of Codes Health is its missing-record review framework. Legal cases can be weakened by incomplete documentation, and gaps in medical history often go unnoticed until late stages of litigation. Through automated provider discovery tools, lawyers can quickly flag missing reports, incomplete treatment timelines, and documentation inconsistencies. This proactive review reduces legal risk and strengthens case preparation by ensuring attorneys work with complete medical narratives.</p> <p>Automation plays a critical role in improving operational efficiency. Automated follow-up mechanisms track outstanding record requests and continuously prompt providers without manual intervention. Legal staff no longer need to dedicate hours to repetitive communication and status monitoring. Instead, they can focus on case analysis, client interaction, and legal strategy. This shift reduces overhead costs and accelerates case timelines.</p> <p>Beyond administrative efficiency, Codes Health enhances legal insight. The platform organizes records into chronological medical timelines that allow lawyers to interpret treatment progression, causation patterns, and expert evidence more clearly. Consolidated reporting tools transform raw medical data into structured summaries, making it easier to communicate complex healthcare information to judges, juries, insurers, and clients.</p> <p>Security and compliance are foundational to the system. Codes Health is designed around privacy-first architecture, ensuring sensitive patient information is handled according to regulatory standards. Secure encryption, audit trails, and controlled access protocols protect both legal firms and their clients from data exposure risks.</p> <p>Ultimately, Codes Health functions as a strategic infrastructure partner for legal professionals. It converts medical documentation from a logistical obstacle into an operational advantage. By combining automation, verification, and structured data organization, the platform enables lawyers to operate faster, more accurately, and with greater confidence. In high-stakes legal environments where precision and time are critical, Codes Health empowers legal teams to deliver stronger advocacy and better client outcomes.</p>	Mass Torts
H		<p><b>40 % Faster Retrieval Time</b></p> <p>Benefit of Using Codes - Health</p> <p>Codes Health delivers a streamlined solution that simplifies the complex process of managing medical records and coordinating healthcare documentation. One of its primary benefits is efficiency. By digitizing and organizing healthcare information, the platform significantly reduces the time spent locating providers, retrieving records, and verifying documentation. This enables both healthcare professionals and legal teams to focus on decision-making rather than administrative work.</p> <p>Accuracy and completeness are another major advantage. Codes Health helps identify missing or incomplete records through structured review systems, ensuring that critical healthcare information is not overlooked. This reduces errors, improves case preparation, and strengthens compliance standards. Automated follow-up systems further enhance reliability by ensuring that outstanding requests and updates are tracked without manual intervention.</p> <p>From a scalability perspective, Codes Health is designed to grow with its users. Whether serving small clinics, large healthcare networks, or legal firms handling complex cases, the platform adapts to increasing data volume without sacrificing performance. This flexibility positions it as a long-term infrastructure partner rather than a short-term tool.</p> <p>Overall, Codes Health enhances productivity, reduces administrative friction, strengthens compliance, and enables faster access to critical medical information — delivering measurable value across healthcare and legal workflows.</p>	Medical Malpractice	
Y Combinator		<p><b>30 Min Review Time</b></p> <p><b>1.3x Average Settlement</b></p>		Workers Compensation
nightcapital				Insurance Litigation
Brief Information About Investors				
Codes Health is supported by investors known for backing high-growth technology companies. Pathlight Ventures focuses on early-stage startups driving innovation in healthcare and enterprise software. General Catalyst is a global venture capital firm investing in some of the world's most promising technology and healthcare companies across technology and healthcare. Haystack invests in ambitious founders building the next generation of AI. Y Combinator, one of the world's most influential startup accelerators, has launched thousands of successful companies through its mentorship programs. Night Capital backs emerging ventures with strong growth potential, providing strategic capital and operational guidance. Together, these investors reflect strong confidence in Codes Health's long-term vision.				
Beyond capital, these investors bring deep industry expertise, operational mentorship, and access to global startup networks. Their involvement signals strong validation of Codes Health's mission and growth potential. With support from firms experienced in scaling technology-driven healthcare platforms, the company is positioned to accelerate product development, expand its user base, and strengthen strategic partnerships. This investor ecosystem enhances credibility, attracts talented professionals, and provides long-term stability — key factors that support sustainable growth in a competitive digital health landscape.				

CH (Codes Health)		Revenue Assumption																											
Assumptions	Unit	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 13	Month 14	Month 15	Month 16	Month 17	Month 18	Month 19	Month 20	Month 21	Month 22	Month 23	Month 24	Month 25			
<strong>Revenue Assumption</strong>																													
<strong>Client Assumption</strong>																													
Opening Active Clients	No.	7	14	28	49	77	111	153	202	257	319	388	464	547	636	731	833	942	1,057	1,179	1,307	1,442	1,583	1,731	1,885	2,045	2,212		
New Client Added	No.	7	14	21	35	42	49	56	63	70	77	84	91	98	105	112	119	126	133	140	147	154	161	168	175	188	204	212	
Client Churn Rate	%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	
Client Lost (Churn)	No.	0	0	0	0	0	0	0	1	1	1	1	1	2	3	3	4	4	5	5	6	6	7	8	8	8	8	8	
<strong>Closing Active Clients</strong>	No.	14	28	49	77	111	153	202	257	319	388	464	547	636	731	833	942	1,057	1,179	1,307	1,442	1,583	1,731	1,885	2,045	2,212			
<strong>Pricing Assumption</strong>																													
Avg. Monthly Subscription Fee	\$	500	500	500	500	500	500	500	500	500	500	500	500	500	500	500	500	500	500	500	500	500	500	500	500	500	500	500	
Per Record / Usage Fee	\$	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
<strong>Average Revenue per Client</strong>	\$	501	501	501	501	501	501	501	501	501	501	501	501	501	501	501	501	501	502	502	502	502	502	502	502	502	502	502	
<strong>Revenue Calculation</strong>																													
Active Paying Clients	No.	14	28	49	77	111	153	202	257	319	388	464	547	636	731	833	942	1,057	1,179	1,307	1,442	1,583	1,731	1,885	2,045	2,212			
ARPU	\$	501	501	501	501	501	501	501	501	501	501	501	501	501	501	501	501	501	502	502	502	502	502	502	502	502	502	502	
<strong>Total Revenue</strong>	\$	7,003	13,996	24,475	38,430	55,850	76,724	101,043	128,796	159,973	194,563	232,556	273,942	318,437	366,262	417,402	471,844	530,633	591,762	656,161	723,817	794,715	868,844	946,191	1,026,742	1,110,485			
<strong>Revenue Assumption</strong>																													
<strong>Client Assumption</strong>																													
Opening Active Clients	No.	5	10	20	35	54	79	108	143	181	225	273	326	383	445	511	581	656	735	819	906	998	1,094	1,194	1,298	1,407	1,519		
New Client Added	No.	5	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	95	100	105	110	115	120	125	130	135	
Client Churn Rate	%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	
Client Lost (Churn)	No.	0	0	0	0	0	0	0	1	1	1	2	2	3	4	5	6	7	8	9	10	11	12	13	14	15			
<strong>Closing Active Clients</strong>	No.	10	20	35	54	79	108	143	181	225	273	326	383	445	511	581	656	735	819	906	998	1,094	1,194	1,298	1,407	1,519			
<strong>Pricing Assumptions</strong>																													
Avg. Monthly Subscription Fee	\$	250	250	250	250	250	250	250	250	250	250	250	250	250	250	250	250	250	250	250	250	250	250	250	250	250	250	250	
Per Record / Usage Fee	\$	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50		
<strong>Average Revenue per Client</strong>	\$	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	
<strong>Revenue Calculation</strong>																													
Active Paying Clients	No.	10	20	35	54	79	108	143	181	225	273	326	383	445	511	581	656	735	819	906	998	1,094	1,194	1,298	1,407	1,519			
ARPU	\$	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	
<strong>Total Revenue</strong>	\$	2,495	4,990	8,698	13,638	19,791	27,148	35,698	45,433	56,342	68,416	81,646	96,023	111,441	127,974	145,609	164,339	184,520	205,449	227,445	250,498	274,599	299,737	325,965	353,091	381,289			
<strong>Revenue Assumption</strong>																													
<strong>Client Assumption</strong>																													
Opening Active Clients	No.	3	6	12	21	32	47	64	84	106	131	159	189	222	266	294	333	375	419	465	513	563	615	670	726	784	844		
New Client Added	No.	3	6	9	12	15	18	21	24	27	30	33	36	39	42	45	48	51	54	57	60	63	66	69	72	75			
Client Churn Rate	%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	
Client Lost (Churn)	No.	0	0	0	0	0	1	1	2	3	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	
<strong>Closing Active Clients</strong>	No.	6	12	21	32	47	64	84	106	131	159	189	222	266	294	333	375	419	465	513	563	615	670	726	784	844			
<strong>Pricing Assumption</strong>																													
Avg. Monthly Subscription Fee	\$	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	
Per Record / Usage Fee	\$	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	
<strong>Average Revenue per Client</strong>	\$	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150
<strong>Revenue Calculation</strong>																													
Active Paying Clients	No.	6	12	21	32	47	64	84	106	131	159	189	222	266	294	333	375	419	465	513	563	615	670	726	784	844			
ARPU	\$	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150
<strong>Total Revenue</strong>	\$	893	1,779	3,099	4,846	7,013	9,591																						

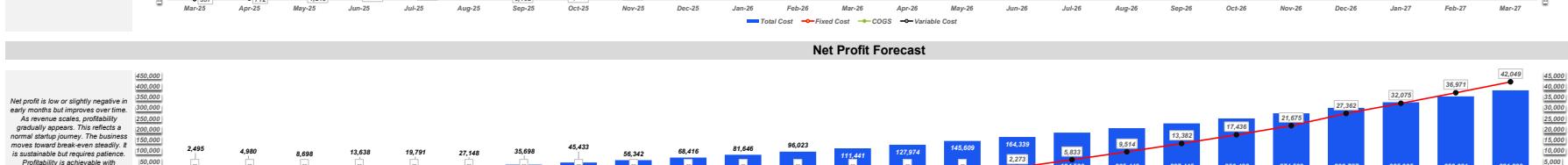
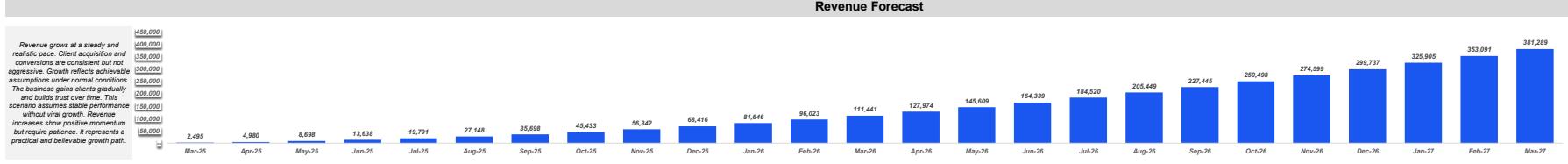
The cost assumptions for Codes Health have been developed to realistically reflect the operational structure of a growing health-tech platform while maintaining clarity and transparency in financial modeling. Costs are classified into variable costs and fixed costs to clearly show how expenses behave with changes in scale, usage, and growth across different scenarios.

**Variable costs primarily include API usage, cloud infrastructure, customer support, and other usage-linked operational expenses.** These costs are assumed to move in line with platform activity, such as the number of active clients and system usage. In the best-case scenario, variable costs grow at a controlled rate due to higher utilization efficiency and economies of scale. In the base case, variable costs increase steadily, reflecting normal operational efficiency and balanced growth. In the worst-case scenario, variable costs remain relatively high per client because of lower utilization levels and limited scale benefits, placing pressure on margins.

**Fixed costs consist of salaries, software subscriptions, compliance expenses, administrative costs, and other overheads that do not vary directly with short-term changes in revenue.** These costs are assumed to be largely stable over time, with planned and gradual increases to support business continuity and compliance requirements. In the best and base cases, fixed costs grow in a predictable and disciplined manner, allowing the business to benefit from operating leverage as revenue expands. In the worst case, fixed costs remain relatively inflexible despite slower growth, highlighting the downside risk to profitability.

*Overall, the cost assumptions aim to capture realistic cost behavior under different operating conditions, enabling a structured comparison between best, base, and worst-case outcomes and supporting informed financial analysis for Codes Health.*

CH (Codes Health)		Income Statement																										
Assumptions	Unit	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27		
		Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 13	Month 14	Month 15	Month 16	Month 17	Month 18	Month 19	Month 20	Month 21	Month 22	Month 23	Month 24	Month 25		
Income Statement		Choose scenario is used for Income Statement for better visualisation																										
		2																										
Revenue	\$	2,490	4,970	8,680	13,611	19,752	27,094	35,627	45,342	56,229	68,280	81,483	95,832	111,219	127,718	145,319	164,011	183,785	204,631	226,539	249,500	273,505	298,543	324,606	351,885	379,770		
Usage Based Revenue	\$	5	10	17	27	40	54	71	91	112	137	163	183	202	225	255	291	328	355	375	398	428	454	484	514	544	574	
Total Revenue	\$	2,495	4,980	8,698	13,638	19,791	27,148	35,698	45,433	56,342	68,416	81,646	96,023	111,441	127,974	145,609	164,339	184,620	205,449	227,445	250,498	274,599	297,737	325,905	353,091	381,289		
COGS	\$	8	16	28	44	53	87	114	145	180	218	261	307	355	409	485	525	588	655	725	788	875	974	1,055	1,139	1,228	1,319	
AI & Cloud Usage	\$	349	698	1,215	1,906	2,785	3,793	4,988	6,348	7,872	9,559	11,408	13,416	15,571	17,881	20,345	22,962	25,730	28,648	31,715	34,930	38,291	38,853	42,202	45,572			
Medical Record Retrieval	\$																											
Total COGS	\$	357	712	1,243	1,949	2,828	3,880	5,192	6,493	8,052	9,778	11,688	13,723	15,927	18,289	20,810	23,496	26,218	29,303	32,440	35,728	39,166	36,721	39,927	43,257	46,712		
Gross Profit	\$	2,138	4,268	7,455	11,689	16,963	23,268	30,597	38,940	48,290	58,639	69,978	82,300	95,515	109,684	124,800	140,852	158,202	176,146	195,005	214,770	235,433	263,016	285,978	309,834	334,577		
Gross Profit Margin %	%	85.77%	85.71%	85.77%	85.77%	85.77%	85.77%	85.77%	85.77%	85.77%	85.77%	85.77%	85.77%	85.77%	85.77%	85.77%	85.77%	85.77%	85.77%	85.77%	85.77%	85.77%	85.77%	85.77%	85.77%	85.77%		
OpEx	\$																											
Variable Cost	\$	50	99	174	272	395	542	713	907	1,125	1,368	1,630	1,917	2,224	2,554	2,906	3,280	3,676	4,093	4,531	4,990	5,470	5,971	6,492	7,034	7,595		
Total Variable Cost	\$	50	99	174	272	395	542	713	907	1,125	1,368	1,630	1,917	2,224	2,554	2,906	3,280	3,676	4,093	4,531	4,990	5,470	5,971	6,492	7,034	7,595		
Contribution Margin	\$	2,089	4,169	7,281	11,417	16,568	22,726	29,884	38,033	47,165	57,273	68,348	80,383	93,291	107,130	121,893	137,572	154,526	172,053	190,474	209,780	229,963	257,046	279,486	302,801	326,982		
Contribution Margin %	%	83.71%	83.71%	83.71%	83.71%	83.71%	83.71%	83.71%	83.71%	83.71%	83.71%	83.71%	83.71%	83.71%	83.71%	83.71%	83.71%	83.71%	83.71%	83.71%	83.71%	83.71%	83.71%	83.71%	83.71%	83.71%		
Fixed Cost	\$	108,333	108,333	108,333	108,333	108,333	108,333	108,333	108,333	108,333	108,333	108,333	108,333	108,333	108,333	108,333	108,333	108,333	108,333	108,333	108,333	108,333	108,333	108,333	108,333			
Salaries & Wages	\$	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000		
Cloud Infrastructure	\$	6,667	6,667	6,667	6,667	6,667	6,667	6,667	6,667	6,667	6,667	6,667	6,667	6,667	6,667	6,667	6,667	6,667	6,667	6,667	6,667	6,667	6,667	6,667	6,667	6,667		
Legal & Compliance	\$	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083		
Office, Tools & Admin	\$																											
Total Fixed Cost	\$	122,083	122,083	122,083	122,083	122,083	122,083	122,083	122,083	122,083	122,083	122,083	122,083	122,083	122,083	122,083	122,083	122,083	122,083	122,083	122,083	122,083	122,083	122,083	122,083			
Total OpEx	\$	122,133	122,183	122,287	122,356	122,478	122,596	122,796	122,990	123,208	123,449	124,000	124,304	124,304	124,304	124,304	124,304	124,304	124,304	124,304	124,304	124,304	124,304	124,304	124,304	124,304		
Total Cost	\$	122,490	122,894	123,500	124,305	125,307	126,505	127,898	129,463	131,227	133,723	137,723	140,927	142,800	145,517	148,802	151,146	154,054	156,744	160,146	163,721	167,468	171,386	175,169	181,057			
EBT	\$	(119,995)	(117,914)	(114,802)	(110,667)	(105,515)	(99,357)	(92,199)	(84,050)	(74,918)	(64,810)	(53,735)	(41,700)	(28,793)	(19,620)	(4,857)	10,822	27,776	45,303	63,724	83,030	103,213	130,296	152,736	176,051	200,232		
Tax	%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%		
Net Profit	\$	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	2,273	5,833	9,514	13,382	17,438	21,675	27,362	32,075	36,971	42,049



# Conclusion

## Revenue Logic

The revenue model for Codes Health is structured around four main drivers: new client additions, churn rate, average monthly subscription fee, and usage-based fees. These drivers were selected because they represent how a healthcare records and support platform realistically generates recurring income.

In the Best Case, the model assumes strong client acquisition driven by referrals, partnerships, and faster onboarding. New client additions increase steadily over time, leading to a rapid rise in active clients. Churn is assumed to be minimal because satisfied healthcare clients tend to maintain long-term vendor relationships. The subscription fee is assumed at approximately \$500 per client per month, reflecting premium pricing or expanded services. Usage fees further increase revenue as higher client activity generates additional billing. This case reflects a scenario where Codes Health achieves strong market acceptance and pricing power.

In the Base Case, growth is moderate and realistic. New client additions increase gradually rather than aggressively, reflecting the slower sales cycles typical in healthcare. Churn is present but controlled, acknowledging that some clients may leave due to pricing or operational changes. The average subscription fee of approximately \$200 per client per month reflects competitive but sustainable pricing. Usage fees provide incremental revenue but do not dominate total income. This scenario represents steady traction and realistic growth.

In the Worst Case, client acquisition is slower, and churn is slightly higher. This reflects potential challenges in onboarding or competition. Pricing is assumed at around \$120 per client per month, representing competitive pressure or limited service scope. Usage fees are lower due to reduced client activity. This scenario acknowledges downside risk while still assuming business continuity.

Overall, the revenue assumptions across all cases are grounded in healthcare industry realities where trust, compliance, and gradual adoption shape growth.

## Cost Logic

The cost model separates variable and fixed costs to reflect how expenses behave in a service-based healthcare startup.

### Variable Costs

Variable costs scale with the number of clients served.

**Best Case:** Variable cost per client is approximately \$27, assuming operational efficiency and scale benefits.

**Base Case:** Around \$41 per client, reflecting normal service effort.

**Worst Case:** Around \$65 per client, assuming higher servicing burden or inefficiencies.

This structure ensures that margins remain realistic as the company grows.

### Fixed Costs

Fixed costs are largely driven by salaries and administrative overhead.

Monthly salary costs range roughly:

\$66k-\$76k in earlier periods

Increasing toward \$110k+ as hiring expands

These assumptions are supported by real job postings showing salaries of \$100k-\$200k annually per employee, which equals roughly \$8k-\$16k monthly per hire. This validates the payroll assumptions and shows that compensation is market-aligned.

Administrative, compliance, and infrastructure costs remain stable across scenarios, reflecting the need for secure systems and regulatory adherence in healthcare operations.

The Best Case assumes costs grow efficiently with revenue. The Base Case assumes controlled cost growth. The Worst Case assumes fixed costs remain high even if revenue grows slowly, creating pressure on margins.

## Income Statement Insight

### Gross Profit

Gross profit improves steadily as client numbers grow. Since subscription revenue per client significantly exceeds variable cost per client, the model shows strong gross margin potential. The Best Case achieves the highest margins due to higher pricing and lower variable costs. The Base Case maintains stable margins. The Worst Case shows thinner margins but still positive gross profit.

### Contribution Margin

Contribution margins remain positive in all scenarios. This indicates that each additional client contributes toward covering fixed costs after variable costs are paid. This confirms viable unit economics and scalability potential.

### Net Profit

Net profit trends clearly show the impact of fixed costs and operating leverage.

In early periods, net profit is limited or negative due to salary and infrastructure commitments. This is typical for startups investing in growth. As revenue scales, fixed costs are absorbed and net profit improves.

**Best Case:** Net profit turns positive earlier and grows strongly as high pricing and strong client growth absorb fixed costs quickly.

**Base Case:** Net profit improves gradually, showing a realistic path to sustainability. Profitability is achieved as revenue catches up with payroll and fixed costs.

**Worst Case:** Net profit remains low or negative for longer because slower revenue growth struggles to absorb fixed costs. This highlights execution risk.

## Overall Conclusion

This financial model provides a balanced and realistic evaluation of Codes Health. Revenue assumptions reflect healthcare client behavior and realistic pricing. Cost assumptions are supported by real-world salary benchmarks and operational needs. The income statement shows clear operating leverage and improving margins with scale.

Across all cases, the model demonstrates that Codes Health has a scalable business model with positive unit economics. However, success is execution-dependent. If client acquisition and retention keep pace with hiring, profitability is achievable. If payroll expands faster than revenue, financial pressure increases.

Overall, Codes Health appears to be a potentially scalable healthcare services business with credible pathways to profitability, but success depends on disciplined growth, hiring control, and strong execution. The model is realistic, analytical, and suitable for investor or academic evaluation.

### Done for educational purposes

*This financial model has been prepared solely for academic, educational, and analytical purposes. The primary objective of this model is to demonstrate financial modeling techniques, scenario analysis, and structured business evaluation within a learning environment. It is not intended to serve as a precise forecast, valuation, or representation of the actual financial performance of Codes Health or any other entity. The figures, projections, and assumptions used in this model are based on hypothetical scenarios, publicly observable information, and logical estimations designed to illustrate how financial models are constructed and interpreted.*

*The model relies on simplified assumptions to simulate how a healthcare services business might behave financially under different conditions. These assumptions include estimated client growth, churn rates, pricing structures, cost behavior, and hiring patterns. While efforts have been made to keep assumptions realistic and aligned with general industry practices, they do not represent verified internal data from Codes Health. They are conceptual inputs used for learning and analytical demonstration. Real-world financial outcomes are influenced by numerous dynamic factors such as market conditions, competition, regulation, operational execution, macroeconomic trends, and company-specific decisions, all of which extend beyond the scope of this model.*

*Revenue assumptions in this model are constructed using theoretical client acquisition patterns and pricing frameworks common in subscription-based or service-oriented healthcare platforms. These assumptions illustrate how recurring revenue models function but should not be interpreted as actual revenue expectations. Real healthcare businesses often experience variability in client onboarding timelines, compliance approvals, contract negotiations, and service utilization, which can significantly affect financial outcomes. The model simplifies these elements to maintain clarity in learning how revenue flows through a financial structure.*

*Cost assumptions are similarly illustrative. Salary ranges referenced in the model are based on general market observations and publicly available job postings to maintain realism in scenario construction. However, actual compensation structures within any organization may vary based on geography, experience levels, internal policies, and equity-based compensation. Infrastructure, compliance, and administrative cost estimates are also conceptual and may differ materially from real operational costs faced by healthcare companies.*

*The scenario framework — best case, base case, and worst case — is included to teach sensitivity analysis and risk awareness. These scenarios are not predictions but analytical tools that show how outcomes change under different assumptions. In practice, real businesses may experience conditions outside these defined scenarios. The purpose here is to illustrate modeling methodology rather than to define future performance boundaries.*

*This model does not incorporate full due diligence factors such as detailed regulatory compliance analysis, legal liabilities, cybersecurity risks, or detailed capital structure considerations. Healthcare businesses, in particular, operate in highly regulated environments where compliance costs and legal requirements can materially affect financial performance. These complexities are simplified in this model to focus on core financial modeling concepts.*

*The model also does not attempt to capture qualitative factors such as management capability, organizational culture, operational execution quality, technological differentiation, or competitive positioning. These elements play a significant role in determining real-world business success but are difficult to quantify in a simplified academic model. Therefore, the absence of these factors should not be interpreted as a reflection of their importance.*

*All financial projections are inherently uncertain. Even professional financial forecasts prepared by experienced analysts can differ significantly from actual outcomes. This model is created in a learning context where the goal is to understand relationships between financial variables rather than to produce precise predictions. Users of this model should view it as an educational exercise in structured thinking and financial planning.*

*The model is not audited, verified, or endorsed by Codes Health or any external party. Any resemblance between modeled figures and actual company performance is purely coincidental. The company name is used as a case study example to apply financial modeling techniques in a practical context. No confidential or proprietary information has been used in the preparation of this model.*

*This model is intended to help students and learners understand how assumptions drive financial results, how income statements are built, how operating leverage works, and how scenario analysis can support decision-making frameworks. It is a tool for developing analytical skills, not for forming business judgments about any real company.*

*Readers should interpret this model as a demonstration of methodology rather than a representation of reality. Financial models are only as strong as their assumptions, and assumptions are inherently subject to change. Market conditions evolve, technologies advance, regulations shift, and consumer behavior adapts. All of these can influence financial outcomes in ways that simplified models cannot fully capture.*

*In an academic setting, models like this are valuable for illustrating cause-and-effect relationships between revenue growth, cost structure, and profitability. They allow learners to test scenarios, explore sensitivity, and understand financial dynamics. That educational purpose is the foundation of this model.*

*The preparation of this model reflects an attempt to apply logical reasoning, publicly observable benchmarks, and structured financial thinking. However, it does not claim to represent professional financial advice, corporate guidance, or strategic recommendations for any organization. It should be evaluated within the context of a learning exercise.*

*By presenting multiple scenarios and clearly stating assumptions, the model encourages transparency and critical thinking. Users are encouraged to question assumptions, adjust variables, and explore alternative outcomes as part of the learning process. This iterative approach is central to financial modeling education.*

*Ultimately, this model is an academic exercise designed to develop financial literacy, analytical reasoning, and scenario planning skills. It is not a substitute for professional financial analysis, corporate disclosures, or audited financial statements. Any interpretation of the model should remain within its educational intent. But one thing to keep in mind that according to our analysis this company needs more funding but one more thing which is true is when this company becomes profitable which may take whole year of 2026 it will not take so much time to touch break - even*