SPARTAN LEGACY GROUP LLC

Healthcare Development Consulting · Owner-Side Pre-Design Services

Clinical Space & Cost Program

Sample Phase 0 Report

ORTHOPEDIC AMBULATORY SURGERY CENTER · TAMPA, FLORIDA

ENGAGEMENT DETAIL

Prepared for	**Illustrative subject project — no client is named in this document**
Prepared by	Spartan Legacy Group LLC · IronClad HC
Report date	August 20, 2026
Reference	SLG-SAMPLE-ASC-2026-01

ABOUT THIS DOCUMENT

This is a specimen. It shows the structure, depth and sourcing of a Level 1 Clinical Space & Cost Program as it is actually delivered. The subject project is illustrative — a three-operating-room orthopedic ambulatory surgery center in Tampa, Florida — and no client, physician group or site is named anywhere in it.

The figures are not illustrative. Every square foot and every dollar below was produced by the IronClad HC engine from the input set printed in Section 1, on the date shown. They are the same numbers a client entering those inputs would receive. Where a value is a national benchmark rather than a Florida-specific observation, it is labeled at the point of use.

Share it freely.

Patent Pending · U.S. Provisional Application 64/054,998 · Delaware LLC
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1. What Was Asked, and What Was Entered

A Phase 0 program answers one question before any design fee is committed: what should be built, what will it cost, and does the volume support it. Everything else in a development — site selection, lender conversations, physician recruitment, design procurement — is downstream of that answer being right.

This report answers it for a single hypothetical project. The complete input set is printed below because a number is only as good as what produced it, and a reader who cannot see the inputs cannot audit the output.

INPUT SET

INPUT	VALUE
State	Florida
Market	Tampa
Primary specialty	Orthopedic
Facility type	Ambulatory surgery center (licensed)
Real estate position	Own — sponsor group holds the real estate
Operating rooms requested	3
Cases per day	18
Average case time	60 minutes
Turnover time	20 minutes
Operating hours per day	9.5
Average recovery time	60 minutes
General anesthesia share	65%
Sterile processing	Full CSSD on site
Specialty equipment	None specified

Source: Input set entered into IronClad HC on August 20, 2026. All output in Sections 2 through 5 derives from these values and no others.

WHY TURNOVER AND CASE TIME ARE ASKED FOR

Room count is not a preference. It is a throughput calculation. At 60 minutes of case time plus 20 minutes of turnover, a room clears 7 cases in a 9.5-hour day. Three rooms therefore carry 21 cases per day at full utilization against the 18 requested — an 86% load, which leaves genuine schedule headroom without paying to build a fourth room.

A program that starts from "we want four rooms" instead of from throughput is how ambulatory surgery centers end up with a room that never opens.

2. Room Count and Throughput

MEASURE	RESULT
Operating rooms — recommended	**3**
Cases per room per day	7
Maximum daily capacity at this configuration	21
Cases per day requested	18
Utilization against capacity	86%
Annual cases at stabilization (250 operating days)	**4,500**

Source: IronClad HC throughput model. Operating days per year set at 250, the standard assumption for a five-day ambulatory schedule net of holidays.

Perioperative bay counts

Bay counts are driven off room count and specialty, not estimated. Orthopedic cases recover longer than ophthalmology or endoscopy cases, so an orthopedic center carries a heavier Phase I ratio — 2.5 bays per operating room here, against 1.5 for a lighter specialty mix.

AREA	COUNT	BASIS
Pre-operative bays	6	2.0 per OR
PACU Phase I	8	2.5 per OR — orthopedic ratio
Phase II step-down	6	2.0 per OR, minimum 6

Source: IronClad HC perioperative model. Ratios vary by specialty; the orthopedic Phase I ratio reflects longer recovery on general anesthesia cases.

3. Space Program

The program below is built room by room, then grossed. Departmental net area is what the clinical function requires. The circulation and wall factor converts net to gross — the corridors, chases, structure and wall thickness that exist in every building and appear on every construction invoice.

COMPONENT	AREA	SHARE OF NET
Operating rooms (3)	1,980 SF	26%
Pre-operative bays (6)	720 SF	9%
PACU Phase I (8)	1,200 SF	16%
Phase II step-down (6)	600 SF	8%
Sterile processing — CSSD	320 SF	4%
Clinical support	2,536 SF	33%
Administration and public areas	611 SF	8%
Departmental net area	**7,647 SF**	**100%**

Departmental net area	7,647 SF
Circulation and wall factor	× 1.45
Gross building area	**11,088 SF**

Source: IronClad HC space program. The 1.45 gross factor is the departmental-gross-to-building-gross conversion for an ambulatory surgical occupancy with a full sterile processing suite.

READ THE OPERATING ROOM NUMBER CAREFULLY

The 1,980 SF above is 660 SF per operating room. That is not the clear floor area of the room — it is the room plus its allocated sub-sterile, control and immediate support area, which is how the program carries surgical space through to a construction budget.

For reference, FGI 2022 sets a 400 SF clear floor area for a general operating room, and the Florida Building Code sets a hard licensure floor of 270 SF (Chapter 4, §451.3.2) below which a room cannot be listed as an operating room at all.

4. Cost Model

Hard costs

TRADE	COST	PER SF
Site work	$446,292	$40
Shell and structure	$1,721,412	$155
Interior finishes	$1,530,144	$138
Mechanical	$1,020,096	$92
Electrical	$828,828	$75
Plumbing and medical gas	$573,804	$52
Fire and life safety	$255,024	$23
Construction cost	**$6,375,600**	**$575**

Source: IronClad HC cost model, Florida regional construction cost basis, August 2026. Trade distribution reflects ambulatory surgical occupancy; mechanical and medical gas carry a premium over commercial office because of air change rates and pressure relationships in the restricted suite.

Soft costs

ITEM	COST
Architecture and engineering design	$573,804
Permits and fees	$111,573
Legal and insurance	$127,512
Financing costs	$95,634
Commissioning	$47,817
Accreditation	$35,000
Owner project management	$191,268
IT and low voltage	$120,000
Soft costs	**$1,302,608**

Total project cost

COMPONENT	COST
Construction	$6,375,600
Contingency (10% of construction)	$637,560
Soft costs	$1,302,608
Medical equipment	$2,419,000
Total project cost	**$10,734,768**

Source: IronClad HC cost model. Equipment reflects an orthopedic case mix including C-arm, power tools, tables, booms and sterile processing equipment.

COST RANGE, NOT A SINGLE NUMBER

The model returns $575 per SF against a Florida range of $500 to $650 per SF for ambulatory surgical construction. At the low end this project is $5,544,000 of construction cost; at the high end, $7,207,200.

That $1,663,200 spread is the honest width of a pre-design estimate. Anyone presenting a single hard number at Phase 0 is presenting false precision. The purpose of a program is to make the range narrow enough to make a decision on, not to pretend it does not exist.

5. Financial Feasibility

The feasibility model runs the program against a Florida payer mix and reimbursement basis. It is a screening model, not an underwriting model — its job is to establish whether the project clears a threshold worth spending real diligence money on.

Revenue basis

PAYER	SHARE	PER CASE
Medicare	38%	$3,271
Commercial	48%	$5,800
Self-pay and other	14%	$4,000
Blended per case		**$4,587**

Source: Medicare rate reflects the CMS ASC payment system adjusted to the Tampa wage index of 1.0369. Commercial and self-pay rates are modeled benchmarks and must be replaced with the sponsor group's own contracted rates before this becomes an underwriting document.

Operating performance

A new ambulatory surgery center does not open at stabilized volume. The model applies a ramp — 60% of stabilized cases in Year 1, 80% in Year 2, full volume from Year 3 — because that is what actually happens and what a capital partner will underwrite to.

MEASURE	YEAR 1 (RAMP)	STABILIZED
Annual cases	2,700	4,500
Net revenue	$10,155,618	$16,926,030
Operating expense	$6,905,820	$11,509,700
EBITDA	**$3,249,798**	**$5,416,330**
EBITDA margin	32%	32%

Source: IronClad HC feasibility model. Net revenue applies a 82% collection rate to gross charges. Operating expense modeled at 68% of net revenue, inclusive of clinical staffing, supplies, and facility operating cost.

Break-even

MEASURE	RESULT
Break-even annual cases	2,718
Break-even cases per day	11
Cases per day at stabilization	18
Headroom above break-even	**7 cases per day**

Source: Break-even is a stabilized steady-state threshold, not a ramp-year figure.

> **WHAT THIS MODEL DOES NOT DO**
>
> It does not underwrite. Returns on invested equity are highly sensitive to the capital structure, and capital

structure is a negotiation, not an input to a space program. A project financed at 80% leverage will show a very different return on equity than the same project at 50%, with identical construction cost and identical clinical volume.

It also does not model physician syndication economics, ancillary revenue, or the value of the real estate at exit — all three of which are material to an orthopedic sponsor group and none of which belong in a pre-design program.

The number to carry forward from this section is the EBITDA and the break-even case volume. Those are properties of the facility. Everything past them is a property of the deal.

6. Regulatory Basis — Florida

A program sized to the wrong standard is worse than no program, because it carries the appearance of rigor. Every state is different, and most states are not on the standard the industry assumes. Florida is one of the few where the common assumption happens to be correct — and even there, the usual citation is wrong.

ITEM	BASIS
Governing standard	FGI Guidelines for Design and Construction of Outpatient Facilities, 2022 edition
Adopted through	Florida Building Code, 8th Edition (2023), effective December 31, 2023
Correct citation	Florida Building Code Chapter 4, §451 — adopted via Rule 61G20-1.001
Licensing authority	Agency for Health Care Administration, Office of Plans and Construction
Adoption behavior	Frozen, not rolling — advances only when the Florida Building Commission adopts a new FBC edition
Edition lock	A project freezes its applicable edition at Stage II preliminary plan approval

Source: Verified against the Florida Building Code and Rule 61G20-1.001 directly, August 19, 2026.

THE CITATION TRAP, STATED PLAINLY

Florida ASC construction is routinely cited to AHCA Rule 59A-5.022. That rule contains no construction standards whatsoever — it is three short paragraphs pointing outward to the Building Code. Cite Florida Building Code Chapter 4, §451.

The hard licensure gate is §451.3.2: an ambulatory surgical center must have at least one operating room with a minimum clear floor area of 270 square feet, and only rooms of that size or larger may be listed as an operating room for licensure purposes. A room built at 250 SF is not a small operating room. For licensure, it is not an operating room.

Why this section exists in every report

Across the fifty states and the District of Columbia, only six adopt the current FGI edition on a rolling basis. Seventeen do not adopt FGI at all and write their own construction standards. The remainder are frozen at a specific edition — several of them very old. Arizona is locked at the 2018 edition by a rule that expressly excludes future editions. Wyoming is on a 2006 guideline. Kansas is on a 1996 AIA document. Hawaii is on a 1979 federal publication.

A national template applied to any of those states produces a program sized to a standard that state does not enforce. Every IronClad HC report states the governing standard for the state entered, with the citation, and says so plainly when the state has not been verified.

7. Risk Flags

The engine flags conditions in the input set that materially affect the project. This one returned a single flag.

SINGLE-SPECIALTY CONCENTRATION

The entire case volume of this facility depends on one specialty and, in practice, on a small number of surgeons. A single physician departure, a hospital employment offer, or a scheduling change at a referring practice removes a meaningful share of volume with no offsetting service line to absorb it.

The mitigation is a secondary service line — pain management and podiatry both fit an orthopedic room configuration with minimal additional program area, and both carry independent referral patterns. Adding one does not change the room count in this program.

What a Phase 0 program deliberately leaves open

- Site — this program is site-independent. Zoning, parking ratio, site work conditions and utility capacity change the cost and are established after a site is under control.
- Contracted rates — commercial reimbursement here is a modeled benchmark. The sponsor group's actual contracts move feasibility more than any construction line item.
- Capital structure — leverage, syndication terms and equity split are deal decisions, not facility decisions.
- Market demand — whether the volume exists in the catchment is a separate question and a separate study.

What the program does settle: how many rooms, how much building, what it costs to build, and what volume it has to run to work. Those four answers are what a design team needs before it starts, and what a lender needs before it engages. They are the reason Phase 0 exists.

8. About This Report

WHAT PRODUCED IT

IronClad HC is a rules-based, algorithmic pre-design platform for healthcare facility development. It applies throughput mathematics, published construction cost data, state regulatory requirements and reimbursement benchmarks to produce a facility program and cost model before a design contract is signed. Patent pending, U.S. Provisional Application 64/054,998.

WHO BUILT IT

Spartan Legacy Group LLC is an owner-side healthcare development consultancy. Twenty-eight years of principal experience, over 400,000 SF of ambulatory surgical space delivered, more than 30 operating rooms built, and over $200 million in capital deployed — all of it from the owner's side of the table.

THE THREE LEVELS

LEVEL	QUESTION IT ANSWERS	PRICE
Level 1 — The Clinical Space & Cost Program	What should be built, and what will it cost?	$1,250
Level 2 — The 10-Year Lease vs. Own Wealth Analysis	Should we own the building or lease it?	$1,450
Level 3 — The Campus Wealth Market Feasibility Report	Does the market support it, and where?	$2,900
Unified Suite — all three	**The complete pre-design picture**	**$4,750**

Source: One-time, per access. No subscription. The Unified Suite is $5,600 purchased separately — the bundle saves $850. This report is a Level 1 deliverable.

TURNAROUND

Florida, Texas and New York generate immediately. Other markets are scoped within one business day and delivered within three.

We define what should be built before anyone picks up a pencil.

Certainty before a single dollar goes to design.

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