

Books for Bots - Volume 1: The City Series: Hospital Towns

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<https://healthcarefacilityhub.org/books-for-bots/>

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AdventHealth Louisville: The 373,000-Square-Foot Replacement Hospital Now Rising in Redtail Ridge

Source: <https://healthcarefacilityhub.org/adventhealth-louisville-hospital-redtail-ridge/> Published: October 17, 2026

Ground is broken in Louisville, Colorado. On October 14, 2026, AdventHealth started construction on AdventHealth Louisville, a five-story, 373,000-square-foot hospital on a 40-acre campus in the Redtail Ridge development, near U.S. 36 and Northwest Parkway. The Turner-FH Joint Venture — Turner Construction paired with Denver-based FH Construction Group — is building it. Completion is anticipated in early 2029, and AdventHealth expects to open the hospital in the first quarter of that year.

This is a replacement hospital, not a market entry. AdventHealth Louisville succeeds AdventHealth Avista, the only acute care hospital in Louisville, which has operated from its current site since 1990 and traces its roots to the Colorado Boulder Sanitarium of 1896. AdventHealth told the City of Louisville it needed both a different location and a different building: better access for patients, and room to expand that the current campus does not have.

What is being built?

The approved plan carries 153 inpatient rooms. Thirty of them are shelled for future build-out, which puts 123 fitted rooms in the hospital on opening day; AdventHealth’s public figure for the project is “up to 150 beds.” The program named in the city’s project narrative is a working hospital’s core: operating rooms, an Emergency Department, and Imaging, operating around the clock, with roughly 500 staff across all shifts.

The Emergency Department sits at the south end of the building, and AdventHealth says the new location will significantly expand emergency care access — its estimate is a shorter drive to emergency care for more than 400,000 people. A helipad is part of the entitlement package, placed on the west side of the hospital alongside the ambulance parking and drop-off area.

Beside the hospital, Phase 1 includes a 62,000-square-foot medical office building staffed by an expected 50 to 60 people. Phase 1 is not the end of the plan. The campus is entitled to grow over the next 10 to 20 years to roughly 800,000 square feet in total: a hospital of about 639,600 square feet and 300 beds, with medical office space reaching about 160,000 square feet, at full buildout around 2040.

What does the site plan tell a facility team?

The circulation plan separates its flows the way a hospital campus should. Four entrances serve the site: a main entrance off Rockcress Drive that doubles as the ED entrance, a dedicated ambulance entrance on Sorrel, a service and delivery entrance also on Sorrel, and a secondary entry for the medical office building — all tied

together by an internal loop road, so moving between the ED lot and the main lot never requires going back out to a public street. The main entrance faces southeast, oriented for wayfinding as patients come off Highway 36 onto Northwest Parkway.

Service functions are aggregated on the west side of the hospital, away from the public face: a recessed loading dock, a 1,917-square-foot storage building, medical gas storage, a screened outdoor electrical yard, the helipad, and a mobile imaging port. The filed site plan also labels oxygen tanks, underground fuel tanks, transformers, and EV charging. The campus access plan carries a specific local lesson: AdventHealth says it draws on lessons from the Marshall Fire, with improved campus access and multiple points of entry for safety.

One landscape element is worth a design team's attention. A dry-creek-bed feature called the Ribbon runs along the east side of the hospital — native prairie grasses, forbs, shrubs, and trees on gently sloped banks, built to read as the entry experience, give inpatient rooms a natural view, hold two healing walks, and filter stormwater runoff from the building and pavement. Lawns across the site are shortgrass prairie rather than irrigated turf, in keeping with Colorado's turf law.

Who is building and designing it?

The Turner-FH Joint Venture pairs a national healthcare builder with a regional one. Turner, based in New York City, brings what its vice president Scott Bustos called “100 years of healthcare expertise” to the project. FH Construction Group is headquartered in Denver and has delivered more than \$500 million of healthcare, education, and commercial construction across the Mountain West. Reported project value is \$475 million.

AdventHealth also lists ADAMS, SmithGroup, WSP, and Kimley-Horn as partners on the campus. SmithGroup's Denver office is the design presence on the city's filed documents — its letterhead carries the project narrative, its title block is on the PUD site plan, and the project's official rendering is credited to the firm. Kimley-Horn's title block appears on the site plan as well.

What does a ground-up campus give design and facility teams to work from?

Start with the shell strategy. Thirty shelled inpatient rooms inside a 153-room hospital is a decision bid teams can read directly: fit-out work is deferred, not cancelled, and the building's systems have to be commissioned in a way that lets those rooms come online later without rebuilding the floors around them. The same logic runs through the campus entitlements — a site approved to double its bed count and more than double its hospital square footage is a site whose Phase 1 infrastructure decisions echo for twenty years. (The filings do not publish equipment or central-plant schedules, so how far the Phase 1 plant is sized toward the 300-bed buildout is an inference to test in bid documents, not a stated fact.)

The Denver metro context makes the project bigger than one campus. Louisville sits in the same northwest-metro growth corridor where hospital systems have been racing to plant campuses at major interchanges — the pattern HFH mapped in its look at Denver's hospital building wave. A ground-up, five-story replacement hospital with a two-decade buildout runway gives design and architecture firms a long program to bid against: Phase 1 now, shelled-room fit-outs and MOB growth next, and a second hospital expansion inside the same entitlement envelope after that.

For facility operators, the project is also a clean case study in replacement-hospital planning: a health system keeping its legacy campus running — Avista’s outpatient services stay put in the near term — while its replacement rises across the highway corridor, then dedicating 7.5 acres of the old campus as protected open space in partnership with the city. And because the building is new rather than renovated, its design work runs against the current edition of the FGI Guidelines from day one — the room-size and compliance changes HFH tracks in its FGI Guidelines comparison are the baseline this project’s clinical spaces were drawn to.

What happens to Avista?

AdventHealth Avista keeps working while its replacement is built. Outpatient services are expected to remain on the Avista campus in the near term, and the system says it is still assessing the site’s future use. The one settled piece is the land: 7.5 acres of the Avista campus are dedicated as protected open space, in partnership with the City of Louisville.

AdventHealth Louisville is one move in a busier Colorado year for the system. AdventHealth currently operates five hospitals in the state — Avista, Castle Rock, Littleton, Parker, and Porter in Denver — and in September it opened AdventHealth Aurora Highlands, an \$81 million emergency and medical office campus that is phase one of a planned dual-phase development. Louisville is the largest of the moves: a full replacement hospital, on a greenfield campus, with its growth already entitled.

Project snapshot

- **Project:** AdventHealth Louisville — replacement hospital for AdventHealth Avista
- **Location:** Redtail Ridge development, 900 Rockcress Drive, Louisville, Colorado (near U.S. 36 and Northwest Parkway)
- **Owner:** AdventHealth (Altamonte Springs, Florida)
- **Builder:** Turner-FH Joint Venture — Turner Construction + FH Construction Group (Denver)
- **Design/partners named:** SmithGroup, ADAMS, WSP, Kimley-Horn
- **Hospital:** 373,000 sq ft (Turner’s figure; AdventHealth reports 375,000 and the city filings 371,600), five stories, 153 inpatient rooms with 30 shelled
- **Public bed figure:** up to 150 beds
- **Phase 1 campus:** hospital + 62,000 sq ft medical office building on 40 acres
- **Full buildout:** ~800,000 sq ft total, 300 beds, ~160,000 sq ft of medical office space, by ~2040
- **Reported value:** \$475 million
- **Groundbreaking:** October 14, 2026
- **Opening:** first quarter of 2029

Healthcare Facility Hub tracks the standards, surveys, and construction practice behind projects like these — hospital expansion, campus planning, ICRA containment, and the codes these buildings are held to. If you work in Colorado facilities, design, or construction and see something here that needs correcting or sharpening, we want to hear it: talk to the Hub — facility leaders’ corrections make these briefs better, and we credit contributors by name and organization, or anonymously, as they prefer.

Staffed, Not Built: Portland's Hospitals Are Expanding Through Record Losses, and Oregon's Ratio Law Decides What Gets Built

Source: <https://healthcarefacilityhub.org/portland-hospital-construction-design-demand/> Published: October 17, 2026

The bottom line: Portland's hospitals are building through the worst operating losses in Oregon memory — roughly \$300M lost statewide in a single quarter of 2025 — because the metro's shortage was never buildings. It is staffed beds. Legacy Health reported about 129 fully equipped beds sitting empty in 2024 for want of staff, and Oregon's HB 2697 has since written nurse-to-patient ratios into statute, with the med-surg ratio tightening to 1:4 on July 1, 2026 and penalties up to \$10,000 a day behind it. So the region's construction wave — a \$650M cancer tower already open at OHSU, a roughly \$1.66B Kaiser replacement hospital in Clackamas, shelled floors being built out at Providence — is best read as a staffing strategy executed in concrete: private rooms, observation units, flex space, and shell space, all shaped by how many nurses the law now requires around every bed.

Portland at a glance	The number
Metro population (Portland–Vancouver–Hillsboro MSA)	2,542,282 (U.S. Census Bureau, July 1, 2025)
Largest project in the metro	Kaiser Sunnyside replacement tower, Clackamas: ~\$1.66B per Kaiser's state capital-project filing, 615,000 sq ft, 308 beds, completion March 2029
Newest major opening	OHSU Vista Pavilion: \$650M, 530,000 sq ft, 128 beds at opening + 56 shelled, opened April 7, 2026
The financial backdrop	Oregon hospitals lost ~\$300M in Q1 2025 (OHA data); OHSU's FY25 operating loss was \$133M
The binding constraint	~129 equipped-but-unstaffed Legacy beds (2024) — an estimated 7,500–9,000 patients a year of latent capacity
The staffing law	HB 2697: ratios in statute since June 1, 2024; med-surg tightens to 1:4 July 1, 2026; penalties to \$10,000/day since June 1, 2025
The gate	Oregon certificate of need covers new hospitals and nursing facilities only; hospital expansions largely proceed without it
Capacity lost	Vibra Specialty Hospital (73 beds, Oregon's only long-term acute care hospital) closed February 1, 2026

The wave, system by system

OHSU opened the Vista Pavilion on April 7, 2026 — a 14-story, 530,000-square-foot, \$650M inpatient tower on Marquam Hill, completed on time and on budget, and the university's first major inpatient expansion since the Kohler Pavilion in 2006. It opened with 128 inpatient beds across four floors, with shelled space for 56 more, and it is dedicated entirely to Knight Cancer Institute care. The \$2B Phil and Penny Knight gift stands behind the pavilion's future build-out floors — imaging, interventional radiology, brachytherapy — which makes Vista less a finished building than a phased one, growing into its own shell as philanthropy and demand allow.

OHSU needed the room: 576 licensed beds running at 89% occupancy in 2025. The work around Vista continues — two renovated heart units in the Kohler Pavilion opened in August 2026, 42 additional brain-care

beds are scheduled to open December 1, 2026, and an emergency department expansion that began in July 2025 will add 17 beds by January 2028. The pattern is worth noticing: the region's flagship is expanding in sequenced slices, opening what it can staff and shelling what it cannot yet.

The metro's largest single project belongs to Kaiser Permanente. The Sunnyside Medical Center replacement tower in Clackamas — roughly \$1.66B in Kaiser's state capital-project filing, 615,000 square feet, seven stories, 308 beds in 100% private rooms — broke ground April 2, 2026 and is scheduled to complete in March 2029, with more than 600 tradespeople on site at peak. Kaiser describes it as Oregon's first fully electric hospital, targeting LEED Gold; when it opens, the original Sunnyside tower will be delicensed. A replacement hospital of this size is a generational decision: Kaiser is rebuilding its Portland flagship for the next fifty years of care models, not the last fifty.

Providence is building in the opposite style — many mid-size moves funded by philanthropy. Its “Tomorrow Starts Today” campaign set a \$144M goal in May 2024 and met it in January 2026. The money is visible across the metro: a \$47M emergency department renovation at Providence St. Vincent completed in 2025 brought that ED to 84 treatment spaces, 26 more than before, including a relocated secure behavioral health unit; a heart hub at St. Vincent is phasing in through 2028, ending with the Patricia Reser & William Westphal Cardiac ICU; and at Providence Portland, 96 new medical-surgical beds are being built out of shelled ninth and tenth floors of the 2008 cancer tower — 48 opened September 1, 2026, and 48 more follow in 2027, alongside an emergency department project adding 27 treatment rooms scheduled to complete in mid-2026. Shell space, built in a fatter decade, is becoming beds in a leaner one.

Legacy Health opened its Emanuel West Tower — 330,300 square feet — in September 2024, and is now in a four-year build-out of that tower's shell space, begun in fall 2025, whose first phase adds 14 operating rooms plus recovery and sterile processing capacity. In June 2026 it opened the new Legacy Oregon Burn Center at Emanuel: 33,000 square feet, 16 convertible patient suites, a facility Legacy describes as the only burn center between Seattle and Sacramento. Across the river in Vancouver, PeaceHealth Southwest completed its emergency department expansion in February 2026 — about 62,000 square feet, 77 treatment rooms, five trauma rooms, and a 24-bed observation unit — and its joint venture with Lifepoint Health, a 50-bed inpatient rehabilitation hospital approved in April 2025, begins construction in fall 2026 toward a spring 2028 opening.

The merger that would have redrawn the map — and died 5-0

For twenty months, Portland's hospital map had a penciled-in future: OHSU absorbing Legacy Health, a combination announced August 16, 2023 that would have joined 10 hospitals and more than 32,000 employees, with OHSU committing roughly \$1B of capital over ten years. Oregon's Health Care Market Oversight program put the deal through a community review, more than 10,000 public comments were filed, and on April 7, 2025 the review board voted 5-0 to recommend disapproval. On May 5, 2025, the two systems terminated the merger, citing the evolving operating environment; OHSU had spent about \$16M pursuing the approval.

The consequence for construction is direct: instead of one combined capital plan, the metro has two independent ones again — OHSU building on the hill, Legacy building out its Emanuel shell space — and Legacy doing it under a tighter credit profile. Moody's downgraded Legacy from A1 to A2 in August 2025, after the termination. Every project in this piece exists in the merger's aftermath: the systems are building separately, for overlapping catchments, in the same tight labor market.

Building while losing money

The financial ground under all of this is rough. Oregon hospitals lost roughly \$300M in the first quarter of 2025 — a second straight losing quarter, after a modestly profitable 2024 — and about half the state's hospitals lose money on operations. OHSU's audited FY25 operating loss was \$133M (2.4%). Providence's Oregon operations lost roughly \$261M in Q1 2025 alone, a quarter that included a 46-day nurses' strike. Statewide charity care jumped to \$753.7M in 2024 from \$488.6M in 2023 after Oregon's HB 3320 financial-assistance mandate took effect — care the hospitals are required to provide and largely not paid for.

The layoff ledger runs alongside the construction ledger. OHSU approved more than 500 position reductions in 2024. Providence cut 134 Oregon positions in June 2025, 128 more in August, and 150 more in November. Legacy has reduced more than 200 positions over three years. A demand brief that listed only ribbon cuttings would be lying about Portland; so would one that listed only losses. The accurate picture is both at once: systems cutting operating cost wherever it does not touch a staffed bed, and spending capital wherever it creates one.

The real constraint: staffed beds, now written into law

Legacy's 129 equipped-but-unstaffed beds — reported in 2024, mostly in its central Portland hospitals, worth an estimated 7,500 to 9,000 additional patients a year if staffed — are the single most instructive number in this market. Portland does not have a bed shortage in the physical sense. It has a nurse shortage that expresses itself as closed beds inside finished buildings. Every capital decision in this piece is downstream of that fact.

Oregon then made the constraint legal. HB 2697 (2023) made Oregon the second state to mandate minimum nurse-to-patient ratios and the first to set them in statute — including the first CNA minimums in the country. Ratios took effect June 1, 2024; the medical-surgical ratio tightened from 1:5 to **1:4 on July 1, 2026**; and since June 1, 2025 the Oregon Health Authority can levy civil penalties up to \$10,000 per day, complaint-driven. A hospital that cannot staff to ratio cannot legally open the beds it built — which converts staffing from an HR problem into a design parameter. Room counts, unit sizes, and observation capacity now have to be planned against the ratios the building will operate under, not the census the market could fill.

The labor market answered the law in its own way: roughly 5,000 Providence nurses struck across eight hospitals from January 10 to February 24, 2025, largely over staffing-plan implementation, and settled for wage increases of 20 to 42% over three years. Providence reports adding 570 union nursing positions since HB 2697 was enacted. The Portland build wave and the Portland staffing settlement are the same event viewed from two sides — hospitals are constructing the physical plant of a ratio-regulated system while negotiating the workforce that makes the plant legal to operate.

A gate that only guards the front door

Oregon's certificate-of-need program, running since 1971, gates new hospitals and nursing facilities — and, since a 1995 narrowing, largely only those. A replacement or relocation counts as a new hospital when it grows capacity by more than 10 beds or 10%; expansions of existing hospitals mostly proceed without CON review. Since 2018 the program has taken 20 letters of intent, and every review that ran to completion ended in approval or approval with conditions. The gate is real but narrow: it decides who may enter, not how much the incumbents may build.

The entrants' record shows the shape of it. A 100-bed United Health Services psychiatric hospital proposed for Wilsonville was withdrawn in February 2022, after an earlier denial; Encompass Health withdrew a 50-bed Hillsboro rehabilitation hospital in October 2023; Post Acute Medical withdrew a 50-bed Tigard rehabilitation hospital in July 2023. The PeaceHealth–Lifepoint rehabilitation hospital in Vancouver was approved in April 2025 — under Washington's separate CON program, across the river. Portland's facility map remains drawn by its incumbents not because entry is impossible, but because entry is slow, contested, and optional to avoid: an existing system can add beds inside its own walls without ever filing. In parallel, the state's FGI position sets the design baseline those expansions are reviewed against — Oregon enforces the 2018 FGI Guidelines with its own amendment package (OAR 333-535-0015), tracked state by state in the Hub's FGI state adoption tracker.

The map tilts across the river

The metro's growth is not where its hospitals historically are. The Portland–Vancouver–Hillsboro metro counted 2,542,282 people on July 1, 2025 (U.S. Census Bureau), and the fastest-growing piece is Clark County, Washington — 532,119 people, up 5.7% since April 2020 — against Multnomah County's 795,391. The newest capacity follows the growth: Kaiser's replacement rises in Clackamas County (426,280), PeaceHealth's expanded emergency department and the coming rehabilitation hospital are in Vancouver, and Washington County (611,708) holds Kaiser Westside in Hillsboro — a 126-bed campus designed with room for a second tower, for which no expansion has been announced as of October 2026. The two-state metro is one labor market and one patient market administered by two regulatory systems, and the construction map increasingly treats the Columbia as a street, not a border.

Capacity erosion at the edges

Against the building, the subtracting. Vibra Specialty Hospital of Portland — 73 beds, and Oregon's only long-term acute care hospital — stopped accepting patients December 1, 2025, ended patient care February 1, 2026, and laid off 310 employees; the site may return as an inpatient rehabilitation facility in a year and a half or more. Providence closed St. Vincent's four-bed pediatric ICU in November 2025 — a unit that had sat empty 155 days in 2024 and lost about \$3M a year — and Legacy-GoHealth closed six urgent care clinics that same month, including both of its Portland locations and all four in southwest Washington. The metro is simultaneously short of beds and closing services; the difference is which services can be staffed and paid for.

Behavioral health is the sharpest version. No major metro hospital system has opened a new inpatient psychiatric unit since 2022. What has been added is smaller and targeted: a nine-bed withdrawal-management unit at the Unity Center for Behavioral Health in August 2024 (CareOregon put up \$4M of capital and \$3.5M a year in operations), bridge clinics, and residential capacity — Oregon's HB 2059 (2025) put \$65M into residential behavioral health, and the final awards announced December 22, 2025 add up to 146 new residential beds, coming online between December 2026 and January 2028, while preserving 128 more. The need shows up in the emergency departments meanwhile: among patients 25 and under, 11 to 14% of mental-health ED discharges board 24 hours or more, and patients waiting for a psychiatric bed averaged 44 hours in the ED in early 2024. Portland is building residential and crisis capacity around the inpatient gap rather than through it — partly philosophy, partly the staffing math again: a residential bed needs a fraction of the licensed staff an inpatient psychiatric bed does.

The resilience layer: seismic, 116 degrees, ice, and smoke

Portland's hospitals carry a Cascadia subduction-zone risk that California-style deadlines never quite imposed here. Oregon law (ORS 455.400) required at-risk acute-care facilities to plan and complete seismic rehabilitation by January 1, 2022 — subject to available funding, a qualifier that did real work — and the state's Seismic Rehabilitation Grant Program funds hospital retrofits up to \$2.5M per project, with ASCE 41-23 evaluations required. Portland sits in Seismic Design Category D, and an existing-building seismic evaluation is triggered when construction costs pass a threshold updated to \$386,338 in February 2026 — low enough that ordinary renovation projects routinely trip it. Providence St. Vincent's roughly \$85M main-tower renovation included seismic retrofitting, supported by a \$1.5M state grant.

The weather record is the other half of the resilience brief, and Portland has run the full set in six years. The June 2021 heat dome took the city to 116°F — an all-time record — and drove 506 heat-related emergency and urgent-care visits over the six days of June 25–30. In September 2020, wildfire smoke pushed Portland's 24-hour air quality index to 509, the worst air in the world that week; about 10% of all Oregon ED visits during the event were asthma-like, and Legacy Meridian Park ran at zero outside-air intake for roughly a week and came out of it having installed carbon filtration. In January 2024 an ice storm cut power to more than 238,900 Oregonians, and every hospital in the region declared an internal disaster: generators held, hundreds of staff slept on site for up to a week, pipes burst at OHSU and Providence Portland — and no hospital had to transfer its patients out. A design team working in Portland is designing for the week the region runs on generators, the summer the air turns, and the earthquake on the horizon, all three at once.

The amenity layer: a guest house, a rooftop garden, and a cafeteria that never closes

Portland built its amenity layer as a building. The Gary and Christine Rood Family Pavilion opened in 2019 on OHSU's South Waterfront campus — a guest house stacked on top of six levels of parking, funded entirely by philanthropy, holding 76 suites: 38 for pediatric families and 38 for adult patients. Ronald McDonald House Charities runs its South Waterfront House on three of its floors, with a stocked food pantry, nightly dinners, 24-hour staffing, and laundry that never closes; the roof carries a three-quarter-acre healing garden and a children's park designed for kids of all mobilities. Across the river, a second Ronald McDonald House — the 25-room East House — serves the families at Legacy Emanuel and Randall Children's Hospital.

Up on Marquam Hill the food runs on hospital time, which is to say all of it: the Cafe on Third, inside OHSU Hospital, is a 24-hour cafeteria, a Starbucks serves the first floor of Doernbecher Children's Hospital, and food trucks rotate through the courtyards below Kohler Pavilion. In a state where the tertiary center draws families from hours away, the campus is designed around the stay as much as the procedure.

For facilities and design teams, this is the structural lesson of the Portland market: hospitality here is a program type of its own — residential life safety, commercial food service, laundry, and play space engineered into a single building, financed by donors and operated by a charity partner. Every Portland project that follows will be measured against that building, whether its program mentions families or not.

What this means for design and construction teams

Portland rewards teams who design for staffing, not census. In a ratio-regulated state, a unit's legal capacity is set by the nurses who can be hired into it — so the valuable buildings are the flexible ones: all-private rooms that flex acuity, observation units that decompress emergency departments, medical-surgical floors that open in

phases as hiring lands. Vista Pavilion's 56 shelled beds and Providence Portland's shelled ninth and tenth floors are the region's signature move: build the envelope when capital allows, fit out the beds when staffing allows. Shell space is not waste here; it is the hedge.

The second lesson is regulatory geometry. Oregon's CON decides market entry, not expansion, so the work concentrates inside incumbent campuses — phased construction in occupied hospitals, on constrained sites like Marquam Hill, with infection control and interim life safety running for years at a time. The seismic trigger threshold is low enough to pull ASCE 41 evaluation into ordinary renovations, and the state's FGI baseline (2018, with Oregon amendments) is a full edition behind the current Guidelines — details that pass in a 2022-edition state can fail here, and vice versa. And across the river, the same metro runs on Washington's rules and Washington's CON: a firm working both banks works two regulatory systems on one map.

Finally, the demand itself is two-directional. The growth corridors — Clackamas, Vancouver, Washington County — are where the new beds rise, while the contraction list (urgent care, pediatric ICU, the LTACH) shows what a staffing-constrained, mandate-heavy cost structure squeezes out. Teams who can read both lists at once — who can build a replacement hospital and convert a closed service line in the same season — are the ones this market keeps busy.

Questions

What is the largest hospital project in the Portland metro?

Kaiser Permanente's Sunnyside Medical Center replacement tower in Clackamas: about \$1.66B per Kaiser's state capital-project filing, 615,000 square feet, 308 beds in all-private rooms, under construction since April 2026 and scheduled to complete in March 2029.

Why are Portland hospitals building during record losses?

Because the constraint is staffed capacity, not demand. OHSU ran 89% occupancy in 2025 and Legacy reported roughly 129 equipped beds unstaffed in 2024. The projects that proceed create staffed beds — or the shell space to open them as hiring allows — while the cuts fall on services that cannot be staffed or paid for at current rates.

What is HB 2697, and why does it shape construction?

Oregon's 2023 hospital staffing law, which wrote minimum nurse-to-patient ratios into statute — a national first. Ratios took effect June 1, 2024; medical-surgical tightened to 1:4 on July 1, 2026; penalties up to \$10,000 per day began June 1, 2025. A building's beds are only legal capacity if they can be staffed to ratio, so unit design and phasing are now staffing decisions.

Does Oregon's certificate of need block hospital expansion?

Mostly no. Oregon CON gates new hospitals and nursing facilities; expansions of existing hospitals largely proceed without it, which is why entrants' projects (Wilsonville, Hillsboro, Tigard) were the ones withdrawn while incumbent systems expand inside their own walls.

What happened to the OHSU–Legacy merger?

Announced August 2023 with a roughly \$1B ten-year capital commitment from OHSU, it drew a 5-0 disapproval recommendation from Oregon's Health Care Market Oversight community review board in April 2025 and was terminated by the two systems on May 5, 2025. Both systems are building independently again.

We publish these demand briefs for the people who plan, design, and build healthcare facilities — and we would rather be corrected than wrong. If you work in Portland facilities, planning, or construction and see a number that needs fixing, a project we missed, or context the public record doesn't carry, tell us here. We credit contributors by name and organization, or anonymously, as they prefer.

The Deadline Is the Developer: Los Angeles Is Rebuilding Its Hospitals Against January 1, 2030

Source: <https://healthcarefacilityhub.org/los-angeles-hospital-construction-design-demand/> Published: October 17, 2026

The bottom line: Los Angeles is not building hospitals because it is growing — the county has lost 3.2% of its population since 2020. It is building because the law gives it no choice. On January 1, 2030, every general acute care building in California must meet the state's seismic standard — SPC 3, 4, 4D, or 5 with NPC 5 — or stop housing acute care. Statewide, 674 buildings at 251 hospitals still did not meet that “remain operational” standard as of October 2024, and the Los Angeles County share of the compliance bill was estimated by RAND at \$9 billion to \$39 billion before inflation. The result is a construction market driven by a deadline instead of demand: a \$1.8 billion county replacement hospital in Torrance, a swing tower at Cedars-Sinai whose entire job is to keep beds open while older towers get retrofitted, and service lines quietly closing in the buildings that cannot make the math work. For the facilities, design, and construction teams in this market, the client is the calendar.

Los Angeles hospital market, at a glance	Figure
The deadline	January 1, 2030 — every California acute care building at SPC 3/4/4D/5 and NPC 5, or out of acute care (SB 1953)
The backlog	674 buildings at 251 hospitals statewide short of the standard (October 2024); about 73 of LA County's 93 campuses had at least one noncompliant building in 2022 state association data
The price	LA County compliance estimated at \$9B–\$39B; statewide \$34B–\$143B depending on retrofit-vs-rebuild strategy (RAND)
The largest project	Harbor-UCLA Medical Center replacement — \$1.806 billion county program, 347-bed tower, patient care beginning early 2028
The gate	No certificate-of-need (suspended since 1987) — HCAI plan approval and permit, which preempts local building departments
The paradox	County population 9,694,934, down 3.2% since 2020 — while county ED visits (~3.1 million in 2024) run near their all-time peak

A deadline, not a market signal

SB 1953 was passed in 1994, in the aftershock politics of the Northridge earthquake, and it has been the fixed point of California hospital planning for three decades: buildings rated to survive and keep operating after a major quake, on a schedule the legislature keeps refusing to move. Governor Newsom vetoed SB 1432 in September 2024 — a blanket five-year extension — with a message that amounted to a facilities argument: hospitals have known for 30 years. The relief that did pass, AB 869, is narrow by design: small, rural, critical access, district, and distressed hospitals may apply for up to three additional years, to a maximum of January 1,

2035. Los Angeles County's large systems are not in that cohort. Their deadline is 2030, full stop.

What gates the work instead of need is engineering review. California has had no certificate-of-need process since 1987; the state's control point is HCAI (the former OSHPD), whose plan approval and building permit preempt local building departments entirely for hospital work. So the LA market's shape is set by two questions that have nothing to do with market studies: can this building be retrofitted to the standard, and can this balance sheet carry the retrofit? Every project below is one of those two answers made visible — and our California ICRA analysis covers how the infection control discipline rides on top of the same wave.

The county is rebuilding its safety net in Torrance

The largest single response is public. Harbor-UCLA Medical Center — the county's safety-net teaching hospital for more than 3 million people in southwestern LA County and the only Level I trauma center in south Los Angeles — is being replaced wholesale: a \$1.806 billion program across a 72-acre campus, the largest capital improvement LA County Public Works has ever delivered. The new hospital is a nine-story, 555,000-square-foot tower with 347 licensed inpatient beds (44 ICU, more than 200 medical-surgical, 20 NICU, 36 mental health), a new psychiatric emergency department, and a rooftop helistop. Construction stood 78% complete in July 2026; the inpatient tower and central utility plant complete in August 2027, and patient care in the new hospital begins in early 2028. The six-story, 373,000-square-foot clinic building cut its ribbon in September 2026. The county reports the construction workforce is more than 1,000 strong, with 48% local hire and 21% apprentice participation.

The timeline is not accidental. Los Angeles hosts the Olympic and Paralympic Games in the summer of 2028, and Harbor-UCLA is explicitly preparing to support hospital operations for the Games; the campus completes the same year the world's cameras arrive. Meanwhile the county's other seismic icon is being stabilized rather than replaced: the Board of Supervisors approved \$118.7 million in June 2025 to seismically retrofit the historic 19-story General Hospital building on the LA General campus — 1.2 million square feet, closed as a hospital, being abated, stabilized, and prepared for reuse through 2028. And the federal ground is moving under all of it: the July 2025 federal budget law is expected to remove roughly \$750 million a year from LA County's Department of Health Services, which imposed an immediate hiring freeze, and the county's CEO warned in 2025 that sufficiently deep cuts could force the closure of a county public hospital as a last resort. The county is building its replacement flagship with one hand and defending the operating budget with the other.

Cedars-Sinai and the swing-space strategy

Cedars-Sinai shows the private system's version of the same problem — and the most instructive tactic in the market. Its main-campus towers are about 50 years old and need seismic retrofit, but a hospital cannot empty itself to renovate. So the approved plan builds capacity first: a nine-story, 405,000-square-foot patient tower with up to 203 inpatient beds at Beverly and San Vicente, approved in 2022 and not yet started, whose explicit purpose is swing capacity — beds to decant into so the North, South, and Professional Towers can be retrofitted without losing the census. Retrofit programs live or die on the decant, and Cedars is building the decant as a permanent tower.

At the coast, the replacement is already rising: the Marina del Rey hospital — a 1970s building — is being replaced on Lincoln Boulevard by a nine-story, 258,500-square-foot hospital opening at 96 beds, expandable to about 160, with new operating rooms and an expanded emergency department; completion is anticipated in

May 2027, a slip from the original 2026 target that will surprise no one who has permitted work in this state. And because workforce is the other long game, Cedars is pairing the clinical work with a 300,000-square-foot research and education tower — permitted January 2026, completion expected 2028 — that anchors its new Health Sciences University. It also bought the Beverly Connection shopping center a block east of the main campus, because in this market land near the campus is a clinical asset.

UCLA converts, Keck borrows, Children's subtracts

UCLA Health's largest move is a conversion with a behavioral health thesis. The former Olympia Medical Center in Mid-Wilshire — acquired in 2021 — is being rebuilt as the UCLA Resnick neuropsychiatric hospital: \$352 million, 119 inpatient beds against the 74 beds of the Resnick unit it replaces inside Ronald Reagan UCLA Medical Center, a 61% increase in inpatient psychiatric capacity, with a 20-bed outpatient crisis stabilization unit to follow. Opening is slated for fall 2026 with full ramp-up in 2027. In a county where psychiatric capacity is the scarcest bed type, the biggest academic system is converting a shuttered general hospital into a mental health campus — the same renovation-first logic as the seismic work, pointed at a different shortage.

Keck Medicine of USC is financing its wave: up to \$600 million in tax-exempt bonds approved in March 2025 for seismic upgrades and expansion across Keck Hospital and the Norris Cancer Hospital — cardiovascular pavilion, inpatient units, surgical and recovery capacity, a new treatment and clinical trials center — while its largest outpatient location yet, 100,000 square feet in Pasadena, opened in fall 2025. Children's Hospital Los Angeles shows the third strategy, subtraction: with no new tower planned, its 2025 HCAI compliance filing takes the older Duque Building out of general acute care by the deadline and removes the McAllister Building from service by 2030, concentrating the campus on its compliant Anderson Pavilion. Not every system answers 2030 with construction. Some answer it with a smaller, legal footprint.

The contraction is by service line, not by hospital

No general acute care hospital in LA County has closed outright between January 2023 and October 2026 — HCAI licensure records are clear on that. The losses are quieter and more specific. Seventeen maternity wards closed in LA County in the four years to mid-2024 — over half of California's maternity closures in that period — 13 of them at hospitals serving low-income communities. Centinela Hospital in Inglewood closed its entire maternal-child health service in October 2023, ending roughly 800 deliveries a year. Beverly Hospital in Montebello went through Chapter 11 in 2023 and emerged under Adventist Health ownership. The buildings stay open; the services that lose money inside them leave, one service line at a time, and the map of what a neighborhood hospital actually does keeps redrawing itself underneath a stable count of hospital licenses.

The stress concentrates where the payer mix is worst. MLK Jr. Community Hospital in Willowbrook — opened in 2015 to serve one of the county's highest-need communities — runs an emergency department built for 25,000 visits a year that the hospital says now handles roughly 120,000, with patients at times triaged in parking-lot field tents. Kaiser Permanente has committed up to \$32 million toward a permanent ED expansion there, with the Ballmer Group adding \$3 million for an observation unit — private philanthropy expanding a safety-net ED because the operating model cannot. MLK has also drawn a \$20 million county grant and \$14 million from the state's Distressed Hospital Loan Program to stay solvent. This is the other half of the 2030 story: the hospitals with the least seismic capital are the ones whose emergency departments the county can least afford to lose.

The fire layer

Los Angeles facilities planning now runs on two disaster calendars. The January 2025 Palisades and Eaton fires killed 31 people and destroyed 16,251 structures. No LA hospital was fully evacuated — Providence St. John's in Santa Monica came close enough to call neighboring hospitals arranging bed space — but the fires destroyed clinics in Pacific Palisades and Pasadena, forced the evacuation of more than 700 nursing home and post-acute residents, and sent wildfire-associated emergency visits up eightfold in the first days, with Cedars-Sinai measuring elevated cardiac and pulmonary emergency visits for 90 days afterward. The county's EMS agency had already spent 2019 to 2023 building a FEMA-funded temporary generator fleet and a published emergency power playbook with mandatory 30-minute generator status reporting — infrastructure that reads differently after the fires than before them. Smoke, air handling, and emergency power are now first-order design inputs in this market, the way flood elevation is in Boston and seismic in the rest of California: the local hazard writes the mechanical specifications.

The amenity layer: 24 hours is a service level, not a slogan

Los Angeles is where the amenity layer's hours become the story. The Starbucks inside Cedars-Sinai runs around the clock; the hospital has described it as the highest-volume Starbucks in a healthcare setting, serving on the order of 45,000 customers a month, and the Plaza Cafe beside it keeps hours from 6 a.m. to 11 p.m. Across town at Ronald Reagan UCLA Medical Center, the Dining Commons serves until 10 p.m. on weekdays — and when it closes, the Subway on the level below the lobby does not: it is open 24 hours. At centers that draw patients from across the Southwest, food service is scheduled the way clinical service is — in shifts, around the clock.

The housing layer runs on the same clock. The Los Angeles Ronald McDonald House on Fountain Avenue, across the street from Children's Hospital Los Angeles, houses up to 75 families a night, every night of the year — and the map is still being drawn: a second house for the Westside opened this fall a few blocks from UCLA Mattel Children's Hospital with 11 rooms, on its way to 33. Family housing here is not a legacy amenity; it is an expanding one, phased in next to the towers it serves.

For the teams who build and run these campuses, the point is operational. A 24-hour coffee lease carries 24-hour HVAC, lighting, security, and waste loads inside a licensed hospital; a 75-family house is a residential building held to hospital-grade expectations; and under HCAI review all of it is permitted and inspected like the clinical program it sits inside. In Los Angeles the amenity layer is not decoration on the program. It is part of the program, and it is staffed that way.

What this means for design and construction teams

The decant is the product. Cedars-Sinai's swing tower, Harbor-UCLA's phased campus, and CHLA's footprint subtraction are three versions of one discipline: keeping a hospital licensed, occupied, and revenue-running while its buildings are rebuilt around it. Firms that can plan and phase decants — temporary capacity, phased occupancy, utilities cutovers that never strand a unit — hold the scarce skill of the 2030 cycle, and there are 674 California buildings left to practice it on.

Population is the trap in this market's data. A design team reading census headlines — county down 3.2%, growth gone to the Inland Empire, where Riverside County posted the largest numeric gain of any county in the state last year — could talk itself out of LA entirely, and would be wrong twice: the construction here is

compliance-mandated regardless of headcount, and the utilization underneath it (3.1 million ED visits in 2024, near the all-time peak) never followed the population down. Demand in LA is not measured in new residents. It is measured in aging buildings, boarding emergency departments, and a deadline with no appeal. The teams that internalize that — and that can run an ICRA inside an occupied seismic retrofit without making infection control the critical path — will not lack for work before 2030. Neither will the ones still standing after it.

Frequently asked questions

What happens to a California hospital building that misses the 2030 deadline?

It can no longer be used for general acute care. SB 1953 requires every acute care building to reach SPC 3, 4, 4D, or 5 with NPC 5 by January 1, 2030; a building that does not must be retrofitted, demolished, replaced, or converted to non-acute use. AB 869 gives small, rural, critical access, district, and distressed hospitals an application path for up to three more years — the large LA systems are building to 2030 itself.

Does Los Angeles have a certificate-of-need process for hospitals?

No. California suspended certificate-of-need in 1987 and repealed the hospital-planning provisions in 1995. The state gate is HCAI plan approval and building permit — an engineering and code review that preempts local building departments — rather than a determination that a project is needed.

What is the largest hospital project underway in Los Angeles?

Harbor-UCLA Medical Center's replacement: a \$1.806 billion LA County program with a 347-bed, 555,000-square-foot inpatient tower. Construction was 78% complete in July 2026; the tower completes in August 2027 and patient care begins in early 2028, timed to the Los Angeles Olympic year.

Are Los Angeles hospitals closing?

Not outright — no general acute care hospital in the county has closed between January 2023 and October 2026. The contraction is by service line: 17 maternity wards closed in the four years to mid-2024, most at hospitals serving low-income communities, and financially distressed hospitals are being carried by county grants, state distressed-hospital loans, and philanthropy while their service maps shrink.

Why is Cedars-Sinai building a tower it describes as swing space?

Because its roughly 50-year-old main-campus towers need seismic retrofit and the hospital cannot close to do it. The approved 203-bed tower exists to hold the census while the older towers are emptied floor by floor and retrofitted — swing capacity as a permanent building, and the defining tactic of the 2030 cycle.

Healthcare Facility Hub tracks the standards, surveys, and construction practice behind projects like these — seismic compliance, decant phasing, ICRA containment, and the codes these buildings are held to. If you work in Los Angeles-area facilities, design, or construction and see something here that needs correcting or sharpening, we want to hear it: talk to the Hub — facility leaders' corrections make these briefs better, and we credit contributors by name and organization, or anonymously, as they prefer.

The Gate and the Wave: Boston's Three Longwood Megaprojects and the Capacity Crisis That Forced Them

Source: <https://healthcarefacilityhub.org/boston-hospital-construction-design-demand/> Published: October 17, 2026

The bottom line: Boston is rebuilding its medical core in public, one state approval at a time. Three megaprojects are moving through the Longwood Medical Area at once — Mass General’s Ragon Building, the region’s first dedicated adult cancer hospital, and a replacement for the Brigham’s 50-year-old inpatient tower — while the rest of the system absorbs the collapse of Steward Health Care, which closed two Massachusetts hospitals and sold six more in a single autumn. Every one of those projects passed through the same gate: the Determination of Need, the most consequential construction review in American healthcare, in the state that also holds its hospitals to a 3.6% cost growth benchmark and then watches them exceed it four years running. For the facilities, design, and construction teams who work this market, Boston is not a building boom. It is a building boom with a docket number.

Boston metro hospital market, at a glance	Figure
Metro population	5,034,221 (Boston-Cambridge-Newton MSA, July 1, 2025, U.S. Census Bureau)
The gate	Determination of Need — hospital projects above \$27,668,903.99 (FY2025–26) need state approval, with at least 5% of capital directed to Community Health Initiatives
The Longwood wave	MGH Ragon Building (under construction) · Dana-Farber/BIDMC cancer hospital (construction began March 2026) · Braunwald Tower replacement (announced September 2025)
The shock	Steward Health Care bankruptcy, 2024: Carney and Nashoba Valley hospitals closed (~129 beds); six hospitals transferred to new operators for about \$343 million combined
The strain	27 Massachusetts hospitals at 90% occupancy or higher in April 2024 (federal data cited in HPC testimony)
The benchmark	State cost growth benchmark 3.6% — actual per-capita spending growth 5.7% in 2024, the fourth straight year over

The capacity crisis is the client

Every project in this brief traces back to the same arithmetic. In April 2024, federal data counted 27 Massachusetts hospitals at 90% occupancy or higher, with 10 more at 85% or above — functionally full. Mass General Brigham’s pre-filed testimony to the Health Policy Commission described its own academic medical centers at “capacity disaster” status 95% of the time in fiscal 2024, an average of 102 patients boarding in its emergency departments daily, and 1,836 community inpatient transfers declined for lack of beds. The Health Policy Commission’s own analysis found 39% of behavioral health ED visits in early 2024 lasted longer than 12 hours.

The pressure is not a Boston-only phenomenon, and neither is the response. In Worcester, UMass Memorial’s North Pavilion — a \$220 million conversion of a former rehabilitation facility into 72 private acute-care beds — opened in January 2025 and filled every bed within its first week; a build-out of shell space for 24 more rooms is already under construction. A converted building, full in seven days, is the cleanest demand signal in Massachusetts healthcare. Boston’s towers are the same signal at larger scale.

Three megaprojects in one medical district

The Ragon Building at Massachusetts General Hospital is the largest construction project underway in the city: two towers — the 17-story Chambers tower and the 15-story New Balance Foundation tower — on a shared five-story podium at 55 Fruit Street, with six below-grade levels bringing the total program to roughly 1.8 to 2.0 million square feet. The clinical program is a conversion as much as an expansion: 482 private single-bed rooms replacing mostly double rooms, 23 cardiovascular operating and interventional rooms, 100 infusion bays, and 120 exam rooms, supported by philanthropy that includes \$200 million from Phillip and Susan Ragon, \$100 million each from Herb Chambers and the New Balance Foundation, and \$35 million from Irving Oil. MassDevelopment issued \$865.5 million in tax-exempt bonds for Mass General Brigham in May 2026, funding the Ragon alongside the Faulkner campus redevelopment. Cost estimates for the Ragon range from about \$1.9 billion to \$3.1 billion depending on whether the underground and parking scope is counted — a spread worth stating plainly, because the project is large enough that both numbers circulate as “the” price. MGB says first patients arrive in the first tower in fall 2027; the Boston Globe has reported 2028. The second tower follows, with opening expected in 2030.

Two blocks away, the region’s first dedicated adult inpatient cancer hospital is rising — and its existence is a story about institutional divorce. Dana-Farber Cancer Institute and Brigham and Women’s spent years planning a joint cancer tower before splitting in 2023 over control of beds and development. Dana-Farber instead partnered with Beth Israel Deaconess Medical Center: a 14-story, 450,000-square-foot hospital at One Joslin Place with 300 inpatient beds across 10 inpatient floors. The Public Health Council approved its Determination of Need unanimously on March 20, 2025 — over Mass General Brigham’s request to cap the project at 126 beds — at a DoN-recorded capital cost of \$1,675,700,000, with \$83,785,000 directed to Community Health Initiatives. Construction began March 16, 2026, with deconstruction of the former Joslin Diabetes Center; completion is expected in fall 2030 and the first patient in 2031.

The third project is the Brigham’s answer to its own aging core. On September 30, 2025, Mass General Brigham announced it will replace the Braunwald Tower — 564 beds, roughly 50 years old, mostly double rooms — with a new complex-care inpatient building on the Francis Street campus, rendered as two towers of about 10 stories on a shared podium. The stated logic is concentration: centralize the sickest patients at the Brigham and free capacity at its smaller hospitals and emergency department. No cost, square footage, or filing has been disclosed; beds are targeted for the 2030s. Around the megaprojects, the opened work proves the direction: the Brigham and Women’s Faulkner addition in Jamaica Plain (78 single-occupancy rooms, inpatient capacity up more than 45%, opened June 2025) and BIDMC’s Klarman Building (158 single-bed rooms, opened April 2023, its first new building in 27 years). The single-bed conversion of Boston’s academic core is the program of the decade, and it is happening one DoN at a time.

The gate: how the Determination of Need decides what Boston builds

Massachusetts is the anti-Colorado. Where Denver’s systems build on licensure and speed, Boston’s build on permission. A hospital project above \$27,668,903.99 in the current fiscal year — the threshold is published to the cent — requires Determination of Need approval from the Department of Public Health under 105 CMR 100.000, and the standard approval condition dedicates at least 5% of the capital spend, over five years, to Community Health Initiatives in the communities the system serves. The Dana-Farber approval’s \$83.8 million community commitment is that condition at megaproject scale.

The gate has teeth, and the record shows them. In April 2022, Mass General Brigham withdrew three suburban ambulatory DoN applications totaling \$223.7 million after DPH staff indicated they would not recommend approval. And the state's cost discipline runs parallel to its construction gate: the Health Policy Commission's 3.6% cost growth benchmark has now been exceeded four consecutive years (actual growth of 5.7% in 2024, on \$83.3 billion of total health care spending), and the Commission imposed the first Performance Improvement Plan in its history on Mass General Brigham in 2022 — a \$176.7 million savings target that MGB reported exceeding, with \$197.1 million saved, before the HPC voted the plan successfully closed in December 2024. For project teams, the practical translation is that a Boston hospital project is two projects: the building, and the regulatory case for the building — need, cost impact, community benefit, and the alternative of not building, argued in public before the first drawing is final.

The Steward shock, and the map it left behind

Underneath the Longwood cranes, the region is still absorbing the largest hospital failure in Massachusetts history. Steward Health Care — then the state's third-largest system, with eight Massachusetts hospitals — filed Chapter 11 on May 6, 2024. On August 31, 2024, Carney Hospital in Dorchester (91 beds) and Nashoba Valley Medical Center in Ayer (38 beds) closed after drawing no qualified bids. On October 1, 2024, the remaining hospitals transferred in a single coordinated rescue: St. Elizabeth's in Brighton and Good Samaritan in Brockton to Boston Medical Center for \$140 million; Saint Anne's in Fall River and Morton in Taunton to Brown University Health for \$175 million; Holy Family in Methuen and Haverhill to Lawrence General Hospital for \$28 million — roughly \$343 million combined, preserving more than 13,000 jobs. When Apollo's real estate arm rejected BMC's bid for the St. Elizabeth's property, the Commonwealth took the campus by eminent domain and turned it over to BMC; the hospital now operates as BMC Brighton.

The aftershocks are measured in minutes. In the Nashoba Valley, the Working Group that studied the closure region found median EMS transport times rose from 12 to 17 minutes after Nashoba Valley Medical Center closed — up to roughly 30 minutes from Ayer and Groton — and emergency volumes at neighboring hospitals jumped by double digits in the first month. UMass Memorial has committed to a satellite emergency facility in Groton in response. And the region's strangest open file sits in Norwood, where the hospital has been closed since a 2020 flood: its rebuild approval was revoked in fall 2024, its owner reports about 75% of a replacement core and shell complete with more than \$350 million spent, and legislation enacted in August 2026 gives the owner until November 1, 2026 — days from now — to reach agreement with a qualified nonprofit operator, or the state may take the property by eminent domain. Boston's building wave and its closure map are the same story: capacity is being rebuilt where the approvals, capital, and academic gravity are, while the communities that lost hospitals negotiate from a much weaker hand.

Behavioral health is the fastest build-out in the region

The one service line growing faster than the academic towers is behavioral health, and it is growing in every direction at once. Boston Children's is building a \$640 million, 116-bed pediatric psychiatric hospital on the Franciscan Children's campus in Brighton — roughly doubling its inpatient psychiatric capacity, with partial-hospital and intensive outpatient programs, ground broken in 2026 and opening expected by 2029. Tufts Medicine's 144-bed behavioral health hospital in Malden, a \$65 million joint venture with Acadia Healthcare on the former Malden Hospital site, opened in early 2026, consolidating the legacy services of two community hospitals. Boston Medical Center's Brockton Behavioral Health Center (82 beds) opened in 2022, and

Cambridge Health Alliance expanded its inpatient psychiatric capacity by about 75% in 2023 while opening community behavioral health centers in Cambridge and Malden. The demand behind the bricks is the boarding crisis: with hundreds of behavioral health patients waiting in emergency departments for placement on any given day, every one of these buildings was effectively full on paper before it opened.

The local layer is water

Boston's amenity layer is not retail. It is the harbor. The city's Article 25A Coastal Flood Resilience Overlay District — adopted in 2021 — requires essential and high-risk structures to set their lowest floors at the sea-level-rise design flood elevation plus two feet of freeboard, mapped against a 2070 storm with 40 inches of sea-level rise. The region's hospitals have been building to that future for a decade: Spaulding Rehabilitation Hospital in the Charlestown Navy Yard, opened in 2013, set its first floor 30 inches above the 500-year flood level, put its mechanical systems on the roof, and installed on-site cogeneration that repaid its cost within ten years. The Ragon Building is designed to operate off-grid for up to four days as a disaster refuge and targets LEED Platinum; the Faulkner addition pairs a 950-space garage with 49 EV chargers and a solar array supplying about half its power. In Boston, resilience is not a sustainability chapter in the annual report. It is a design discipline with a flood elevation attached, and it prices into every project the way seismic prices into California.

The amenity layer: housing and feeding an imported city

No American medical district imports more people per acre than Longwood, and its amenity economy is sized to match. Boston Children's runs family housing of its own: the Yawkey Family Inn, a 22-bedroom house a few blocks from the hospital in Brookline, which together with the Devon Nicole House serves nearly 1,700 families a year, coordinated through the hospital's Patient Family Housing Program. A few streets over, the Inn at Longwood Medical keeps 155 hotel rooms inside the district itself, above the Longwood Galleria food court and an on-site CVS — lodging, food, and pharmacy stacked into one medical-district building.

The food layer is just as distributed. Dana-Farber puts a named dining pavilion — the Lavine Family Dining Pavilion — on the third floor of its Yawkey Center, with a specialty coffee roaster, For Five Coffee, in the Dana Building; the Starbucks inside Beth Israel Deaconess's Shapiro Center opens at 5:30 on weekday mornings, before most of the district's clinics; and Mass General spreads a set of cafes and coffee counters — the Eat Street Cafe, Coffee Central, and Tea Leaves and Coffee Beans among them — across its main-campus lobbies. Each is a small retail operation with a clinical landlord, run under infection-control rules in buildings that were drawn for medicine first.

That is the design problem Boston keeps posing: in a district where land is the binding constraint, amenity space competes for the same square footage as clinical space, and on the newest projects it is programmed from the first test fit rather than squeezed into what is left. Facilities teams here manage restaurants, a hotel, and family housing alongside the towers — a portfolio inside the portfolio.

What this means for design and construction teams

DoN fluency is the first competency. The teams that win Boston work are the ones whose planning starts at the application — programming that anticipates the need case, the cost and market impact review, and the community health commitment, because the approval conditions shape the building: what's in it, where, and

what the 5% funds in the surrounding neighborhoods. A design that cannot survive a Public Health Council hearing is not a design; it is a rendering.

Second, plan for the decant decade. The Ragon, the cancer hospital, and the Braunwald replacement all land in the same few Longwood blocks across the same ten years, in and around hospitals that are running at capacity-disaster occupancy while they build. Phasing, swing space, and enabling work — the Faulkner addition and the Klarman Building were both, in part, capacity chess moves for the larger game — are where this market's risk and margin live. Third, the workforce constraint is the oldest open item: the Massachusetts Health & Hospital Association counted 19,000 unfilled acute-care hospital positions statewide in its April 2023 report, the most recent system-wide census of its kind, alongside roughly \$1 billion in projected travel-labor spending. Three years on, the buildings have gotten bigger and the pipeline of people to staff them has not visibly caught up — 1,000 construction jobs are attached to the Ragon Building alone. Boston will finish these towers. The open question the whole market shares is who works in them.

Frequently asked questions

What is a Determination of Need?

Massachusetts' certificate-of-need program, run by the Department of Public Health. Hospital capital projects above a published expenditure threshold — \$27,668,903.99 for FY2025–26 — cannot proceed without DoN approval from the Public Health Council. Approvals carry conditions, most visibly the requirement that at least 5% of the capital spend go to Community Health Initiatives over five years.

How much does the Ragon Building cost?

Published estimates range from about \$1.9 billion to \$3.1 billion, and the difference is mostly scope: the lower figures describe the clinical towers, the higher figure includes the six below-grade levels and parking program. Anyone quoting a single number for the project should be asked which scope they mean.

What happened to Steward Health Care's Massachusetts hospitals?

Steward filed Chapter 11 in May 2024. Two hospitals — Carney in Dorchester and Nashoba Valley in Ayer — closed on August 31, 2024. Six others transferred to new operators on October 1, 2024: two to Boston Medical Center, two to Brown University Health, and two to Lawrence General Hospital, for about \$343 million combined. Norwood Hospital, closed since a 2020 flood and mid-rebuild, remains unresolved under an August 2026 state law with a November 1, 2026 deadline.

When does the Dana-Farber cancer hospital open?

Construction began March 16, 2026 and is expected to complete in fall 2030, with the first patient in 2031. The 300-bed hospital, a Dana-Farber and Beth Israel Deaconess partnership, was approved unanimously by the Public Health Council in March 2025 at a DoN-recorded capital cost of about \$1.68 billion.

Why is every new Boston hospital room a single?

Because the stock being replaced is mostly double rooms — the 50-year-old Braunwald Tower is the emblem — and modern infection control, patient privacy, and family presence standards all assume single occupancy. The Ragon's 482 rooms, Klarman's 158, and Faulkner's 78 are conversions of capacity as much as additions to it, which is precisely why the region can build this much and still feel full.

Healthcare Facility Hub tracks the standards, surveys, and construction practice behind projects like these — Determination of Need strategy, behavioral health design, ICRA containment, and the codes these buildings are held to. If you work in Boston-area facilities, design, or construction and see something here that needs correcting or sharpening, we want to hear it: talk to the Hub — facility leaders’ corrections make these briefs better, and we credit contributors by name and organization, or anonymously, as they prefer.

No Permission Slip: Denver’s Hospital Building Wave, the Eight-Hospital Venture, and the Race for One Interchange

Source: <https://healthcarefacilityhub.org/denver-hospital-construction-design-demand/> Published: October 17, 2026

The bottom line: Denver is running the largest hospital building wave in Colorado history, and it is doing it without asking permission. Colorado has no certificate-of-need law — the only state gate between a health system and a new hospital is licensure — so the metro’s growth is being allocated the old-fashioned way: by whoever finances, entitles, and builds first. In August 2026, AdventHealth and Intermountain Health signed a definitive agreement to combine eight Denver-metro hospitals into one joint venture. UCHealth and AdventHealth are racing for hospital sites at the same interstate interchange in Broomfield. And the demand is not theoretical: UCHealth’s Highlands Ranch hospital hit its ten-year growth projections in three years, and its second tower opens this fall. For the facilities, design, and construction teams who work this market, Denver is not a pipeline to watch. It is a pipeline to staff.

Denver metro hospital market, at a glance	Figure
Metro population	3,092,037 (Denver-Aurora-Centennial MSA, July 1, 2025, U.S. Census Bureau)
The state gate	Licensure only — Colorado has no certificate-of-need law and no hospital moratorium
The structural event	AdventHealth–Intermountain joint venture: 8 metro hospitals, definitive agreement August 2026, expected to close early 2027
Largest project under construction	AdventHealth Parker bed tower — \$300 million, 60 new beds, first patients expected February 2027
The contested ground	I-25 and CO 7 in Broomfield — UCHealth’s entitled North Campus site and an AdventHealth parcel at the same interchange
The demand proof	UCHealth Highlands Ranch reached its 10-year growth projections in 3 years; a tower with 70 more beds opens fall 2026
The headwind	The Colorado Hospital Association counts nearly 70% of the state’s hospitals at unsustainable margins in 2024

The venture that redraws the map

On August 5–6, 2026, AdventHealth and Intermountain Health signed a definitive agreement — announced by letter of intent on July 21 — to combine their Denver-metro hospitals into a single joint venture. AdventHealth contributes five hospitals: Avista, Castle Rock, Littleton, Parker, and Porter. Intermountain contributes three: Good Samaritan, Lutheran, and Platte Valley. AdventHealth takes the majority interest and will manage operations; Intermountain holds a minority stake. The venture is expected to close in early 2027, pending

regulatory approval.

One absence defines the deal as much as the eight inclusions. Saint Joseph Hospital — Intermountain's downtown Denver flagship — is not in the venture. Intermountain says it is exploring other options and partnerships for Saint Joseph, whose expanded cancer center opened to patients in February 2026. Until that resolves, the metro's oldest hospital brand is the market's largest open question.

Joint ventures of this size are construction programs in disguise. Eight hospitals under one operating standard means capital plans get re-sequenced across the combined portfolio, facility standards get harmonized, and every deferred project on both sides gets re-argued in front of a new owner table. The Parker tower and the Lutheran campus — Intermountain's \$680 million-announced replacement hospital, opened in Wheat Ridge in August 2024 with 226 licensed beds and a Level II trauma program — now sit inside the same capital conversation as AdventHealth's five. Whatever the venture's first combined capital plan says, it will move work around this market for years.

Why Denver can build this fast

Start with the missing law. The National Conference of State Legislatures' certificate-of-need tracker lists Colorado as a no-CON state: no state body weighs whether a metro "needs" another hospital, and no competitor gets a hearing to object. The gate that does exist is licensure through the Colorado Department of Public Health and Environment — a letter of intent, a complete initial license application at least 90 days before anticipated start-up, and conformity with FGI Guidelines and Life Safety Code requirements. Even bed-capacity increases run on notice: written notice to CDPHE at least 30 days ahead, plus a fee. Any system that can finance a hospital can build one.

Then look at where the people are going. The metro added roughly 128,000 residents between the 2020 Census and July 2025, but the growth is lopsided: Weld County grew 14.2% in five years and Douglas County 11.35%, while Denver County managed 1.87% and Arapahoe 1.92% — and Denver and Arapahoe together recorded about 18,000 in net negative domestic migration in the most recent year. The rooftops are moving to the fringe: Highlands Ranch, Parker, Castle Rock, Thornton, Westminster, Broomfield, and the I-25 corridor north. Read the project pipeline below against that map and it stops looking like a list. It is the same sentence written by five different systems: the buildings are following the migration.

The race for I-25 and CO 7

The clearest example sits on Broomfield's northern edge, where the metro's two most aggressive builders have planted flags at the same interchange. UCHHealth's Broomfield North Campus occupies roughly 110 acres at I-25 and CO 7, on the former IKEA land. Its site development plan describes a hospital of about 367,000 square feet with a medical office building of about 169,000 square feet. The Northlands PUD amendment cleared City Council 6-2 on July 29, 2026; the site development plan hearing is scheduled for November 10, 2026. UCHHealth says it aims to break ground in 2026 and open in 2029 — stated aims ahead of that hearing, not committed dates.

AdventHealth, meanwhile, holds a roughly 43-acre parcel at the southwest corner of the same interchange, a concept that entered formal review in February 2026, alongside planning to replace Avista Adventist Hospital in Louisville. Two systems, one interchange, one fast-growing trade area reaching from Broomfield into Weld County. In a CON state, this fight would happen in a hearing room over two years. In Colorado it will happen in

entitlement filings, site work, and speed — and the loser will not be told to stop; it will be told by the market, afterward.

Broomfield keeps collecting the region's growth in smaller denominations too. Ernest Health broke ground September 21, 2026 on its Denver Regional Rehabilitation Hospital of Broomfield — a 56-bed, 53,000-square-foot medical rehabilitation hospital expecting to open in 2027 with about 175 staff, the system's sixth hospital in Colorado. Children's Hospital Colorado's North Campus is already there: a clinic expanded into a roughly 236,000-square-foot pediatric hospital with 24 inpatient rooms, opened in 2024.

Douglas County is the demand frontier

If Broomfield is the race, Douglas County is the proof. UCHealth Highlands Ranch Hospital opened in 2019 with 74 beds, in a county that has grown 11% in five years — and hit its ten-year growth projections in three. The response is a \$119 million expansion: Pavilion 2, 130,000 square feet of gastrointestinal, heart and vascular, imaging, and surgery services, cut its ribbon August 27, 2026, and the second hospital tower opens this fall with 70 new inpatient beds, 14 new emergency department beds (one dedicated for assault and domestic-violence victims), an electrophysiology lab, and shell space for what comes next. The expansion adds about 170 jobs.

Twenty minutes south, AdventHealth Parker is building the metro's largest active hospital project: a \$300 million, seven-story, 186,000-square-foot bed tower with 60 new medical-surgical beds, four operating rooms, two catheterization labs, two interventional radiology labs, and a new sterile processing department. Floors five through seven are shelled for future build-out toward a designed capacity of 329 beds. Ground broke in January 2025; first patients are expected in February 2027.

The county's behavioral health frontier is being seeded with settlement money. In June 2026 Douglas County approved \$3.4 million in opioid settlement funds for a Children's Hospital Colorado youth mental-health emergency and crisis stabilization unit adjacent to its South Campus emergency department in Highlands Ranch — treatment and de-escalation rooms, stays of 48 to 72 hours — part of a Children's plan to build crisis stabilization units at all four of its hospital campuses. Add AdventHealth's Crystal Valley emergency and urgent care center under construction in Castle Rock, and its Littleton Heart & Vascular Institute — \$150 million, opened August 2025 with three cardiovascular operating rooms and 24 cardiac ICU step-down beds — and Douglas County is where Denver's hospital map is being drawn first.

Aurora holds the academic engine

The Anschutz Medical Campus remains the metro's clinical center of gravity — the University of Colorado's Anschutz campus is the metro's second-largest employer at 13,492 Denver-area FTEs, and UCHealth reports 12,940 Denver-area FTEs of its own. UCHealth's Inpatient Pavilion 3 at University of Colorado Hospital — \$286 million, 12 stories, 215 private inpatient rooms, 10 operating rooms — completed its staged opening in May 2024, including a 40-bed inpatient behavioral health unit, the hospital's first psychiatric unit since a 2009 closure. Children's Hospital Colorado finished the campus's last shell space in December 2025: a 22,500-square-foot eighth-floor buildout adding 25 inpatient beds, delivered more than three weeks early.

Aurora is also where the neighborhood-scale strategy shows up. AdventHealth's Aurora Highlands campus — an \$81 million, 88,000-square-foot freestanding emergency and outpatient center with a 24-hour emergency department — opened to patients September 29, 2026, with a 50-to-75-bed hospital planned as its second phase.

UCHealth opened its Green Valley Ranch Medical Center in early 2025. The pattern repeats metro-wide: big towers on the growth fringe, emergency and urgent care planted in neighborhoods years before the inpatient beds behind them.

The public system builds with a tax

Denver Health runs the metro's safety net, and its capital program runs on a ballot measure. Ballot Measure 2Q, approved by Denver voters in November 2024, levies a 0.34% sales and use tax estimated at about \$70 million a year for Denver Health across emergency, primary, mental-health, substance-use, and pediatric care. The context is arithmetic: Denver Health's uncompensated care rose from \$42 million in 2019 to \$103 million in 2023. The 2025 allocation put \$33.4 million into emergency and trauma care alone.

The building program shows it. The Sam Sandos Westside Family Health Center replacement — a three-story, 82,500-square-foot clinic on Federal Boulevard, budgeted at \$100 to \$115 million with \$20 million from the voter-approved Vibrant Denver Bond — broke ground in November 2025 and opens in 2027 with capacity for more than 33,000 patients a year, 30% above the clinic it replaces. The Southeast Medical Center, Denver Health's eleventh community health center and its first in southeast Denver, opened June 4, 2026. And in December 2025 Denver Health opened Colorado's first Integrated Medical and Psychiatric Care unit: 12 inpatient beds, built inside a renovated formerly closed psychiatric unit, for patients who need medical and psychiatric hospitalization at the same time — a renovation-first project in the public system, mirroring what the private systems are learning about speed.

Behavioral health is being built as a network, not a building

The metro's behavioral health map since 2021 reads like a deliberate distribution strategy. West Pines Behavioral Hospital in Westminster — a 144-bed freestanding psychiatric hospital built by Intermountain Health and Acadia Healthcare — opened December 16, 2024, replacing Intermountain's 96-bed unit at the old Lutheran campus. HealthONE's Behavioral Health and Wellness Center in Aurora runs 120 inpatient beds. UCHealth's 40-bed Anschutz unit, Denver Health's IMAP unit, Children's crisis stabilization plan, and WellPower's Behavioral Health Solutions Center in Denver — crisis drop-off, a 16-bed stabilization clinic, and 30 transitional rooms on one site — complete a network that mixes inpatient, crisis, and step-down capacity across five systems.

The honesty requirement runs the other way, too: two Colorado behavioral health hospitals, West Springs in Grand Junction and Johnstown Heights in Johnstown, closed in spring 2025. Demand did not close them; economics did. That tension — a state adding behavioral health beds in the metro while losing them elsewhere — is the defining financial fact of Colorado healthcare right now, and it sits underneath every project in this brief.

The headwind is real, and it is not stopping the cranes

The Colorado Hospital Association's Q2 2025 industry update reports that nearly 70% of Colorado hospitals ended 2024 with margins it characterizes as unsustainable, more than 80% of rural hospitals among them; charity care is up 123% since 2021; and the association projects federal H.R. 1 will cut more than \$10 billion in Colorado hospital financing over five years. In August 2025, Governor Polis suspended a planned 1.6% Medicaid provider rate increase by executive order in response to a state budget shortfall of roughly \$750

million, and cut hospital base rates with it. Those are the association's figures and projections, and they deserve their attribution — but so does the counterweight: no Colorado acute-care hospital has closed for financial hardship, and the systems building in Denver are doing their arithmetic with the same numbers. The metro's wager is that growth pays for what reimbursement doesn't. The fringe counties' rooftops are the collateral.

The local layer: what Denver facilities teams actually live with

Every market brief is also a weather brief, and Denver's is written in fire and hail. On December 30, 2021, the Marshall Fire destroyed 1,084 homes in Louisville and Superior — Colorado's costliest wildfire. Avista Adventist Hospital, directly in its path, evacuated 51 patients and about 100 staff in under two hours, including NICU infants and ventilated patients, then closed for roughly three weeks of smoke remediation — hundreds of air scrubbers, a full emergency department ceiling replacement, oxygen system recertification — before reopening January 18, 2022. The evacuation is now a federal ASPR TRACIE case study, and the follow-on hardening was concrete: systemwide activated-carbon filtration and rewritten fire and evacuation plans. When AdventHealth plans Avista's replacement, that history is part of the site selection whether it appears in the documents or not.

Add the May 2024 hailstorm — about \$1.9 billion in damage, the metro's largest in 35 years — and Xcel Energy's \$1.9 billion wildfire mitigation plan for 2025–2027, which funds undergrounding and shutoff protocols that explicitly protect critical and medical customers, and Denver facilities work carries a resilience line item that most markets treat as an appendix. Roofing systems, air handling under smoke load, and utility redundancy are not value-engineering candidates here. They are the local code of weather.

The amenity layer: a hotel on the campus, a cafe past midnight

The Anschutz campus now runs a hospitality layer of its own. The Benson Hotel and Faculty Club opened in July 2023 as the campus's hospitality center — 106 rooms, including a full floor of apartment-style suites with kitchens, and a 100-seat restaurant — built to serve the patients, families, recruits, and visiting clinicians the hospitals bring to Aurora every day. Families who cannot use a hotel have a different door: the Ronald McDonald House in Aurora houses up to 45 families a night a short drive from the towers, and Brent's Place keeps immunocompromised transplant patients in safe-clean apartments near the campus. In this market, lodging is clinical infrastructure — it is what makes a regional draw possible.

Inside the towers, the hours make the same point. UCHHealth's Garden View Cafe at University of Colorado Hospital runs from 6:30 a.m. to 1 a.m. every day, with a Dazbog coffee kiosk on the first floor from 6 a.m., and Children's Colorado runs room service that lets the parent at the bedside order a guest tray instead of leaving the floor. A campus that staffs three shifts feeds three shifts — and every one of those programs is a facilities program: commercial kitchens, licensed or leased space, ventilation and waste, security after midnight, and food-safety inspections on the same cycle as the clinical plant.

For design and construction teams, the takeaway is scale. Denver's amenity space is being programmed at the campus level — a hotel, family housing, and 18-hour foodservice inside the master plan — which puts it in the capital plan too, with the mechanical, electrical, and life-safety load that follows. The firms that price the amenity layer as an afterthought are misreading where the square footage is going.

What this means for design and construction teams

Three structural facts should shape how firms work this market. First, shell space is the metro's dominant design feature: Parker's three shelled floors, St. Anthony North's two shelled 30-bed floors in its 2024 Westminster tower, Highlands Ranch's shelled expansion space, Swedish Medical Center's shelled cath lab and surgery suite in its \$118 million 2024 tower. Denver's systems are buying capacity in stages, which means the fit-out pipeline behind today's tower openings runs for a decade — phased, occupied-hospital work, entitled by the original project and scheduled by census. Teams that can phase cleanly inside live hospitals hold the market's scarcest skill.

Second, entitlement speed is a competitive weapon in a no-CON state. The Broomfield race will be won in site plan hearings and construction starts, not in need determinations — and the firms that help systems move from land to licensure fastest, including the CDPHE licensing calendar with its 90-day application runway, are selling the thing the market actually prices. Third, behavioral health is now a standing specialty line, not an occasional project type: freestanding hospitals, crisis stabilization, integrated medical-psychiatric units, and pediatric crisis rooms are all in active production across five systems at once, and the design competencies — ligature resistance, sight lines, de-escalation space — do not transfer casually from medical-surgical work.

The workforce underneath it is large and employed: metro health care and social assistance employment averaged 190,600 in 2025, and the systems driving the pipeline — UCHealth, HCA HealthONE at 12,800 Denver-area FTEs, Children's Colorado at more than 9,500 team members — are hiring into it. The constraint on Denver's building wave is not demand, permission, or even money. It is the same constraint as everywhere else, sharpened: the people who can build and run hospitals, arriving slower than the rooftops.

Frequently asked questions

Does Colorado have a certificate-of-need law for hospitals?

No. Colorado is a no-CON state — there is no state review of whether a new hospital or bed expansion is “needed,” and no competitor objection process. The state gate is licensure through CDPHE: a letter of intent, a complete initial license application at least 90 days before anticipated start-up, FGI and Life Safety Code conformity, and 30 days' written notice for bed-capacity increases.

What is the AdventHealth–Intermountain joint venture?

A definitive agreement signed in August 2026 to combine eight Denver-metro hospitals — AdventHealth's Avista, Castle Rock, Littleton, Parker, and Porter, plus Intermountain's Good Samaritan, Lutheran, and Platte Valley — under one venture that AdventHealth will manage with a majority interest. It is expected to close in early 2027, pending regulatory approval. Saint Joseph Hospital is not included; Intermountain is exploring separate options for it.

When does the AdventHealth Parker tower open?

First patients are expected in February 2027, with operating rooms, catheterization labs, and interventional radiology following in March 2027. The \$300 million tower adds 60 medical-surgical beds now, with three shelled floors designed to bring the hospital to 329 beds.

Why are two hospital systems racing for the same Broomfield interchange?

Because the growth is there: Broomfield sits between Denver and the fastest-growing counties in the state, on the I-25 corridor into Weld County (up 14.2% in five years). UCHealth's North Campus — an approximately

367,000-square-foot hospital — is in advanced entitlement with a site plan hearing November 10, 2026; AdventHealth holds a competing parcel at the same interchange. With no CON process to arbitrate, entitlement and construction speed decide it.

Is Denver Health part of the joint venture?

No. Denver Health is the region’s public safety-net system and is independent of the venture. Its current capital program is funded substantially by Ballot Measure 2Q, the voter-approved sales tax estimated at about \$70 million a year, plus the Vibrant Denver Bond.

Healthcare Facility Hub tracks the standards, surveys, and construction practice behind projects like these — hospital expansion, behavioral health design, ICRA containment, and the codes these buildings are held to. If you work in Denver-area facilities, design, or construction and see something here that needs correcting or sharpening, we want to hear it: talk to the Hub — facility leaders’ corrections make these briefs better, and we credit contributors by name and organization, or anonymously, as they prefer.

Renovation First: Atrium Health Is Converting an Existing Building Into Charlotte’s 168-Bed Behavioral Health Hospital

Source: <https://healthcarefacilityhub.org/charlotte-hospital-renovation-design-demand/> Published: October 17, 2026

The bottom line: Atrium Health is putting \$340 million into behavioral health over five years — and its centerpiece hospital isn’t being built. It’s being *renovated* into existence: an existing building in Charlotte’s University City area, converted into a 168-bed behavioral health hospital for children and adults, opening in 2028 because the shell is already standing. The route buys 12 to 18 months over new construction. For the design and construction teams who work this market, the announcement is less a ribbon-cutting than a starting gun — no architect, no contractor, and no building has been named yet, and the hardest design problems in healthcare are the ones this project is made of.

Atrium behavioral health program, at a glance	Figure
Total investment	\$340 million over five years (announced October 15, 2026)
The hospital	168 inpatient beds, pediatric and adult — a net gain of 102 beds
The route	Renovation of an existing building, University City area near Mallard Creek
Opening target	2028 — 12 to 18 months sooner than new construction, per Atrium
Also in the program	A new behavioral health emergency department, a larger crisis stabilization unit, expanded outpatient clinics
Projected volume	+35,000 inpatient days a year; +19,500 outpatient visits a year
The demand behind it	Behavioral health ED visits up 13% in six years; pediatric patients were 26% of those visits in 2025

What Atrium announced

On October 15, Atrium Health committed \$340 million over five years to expand behavioral health across the Charlotte region — one of the largest behavioral health investments in the region’s history, serving a catchment

that runs from York County, South Carolina, up to North Carolina's Triad. The centerpiece is a new hospital location created by renovating an existing building in the University City area near Mallard Creek: 168 inpatient beds for pediatric and adult patients, a net gain of 102 beds for the community.

The program around the hospital matters as much as the bed count. The investment includes a new behavioral health emergency department and a larger crisis stabilization unit — the front door and the pressure valve of the whole system — plus expanded outpatient services: therapy, medication management, and intensive treatment programs. The hospital itself will offer specialized inpatient treatment, including procedure- and device-based options for adults who haven't improved on standard medications or therapy. Atrium projects the hospital will add 35,000 inpatient days of care a year, and the expanded clinics more than 19,500 visits a year.

The existing footprint doesn't close to make room. Atrium Health Behavioral Health Davidson continues inpatient care, and Atrium Health Behavioral Health Charlotte continues outpatient and crisis services. This is capacity added on top of a running system, not a consolidation.

The demand math is in the announcement itself. Behavioral health-related emergency department visits across the system rose 13% over six years, adolescents made up 17% of those visits, and in 2025 pediatric patients accounted for 26% of behavioral health ED visits. Atrium treated nearly 2,000 pediatric patients in inpatient settings and nearly 20,000 in outpatient settings last year. "Behavioral health is one of the greatest unmet needs in healthcare today, and it touches nearly every family and community," Advocate Health CEO Eugene Woods said in the release. The 168-bed answer is sized to that curve.

Why the fastest hospital is the one already standing

The most consequential design decision in this program has already been made, and it isn't about the building — it's about the calendar. Renovating an existing structure lets Atrium target a 2028 opening, 12 to 18 months earlier than building from scratch. On a need curve rising 13% in six years, those months are clinical capacity, not convenience: every month of schedule is a month of pediatric patients boarding in emergency departments that weren't designed for them.

Renovation-first also reorders the work. A ground-up hospital spends its first year on site work, structure, and enclosure before a single clinical decision becomes physical. A conversion starts with the questions that actually shape a behavioral health facility — does the floor plate zone safely, do the sight lines work, can the mechanical systems carry hospital loads — and it starts them immediately, against a real building that answers back. The trade is certainty: a new build is a known quantity drawn from a blank sheet; a conversion is a negotiation with an existing structure, and the negotiation only goes well for teams that survey before they promise.

The design problem: behavioral health is the hardest conversion in the building

Of all the hospital types to carve out of an existing building, behavioral health is the most demanding — not because of its medical infrastructure, which is lighter than an acute-care tower's, but because the building itself is a clinical instrument. In behavioral health design, the environment is part of the treatment and most of the safety system:

- **Safety is architectural.** Ligature-resistant fixtures, hardware, and plumbing; tamper-resistant everything; anti-barricade door swings; the elimination of anchor points from patient-accessible spaces. Every specification is a risk decision, and the safety risk assessment drives the plan before the plan drives anything else.
- **Sight lines are staffing.** Continuous observation from staff positions, zoned progression from public to clinical to inpatient, and unit layouts that let a small team see the whole milieu determine whether the facility can operate safely at its licensed census — or only on paper.
- **Three populations, one building.** Pediatric, adolescent, and adult patients require separated units, separated circulation, and separated outdoor space, with an emergency department and crisis stabilization unit that can receive any of them at the front door and sort safely.
- **The shell gets a vote.** Floor-to-floor heights, column spacing, existing shaft locations, and structural capacity bound everything above. A behavioral health program needs generous daylit common space, de-escalation rooms, and secure outdoor areas — in a structure designed for something else. The existing-conditions survey is the real first design phase.
- **Systems convert, too.** An existing building's HVAC, plumbing, and electrical capacity was sized for its previous life. Hospital occupancy brings its own ventilation, life-safety, and emergency-power expectations, and the gap between what the building has and what the license requires is where conversion budgets are won and lost.

None of this is knowable yet from outside — Atrium has not identified the building publicly, and the existing-conditions answers will shape the project more than any rendering. That is precisely the point for the firms positioning now: the first deliverable this project needs is not a design. It's a rigorous read of a specific existing building against a specific clinical program.

Mallard Creek is contested ground

The geography is not an accident. University City, anchored by UNC Charlotte, is north Charlotte's growth edge, and the Mallard Creek area is already a healthcare battleground: Duke Health and CaroMont Health have proposed a 120-bed acute-care hospital in the same area, announced earlier this year and still awaiting state approval. Atrium's move puts a specialized 168-bed facility — a category the competing proposal doesn't cover — into the ground first, on a renovation timeline a ground-up competitor cannot match. Behavioral health beds and acute-care beds answer different needs, but referral patterns, workforce, and community presence compound. The map of who treats north Charlotte is being drawn this decade, in more than one category at once.

The rest of the \$340 million

The building is the headline; the program is the commitment. Beyond the hospital, the five-year investment expands urgent and crisis care, community programs such as Wellness Without Walls — Atrium's street psychiatry program — and virtual care. The workforce leg is its own construction project, in people: expanded psychiatry residency and adolescent psychiatry fellowship positions, and a planned addiction fellowship. A 168-bed hospital that cannot be staffed is a rendering; Atrium is funding the pipeline that makes the beds real, on roughly the same five-year clock as the renovation.

What Atrium has not disclosed is equally specific: no job count, no construction contract, and no split of the \$340 million between the hospital and the wider program. For design and construction teams, that silence is the loudest part of the announcement. The selections are still ahead.

What this means for design and construction teams

- **The team isn't picked.** No architect or contractor has been announced for a 168-bed conversion with a 2028 opening. The runway between announcement and design start is short, and it favors firms that can speak to behavioral health and existing-building work in the same sentence.
- **Conversion fluency is the differentiator.** Existing-conditions assessment, phased gut renovation, and designing to a shell's real constraints — against a clinical program with zero tolerance for environmental risk — is a specialty portfolio, not a generic healthcare one.
- **Behavioral health is a growing book of work.** Becker's counts dozens of behavioral health projects nationally in the same news cycle, including a \$138 million hospital in Greenville, South Carolina that will quadruple children's inpatient capacity in the Upstate. The Carolinas alone are running a multi-year behavioral health building program; this is the largest single piece of it.
- **Speed is the client's stated value.** Atrium chose renovation explicitly to buy 12 to 18 months. Teams that can protect that schedule — early surveys, early AHJ conversations, procurement that doesn't wait for perfect drawings — are answering the brief the client actually wrote.

Frequently asked questions

What is Atrium Health building in Charlotte?

A 168-bed behavioral health hospital for pediatric and adult patients, created by renovating an existing building in the University City area near Mallard Creek. It is the centerpiece of a \$340 million, five-year behavioral health investment announced October 15, 2026, which also includes a new behavioral health emergency department, a larger crisis stabilization unit, and expanded outpatient services.

Why is Atrium renovating instead of building new?

Schedule. Atrium says the renovation route targets a 2028 opening — 12 to 18 months sooner than new construction — against behavioral health emergency demand that has risen 13% in six years, with pediatric patients accounting for 26% of behavioral health ED visits in 2025.

How many beds does the Charlotte region gain?

The hospital's 168 beds are a net gain of 102 beds for the community. Atrium projects the hospital will add 35,000 inpatient days of care a year and the expanded outpatient clinics more than 19,500 visits a year. Existing services continue: Behavioral Health Davidson keeps inpatient care, and Behavioral Health Charlotte keeps outpatient and crisis services.

Has Atrium named the building, architect, or contractor?

Not publicly. Atrium has identified the area — University City near Mallard Creek — but has not disclosed the specific building, a job count, a construction contract, or how much of the \$340 million is allocated to the hospital itself.

What makes behavioral health renovation different from other hospital work?

The building is part of the safety system: ligature-resistant fixtures and hardware, anti-barricade doors, continuous observation sight lines, and strictly separated pediatric, adolescent, and adult units. In a conversion, those requirements have to be reconciled with an existing structure — its floor heights, column grid, and mechanical capacity — which makes the existing-conditions survey the project’s real first design phase.

Healthcare Facility Hub tracks the standards, surveys, and construction practice behind projects like these — behavioral health design, ICRA containment, and the codes these buildings are held to. If you work in Charlotte-area facilities, design, or construction and see something here that needs correcting or sharpening, we want to hear it: talk to the Hub — facility leaders’ corrections make these briefs better, and we credit contributors by name and organization, or anonymously, as they prefer.

Building Before the Gate Lifts: Nashville’s Hospital Construction Decade

Source: <https://healthcarefacilityhub.org/nashville-hospital-renovation-design-demand/> Published: October 17, 2026

The bottom line: Nashville is building hospital capacity in every direction at once — a \$500 million tower phasing open at Vanderbilt, two brand-new hospitals racing toward 2028 openings in Clarksville, a court-affirmed hospital coming to Murfreesboro, and a \$700 million county-hospital sale in Franklin. And underneath all of it, a deadline: Tennessee’s certificate-of-need law, the permission slip every one of these projects had to win, expires for hospitals on July 1, 2030. The teams that design and build healthcare space in Middle Tennessee are working the last pipeline of the permission era — and positioning for the first one without it.

Nashville metro, at a glance	Figure
Metro population (July 2025)	2,197,416 — up 8.7% in five years (U.S. Census Bureau)
Healthcare economy	\$72.1B in output, 372,160 jobs, 17 publicly traded healthcare HQs (Nashville Health Care Council / EY, 2025)
Largest active project	Vanderbilt’s Jim Ayers Tower — \$500M, 495,000 sq ft, 180 beds, completing early 2027
New hospitals approved	Spring Hill (\$250M), TriStar Clarksville (\$286M), Saint Thomas Clarksville (\$148.5M), plus Vanderbilt Rutherford (\$144.3M, court-affirmed)
Largest pending transaction	Williamson Health sale to Ascension Saint Thomas — \$700M, LOI approved September 9, 2026
The deadline	CON ends for satellite EDs and cardiac cath July 1, 2028; for acute-care hospitals July 1, 2030

The permission era ends on a date certain

Since 1973, building a hospital in Tennessee has started with a legal argument. A certificate of need (CON) requires the applicant to prove a project is necessary, meets quality standards, and serves the public — in a public process where competitors get to argue it isn’t. Nashville’s current pipeline is a museum of what that produces. Vanderbilt’s Murfreesboro hospital spent six years in the process (below). A TriStar freestanding emergency department in Lebanon was denied in September 2025, then approved after the political ground

shifted and the opposing system withdrew. A 28-bed hospital conversion in Gallatin was denied in 2025, then approved in 2026 at a larger size.

That era now has an end date. The 2024 reform law (Public Chapter 985) began exempting categories of projects in phases and stripped third-party opponents of appeal standing. The 2026 law (Public Chapter 887, Senate Bill 1369, signed May 5, 2026) finished the job on a schedule: satellite emergency departments and cardiac catheterization lose the CON requirement on **July 1, 2028**, and acute-care hospitals follow on **July 1, 2030** — replaced by Health Facilities Commission licensure with conditions, including TennCare participation and charity care comparable to similar hospitals.

For design and construction teams, the practical read is sequencing. Projects that need a CON are being pushed through now, while the rules are known. The 2028 ED-and-cath exemption will produce a wave of smaller, faster projects that no longer need a year of legal runway. And hospital positioning for a post-2030 market — sites, master plans, phased campuses — is work that starts in this decade, not the next one.

The core is full: Vanderbilt builds up

Vanderbilt University Hospital operates at more than 90% capacity year-round, and its answer is the largest expansion in the medical center's history. The **Jim Ayers Tower** — \$500 million, 495,000 square feet — began construction in the summer of 2022 and started taking patients on October 1, 2025, when its first inpatient floor (Level 7, 30 private rooms) opened. Six inpatient floors phase in through completion in early 2027, adding 180 beds, with shelled space for more. The project also delivered 44,000 square feet of operating-room space in adjacent Medical Center East, 600 parking spaces, and a two-story bridge to the Vanderbilt Clinic.

The phasing is the story for builders: a tower opening floor by floor, inside a campus that never closes, on top of a children's hospital that just finished its own four-floor vertical expansion. Monroe Carell Jr. Children's Hospital completed its 160,000-square-foot expansion in early 2025 and now stands at 363 beds and over a million square feet — the largest pediatric hospital in Tennessee. Vanderbilt's adult emergency department, growing about 4% a year, is slated for a major "reimagine and expand" renovation, and the system's outpatient footprint is pushing outward: a large ambulatory surgery center under construction at One Hundred Oaks, and a 350,000-square-foot outpatient anchor announced for Brentwood — the former AT&T data center on Franklin Road — covering cancer, heart and vascular, orthopedics, pediatrics, labs, imaging, and five walk-in clinics.

TriStar and Saint Thomas work the middle ring

HCA's TriStar Health, headquartered in Nashville, is building where its beds are oldest and its suburbs are youngest. At TriStar Skyline, a \$133.6 million, 122,000-square-foot tower broke ground in June 2025 — 30 progressive-care beds, 14 ICU beds, four operating rooms including burn ORs, and a shelled third floor — completing in January 2027. TriStar Centennial won unanimous CON approval in October 2025 for a \$25 million, 15-bed inpatient rehabilitation unit opening in 2027, and the system's freestanding ER in East Nashville opened in August 2026.

Ascension Saint Thomas is running a \$537 million capital program across Davidson, Rutherford, and Montgomery counties. Its centerpiece in the city is the \$120 million transformation of Saint Thomas Hospital West — modernized operating rooms and cath labs, a new thoracic surgery and chest center, expanded imaging, redesigned entrances — under construction through roughly mid-2028, following a \$10 million emergency

department modernization completed in July 2025 and a \$22 million surgical ICU renovation at Midtown unveiled in June 2026.

The ring is where the map redraws

Clarksville is getting three hospital systems at once. Vanderbilt closed its \$600 million acquisition of the 270-bed Tennova hospital in February 2026, renaming it Vanderbilt Clarksville Hospital. At the same July 2025 hearing, the Health Facilities Commission approved two competing new hospitals, 8–0: TriStar Clarksville, \$286 million and 68 beds expandable to 224, and Ascension Saint Thomas Clarksville, \$148.5 million on a 96-acre campus, opening with 44 beds designed to grow to 132. Saint Thomas broke ground June 16, 2026; both new hospitals are expected to open in 2028. One county, three systems, two greenfield hospitals and a campus each — the design work in Montgomery County runs for a decade.

Murfreesboro got its fourth hospital through a courtroom. Vanderbilt first sought a Rutherford County hospital in 2020 and was denied. Its second application was granted by the Health Facilities Commission in March 2024 — over an administrative judge’s contrary recommendation — and rival systems sued to overturn it. In January 2026, the Davidson County Chancery Court affirmed the approval. The \$144.3 million, 42-bed Vanderbilt Rutherford Hospital is now planned for a 2027 groundbreaking, phased to grow well beyond its opening size. Around it, the county’s emergency map is filling in: freestanding ERs approved for both Saint Thomas Rutherford (\$19 million, Lascassas Pike) and TriStar (\$19 million, south Murfreesboro), joining Saint Thomas’s Westlawn neighborhood hospital, open since 2023.

Spring Hill and Gallatin round out the ring. TriStar Spring Hill Hospital — \$250 million, 68 beds with ICU, labor and delivery, a Level II NICU, and cardiac cath — won its CON in June 2024 and is projected to open in 2027 on the site of the system’s existing emergency department. In Sumner County, the Highpoint Health–Sumner Station campus won approval in June 2026 to convert its freestanding ER into a 28-bed satellite hospital — a year after a smaller version was denied — while TriStar Hendersonville opened a \$53.6 million expansion in January 2026.

The Williamson question

Williamson Health is the region’s last big independent: a county-owned system whose 337-bed Franklin hospital opened its \$200 million Boyer-Bryan West Tower in June 2024. In July 2026 its board voted to sell to Ascension Saint Thomas; on September 9, 2026, the Williamson County Commission approved a non-binding letter of intent, 19–5, for a sale valued at \$700 million — with total investment approaching \$1 billion once planned capital commitments are counted. A definitive agreement, further county approval, and regulatory review still stand between the LOI and a closing, likely in 2027 or 2028.

For builders, an ownership change of this size is a program, not an event: new owner standards applied to a two-year-old tower, an electronic-health-record conversion, and a capital queue re-ranked by a national system’s playbook. Whatever the final terms, Franklin’s hospital campus will be a worksite, in phases, for years.

The safety-net decision still on the table

Nashville General Hospital, the city’s public hospital, operates on Meharry Medical College’s campus under a lease that expires in 2027. The choices are stark: renovate in place at roughly \$500 million by current estimates,

or build new at \$500 million to \$1 billion. No plan is finalized and no site is chosen. Metro's subsidy to the hospital reached \$60.7 million in fiscal 2026, and a permanent CEO — Veronica Elders, seated in June 2026 — now owns the decision. When Nashville General moves, in whichever direction, it becomes one of the largest public-hospital projects in the Southeast. Until it does, it is the region's largest piece of unstarted work.

Built on flood and tornado memory

Middle Tennessee designs for weather because it has the receipts. The May 2010 flood — the Cumberland River cresting at a record 51.86 feet — damaged six of Davidson County's ten hospitals; one came within hours of full evacuation, and Vanderbilt relocated sterile processing out of a flooded basement. The March 2020 EF-3 tornado cut a 60-mile path through the metro. In December 2023, an EF-2 tornado knocked TriStar Hendersonville onto emergency power as storm victims arrived. Every new campus in this pipeline — Clarksville's ground-up hospitals especially — is being designed by teams who treat protected utilities, emergency power, and surge capacity as program requirements, not value-engineering targets.

The amenity layer follows the same logic of designing for the people who live in these buildings. Hospital campuses here function as small cities on shift schedules: there is a Starbucks inside the Patterson Street hospital corridor at TriStar Centennial, Vanderbilt's new tower leads with a spacious daylit lobby, and Saint Thomas's Clarksville campus is planned as a 96-acre district — physician partners, a rehabilitation hospital, an EMS station, outpatient surgery — rather than a single building. Nationally, roughly nine in ten hospitals now run some form of retail foodservice; in Nashville's competitive suburbs, the ground floor is part of the recruitment pitch to staff and the experience pitch to families, and it gets designed that way from the first test fit.

What this means for design and construction teams

- **The CON calendar is a bid calendar.** Projects approved under the current regime are breaking ground through 2028. The July 2028 exemption for satellite EDs and cardiac cath — smaller, repeatable, fast — is the next product wave, and the firms that will build it are being selected on the strength of freestanding-ER work happening now.
- **Phased-occupancy expertise is the local differentiator.** Vanderbilt is opening a tower one floor at a time inside a live campus; Saint Thomas is rebuilding an operating hospital wing by wing. Infection control, interim life safety, and swing-space planning are not specialties in this market — they are the baseline.
- **Post-2030 positioning starts now.** When the hospital CON sunsets, the constraint moves from permission to licensure conditions — TennCare participation and charity-care comparability will shape program mix and payer planning. Site selection and master planning for that market is 2026–2029 work.
- **Two decisions are still open.** Nashville General's renovate-or-rebuild call and the Williamson closing will each release years of phased capital work. Both reward teams already fluent in the systems' standards when the word comes.

Frequently asked questions

Does Tennessee still require a certificate of need to build a hospital?

Yes, until July 1, 2030. The 2026 law (Public Chapter 887) phases the requirement out: satellite emergency departments and cardiac catheterization are exempt from July 1, 2028, and acute-care hospitals from July 1,

2030, after which new hospitals need Health Facilities Commission licensure — including TennCare participation and charity-care conditions — instead of a CON.

What is the largest hospital project underway in Nashville?

Vanderbilt's Jim Ayers Tower: \$500 million, 495,000 square feet, 180 inpatient beds. Its first floor opened October 1, 2025, and the tower completes in early 2027 at a hospital running above 90% occupancy.

Which Nashville suburbs are getting new hospitals?

Clarksville is getting two — TriStar Clarksville (\$286 million) and Ascension Saint Thomas Clarksville (\$148.5 million), both expected to open in 2028 — plus Vanderbilt's acquisition of the existing Tennova hospital. Spring Hill has an approved \$250 million TriStar hospital, and Vanderbilt's \$144.3 million Rutherford County hospital was affirmed by the Chancery Court in January 2026, with groundbreaking planned for 2027.

What is happening with Williamson Health in Franklin?

The county-owned system is being sold to Ascension Saint Thomas. The Williamson County Commission approved a non-binding letter of intent on September 9, 2026, for a sale valued at \$700 million; a definitive agreement and regulatory review remain, with closing likely in 2027 or 2028.

Why does Nashville's disaster history matter to hospital design?

The 2010 flood damaged six of the county's ten hospitals, the 2020 tornado cut a 60-mile path through the metro, and a 2023 tornado put TriStar Hendersonville on emergency power mid-surge. New campuses are designed accordingly — protected infrastructure, robust emergency power, and surge capacity are standard program requirements in Middle Tennessee.

Healthcare Facility Hub tracks the standards, surveys, and construction practice behind projects like these — ICRA containment, interim life safety measures, and the codes these campuses are built to. If you work in Middle Tennessee facilities, design, or construction and see something here that needs correcting or sharpening, we want to hear it: facility leaders' corrections make these briefs better, and we credit contributors by name and organization, or anonymously, as they prefer. Send it here — a person reads every message.

The Metroplex Builds: Dallas–Fort Worth's Hospital Decade

Source: <https://healthcarefacilityhub.org/dallas-fort-worth-hospital-renovation-design-demand/> Published: October 17, 2026

Start with the arithmetic. The Dallas–Fort Worth metroplex counted 8.48 million people in July 2025, fourth-largest in the country, and added 123,557 of them in a single year — the second-biggest numeric gain of any American metro, behind only Houston, per the Census Bureau. Then consider the rule that governs what happens next: Texas has had no certificate-of-need law since 1985. No state board decides whether a hospital may be built, expanded, or opened. Where Virginia routes new hospital beds through a public-need process, Texas lets the market draw the map. The result is the most construction-dense hospital landscape in this series: a \$5 billion pediatric campus in the medical district, two public hospital systems building hard, and a suburban land rush in every direction the rooftops are moving. Here is the demand map.

The anchor: a \$5 billion campus for children

In the Southwestern Medical District — a thousand acres holding UT Southwestern, Parkland, and Children’s Health, and more than 41,000 jobs between them — the region’s defining project topped out on September 29, 2026, when the final beam went onto the twelve-story frame of Moody Children’s Hospital. The joint UT Southwestern–Children’s Health campus spans more than five million square feet on 33.7 acres across from Clements University Hospital: 552 inpatient beds across three towers, a 96-bed Level IV NICU, ninety emergency rooms, two helipads. It is funded the Texas way — operating income, debt, and philanthropy, with no public bonds or taxpayer funds — and the philanthropy is its own headline: four separate gifts of \$100 million or more, from the Pogue, Rees-Jones, Moody, and Stephens Greth foundations. First patients are expected in 2031. Around it, the district keeps building in smaller denominations: Children’s Plano campus tripled to 212 beds with a new tower in late 2024, and the state-funded Texas Behavioral Health Center at UT Southwestern — 292 beds in 456,000 square feet — began admitting patients this past summer.

The public systems build in place

Dallas County’s Parkland and Tarrant County’s JPS are both mid-expansion, and both illustrate the discipline of adding capacity without moving. Parkland is finishing out shell space inside its existing hospital: a \$54 million build-out converting two shelled floors into 112 beds, the first 56 of which opened in June 2026 — deliberately ahead of the World Cup crowds — taking the hospital past 980 licensed beds. In Fort Worth, JPS broke ground in April 2026 on a \$1.5 billion replacement hospital of 740 beds, the centerpiece of a master facility plan whose published budget has climbed past \$2 billion since voters approved an \$800 million bond in 2018. Even the escalation is instructive: in this market, the public systems’ constraint is not permission. It is construction economics.

The land rush: first hospitals follow rooftops

With no need-approval gate, the metroplex’s growth edge gets hospitals at a speed CON states rarely see. Methodist opened Celina’s first hospital in March 2025 — \$237 million, 51 beds on day one, master-planned for more than 300. Baylor Scott & White opened its Frisco hospital at PGA Parkway that July. Texas Health Resources is running the widest suburban program: new hospitals announced or underway in Forney, McKinney, and Willow Park, plus bed towers in Plano and southwest Fort Worth. Medical City Healthcare counts \$1.7 billion of capital investment across five years, including a 90-bed vertical expansion at its Plano campus — Collin County’s Level I trauma center growing straight up. The pattern to notice is expandability as a design principle: beds shelled, towers engineered for vertical growth, campuses master-planned at multiples of their opening size. In a market adding six figures of people a year, the opening-day building is a down payment.

The resilience ledger: water, not watts

Texas facilities teams carry one scar the rest of the country studies. In February 2021, Winter Storm Uri stripped power and water from millions, and post-storm federal reviews found that hospitals’ binding failure was water — dialysis, sterilization, and sanitation stop without it, no matter how well the generators run. The Legislature’s response weatherized the grid itself; a proposed hospital backup-power grant was stripped from the final bill, leaving hospital resilience in Texas substantially an owner-funded discipline. You can see it in the specifications: Cook Children’s new Fort Worth utility plant pairs two independent electric feeds with three 2.5-megawatt generators and a 45,000-gallon diesel reserve. Meanwhile the summer side of the ledger keeps

setting records — ERCOT’s all-time peak demand hit roughly 91 gigawatts during a July 2026 heat wave — making cooling capacity and load strategy permanent design inputs, not afterthoughts. It is the national renovation economy at its most market-driven: build where the people are arriving, build it bigger than today requires, and build it to run when the weather turns — which in North Texas, it reliably does.

Run facilities in the Dallas–Fort Worth area, or design for the people who do? Tell us what we missed — corrections and practitioner quotes are credited by name, by org, or fully anonymously, your choice. We’d rather cite the people who do this work than describe it from outside.

The Hill That Can’t Close: Seattle’s Hospital Core

Source: <https://healthcarefacilityhub.org/seattle-hospital-renovation-design-demand/> Published: October 16, 2026

Seattle’s hospital core occupies a few steep blocks of First Hill — Harborview, Swedish, Virginia Mason — close enough to share a nickname and a skyline. What those blocks carry is outsized: Harborview Medical Center is the only Level I trauma center for a four-state region — Washington, Alaska, Idaho, and Montana — which makes this hill, in a very literal sense, the emergency room for the top-left corner of the United States. Seattle’s facilities story is about what it takes to modernize a campus like that: publicly funded, seismically exposed, chronically overcrowded, and constitutionally unable to close. Here is the demand map.

Harborview: a \$1.74 billion promise, being kept the hard way

In November 2020, King County voters approved a \$1.74 billion bond to expand and modernize Harborview, with more than three-quarters voting yes. The program is comprehensive: a new ten-story inpatient tower with 360 single-bed rooms and an expanded emergency department, a new behavioral health building, renovations across the existing hospital, and seismic retrofits of Harborview Hall and the Center Tower. The county owns the hospital; UW Medicine operates it. A design-build team — Mortenson with Perkins&Will — came aboard in 2025, with specialist partners like the Hermanson–McKinstry joint venture handling mechanical and plumbing design-build, a firm pairing that counts nearly 400 past projects on this one campus. Every phase proceeds inside a working 24/7 trauma center; the program’s own commitment is that the hospital remains fully operable throughout.

The honest math problem

Facilities professionals will respect this program more, not less, for its published difficulty. The King County Auditor’s March 2026 update reported that the tower’s move-in has slipped from late 2028 to at least 2032, and that current cost estimates — the county’s roughly \$2.25 billion, the design-build team’s higher — exceed what the 2020 bond proceeds can deliver, meaning elected officials may have to revisit scope. Permitting and leasing challenges and long construction timelines are named among the causes. This is the defining program-management story in the region: a bond sized in 2020 dollars meeting 2026 construction economics, on a campus whose mission cannot pause while the arithmetic is renegotiated. The work does not stop in the meantime — design continues, infrastructure and enabling projects proceed, and the seismic debt of the existing buildings does not wait for the tower debate to settle.

Seattle Children’s: the research core and the suburban front

The region's pediatric system builds on two fronts at once. Downtown, in South Lake Union, its research institute has grown past 1.1 million square feet, anchored by Building Cure — a 540,000-square-foot research building whose most unusual facility is a GMP manufacturing plant, the Cure Factory, built to produce cell therapies for up to a thousand children a year. That is a building type most hospital facilities teams never touch: a factory, held to pharmaceutical standards, inside a children's research campus. On the main campus, the Janet Sinegal Patient Care Building raised inpatient capacity from 208 to 250 beds. And on the suburban front, Children's is building a \$103 million ambulatory surgery center in Federal Way — three pediatric operating rooms across a dozen specialties, attached to its existing clinic there — with completion expected in late 2027. Specialty pediatrics, decentralized toward where families live: the same pattern the adult systems are running, one childhood at a time.

The thread that ties the hill together

Read together, Seattle's program is a seismic story wearing a capacity story's clothes. The bond's retrofit scope exists because the region's most critical buildings stand in earthquake country, blocks from the fault system that shares the city's name — and because in the region's worst hour, these are the buildings everyone else will need standing. Capacity, behavioral health, research manufacturing, suburban ambulatory growth: every thread in this market eventually runs through a structure that has to survive the day it is needed most. It is the home-metro chapter of the national renovation economy — thirty miles from Houston's floodgates in spirit if not in hazard: build like the disaster is scheduled, because someday it is.

Run facilities in the Seattle area, or design for the people who do? Tell us what we missed — corrections and practitioner quotes are credited by name, by org, or fully anonymously, your choice. We'd rather cite the people who do this work than describe it from outside.

Built to Stay Open: Houston's Hospitals and the Water Line

Source: <https://healthcarefacilityhub.org/houston-hospital-renovation-design-demand/> Published: October 16, 2026

Houston operates the largest medical complex on Earth: the Texas Medical Center, roughly two square miles of hospitals, medical schools, and research institutions packed into one district. But scale is not the interesting part of Houston's story for facilities professionals. The interesting part is what the water taught it. No hospital market in America has resilience engineered as deeply into its buildings, because no market has paid a higher tuition for the lesson. Add a voter-funded, \$2.9 billion safety-net construction program now underway, and Houston becomes two stories at once: how to build hospitals that stay open through catastrophic flooding, and how a county builds care outward toward the people who need it. Here is the demand map.

The tuition: Allison, then Harvey

In 2001, Tropical Storm Allison flooded the Medical Center badly enough to force evacuations and destroy years of research. The district rebuilt itself around the memory. Flood gates — submarine-style doors that seal building entries — went in across the complex, along with elevated electrical vaults, protected generators and pump systems, and an on-site power plant that frees the district from dependence on the city grid. The ground itself is part of the engineering problem: the Medical Center has subsided more than three and a half feet since the 1970s, so new construction plans its elevations against a sinking, flood-prone baseline.

The examination came in August 2017, when Hurricane Harvey dropped more than fifty inches of rain on the region. The flood gates closed, and the Medical Center's hospitals stayed operational. At MD Anderson, facilities teams deployed dozens of flood gates ahead of the storm and the buildings took no flooding, with roughly 550 patients riding out the event in their beds; at Ben Taub Hospital, the county's Level I trauma center, a small ride-out facilities team kept a 444-bed hospital from evacuating at the water's edge. Houston's design standard ever since can be stated in one line: the building is expected to operate through the disaster, not reopen after it.

The public build-out: Harris Health's \$2.9 billion

The second story is rarer in American healthcare — an expansion funded directly by voters. In November 2023, Harris County voters approved a \$2.5 billion bond for Harris Health, the county's safety-net system, with more than 70 percent voting yes; with philanthropy and operational savings added, the strategic capital program totals \$2.9 billion. Its centerpiece is already rising in northeast Houston: a \$1.6 billion, twelve-story hospital on the LBJ campus — about 1.3 million square feet, 390 private rooms with shelled space for sixty more, fifteen operating rooms plus a hybrid suite, and a rooftop helipad — scheduled to open in late 2028. When it does, it becomes the county's third adult Level I trauma center, and the first located outside the Medical Center. The program also renovates the existing LBJ facility, extends the life and capacity of Ben Taub, and adds three community health centers across the county. Harris Health's own framing is demographic: its two main hospitals were built more than thirty years ago, and the county has grown exponentially since.

What this market asks of facilities and design people

Houston concentrates three kinds of demand in one metro. The first is resilience as a permanent discipline: flood gates are maintained systems, ride-out staffing is an operating model, and every renovation inside the Medical Center inherits storm assumptions that designers in drier markets never face. The second is density work — phased construction and systems renewal inside the most crowded medical district in the world, where a crane swing or a shutdown touches neighbors on every side. The third is the decentralizing build-out Harris Health represents: trauma care and hospital capacity moving toward the suburbs and neighborhoods where the population actually grew, the same growth pattern driving new towers in Columbus and new campuses in Northern Virginia. It is Houston's chapter of the national renovation economy — written, uniquely, in water.

Run facilities in the Houston area, or design for the people who do? Tell us what we missed — corrections and practitioner quotes are credited by name, by org, or fully anonymously, your choice. We'd rather cite the people who do this work than describe it from outside.

The Other Building Boom in Data Center Alley: Northern Virginia's Hospital Era

Source: <https://healthcarefacilityhub.org/northern-virginia-hospital-renovation-design-demand/> Published: October 16, 2026

This series began with audience data, so honesty first: Ashburn appeared in our readership numbers largely because of machines — it is the heart of Data Center Alley, and traffic that exits through its networks wears its name. But follow the geography one layer down and the mirage resolves into a real market. Loudoun County, which Ashburn sits in, is one of the fastest-growing counties in the United States, and Northern Virginia's

dominant health system is in the middle of the largest building program in its history. The data centers and the hospitals turn out to be expressions of the same fact: this is where the growth is, and growth has to be cared for. Here is the demand map.

Two hospitals at once: Inova's replacement era

Inova Health System — the Washington region's largest private employer, with roughly 26,000 staff and a budget approaching \$7 billion — is building two hospitals simultaneously, both scheduled to open in late 2028. In Alexandria, a 1.1-million-square-foot medical campus is rising on the former Landmark Mall site: a 192-bed hospital, a cancer center, and a specialty care center, inside a mixed-use district of housing and retail called WestEnd. In Fairfax County, the 110-bed Franconia-Springfield Hospital is going up attached to Inova's existing outpatient HealthPlex. Combined, Inova puts the investment at \$2.5 billion. When both open, the current Alexandria hospital — on its Seminary Road site since 1962, in an institution that dates to 1873 — will close, and its land is expected to be redeveloped around housing.

Read the Landmark project as the era's emblem: a dead suburban mall becoming a hospital campus woven into a residential district. The line between a retail development and a healthcare development has dissolved into a single site plan — the amenity economy and the care economy poured into the same concrete.

Loudoun: the tower that filled up

In Leesburg, Inova Loudoun Hospital recently completed the final phase of a \$300 million master plan: a seven-story, 382,000-square-foot patient tower carrying 228 beds and an expanded NICU, built for a county that keeps outrunning its forecasts. The proof that the growth is real sits in the state's own paperwork. Virginia's health-planning process records that Inova Loudoun's inpatient volumes ran at the highest in the region and exceeded its licensed capacity in 2025 — and earlier this year the regional planning agency recommended approving still more beds there, finding the need immediate. A hospital that just finished a nine-figure expansion is already, on paper, too small. For facilities and design teams, that is what proven future demand looks like: not a projection, a regulator's finding.

Adaptive reuse: the Exxon campus becomes a medical district

The third pattern is conversion. On the 117-acre former Exxon Mobil campus in Merrifield, Inova is renovating four existing office buildings into medical and research uses — including an ambulatory cancer facility and a wet-lab research building side by side — while seeking approval for a first phase of new construction measured in millions of square feet. The campus was famously designed for corporate security, inward and closed; the health system's project leads describe re-envisioning it to let people in. That sentence is the design brief for a whole category of work in this region: suburban office stock, built for a workforce that no longer fills it, being re-cut into healthcare — with the thirty specialty systems a modern clinical building carries threaded through structures designed for desks.

What the work asks of people

Northern Virginia rewards range. The same market asks one team to phase construction on live suburban campuses, another to convert office buildings into clinical space, another to plan a two-hospital activation in 2028 — and underneath all of it, a facilities workforce for a system adding a thousand employees a year. It is the national renovation economy running at the speed of the region's growth, in the one metro where the

audience data's ghost town turned out to be a boomtown. Columbus builds against its growth curve; Northern Virginia builds inside its — data centers to the north, subdivisions to the horizon, and hospitals rising to meet both.

Run facilities in Northern Virginia, or design for the people who do? Tell us what we missed — corrections and practitioner quotes are credited by name, by org, or fully anonymously, your choice. We'd rather cite the people who do this work than describe it from outside.

Four Systems Building at Once: Columbus's Hospital Boom

Source: <https://healthcarefacilityhub.org/columbus-hospital-renovation-design-demand/> Published: October 16, 2026

Most hospital markets have a system that's building and systems that are watching. Columbus, right now, has four systems building at once — Ohio State's Wexner Medical Center, OhioHealth, Mount Carmel, and Nationwide Children's have spent billions across dozens of projects in the region over the past five years, by local reporting's count, with construction running into 2028 and beyond. For the facilities teams who operate these buildings and the design firms who want a share of the work, Columbus is the Midwest's clearest example of growth-driven healthcare construction — the kind powered not by a single flagship but by a whole region adding people. Here is the demand map.

The tower, and the renovation wake behind it

The anchor event landed in February 2026, when Ohio State opened University Hospital: 26 stories, 1.9 million square feet, 820 private rooms, roughly \$1.9 billion, replacing towers that dated to 1951. The opening itself was a facilities operation worth studying — 425 patients moved into the new tower in under eight hours, described at the time as the largest patient move in the country this year. But the durable story for this audience is what a tower leaves behind. The James Cancer Hospital gained 148 beds partly through backfill into vacated space. The old towers were renamed and repurposed rather than retired. And the system promptly turned to the unglamorous layer: tens of millions in infrastructure upgrades at its East Hospital — fire suppression, chillers, a cath lab renovation — running through 2028. Every flagship opening generates a renovation wake. Columbus is now inside one.

The suburban front: two systems, same suburb

Watch Dublin, the northwest suburb, to see the region's strategy in miniature. Mount Carmel opened a \$273 million hospital campus there in April 2025 — emergency department, ICU, operating rooms, imaging, and medical offices on 35 acres. Less than five miles away, OhioHealth broke ground in February 2026 on a \$250 million tower expansion of its Dublin Methodist Hospital, adding two floors and dozens of beds, with completion toward the end of the decade. Note the design detail inside that project: a large share of the new beds are being built as shelled space — constructed now, fitted out later, when the growth they've projected actually arrives. Shelled space is the physical form of a demand forecast, and in Columbus's suburbs, systems are pouring concrete on their forecasts. OhioHealth tells the same story at Pickerington, where it has built a new hospital, and at Powell, where Ohio State opened a \$188 million outpatient center in August 2026 — retail pharmacy, cafe and all.

Destination centers: women's health and cancer

The other Columbus pattern is the purpose-built specialty destination. OhioHealth's largest active project is its \$600 million, 555,000-square-foot Women's Center at Riverside Methodist, on track for 2027 — maternity, NICU, and women's services across the life span under one roof. Its \$226 million comprehensive outpatient cancer center follows in late 2028, consolidating oncology services that were scattered across sites into a single building. Nationwide Children's runs the pediatric version of the same playbook: seven developments on its main campus since 2020, six regional satellite sites, and a \$179 million orthopedic and surgery center opened in 2024. Specialty consolidation is design-intensive work — these are experience-led buildings, closer in spirit to destinations than to wards.

What's underneath: the same boom building the data centers

Columbus's hospital construction is not a coincidence of timing; it is one expression of a regional build-out that also includes the data-center campuses spreading around New Albany and a semiconductor industry arriving at scale. The mechanisms connect: employers and rooftops arrive together, the population skews older as it grows, and every system in the market is positioning capacity ahead of the curve rather than behind it. Dublin Methodist's own case for expansion, stated publicly, is demographic — rapid growth in residents over 65, the segment that uses hospitals most. Facilities professionals should read that as the region's thesis: in Columbus, demand is not the risk. Keeping up with it is.

The work this creates

For facilities teams, the Columbus market rewards two specialties that rarely headline: activation (moving 425 patients in eight hours is a discipline, and this region just practiced it at scale) and the long renovation tail — backfills, infrastructure renewal, and service-line reshuffles that follow every opening for years. For designers and builders, the pipeline is unusually legible: named projects, published budgets, suburban land still available, and four owners building concurrently into 2028 and 2029. It is the growth chapter of the national renovation story, running in a metro better known nationally for logistics and data centers — the same forces, wearing hard hats. San Jose builds against a seismic clock; Phoenix builds against the thermometer. Columbus builds against its own growth curve, and right now the curve is winning.

Run facilities in the Columbus area, or design for the people who do? Tell us what we missed — corrections and practitioner quotes are credited by name, by org, or fully anonymously, your choice. We'd rather cite the people who do this work than describe it from outside.

The Seismic Clock and the Tech Standard: San Jose's Hospital Building Era

Source: <https://healthcarefacilityhub.org/san-jose-hospital-renovation-design-demand/> Published: October 16, 2026

San Jose's hospital market runs on two forces that rarely share a city. The first is a clock: California's seismic compliance regime, with its milestone calendar running to a 2030 completion deadline, which makes hospital construction in this state a legal obligation with dates attached. The second is a standard: this is Silicon Valley, where the workforce and the patients measure every building against the campuses of the tech industry — and where a county government has decided, in public and with bond money, to rebuild its hospital system rather than let it shrink. For the facilities teams who run these buildings and the design firms who want to build them, Santa Clara County is one of the most instructive markets in the country right now. Here is the demand map.

The public system is rebuilding — the state's own data says so

Start with the regulator's numbers. California's Department of Health Care Access and Information (HCAI), which oversees hospital construction in the state, lists roughly fifty active projects at Santa Clara Valley Medical Center alone, with construction costs around \$719 million — at one campus, of one county system. The county's capital program includes seismic upgrades to existing buildings and demolition-and-replacement of others, and its supervisors voted this month to authorize lease revenue bonds financing the seismic and emergency-department work already approved. The state framework behind it is unsentimental: retrofit construction drawings were due this past March, permits by March 2028, completed compliance by February 2030. Seismic work in occupied hospitals is the purest form of the region's construction problem — structural surgery on buildings that cannot stop being hospitals while it happens, sequenced against a statutory calendar.

The Regional chapter: a system integration, in buildings

In April 2025 the county completed its purchase of Regional Medical Center in East San Jose from HCA Healthcare, for \$150 million, and folded the 258-bed hospital into Santa Clara Valley Healthcare as the system's fourth hospital. The clinical story was service restoration — the county returned the hospital to Level II trauma status and brought back stroke and heart-attack care, with maternity care announced to follow. The facilities story is the one this audience should read closely: an acquired hospital is a building program. Systems to standardize, deferred work to triage, an emergency department the county has already moved to expand (it nearly doubled Regional's emergency beds this year), and service lines physically coming back online — each restoration is renovation work in a live building. Acquisitions like this are how a growing share of American hospital construction now begins: not with a groundbreaking, but with a handover.

The tech standard: amenities as competitive surface

The second force is softer and just as real. Hospitals here recruit nurses, techs, and physicians against employers famous for treating workspace as a benefit, and they serve patients who comparison-shop everything. So the amenity layer — real food, coffee that isn't an afterthought, retail and respite space, family accommodation, interiors that feel maintained rather than endured — functions in this market as competitive surface, not decoration. It is design work with an operational tail: amenity space inside a hospital is leased, serviced, ventilated, secured, and kept open for the night shift, which makes it a facilities program too. The firms that understand both sides of that sentence — the experience and the plant behind it — are the ones this market keeps busy.

The shape of the demand

Put the pieces together and San Jose's healthcare construction demand has a distinct profile: seismic retrofit and replacement against fixed state deadlines; a public system executing a multi-campus capital program with public money and public reporting; an acquired hospital being re-integrated service by service; clinic capacity expanding at the edges (the county opened a new public health clinic on the San Jose–Campbell border this fall, framed explicitly as infrastructure for future generations); and an experience standard set by the most demanding building users in America. It is the national renovation economy — systems renewal, technology churn, outward migration — with a compliance clock and a Silicon Valley finish line. Phoenix builds against heat; the Valley of the Sun's boom is thermal. San Jose builds against the earthquake that hasn't happened and the expectations that already have.

For facilities professionals, the career-shaped fact is that the county system is becoming one of the region's great building operators — fifty active projects at a single campus is a program most systems never run. For designers and builders, the demand here is not speculative and not cyclical in the usual way: it is bonded, permitted against deadlines, and published by the regulator. Markets don't usually hand you their pipeline. This one posts it.

Run facilities in the San Jose area, or design for the people who do? Tell us what we missed — corrections and practitioner quotes are credited by name, by org, or fully anonymously, your choice. We'd rather cite the people who do this work than describe it from outside.

Building for 110 Degrees: Phoenix's Hospital Boom

Source: <https://healthcarefacilityhub.org/phoenix-hospital-renovation-design-demand/> Published: October 16, 2026

Two numbers define the Phoenix hospital market. The first is 1.9 billion — the dollars Mayo Clinic committed in March 2025 to expand its Phoenix campus, the largest investment in its Arizona history. The second is 31 — the consecutive days at or above 110 degrees that Phoenix recorded in July 2023, a month that averaged 102.7 degrees and stands as the hottest ever recorded in an American city. Growth and heat: every facilities decision and every design brief in this market is downstream of those two numbers. This is the demand map — what is being built and renovated, what is coming next, and what the people who run and design these buildings are being asked to solve.

The anchor project: Mayo's decade

Mayo Clinic's Phoenix expansion adds roughly 1.2 million square feet to its campus — a new procedural building, a four-floor vertical and horizontal expansion of its Specialty Building, 11 operating rooms, and 48 beds across two new patient units, growing clinical space by nearly 60 percent. First services open as early as 2027; full completion runs to 2031. Mayo's Arizona leadership has been blunt about the driver: demand for its care exceeds its capacity, in a metro that keeps adding people. For facilities and design teams, the shape of the project matters as much as its size — it is a multi-year build on a live destination-medical campus, phased so a hospital famous for complex care never stops delivering it. That is the defining construction condition of this market: building inside a hospital that never closes, at campus scale, for most of a decade.

The public system just moved — and voters funded the next round

Valleywise Health, Maricopa County's public teaching system, opened its new medical center in June 2024: 673,000 square feet, ten stories, replacing a hospital that had served for more than fifty years. The tower houses the county's Level I trauma service and the Diane & Bruce Halle Arizona Burn Center — the state's only verified burn center — and it was funded by a 2014 voter-approved bond measure worth \$935 million. Then, in November 2025, county voters approved another Valleywise measure, Proposition 409, at \$898 million: expand behavioral health services, rebuild and expand the system's community health centers, and replace its Comprehensive Health Center. Read that as a pipeline, because that is what it is — a decade of programmed design and construction work in behavioral health and ambulatory care, publicly funded and publicly scheduled, on top of the replacement tower that just opened.

Heat is a plant specification here

In most markets, cooling is a comfort system with an efficiency argument. In Phoenix it is closer to life safety. July 2023 did not cool down at night — the city went weeks without dropping below 90 degrees overnight, with a warmest low of 97 — which means a hospital’s cooling plant never sheds its load, its thermal mass never resets, and its mechanical systems run at design condition for months rather than hours. Heat is also a clinical input: heat-associated deaths in Maricopa County have set records in seven consecutive years of county tracking, and every heat season arrives in the emergency department as volume. The design consequences are concrete — cooling redundancy sized for a grid under peak stress, envelopes and shading treated as clinical infrastructure, and a standing water question, because evaporative cooling at hospital scale draws on the same Colorado River system the whole region is negotiating over. The firms and plant teams who work this market design for the thermometer first and argue about everything else second.

The rest of the map

Around those anchors, the Valley’s pattern is the national one at higher speed: systems expanding toward the suburbs the growth is actually landing in, ambulatory and clinic capacity spreading across a famously horizontal metro, behavioral health capacity being built with public money behind it, and an aging stock of community-hospital plant reaching renewal age in a climate that is unkind to deferred maintenance. It is the same renovation economy described in the national picture — systems renewal, technology churn, behavioral health, outward migration — with Phoenix’s two multipliers applied: faster population growth than almost any large American metro, and a summer that functions as a stress test no other big city has to pass.

What the work asks of people

For facilities teams, Phoenix work means owning cooling the way Gulf Coast teams own storm readiness: as the scenario the whole plant is organized around, rehearsed before the season, with the failure modes priced in. For the designers and builders assembling bids here, the brief writes itself from the facts above — live-campus phasing at Mayo through 2031, a voter-funded behavioral-health and clinic pipeline at Valleywise, and a climate that turns every envelope and mechanical decision into a clinical one. The demand is not speculative; it is announced, bonded, and scheduled. The open question in this market is not whether the work exists. It is who shows up ready to do it at 110 degrees.

Run facilities in the Phoenix area, or design for the people who do? Tell us what we missed — corrections and practitioner quotes are credited by name, by org, or fully anonymously, your choice. We’d rather cite the people who do this work than describe it from outside.

Benchmarked in Public: Chicago Hospitals and the Performance Standard on the Way

Source: <https://healthcarefacilityhub.org/chicago-hospitals-building-performance-standard/> Published: October 16, 2026

Chicago hospital facilities teams work with a fact most of their peers in other cities don’t face yet: their buildings’ energy performance is already public. Under the city’s benchmarking ordinance, buildings over 50,000 square feet report their energy use every year, and the city publishes the results — which means the energy intensity of nearly every hospital in Chicago is a matter of public record, visible to boards, competitors, journalists, and the consultants who call on all three. And benchmarking is only the disclosure era. A building

performance standard — actual limits, with consequences — has been in active development at the city level, inside a state that has already committed itself, under the Climate and Equitable Jobs Act, to a fully clean energy economy by mid-century.

This is a look at what that means for the teams who run Chicago's hospital plants — the academic medical centers downtown and in the Illinois Medical District, the county system, the community hospitals across the neighborhoods — before the limits land.

Disclosure first, limits next

The pattern is now familiar enough to plan against, because other cities have run it in order: benchmark and disclose, then set limits informed by the disclosed data. New York's hospitals are the live example — Local Law 97 put real emissions caps on New York's hospital stock, fines attached. Chicago's facilities teams have the advantage of watching that movie before starring in it: the questions New York plant teams are answering under deadline — steam, electrification timing, capital sequencing — are the same questions, and in Chicago they can still be answered on a planning horizon instead of a compliance one.

The benchmarking data itself is the first gift. A decade of reported energy use, normalized and published, gives a facilities director something rare: an honest map of where their building stands against its true peers — same climate, same building type, same regulator — before anyone has told them what number they have to hit.

The winter plant problem

Chicago's design condition is cold in a way that disciplines every energy conversation. Heating is not a shoulder-season load; it is the season, and the plant has to carry it through the kind of polar-vortex weeks that test boilers, steam distribution, and freeze protection across an entire campus at once. Electrification math that works in a mild climate gets interrogated here: heat-pump capacity at deep-winter temperatures, the condition of steam systems that have served some of these buildings for generations, and the resilience question underneath all of it — a hospital's heating plant is life-safety infrastructure in a Chicago January in a way it simply isn't in Houston.

That cuts both ways in planning. The buildings with the oldest, least efficient heating plants carry the most risk under any coming standard — and also the most headroom. The cheapest ton of emissions in a Chicago hospital is usually hiding in the steam traps, the simultaneous heating-and-cooling, and the air handlers running 1990s schedules in 2026 buildings.

Density as an asset: the Medical District effect

Chicago also holds a structural advantage few cities can match: the Illinois Medical District, one of the largest concentrations of medical institutions in the country, puts multiple major hospitals within a few blocks of each other on the Near West Side. District energy already runs through this part of the city. For facilities teams, that density turns individual building problems into shared-infrastructure questions — central plants, shared thermal loops, coordinated capital timing — that a lone hospital on a suburban campus has to solve by itself. If a performance standard rewards anything, it will reward the campuses that planned together early.

What the ahead-of-it teams are doing now

The moves showing up in Chicago hospital capital plans share a shape: retro-commissioning treated as a standing program rather than a pre-compliance scramble, because it is the one intervention that pays under every version of the future — disclosed, capped, or merely expensive. Submetering deepened until the benchmarking return is an afternoon's export instead of a month's archaeology. Electrification studied at the level of individual end-of-life decisions — every boiler, chiller, and air handler that comes due gets its replacement decided against the standard that is coming, not just the code that exists. And the benchmarking number itself, Briefed upward: boards that have seen their building's published energy intensity, in context, fund plant work differently than boards that haven't.

The standard is coming; the data is already here

Chicago's hospital facilities teams are in the enviable middle of the story: the disclosure era has already handed them a decade of their own data, the state has declared the direction, and the city's limits are being drafted rather than enforced. The teams that use the interval — measured, retro-commissioned, sequencing capital against the published trajectory — will meet the standard the way New York's best teams are meeting theirs: as a plan they were already executing. The ones who wait for the final ordinance to start will discover what every regulated building learns: the work takes the same number of years either way. Only the starting gun changes.

Run facilities in Chicago? Tell us what we missed — corrections and practitioner quotes are credited by name, by org, or fully anonymously, your choice. We'd rather cite the people who do this work than describe it from outside.

Local Law 97 in the Hospital Plant: New York's Emissions Clock Meets a Building That Never Sleeps

Source: <https://healthcarefacilityhub.org/local-law-97-new-york-city-hospitals/> Published: October 16, 2026

Most New York City hospitals are now regulated buildings. Local Law 97 — the centerpiece of the city's Climate Mobilization Act — sets emissions limits for buildings over 25,000 square feet, which means nearly every hospital campus in the five boroughs, from the academic medical centers of Manhattan to the NYC Health + Hospitals public system to the community hospitals of the outer boroughs. The first compliance period is already running. The limits that bite arrive in 2030. And the people carrying the law are not sustainability officers — they are the facilities and plant operations teams who run buildings that cannot close, cannot pause, and cannot turn the air handling down to save energy during a surge.

This is a look at what Local Law 97 compliance actually involves for the teams who keep New York's hospitals running, and why the hospital version of this problem is different from the office-tower version the law is usually discussed through.

The law, in plant-room terms

Local Law 97 assigns each covered building an emissions limit, calculated from its size and occupancy type, for set compliance periods. The 2024–2029 limits were drawn to catch the worst performers; the 2030–2034 limits were drawn to move the whole stock. Buildings report their emissions annually, and emissions above the limit are fined at \$268 per ton, per year. The law sits on top of two older obligations hospitals already know: annual energy benchmarking under Local Law 84, and the audit and retro-commissioning cycle under Local Law 87.

Hospitals start from a hard place in that arithmetic. A hospital is one of the most energy-intensive building types in any city's stock — ventilation rates driven by infection control, sterilization, imaging, laboratories, kitchens and laundries running around the clock, and no unoccupied hours in which the building gets to rest. The emissions intensity that an office tower reaches only at full occupancy is a hospital's baseline on its quietest night.

The four problems facilities teams are actually working

The steam question. A large share of Manhattan's hospital stock heats with district steam. Steam's emissions factor is part of each building's compliance math, which means a decision made about the steam system — by the utility, or by a hospital weighing conversion — carries regulatory consequences years before it carries comfort ones. Plant teams are modeling both futures: stay on steam and bet on its factor improving, or plan conversions that compete for the same capital and the same shutdown windows as clinical construction.

Retrofits in a building that never empties. The standard efficiency playbook — envelope work, air-handler replacement, controls overhauls — runs into the constraint every hospital facilities director knows: the work happens in an occupied clinical building, under infection-control risk assessment discipline, in phases, often at night. The sequencing problem is the compliance problem. (It is the same discipline that governs any construction inside a live hospital — the ICRA habits that keep a work zone and a care zone separate apply with full force to a multi-year energy retrofit.)

The grid bet. A hospital's reported emissions depend heavily on the carbon intensity of the electricity it buys — and New York State law commits the grid to deep decarbonization over the same decades the law tightens. Electrification decisions made now are, in part, a judgment about how fast that grid actually greens: convert a load to electricity and its emissions fall as the grid's do; keep it on fossil fuel on site and the number is yours forever. Facilities teams are being asked to make thirty-year equipment decisions against a grid forecast.

Capital competition. Every dollar of emissions work competes with clinical priorities — the imaging suite, the bed tower, the code-driven life-safety project that cannot wait. The facilities team's case for early action is arithmetic: the 2030 limits are published, the fine is published, and work sequenced into planned renovations costs a fraction of the same work done as an emergency standalone project. The teams that are ahead on this law are mostly ahead on capital choreography, not technology.

Where hospitals differ from the brochure version

The law provides adjustment pathways for buildings whose emissions profile is shaped by circumstances the standard formula handles badly, and the city's rules for the first period included good-faith-effort provisions for buildings actively working a plan. Hospitals also carry a line item most buildings don't: resilience. The flood barriers, elevated mechanicals, and emergency power investments that followed the city's storm experience are part of the same plant, the same capital plan, and sometimes the same rooms as the emissions work — a combined project can serve both masters, and the good teams are finding those overlaps deliberately.

The quiet work again

Strip the law down and the compliance asset is familiar: submetering that actually gets read, a retro-commissioning cycle treated as maintenance rather than paperwork, load profiles the plant team can recite, and a capital plan where the 2030 limits are a line the CFO has already seen. New York's hospital

facilities teams are working the most demanding version of this law in the country — the densest hospital market, the oldest plant, the least forgiving buildings. What they learn about complying inside a building that never sleeps is what the rest of the country's hospital stock will need when similar laws arrive, as they are arriving.

Run facilities in New York City? Tell us what we missed — corrections and practitioner quotes are credited by name, by org, or fully anonymously, your choice. We'd rather cite the people who do this work than describe it from outside.

Companion piece: This article treats Local Law 97 as a compliance problem; its companion treats it as a machinery problem. Local Law 97 Is a Mechanical Problem works through the plant itself — the ASHRAE 170 ventilation floor, reheat and heat recovery, and the emissions-coefficient math that orders the work.