

Books for Bots - Volume 2: The County Corridor: Puget Sound

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One Hospital, No District: Whatcom County's Single-Tower Bet

Source: <https://healthcarefacilityhub.org/whatcom-county-hospital-construction-design-demand/> Published: October 19, 2026

The bottom line: Whatcom County has exactly one hospital, and it belongs to no one local. PeaceHealth St. Joseph Medical Center in Bellingham — 255 licensed beds, the county's only Level II trauma center — sits outside every public hospital district, in a county where most land is in no district at all. So the largest hospital expansion in the county's history, an 80-bed pavilion with a state-approved capital budget of \$336 million, is being financed the old way: from reserves and gifts, including \$50 million from a single donor. The piles for it are being drilled eighty feet into the Squalicum hillside this fall, beside an emergency department that has run ten to eighteen points above its target occupancy for the better part of a decade, while the hospital stays open

around the work. For the facilities, design, and construction teams who read this corridor, Whatcom is the control case: what a hospital town looks like when there is no district, no bond, and no second hospital to catch the overflow.

Whatcom County, at a glance	Figure
Licensed hospitals	One — PeaceHealth St. Joseph Medical Center, Bellingham (state license 145), founded 1891. Level II trauma, Level II neonatal, open-heart surgery.
Hospital districts	Effectively none for the hospital. Most of the county is in no district; the footprint is a clinic district in Point Roberts and a 28-voter sliver of a Skagit County district in the east county.
The project	Peter Paulsen Pavilion — six stories, 120,000 square feet, 80 beds, all private rooms, rooftop helipad. Certificate-of-need capital: \$336,323,637, from reserves and philanthropy. Piles began September 2026; public opening 2028.
The pressure	Acute beds fixed at 207 for over twenty years while county population grew past 230,000. The hospital's own state filing puts midnight occupancy 10–18 points above the 70% target since at least 2017–18; 72,223 emergency visits in fiscal 2025.
The exclave	Point Roberts: a voter-created district that taxes itself about \$300,000 a year to subsidize a clinic in a fire station, on a peninsula reachable by land only through Canada.

The district that isn't

Every other county in this corridor organizes its hospital map around public hospital districts. Whatcom mostly doesn't have one. The county's taxing-district roster names two: the Point Roberts Public Hospital District, and Skagit County Public Hospital District No. 304 — its neighbor's landlord district, which reaches into East Whatcom far enough to hold, by the county auditor's count, 28 registered voters. St. Joseph answers to neither. When Cascadia Daily News walked the county through its district geography in 2025, the story was absence: a council member and an advocate arguing for a new district, and the procedural fact that one cannot simply be drawn over the whole county by council action, because two districts already exist — a new one requires a petition of ten percent of the voters in the proposed area. The Association of Washington Public Hospital Districts' own director adds the quieter problem: fewer than 35 percent of the people who live in hospital districts know that they do.

Point Roberts is the exception that proves the geography. The exclave — American soil you reach by road only through Canada — voted in February 2005 to create a district not to build a hospital but to keep a clinic. The district contracts with the local fire district for space, so the clinic shares the fire station, and contracts an operator, currently SuperTrack Urgent Care, to staff it. Before the clinic existed, residents crossed an international border to reach American care in Blaine, 25 miles away, or Bellingham, 50. The economics are miniature and unsparing: a levy of about 28 cents per \$1,000 raising on the order of \$300,000 a year — 94 percent of the district's 2024 revenue was taxes — against clinic costs of about \$500,000 a year and patient revenue of a little over \$200,000. The district has never passed a levy increase. In August 2025 it more than doubled the operator's monthly subsidy, from \$16,000 to \$36,000 for the rest of the year, and its commissioners are aiming a levy lift at a future ballot, arguing in public that a provider should make a small profit rather than subsidize the district. District 304's single Whatcom precinct, meanwhile, cast seven ballots in August 2026 —

3 for, 4 against that district's levy lift — which failed across both counties, 45.42 to 54.58 percent. That district's story belongs to Skagit; its Whatcom footprint is a reminder that district lines were drawn for another century's map.

One hospital, running hot

St. Joseph is the sole acute-care hospital for Whatcom County — and, on its own state filing, the primary hospital for San Juan County and the hospital of choice for about 13 percent of Skagit County residents and 27 percent of northern Skagit. PeaceHealth's fiscal 2025 fact sheet counts 255 licensed beds, 3,618 caregivers, 15,944 inpatient discharges, 1,886 births, 9,967 surgeries, and 72,223 emergency visits, with quality marks of a CMS four-star rating and a Leapfrog A. The hospital was founded in 1891 by the Sisters of St. Joseph of Peace — the first hospital their order founded — and it carries the county's only Level II trauma program, a Level II neonatal unit, elective heart-catheter procedures, and open-heart surgery.

The pressure is documented in the hospital's own certificate-of-need application. Its acute-bed complement stood at 207 for more than two decades while the county's population grew by more than a third. The state's target midnight occupancy for a unit that size is 70 percent; the application says St. Joseph had run 10 to 18 points above that at midnight since at least 2017–18, and higher at midday. When the hospital is full, the filing names the next higher-level hospital: Providence Everett, 64 miles and 71 minutes away in normal traffic — described in the same document as also full, with ambulance diversions reaching Seattle. Chief Executive Charles Prosper, at a community meeting the city requires, put the emergency department's position in one sentence — “We realized that our emergency department is very, very busy” — and credited a new triage system with cutting the average time to a physician to twelve minutes. There is no relief valve in this county. There is one door, and the county, two neighboring counties' worth of patients, and an international border all use it.

The pavilion: reserves, gifts, and eighty feet of piles

The Peter Paulsen Pavilion is how a hospital with no district pays for growth. The Department of Health's certificate, issued in March 2025 after an intent-to-issue held for environmental review, approves \$336,323,637 of capital for 80 additional acute beds, financed by reserves and philanthropic gifts. The application separates another \$64.8 million of work — the parking garage, the central utility plant, the emergency-department renovation — from the certificate's accounting, putting the applicant's all-in program at about \$401 million. The philanthropy is concrete: \$74 million counted toward the project, half of it and more from Peter Paulsen, the Hotel Bellwether developer who died in 2024 and whose name the building carries, within a broader campaign that raised \$103 million. No ballot measure appears anywhere in this capital stack. The voters who decided hospital levies in every other corridor county were never asked about this one.

What the money buys is a six-story, 120,000-square-foot pavilion — designed by Savely Healthcare Architects, built by Turner Construction — with a unified emergency department replacing a split one, advanced inpatient floors, two floors for women's and children's services, and a rooftop helipad, so Airlift Northwest patients come straight down into the building instead of landing on a ground pad and riding an ambulance across campus; Coast Guard aircraft keep the ground pad. Every new bed is a private room. PeaceHealth puts the end-state capacity at 320 beds — the figure its chief executive calls the capacity “for the next 10 or 20 years.” The sequence is already well advanced: the central garage opened in June 2024 with more than 600 stalls, free parking, and, by PeaceHealth's account, 90 percent local subcontractors and more than \$16 million spent with

Whatcom and Skagit businesses; the planned-development permit followed in January 2025; the certificate in March. The west entrance closed that July, making the East Tower the front door. This past August the old front entrance came down and a new cooling tower was set on the roof; in September, mass excavation and pile installation began, with pilings drilled as far as eighty feet and Turner extending its four-day week to Fridays through the noisy stretch. On the hospital's published plan, 73 tower beds are licensed by the end of June 2027 — obstetrics, postpartum, pediatrics, cardiac, medical-surgical — the pavilion opens to the public in 2028, the consolidated emergency department comes online that year, and the emergency-department expansion and renovation follows.

All of it happens inside a working Level II trauma center, and the construction log reads like an operations manual: 33 emergency-department stalls closed since May for stormwater infrastructure, for the rest of the project; a temporary fire egress marked across the cafeteria floor; pedestrians rerouted; a courtesy shuttle between parking and the East Tower entrance on weekday hours; valet parking improvised when 18 more ED spaces closed in July; and, during pile driving, ear plugs, earmuffs, and white-noise machines offered to patients and visitors. The hospital is also hiring for the work — its Bellingham design-and-construction requisitions ask for experience with the Department of Health's Construction Review Services and with CMS and DNV jurisdiction. The pavilion's CRS file has been open since February 2023. In Whatcom, as everywhere in this corridor, the certificate is permission to start the conversation with the reviewers, not the end of it.

Surgery spreads out, and the safety net builds its own system

The hospital's operating rooms told the same story as its beds. PeaceHealth told the state its eight mixed-use rooms ran at 118 percent of capacity in 2021, producing "scheduling delays and bumped cases." Two hospital rooms were added in 2023, and that July the state approved PeaceHealth's own six-operating-room ambulatory surgery center on Squalicum Parkway — \$12.5 million of approved capital, in the building Pacific Rim had occupied until its lease was not renewed and it closed that August. The endoscopy service consolidated onto the campus street in July 2026, into the Mt. Baker Imaging building with three rooms, and by September the state had logged a cost-overrun amendment on that certificate — the amount unpublished, the direction familiar. Around the hospital stands a genuinely independent layer: Family Care Network, owned by its own providers, with clinics from Blaine to Lynden and a family-medicine practice on the hospital campus itself; North Cascade Cancer Center, a free-standing radiation-oncology center built, on its own history, because the local hospitals could not meet the need; Proliance's Bellingham surgery center, accepting patients since February 2025; dialysis in Bellingham and Ferndale.

The second capital system in the county is public and tribal, and it is behavioral. The county's Anne Deacon Center for Hope, opened January 2021 on Division Street, holds 32 crisis beds — 16 mental-health beds run by Compass Health, 16 withdrawal beds run by Pioneer Human Services — and the county's 2023 count shows it busy but not full, with the hospital a major referral source. Beside it, the county designed a 23-hour crisis relief center in unusual detail — 24,000 square feet, recliner bays instead of beds, no-refusal, stays capped at 23 hours and 59 minutes — and then paused it in early 2025, with under \$40,000 spent, while operating money is sorted out and the legislature blesses folding it into a combined behavioral care center on the jail project's Hannegan Road site, itself out to a progressive design-build solicitation under the same public-works statute the hospital districts use. On the Lummi Reservation, the tribal health center that opened in June 2024 was joined this August by a 16-bed secure withdrawal and stabilization center — the first tribally owned and operated withdrawal facility on tribal land in Washington, funded by \$23 million of state commerce money, \$10.6

million from the Indian Health Service, and \$4 million from the Lummi Nation, with admission priority for Lummi members, then other tribal members, then everyone else. “We want to be a healing campus,” the Lummi chairman said when the health center opened. And the county’s safety-net clinic, Unity Care NW, is holding its own 90,000-square-foot campus remodel in a stated “holding pattern” — its new chief executive told the county’s paper in October that Medicaid is about 60 percent of its patient mix and that patients who lose coverage “don’t get care until they end up in the emergency department.” The door she means is the one under construction.

The amenity economy: a public cafeteria, a volunteer gift shop, a negotiated hotel rate

St. Joseph’s ground-floor cafeteria is one of the few genuinely public rooms in this county’s hospital system: open to families, visitors, and the public, 6:30 in the morning to 7 at night every day, grill and salad bar and made-to-order sandwiches. The espresso bar runs weekdays to 8. After that, the overnight layer is what it is everywhere in this corridor — vending machines, placed with some care: by the cafeteria, in the emergency-department lobby, off the East Tower lobby, in the Childbirth Center lobby. The Gift Nook by the main entrance is run by the Central Auxiliary, a volunteer group raising money for patient equipment; volunteers will deliver a purchase to a patient’s room during shop hours, and the shelves mix flowers and Seattle Chocolates with the sundries people actually forget — phone chargers, toothbrushes, shampoo. Spiritual care answers around the clock, for any faith or none. For surgical families, a guest services coordinator works the East Tower lobby — visiting before surgery, relaying delays, walking families to the surgeon’s post-operative conversation — in a lobby stocked with coffee, cocoa, magazines, and board games.

Lodging is published with unusual candor. PeaceHealth prints its own list of nine properties with distances and the rates to ask for: the Rodeway Inn at 1.4 miles, the Oxford Suites at 1.8 with a PeaceHealth rate, the Holiday Inn Express at 2.2 with a corporate rate, the SpringHill Suites at 3.1 with a “medical compassion rate.” None of the nine is on campus; all sit on the Guide Meridian and Lakeway commercial strips. The same list tracks each property’s distance to the Whatcom Hospice House — which is itself the county’s most considered family product: twelve beds on Douglas Avenue, every room with a ceiling lift, individual climate control, a mini-fridge, and doors wide enough to roll the bed or recliner onto a private patio; day beds and storage built in so a family can simply stay; a family room with a fireplace; a laundry; a sanctuary; care sustained by a foundation committed to providing it regardless of ability to pay. And on the Lummi campus, the amenity brief is written in another language entirely: a health center built in the form of a cedar log house, a stream with salmon statues running through it, a wall of native plants, a stand for fresh produce, drop-in daycare for the children of staff and patients — and, at the withdrawal center next door, cedar, high ceilings, views to planted ground, and a healing room. The pavilion will eventually join this list on its own terms: private rooms, one emergency department, a helipad on the roof. In Whatcom the amenity economy is not a retail strategy. It is a set of decisions — about patios, volunteers, negotiated rates, and salmon — made by the institutions that happen to be standing there.

Drivers: one planning area, a border, and a lake

Whatcom is its own hospital planning area under the state’s certificate-of-need law, which means the pavilion’s charity-care condition was benchmarked against the Puget Sound region’s 25 hospitals — a calculated average of 1.40 percent of gross revenue in the evaluation’s own table, printed as “140%” in one condition letter, a

document error worth more than a laugh to anyone pricing compliance. Bellingham’s code package, in force since March 2024, is the 2021 state suite with published structural defaults a design team can hold in one hand: Site Class D, Risk Category IV wind at 109 miles per hour — St. Joseph, with surgery and emergency treatment, is a Risk Category IV essential facility — 20 pounds of snow, twelve inches of frost, 2,000 pounds per square foot of assumed bearing unless a soils report says better. Outside the city, the county’s clinic-scale regime takes over, with extra stormwater rules in the named watersheds. Water is a design input here, not a backdrop: about half the county drinks from Lake Whatcom, drawn through a 1,200-foot wooden pipeline to a 24-million-gallon-a-day plant, supplemented by a glacial river diverted through a tunnel under a mountain — and the pavilion job has already spent a season installing stormwater infrastructure beside a creek whose shoreline plan describes hospital zoning, high-runoff soils, and buffers fifty feet and wider.

The border is the last driver, and it runs both directions. Washington’s Apple Health will pay enrolled British Columbia providers for Point Roberts residents, and for border communities when the Canadian provider is closer and no American provider is within 25 miles — public money following patients across the line, in U.S. dollars. Inbound, KOMO News has reported British Columbia doing the same in reverse, earmarking funds to send cancer patients to Bellingham’s two radiation centers, North Cascade and the hospital’s own; the reporting is undated in the record reviewed here and its current status could not be confirmed, but the planning implication stands either way — this county’s cancer capacity has a foreign payer in its history. Meanwhile the county’s east end, 15,135 people across 649 square miles of the Mount Baker foothills, is the state’s first Rural Health Equity Zone, where residents asked for access, transportation, and environmental safety — and where the live district proposal on the table is a clinic lease, not a tower. Bellingham’s bet is concentration: one hospital, grown once, properly. The county around it is making the opposite bet in small pieces.

What this means for design and construction teams

Price the client correctly: there is no district here, no bond calendar, no commission vote — the owner is a regional system paying from reserves and named gifts, which changes everything about how decisions get made and how philanthropy shows up in the program (a donor’s name on the pavilion, a grocer family’s name on the emergency department). The work on the table is occupied-site major construction at a Level II trauma center — piles beside a live emergency department, egress redrawn through a cafeteria, stormwater built in the ED’s own parking lot — plus a county behavioral-health pipeline that runs on public procurement and a tribal campus setting the region’s design standard for culturally specific care. The firms in the record, Savely and Turner on the pavilion and Abbott on the garage, won work that rewards phasing discipline over renderings. And read the state’s file before the press releases: the certificate, the construction log, and the community-meeting transcript together contain the occupancy math, the bed phasing, and the chief executive’s own account of what federal cuts might do to the schedule. In a one-hospital county, all of it is public, and all of it matters.

Frequently asked questions

How many hospitals does Whatcom County have?

One. PeaceHealth St. Joseph Medical Center in Bellingham is the county’s only licensed hospital (state license 145): 255 licensed beds on PeaceHealth’s fiscal 2025 fact sheet, Level II trauma, and the primary hospital for San Juan County and much of northern Skagit County as well.

Why isn't St. Joseph in a public hospital district?

Because most of Whatcom County was never organized into one. The county's only district footprints are the Point Roberts clinic district and a 28-voter sliver of Skagit County's District 304 in the east county. Creating a new district would require a voter petition; the hospital's \$336 million expansion is therefore financed from PeaceHealth's reserves and philanthropy rather than a district bond.

What is the Peter Paulsen Pavilion?

A six-story, 120,000-square-foot addition to St. Joseph — 80 beds, all private rooms, a unified emergency department, two floors for women's and children's services, and a rooftop helipad. Pile installation began in September 2026; the first tower beds are planned to be licensed by the end of June 2027 and the pavilion opens to the public in 2028, taking the hospital to a capacity PeaceHealth puts at 320 beds.

What happens when St. Joseph is full?

On the hospital's own certificate-of-need filing, the next higher-level hospital is Providence Everett, 64 miles and about 71 minutes away — described in the same filing as also full, with ambulance diversions at times reaching Seattle. That single-door geography is the core of the expansion case: acute beds had been fixed at 207 for over twenty years while the county grew by more than a third.

What does the Point Roberts hospital district actually fund?

A clinic, not a hospital. The district — created by voters in 2005 on the exclave reachable by land only through Canada — leases space in the fire station and subsidizes an operator, currently SuperTrack Urgent Care, on a levy of about 28 cents per \$1,000 that raises roughly \$300,000 a year against clinic costs of about \$500,000. It has never passed a levy increase.

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 Whatcom County 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.

Three Districts, Three Different Deals: Skagit County's Hospital Map

Source: <https://healthcarefacilityhub.org/skagit-county-hospital-construction-design-demand/> Published: October 19, 2026

The bottom line: Skagit County is the rare American county where the hospitals still belong to the public — and where “the public” turns out to mean three different governments running three different deals. One district operates a 137-bed hospital in Mount Vernon and, with the same tax base, a second hospital and a new medical building in the next county. One runs a 43-bed hospital on an island, on a levy its voters raised in 2025, under a state payment law written in 2026 whose geographic clause describes exactly one hospital in Washington. And one owns a hospital campus in Sedro-Woolley that it leases to PeaceHealth, while asking its voters — unsuccessfully, this August — for prevention money it promised would never touch the hospital at all. No Seattle system has a hospital in this county. For the facilities, design, and construction teams who work here, Skagit is the corridor's clearest look at what public ownership actually builds: a surgery center designed to empty a hospital's operating rooms, a kitchen older than the interstate, a chiller still running on a retired

refrigerant, and an amenity economy that closes at seven.

Skagit County, at a glance	Figure
Public hospital districts	Three — No. 1 (Skagit Regional Health, Mount Vernon), No. 2 (Island Health, Anacortes), No. 304 (United General District, Sedro-Woolley). An operator, a levy hospital, and a landlord.
The hospitals	Skagit Valley Hospital, 137 licensed beds · Island Health, 43 licensed beds · PeaceHealth United General, 25-bed critical access (35 beds facility-wide with its rehabilitation unit).
The 2025–26 votes	Island Health's levy lift passed in April 2025 (34¢ -> 75¢, about \$4 million a year). District 304's first levy increase since about 1965 failed in August 2026, 45.42% to 54.58%.
The signature project	The Mount Vernon Surgery Center — 60,000 square feet, opened December 2023, built to “decant” the hospital's over-capacity operating rooms rather than rebuild them in place.
The law	Chapter 84, Laws of 2026 (SSB 5923): cost-based Medicaid payment eligibility for a critical-access hospital “located on an island operating within a public hospital district in Skagit county.”
Metro systems present	None. No MultiCare, Providence, UW Medicine, EvergreenHealth, Overlake, or Valley hospital operates in the county (state hospital-association map).

Three districts, three different deals

District No. 1, Skagit Regional Health, is the operator. A municipal corporation with a seven-member elected board, it runs Skagit Valley Hospital in Mount Vernon — opened in 1958, expanded in 2007, licensed for 137 beds — where its federal cost report for fiscal 2024 counts 44,593 inpatient days against 50,142 bed-days available, an occupancy the arithmetic puts near 89 percent, alongside 36,760 emergency visits and nearly half a million outpatient clinic visits across the system. The same district staffs pediatric hospitalists around the clock through partnerships with Seattle Children’s and UW Medicine, runs a rural health clinic on Camano Island, and since 2016 has operated Cascade Valley Hospital in Arlington — another county’s district hospital, held on a 30-year lease at ten dollars a year. Its audited statements describe a system with \$690.5 million in operating revenue that claims, in its own strategic language, market dominance in Skagit County and growth drawn from three counties’ population.

District No. 2, Island Health, is the levy hospital. Its boundaries are islands — Fidalgo, Cypress, Guemes, Sinclair — governed by five elected commissioners, and its 43-bed hospital in Anacortes (six intensive-care beds, six labor-and-delivery, thirty-one medical-surgical, by its own fact sheet) is the closest acute-care hospital for many residents of San Juan County, where it also runs a primary-care clinic on Orcas Island. District 304 is the landlord: formed in 1966 by merging the Sedro-Woolley and Burlington districts, it is the county’s largest district by land — more than 2,000 square miles reaching into Whatcom County, overlapping the Upper Skagit, Sauk-Suiattle, and Swinomish tribal communities — and it owns the United General campus while PeaceHealth has run the medical services since 2014. The district is explicit that levy money stays with the district. PeaceHealth does not get it.

Anacortes compresses the whole arrangement into one campus map. Island Health’s own 2025 map shows Skagit Regional Health’s cardiology clinic inside its M Avenue building; PeaceHealth keeps a cardiology clinic

across town whose directory entry names Bellingham, in the next county, as its nearest hospital. Three systems share one island's patients, parking, and medical staff — and none of them is the tertiary center. Transfer relationships and ambulance time are part of every facility program here, because the high-acuity bed is never on campus.

Mount Vernon: the decant

The county's signature capital decision was a refusal. Skagit Valley Hospital's six mixed-use operating rooms were running above the state's capacity standard — “bumping, delays and rescheduling are common,” the district told the Department of Health, and the shortage was limiting surgeon recruitment. The conventional answer, a new surgical department inside the hospital, was also the most expensive: the district priced surgical space above \$1,200 a square foot, before counting the infection-control risk of building inside a working department. So the district's 2021 certificate-of-need application proposed the opposite — to *decant* the hospital, moving outpatient surgery into a separate building and letting the hospital's rooms breathe.

The state approved it on April 1, 2022, with a charity-care condition pegged to the regional average, and the structure of the deal is as instructive as the medicine. The district did not build the building. A developer built a three-story, 60,000-square-foot medical office building on land zoned for health care within 250 yards of the hospital, and the district's \$23,367,584 of approved capital bought the surgery center's equipment, technology, and fit-out from its own reserves. BNBuilders built it; Zervas Group designed it. The Mount Vernon Surgery Center opened on December 12, 2023 — four operating rooms, three endoscopy suites, a procedure room, imaging, 62 exam rooms — on time and on budget, by the district's account, after an open house that drew an estimated 700 people. The district then exercised the same playbook downtown: Station Square, a 30,000-square-foot medical office building on South 5th Street that opened under lease in January 2023, it bought outright in April 2024 for \$26.4 million, funded with a \$75.2 million revenue-bond issue that also equipped the surgery center and seeded a third building — a 30,000-square-foot medical plaza now under construction beside Cascade Valley in Arlington, in partnership with that hospital's Snohomish County district, due to open in fall 2027. A Mount Vernon district is exporting its model down the corridor.

The surgery center is still being tuned. In 2026 the district bid two interior conversions there: a 375-square-foot pain procedure room becomes a fifth operating room — medical-gas piping, a ceiling boom, sprinkler and fire-alarm revisions, and the same visible-light continuous disinfection system the original operating rooms were specified with, extended rather than treated as a one-time experiment — and a conference room becomes a third x-ray room. Both solicitations closed over the summer; the district's public record does not yet say who won them.

The back-of-house decade

If the surgery center is the county's front of house, its 2026 bid list is the back of it — and the back of house at Skagit Valley Hospital is mid-century. The hospital's own blog, announcing a kitchen renovation this spring, says it plainly: “much of our kitchen infrastructure dates back to the 1950s.” From June 1 to October 1, 2026, on the hospital's announced schedule, the Skagit Bistro closed while the back-of-house equipment was replaced and the workflow rebuilt for more cooking capacity. Patient meals kept coming — from temporary kitchen units. Everyone else ate from an improvised amenity economy the hospital assembled in public: a “San Juan Market” of grab-and-go and heat-and-eat meals in a conference room, refrigerators branded Bistro Express at three locations, food-truck days, and an expanded coffee counter.

The rest of the plant list reads the same way. The MRI renovation, bid in 2025, removes the existing magnet and cranes an owner-furnished Siemens 1.5T scanner in through a removable concrete roof panel the building was considerate enough to be built with — replacing the dedicated rooftop chiller and the raised access floors on the same pass. The south-campus cooling-plant solicitation, which closed October 1, retires an air-cooled chiller still running on R-22 — a refrigerant whose production era ended years ago — for a water-cooled machine, with new pumps, refrigerant exhaust fans, and a building-automation upgrade. The kitchen ventilation job replaces the hood, exhaust, and make-up air, and the plaster-and-tile ceilings above them. None of this is a tower. All of it is the actual capital program of a hospital whose last expansion opened in 2007: equipment-era infrastructure, replaced one solicitation at a time, in a building that does not close.

Anacortes: the island hospital and the law written for it

Island Health asked its voters first, and its voters said yes. In April 2025, in a special election with turnout near 48 percent, the district’s Proposition No. 1 passed 4,975 to 4,129, lifting its maintenance-and-operations levy from 34 cents to the 75-cent statutory ceiling — about \$4 million a year for equipment, facility improvements, and specialty care. Chief Executive Elise Cutter’s case was arithmetic: operating costs up 21 percent since 2020, against Medicare, Medicaid, and Tricare rates that had not kept pace. Taxpayers supply only about 3 percent of the hospital’s revenue; the levy is small money with an outsized job, and the hospital has published exactly what it is buying. A dedicated cesarean operating room inside the Island Birth Center, built into an existing courtyard for about \$1.6 million — in 2024 the hospital performed 119 cesarean sections, 44 of them urgent or unscheduled, each one displacing the main operating schedule. An endoscopy renovation at about \$4 million, tied to a full-time gastroenterologist and colon-cancer screening capacity. And about \$9.8 million to gather orthopedics, sports medicine, physiatry, physical therapy, and imaging — today, in the hospital’s words, “dispersed across campus due to space constraints” — onto one floor of the 25th Street Building.

Then the state wrote a law for this island. Substitute Senate Bill 5923 passed the Senate 49–0 and the House 96–0, was signed on March 17, 2026, and took effect June 11. As codified, it makes a critical-access hospital eligible for cost-based Medicaid payment if the hospital “is located on an island operating within a public hospital district in Skagit county.” The Senate’s own bill report states that the only hospital meeting that geographic description is the one in Anacortes. The open question is equally plain in the record: the federal critical-access test the bill report restates caps a hospital at 25 acute beds, Island Health’s own fact sheet lists 43 licensed beds, and nothing in the public record reviewed for this piece shows a federal critical-access certification for the hospital. A legislature has aimed a payment statute at a single 43-bed island hospital; how the designation gets reconciled is a facilities-and-finance story still being written, and anyone planning capital on Fidalgo Island should be reading it as it develops.

Sedro-Woolley: the landlord, the swing beds, and the no

PeaceHealth United General is a study in proportions: a 25-bed critical-access hospital whose own fact sheet reports an average daily census of seven — and 16,699 emergency visits a year. The emergency department is the region’s front door for the upper valley, from Sedro-Woolley and Burlington to Concrete and Marblemount; the inpatient census is a small town. In March 2026 the state approved the hospital’s request to let all 25 of its acute beds swing between acute and post-acute care, up from 15, with its separate 10-bed rehabilitation unit unchanged and no construction involved — the hospital asked, in its application’s words, for “maximum flexibility within our acute care/swing bed programs to manage fluctuations in census and patient

acuity/eligibility,” and the permission was the project.

Three months later the landlord asked its own question and lost. District 304’s Proposition No. 1, on the August 2026 primary, proposed lifting a levy unchanged since about 1965 — 9.42 cents — to 50 cents, for nutrition, youth, senior, family, and mental-health programs run by the district itself, with the district repeating that none of it would fund PeaceHealth’s hospital operations. The estimated take was about \$5.4 million a year, about \$17 more a month on a \$500,000 home. It failed, 45.42 to 54.58 percent. Island Health’s hospital-operating levy had passed the year before; District 304’s prevention levy, argued on the instability of state and federal grants, did not. The corridor’s two 2025–26 Skagit verdicts are the honest summary of what voters here will fund: the hospital, yes; the programs around it, not yet.

The parallel campus

Count only the three hospital licenses and you miss where much of Skagit’s care actually happens. On March Point in Anacortes, the Swinomish Indian Tribal Community’s didgwalic Wellness Center opens at 5:30 in the morning — substance-use and mental-health counseling, primary medical care, psychiatric medication management, methadone and other medication-assisted treatment, dental services, transitional housing — with more than 150 staff, serving tribal and non-tribal patients alike, with sister sites in Concrete and La Conner. Sea Mar runs a Mount Vernon campus of medical, dental, pharmacy, and maternity-support services plus women’s, substance-use, and mental-health clinics, and a clinic upriver in Concrete. The Upper Skagit Tribal Clinic anchors chemical-dependency care in Sedro-Woolley. And in August 2026, Pioneer Human Services opened a crisis stabilization center on State Route 20 in Sedro-Woolley for adult detox and residential co-occurring treatment, with mental-health crisis stabilization to follow — while the county itself solicited architects to convert its 1988 crisis center in Burlington into temporary housing. Island Health’s own community health needs assessment records why this layer keeps growing: 87 percent of its stakeholders called behavioral-health access a significant need, and about 60 percent said the same of primary care, with waits described at three to six months.

The amenity economy: dinner ends early in the tulip valley

Skagit’s hospitals feed people well, briefly, and early. The Skagit Bistro serves weekdays from 7 to 7 and weekends from 9 to 4; the Whidbey Coffee counter by diagnostic imaging opens at 6 on weekdays. The gift shop in the front lobby is run by volunteers to raise money for equipment and programs, and it is open three days a week, four hours a day — Tuesday through Thursday, 10 to 2. That is not a criticism; it is the county’s amenity economy in one datum: staffed by neighbors, open when the neighbors can staff it. Families staying longer improvise, the way the hospital itself did during the kitchen closure. The hospital names no hotel — visitors are “within minutes of several hotels in Mount Vernon and Burlington, just off Interstate 5” — and the one property that publishes its own distance, the Hampton Inn & Suites in Burlington, puts itself four miles away and competes on the free hot breakfast the hospital’s weekend bistro, closed until 9, is not serving at six in the morning. There is no hospital inn and no Ronald McDonald House in Mount Vernon.

What the county does spend on, it spends on the clinical rooms families actually wait in. The Family Birth Center’s 21 private rooms each carry a jacuzzi tub, a private bathroom, aromatherapy and nitrous oxide among the comfort measures, a host who takes meal orders in the room, and visiting hours the hospital does not restrict. The surgery center’s waiting spaces were designed with windows, calming colors, and cleanable materials, and its gastroenterology lead described the mission as “not only to diagnose and treat, but also to

enhance the overall patient experience.” The cancer program’s current services run to patient navigators, dietitians, and social workers. In Sedro-Woolley, the Coho Cafe serves weekday breakfast and lunch — scratch-made soups, mostly gluten-free — under a culinary manager and sous chef the hospital names on its own page, who buy produce, cheese, meat, and fish from within a 50-mile radius when they can; this is the one hospital kitchen in the corridor that treats the surrounding farm economy as a supply chain. The Gift Nook beside it keeps weekday hours of 11 to 3. And the district that owns that campus runs its own fitness center next door at 2015 Hospital Drive — fifty-plus programs, staff certified for people with chronic conditions — an amenity held on the public side of the PeaceHealth lease. On Fidalgo Island, the Island Bistro sits on the hospital’s main level beside the chapel; the hospital publishes no hours for it at all, which families discover the way they discover the Guemes ferry schedule — because in District No. 2, some of the people planning around a hospital stay are also planning around a boat.

Drivers: permission, water, and three feet of freeboard

The regulatory stack here is specific enough to plan around. Certificate of need gates the services — the surgery center’s approval carried a charity-care percentage; the swing-bed approval carried a condition that any change is a new project; the hospital’s next service line, a special-care nursery growing from three beds to eight, exists so far as a letter of intent on the state’s project list. Department of Health construction review sits over every hospital alteration of \$500,000 or more, infection-control risk assessment and interim life-safety plan included, and the district’s projects are bid as public works — the bid list itself is the county’s most honest capital document. Mount Vernon has adopted the 2021 state codes and energy code and publishes Seismic Design Category D1; its flood code classifies hospitals as critical facilities that belong outside the base floodplain, and if no feasible site exists, with their lowest floor at least three feet above base flood elevation and their access routes elevated to match — in a city that warns owners that many of its properties sit in the 100-year floodplain. The state’s Clean Buildings calendar reaches the new buildings on published areas: the 60,000-square-foot surgery center falls in the June 1, 2028 Tier 1 band, and 30,000-square-foot Station Square in the July 1, 2027 Tier 2 band, if each is covered and not exempt. And underneath everything is water law: the state’s instream-flow rule for the Skagit basin bars new uses that impair the river’s flows — and expressly excludes the islands, whose city treats its drinking water at a plant on the river in Mount Vernon. A facilities plan that ignores the flood code, the flow rule, or the bid list will misunderstand this county; one that reads all three will not.

What this means for design and construction teams

Skagit’s buyers are governments with published paper trails, and the work is won by reading them. The districts post their solicitations, their audits read like strategy documents, and their applications to the state — the decant argument, the swing-bed request — state the operational problem before they state the building. The near-term market is not a tower market: it is operating rooms converted out of procedure rooms, scanners craned through roof panels, a refrigerant retired, a kitchen rebuilt behind temporary units, an island hospital fitting a cesarean room into a courtyard and gathering a scattered orthopedics service onto one floor. The firms already in the record — Zervas designing in Mount Vernon and Arlington, BNBuilders, Kirtley-Cole, Visconsi developing across the county line — got there on public projects executed in public. The design questions are correspondingly concrete: how to build inside a hospital running near 89 percent occupancy, how to keep a birth center’s families fed when the kitchen is a trailer, how an island hospital phases construction around a

ferry-fed workforce and a levy that ends its bond in 2028. The corridor’s other counties make the same point at larger scale (Snohomish County’s ballot-box map); Skagit is where the public-hospital model is not the exception but the entire system — three districts, three deals, and no one else coming.

Frequently asked questions

How many public hospital districts does Skagit County have, and how do they differ?

Three. District No. 1 (Skagit Regional Health) operates Skagit Valley Hospital in Mount Vernon and Cascade Valley Hospital in Arlington. District No. 2 (Island Health) operates the 43-bed hospital in Anacortes on a voter-approved levy. District No. 304 owns the United General campus in Sedro-Woolley and leases it to PeaceHealth, which has run medical services there since 2014.

Why did Island Health’s levy pass while District 304’s failed?

Island Health’s April 2025 measure funded the hospital itself — equipment, facility improvements, specialty care — and passed 4,975 to 4,129. District 304’s August 2026 measure funded district-run community programs (nutrition, youth, senior, family, and mental-health services), explicitly not the PeaceHealth-operated hospital, and failed 45.42 to 54.58 percent.

What is a swing bed, and what did United General win in 2026?

A swing bed is an acute-care bed that can alternate between hospital-level and post-acute (skilled) care as a patient’s needs change. In March 2026 the Department of Health approved PeaceHealth United General to swing all 25 of its acute beds, up from 15 — an operational permission requiring no construction, at a hospital whose average daily census is 7 against nearly 17,000 emergency visits a year.

What did Washington’s 2026 hospital payment law do for Island Health?

Chapter 84, Laws of 2026 (SSB 5923) made cost-based Medicaid payment available to a critical-access hospital “located on an island operating within a public hospital district in Skagit county” — a description the Senate’s bill report says fits only the Anacortes hospital. Island Health’s own fact sheet lists 43 licensed beds, above the 25-bed federal critical-access test restated in the same report, and no federal certification for the hospital appears in the public record; the reconciliation is still open.

Where do families stay when someone is hospitalized in Skagit County?

In Interstate 5 hotels the hospitals do not operate. Skagit Valley Hospital names none; the Hampton Inn & Suites in Burlington publishes its own distance as four miles from the hospital. Anacortes has a cluster of small inns within about a mile of Island Health. There is no hospital-run guest house or Ronald McDonald House in the county, and hospital cafeterias at all three campuses close in the afternoon or early evening.

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 Skagit County 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.

Two Landlords, One Ballot Box: Snohomish County’s Hospital Map

Source: <https://healthcarefacilityhub.org/snohomish-county-hospital-construction-design-demand/> Published: October 19, 2026

The bottom line: Snohomish County’s hospital map is an ownership puzzle. Its largest hospital — Providence in Everett, 595 licensed beds and the county’s only adult Level II trauma center — belongs to no local government at all. Two of its three public hospital districts no longer operate the hospitals they own: one leases its campus to Swedish for thirty years, the other leases its hospital to the next county’s system for ten dollars a year. And the one district still running its own hospital, in Monroe, is asking voters for \$382 million to replace it — after a first vote in August 2026 delivered a clear majority, 55.63 percent, and lost anyway, because Washington hospital bonds need sixty. The same question is on the November 3 ballot. For the facilities, design, and construction teams who work this county, Snohomish is a lesson in reading the deed and the ballot before the drawings.

Snohomish County, at a glance	Figure
Population	879,700 (Washington Office of Financial Management, April 1, 2026)
Public hospital districts	Three — No. 1 (EvergreenHealth Monroe), No. 2 (Verdant, landlord of Swedish Edmonds), No. 3 (Stilly Valley, landlord of Cascade Valley). Two of the three are landlords.
The anchor	Providence Regional Medical Center Everett — 595 licensed beds across two downtown campuses; the county’s only adult Level II trauma center. Not a district hospital.
The live question	EvergreenHealth Monroe’s \$382 million replacement-hospital bond: 55.63% yes in August 2026 — a majority, short of the required 60%. Voters decide again November 3, 2026.
The quiet deals	Swedish Edmonds operates under a 30-year district lease dating to 2010. Cascade Valley in Arlington is run by Skagit Regional Health under a 30-year lease at \$10 a year.

Three districts, two landlords

Snohomish County has three public hospital districts, and only one of them still runs a hospital. District No. 1 is EvergreenHealth Monroe, formed in 1960 to serve the Skykomish valley corridor — Snohomish, Maltby, Monroe, and east along U.S. 2 to Index. Since March 2015 it has operated in a strategic alliance with King County’s District No. 2, the EvergreenHealth system in Kirkland, governed jointly by an alliance board of commissioners from both districts. Its regular levy is 15.6 cents per \$1,000 of assessed value — an operating trickle that explains, before anything else about Monroe makes sense, why a replacement hospital has to go to a bond vote.

District No. 2 is the Verdant Health Commission. Voters created it in 1962; its Stevens Memorial Hospital opened in Edmonds in 1964. On September 1, 2010, the district leased the hospital and its campus to Swedish under a certificate-of-need-approved 30-year lease with two ten-year renewal options — and became a landlord and grantmaker. Verdant still owns the Edmonds campus, collects the lease, and has invested more than \$95 million in community organizations since 2011. Its hospital took its last contractual 3 percent lease increase in September 2025.

District No. 3, Stilly Valley Health Connections, made the same turn six years later. Created in 1964 for Arlington and Darrington, it handed operations of Cascade Valley Hospital to Skagit Regional Health — the neighboring county’s district — on June 1, 2016, under a 30-year lease at ten dollars a year in base rent. Skagit operates, maintains, and funds capital; the Snohomish district still exists to levy for its own bond debt and enforce the deal. The corridor pattern is bigger than one county: across this region, the district on the deed and the system at the bedside are increasingly different organizations, and the facilities work flows through whichever one holds the lease.

Everett: the regional anchor nobody local owns

Providence Regional Medical Center Everett has been in the city since 1905 and publishes 595 licensed beds. It works out of two downtown campuses. Colby, with the twelve-story Cymbaluk Medical Tower — a 710,000-square-foot, \$460 million addition opened in 2011–12 with a 79-room emergency department — is the county’s only adult Level II trauma center and its referral center for stroke and heart care. Pacific, on Pacific Avenue, carries maternity with a Level III nursery, inpatient substance-use treatment, rehabilitation, and transitional care. Providence’s own needs assessment describes a service area of about 800,000 people reaching into Skagit, Whatcom, Island, and San Juan counties: Everett is a regional hospital that happens to sit in Snohomish County, and its 2017 state approval to grow from 501 to 571 acute beds — \$32 million to finish shelled tower space — was argued on that regional math.

The current Everett work is fit-out, not towers. A new infusion center gave its first treatment in September 2025, opened with four chairs, doubled to eight, and is planning fourteen — its clinical director told the Everett Herald it was hitting seven-year volume targets within months, absorbing patients who had been referred south to Edmonds, and drawing from north Snohomish and Island counties. Seattle Children’s runs an outpatient specialty clinic on the campus. The campus is also, quietly, a behavioral-health address: Fairfax operates a 30-bed adult psychiatric unit on the Pacific campus’s seventh floor.

Monroe: a majority was not enough

EvergreenHealth Monroe is the only full-service hospital between Everett and Wenatchee, and it is full. At the end of 2023 the district reported 72 licensed acute beds but only 26 medical-surgical beds in service, running 43 percent occupancy across them while its emergency department — 14 treatment beds — saw 60 to 80 patients a day and its inpatient unit was, in the district’s words to the Snohomish City Council, frequently full. The plant is a decades-long accretion of additions, and the district’s June 2026 application to build a replacement states the operating problem plainly: a complete replacement of an existing hospital, on the same site, while that hospital continues to operate around the clock.

The plan is a new 190,000-square-foot hospital beside the old one — the buildings do not touch, so care never stops — with beds in service rising from 26 to 48, at least six operating rooms and five procedure rooms, at least 24 private emergency rooms designed to convert for behavioral-health patients, and a helipad. The old building comes down after a same-day move-in. The application, filed for GC/CM authority under Washington’s alternative public-works statute, names NBBJ as architect, prices mechanical and electrical packages at about \$70 million each, books a \$29.5 million escalation contingency against labor and material risk, and totals \$382,559,442 — about \$559,000 more than the \$382 million the ballot measure would authorize. Construction, on the application’s schedule, runs March 2028 to March 2030, with occupancy that July.

All of it waits on arithmetic. Washington requires 60 percent for a hospital district bond. On August 4, 2026, Monroe's Proposition No. 1 drew 17,217 yes votes to 13,732 no — 55.63 percent, a majority of nearly 3,500 votes — and failed. The board had already filed the same measure for November 3, at an estimated average excess levy of 43.7 cents per \$1,000, about \$40.75 a month on a \$745,000 home. Ballots were mailed in mid-October. Whatever design teams think of the project, the county's largest construction decision of the decade is being made this month, by a supermajority rule, in a district whose regular levy is fifteen cents.

Edmonds: the hospital is a leasehold

Swedish Edmonds publishes 217 licensed beds, more than 450 physicians, and a Level IV trauma emergency department — on land and in buildings owned by the Verdant Health Commission. The operator's recent work is clinical capacity inside the existing shell: in June 2026 the campus opened its expanded Jeffery C. Ward, M.D. Infusion Center, doubling from 19 chairs to 38, and a renovated outpatient behavioral-health clinic raised capacity from 12 patients to 30 the year before.

The landlord's construction program is humbler and more typical of district ownership: Verdant's 2026 capital plan puts \$1,046,906 into replacing the remaining nineteen rooftop HVAC units on its Langer Building — several at end of life, a winter-heat risk to the clinic tenants inside — plus \$452,238 to repave the parking lot. The district budgets a reserve projected at \$71.8 million by the end of 2026, built by reserving a quarter of the hospital's gross lease income. That is landlord money, not Providence Swedish operating cash, and the distinction matters to anyone reading the district's balance sheet as hospital capital capacity.

North county and the behavioral layer

Cascade Valley Hospital in Arlington — opened 1901, rebuilt in 2010, 48 licensed beds, a Level IV emergency department — is where the corridor's service geography changed most recently. On August 18, 2024, labor and delivery ended there: about thirteen births a month had fallen below what pediatrics and anesthesia coverage could safely support, and births centralized at Skagit Valley Hospital in Mount Vernon, in the next county. Six birth-center beds became medical-surgical beds, operating-room time went to other surgery, prenatal and postpartum clinics stayed in Arlington, and the emergency department stabilizes pregnant patients for transfer. The service commitments written into the operating arrangement — inpatient and outpatient surgery, general acute care, a 24-hour emergency department — run through 2026 in Skagit Regional Health's audited account of the deal.

Underneath the general hospitals sits a psychiatric layer most county maps omit. Smokey Point Behavioral Hospital in Marysville, opened by US HealthVest in 2017, says it has grown from 115 beds to 145, including 45 adolescent beds, treating more than 4,000 patients a year. Fairfax runs 34 beds on the Monroe campus to go with its 30 in Everett. Providence and Lifepoint opened a 40-bed inpatient rehabilitation hospital in Lynnwood in August 2024 — built under a \$53.4 million certificate-of-need approval, doubling the rehabilitation beds Providence Everett previously ran in-house. And Compass Health's Marc Healing Center, opened on Broadway in Everett in September 2025 at a cost Compass puts at \$71 million, pairs a 16-bed evaluation-and-treatment unit with a 16-bed crisis triage center designed to take ambulance and law-enforcement drop-offs directly — beds for court-ordered treatment that would otherwise queue for the state hospital, in a building whose stated design choices are natural light and secure outdoor space.

The amenity economy: everything closes

No hospital campus in Snohomish County publishes a 24-hour cafeteria. What families get instead is a set of good rooms on short clocks. Providence Colby's FRESH Inspirations Cafe serves made-to-order meals, pizza, pasta, and a salad bar from 6:30 in the morning to 7 at night; the Bistro in the Cymbaluk Tower lobby runs to 11 p.m., the latest food hour in the county; inpatients order room service until 7, and a visitor meal costs seven dollars. The Pacific campus runs shorter: the Monte Cristo Cafe closes at 2 p.m. on weekdays — the schedule that Fairfax's psychiatric families, one floor up in the same building, live with. Swedish Edmonds serves breakfast and weekday lunch in its second-floor cafe, dinner as room service until 8, and vending after that, with a Starbucks in the lobby and a chaplain reachable around the clock. Monroe's Trax Cafe — Whidbey Coffee, named for the railroad tracks outside — closes at 3:30 on weekday afternoons. Arlington's Cascade Cafe keeps the longest small-hospital day, and its Clover Coffee doubles as the gift shop by the fireplace in the lobby.

Lodging is a list, not a building. Providence publishes hotels within ten miles — the Courtyard and Delta downtown, the Hotel Indigo on the waterfront, the Tulalip Resort up the freeway — noting only that some may offer a patient rate. There is no Ronald McDonald House in Snohomish County, and the Seattle house's published terms fit children treated at Seattle Children's, living at least 45 miles away, staying at least four nights; a family whose baby is in Providence's own Level III nursery in Everett does not meet that test and is handed a phone number for Seattle Children's guest services instead. Swedish publishes no Edmonds hotel list at all. In this county, the amenity economy is a cafe that closes, a hotel the hospital doesn't run, and — at the new infusion center — a family waiting room with windows on Jetty Island and a puzzle table, which the cancer program counts, correctly, as part of the treatment plant.

Drivers: supermajorities, planning areas, and a code that lags itself

Three structures decide what gets built here. The first is electoral: district capital runs on 60 percent bond votes and 1-percent-capped levies, so the county's building program is set as much in the voters' pamphlet as in any capital plan — the state pamphlet for Monroe's measure is a facilities document, complete with the levy math per \$1,000. The second is certificate of need, which in this county currently turns on small numbers: two dialysis stations in Lynnwood filed under the no-net-need exception (decision expected November 30, 2026), a hospice expansion (December 7), an Arlington surgery center asking to convert its exemption into a full certificate so it can clear a backlog. The third is the code stack. The county sits in climate zone 4C under the 2021 state energy code — in force since March 2024, with a December 2024 exception written for I-2 occupancies that must keep redundant backup heat — yet the county code section an applicant finds first still cites the 2018 edition. Everett layers its own stormwater manual and a grease-control ordinance that reaches directly into any new hospital kitchen. And every hospital project still passes Department of Health construction review — Monroe's own schedule books "Permitting and DOH" as a discrete season — before a city permit lets work start. The seismic story is real but specific: planners model a magnitude 7.4 quake on the Southern Whidbey Island Fault, and the county's 50-foot active-fault setback binds unincorporated land, not the downtown Everett and Edmonds campuses, which answer to their city building officials.

What this means for design and construction teams

Know which entity you are actually contracting with. In Snohomish County the owner of record may be a landlord district whose board spends its income on grants, while the operator who will live in the building holds a lease; the replacement hospital is a public-works GC/CM procurement run by a district that has never built

one, with the architect named and the engineers still to be selected when the application was filed. The Monroe documents are unusually candid about what the market is being asked to price: occupied-site replacement, a same-day cutover, shutdowns coordinated with clinical operations, target-value design, and an escalation line that is itself a confession about lead times and labor. The rest of the county's near-term work is the unglamorous kind that keeps leased and aging plants alive — rooftop units, infusion chairs, clinic conversions — bought by landlords, operators, and a behavioral-health nonprofit, each with a different procurement rulebook. The team that reads the lease, the ballot, and the board packet before the RFP will understand this county faster than the team that reads the drawings first. The county to the south runs on the same district machinery with different numbers (King County's district map); Snohomish is where that machinery meets its supermajority.

Frequently asked questions

How many public hospital districts does Snohomish County have?

Three. District No. 1 operates EvergreenHealth Monroe. District No. 2 (the Verdant Health Commission) owns the Swedish Edmonds campus and leases it to Swedish. District No. 3 (Stilly Valley Health Connections) owns Cascade Valley Hospital in Arlington and leases it to Skagit Regional Health.

Why did Monroe's hospital bond fail after winning a majority?

Washington law requires a 60 percent supermajority for hospital district general-obligation bonds. Proposition No. 1 received 55.63 percent yes votes in the August 4, 2026 primary — 17,217 to 13,732 — which is a majority but not 60 percent. The district placed the same \$382 million measure on the November 3, 2026 ballot.

Who owns Swedish Edmonds?

The campus is owned by Snohomish County Public Hospital District No. 2, the Verdant Health Commission, and leased to Swedish (now Providence Swedish) under a 30-year lease that began September 1, 2010, with two ten-year renewal options. Verdant reinvests lease income in community health grants and its own buildings.

Where do Arlington families deliver babies now?

Labor and delivery at Cascade Valley Hospital ended August 18, 2024. Births centralized at Skagit Valley Hospital in Mount Vernon. Prenatal and postpartum clinic care remains in Arlington, and Cascade Valley's emergency department stabilizes pregnant patients for transfer to the hospital the family chooses.

Is there a Ronald McDonald House in Snohomish County?

No. The nearest house is in Seattle, and its published eligibility covers children in treatment at Seattle Children's or its satellite clinics, living at least 45 miles away, for stays of four nights or more. Families of babies in Providence Everett's nursery are directed to Seattle Children's Guest Services.

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 Snohomish County 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.

Four Districts, Two Levies: King County's Hospital Map Beyond Seattle

Source: <https://healthcarefacilityhub.org/king-county-hospital-renovation-design-demand/> Published: October 19, 2026

The bottom line: Seattle’s hospital hill has its own map — Harborview, Swedish, and Virginia Mason are covered there. This is the rest of King County: the part run not by famous systems but by four public hospital districts, two voter-approved tax levies passed in 2025, and a ring of suburban campuses from Bellevue to Enumclaw that most metro coverage treats as footnotes. In a single year, King County voters raised the EvergreenHealth levy from 14 cents to 50 cents per \$1,000 of assessed value and lifted Valley Medical Center’s levy to 75 cents — the first increase that district had asked for in twenty years. EvergreenHealth is building seven operating rooms into shell space inside a hospital that stays open throughout. A 25-bed critical access hospital in Snoqualmie is building an 85,000-square-foot hub with a climbing gym in the same application as its operating rooms. For the facilities, design, and construction teams who work this county, the action is not on the hill. It is in the districts.

King County beyond Seattle, at a glance	Figure
Public hospital districts	Four — No. 1 (Valley, Renton), No. 2 (EvergreenHealth, Kirkland), No. 4 (Snoqualmie Valley), No. 5 (Vashon). There is no No. 3.
The 2025 votes	District No. 2 levy passed Aug 2025 at 60.83% (\$0.50 per \$1,000 for 2026, up from \$0.14). District No. 1 levy passed Nov 2025 at 57.53% (up to \$0.75, about \$42 million a year).
Largest active suburban build	EvergreenHealth’s 2-Silver surgery expansion in Kirkland — about 73,000 square feet of shell build-out; the district’s state application budgets \$170 million all-in, its builder publishes \$115 million.
The exception	Overlake in Bellevue — 349 licensed beds, the Eastside’s anchor — is not a district at all. It has been a MultiCare member since October 2024.
The smallest district	Vashon (No. 5): a hospital district with no hospital, funding primary care through a partnership instead.

Four districts, and the one that never was

Washington’s public hospital districts are municipal corporations under RCW 70.44 — governments, not nonprofits — governed by elected commissioners and funded in part by property-tax levies their voters set. King County’s hospital-district map has four polygons, numbered 1, 2, 4, and 5. The numbering preserves a decision made before 1960: Overlake, in Bellevue, was intended to be Public Hospital District No. 3, but opened as a private nonprofit instead. The Eastside’s largest hospital is the county’s governance exception, and the missing number is still on the map.

District No. 1 is Valley Medical Center in Renton, the oldest and largest public hospital district in Washington. It serves most of Kent, Renton, and Covington and parts of nine other cities across south King County, and its audited financial statements for fiscal 2025 describe a 341-licensed-bed hospital with a Level III trauma program. Valley operates inside the UW Medicine system — but as an independent, community-owned district, and the same audit records a quiet change: Valley is no longer reported as a component unit of the University, and two trustee seats reserved for UW Medicine sat unfilled at the end of fiscal 2025.

District No. 2 is EvergreenHealth in Kirkland, governed by seven elected commissioners, serving a district that covers most of the northern Eastside and, by the system's count, more than a million residents across north King and south Snohomish counties. District No. 4 is Snoqualmie Valley Health, formed by voters in 1972 along boundaries that roughly match the Snoqualmie Valley School District: a 25-bed critical access hospital, Level V trauma, running an average daily census of about nineteen to twenty patients including swing beds. District No. 5 is Vashon — a hospital district without a hospital. It levies taxes to subsidize primary, urgent, and behavioral-health care delivered through a partnership with Sea Mar, and its 2025 strategic plan builds two reserves: a primary-care reserve funded at \$750,000 toward a \$1.2 million target, and a capital reserve funded at \$500,000 toward a \$3 million facility-acquisition target. In February 2026, island reporting described the partnership's new clinic across from the Vashon IGA Plaza — about 21 exam rooms and six dental operatories — as expected complete by mid-to-late July 2026.

Just as important is what sits outside every district. Overlake in Bellevue, St. Francis in Federal Way, St. Anne in Burien, and St. Elizabeth in Enumclaw are licensed hospitals whose surrounding residents pay no hospital-district levy at all. King County hospital care is a patchwork of tax-backed governments and private nonprofits sharing the same roads — and, increasingly, the same construction market.

The 2025 money: two lid lifts

A public hospital district may levy up to 75 cents per \$1,000 of assessed value for operations and maintenance, but raising the rate past the statutory limit factor takes a public vote. In 2025, King County's two big districts both asked — and both won.

EvergreenHealth went first. On August 5, 2025, District No. 2 voters approved Proposition No. 1 with 60.83 percent of the vote, authorizing a regular levy of 50 cents per \$1,000 for collection in 2026 — up from 14 cents levied in 2024. The county assessor's computed 2026 rate for the district is 0.49639. The district had already sold \$39.6 million of bonds in February 2024, structuring debt service to stay under 70 percent of its maintenance-and-operations levy.

Valley Medical Center followed in November. District No. 1's Proposition No. 1 passed with 57.53 percent, authorizing a maximum regular rate of 75 cents per \$1,000 for 2026 — a 46-cent increase the district estimates at about \$42 million a year. It was the district's first levy-lift request in twenty years; the 2005 lift helped fund its South Tower. The stated purposes are operational, not monumental: keep labor and delivery, trauma, emergency, and intensive care running around the clock, and keep the workforce that staffs them. The assessor's computed 2026 rate is 0.74215. Districts 4 and 5 ran no lid lift in the 2025 results; their computed 2026 rates are 0.25006 and 0.43024. King County voters also renewed the countywide Medic One emergency-medical-services levy that November at 80.70 percent — EMS funding that delivers patients to these hospitals, though not a dollar of it is hospital capital.

Kirkland: surgery built inside a hospital that cannot pause

EvergreenHealth's active construction program is a study in occupied renovation. The 2-Silver surgery expansion builds out roughly 73,000 square feet of existing shell space for seven operating rooms, six catheterization labs, and one hybrid operating room, with prep and recovery; modernizes about 5,000 square feet of C-section operating rooms under a new rooftop air-handling platform; and renovates about 15,000 square feet on the Blue building's first level into five endoscopy rooms. The district's application to the state

Project Review Committee budgets the work at \$170 million all-in, including \$98 million of construction; Mortenson, the GC/CM contractor, publishes a \$115 million project cost. Both figures are in print; they are different accountings of the same job, and any team pricing work here should know which one a given conversation is using. Construction runs from October 2026 to substantial completion in September 2027, with NBBJ as designer of record.

The application's own language is the demand signal: the work sits "within a fully operational hospital," with patients in the intensive care unit above, the emergency department below, and rooms adjacent at all times. A smaller solicitation tells the same story at \$595,000 — an IDF refresh in the Coral Building requiring "uninterrupted patient care, building operations, infection control requirements, and continuous operation of critical hospital systems." And the district's next decade arrived as a gift: in September 2026, EvergreenHealth announced a \$100 million donation from the Dean Weidner estate — the largest in its history — toward an eight-story patient-care tower. No budget, size, or timeline for the tower has been published; what exists is the gift, the levy behind it, and a district that has now funded its future in public, twice, in thirteen months.

Kirkland's system also reaches into Redmond, where EvergreenHealth runs a 24-hour emergency department on 161st Avenue Northeast — not a second hospital, but the east side's always-open front door, with urgent care upstairs on a shorter clock.

Renton: the phased build, funded in advance

Valley Medical Center's capital program is smaller than Kirkland's and more patiently sequenced. Its cancer center is being built in phases on the Renton campus: Phase 1A opened February 3, 2025 — about \$15 million of a roughly \$60 million program — bringing infusion and immunotherapy, an infusion pharmacy, and the Trapper & Samantha Wellbeing Resource Center, connected by a skywalk the district calls the Bridge of Hope. A \$6 million Norcliffe Foundation grant followed, directed at Phase 1B, which finishes the floor with oncology and hematology clinics, a multidisciplinary clinic, and a cafe; the district's reporting describes Phase 1B as under construction with a September 2026 opening. Phase 2, aimed at late 2027 in the district's public account, adds radiation oncology and imaging — and is explicitly contingent on fundraising.

The district's second front is in Covington, where it owns a two-story, 37,550-square-foot medical office building whose first floor is an occupied urgent-care clinic. A September 2026 application proposes to convert that floor into a combined freestanding emergency department and urgent care — new air-handling unit, structural stiffening of the second-floor slab — and to build out about 9,400 square feet of shell above it as a multispecialty clinic. The application's total budget is \$17,961,032, funded from operating capital and property-tax revenue, with construction phased across 2027 and into 2028. It is an application, not an approval. It is also a document worth reading for what it admits: Valley writes that its clinics may remain operational throughout construction, and that before filing its second-ever GC/CM application it studied EvergreenHealth — the district across the county — as the model public-owner. The districts are learning public-works delivery from each other.

The valley: a 25-bed hospital builds a hub

Snoqualmie Valley Health's expansion is, proportionally, the boldest project in the county. The district broke ground August 22, 2025 on a hub of about 85,000 square feet beside its 25-bed hospital: imaging, immediate care, lab, a retail pharmacy, physical therapy, clinics, and a four-operating-room ambulatory surgery facility —

operating rooms that will be licensed as part of the hospital even though they do not physically touch it, which is precisely why the project needed a certificate-of-need application at all. The district's January 2026 account prices the expansion at \$147 million, funded substantially by \$130 million in revenue bonds and \$17 million in limited-tax general-obligation bonds, with more than 30 new providers and 225 staff expected, and an opening expected in fall 2026.

The certificate-of-need filing makes the case in the language of out-migration: valley residents now travel to Bellevue or Seattle for routine procedures scheduled months out, past a state interchange project — I-90 and SR 18, about 31,000 vehicles a day — that is being rebuilt beside the campus. And the building program refuses the usual separation between clinical and civic: the same application that carries the operating rooms carries a restaurant, meeting space, a retail gym, and a climbing gym, with the massing opening toward the wetlands north of the site. In a valley with no cafe street outside the hospital door, the hospital is building the street.

The private map: south county and the second Eastside anchor

South of Seattle, the non-district systems hold the map. Virginia Mason Franciscan Health runs three hospitals down the county's southern tier: St. Francis in Federal Way, certificate-of-need approved for 148 beds and Level IV trauma; St. Anne in Burien, at 159 licensed beds, also Level IV; and St. Elizabeth in Enumclaw, a 38-bed critical access hospital that counts as 25 beds in the state's need math, Level V. MultiCare holds Auburn Medical Center — 195 licensed beds, 131 medical-surgical and 58 psychiatric, Level III trauma — and the 58-bed Covington Medical Center, and has asked the state to move a six-bed Level II nursery from Auburn to Covington: a \$2.85 million application, still pending, argued on drive times and the newer building's family-centered design.

On the Eastside, Swedish Issaquah — licensed for 175 beds — has applied for the third time in five years to add adult elective PCI, the scheduled heart-catheter procedures it says are leaking out of the King East planning area at roughly a third of all PCI volume and closer to half of outpatient volume. The application carries a capital cost of zero: the rooms and the emergent program exist; what is being requested is permission. And Overlake, the would-be District No. 3, completed its six-year Project FutureCare renewal in January 2023 — a 240,000-square-foot tower, a childbirth center with a Level III nursery, a 14-bed behavioral-health unit — and then changed owners without changing address: since October 1, 2024, MultiCare has been Overlake's sole corporate member, with Overlake's own governance, management, and foundation left in place and its 349 beds anchoring MultiCare's new North Sound region. Two of the county's three system flags changed at the governance level in the past three years. None of it shows from the street.

The amenity economy: where King County families actually eat

Read the visitor pages of these campuses together and a pattern emerges: a named daytime food hall, a branded espresso operator, a list of hotels the hospital does not run, and a thin all-night layer underneath.

Overlake runs three food counters — Stanzas Cafe, serving Starbucks by a fireplace in the north lobby; the Atrium Cafe, with Starbucks, a Boar's Head deli, and a salad bar, open daily into the evening; and a Beecher's Handmade Cheese cafe by the main entrance — inside a campus whose renewal added a 6,500-square-foot interior courtyard and a single front door two blocks from the Wilburton light-rail station. Its lodging page hands families an unendorsed list: the Hilton Garden Inn and Residence Inn downtown, the Hilton Bellevue, and properties stretching toward Redmond. EvergreenHealth's Cafe 128 serves seven stations and about thirty

entrees a day, while Whidbey Coffee runs three satellite delis, including the espresso bar at the cancer center's entrance; its lodging list starts with a Comfort Inn six-tenths of a mile away and includes Madison House, across the street — furnished apartments that serve three meals a day, the closest thing in the county to a purpose-built family residence. Valley's Trendz Cafe anchors three espresso bars, one of which — the Legacy Espresso Bar, between surgery and the emergency department — never closes: twenty-four hours, seven days, the one all-night coffee counter in this county's hospital record. Its cancer center bakes the amenity into the capital program, pairing a family resource center with Phase 1A and a cafe with Phase 1B.

Swedish Issaquah's Cafe 1910 runs a menu without fryers or soda machines — Wood Stone oven pizza, a wok, made-to-order salads — beside a Starbucks and a gift shop selling local craft. St. Anne's cafeteria feeds Burien from a fourth floor with three hot-meal windows a day and free parking below. St. Francis pairs its Rose Garden Cafe with an actual rose garden and a chapel that stays open all night. And in Snoqualmie, the amenity layer is not a tenant list at all — it is a line item in a construction budget, restaurant and climbing gym included, because the alternative was to build a hospital that assumes families will drive somewhere else. After the counters close, the county's families rely on the Renton espresso bar, emergency-department vending, and the two 24-hour emergency departments in Redmond. Evening restaurant service inside these hospitals remains the exception, and every campus that has closed that gap has done it deliberately, as a design decision with a budget line.

Two authorities for every project

Every substantial hospital project in King County answers to two reviewers. The Department of Health's Construction Review Services must approve construction documents — projects of \$500,000 or more need a presubmission conference by the halfway point of design — and the submittal must include an infection-control risk assessment and an interim life-safety plan. That state review sits on top of, never instead of, the local building permit. Then certificate of need gates the service itself: detached operating rooms in Snoqualmie, a six-bed nursery crossing between two licenses in southeast King, elective PCI in Issaquah at zero capital cost. The planning-area line between King East and Southeast King is the regulatory geography that decides whose migration numbers count.

The energy clock is also already running. Washington's Clean Buildings Performance Standard puts hospital campuses on a square-footage calendar — reporting deadlines of June 1, 2026 for the largest buildings, 2027 for the middle tier, 2028 for the rest — against a climate-zone 4C hospital energy target of 215. The standard counts the hospital activity's gross area including its cafeterias and retail: the amenity square footage is inside the compliance math whether it was designed to be or not. And the code stack under all of it is municipal: unincorporated King County enforces the 2021 state codes, the wildland-urban interface code is not in effect in the county — the foothill fact for Enumclaw and Snoqualmie — and a campus in Bellevue, Kirkland, Renton, or Federal Way answers to that city's code and that city's stormwater manual.

What this means for design and construction teams

The corridor's client is often a government. Districts 1 and 2 buy major construction through Washington's GC/CM statute, with elected commissioners, prevailing wage, public bid openings, and a debt-service test measured against the maintenance-and-operations levy. A design contract written for a private nonprofit owner will miss the commission meeting where the project is actually decided. The owners here say so themselves: the two big districts are explicitly copying each other's public-works practice, and both name infection control and

continuous operation as the delivery constraint — EvergreenHealth’s solicitation documents put it in writing down to a \$595,000 IT refresh.

The work itself is shell space, roofs, and clinics that stay open: operating rooms built into a Kirkland shell floor, a new air handler set on an existing roof, an occupied urgent-care clinic in Covington converting into an emergency department underneath a shell build-out, operating rooms in Snoqualmie licensed across a parking lot. Firms already named in the owners’ own filings — NBBJ designing in Kirkland and drawing in Renton, Mortenson building in Kirkland, Sellen in Renton’s first phase, Flourish advising both districts — are the visible bench. The county to the south has its own map (Pierce County’s facility types); this county’s distinguishing fact is that so much of its hospital plant belongs, literally, to its voters.

Frequently asked questions

How many public hospital districts does King County have?

Four: No. 1 (Valley Medical Center, Renton), No. 2 (EvergreenHealth, Kirkland), No. 4 (Snoqualmie Valley Health), and No. 5 (Vashon Health Care District). There is no No. 3 — Overlake in Bellevue was intended to take that number but opened as a private nonprofit in 1960.

What did King County hospital districts ask voters for in 2025?

Both large districts won levy lid lifts. EvergreenHealth’s District No. 2 passed in August 2025 at 60.83 percent, setting a 50-cent-per-\$1,000 levy for 2026, up from 14 cents. Valley Medical Center’s District No. 1 passed in November 2025 at 57.53 percent, authorizing up to 75 cents — its first lift in twenty years, estimated at about \$42 million a year for 24/7 operations.

Is Overlake a public hospital?

No. Overlake is a private nonprofit in Bellevue. Since October 1, 2024, MultiCare has been its sole corporate member; Overlake’s local governance, management, medical staff, and foundation remained in place. It is licensed for 349 beds and is the Eastside’s anchor hospital.

What is certificate of need deciding in King County right now?

Three suburban applications were pending in the record reviewed for this piece: Swedish Issaquah’s request to add elective PCI, MultiCare’s request to move a six-bed nursery from Auburn to Covington, and Snoqualmie Valley Health’s detached operating rooms — each a service decision, separable from whether the building exists.

Which King County hospital district has no hospital?

District No. 5, Vashon Health Care District. It funds and backstops primary, urgent, and behavioral-health care on Vashon Island through a partnership with Sea Mar, and is building reserves toward acquiring facilities of its own.

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 King County 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.

Twenty Years of Construction, Starting With the Kitchen: Good Samaritan's Puyallup Buildout

Source: <https://healthcarefacilityhub.org/good-samaritan-puyallup-expansion/> Published: October 18, 2026

On January 27, 2026, the Puyallup City Council authorized a development agreement with MultiCare that sets the rules for twenty years of construction at Good Samaritan Hospital — a new patient tower, an expanded central utility plant, new parking structures, and a campus that grows from roughly 1.24 million square feet to as much as 2.25 million. But the first construction crews on campus are not building any of that. They are remodeling the kitchen.

That sequence is not an accident, and it is the most honest thing in the plan. Before a hospital can add 160 beds, it has to be able to feed the people who will fill them — and Good Samaritan's kitchen, by its own operations chief's account, is already out of room.

The busiest front door in East Pierce

Start with why this campus has to grow. MultiCare describes Good Samaritan's emergency department as recently ranked the fourth busiest in the nation — the health system does not name the ranking, but it publishes the volume behind the claim: more than 160,000 patients a year through the ED, and inpatient volumes averaging 21,000 a year. Good Samaritan is, in MultiCare's words, the only provider of inpatient care in East Pierce County. When this hospital is full, the county's next option is a drive to Tacoma.

That is the demand side of the master plan the council adopted on June 10, 2025, after a final environmental impact statement issued the month before. The plan runs twenty years on a 34.86-acre campus and is organized in four major phases — a horizon long enough that the facilities team planning phase one is also, whether they like it or not, planning for colleagues who have not been hired yet.

Why the kitchen is the critical path

"The kitchen is the heartbeat of this campus," Nathan Butts, Good Samaritan's associate vice president of hospital operations, told MultiCare's own newsroom. "So we're still producing over 1,000 meals a day out of just one tray line. This new expansion is going to allow us to quadruple that."

One tray line, a thousand meals a day, and a campus about to add beds: food service here is not an amenity being upgraded, it is a utility at capacity. The project Abbott Construction began in late 2025 remodels the existing kitchen and builds new space alongside it — new storage, ware wash, cooking, and office space in the development agreement's itemized scope, then new tray-makeup and cooking lines, with all-new appliances and equipment. In the agreement's language, this is enabling work: construction that exists to make the patient tower possible. A tower that opens before its kitchen can feed it is not an opening; it is a queue.

Every facilities manager who has sequenced a campus buildout knows this shape. The glamorous project — the tower — sits at the end of a chain of unglamorous ones: the plant, the kitchen, the parking, the ambulance bay. The chain is the plan. Good Samaritan's documents simply say it out loud, in a filed agreement anyone can read.

What the plan actually builds

The centerpiece is a new patient care tower carrying the 160 new licensed inpatient beds the state Department of Health approved in a certificate of need back in August 2023, plus 30 observation beds — and one detail that tells you the plan expects to be outgrown: a shelled floor, built empty, sized for up to 40 more inpatient beds when the county needs them. Between the tower and the shelled floor, the agreement anticipates the campus accommodating up to roughly 200 licensed beds.

The environmental review's first phase wraps the tower in the infrastructure it needs: a new parking garage, a small expansion of the emergency department, an expansion of the existing central utility plant, and the tower shell buildout. The utility plant line deserves a plant manager's pause. A central plant is sized to a campus; expand the campus by a million square feet over twenty years and the plant has to be expanded ahead of the load, in a building that cannot go down while you do it. The phases after the first are deliberately looser — two medical office buildings of about 100,000 square feet each, a second parking garage, a 90,000-square-foot central support tower, a 30,000-square-foot expansion of the existing Dally Tower — and the environmental review is blunt that everything past that first phase is speculative, built as needed, as the hospital decides.

The agreement is itself a facilities instrument

Most hospital construction fights a quiet war with the calendar: permits expire, codes change, street-improvement requirements arrive all at once at the worst phase. The development agreement is Good Samaritan's answer, and for facilities teams it may be the most transferable idea in the whole project. Under Washington's development-agreement statute, the agreement vests the development standards that govern the campus — for ten years from execution, on a plan whose term runs twenty — and codifies permit-processing timelines the city and the health system had first sketched in a nonbinding memorandum in October 2024. The timelines lean on the state's 2023 permit-streamlining law, SB 5290, which the city's planners cited when they briefed the council.

The street work gets the same treatment. Instead of requiring every frontage improvement up front, the agreement phases curb, gutter, sidewalk, and lighting work to the construction phases that trigger it, and builds in a procedure for reassessing traffic impacts if a future building's size or scope changes. For a campus that will be a construction site for two decades, that is schedule certainty purchased in advance — the municipal version of a long-lead equipment order.

The ambulance bay is the pressure valve

The agreement's other piece of enabling work is smaller and more urgent. The hospital's ambulance bay — already improved under conditions in the master plan and the environmental review — gets an immediate phase of work tied to the emergency department expansion, aimed at vehicle queueing, with a larger ambulance expansion to follow. At the January council meeting, a local first responder told the council that ambulance activity on 12th Avenue had risen, in the record's words, “from 6 a week ... to at times 6 a day,” and asked the city to look at the street infrastructure well beyond the hospital's frontage.

That is what growth looks like from the cab of an ambulance: not a bed count, a queue. The development agreement treats the queue as infrastructure — phased, conditioned, and tied to certificates of occupancy — which is to say, it treats ambulance access as a utility the campus has to build, not a complaint the neighborhood has to file. On a campus whose emergency department is among the busiest in the country, the bay is plant equipment.

Twenty years on a campus that never closes

Everything above happens on a working hospital — the only inpatient hospital in its half of the county — that does not get a single closed day in twenty years. That is the discipline this site has written about before, from the infection-control side: building inside a hospital that never closes is a phasing practice before it is a construction one. Good Samaritan is that practice at campus scale and decade scale: containment and dust control become traffic control and utility cutovers; the one-project infection-control plan becomes a twenty-year sequence in which every phase has to leave the hospital fully operable for the next.

It also makes Good Samaritan the sharpest example in the county of the pattern this series mapped in Pierce County's facility types: a Level III trauma center whose building program is being driven, visibly and on paper, by the volume of the community around it. The plan's first visible act is a kitchen. The plan's last act, sometime in the 2040s, is a campus twice its current size. Between those two points is twenty years of facilities work — most of it, as usual, in the buildings nobody photographs.

Sources: MultiCare Vitals, "Good Samaritan Hospital expansion kicks off with kitchen remodel"; City of Puyallup, Good Samaritan development agreement (authorized January 27, 2026) and final EIS fact sheet (May 21, 2025); Puyallup City Council records, December 2, 2025 and January 27, 2026, via Citizen Portal. Master plan adopted by the Puyallup City Council, Ordinance No. 3322, June 10, 2025.

Run facilities in Pierce County? 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.

Mary Bridge Comes Home: Tacoma's Children's Hospital Gets a Building of Its Own

Source: <https://healthcarefacilityhub.org/mary-bridge-childrens-hospital-tacoma/> Published: October 18, 2026

On May 16, 2026, Mary Bridge Children's Hospital welcomed its first patients into a building of its own — a six-story, 262,114-square-foot hospital at 305 South L Street in Tacoma, across the street from MultiCare Tacoma General and on the site of the original Mary Bridge campus that opened in 1955. Becker's Hospital Review prices the project at \$479 million; the Puget Sound Business Journal's final tally, reported by KIRO 7, is \$480 million. Either way, it is the building Mary Bridge has been waiting nearly forty years to come home to.

Because until this spring, Mary Bridge was a hospital inside a hospital. It opened as a standalone children's hospital in 1955, funded by the estate of Tacoma family-medicine physician Albert Bridge. In 1987, needing room, it moved into a wing of Tacoma General — and stayed for nearly four decades, sharing space and resources with an adult hospital whose building it did not control.

A project that had to be redesigned before it could be built

The road back to a building of its own was not straight. The project was announced in 2020 with an original estimate of \$344 million. Pandemic-era supply chains broke that number, and in August 2022 MultiCare published redesigned plans: a \$415 million project, the inpatient tower trimmed from 300,000 to 250,000 square feet, the ambulatory building split into its own phase, parking cut from 1,100 stalls to 800. Construction broke ground in spring 2023. The final building opened at roughly \$480 million — a cost arc that will be familiar to any facilities leader who carried a capital project through the last six years: the building that opened

is smaller than the one announced and cost about forty percent more.

What did not get cut is the part that matters to the region. The new hospital carries 82 licensed inpatient beds on its medical-surgical and pediatric intensive care units, every room private, every room built with family quarters — a pull-out bed and a bathroom for the parents who are, in a children's hospital, part of the care team whether the floor plan admits it or not.

What the building is

The emergency department is pediatric-only and runs around the clock: 29 exam rooms, a 10-bay treatment-in-process and results-waiting area, a dedicated ambulance bay, and four behavioral-health reduced-risk rooms — the last item being the one that dates the design honestly. A children's ED drawn a decade ago would not have carried dedicated behavioral-health rooms; one drawn after 2020 does, because the patients were already arriving.

Upstairs are eight operating rooms and an all-pediatric surgical center built around a hybrid catheterization and interventional radiology suite — one room that can image and intervene without moving a child between suites. A dedicated neonatal and pediatric transport team works fixed-wing, rotor-wing, and ground, with a rooftop helipad above them. The project team was ESa on design, WSP on building systems engineering, Structural Design Group on structure, and Layton | Abbott Construction as general contractor, with Tacoma's AHBL on civil and landscape work.

And then there is the program a children's hospital carries that no adult hospital does: three patient play and activity rooms, a space built for teenagers, an outdoor garden, the hospital's first therapy gym, and the Kite Cafe pouring a Mary Bridge blend from Sumner-based Dillanos Coffee Roasters. A 400-space garage serves patients and visitors, connected to the hospital by a covered walkway. None of that is decoration. In pediatric care, play is assessment and therapy at once, a parent who can sleep in the room is a calmer patient in the bed, and a garden on the campus is a clinical tool with a groundskeeping budget. The floor plan is the philosophy.

Move day

The community got its look first — a ribbon cutting on May 2 — and then the building had to be activated and the patients moved. Staff rehearsed procedures with manikins to learn a facility none of them had worked in, because a children's hospital cannot be learned on its patients. On opening day, roughly sixty children were transferred across the street from the old Mary Bridge space inside Tacoma General to the new hospital — published counts of the day's moves differ slightly, 57 in one account and 61 in another, which is about right for a day that counts patients several ways.

“We have a lot of work ahead of us to get the patients moved over and get the building activated,” chief operating officer Ben Whitworth told KNKX before the opening. That sentence contains the whole discipline. A hospital move is not a relocation; it is a commissioning event with patients in it — every medical-gas outlet, every nurse call, every isolation room verified in a building whose staff are simultaneously learning where the supply rooms are. Across the street helped: the transport was measured in yards, not miles. But yards or miles, the rule is the same — the new building is a construction project until the first patient is in a bed and the systems hold, and after that it is a hospital with a punch list.

What Tacoma General gets back

The move is also the largest gift Tacoma General has received in years: its pediatric tenant's space, returned. "The space that pediatric patients were taking up at Tacoma General, now that's clear for adult patients to have more access," Whitworth told KNKX. "We truly are expanding access to care in this whole community for kids and adults." One construction project, two hospitals' capacity problems addressed — the children's hospital gets a building designed for children, and the adult hospital gets room to grow into, on the campus pattern this series described in Pierce County's facility types.

The designation that anchors the new building's regional role did not change with the address. On the Washington Department of Health's trauma list, Mary Bridge remains the Level II pediatric trauma center for Western Washington — the only other Level II pediatric designation in the state is in Spokane, with Harborview holding Level I in Seattle — and it serves more than 100,000 children a year. In the county's trauma ladder, the rung the whole system plans around, in emergency planning between the mountain and the fault, now sits in a building built for exactly that job.

Still building

The campus is not finished. In August 2026, MultiCare opened an expanded Mary Bridge outpatient center on the campus — 85 exam rooms and 10 infusion bays among its program — and the hospital projects more than 250 new positions by 2028 as the new capacity fills. During construction, AHBL's team notes, Tacoma General, the operating Mary Bridge, and the neighboring clinic building all stayed active while crews coordinated the unglamorous essentials — water, sewer, medical gases, emergency power — across a site where three facilities never closed. That is the real story of this project, and it is the same story as every project this site covers: the building the public photographs is the last ten percent. The other ninety is keeping the old one alive until the new one can take the weight.

Mary Bridge began in 1955 as the region's first standalone children's hospital, spent nearly forty years as a guest inside an adult hospital's walls, and has now come home to its own ground — bigger, private-roomed, and built around the families who were always part of the care plan. Tacoma's children's hospital has its own plant again. The people who run it have the work orders to prove it.

Sources: Becker's Hospital Review (April–September 2026); Building Design+Construction project profile (July 17, 2026); KNKX (May 4, 2026); KIRO 7 / MyNorthwest; Healthcare Design Magazine photo tour (July 9, 2026); Mary Bridge Children's, "Our New Hospital"; Washington State Department of Health, Trauma Designated Services (DOH 530-101, May 2026).

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One County, Six Kinds of Building: How Pierce County Facility Types Change the Work

Source: <https://healthcarefacilityhub.org/pierce-county-facility-types/> Published: October 16, 2026

Ask a facilities director what kind of building they run and you will get a longer answer than you expected — because "hospital" is at least six different jobs wearing one word. Pierce County happens to hold the full cross-section inside one county line: two Level II trauma centers, a children's hospital that spent nearly four

decades inside one of them before moving into its own building in May 2026, a Level II military hospital, the state psychiatric campus, a purpose-built behavioral health hospital, a VA medical center, and a long tail of nursing facilities, surgery centers, dialysis clinics, and community health centers. The differences are not trivial. They decide who licenses the building, what the plant is designed to survive, and whose phone rings at 3 a.m.

This is a field guide to those differences — and to what they mean for the teams who keep each kind of building running.

The trauma ladder is a designed system, not a coincidence

Washington designates trauma care in levels, and Pierce County's ladder is unusually complete. At the top of the county sit two Level II adult trauma centers — MultiCare Tacoma General and St. Joseph Medical Center — which since November 2024 both operate around the clock; before that expansion, the two rotated trauma duty through the Tacoma Trauma Trust, a shared arrangement dating back years. Mary Bridge Children's Hospital, which moved into its own free-standing building beside Tacoma General in May 2026, carries the county's Level II pediatric trauma designation. Below them: MultiCare Good Samaritan in Puyallup at Level III, MultiCare Allenmore in Tacoma at Level IV, and above the whole county, Harborview in Seattle as the state's only Level I.

For facilities teams the designation is a plant specification. A trauma level commits a building to surgical capability, imaging, blood bank, and critical care that must be ready continuously — which means the emergency power, medical gas, and HVAC serving those spaces are maintained to a readiness standard, not a comfort standard. When the county went from one on-duty trauma plant to two, it didn't just add surgeons; it duplicated a building posture.

The federal islands run on different rules

Two of the county's biggest medical campuses answer to Washington, D.C., not Olympia. Madigan Army Medical Center at Joint Base Lewis-McChord is run by the Defense Health Agency — and it also holds a state Level II trauma designation and works inside the Tacoma trauma partnership, treating military patients and, as needed, civilians. The American Lake VA Medical Center, part of VA Puget Sound, is a campus of numbered buildings rather than a single tower, with a service mix weighted toward mental health, geriatrics, rehabilitation, and substance-use treatment.

Federal facilities plan on federal capital cycles, build to federal standards, and can be tasked in a national emergency in ways a community hospital cannot. For the county around them, they are both neighbors and sovereign territory at once — which is precisely why the relationships between their plant teams and the civilian systems matter when the county plans for the bad day: mutual aid here crosses governments, not just corporate logos.

The state psychiatric campus is a different design problem

Western State Hospital in Lakewood — operated by the state Department of Social and Health Services, with 745 beds by the department's own count, among the largest inpatient psychiatric facilities in the West — inverts the acute-care design brief. The risks the building is engineered against are self-harm, elopement, and assault: ligature-resistant fixtures, controlled sightlines, secured outdoor space, and environments designed to de-escalate rather than to treat a body in crisis. Its campus also holds the Child Study and Treatment Center, the

state's psychiatric hospital for children, and a new 350-bed forensic hospital now under construction — one of the largest hospital building projects in the county, on the campus of its oldest institution.

The purpose-built end of the same specialty looks different again: Wellfound Behavioral Health Hospital in Tacoma — a 120-bed inpatient psychiatric hospital opened in 2019 as a joint venture of the county's two big systems — was designed from a blank page for acute psychiatric care, voluntary and involuntary, with the safety engineering built in rather than retrofitted.

Its own building, still not the same building

For nearly four decades, Mary Bridge and Tacoma General shared a campus and a wall — one plant infrastructure effectively serving two hospitals, two licenses, and two patient populations whose needs diverge in everything from isolation practice to family space to the scale of the equipment. In May 2026 the children's hospital moved across the street into a free-standing building of its own — covered in full here — and the type difference the shared wall used to hide is now drawn as a property line. Children's hospitals run hotter on family presence and play as clinical tools, cooler on tolerance for downtime in the systems kids depend on. Anyone who has maintained either building knows the difference still shows up in the work orders: same street, different buildings, in every way that matters.

The long tail has one critical system each

Beyond the hospitals, the county's care runs through facilities whose entire plant risk concentrates in a single system. A dialysis center is, mechanically, a water-treatment plant with patients attached — its purified-water loop is the life-safety system. An ambulatory surgery center lives on its operating-room air: pressurization, filtration, and sterile-core discipline in a building a fraction of a hospital's size. Skilled nursing facilities trade acuity for duration — their emergency question is never the next four hours, it is moving or sheltering fragile residents for days. And the community health centers — the FQHC clinics of Community Health Care and Sea Mar — are the county's front door: high-throughput clinic plants whose resilience shows up as continuity for everyone who has no other door.

Why the patchwork is the point

A county's healthcare is not a system; it is a negotiated peace among systems — private nonprofits, a state agency, two federal governments' worth of facilities, and dozens of small licensees, each maintaining a different kind of building to a different regulator's standard. The facilities professionals who run them share a labor market, a mutual-aid map, a weather forecast, and a fault line. What they don't share is a template — and the county works because the people running each kind of building understand, concretely, how the other kinds differ. That understanding is built the same way the rest of this work is: on purpose, in the quiet years, one relationship between plant teams at a time.

Update, October 18, 2026: when this guide was published, Mary Bridge Children's Hospital still operated inside Tacoma General. It opened its own free-standing hospital on May 16, 2026; the passages above have been corrected, and the new building is covered in full here.

Run facilities in Pierce County? 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.

Emergency Preparedness in Pierce County: Planning Between the Mountain and the Fault

Source: <https://healthcarefacilityhub.org/pierce-county-hospital-emergency-preparedness/> Published: October 16, 2026

Every hospital facilities team runs a hazard vulnerability analysis. Few run one with a volcano on one side of the county and a subduction zone under the other. Pierce County teams do — and the planning that comes out of it is some of the most honest emergency preparedness work in the state, because the hazards here aren't hypothetical and the neighbors you'd call for help are planning around the same map.

This is a look at what that planning involves for the facilities professionals who keep Pierce County's hospitals running — from MultiCare Tacoma General and Mary Bridge Children's in Tacoma, to St. Joseph Medical Center, to Good Samaritan in Puyallup, with Madigan Army Medical Center at Joint Base Lewis-McChord as the region's federal anchor.

The hazard list is local, not generic

A Pierce County HVA starts where every CMS-compliant one does — the all-hazards approach required under the federal Emergency Preparedness Rule — but the rankings are shaped by geography:

Seismic. The Cascadia Subduction Zone offshore and the crustal faults under the Puget Sound lowland (Tacoma experienced the 2001 Nisqually earthquake within living professional memory) put earthquake at or near the top of most local HVAs. For facilities teams that means the questions are structural *and* non-structural: anchored equipment, braced piping, ceiling systems, and the medical gas and water lines that fail quietly long before a building does.

Lahar pathways. Mount Rainier's lahar inundation zones run down the Puyallup and Carbon river valleys — through the valley communities east of Tacoma, including Puyallup. A hospital doesn't need to sit in the inundation zone for this to be its problem: staff live there, supply routes cross there, and mutual-aid partners sit on both sides of the river.

Corridor disruption. Pierce County's hospitals hang on a small number of arterials — I-5, SR-167, SR-512, SR-410. An event that closes two of them at once is a staffing event, a supply event, and a patient-transfer event simultaneously, and every facilities director here has run some version of that tabletop.

What the plan has to cover

The CMS Emergency Preparedness Rule asks hospitals for four things, and facilities teams carry most of the weight in all of them: an emergency plan built on the HVA, policies and procedures that make the plan operable, a communications plan that works when normal systems don't, and a training and testing program — including two exercises a year — that proves people can actually execute it. The Joint Commission's Emergency Management standards layer on top, and Washington's Department of Health licensing expects the same bones.

Where that gets facilities-specific is the utility layer:

Emergency power. Generator runtime is a fuel-contract question, not a nameplate question. Teams here plan around how many hours of on-site fuel they hold, what their delivery contracts actually promise during a

regional event (when every hospital in the county calls the same vendor), and which loads are truly life-safety versus merely convenient.

Water. A hospital that loses municipal water loses surgery, sterilization, dialysis, and cooling — fast. Emergency water planning sits right beside the facility’s everyday water management program: the same people, the same valves, a very different day.

The 96-hour conversation. Federal guidance has long used roughly four days of self-sufficiency as the planning horizon for hospitals cut off from resupply. In a county where the hazard can isolate the whole region at once, that number drives real capital decisions: tankage, fuel, food service, and which non-urgent services shut down first to protect the core.

Mutual aid is a facilities function here

Pierce County’s hospital map is a systems map — MultiCare, Virginia Mason Franciscan Health, and the federal presence at Madigan — and regional preparedness runs through Pierce County’s healthcare coalition structures and the state Region 5 network. For facilities leaders, the coalition work that matters most is unglamorous: knowing whose loading dock can take your delivery, whose engineering shop has the part, and what a sister facility can absorb if you have to move patients at 3 a.m. That knowledge lives in relationships between plant operations teams, and it’s built in the quiet years, not the loud week.

The quiet work that decides the loud week

Ask Pierce County facilities veterans what actually determines how an event goes, and the answers are maintenance answers: valves that get exercised and labeled before anyone needs them at midnight; shutoff maps that match the building as it is today, not as it was drawn; generator load tests run like they matter; an HVA that’s re-argued every year instead of re-filed. The plan is a document. The preparedness is the building’s condition and the team’s habits — and in this county, the teams know exactly which mountain and which fault they’re maintaining against.

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