QUICK CARD LIVE-CAMPUS PHASING: THE GOOD SAMARITAN 20-YEAR EXPANSION

The Operating Condition: Most capital programs are a project. A 20-year campus master plan is a *condition* — two decades in which the hospital is simultaneously a fully operating acute-care facility and a construction site, and the facilities team owns both halves of that sentence every single day.

$430M+	20 Years	249 Beds
PATIENT CARE TOWER BUDGET	MASTER PLAN DURATION (TO 2046)	REGIONAL BED NEED (BY 2036)

1. THE DEVELOPMENT AGREEMENT: THE FACILITIES TEAM'S REAL CHARTER

MUNICIPAL LOCK & INSTITUTIONAL MEMORY

MUNICIPAL AUTHORITY & ENTITLEMENT LOCK

- **City Council Action:** Authorized by Puyallup City Council on January 27, 2026 for MultiCare Good Samaritan Hospital.
- **Locked Game Rules:** Secures entitlements, building standards, height limits, and sequencing expectations for the 20-year life of the master plan.
- **Survives Staff Turnover:** Twenty years is long enough that the team opening the final phase will not be the people who designed the first; the agreement preserves original intent across multi-decade handoffs.

OPERATIONAL CONVERSION FOR PLANT TEAMS

- **From Rendering to Sequence:** Turns "the tower, someday" into a strict, schedulable sequence of enabling works, tie-ins, and department decants.
- **Standing Boundary Shield:** Prevents administrative scope shifts from trampling physical plant pre-requisites or utility capacity corridors.
- **Institutional Continuity:** Acts as the binding operating charter between hospital leadership, clinical operations, and municipal building officials.

2. ENABLING WORKS DECIDE EVERYTHING: THE NON-NEGOTIABLE ORDER

SUPPORT & LOGISTICS BEFORE CLINICAL TOWERS

The Good Samaritan program lists **parking structures** and a **central support tower** alongside the clinical tower. That ordering is not administrative — it is the entire operating game:

Phasing Phase	Why It Must Precede the Clinical Tower	Facilities Craft & Operational Risk Controlled
1. Parking & Access First	A campus under construction loses critical surface parking lots to contractor laydown, crane pads, and the tower footprint itself.	Structured parking built early preserves patient, visitor, and staff circulation. *Circulation failures on a hospital campus are not inconveniences; they are access-to-care problems.*
2. Support Capacity Before Clinical Capacity	Central loading, waste handling, materials logistics, and back-of-house arteries must be sized for the campus the tower creates, not the campus that exists today.	Building the central support tower into the early program prevents discovering fatal service shortfalls at patient tower opening. The mark of a facilities-led master plan.
3. Utilities Micro-Shutdown Program	Every tie-in to power, domestic water, medical gas, and data on an occupied campus is a planned micro-shutdown requiring clinical risk review.	Over 20 years, tie-ins number in the hundreds. The master plan sequences them as a coordinated program instead of surviving them as emergency surprises.

LIVE-CAMPUS UTILITY TIE-IN PROTOCOL (POWER, WATER, MED-GAS, DATA)

1. Clinical Risk Review: Identify every ICU, OR, med-surg, pharmacy, and telemetry load dependent on the utility leg before issuing outage permits.

2. Planned Micro-Shutdown: Schedule redundant feeds, battery bypasses, or temporary medical gas manifold switchovers during off-peak clinical windows.

3. Abort & Rollback Gates: Establish hard time-to-restore boundaries and named facilities/clinical sign-off authorities before severing lines.

CAPACITY & SAFETY SHELLED FLOORS, INFECTION CONTROL & SWING-SPACE DISCIPLINE

3. THE SHELLED FLOOR: PURE CAPACITY STRATEGY IN THE INITIAL BUILD

PRE-BUYING FUTURE CAPACITY AT SHELL PRICES

GOOD SAMARITAN BED ARITHMETIC (TOWER PROGRAM)

New Licensed Inpatient Beds	**160 beds**
Observation Units (Main Program)	**30 beds**
Initial Active Program Total	**190 beds**
Shelled Floor Pre-Built Capacity	**+40 beds**
Total Patient Tower Capacity	**230 beds**
MultiCare Regional Projected Need by 2036	**249 additional beds**

The 40 shelled beds admit the 190-bed initial build is conservative against the 249-bed need, pre-buying correction at initial shell rates.

WHY FACILITIES PRE-BUYS SHELL SPACE

- **Fractions of Vertical Expansion Cost:** Shell built initially requires zero new foundation, zero core expansion, and zero re-entering an occupied building's roof structure later.
- **Defers High-Dollar Fit-Out:** Expensive finishes, clinical headwalls, medical gas outlets, and nurse staffing overhead remain deferred until inpatient demand actually arrives.
- **The Facilities Maxim:** *The cheapest bed is the one whose structure you already built.* Trying to punch through a live acute-care tower roof for vertical expansion creates intolerable clinical disruptions.

4. OCCUPIED-CAMPUS INFECTION CONTROL: A 20-YEAR PRODUCTION SYSTEM

IMMUNOCOMPROMISED ADJACENCY • ICRA • ILSM

Every construction phase happens directly beside immunocompromised patients. A 6-month job sprints on vigilance; a 20-year program requires **systematized controls**:

Containment & Air Balance

- Standardized airtight containment details across all phases.
- Continuous negative-air monitoring and differential pressure logging.
- HEPA-filtered exhaust ducted away from hospital HVAC fresh-air intakes.

Domestic Water Management

- Strict flush and disinfection protocols every time aging water legs are opened.
- Zero dead-leg tolerance when domestic lines are capped or diverted.
- Thermal & biocide verification prior to re-energizing hospital risers.

Onboarding & ILSM Rhythm

- Contractor onboarding treats ICRA as the mandatory price of admission.
- Standing daily/weekly containment inspection rhythms.
- Interim Life Safety Measures (ILSM) active for every egress change.

5. SWING SPACE: THE UNGLAMOROUS DISCIPLINE THAT MAKES PHASING REAL

ROLLING LOGISTICS & CLINIC DECANT ECOLOGY

THE SWING-SPACE ARITHMETIC

- **Rolling Multi-Year Logistics:** Every renovation creates a displacement: the clinical function must live somewhere while its home is rebuilt.
- **Sequential Backfill Chains:** Departments move in strict cascading order into spaces vacated and refreshed by preceding phases.
- **Execution vs. Press Releases:** Swing-space logistics never make the press release, but they determine whether opening dates survive contact with reality.

MEDICAL OFFICE BUILDING (MOB) DECANT STRATEGY

- **MOBs in the Phasing Ecology:** Medical office buildings in the master plan are functional swing-space enablers, not just real estate additions.
- **Frees Inpatient Footage Immediately:** Decanting outpatient clinics out of the main hospital tower liberates prime acute-care floor space without waiting for new towers to finish.
- **Low-Disruption Volume Shifts:** Relocates ambulatory foot traffic away from construction laydown zones and acute emergency routes.

TRANSFERABLE PRINCIPLE FOR SUBURBAN CAMPUS OPERATORS: East Pierce County's aging demographics and 249-bed shortfall mirror suburban growth nationwide. The Good Samaritan master plan succeeds because it treats phasing as craft: enabling works locked first, central support pre-sized, utility tie-ins programmed, and future capacity pre-shelled at day one.