APPENDIX F
WRITTEN COMMENTS ON THE DEIS

ELECTED OFFICIALS

LIZ KRUEGER
SENATOR, 28TH DISTRICT

ALBANY OFFICE
STATE CAPITOL BUILDING
ROOM 416
ALBANY, NEW YORK 12247
(518) 455-2297
FAX (518) 426-6874

DISTRICT OFFICE
211 EAST 43RD STREET, STE. 2000
NEW YORK, NEW YORK 10017
(212) 490-9535
FAX (212) 499-2558

E-MAIL
LKRUEGER@NYSENATE.GOV

NEW YORK
STATE
SENATE
ALBANY, NEW YORK 12247

CHAIR, MAJORITY MEMBER
FINANCE

COMMITTEES:
RULES
BUDGET & REVENUE

Testimony of Senator Liz Krueger
Before the New York City Planning Commission's Public Hearing on
Lenox Hill Hospital's Zoning Application
ULURP Nos. N250152ZRM, C250153ZSM, N250155ZCM, N250154ZAM, and C250151ZMM
May 21, 2025

My name is Liz Krueger and I am the State Senator representing the 28th State Senate District, which includes the Upper East Side, Midtown, Roosevelt Island, and Lenox Hill neighborhoods of Manhattan, the latter of which is the subject of the proposed zoning changes. I appreciate this opportunity to comment on Lenox Hill Hospital's application to rezone its site to upgrade the hospital facilities and add patient rooms. I regret that because the State Senate is in session today in Albany, I am unable to appear in person.

I join Community Board 8, Committee to Protect Our Lenox Hill Neighborhood, Inc., Friends of the Upper East Side Historic Districts, the New York Landmarks Conservancy, Carnegie Hill Neighbors, CIVITAS, and thousands of community members in strongly urging the City Planning Commission to reject Lenox Hill Hospital's application unless all of the modifications recommended by Community Board 8 are made. Due to the extensive scope of the proposed hospital expansion project under Envelope 1 or Envelope 2, there are significant impacts to the community and to city hospital infrastructure that must be considered when evaluating the rezoning application before the City Planning Commission.

I am proud to have included in my district the incredibly talented and dedicated members of Community Board 8, in whose boundaries this rezoning is being proposed. The board has worked diligently to analyze and assess this rezoning proposal, including Envelopes 1 and 2, since it was first proposed in 2019, which has included holding public meetings and considering testimony from hundreds of community members and stakeholder groups. With a unique understanding of the character of the neighborhood, as well as of the district that is home to multiple hospital facilities, the determination of the board to disapprove the zoning application as presented should carry significant weight moving forward in the Uniform Land Use Review Procedure (ULURP) process.

The zoning application would authorize a protracted hospital expansion project that proposes to modernize and enlarge Lenox Hill Hospital far beyond what is permitted under current zoning. My opposition to this zoning application does not reflect the integral role that Lenox Hill Hospital has served for decades, providing critical hospital care to New Yorkers and working tirelessly during the Coronavirus pandemic. The hospital has provided care in its current location since approximately 1905

and under the name of Lenox Hill Hospital since 1918. I appreciate the need for renovation in order to meet current standards of healthcare delivery, as well as Northwell Health's participation in meetings with community members. However, in spite of hearing extensive and detailed concerns about the duration and impacts of the expansion project under Envelope 1 and Envelope 2, the modifications that have been made to the project fail to address the concerns of community members. Furthermore, adoption of this expansive proposal is not justified and could have detrimental implications to city hospital infrastructure. Below, I highlight some of my primary concerns about the proposed hospital expansion project.

Scope of the Hospital Expansion Project

The Lenox Hill Hospital expansion project is extensive, in that it aims to upgrade the hospital's emergency department, surgical suites, clinical spaces, and patient rooms, as well as make additional renovations to the ambulance bay and maternity unit. Envelopes 1 and 2 would both involve prolonged periods of construction during and outside of business hours, as well as adding an uncharacteristically and excessively high tower, as per community zoning standards, to the current hospital facility. As Community Board 8 concluded in its resolution, the applicant's proposed FAR of 12.5 is unprecedented for a hospital campus in Manhattan.

The plan to upgrade patient rooms warrants particularly close scrutiny, as the size of the upgraded patient rooms significantly impacts the scope of the expansion project. The full complement of single- and double-bedded patient rooms would be modified, resulting in 475 larger sized single-patient rooms, all of which could be converted to critical care units. Although Lenox Hill Hospital would only gain 25 additional hospital beds, authorization to upzone has been requested to accommodate the additional space needed for these larger single-patient rooms.

The most recently available *Facility Guidelines Institute's (FGI) Guidelines for Design and Construction of Health Care Facilities* provides recommended dimensions for two types of single-bedded rooms: single-patient rooms and patient/family-centered care rooms. While both types of patient rooms are single-bedded, patient/family centered care rooms are notably larger. Recommended dimensions are also provided for intermediate care units (ICUs) and critical care units, the latter of which are larger in size. Based on my understanding from review of the guidelines and consultation with public health experts, the upgraded patient room size under the Lenox Hill Hospital expansion plan would be close to the maximum recommended size for single-bedded and critical care units.

Based on the high volume of hospital beds and low patient-to-bed ratio on the Upper East Side, the plan to upgrade all patient rooms to meet recommendations for patient/family-centered care rooms and critical care units is ambitious but may also be viewed as extravagant and unwarranted. Lenox Hill Hospital should reconsider this aspect of the proposed expansion project and opt for a more moderate patient room configuration.

How Would the Hospital Expansion Project Improve Health Equity?

The purpose of the ULURP process is to provide a standardized and transparent review process for important land use decisions. In the case of this application, at a time when health equity is an issue of significant concern, and because Northwell Health seeks rezoning authorization to undertake an extensive hospital expansion project that would be detrimental to the Lenox Hill community, as well as impact city hospital infrastructure, it is imperative to consider whether the requested land use would improve health equity in New York City.

New York City is home to world-renowned, highly-respected hospitals that excel in providing emergency, surgical, OB-GYN, and specialized health care services. Yet, there are millions of

residents of New York City who have inequitable access to hospital care due to where they live or their health insurance. Health inequities are further exacerbated by the current state of our citywide hospital infrastructure; namely, that as a result of hospital consolidation, closures, and bed de-certifications, there is a citywide shortage of hospital beds. Although we are fortunate to have quality hospitals, there are gross disparities in where hospitals are situated throughout the five boroughs, which is due in part to hospital closures. A prime example of this exists in my district, where there is a conglomeration of community and specialty hospitals located on the Upper East Side, while there are individuals and families living throughout the city who must travel long distances to receive the hospital care they need.

We need more hospital beds in New York City, but not on the Upper East Side, which has the lowest patient-to-bed ratios in the city. There are shortages of hospital care in Brooklyn, Queens, and the Bronx, and the recent closure of Mount Sinai Beth Israel left residents of the Lower East Side of Manhattan and parts of Brooklyn without a full service hospital in their communities. Under these circumstances, the scope and duration of this rezoning application cannot be justified. The hospital expansion project will not address a critical unmet public health need on the Upper East Side or make needed hospital services more accessible. Ultimately, upgraded patient rooms would increase the costs and decrease accessibility of receiving inpatient services at Lenox Hill Hospital for uninsured and underinsured New Yorkers.

I do support necessary upgrades being made to the hospital's emergency department, surgical suites, and clinical spaces, as well as moderate patient room upgrades that would adequately decrease the construction period and keep Lenox Hill Hospital within the zoning limits recommended by Community Board 8.

Impacts of a Protracted Hospital Expansion Project Timeline

Under Envelope 1 or 2, the Lenox Hill Hospital expansion project would have a minimum duration of at least nine years. Such a prolonged project timeline would be highly disruptive to the community and could have implications for citywide hospital infrastructure.

Community members surrounding Lenox Hill Hospital have voiced strong opposition to the hospital expansion project, as devised under Envelopes 1 and 2, based on concerns about the impacts of such a prolonged project timeline on residents and businesses in the community. Some of these include: prolonged noise pollution, including outside of usual permit work hours, caused by project construction, air pollution due to dust and debris from construction, traffic congestion, loss of natural light, and loss of revenue for local businesses.

We learned many lessons from the COVID-19 pandemic, including the crucial role of hospitals in treating large volumes of patients, and the importance of their ability to quickly implement hospital surge protocols. Even the Hospital for Special Surgery treated Coronavirus patients, and the former Mount Sinai Beth Israel Hospital, which had been providing inpatient care to a lower daily patient census, opened up beds out of necessity. Furthermore, it became necessary to direct all hospitals in the State to increase their bed capacity by 25%. Should another pandemic or epidemic strike, such as influenza A subtype H5N1 or measles, a protracted project timeline could compromise NYC hospital infrastructure, decreasing citywide hospital capacity to treat a large scale of infected patients, in addition to patients with other health issues. Even though Lenox Hill Hospital would remain open, prolonged work on patient rooms and surgical suites would reduce hospital capacity for a concerning period of time.

We must also consider the current status of hospital capacity in New York City when evaluating the appropriateness of the rezoning application and project timeline at hand. Since the COVID-19 public

health emergency expired, there have been reports of long waiting periods to be seen at many/most hospital Emergency Departments and to be admitted, as well as high inpatient occupancy rates. Even though Lenox Hill Hospital's inpatient occupancy rates have been trending lower than rates of other Manhattan hospitals, when one hospital's bed capacity decreases, this causes the inpatient occupancy rates of other hospitals to increase, especially for those hospitals that are in closer vicinity. Most recently, Bellevue and NYU Langone have experienced increases in Emergency Department visits as a result of Mount Sinai Beth Israel closing.

Implications for Health Care Costs

Healthcare affordability is an issue of increasing concern as commercial and Medicare health insurance premiums, as well as out-of-pocket health care costs continue to rise. The primary cause of this trend are increases in hospital costs.

Northwell Health representatives have asserted that health care costs will not increase as a result of the conversion to a full complement of larger sized single-patient rooms: currently, single-bedded patient rooms are not billed differently than double-bedded rooms unless a patient requests a single-bedded room without there being medical necessity.

While this billing policy could remain in effect throughout the duration of the proposed expansion project, there most certainly would be implications for health care costs upon its completion if not sooner. A full complement of larger sized single-patient rooms would provide added leverage to negotiate higher inpatient reimbursement rates with insurance providers and to raise the cost of inpatient care for patients who are paying out of pocket.

When speaking about rising health care costs, people in the industry frequently say that patients will not be impacted. I must respectfully disagree. As hospital and other health care costs increase, so do health insurance premiums. My office receives calls every year from constituents who are deeply concerned about the premium rate increases they face and whether they will be able to maintain their health insurance coverage. These concerns are further exacerbated by the massive federal funding cuts that are looming. The implications for health care costs is yet another reason that I am opposed to such an extensive rezoning and expansion project. The current application should be rejected, with the recommendation that Northwell Health modify the project to conduct more moderate upgrades to Lenox Hill Hospital.

The application before the City Planning Commission today addresses the need for renovations at Lenox Hill Hospital in order to meet current standards of healthcare delivery. However, the proposed expansion project is unjustifiably extensive, would negatively impact city hospital infrastructure, and would unnecessarily disrupt the neighborhood for a decade. Although Lenox Hill Hospital representatives have met with and heard extensive and detailed concerns from community members, the project modifications that have been made fail to address community concerns related to the project duration and community impact, including protracted disruption to the community and the addition of a high tower that is inappropriate given the zoning in the surrounding community. I strongly urge the City Planning Commission to reject Lenox Hill Hospital's application unless all of the modifications recommended by Community Board 8 are made.

Thank you for your time and consideration of my comments.

ORGANIZATIONS AND BUSINESSES

Committee to Protect Our Lenox Hill Neighborhood, Inc.

May 16, 2025

Hon. Dan Garodnick, Chair
Hon. Kenneth Knuckles, Vice Chair
Hon. Gail Benjamin
Hon. Juan Camilo Osorio
Hon. Alfred C. Cerullo III, Esq
Hon. Anthony W. Crowell
Hon. Joseph Douek
Hon. David Gold
Hon. Leah Goodridge
Hon. Rasmia Kirmani Frye
Hon. Orlando Marin
Hon. Raj Rampershad
Hon. Raju Mann

Re: **Lenox Hill Hospital (ULURP Nos. N250152ZRM, C250153ZSM, N250155ZCM, N250154ZAM, and C250151ZMM)**
City Planning Commission Public Hearing on May 21, 2025 (Calendar Nos. 112, 13, 14, and DEIS)

Dear Chair Garodnick and Commissioners:

We, the non-profit organization, the Committee to Protect Our Lenox Hill Neighborhood write to you today on behalf of the neighborhood's population of approximately 220,000 regarding our community's vehement opposition to the proposed massive rebuild of Lenox Hill Hospital that you are tasked to vote on within the next 60 days.

As Borough President Levine aptly noted in his recommendation to the CPC, there is broad consensus that Lenox Hill is in urgent need of modernization, but he rightfully added that local residents have raised "significant concerns" about the current plan, including building height, construction timeline and disruptions, patient experience and access to care. This led him to recommend approval subject to seventeen conditions including lowering the building height and reducing the construction timeline.

Similarly, Community Board 8 acknowledged that Northwell Health needs to modernize certain aspects of the hospital's campus. For its part, the community board voted overwhelmingly to disapprove the project, and, like the BP, they listed conditions which if satisfied would translate to CB support for the project. The CB listed eight conditions including the reduction of the maximum building height across the entire footprint of the building to 215 ft.

As you may be aware, Northwell Health earlier sought to rebuild Lenox Hill Hospital in 2019, involving a 516-foot hospital tower along its Lexington Avenue frontage and a 490-foot residential tower at its Park Avenue frontage, a proposal that the community united at the time to beat back. Northwell then returned in 2023 with a new proposal that sent shockwaves through our Upper East Side neighborhood when we came to understand that little had changed from the project that Northwell attempted to steam roll through the process in 2019. Except for the elimination of the residential tower on Park Avenue, to our dismay, the scale of the proposed hospital expansion along with the plethora of construction and permanent impacts threatening the health, safety, and welfare of our Lenox Hill neighborhood, were virtually the same. While the height of the Lexington Avenue hospital tower was moderately reduced, Northwell ignored wholesale the input that it received from our community stakeholders and elected officials since its 2019 proposal was withdrawn.

To our dismay, and especially in the face of extreme public outcry against Northwell's iteration of the project at the time of your Public Scoping Meeting in 2023, it continued to turn its back on our community with the certified ULURP application package by not budging from its plans to construct a colossal hospital tower on Lexington Avenue requiring a massive rezoning and other significant zoning approvals. What is worse, between the time of the Public Scoping Meeting and your certification of the application, Northwell steadfastly refused to meet with the community to discuss changes. It has become patently clear to us and our community partners, including FRIENDS of the Upper East Side, Carnegie Hill Neighbors, and CIVITAS, that Northwell, being the hospital behemoth that it is, fully expects that the City Planning Commission will rubber stamp their nine zoning actions and then Northwell will take their chances negotiating some minor changes with the Council, expecting that once they get beyond CPC review, they have the political gravitas to be home free at the City Council.

We implore you to take heed of the very detailed and thoughtful recommendation you have received from Community Board 8, which responsibly and appropriately considered from a land use perspective the extent to which the proposed rebuild of Lenox Hill Hospital is grossly out of context with the surrounding neighborhood. In this regard, it bears emphasis that by reason of the location of the hospital and the relatively limited footprint of its campus, from a land use perspective, Lenox Hill Hospital is not comparable to the other standalone hospital campuses on the Upper East Side or other in parts of the borough, where those other hospitals may exceed the square footage proposed for Lenox Hill.

As city planners and the shepherds of our great city's land use framework, we know that you appreciate and will consider that while NYU Langone, Mount Sinai, New York-Presbyterian/Weill-Cornell, Memorial Sloan Kettering Pavilion, MSK-CUNY, and NYP/Columbia, may have zoning square footages ranging from 2.65 million to 4.58 million, as well as comparable heights comparable to what is proposed for Lenox Hill Hospital, their

respective locations as well as the size and configuration of their respective zoning lots are not comparable. These other Manhattan-based hospitals either face a river or a major park while Lenox Hill Hospital is locked into the narrow streets of a congested and dense residential neighborhood. The scale of the project is unprecedented for its location in a residential area such as our Lenox Hill Neighborhood and grossly out of context. It will increase the hospital campus in size from its current development of approximately 781,500 gsf (620,500 zsf), which is approximately 7.5 FAR and already exceeds the current zoning limits for the site, to approximately 1,390,000 gsf (1,034,471 zsf), which is approximately 12.5 FAR.

The proposed hospital tower will rise to a staggering height of 436 ft. at Lexington Avenue, where current zoning limits building height to 175 ft. At 436 ft. the proposed tower height is the equivalent of a 44-story building (based on the standard 10-ft. ceiling height), not the 26 stories depicted by Northwell based upon its proposed 16-ft. ceiling heights. The ULURP application proposes an alternate plan that reduces the tower height to 395 ft. at Lexington Avenue, but it does not reduce the overall bulk of the new building and instead shifts the bulk by raising the height of the building at the midblock from 210 ft. to the confounding height of 360 ft., which is a midblock zoning envelope that we cannot even imagine your commission would ever consider.

The Committee to Protect Our Lenox Hill Neighborhood – joined by our community partners including FRIENDS of the Upper East Side, Carnegie Hill Neighbors, and CIVITAS, along with prominent public interest groups including The New York Landmarks Conservancy and The City Club – mounted a concerted effort before CB 8 in opposition to the project. Our opposition echoed the many thousands of our Upper East Side neighbors who by petition, letter, email, and public testimony, have consistently registered their vehement disapproval of a project of this scale at the Lenox Hill Hospital campus. More than 6,000 have signed a petition opposing what is proposed for the hospital. The community's overwhelming voice in opposition was joined by members of the Nation's largest residential building service workers union Local 32BJ, who testified at the CB 8 public hearing expressing serious concerns over the impact that this project would have on health care costs for their members and the public at large.

Here are key issues for the CPC to consider:

1. Northwell's plan seeks nine unprecedented zoning actions that will forever change the character of our neighborhood with its12.5 FAR, which represents staggering 250-500% zoning increases. Buildings of this scale are found only in Midtown, Hudson Yards and the Financial District – they have no place in a crowded residential neighborhood. The extreme upzoning sought by Northwell ignores the context of the existing zoning laws, which were intended to protect the iconic streetscapes of the surrounding historic neighborhood and beyond.

2. The decade of construction that Northwell admits will be required by the current proposal is an intolerable burden on our densely populated residential

neighborhood. The environmental impacts of construction of this scale for such an extended period threaten the health and safety of residents as well as the hospital's patients and staff. In this regard, we ask you to consider the psychological impact and potential harm on our neighborhood children and seniors forced to live in a construction zone for a decade.

3. The expansion of the hospital as proposed is not needed in order for Northwell to make the hospital improvements that all of us agree are required. The hospital already has more hospital beds than it can fill. Results of the NYS Department of Health's hospital capacity survey, which hospitals must fill out daily, showed that as of May 15, the hospital reported that it had a seven-day average of 25% of its beds available – in other words vacant. Lenox Hill's 25% vacancy rate is far above the seven-day average rates for some other Manhattan hospitals, such as Harlem Hospital (2%), NY Presbyterian (11%), NYU Langone (13%), Bellevue (14%) and Mount Sinai (17%). Lenox Hill's vacancy rate also far exceeded those reported for Brooklyn hospitals, including Coney Island Hospital (6%), Woodhull (7%) and Kings County Hospital (10%), as well as such Queens hospitals including Jamaica Hospital Center (11%) and Northwell's own Long Island Jewish Medical Center (8%). In fact, the hospital's occupancy rate has been declining for a decade. The proposed expansion of Lenox Hill Hospital would give it 475 beds – but the hospital's recent occupancy rates would suggest a smaller, not larger, number of beds to "right size" Lenox Hill – perhaps 300 to 350 beds.

4. As proposed, the hospital expansion would be extremely costly at over $2 Billion, resulting in ever higher healthcare costs for patients in order for Northwell to make the project financially viable – one of the reasons that Local 32BJ testified in opposition to the project at CB 8's March public hearing.

5. This is a plan driven by market share forces and corporate egos, not by medical needs. The hospital is trying to attract wealthy patients who can afford to pay for single rooms not covered by insurance (Lenox Hill already charges 330% of what Medicare reimburses). This $2+ Billion construction project will add more than $100 million in annual interest expense not including amortization and debt payback, as well as much higher operating costs, when today Lenox Hill Hospital just covers costs. Northwell has never publicly addressed the immense financial implications of this project.

6. The Upper East Side is already overserved with hospitals. The five major hospitals in the immediate area provide a combined total of 10.58 acute care hospital beds for every 1,000 residents – nearly four times the citywide rate of 2.7 beds per 1,000 residents. At the same time, other neighborhoods in Manhattan as well as the outer boroughs are "hospital deserts" and desperately in need of new and better hospitals – one of the reasons that health equity advocates gave voice to this concern at CB 8's March public hearing.

7. While the proposed subway improvement is a welcome aspect to the project and most certainly a step in the right direction, it falls far too short. Moreover, as a community amenity, the subway improvement simply represents too thin a reed upon which to support what is otherwise a hopelessly inappropriate development scheme. The subway improvement falls short because the plan only addresses the downtown subway platform – NO uptown elevator access. Moreover, the proposed elevator only goes to the tollbooth level and then a long ramp reaches the platform. Wheelchair/walker-bound patients will have a difficulty navigating the steep uphill ramp arriving at the station.

For these reasons, we ask that you DISAPPROVE Northwell's current plan. The proposal is without merit as a matter of public policy, and it will destroy one of the most densely populated residential neighborhoods in the City. Approval of the project, even with conditions, almost guarantees no changes and no relief to the community. Your disapproval will ensure that these articulated concerns are highlighted for the next steps in the ULURP process.

Respectfully,

Committee to Protect Our Lenox Hill Neighborhood, Inc. by

Andrew Gaspar	Andrew Soussloff
Alfred Hurley, Jr.	Ann Goodbody
Stephanie Reckler	Stacy Krusch

CARTER LEDYARD MILBURN

Memorandum

To: Members of the New York City Planning Commission
Hon. Daniel Garodnick, Chair
Department of City Planning - Environmental Assessment and Review Division
Stephanie Shellooe, AICP, Director
From: Karen Meara
Subject: Lenox Hill Hospital Redevelopment – CEQR No. 23DCP079M
Date: June 2, 2025

We write as environmental counsel to the Committee to Protect Our Lenox Hill Neighborhood to expand on our testimony delivered May 21, 2025 regarding the Draft Environmental Impact Statement ("DEIS") prepared for the Lenox Hill Hospital Redevelopment application (the "Application").

The Applicant's proposal to substantially expand the existing Lenox Hill Hospital ("LHH") with a structure the size and shape of a midtown office building (the "Project") over a construction timeframe of nine or more years for, at best, a *de minimis* net public benefit is likely to result in a range of significant adverse impacts on the immediate community and beyond. The DEIS does not meet the requirements of the State Environmental Quality Review Act ("SEQRA") as it fails to identify and take a "hard look" at the Project's foreseeable environmental impacts and to consider a range of alternatives that could mitigate them. Instead of providing the transparency required under SEQRA, the DEIS downplays, obfuscates and in some cases altogether ignores potential adverse impacts. In turn, its proposed mitigations (including alternatives) fall predictably short, particularly in areas relating to changes in bulk controls, construction impacts other than noise, and health care inequities. Even where the DEIS identifies significant adverse impacts in the areas of shadows and construction noise, the DEIS claims, with insufficient evidence, that there are no feasible alternatives that could reduce or avoid such impacts. Thus, the DEIS does not provide an adequate basis for the Commission to make the required SEQRA findings and must be substantially revised or the Application should be rejected.

SUMMARY OF FINDINGS

The Project's proposed zoning scheme and building form would be a dramatic departure from current conditions and from the Commission's longstanding practice with regard to bulk controls in residential neighborhoods. The proposed combination of very large floor plates (over 30,000 sq. ft), height (436' or 395'), and minimal setbacks, would be unprecedented outside the City's central business districts. The proposed tower would extend 80 feet - almost halfway - into the midblock. The proposed tower would rise to two and a half times the height permitted on Lexington Avenue, and five times the heights permitted on the midblock on East 76th and 77th Streets. The Project would increase density on the block from 7.5 zoning FAR to 12.5 zoning FAR – unheard of in the Study Area or in any residential neighborhood in New York City. At every step, the DEIS downplays and obfuscates the magnitude and unprecedented scale of the

project, with predictable results; it incorrectly concludes that there would be no adverse impacts in the areas of zoning, public policy, urban design, visual resources, historic resources and neighborhood character. The substantial and unprecedented nature of the proposed changes in bulk controls must be directly acknowledged and honestly evaluated in accordance with SEQRA's mandate to take a hard look.

The DEIS fails to articulate a clear and consistent need for the Project. To be clear, we do not question the Applicant's desire to embark on some form of renovation of its aging facility. Rather, what the DEIS fails to articulate is the need for this specific, costly, massive Project over alternatives that could meet many of the Applicant's programmatic needs while imposing fewer adverse impacts on the community. While the DEIS claims that 475 single bedded inpatient rooms will be needed to meet future projected hospital admissions, this claim is not supported with data in the DEIS. Worse, the claim is contradicted by various publicly available databases showing that LHH's self-reported average daily inpatient census has been far below levels that would indicate anything close to a need for 475 beds. Although LHH is theoretically certified for 450 beds, last week alone the hospital reported that it had only 344 "total beds", 71 to 75 of which were "available," begging the question as to why LHH is planning to increase the number of beds rather than decrease them. And to the extent the Applicant is counting on increases in market share to fill beds (dubbed "programmatic growth" in the DEIS), the DEIS fails to evaluate whether approval of the Project could exacerbate health care inequities, contrary to City policy goals.

The Projects' proposed nine-year construction timeline would impose substantial burdens on the immediate community. While the DEIS acknowledges the burden of construction noise, it substantially understates other adverse construction impacts in the form of traffic gridlock, reduced air quality, loss of parking, and pedestrian hazards, and, in turn, fails to offer any mitigation. While public decisionmakers sometimes issue public approvals for a project with such substantial construction impacts, they typically only ask the community to bear such outsized burdens when the project brings an outsized, compelling public benefit, like construction of the Second Avenue subway. Here, even by the Applicant's own statements, there would be no significant net increase in public services, just a "continuation" of existing services in an area that has the highest concentration of inpatient hospital beds of any neighborhood in the City.[1] Respectfully, any net benefit does not justify the extraordinary burdens that Northwell would impose on this community.

ANALYSIS OF DEIS

Project Description

The DEIS's Project Description provides incomplete Project information, and mischaracterizes the severity of proposed changes in bulk controls, as well as the character and conditions of the existing neighborhood against which its impacts must be assessed.

The Description of the Surrounding Area

Although the surrounding area is primarily residential, (as is clear from Figure 2-1), with secondary institutional and retail uses typical of residential neighborhoods, the text of the DEIS never says so. Instead it downplays the residential character and elevates the institutional and

[1] See, e.g., statement of Dr. Daniel Baker, Executive Director of LHH at May 21, 2025 public hearing at roughly, 1:45:00-1:45:30, available at May 21st, 2025: City Planning Commission PUBLIC MEETING.

commercial character by, for example, describing the area as “a mix of institutional, residential and retail uses,” and mentioning “mixed-use commercial/community facility buildings” in the same breath as “residential uses,” without qualification, even though there are very few of the former, and residential buildings predominate. Similarly, although about half of the Study Area is zoned R8B – a medium density district subject to contextual bulk controls, the DEIS’ characterization of existing zoning implies that high density zoning predominates.[2] The text should be revised to make clear that this is a predominantly residential neighborhood. The Description would also benefit from inclusion of an aerial photo of the Study Area like the one below, which conveys, perhaps more effectively than words, the existing conditions at the Project site and in the surrounding area.

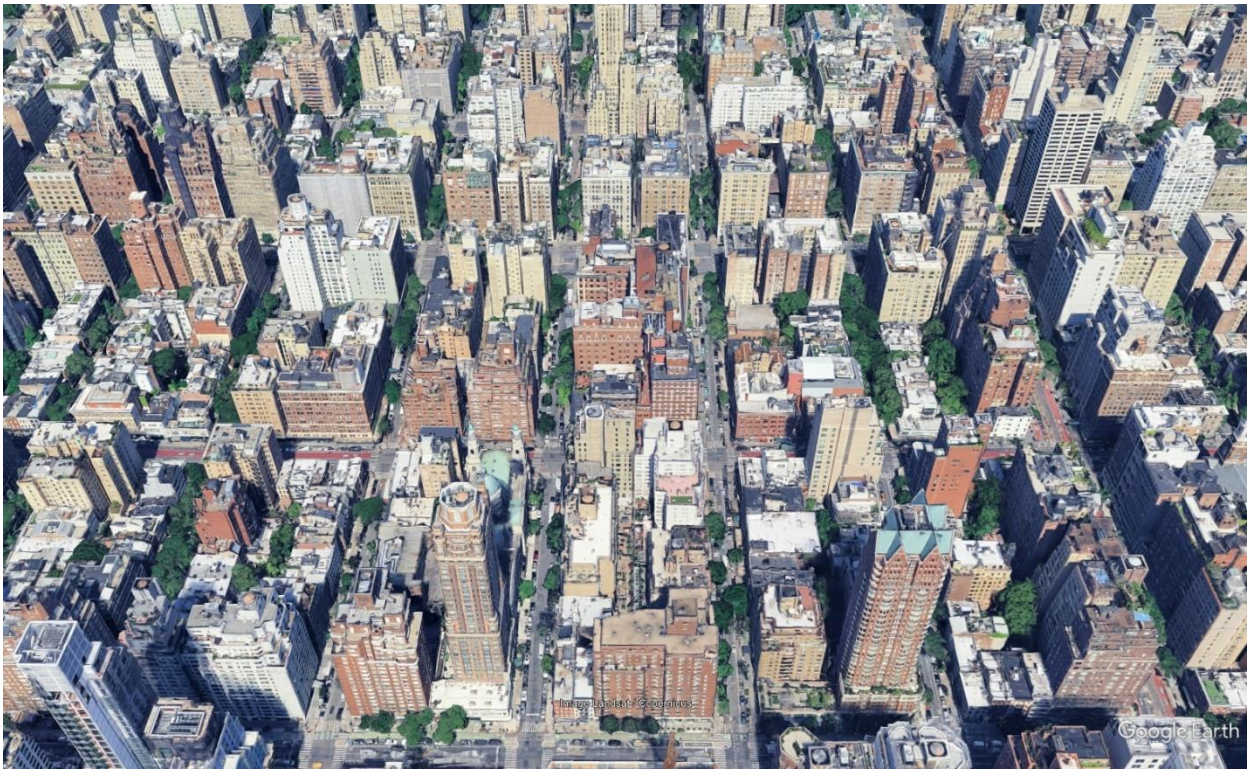

Photo provided by George Janes, AICP. Looking west from Third Avenue at the bottom of the image towards Madison at the top. The Project Site lies roughly in the middle of the image.

Description of the Proposed Project

The Description of the Proposed Project lacks basic information and contains inaccuracies. For example, the Description fails to fully disclose how the facility’s proposed 1,034,500 zsf would be allocated to programmatic needs. It provides “sf” allocations for the applicant-identified primary drivers of the need to enlarge – 415,500 sf for single patient rooms, 132,000 sf for operating rooms and 41,500 sf for the emergency department (including support areas for all three.[3]) for a total of 589,000 “sf” -- but does not explain how the remaining 440,000 square feet (assuming sf refers to zsf) would be utilized. Without a complete delineation of

[2] See DEIS at 1-4 to 1-5 (describing high density zoning on seven different wide streets, four of which are beyond the Study Area).

[3] These totals indicate the Applicant has allocated 874 square feet for each single patient room, 4400 square feet for each operating room and 864 square feet for each emergency room treatment position.

current and proposed use of space, the Commission will not have the information it needs to evaluate the claimed need for 12.5 zoning FAR, 16.9 gross FAR and the viability of alternatives.

The Description also implies there would be no change to heights at the midblock. That is simply not true. As the DEIS notes, the "midblock" here and throughout the Study Area and beyond, is zoned R8B. That includes all portions of East 76th and 77th Streets beyond 100' of Park Avenue and 100' of Lexington Avenue, currently occupied by buildings ranging from 40 to 200 feet. The Project would introduce a building that rises to 436' (or 395' under Envelope 2) a full 180' feet from Lexington, or 80 feet into the midblock. The DEIS does not acknowledge that fact. Instead, it claims that "the midblock portion of the new building under Envelope 1 could be approximately 210 feet tall." See DEIS at 1-5. That plainly inaccurate statement, which is repeated throughout (see, e.g. DEIS at ES-5, 1-14, etc.), is contrary to SEQRA's purpose to provide a transparent and thorough assessment. It must be corrected to clearly state all heights proposed at the midblock.

Finally, the DEIS provides incomplete information regarding the LHH site's existing buildings, how much square footage would be retained versus lost via demolition,[4] and how the six buildings to remain – which the DEIS describes as lacking "the appropriate space and structural elements needed to create the modern- hospital compliant with the [FGI Guidelines[5]]" -- are proposed to be utilized to meet the Project's stated programmatic needs after renovation. To the extent data is provided, it raises more questions than it answers. For example, Appendix A, Attachment 1 suggests that 139 double patient rooms in the buildings to remain would be converted to single patient rooms. See DEIS App. A, Att. 1 at 1-6. What's unclear is whether that's the total number of rooms that would be located in the remaining buildings versus the new building. Regardless, the new building would only need to provide at most 336 of the 475 rooms. However, the eight floors above the podium alone would seem to have space for 240 rooms.[6] That begs the question of whether five floors of the podium must be dedicated to patient rooms and if not, how that space would be used. The Project Description must provide a full accounting of the current and proposed zsf and gsf by programmatic area so the Commission has a complete rather than piecemeal understanding of which project elements are driving the proposed increase in scale.

<u>The Purpose and Need is Vague and Incomplete</u>:

The "Need" for 475 Inpatient Beds

The Applicant claims the Project is necessary due in substantial part to (a) increase the total number of beds from 450 to 475 and (b) to replace the 139 double-bedded patient rooms with single-bedded patient rooms to meet the 2018 FGI Guidelines for new hospitals. However, in the first instance, the DEIS fails to make even a conclusory case that 475 beds will be needed in 2036 and beyond.

Nowhere mentioned in the DEIS but critical to evaluating the stated 475-bed need is actual utilization rates of the 450 beds currently certified by the State. According to data submitted by LHH to the American Hospital Association, the hospital's average daily patient census in 2022,

[4] While some of this information is listed in the ULURP application, it is not discussed in the DEIS.
[5] The Facility Guidelines Institute's 2018 Guidelines for Design and Construction of Hospitals.
[6] See Lenox Hill Redevelopment Plan ULURP Application, Drawing Set A at Sheet ZZ-01 (depicting 30 rooms per floor at 22nd and 23rd floors)

2023 and 2024 was 298, 331 and 312 respectively, for annual utilization rates of 70.1%, 75.9% and 70.0%.[7] Over the past seven days, a separate State report (also based on data self-reported by LHH) indicates that Lenox Hill Hospital had an available bed rate of 21%, but on a baseline of 344 (not 450) total beds. In other words, LHH reported an average inpatient census of 269.[8]

While Dr. Baker claimed at the Public Hearing that an 80% utilization rate was more "accurate" than what had been previously reported by LHH to the State due to an "error" in the denominator, it appears LHH's suddenly improved utilization rates are based not on any increase in total inpatient numbers but on a decrease in "total beds" reported to the State (344). Without that adjustment, it would appear LHH's utilization rates are about 60%. The Commission must supplement its demands that the Applicant back up its inpatient projections with a demand that it explain why it is reporting to the State that it has only 344 "total beds" at the same time it is asking the Commission to assume a future No Action condition with 450 beds and With Action condition of 475 beds. Understanding utilization is critical because it goes to the purpose and need for a hospital of this size and the bulk waivers that are requested.

According to the DEIS, although inpatient utilization rates have been dropping for two decades, Northwell expects that trend will reverse both because the population is aging and because Lenox Hill expects "programmatic growth" in "cardiac surgery and neurosurgery" as well as other specialties "for which LHH is renowned such as cardiovascular, neurosciences, and women's health." Appendix A, Attachment 1 at 1-4. There are three problems with these claims. First, anticipated programmatic growth is not quantified and directly contradicts Dr. Baker's response to Commissioner's questions on the purpose and need for the Project, which he described as merely a continuation of existing operations. The Commission must be given a straight answer on this point – is LHH's goal to grow and to pull market share from other hospitals, or simply to continue current service levels?

Second, the data provided to support the Applicant's "aging population" argument (a projected 2% increase in admissions and 8% increase in length of stay over the next decade) falls far short of justifying 475 beds, particularly given current trends in utilization at LHH (an average daily census of about 314 over the last three years, 269 over the last seven days).

Third, as Dr. Baker testified, it is much easier for a hospital to fill beds if it has all single-bedded rooms. Yet he still seemed to insist that an 80% utilization rate was an appropriate target, without differentiating between LHH's current and future mix of single versus double-bedded rooms. Dr. Fred Hyde, MD, JD, MBA, a hospital expert with substantial experience developing and running large medical facilities, has previously testified in this ULURP that utilization rates can approach 90% if a hospital has all single rooms and need not worry about ensuring compatibility of roommates.[9] Although this issue speaks directly to inpatient bed projections, the DEIS does not address it at all. In sum, the Applicant has failed to justify a need for 475 beds, and the scope of the Project must be reduced accordingly. Health experts submitting comments on this ULURP have suggested 300-350 beds.[10]

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[7] See Attachment A: Lois J. Uttley, M.P.P, Supplemental Letter to the New York City Planning Commission on the Application, May 29, 2025 (citing American Hospital Association data)

[8] See New York State Department of Health, Hospital Bed Capacity Dashboard, available at Hospital Bed Capacity | Department of Health (data from 5/31/2025)

[9] See Attachment B (Fred Hyde, MD, JD, MBA, Letter to Community Board 8 on the Application, March 12, 2025, at 3).

[10] See Attachments A and B to this memo.

Finally, as a Citywide policy matter, the DEIS does not and could not point to any authority identifying a public need for more inpatient beds on the Upper East Side. As others have pointed out, the Upper East Side already has far more hospital beds per 1000 residents (10.58) than any other part of the City, which averages 2.7 beds per 1000 residents. See Attachment C.[11]

The "Need" for other Bulk Increases

The DEIS claims that to fully meet future hospital needs, it must grow from 620,500 zsf (781,500 gsf) to about one million square feet (1.4 million gsf). As noted above, although the DEIS provides some square footage estimates for specific programmatic uses like inpatient rooms and operating rooms plus support space, it nowhere fully explains why the hospital needs such huge expansions in zoning FAR (from 7.5 to 12.5) and gross FAR (9.6 to 16.9) to accommodate such modest increases in scope of service (i.e. 25 additional beds, 5 additional operating rooms and 14 additional emergency treatment stations). Beyond the claimed need for 475 single-bedded inpatient rooms, the DEIS relies heavily on "industry standards" (without attribution) and dimensions included in the 2018 FGI Guidelines to justify added bulk. Nevertheless, there are gaps. For example, the DEIS states that 14 to16 foot ceiling heights for patient room floors are "industry standard" but does not explain why the Applicant "needs" 16-foot floor-to-floor heights rather than something closer to 14 feet. In fact, Project incorporates lower floor-to-floor heights below the podium in one of the two proposed scenarios, indicating that lower floor-to-floor heights could be used throughout.

The DEIS also cites no authority for the Applicant's decision to make all inpatient rooms "critical care" capable. This decision results in an average room size of 340 square feet, at the high end of the range cited in the DEIS as "industry standard" (250 to 375 sq. ft). DEIS 1-8. Finally, with minor exceptions relating to the size and height of operating rooms and emergency room treatment stations, the DEIS provides no discussion at all that would explain why other spaces that contribute to the Project's bulk, including the 440,000 zsf that the DEIS does not programmatically break out, as well as the support areas associated with the patient rooms, ED and OR, require the amount of floor area proposed.[12]

The "Need" for a 9-year Construction timeline

The Applicant claims the highly unusual nine-year construction timeline is impossible to further compress in part because it would inconvenience LHH doctors, "many of whom have located their offices in proximity to LHH," to require them to possibly leave the neighborhood or Manhattan to carry out "rounds" or "deliver emergent interventions in a timely manner." Appendix A, Attachment 1 at 1-9. But it is hardly a rarity in the medical field in New York City and elsewhere for health care employers to require physicians and other caregivers to deliver services across multiple and occasionally changing locations. Inconvenience is not a basis to impose the impacts of nine-years of construction on the community.

The DEIS also claims that closing a hospital is a complicated process. What it does not do is provide further detail so that the Commission can make up its own mind as to whether

[11] Lois J. Uttley, Comment Letter dated May 20, 2025 submitted to City Planning on behalf of Community Voices for Health Care Accountability.
[12] See also Attachment B (Hyde letter discussing decline in birth rates and emergency visits).

temporary closure is so complicated as to render it impossible, or simply something that is achievable but inconvenient.

The DEIS also fails to explore whether there is a way to keep a smaller part of the existing hospital open and utilize space in the many other Northwell-owned facilities in the area to enable both continuity of care and whether the Project's Stage 3 and 4 work can be carried out at the same time as Stage 2 work. These other Northwell-owned facilities include the new 200,000 square foot ambulatory care facility under construction on Third Avenue, scheduled to open in 2026, the Manhattan Eye, Ear and Throat Hospital on 64th Street, and smaller facilities on East 75th and 76th Streets. Finally, the DEIS fails to mention how the Northwell facility in Greenwich Village is related to the LHH program both during construction and afterwards.

Analysis Framework and Staffing Assumptions

The analysis framework is fundamentally flawed in a way that downplays and undercounts the Project's significant adverse impacts. The DEIS assumes that in the future without the Project, LHH would operate and staff 450 beds. While LHH is entitled to operate that many beds under its certification, recent utilization rates noted above indicate much lower actual utilization rates and staffed bed rates (344 on May 31 with an average of 269 filled over the prior 7 days), and the DEIS provides no evidence that such rates could be expected to substantially reverse under the No Action condition. Thus, both Existing conditions and the No Action condition should be corrected accordingly. The overstatement of Existing conditions vis-a-vis staffed bed numbers carries over into the staffing and visitor figures reported in the "Typical Average Weekday Daily Persons" chart. See DEIS Table 1-1. Specifically, Table 1-1's "Existing" inpatient staff, patient and visitor totals under both the Existing conditions and Future No Action condition assume (without basis) that 450 inpatient beds are being or will be staffed. Both the Existing conditions and Future No Action inpatient staffing figures must be updated to reflect lower actual and projected staffing rates without the Project. Failure to do so would result in undercounting projected impacts related to staffing and patient visit levels compared to a 475 bed With Action condition in areas such as Transportation.

Land Use, Zoning and Public Policy:

The DEIS's analysis of the Project's adverse impacts on land use, zoning and public policy is incomplete and understates or ignores the significance of the proposed changes and resulting impacts.

According to the City's CEQR Technical Manual, a proposed action has adverse impacts when it "would result in significant material changes to existing regulations or policy" or when "the project would create a land use conflict or would itself conflict with public policies and plans for the site or surrounding area." CEQR Technical Manual at 4-25.

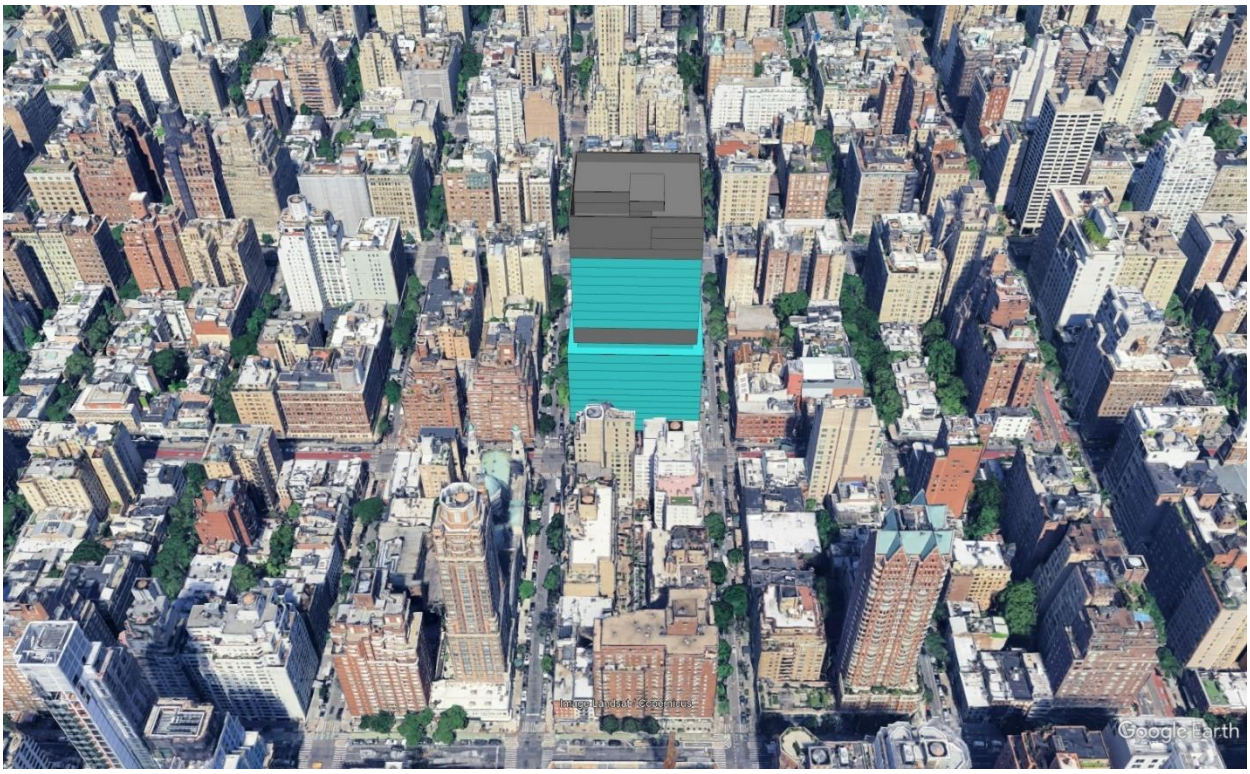
The proposed zoning changes to the Project Site, particularly the proposed bulk changes, would unquestionably be a "significant material change to existing regulations or policy." As discussed above, the Commission's longstanding policy and practice in residential neighborhoods, reflected in the City's Zoning Resolution and Map, is to map higher density and bulk on wide streets and zone lower density on midblocks. This strikes a balance between providing for growth and density while preserving light and air for residents. The wider the street, the greater the density permitted (see, e.g. high density zoning adjacent to the entrance to the Queensborough Bridge, York Avenue and the FDR) and the narrower the street, the greater prevalence of bulk controls such as the height limits and setback requirements under R8B

mapped on midblocks across the Upper East Side and elsewhere. Contextual protections, including a 170-foot height limit,[13] were mandated on Lexington from 61st to 98th Street in recognition of the fact that Lexington, at 75 feet wide, is one of the narrowest avenues on the Upper East Side, in contrast to Third Avenue which is 100 feet wide and has commensurately less restrictive bulk controls. This zoning pattern is by no means unique to the Upper East Side; the Commission has been protecting access to light and air across the City's neighborhoods while upzoning for growth on wider streets for decades.[14]

The Proposal would take several unprecedented actions that starkly conflict with longstanding zoning policy embodied in the City's Zoning Resolution and Zoning Map. First, it would map C1-8 in a midblock location. There is not a single midblock in the entire City that has been mapped C1-8. And although the DEIS notes that a midblock on 67th Street was zoned C2-7 in 2020, that amendment capped midblock height at 233 feet, in contrast to a midblock height of 436' or 395' proposed here. Second, it would convert a block with a total density (7.5 zoning FAR and 9.4 gross FAR) that is comparable to the density of other blocks in the Study Area and beyond into a block that is jarringly inconsistent, with 12.5 zoning FAR and 16.9 gross FAR. An analysis prepared by planner George Janes for CPOLHN illustrates that not a single block outside the City's Central Business Districts has such high gross FAR.[15] Third, the Project's bulk waivers would introduce a building form – large floorplate, minimal setback, substantial height – that is (i) completely inconsistent with existing zoning and built conditions in the Study Area and well beyond and (ii) comparable to the bulk of buildings like One Vanderbilt and the Empire State Building.

The DEIS completely downplays, glosses over or entirely avoids these stark departures. For example, it asserts that the Project's "proposed bulk would be consistent in scale with other institutions and medical facilities in the area." That is nonsense. The proposed bulk would be absolutely inconsistent with the scale of "other institutions and medical facilities in the" Study Area:

[13] Increased in 2024 to 175 under City of Yes.
[14] See NYC Zoning Map, available at ZoLa | NYC's Zoning & Land Use Map
[15] See Attachment D, George M. Janes, AICP, Lenox Hill Hospital Proposal; 2025 update, at 4.



Source: George M. Janes AICP.

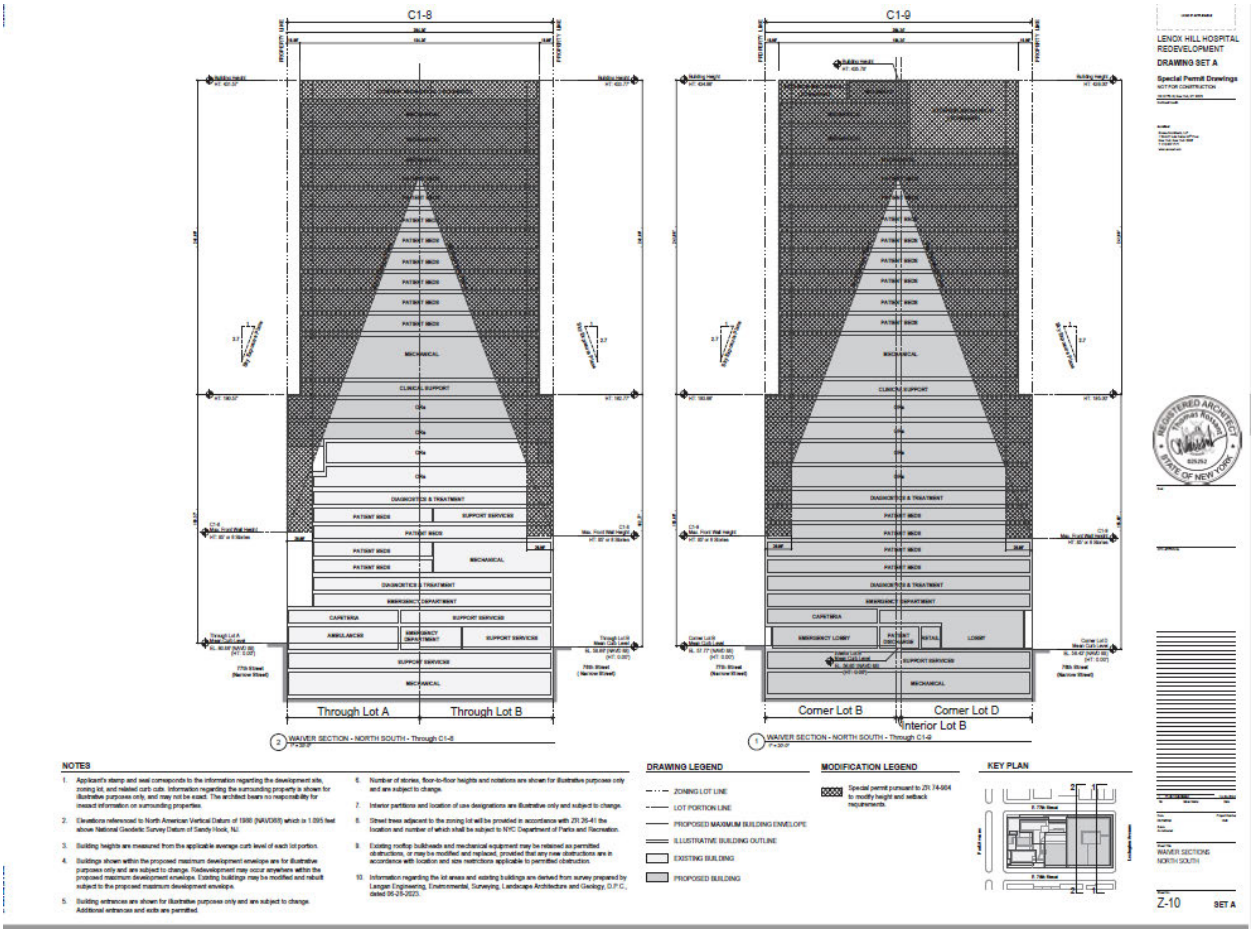
The only “institutions” in the Study Area are churches, schools and medical offices whose building forms bear no resemblance whatsoever to the proposed Project. Nor do any non-institutional buildings in the Study Area bear even a remote resemblance to the Project’s proposed building form. Even the tallest apartment buildings are dwarfed by the Project’s floorplates, which are more than five times the size of any 400’ tower in the Study Area and at least three times the size of any 300’ towers.

To the extent the DEIS implies it may evaluate a zoning proposal’s bulk consistency by comparing the Project to facilities that lie far outside the Study Area, such as Mount Sinai, which is about 0.9 miles north or MSK, which is about 0.5 miles east, that is wrong. As the DEIS’s Land Use and Zoning chapter acknowledges in its Methodology discussion: “According to the CEQR Technical Manual, the 400-foot study area is the area within which the Proposed Project could reasonably be expected to have potential effects.” DEIS at 2-2. Thus, the DEIS’s attempt to evaluate bulk consistency by comparing it, not to the area “expected to have potential effects” but to hospital campuses far outside the Study Area must be rejected as failing to conform to the CEQR Technical Manual’s guidance and SEQRA’s mandate to evaluate adverse impacts on those most likely to experience an action’s adverse effects. Through that lens, there is no question that the proposed zoning changes would create a substantial and jarring inconsistency with bulk controls in the Study Area and with the City’s longstanding zoning policy in residential neighborhoods. The DEIS must be revised to accurately reflect that the Project’s unique combination of height, huge floorplates and lack of setbacks is substantially inconsistent with bulk controls in the Study Area and, in turn, that the Project’s reversal of decades of precedent would have a significant adverse zoning impact.

While it is not appropriate in a SEQRA analysis to evaluate the Project’s zoning consistency against hospital campuses far outside the Study Area, we note for the record that the Project

site and context is entirely distinguishable; (a) all have lower gross FAR than what's proposed here, (b) all have larger campuses than LHH, (c) all are located in very different contexts, such as adjacent to the FDR and/or within a cluster of larger institutional uses, or adjacent to Central Park, as opposed to wedged between four residential blocks with contextual bulk controls, (d) all tall large floorplate buildings approved on these campuses have greater separation from residential uses than the Project, and (e) each were evaluated under SEQRA, taking into account the unique contexts of their own study areas.[16]

Finally, we note that the DEIS should but does not even attempt to quantify the extent of the proposed bulk waivers with images or text capturing the increment between the building forms that would be permitted under the new C1-8/C1-9 zoning without waivers and the special permit bulk waiver condition. Most stark would be the waivers on East 76th and 77th Streets, even after the substantial upzonings to C1-8 and C1-9. As is clearly illustrated in the Application's Drawing Set A at Z-10, the requested bulk waivers would obliterate the sky exposure plane on the side streets (gray shading represents massing permitted only via bulk waiver):



Although that information may be gleaned by a search through the detailed drawings for the application, it should have been clearly and comprehensively disclosed in the DEIS as required under SEQRA.

[16] See, e.g., Attachment D at 8-16.

The DEIS fails to analyze the "with action" condition as-of-right under C1-8 and C1-9

The DEIS is flawed in that it fails to analyze an as-of-right development on the Project site. An approval to rezone the Project site from C1-8X to C1-9 and R8B to C1-8 would enable the site to be redeveloped not only with the Project, but also with an as-of-right R9/R10 use, including an alternative large scale community facility use, each of which could have different and possibly more significant adverse impacts. Absent an enforceable restriction on the Project Site preventing other as-of-right developments under the rezoning without further environmental review, the Commission has an obligation to take a hard look at the reasonably foreseeable potential consequences of its action. In its determination to adopt a slightly enlarged version of the Project as the "Reasonable Worst Case Development Scenario," the DEIS did not even consider the possibility that the Project Site could be redeveloped in a manner different from the Project. Although the Technical Manual allows that in certain instances the RWCDS and the specifically proposed project could be one and the same, such as where "a restrictive declaration, a lease or other agreement between the project sponsor and the City" limit the range of development scenarios, those are not the facts here. DEIS at 2-9. The DEIS must be corrected or a restrictive declaration imposed.

The DEIS Evaluation of Consistency with Public Policy is Cursory and Wrong

The DEIS concludes that the Project would contribute to OneNYC's goals, which include promoting "healthy lives," defined earlier in the DEIS to mean "reducing inequities in health outcomes". See DEIS at 2-17 and 2-9. However, health care advocates and experts commenting on this ULURP application have argued just the opposite. According to Community Voices for Health System Accountability representative Lois Uttley and health care administration expert Dr. Fred Hyde, the Project would likely (a) increase health care costs at Lenox Hill Hospital; and (b) exacerbate a concentration of health care resources on the Upper East Side. See Attachments A to C. According to US News and World Reports rankings, LHH ranks in the bottom third of US institutions in terms of its provision of care to Medicaid recipients and the uninsured. See Attachment A at 1-3. New York State databases indicate that LHH provides less pregnancy and childbirth care to Medicaid recipients than every hospital in New York City except one. See Attachment A at 3, 5-6. The DEIS fails to consider how the hospital's redevelopment would impact these inequities. Would the creation of a separate maternity entrance on Park Avenue and all single rooms further reduce LHH's provision of maternity care to women who are uninsured or on Medicaid? Dr. Baker stated at the Public Hearing that the Project would improve health outcomes at LHH, but even if that is true for LHH patients, the Project could nevertheless lead to greater inequities in health outcomes depending on who will be served by the future LHH. The DEIS must reevaluate the Project's consistency with the City's goal of "reducing inequities in health outcomes" and provide a transparent and complete assessment based on payor mix projections, which the Applicant should be required to provide.

The DEIS also claims the proposed Project would advance the LifeSci NYC Vision Plan. However, there is no indication that LHH's participation in two student health related mentorship programs -- one based out of Northwell's Hofstra Zucker School of Medicine and the other, a seven-week program for high school students that includes visits to several Northwell owned facilities, not just LHH – would be reduced or discontinued under a No Action scenario or rely in any way on the specifically proposed zoning amendments sought here. In fact, the DEIS says as much in its discussion of the No Action Condition: "it is anticipated that NYC will continue to advance its existing plans and policies throughout the City, including . . . LifeSci NYC Vision Plan."

Finally, grasping at straws, the DEIS addresses consistency with (i) an eight-year-old economic development plan ("New York Works") that appears to be no longer available on the City's websites, and (ii) three completed City of Yes zoning initiatives. As to New York Work's goal to support employment in healthcare, the DEIS's single sentence concluding that the Project would provide "new job opportunities" in the "healthcare industry" is conclusory and does not assess how the Project would impact overall healthcare employment in the City. While the DEIS assumes a modest increase in employment at LHH, it does not consider whether that increase may be offset by decreases at other hospitals due to a shift in where services are sought, or whether an alternative to the Project might be more beneficial to employment in the healthcare industry. As to the discussion of the completed City of Yes zoning text amendments, the DEIS does not conclude that the Project would advance any important City policy, but rather, that the Project would "not hinder or be inconsistent with the three City of Yes Initiatives." DEIS at 2-17. Respectfully, that is a low bar.

In sum, the Project would not substantially advance any important City policy goal, may undermine OneNYC's goal to reduce inequities in health outcomes, and would certainly undermine the City's longstanding policy to regulate bulk in residential neighborhoods in ways that balance density with access to light and air, as is reflected in the Zoning Resolution and Map. The DEIS should be revised accordingly.

Community Facilities

The DEIS community facility analysis should be revised to include an analysis of the Project's indirect effects on access to health care. As part of its Socioeconomic Conditions guidance, the CEQR Technical Manual advises that agencies must consider whether an action could cause indirect residential or business displacement through gentrification or similar mechanisms. To the extent LHH's redevelopment may have the effect of drawing well-insured patients away from other facilities, the Project could exacerbate inequities in access to hospital services. Although the Community Facilities chapter of the CEQR Technical Manual does not call for such an indirect impact assessment, we note that the State SEQRA statute takes a broad view of potential "impacts," and there is no reason why, in a situation like this, the City shouldn't consider indirect impacts on health care access, especially where, as here, the Applicant appears to assume it will gain market share.

Historic and Cultural Resources

An assessment of adverse impacts on historic and cultural resources considers whether the Project would result in a "change in scale, visual prominence, or visual context of any building, structure, or object or landscape feature." Visual context refers to "the character of the surrounding built or natural environment" and may include "the architectural components of an area's buildings (*e.g.*, height, scale, proportion, massing, fenestration, ground-floor configuration, style), streetscapes, skyline…" CEQR Technical Manual at 9-7, 9-8.

Although the study area for a historic resources analysis is typically 400', given that in many cases "visual context" impacts would only be experienced by those in relatively close proximity to a project site, the CEQR Technical Manual lists exceptions to that general rule. Relevant here, a larger study area is appropriate for "projects that result in changes that are highly visible and can be perceived from farther than 400 feet *and* could affect the context of historic resources some distance away (*e.g.*, changes to the skyline around Central Park . . . .)" CEQR Technical Manual at 9-9.

Although the Project would result in a substantial change in the "visual context" of a number of historic resources located within the 400' Study Area, as well as of the "skyline around Central Park," the DEIS concludes that there will be no adverse impacts to historic resources. It does so using conclusory and vague statements that inaccurately portray the scope of the Project, the existing conditions, and the change in visual context that will result, and without providing any supporting data like photo studies.[17]

Like other sections of the DEIS, the Historic Resources analysis repeatedly states that the "midblock" of the new facility under Envelope 1 would be 210' even though the 436' tower would extend 80 feet into the midblock, see DEIS at 6-12. It also claims that the break between the new building's 195-foot podium and the slightly set back 436' tower (which it omits to mention has 30,000 square-foot floor plates) creates a "visual break in the massing, reducing the perceived height of the building," DEIS at 6-15, but again, provides no photos. It nowhere mentions that the 436-foot tower would be two and a half times the current height limits of 175' after setback on Lexington, and five times the height limits on the midblock. It inaccurately states that the portion of the Upper East Side Historic District on Park Avenue is "physically and visually" separated from the Project site "by the approximately 140-foot width of Park Avenue, which also includes planted malls." However, the malls, as well as the west side of Park Avenue north and south of the Project site are part of the Historic District, so there is no such separation. See DEIS Figure 6-1 (outlining boundaries of UES Historic District). It implies that because the buildings in the Historic District "already exist within the context of the LHH complex" there is nothing further to consider, notwithstanding that the proposed Project would dramatically change that "context" and it is the impact of that change that SEQRA requires be evaluated. DEIS at 6-16. Finally, the DEIS claims that, because there are three tall buildings at the outer edges of the Study Area (without mentioning that their floorplates are a fraction of the Project's 30,000 square feet) tall buildings are already "part of the visual context," DEIS at 6-15, and, in turn, that the Project would not change the visual context. However, the DEIS offers no photo studies or other evidence that these other tall buildings are part of the visual context of the identified historic resources, or have any bearing on whether the Project would significantly change the visual context of the identified historic resources.

Furthermore, the DEIS fails to consider the impacts to the skyline around Central Park. As noted above, such an analysis is required by the CEQR Technical Manual in a situation like this one. We submitted an image depicting the Project's significant visual impacts on the Central Park Sheep Meadow in connection with the scoping for this Project, and we resubmit it here.

[17] The SEQR Handbook anticipates that a draft EIS will be based on "studies, reports, and information," a list of which "are typically included as appendices to the draft EIS." SEQR Handbook, 4th ed. (2020) p. 127.



Source: George Janes, AICP, submission to the New York City Department of City Planning, March 13, 2023.

On this incomplete and distorted record, the DEIS ultimately concludes that the Project "would not result in any significant adverse visual or contextual impacts on architectural resources in the study area." It attempts to defend that conclusion with what is perhaps the chapter's most conclusory and unsupported statement of all:

> While the new building with either Envelope 1 or Envelope 2 would be taller than existing buildings on Lexington Avenue in the study area, it would be located among other buildings that are representative of the changes in development over time that have occurred on Lexington Avenue. DEIS at 6-15

There is not one word in the entire chapter that describes "changes in development over time" on Lexington Avenue that bear any resemblance whatsoever to the Project.

In sum, the DEIS's conclusions are unsupported and do not provide any basis for the Commission to conclude there would be no adverse impacts. If the DEIS accurately characterized the Project's impacts on a complete set of historic resources, it would have to conclude that the Project would "alter[ ] the setting" and "introduce[s] incompatible visual elements" to numerous historic resources, including at least the Central Park Sheep Meadow, the Park Avenue Malls, the portions of the UES Historic District directly across the street from the Project Site and the individually-landmarked Eglise St. Jean Baptiste.

Urban Design and Visual Resources; Neighborhood Character

Like the DEIS Chapter on Land Use, Zoning and Public Policy, and the Historic Resources chapter, the Urban Design and Visual Resources Chapter dramatically downplays how unusual and discordant it would be to insert a building the size of a Midtown skyscraper into this location.

The CEQR Technical Manual advises:

> Determining the significance of an urban design impact requires consideration of the degree to which a project would result in a change to the built environment's arrangement, appearance, or functionality and whether the change would negatively affect a pedestrian's experience of the area. One important consideration is a project's context -- for example, the scale and use of surrounding buildings.[18]

The Urban Design chapter's analysis fails to acknowledge the degree to which the Project's scale would represent a major change in the built environment. The chapter's photos and descriptions of existing conditions make clear that the typical building forms in the study area bear no resemblance to the Project's proposed tower, with its unprecedented combination of height, huge floor plates, and minimal setbacks. However, rather than acknowledge those inescapable facts when drawing its conclusions, the DEIS instead states

> the new hospital building's overall height would be taller than other study area buildings; however, it would be compatible with the variety of building heights in the study area, which includes the approximately 427-foot-tall Carlyle Hotel to the west at 981 Madison Avenue. The Proposed Project would be viewed in the context of existing buildings with different massings, heights, and forms that characterize the varied urban design of the study area, including the range of building scales, forms, and styles along Lexington Avenue.

This conclusion is indefensible. There is nothing about the Project's height that is compatible "with the variety of building heights in the study area." With three distinguishable exceptions, every building in the Study Area is less than half the height of the proposed tower, and some are closer to three to five times lower, particularly those at the midblock. The conclusion also utterly ignores the issue of large floorplates at 300 and 400 feet. As can be clearly seen in the image on page 9 of this memo, the handful of other tall buildings in the area are slender, with substantial setbacks, intentionally so, to preserve light and air, and the Project's bulky form stands alone. Finally, the conclusion ignores the dramatic difference in pedestrian experience that is effectively captured in many of the chapter's "With Action" renderings. For example, Figures 7-32 and 7-33 reveal that pedestrians walking on Lexington would lose half the sky and experience a jarring break in what is otherwise a relatively consistent street wall on that 75-foot wide street.

The Neighborhood Character discussion is similarly flawed. As noted in the CEQR Technical Manual, neighborhood character is defined by its "land use, urban design visual resources" and "historic resources" among other factors. Although the Project would have significant impacts on urban design, historic resources and zoning, the DEIS nevertheless concludes there would be no adverse impacts to neighborhood character. For the reasons discussed above in the Urban Design, Historic Resources and Land Use sections, that conclusion is not supported by the facts and must be revised.

[18] CEQR Technical Manual at 10-6.

Transportation

The DEIS's flawed analysis framework understates the likely transportation impacts of the Project. Specifically, because the DEIS overstates the likely number of patients, staff and visitors that would travel to and from the Project site in the future No Action condition (see Analysis Framework at 7 above), it understates the incremental transportation impacts of the Project. For example assuming for illustration's sake a "staffed bed" level of 350 in the Future without the Project (higher than LHH reported to the State just last week), the Table 1-1 Project increment between the No Action and With Action condition for inpatient staff would be about 920 versus the 348 currently listed in the DEIS, and the inpatient visitors increment would be approximately 281 rather than 57 (applying the same bed to staff/visitor ratios as the DEIS assumed for 450 beds). The DEIS must repeat the transportation analysis with corrected No Action assumptions to evaluate whether the Project will result in adverse transportation impacts.

The Transportation analysis also fails to evaluate potential risks associated with pedestrian/truck/ambulance conflicts that could result from the proposed new curb cuts and ambulance bays on 77th Street and increased number of curb cuts and truck bays on 76th Street. All vehicles would pull in and back out across the sidewalk. The CEQR Technical manual states that "if an action would increase the number of conflict points between vehicles, bicycles, and/or pedestrians . . . these intersections should be assessed for safety impacts." The impacts of this proposed increase in curb cuts and loading bays and the potential for conflicts with pedestrians on the sidewalks must be assessed but have not been.

Construction

The DEIS asks the public to simply take the Applicant's word for it that no lanes of traffic will be closed despite an average of 27 trucks needing to be loaded/unloaded daily in Year 4 of the Project, with extremely limited explanation as to how that would be achieved ("material deliveries to the construction area would be controlled and scheduled" DEIS at 16-8). It also concludes that there would be no parking impacts, despite an estimated additional 144 construction worker vehicles daily and the removal of street parking on Lexington, 76th and 77th. It is easy to imagine – and likely supported by on the ground experience for major projects -- that additional street parking will be eliminated after construction commences to the extent deliveries become backed up along 76th Street. And while the Applicant points to commercial parking as a solution to nine years of parking impacts, the availability data is over 6 years old, and paid parking is not a feasible alternative for some residents. The construction analysis must be amended to provide more detail regarding construction staging and account for the fact that lane closures are entirely within the realm of possibility, as are additional parking impacts.

Finally, the DEIS concludes that the Project will not have any adverse impacts on air quality, including diesel emissions, dust and particulate matter. While it is understood that the site is required to comply with all applicable laws designed to minimize such emissions, the DEIS does not grapple with the reality that such mitigations are imperfect, and in turn, that the Project is likely to decrease air quality over its nine-year duration.

Alternatives

The DEIS's alternatives discussion is deficient in multiple respects. First, because it fails to acknowledge or fully evaluate adverse impacts in the areas of zoning, health care disparities,

historic resources, urban design, neighborhood character, traffic, vehicle-pedestrian conflicts, and construction impacts in the areas of traffic, parking and air quality, the DEIS fails to offer alternatives that could mitigate these adverse impacts and potential impacts. The DEIS must include a range of alternatives such as reduced scale alternatives and multi-site programming alternatives to reduce bulk related impacts, to reduce the possibility of exacerbating health inequities, and to shorten the duration of construction. It must also offer supplemental mitigations for specific impacts.

Second, although the DEIS acknowledges adverse impacts from shadows and construction noise, it claims these impacts cannot be reduced or avoided. In the case of shadows, it concludes the impact is unavoidable because "virtually any development on Projected Development Sites 1 or 1a that would be taller than the existing buildings would cause significant adverse shadow impacts on the March 21/September 21 analysis day." DEIS at 17-2 But it does not consider alternatives that would not increase building height at all, or increase them more modestly than the levels considered, which were 236 feet. See DEIS at 17-8. As is noted in the DEIS, the existing structures range in height from 40 to 200 feet, so there is substantial room for growth within a theoretical building envelope that is lower than 236 feet but higher than the 40-200 that exists now. The Commission could and should request that the Applicant explore alternatives that increase square footage on the Project site without increasing height.

As to construction noise, the DEIS takes a similarly narrow view of options for "reducing" or "avoiding" noise impacts. It concludes that, short of moving to another site, nothing can be done to reduce adverse noise impacts. However, shortening the duration of construction would "reduce," if not fully avoid, noise impacts. The applicant should be required to explore alternatives that would shorten construction duration.

We close by respectfully requesting that any supplemental data provided to the Commission by the Applicant in response to questions raised at the Public Hearing be made available to the public. To the extent those supplemental submissions may be relevant to our review of the DEIS, was also ask that the deadline to submit DEIS comments be briefly extended for the limited purpose of commenting on those supplemental materials.

Thank you for your consideration

K.E.M.

ATTACHMENT A

Lois J. Uttley, MPP
545 West 111th Street, Apt. 8E
New York, NY 10025

May 29, 2025

Daniel Garodnick, Chair
New York City Planning Commission
Equitable Life Building
129 Broadway, 31st Floor
New York, NY 10271

RE: Lenox Hill Hospital request for zoning actions

Dear Mr. Garodnick and commission members:

I write to provide some supplemental information and analysis elaborating on my testimony before your commission on May 21, 2025, opposing Lenox Hill Hospital's request for zoning changes to allow for a significant expansion in the height and mass of the hospital. I am particularly concerned about the health equity impact of this project. Your approval of the requested zoning changes would allow Lenox Hill Hospital to add capacity in a facility that does not serve a fair share of low-income people and in a location where more hospital beds are least needed in our city, thereby worsening existing inequities in access to hospital care.

I have worked for more than 30 years with coalitions across the nation to protect and expand access to care for medically underserved people and communities. I founded the Hospital Equity and Accountability Project at Community Catalyst, a national non-profit health advocacy and policy organization. I earned a Master's in Public Affairs and Policy from the Nelson A. Rockefeller College of Public Affairs and Policy at the University at Albany and teach in the Master's in Health Advocacy Program at Sarah Lawrence College. I have served as Director of Public Affairs for the New York State Department of Health, President of the Public Health Association of New York City and Chair of the American Public Health Association's Action Board. I am co-convenor of the statewide Community Voices for Health System Accountability network.

Lenox Hill Hospital does not serve a fair share of low-income patients

The same U.S. News and World Report rankings that the hospital's President, Dr. Daniel Baker, proudly cited during your public hearing as evidence that the facility is top ranked nationally when it comes to quality also rate the hospital poorly in health equity measures. Lenox Hill is ranked as "lower than other hospitals" in provision of charity care and in service to low-income patients insured through Medicaid, as shown in the charts below

copied directly from the U.S. News rankings website: https://health.usnews.com/best-hospitals/area/ny/lenox-hill-hospital-6212990





Analysis of 2022 hospital inpatient data from the NYS Department of Health SPARCS database also shows that Lenox Hill Hospital lags behind borough-wide and city-wide hospital percentages for service to patients who are low income and insured by Medicaid. [1]

Table 7 - NYC Hospital Discharges + Primary Payor, 2022
2022 SPARCS Discharges - De-identified
Accessed March 25, 2025

	Lenox Hill Hospital		Manhattan Hospitals		NYC Hospitals	
Primary Payor	**Discharges**	**% of Discharges**	**Discharges**	**% of Discharges**	**Discharges**	**% of Discharges**
Medicaid	5,288	18%	106,600	29%	373,003	39%
Medicare	11,192	37%	126,799	34%	329,378	35%
Private Health Insurance + BC/BS	13,026	43%	128,357	35%	227,074	24%
All Other	700	2%	8,541	2%	21,512	2%
Grand Total	**30,206**		**370,297**		**950,967**	

[1] Data extracted and analyzed by consultant Patty HasBrouck, MBA.

Even more striking is the gap between Lenox Hill Hospital's low levels of service to Medicaid enrollees needing pregnancy and childbirth care. A table appended to this letter shows that Lenox Hill Hospital has the second lowest percentage of Medicaid pregnancy/childbirth patients of any hospital in New York City. Only 15.1 percent of its 4,184 discharges for pregnancy and childbirth in 2022 were Medicaid enrollees. By comparison, there were 13 hospitals where more than 85 percent of pregnancy/childbirth discharges were for Medicaid enrollees, 12 with 75 to 85 percent Medicaid and 11 with 50 to 74 percent Medicaid. Even Long Island Jewish Hospital (another of the Northwell system's hospitals) had 42.6 percent of its pregnancy/childbirth discharges who were Medicaid enrollees.

Lenox Hill Hospital's maternity service, which is highly rated for quality by U.S. News and World Report, has attracted celebrity patients such as Beyonce. In fact, if you google "Where do wealthy people give birth in New York City?" you get this answer: "Lenox Hill Hospital is popular among the rich and elite." Clearly, the hospital is not serving a fair share of low-income pregnant people.

Lenox Hill Hospital is in a neighborhood saturated with other hospitals and has a relatively high vacancy rate compared to other New York City hospitals

In his testimony to your commission, Dr. Baker said that Lenox Hill Hospital has an occupancy rate of about 80 percent. He said his hospital had been making a "denominator error" when reporting its vacant beds to the New York State Department of Health, which displays them in a hospital capacity page on its website[2] that earlier this year showed 40 percent of Lenox Hill Hospital's 455 beds were vacant. After that vacancy rate became publicized, the hospital reduced the number of beds on which it is reporting to 344, thereby taking 111 beds off its total bed count (although there has been no explanation for why these beds were no longer being counted). On May 29, that website showed that 71 of the 344 beds were vacant and there was a seven-day average vacancy rate of 23 percent. If you take the 71 vacant beds and add back in the 111 missing beds, you get 182 beds, which if all of them are vacant would give the hospital a 40 percent vacancy rate in 455 beds.

Even if we were to take the 23 percent vacancy rate as a valid number, Lenox Hill Hospital still has a higher percentage of empty beds than a number of other hospitals in Manhattan and other boroughs. On May 29, for example, Harlem Hospital had a 2 percent average seven-day vacancy rate, the NY Presbyterian Allen Hospital had an eight percent vacancy rate, NY Presbyterian Columbia Hospital was 11 percent, NYU Langone was at 13 percent and Bellevue was at 15 percent. Brookdale and Coney Island Hospital were at 12 percent, Coney Island Hospital was at eight percent, Kings County Hospital was at nine percent, Jamaica Hospital Center, 11 percent, and Queens Hospital, 12 percent vacant, As Dr. Baker

[2] Accessed at https://coronavirus.health.ny.gov/hospital-bed-capacity

explained during your public hearing, hospitals with occupancy of greater than 80 percent (or vacancies of less than 20 percent) are struggling, with backups in the emergency department while patients wait for beds to open up.

Below is a table depicting the occupancy rates that Lenox Hill Hospital itself has reported to the American Hospital Association over the last 20-plus years, demonstrating that the hospital has not had an 80 percent occupancy rate, but rather has been around 75% and as low as 70 percent in both the 2024 report on 2023 data and the 2023 report on 2022 data. The average daily census has been under 350 since 2017. (Source: American Hospital Association annual reports.)

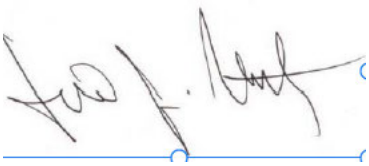
Lenox Hill Hospital, Historical Key Indicators
(Includes Manhattan Eye, Ear and Throat Hospital, 2011-present)

AHA Edition (based on prior year's hospital information)	Staffed Beds	Admissions	Census (Average Daily Census, ADC)	Occupan (ADC/Stat Beds)
2025	**446**	**28,465**	**326**	**73%**
2024	446	27,311	312	70%
2023	436	29,419	331	76%
2022	425	25,709	298	70%
2021	414	30,986	348	84%
2020	440	29,485	339	77%
2019	440	29,560	332	75%
2018	441	28,540	327	74%
2017	441	28,449	341	77%
2016	441	28,699	373	85%
2015	508	29,417	384	76%
2014	508	29,441	386	76%
2013	539	29,222	383	71%
2012	539	29,066	398	74%
2008	515	30,008	426	83%
2002	652	28,576	491	75%

I hope this additional information is helpful to you in evaluating whether Lenox Hill Hospital should receive zoning changes to allow an increase in the number of beds from 450 to 475. I urge you to recommend that the hospital come back with a reduction in the size and number of rooms it plans to build, and a strong commitment to doing better in serving low-

income people in New York City. I am available to answer any questions you may have at ljuttley@outlook.com

Sincerely,



Lois J. Uttley, MPP

Table 4 - MDC 14 (Pregnancy+Childbirth) NYC Hospital Discharges and Medicaid %, 2022
2022 SPARCS Discharges - De-identified
Accessed March 25, 2025

Hospital	All Discharges MDC 14	Medicaid as % Total
Kingsbrook Jewish Medical Center	1	100.0%
BronxCare Hospital Center	1,779	91.1%
Bellevue Hospital Center	1,563	91.1%
Woodhull Medical & Mental Health Center	1,446	90.9%
Lincoln Medical & Mental Health Center	1,763	90.1%
Elmhurst Hospital Center	2,385	89.1%
St Johns Episcopal Hospital So Shore	478	88.7%
SBH Health System	804	88.1%
New York Presbyterian Hospital - Allen Hospital	2,352	87.7%
Wyckoff Heights Medical Center	1,178	87.3%
Queens Hospital Center	1,559	86.6%
Coney Island Hospital	1,540	86.6%
Metropolitan Hospital Center	1,028	86.2%
North Central Bronx Hospital	1,166	85.8%
Harlem Hospital Center	786	84.6%

Mount Sinai Brooklyn	6	83.3%
Jacobi Medical Center	2,123	83.3%
Maimonides Medical Center	6,468	82.5%
Kings County Hospital Center	1,575	81.7%
Flushing Hospital Medical Center	2,572	81.2%
Jamaica Hospital Medical Center	1,790	80.9%
NYU Langone Hospital-Brooklyn	4,191	80.3%
Brookdale Hospital Medical Center	786	78.2%
Montefiore Medical Center-Wakefield Hospital	1,308	78.1%
Montefiore Medical Center - Henry & Lucy Moses Div	60	76.7%
Montefiore Med Center - Jack D Weiler Hosp of A Einstein College Div	3,602	74.6%
Long Island Jewish Forest Hills	2,192	73.9%
Brooklyn Hospital Center - Downtown Campus	1,479	73.8%
University Hospital of Brooklyn	780	72.8%
Staten Island University Hosp-North	2,943	70.4%
New York - Presbyterian/Queens	2,731	70.2%
Mount Sinai Morningside	9	66.7%
Interfaith Medical Center	7	57.1%
New York - Presbyterian Brooklyn Methodist Hospital	4,642	52.5%
Cohen Children's Medical Center	2	50.0%
NYU Langone Orthopedic Hospital	2	50.0%
Long Island Jewish Medical Center	8,530	42.6%
Richmond University Medical Center	2,857	42.6%
New York-Presbyterian Hospital - Columbia Presbyterian Center	4,736	41.8%
Mount Sinai Beth Israel	12	41.7%
Mount Sinai Hospital	6,953	35.4%
Mount Sinai Hospital - Mount Sinai Hospital of Queens	17	29.4%
Staten Island University Hospital Prince's Bay	14	28.6%
NYU Langone Hospitals	5,284	28.0%
Mount Sinai West	4,674	23.4%
New York-Presbyterian/Lower Manhattan Hospital	1,872	19.9%
Lenox Hill Hospital	**4,184**	**15.1%**
New York-Presbyterian Hospital - New York Weill Cornell Center	8,006	12.9%

ATTACHMENT B

March 12, 2025

Community Board 8, ULURP Hearing
Held at MSK-Rockefeller Research Laboratories
430 E 67th Street, Room RRL-B20

Ladies and Gentlemen of Community Board 8,

My name is Fred Hyde. I have been a consultant to the Committee to Protect Our Lenox Hill Neighborhood. However, the opinions expressed here are my own, and do not represent any official position of CPOLHN. This testimony expands on my oral presentation in your hearing held this date.

First, your volunteer activity here is the last time the public will directly participate in the approval, disapproval or modification of this project. You enjoy the democratic privilege of citizen involvement, without the bondage of campaign expense and campaign contribution which may inhibit the professional politician. Northwell Health is an especially vigorous participant in the professional politician world, with $1,040,000 in lobbying expenses in 2023, $970,000 in 2024, $692,786 in campaign contributions from Northwell executives in the 2024 election cycle, and five (of a total of six) Northwell Health lobbyists previously holding government jobs.[1] Understanding the generosity of contributions from executives is made easier by noting that more than 100 such individuals on the Northwell Health payroll earn more than $1 million per year.

No untoward motive is intended or to be inferred from this record. This is merely a statement concerning the importance of your citizen involvement, a privilege in democracy.

In addition to City review, there is a challenge with State review. The Chair of the New York State Certificate of Need agency, the Public Health and Health Planning Council, is a person who is employed as the top strategy officer for Northwell Health. I know him to be a man of integrity, probity and extremely high intelligence. He is, however, in a position which makes it impossible to escape scrutiny or even criticism. Who among this close-knit, politically connected, collegial Council will vote “No” on a project of import to Northwell?

These structural conflicts at the City and State level mean that your foot—the unpaid and largely unrecognized authority of the citizen—is the last one in the closing door.

Second, you should know that rational planning of the type which historically characterized hospital and health facility planning is largely absent from this project.

[1] OpenSecrets, https://www.opensecrets.org/orgs/northwell-health/summary?id=D000054776&form=MG0AV3, accessed March 10, 2025.

How did “rational” planning formerly take place? In the past, architects employed programming professionals, or hospitals themselves employed feasibility consultants. Both groups would examine historical utilization (see **Exhibit 1**). The past has always been, as least in hospital and health facility programming, the best guide for planning the future, on grounds that the past represented the incidence and prevalence of illness requiring institutional care, even if those facts and that history was not supportive of conjecture and projection for the future.

These habits changed in the era of modern hospital finance. Debt financing accounts for 85% or more of all capital formation in the hospital field, with income from operations, philanthropy or shareholder investment making up the remainder. Public debt financing was made possible through the commitment of the Medicare and Medicaid programs to pay for the hospital care—or at least a major part of it—needed by the aged and the indigent. Public debt financing took most hospital capital projects out from under the scrutiny of hospital Board members. Public money—in the form of public and private insurance payment for hospital expenses—substituted for philanthropy, or for private debt overseen by lending institutions. Public debt markets believe that the government’s pledge to reimburse hospitals for their expenses, including their debt, will go on in perpetuity. Nobody is actually “in charge” of these matters, and therefore nobody can be found to be responsible for outrageous price inflation in the hospital field; there are only organizations and individuals who make a living from part or all of the commerce involved.

What about volume—is it really declining, or will a “rising tide” (of patients needing hospitalization) buoy Lenox Hill finances?

Exhibit 1 to this testimony summarizes the last 25 years of hospital inpatient utilization for Lenox Hill. The figures themselves are submitted by the hospital each year to the American Hospital Association, and are taken directly from the “Guide” published by the AHA, for the years cited. (These numbers will not always comport exactly with those submitted by the hospital to the State of New York, or for those found on the hospital cost reports to Medicare. Different methodologies, timing and fidelity with numbers account for minor differences; the trend shown by all methods is, however, the same.)

This exhibit 1 tracks the number of staffed beds (those for which there is staff needed and available, a smaller number than “licensed” beds); inpatient admissions; the census—the population of occupied inpatient beds, taken at the same time each day, known as the Average Daily Census or ADC; and the occupancy—the ADC as a percentage of the staffed beds. Each number was higher two decades ago than it is now. In fact, the number of staffed beds has declined by 32% in that time period, and the average daily census by 36%.

These numbers give the lie to the representation that a larger Lenox Hill is needed. Of greater import, they show that *a smaller Lenox Hill would be responsible*. First, the ADC of 312 in 2024 is only 70% of the staffed beds. Second, this 70% is achieved with a mix of single, double and multi-bedded rooms. Achieving high occupancy with multi-bedded rooms is notoriously difficult, because of the necessity to isolate patients with communicable disease, to have

appropriate clinical categories of patients grouped, to respect gender and to make space for in-room equipment and families etc. It is well known that 85% or more occupancy in a hospital with multi-bed rooms makes for a working environment which is chaotic, with patients boarding in the emergency department, on gurneys in hallways, in rooms without telemetry or other needed resources. At the same time, it is known that occupancy of *90% or more can be achieved with single bed rooms*, large enough to accommodate equipment and visitors. In fact, an entire hospital of single bedded rooms is what Northwell is proposing for Lenox Hill. But how many such rooms would be needed?

Here is where the Northwell plan and the community interest could intersect. With a census of 312, and single bedded rooms, all patients could be accommodated at 90% occupancy with (312/.9=) 347 beds, not 475. In fact, 475 beds for 312 patients would yield 66% occupancy, an enormous waste. Reducing the project size by 125 beds would enable the architects to plan the project footprint, height and scope with greater freedom. Simply put, if Lenox Hill could build 350 single bed rooms, it could accommodate all of the patients who seek care there, and have more rooms to spare as the national decline in inpatient hospital utilization continues.

Moreover, over-bedding and over-sizing of this project is not confined to inpatient services generally. The same AHA Guide issues show that Lenox Hill reached a peak of births of 4,400 in the year 2014, with the most recent edition (pg. A452, 2024 edition) showing 3,882 births. An expectation of continuing decline in births (consistent with national trends) is reaffirmed in the staffing budget sent by Lenox Hill to the State of New York as part of the State's continuing study of staffing adequacy. Of 28 newborn special care units, the 2025 plan is for an average staffing of 11 babies.[2]

Other areas of the program--to the extent they have been shared with your Board—demonstrate program scope in the proposed Northwell-Lenox Hill project far in excess of current needs. In addition, the trend in each of these areas (for example emergency room visits, which reached a peak of 55,926 in the year 2012) is downward.

What is the public interest in the cost of the planned over-building?

In the midst of the financial calamity of health prices, Northwell proposes a $2.5 billion+ project. It is a matter of record that **Northwell has primarily paid for projects like this largely through debt**, despite impressive shows of philanthropy, and that this project will add nearly $150 million *per year* to the current charges levied by Lenox Hill, with payment of more than $2 billion *in interest* by the time the borrowing is repaid.

Northwell and Lenox Hill represent that philanthropy and net income will offset the additional expense. This is incorrect, and in fact disingenuous. In its building projects, Northwell has always relied on debt, one reason that there is more than $13 billion of total liabilities on the Northwell

[2] Lenox Hill, Acute Inpatient Unit Staffing Plan, NICU/28 beds, page 55.

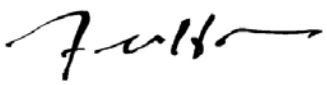
books.[3] In its most recent building project, Northwell has financed only 13% of the project through net income and philanthropy, the remaining 87% through debt.[4]

The implication is clear. If this project (which grows in cost with each iteration) is a $2.5 billion commitment of the public's money, 13% in equity would be $325 million, an heroic amount even for Northwell fundraising. (Operating income for Northwell, cited as another source of equity funds for this project, is not a significant source of capital, amounting to 1-2% for the entire Northwell system.)

Who will pay for 87% of this project? Financing of $2.2 billion at 5% over 30 years will add $141.8 million to the Lenox Hill expense budget (**see Exhibit 2**), for which the only source of payment is a declining volume of patient services paid for through patient and insurer funds, the public in other words. At this early project stage, such an estimate would include none of the increased operating expenses which almost always accompany new technology and new facilities in the hospital field.

In summary, much depends on your judgment, the involvement of the public. This project is enormously over-sized, extraordinarily expensive (with public, not private money). Offering this project in this form will work against the interests of the patients, employees, doctors and community served by Lenox Hill, all of whom deserve a thorough realistic reconfiguration and renewal of this hospital.

Very truly yours,



Fred Hyde, M.D., J.D., M.B.A.
Colt's Pond
Ashford, CT 06278

[3] Unaudited interim financial statements, Northwell Health, Inc., for the six months ended June 30, 2024, from Appendix B-2 of the Supplement Dated January 23, 2025 to the Official Statement dated October 2, 2024, Related to $1.13 billion of DASNY Northwell Health Obligated Group Revenue Bonds.

[4] South Shore University Hospital, Public Health and Health Planning Council project 24-2247C, project cost $530 million, equity $70 million, remaining $460 million "balance financed with a tax-exempt bond issued through the Dormitory Authority of the State of New York (DASNY) at an interest rate of 5% for a thirty-year term." PHHPC Executive Summary of project, acknowledged November 18, 2024.

Exhibit 1

Lenox Hill Hospital, Historical Key Indicators
Inpatient Utilization

AHA Edition	Staffed Beds	Admissions	Census (Average Daily Census, ADC)	Occupancy (ADC as a % of Staffed Beds)
2024	**446**	**27,311**	**312**	70.0%
2023	436	29,419	331	75.9%
2022	425	25,709	298	70.1%
2021	414	30,986	348	84.1%
2020	440	29,485	339	77.0%
2019	440	29,560	332	75.5%
2018	441	28,540	327	74.1%
2017	441	28,449	341	77.3%
2016	441	28,699	373	84.6%
2015	508	29,417	384	75.6%
2014	508	29,441	386	76.0%
2013	539	29,222	383	71.1%
2012	539	29,066	398	73.8%
2011	483	na	na	
2010	524	na	na	

Lenox Hill Hospital, Historical Key Indicators
Inpatient Utilization

AHA Edition	Staffed Beds	Admissions	Census (Average Daily Census, ADC)	Occupancy (ADC as a % of Staffed Beds)
2009	515	na	na	
2008	515	30,008	426	82.7%
2007	626	28,576	491	78.4%
2006	531	30,673	458	86.3%
2005	na	na	na	
2004	626	na	na	
2003	652	na	na	
2002	652	28,576	491	75.3%
na=not available				
Change %2002-2024	**-32%**		**-36%**	

Loan Amortization Schedule

Exhibit 2

	Enter Values
Loan Amount	**$2,200,000,000.00**
Annual Interest Rate	**5.00%**
Loan Period in Years	**30**
Start Date of Loan	1/1/2024
Optional Extra Payments	

Scheduled Monthly Payment	**$ 11,810,075.71**	Annual total	$141,720,908.48
Scheduled Number of Payments	180		
Actual Number of Payments	180		
Total Early Payments	$ -		
Total Interest	$ 2,051,627,254.26		

No.	Payment Date	Beginning Balance	Scheduled Payment	Extra Payment	Total Payment	Principal
1	1/1/2024	$ 2,200,000,000.00	$ 11,810,075.71	$ -	$ 11,810,075.71	$ 2,643,409.04
2	2/1/2024	2,197,356,590.96	11,810,075.71	-	11,810,075.71	2,654,423.24
3	3/1/2024	2,194,702,167.72	11,810,075.71	-	11,810,075.71	2,665,483.34
4	4/1/2024	2,192,036,684.38	11,810,075.71	-	11,810,075.71	2,676,589.52
5	5/1/2024	2,189,360,094.85	11,810,075.71	-	11,810,075.71	2,687,741.98
6	6/1/2024	2,186,672,352.88	11,810,075.71	-	11,810,075.71	2,698,940.90
7	7/1/2024	2,183,973,411.97	11,810,075.71	-	11,810,075.71	2,710,186.49
8	8/1/2024	2,181,263,225.48	11,810,075.71	-	11,810,075.71	2,721,478.93
9	9/1/2024	2,178,541,746.55	11,810,075.71	-	11,810,075.71	2,732,818.43
10	10/1/2024	2,175,808,928.12	11,810,075.71	-	11,810,075.71	2,744,205.17
11	11/1/2024	2,173,064,722.95	11,810,075.71	-	11,810,075.71	2,755,639.36
12	12/1/2024	2,170,309,083.59	11,810,075.71	-	11,810,075.71	2,767,121.19
13	1/1/2025	2,167,541,962.40	11,810,075.71	-	11,810,075.71	2,778,650.86
14	2/1/2025	2,164,763,311.53	11,810,075.71	-	11,810,075.71	2,790,228.57
15	3/1/2025	2,161,973,082.96	11,810,075.71	-	11,810,075.71	2,801,854.53
16	4/1/2025	2,159,171,228.43	11,810,075.71	-	11,810,075.71	2,813,528.92
17	5/1/2025	2,156,357,699.51	11,810,075.71	-	11,810,075.71	2,825,251.96
18	6/1/2025	2,153,532,447.55	11,810,075.71	-	11,810,075.71	2,837,023.84
19	7/1/2025	2,150,695,423.71	11,810,075.71	-	11,810,075.71	2,848,844.77
20	8/1/2025	2,147,846,578.94	11,810,075.71	-	11,810,075.71	2,860,714.96
21	9/1/2025	2,144,985,863.98	11,810,075.71	-	11,810,075.71	2,872,634.61
22	10/1/2025	2,142,113,229.37	11,810,075.71	-	11,810,075.71	2,884,603.92
23	11/1/2025	2,139,228,625.45	11,810,075.71	-	11,810,075.71	2,896,623.10
24	12/1/2025	2,136,332,002.35	11,810,075.71	-	11,810,075.71	2,908,692.36
25	1/1/2026	2,133,423,309.99	11,810,075.71	-	11,810,075.71	2,920,811.91
26	2/1/2026	2,130,502,498.08	11,810,075.71	-	11,810,075.71	2,932,981.96
27	3/1/2026	2,127,569,516.11	11,810,075.71	-	11,810,075.71	2,945,202.72
28	4/1/2026	2,124,624,313.39	11,810,075.71	-	11,810,075.71	2,957,474.40
29	5/1/2026	2,121,666,838.99	11,810,075.71	-	11,810,075.71	2,969,797.21
30	6/1/2026	2,118,697,041.78	11,810,075.71	-	11,810,075.71	2,982,171.37
31	7/1/2026	2,115,714,870.41	11,810,075.71	-	11,810,075.71	2,994,597.08
32	8/1/2026	2,112,720,273.33	11,810,075.71	-	11,810,075.71	3,007,074.57
33	9/1/2026	2,109,713,198.76	11,810,075.71	-	11,810,075.71	3,019,604.04
34	10/1/2026	2,106,693,594.72	11,810,075.71	-	11,810,075.71	3,032,185.73
35	11/1/2026	2,103,661,408.99	11,810,075.71	-	11,810,075.71	3,044,819.84
36	12/1/2026	2,100,616,589.16	11,810,075.71	-	11,810,075.71	3,057,506.58
37	1/1/2027	2,097,559,082.57	11,810,075.71	-	11,810,075.71	3,070,246.20
38	2/1/2027	2,094,488,836.38	11,810,075.71	-	11,810,075.71	3,083,038.89
39	3/1/2027	2,091,405,797.49	11,810,075.71	-	11,810,075.71	3,095,884.88
40	4/1/2027	2,088,309,912.60	11,810,075.71	-	11,810,075.71	3,108,784.40
41	5/1/2027	2,085,201,128.20	11,810,075.71	-	11,810,075.71	3,121,737.67
42	6/1/2027	2,082,079,390.53	11,810,075.71	-	11,810,075.71	3,134,744.91
43	7/1/2027	2,078,944,645.62	11,810,075.71	-	11,810,075.71	3,147,806.35
44	8/1/2027	2,075,796,839.27	11,810,075.71	-	11,810,075.71	3,160,922.21
45	9/1/2027	2,072,635,917.06	11,810,075.71	-	11,810,075.71	3,174,092.72
46	10/1/2027	2,069,461,824.34	11,810,075.71	-	11,810,075.71	3,187,318.10
47	11/1/2027	2,066,274,506.23	11,810,075.71	-	11,810,075.71	3,200,598.60
48	12/1/2027	2,063,073,907.64	11,810,075.71	-	11,810,075.71	3,213,934.42
49	1/1/2028	2,059,859,973.21	11,810,075.71	-	11,810,075.71	3,227,325.82
50	2/1/2028	2,056,632,647.39	11,810,075.71	-	11,810,075.71	3,240,773.01
51	3/1/2028	2,053,391,874.39	11,810,075.71	-	11,810,075.71	3,254,276.23
52	4/1/2028	2,050,137,598.16	11,810,075.71	-	11,810,075.71	3,267,835.71
53	5/1/2028	2,046,869,762.44	11,810,075.71	-	11,810,075.71	3,281,451.70
54	6/1/2028	2,043,588,310.75	11,810,075.71	-	11,810,075.71	3,295,124.41

ATTACHMENT C

May 20, 2025

Daniel Garodnick, Chair
New York City Planning Commission
Equitable Life Building
129 Broadway, 31st Floor
New York, NY 10271

RE: Lenox Hill Hospital expansion project

Dear Mr. Garodnick and Commission Members:

Northwell Health System is asking you and other New York City officials to grant it multiple zoning changes to allow construction of a much larger replacement facility for its aging Lenox Hill Hospital on the Upper East Side of Manhattan. There are two compelling reasons why you should not approve this request in its current form:

- **The project would add hospital capacity where it is not needed,** while other New York City neighborhoods are losing their community hospitals and/or already have too few hospital beds, leading to overcrowding and long waits.
- **The $2 billion-plus project appears likely to increase already high prices at Lenox Hill Hospital,** which is charging commercial health insurers an average of more than three times the prices Medicare pays and thereby contributing to higher health plan costs that are plaguing employers, union benefit funds and enrollees.

City and state approval for such a proposed project should be granted only if it would contribute to the public good, such as by providing recognizable benefits to the affected community and the rest of the city. Unfortunately, Community Voices for Health System Accountability has concluded that the downsides of the current proposal for replacing and expanding Lenox Hill Hospital far outweigh the supposed benefits.

More hospital capacity is needed elsewhere in NYC, not on the Upper East Side

Upper East Side Community District 108 has five hospitals (including Lenox Hill Hospital) providing a combined total of 10.58 acute care hospital beds for every 1,000 residents -- nearly four times the citywide rate of 2.7 beds per 1,000 people. The boroughs of Brooklyn and Queens are especially lacking in adequate hospital capacity. But some other Manhattan neighborhoods also have too few hospital beds for their population size, including the Lower East Side, which has recently lost its long-time community hospital, Beth Israel Medical Center.

A look at the New York City Department of Health's community health profiles reveals that residents of the Upper East Side community district are far healthier and more affluent than are people in other places in our city where COVID 19 hit harder, and where residents need medical care for chronic diseases and to reduce high rates of infant and maternal mortality.

Moreover, Lenox Hill Hospital already has more hospital beds than it can fill. Results of the New York State Department of Health's hospital capacity survey, which hospitals must fill out daily, showed that on May 15, Lenox Hill Hospital reported it had a seven-day average of 25% of its beds available — in other words, vacant. (Note that the hospital reduced the number of beds it was counting from 465 down to 344 after we spotlighted the fact that its own reporting had said that 42% of its 465 beds were vacant on March 6.) Lenox Hill's 25% vacancy rate is far above the seven-day average rates for some other Manhattan hospitals, such as Harlem Hospital (2%), NY Presbyterian (11%), NYU Langone (13%), Bellevue (14%) and Mount Sinai (17%). Lenox Hill's vacancy rate also far exceeded those reported for most Brooklyn hospitals, including Coney Island Hospital (6%), Woodhull (7%) and Kings County Hospital (10%), as well as such Queens hospitals as Jamaica Hospital Center (11%) and Northwell's own Long Island Jewish Medical Center (8%). The disparity between Lenox Hill's vacancy rate and those of other New York City hospitals is quite typical of what we have seen in checking over a period of several months.

The proposed expansion of Lenox Hill Hospital would increase its current total number of beds from 450 to 475, all in overly large private rooms. We refer you to Sen. Liz Krueger's insightful comments on the size of the rooms. The new hospital building that would have a colossal tower 436 feet tall (the equivalent of 43 stories with 10-foot-high ceilings), far exceeding existing zoning. **But the hospital's recent occupancy rates would suggest a smaller, not larger, number of beds to "rightsize" Lenox Hill Hospital – perhaps 300 to 350 beds**. A smaller replacement facility would not tower quite so high over a residential neighborhood up in arms against the plan and would likely have a shorter construction time than the exhausting nine years currently predicted. **A smaller Lenox Hill project would also potentially free up funds that Northwell could invest to expand capacity at other places in the city where there are not enough hospital beds, such as the East Side of Lower Manhattan and the outer boroughs.**

As you are aware, Manhattan Community Board 8 voted against this project, citing it as too tall and massive for the residential neighborhood – urging a replacement building no taller than the existing 215 -foot building -- and noting it would subject the community to anywhere from six to nine years of construction. Manhattan Borough President Mark Levine attached 17 conditions to his approval of the project, but none of those would meaningfully address the existing disparities in hospital capacity across our city, which would only grow worse if this expansion project is allowed to move forward.

The cost of the project could increase Lenox Hill Hospital's already-too-high prices

Lenox Hill Hospital already has among the highest prices for hospital care in Manhattan, charging commercial health insurers an average of 335 percent of what it receives from Medicare for the same services, according to SAGE Transparency, a dashboard of hospital prices calculated by the Rand Corporation. The hospital's commercial break-even price would be just 132 percent of Medicare, according to SAGE's application of a pricing formula from the National Academy for State Health Policy (NASHP). By comparison, Mount Sinai Hospital charges commercial insurers 279

percent of Medicare prices, the recently-closed Mount Sinai Beth Israel charged just 226 percent and Mount Sinai Morningside/St. Luke's charges 219 percent. The city's public hospitals mark up commercial rates far less, with Harlem Hospital at 147 percent of Medicare and Bellevue 121 percent. Only NYU Langone and NY Presbyterian are more expensive than Lenox Hill Hospital.

How would Lenox Hill Hospital's already-high prices be affected by having to pay debt service costs from borrowing to carry out a $2 billion-plus expansion project? During a January Manhattan Community Board 8 meeting to present the hospital's latest version of its expansion plans, hospital Executive Director Daniel Baker seemed flummoxed by this question and eventually said they would be relying partly on philanthropy and net income.

Fred Hyde, M.D., J.D., M.B.A, a former hospital administrator and consultant, calculated the possible debt service costs by looking at a recently-proposed Northwell project on Long Island, expansion of South Shore University Hospital at a cost of $529.8 million. That project, according to documents provided by Northwell to state health officials, would rely on $69.7 million in equity (13 percent of the cost) and borrowing $460 million at 5 percent interest for 30 years. A similar financing strategy for a $2.5 billion potential cost of Lenox Hill Hospital's expansion would involve paying $325 million (13 percent) from the hospital's equity and then borrowing $2.2 billion, which at 5 percent interest over 30 years would require $142 million in annual principal and interest payments.

How much would adding so many millions in annual debt service costs force up the already high prices at Lenox Hill Hospital? Manhattan Borough President Mark Levine's approval recommendation for this project simply stated that "I am still asking the hospital to ensure that cost of care not increase as a result of the renovation." In other words, there were no answers, guarantees or firm commitments from the hospital.

Conclusion

We urge you to reject the current ill-considered expansion proposal for Lenox Hill Hospital and instead suggest that the Northwell Health System downsize the project and invest any savings in increasing hospital capacity elsewhere in the city, such as in the Lower East Side.

Sincerely,

Lois Uttley
CVHSA co-convenor
ljuttley@outlook.com

Community Voices for Health System Accountability (CVHSA) is a statewide collaboration of non-profit health and human service advocacy organizations based out of the Health Care for All New York coalition. CVHSA focuses on hospital and health system issues in New York as they affect local communities, working to ensure that access to health facilities is equitable and affordable. Participating organizations include:

- *Center for Independence of the Disabled New York*
- *Coalition for Asian-American Children and Families*
- *Community Service Society of New York*
- *Empire Justice Center*
- *Hispanic Federation*
- *Make the Road New York*
- *March of Dimes*
- *Medicaid Matters New York*

- *Metro New York Health Care for All*
- *New York Association for Independent Living*
- *New York Statewide Senior Action Council*
- *Save Beth Israel and New York Eye and Ear Campaign*
- *Save Burdett Birth Center Coalition*
- *Schenectady Coalition for Healthcare Access*
- *Sullivan County Senior Legislative Action Committee*

ATTACHMENT D

George M. Janes
& Associates
250 E. 87th Street
New York, NY 10128

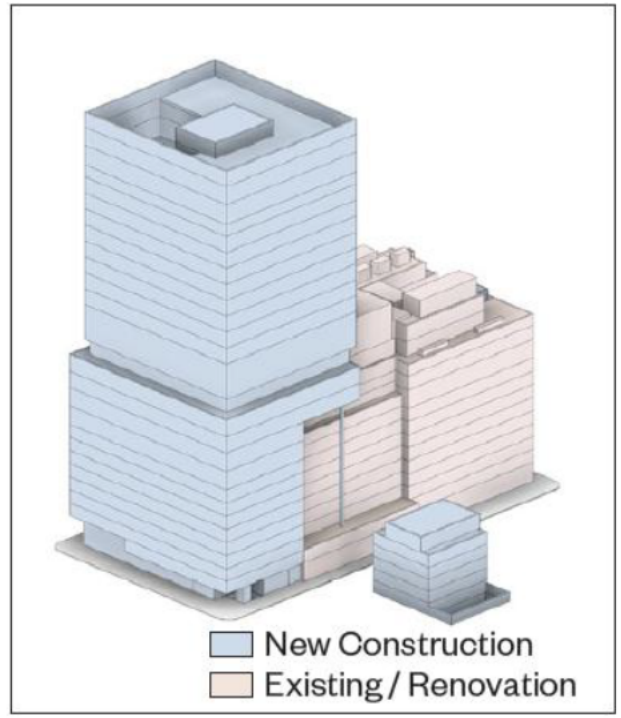
Tel: 646.652.6498
george@georgejanes.com

Lenox Hill Hospital Proposal

Prepared for:
COMMITTEE TO PROTECT OUR
LENOX HILL NEIGHBORHOOD, INC.

George M. Janes, AICP
2025 update

Lenox Hill is proposing a massive expansion of their facility on Lexington Ave.



HT. 436'
26 Stories

HT. 195'
13 Stories

Projected Development Site 1

Projected Development Site 1a

NEW SUPPORT BUILDING

Lexington Avenue

76th Street

77th Street

Inpatient Beds

Diagnostic and Treatment
ORs

Inpatient Beds
Patient Beds
Labor & Delivery
NICU

Diagnostic and Treatment
Imaging
Emergency Department

Public Lobby

Emergency Walk-In

Subway Entrance

Staff Entrance

Public Lobby
Diagnostic & Treatment
Inpatient Beds
Support
Mechanical

Mother / Baby Discharge

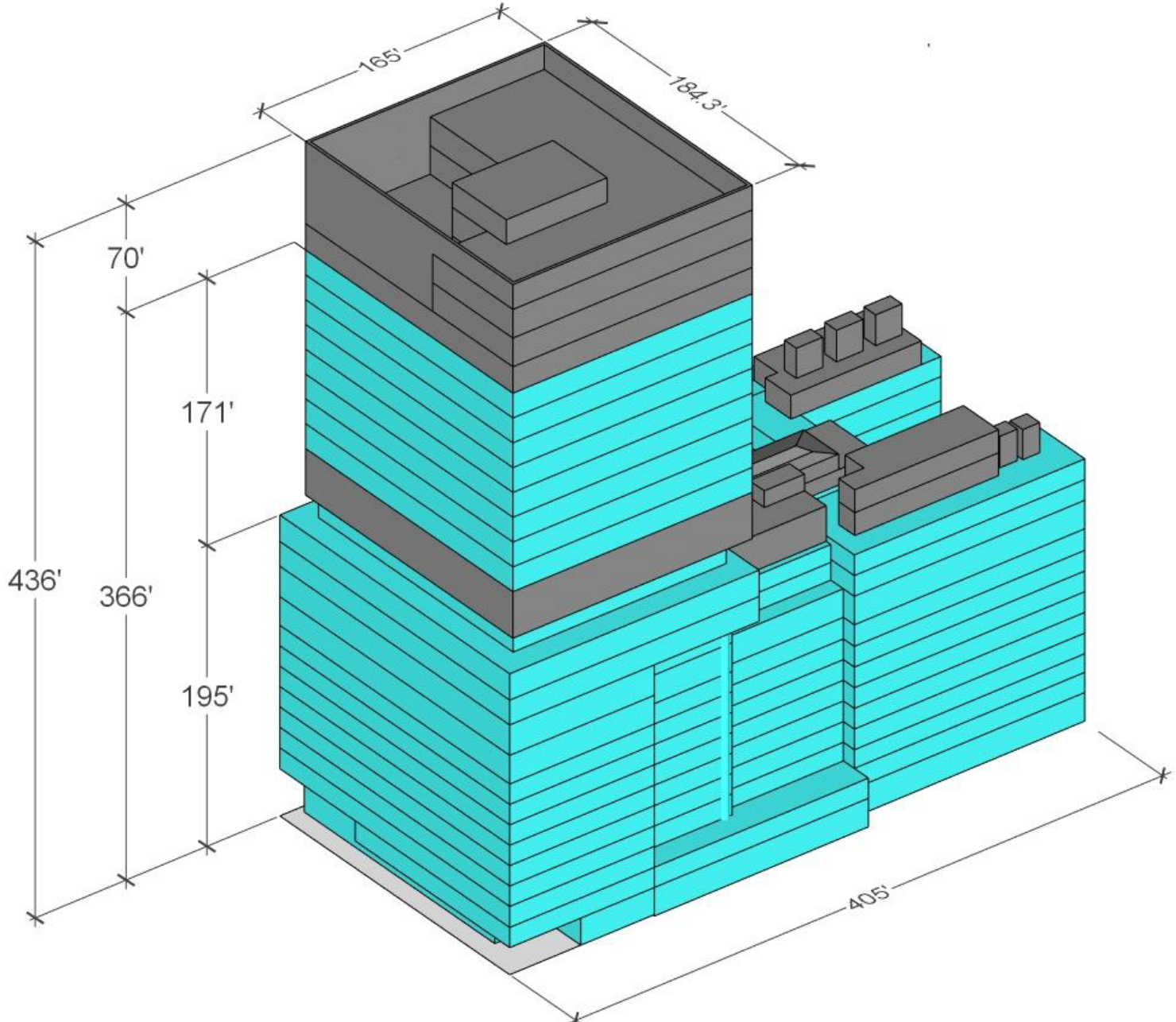
Education / Administration

Hospital Electrical Service

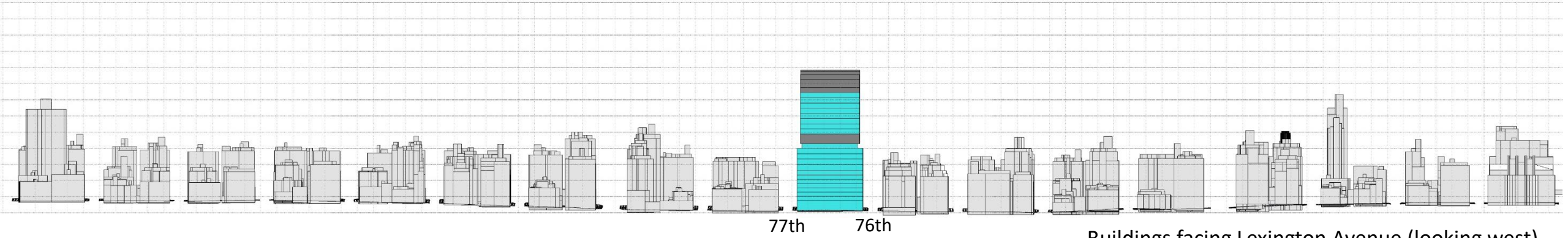
Ambulance Bays

Utility Tunnel

Lenox Hill is proposing a massive expansion of their facility on Lexington Ave.



It is vastly out of scale with the neighborhood



Buildings facing Lexington Avenue (looking west)



Buildings facing Park Avenue (looking east)

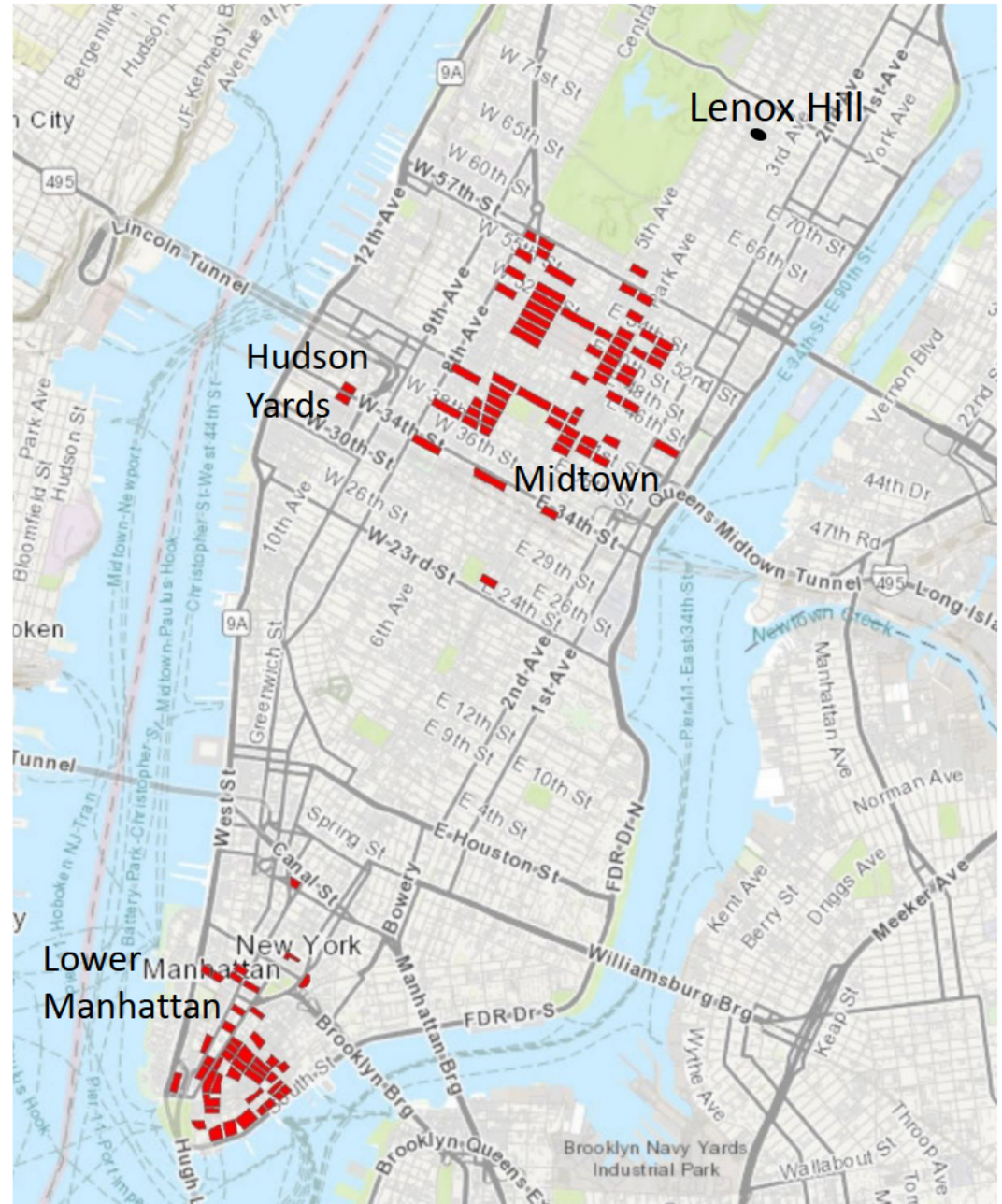
All buildings between Lexington and Park Avenues area shown

Developments of this size are not found on the UES

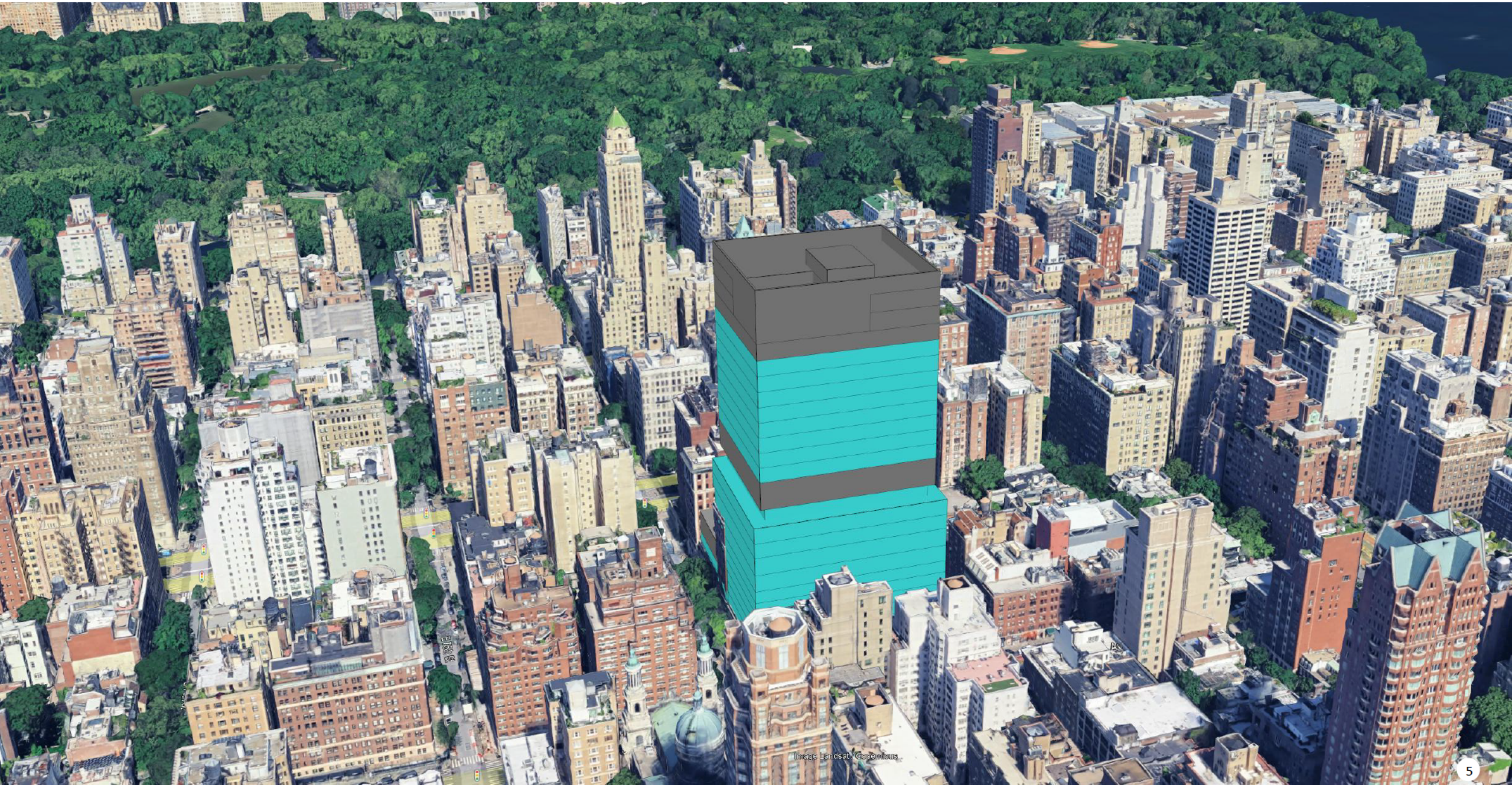
- It is proposed at 16.9 gross floor area ratio (FAR)
- This density is normally reserved for Central Business Districts

Blocks over 40,000 SF. GFA and block area from PLUTO, as corrected

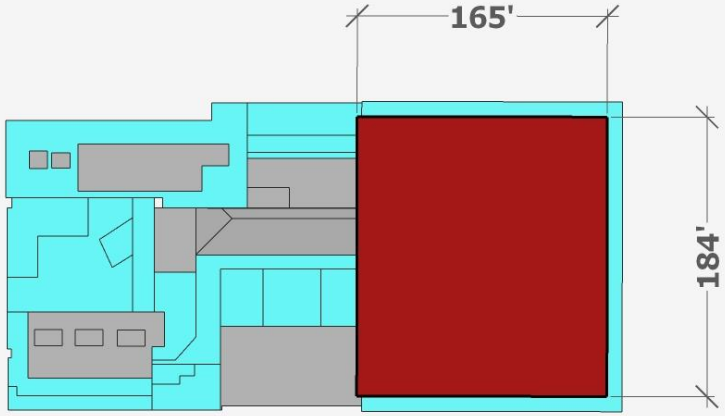
Blocks with development the size of the proposed Lenox Hill



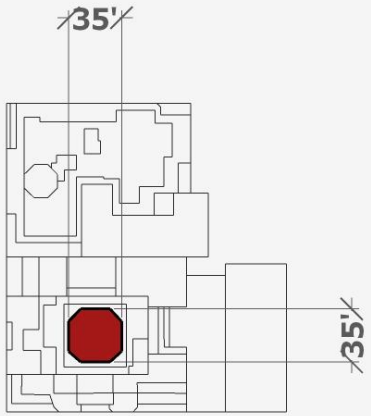
The proposed tower's floor plate is huge, freakishly large for the UES



The UES has towers that are 400+ feet tall, but they are slender



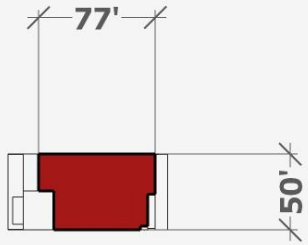
Proposed Lenox Hill Hospital



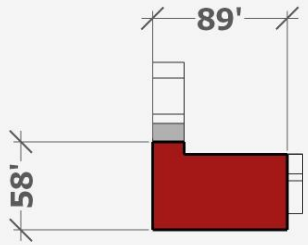
Carlyle Hotel

UES tower floorplates are nearly always less than 8,000 SF, usually much less

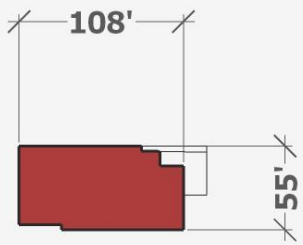
The tower on Lenox Hill is 30,000 SF!



1059 Third Ave



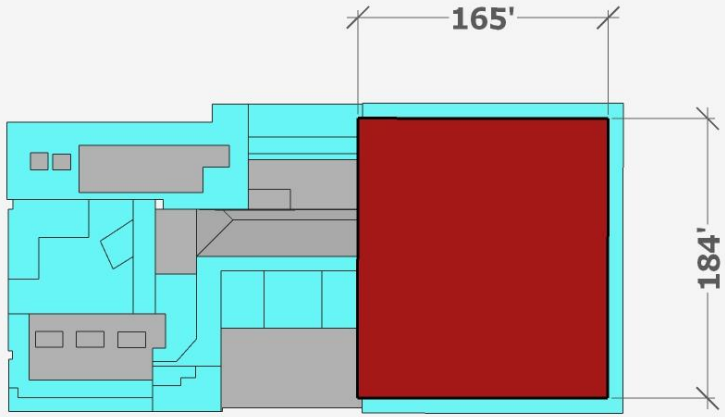
180 East 88th Street



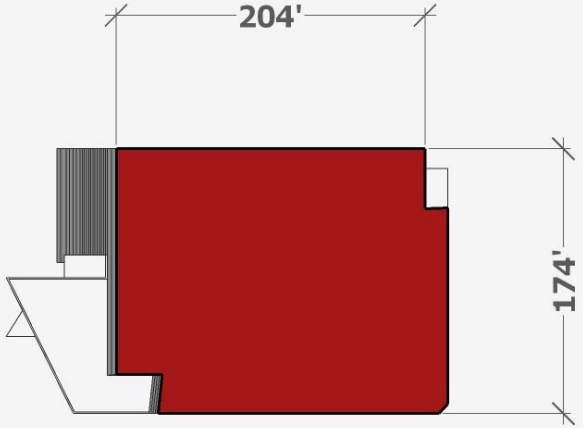
360 East 88th Street

Floorplates of selected UES buildings at 400’ height

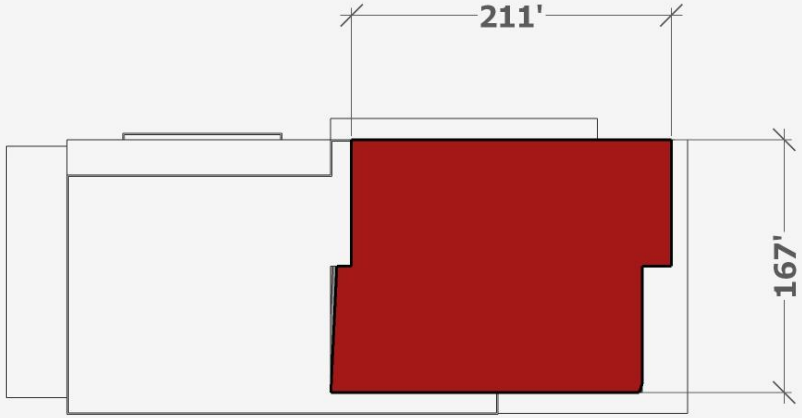
The proposed tower is more like these substantial commercial buildings



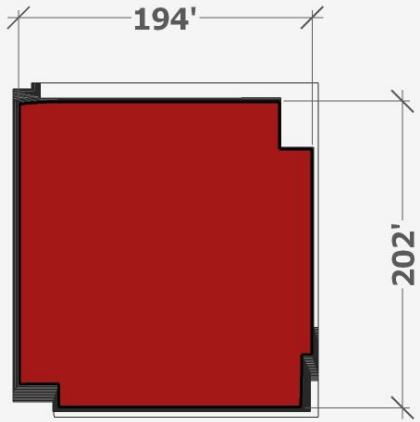
Proposed Lenox Hill Hospital



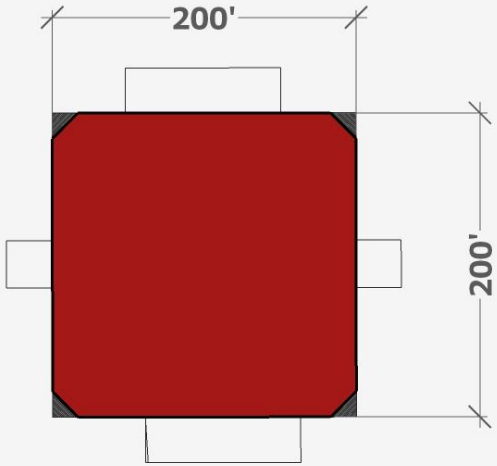
10 Hudson Yards



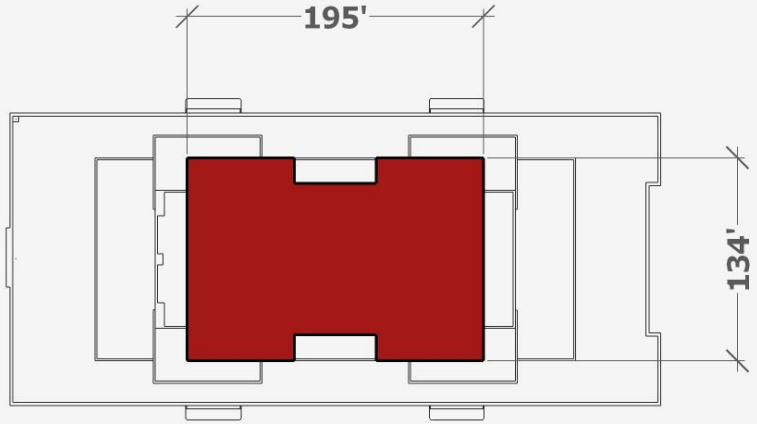
One Vanderbilt



One Bryant Park



Freedom Tower



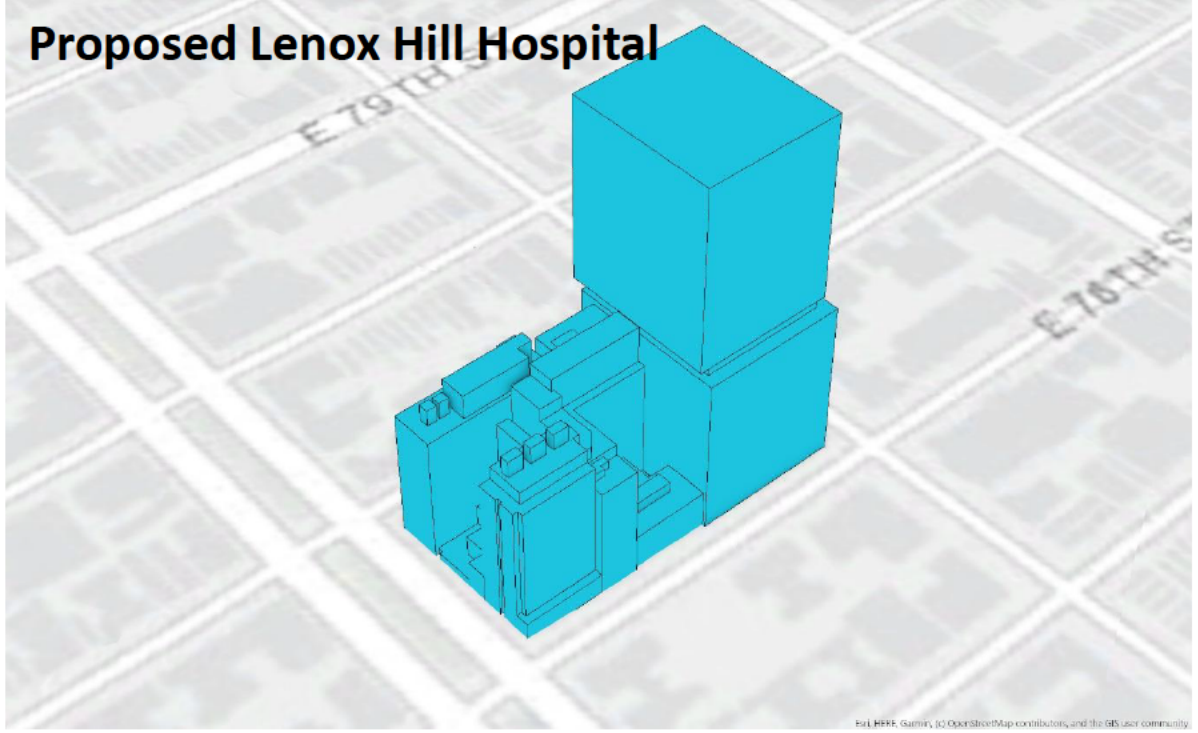
Empire State Building

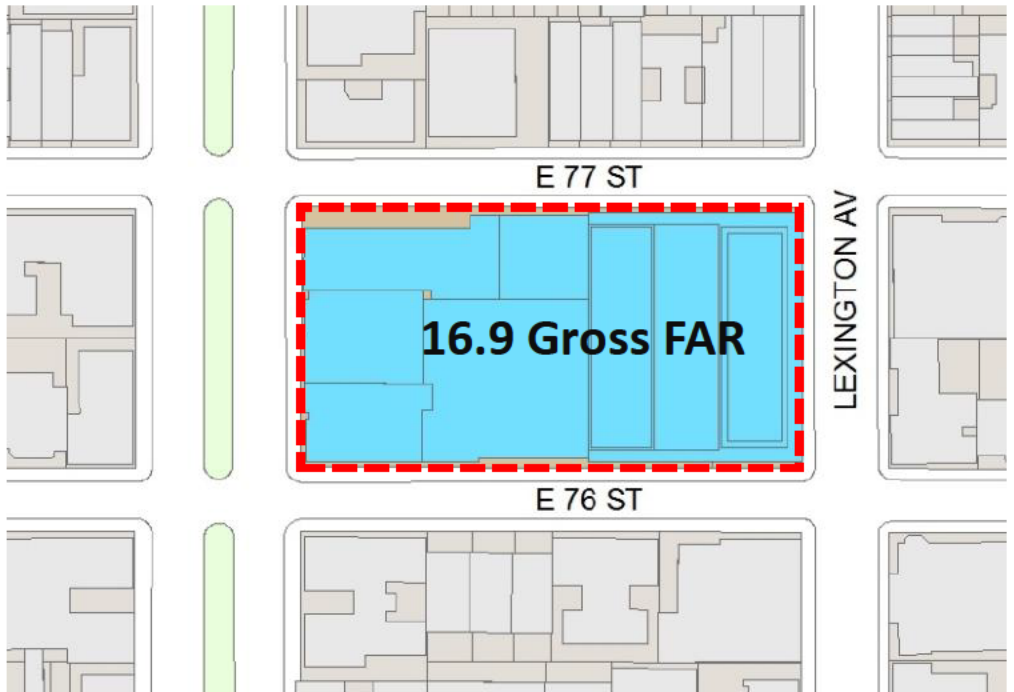
Floorplates of selected buildings at 400’ height

Even compared to other hospitals, Northwell's proposal is exceptional

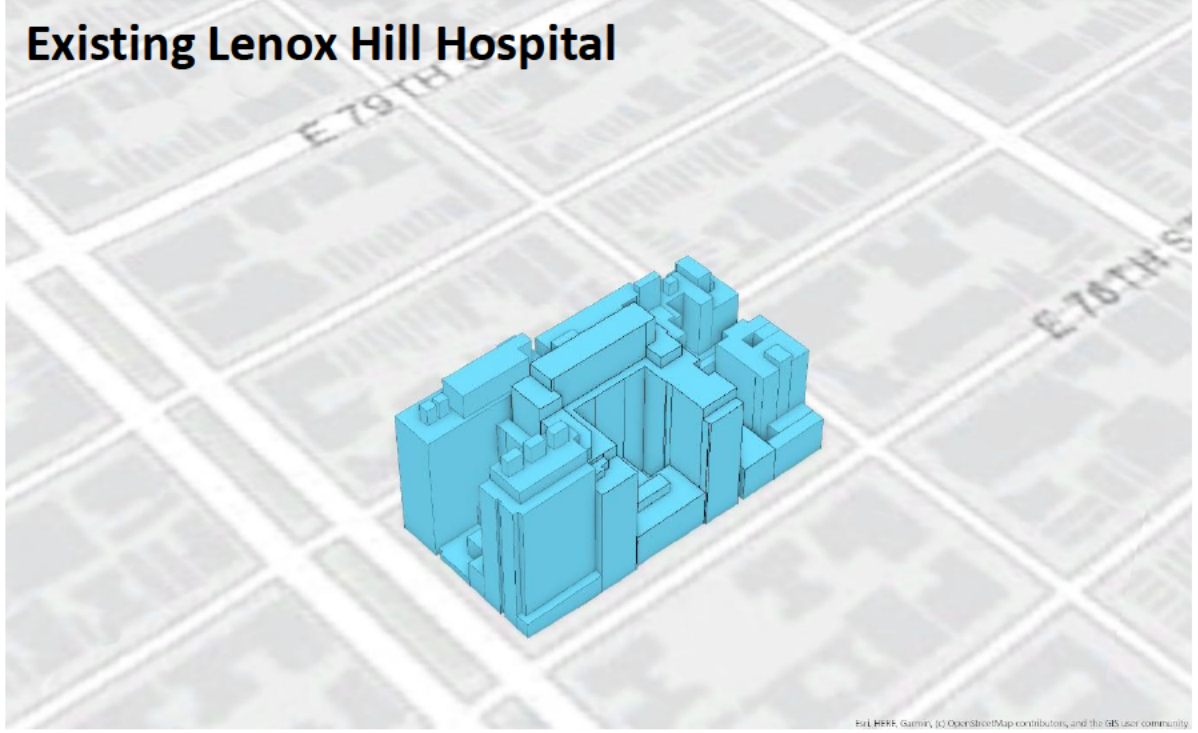
- The following compares other Manhattan hospitals with the Lenox Hill proposal

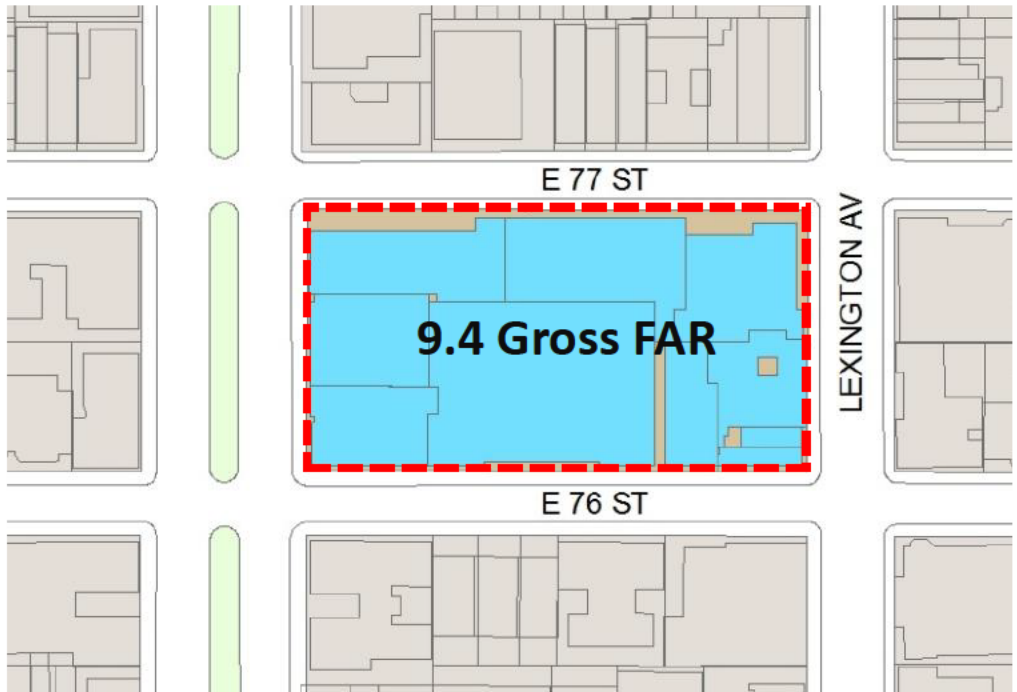
Proposed Lenox Hill Hospital

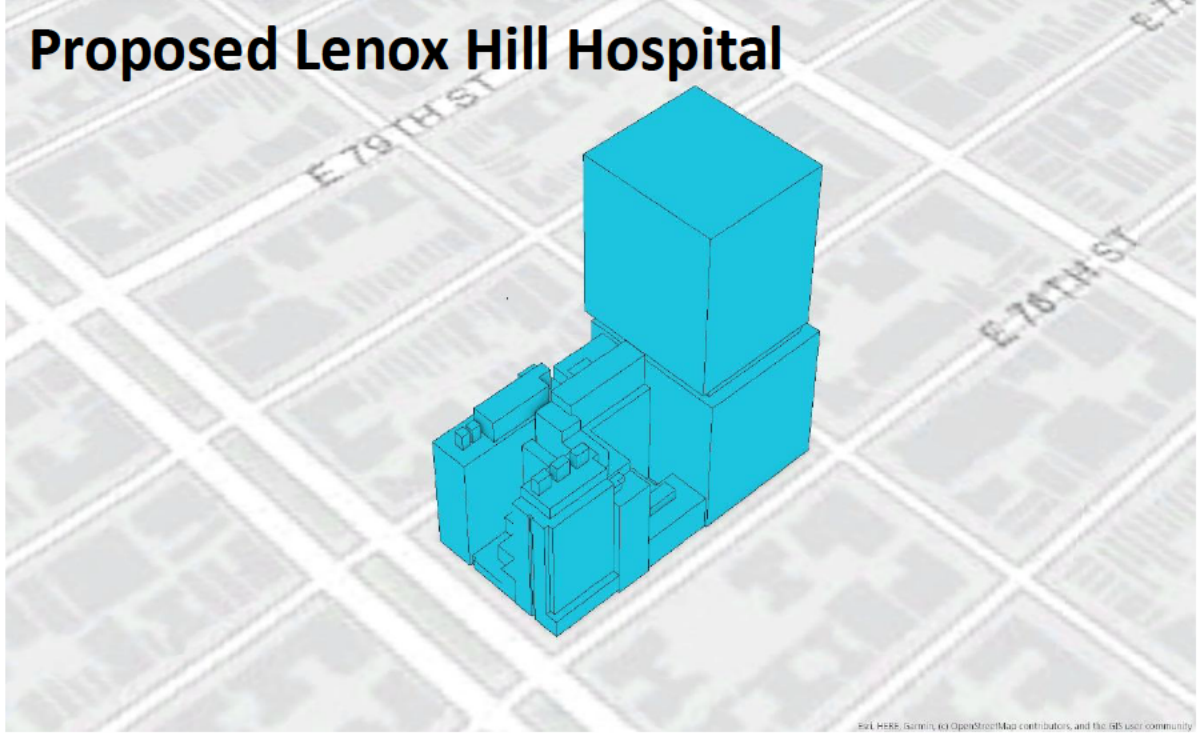


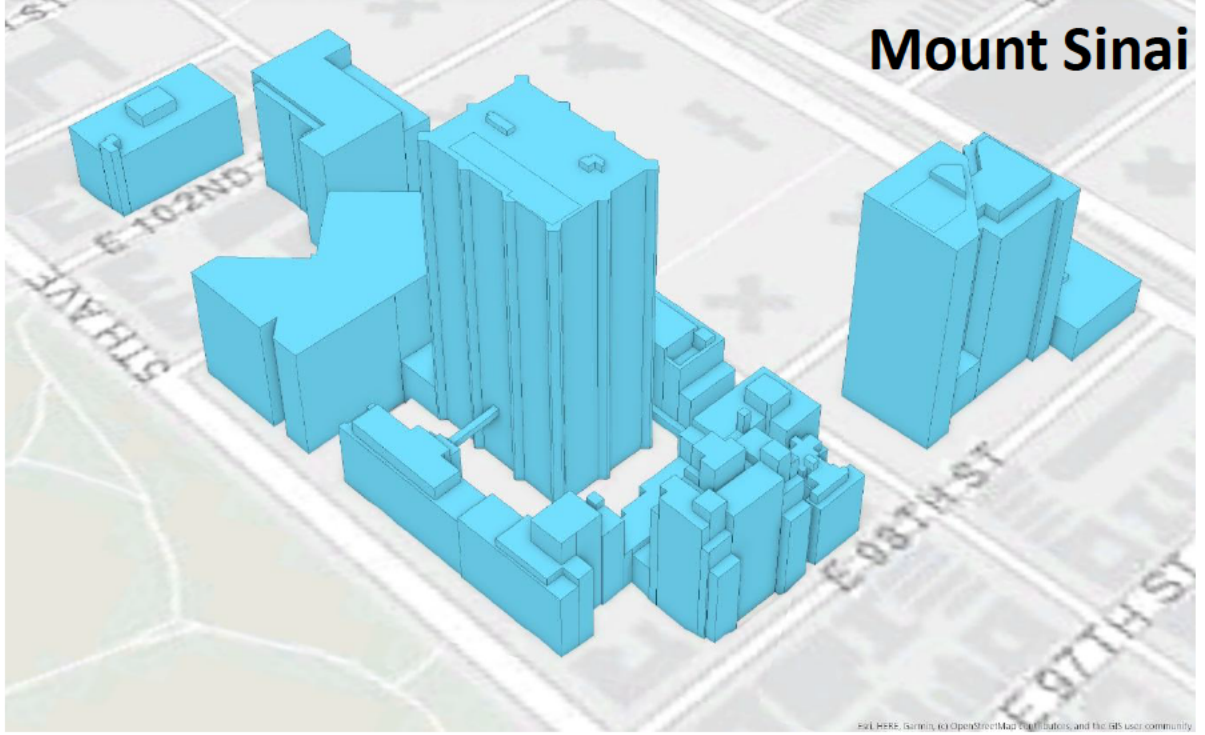


Existing Lenox Hill Hospital





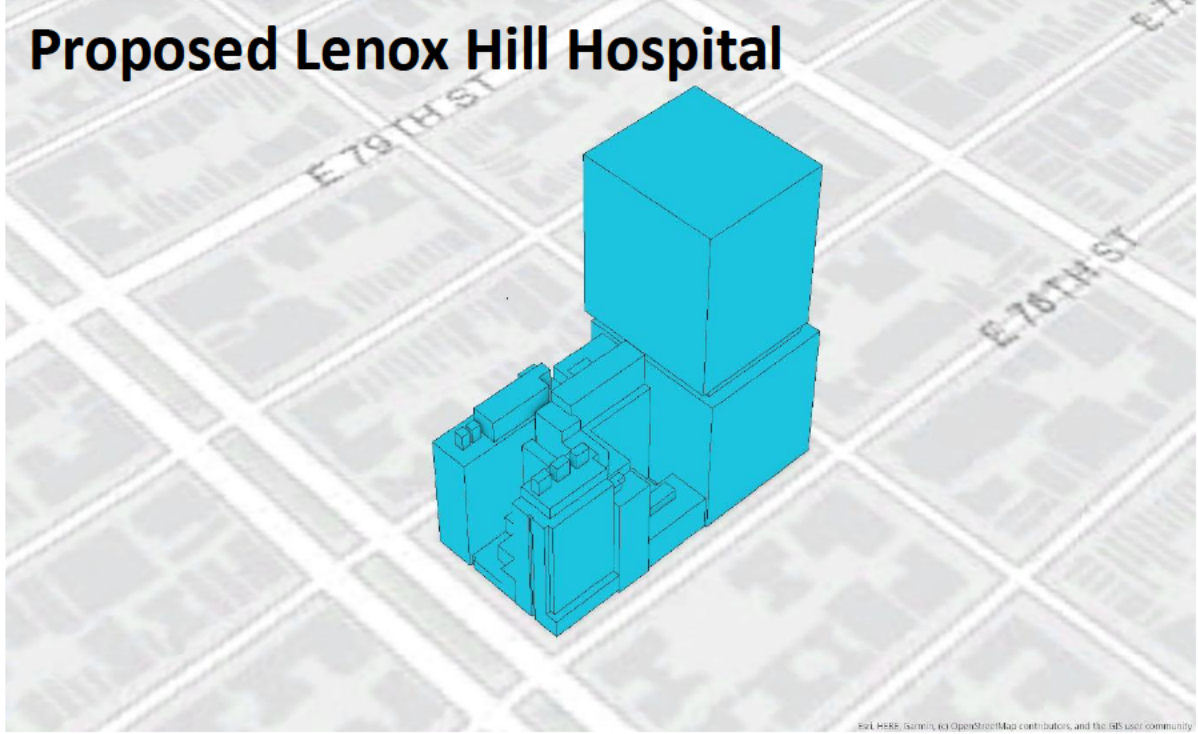

Proposed Lenox Hill Hospital
E 79TH ST
E 78TH ST


Mount Sinai
E 102ND
5TH AVE
E 98TH ST
E 97TH ST

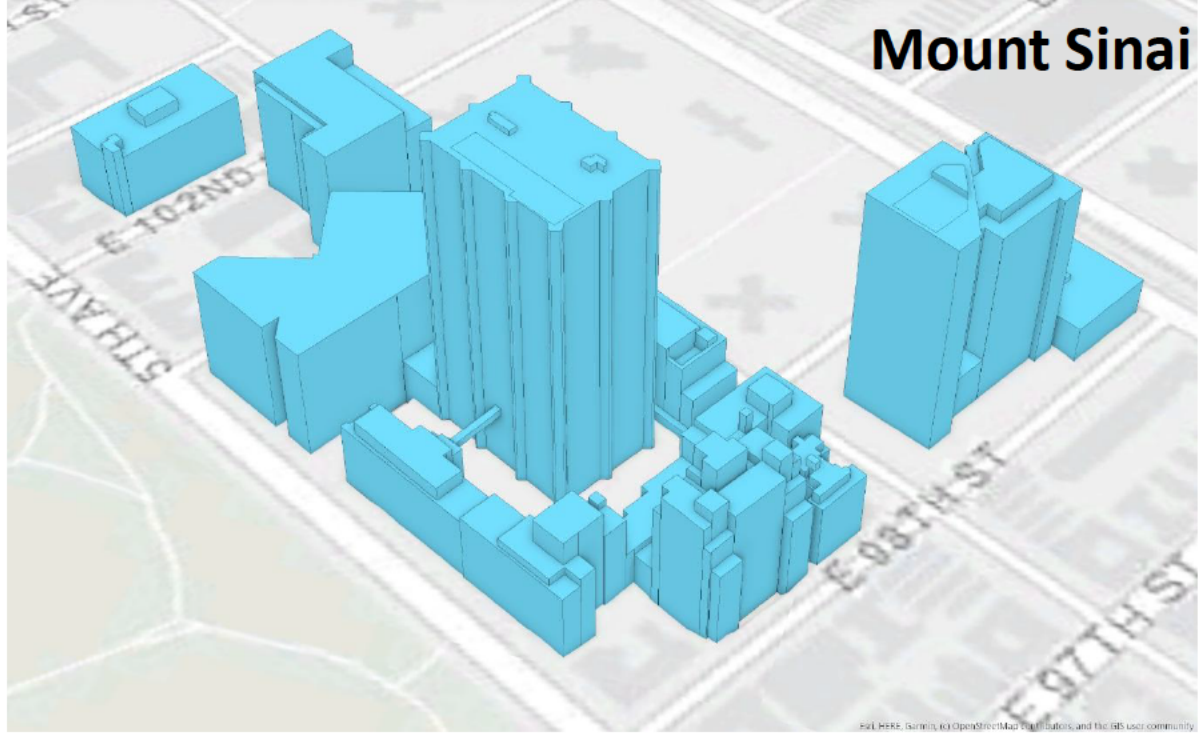

PARK AV
E 78 ST
E 77 ST
MADISON AV
16.9
LEXINGTON AV
3 AV
E 76 ST
E 75 ST


PARK AV
E 99 ST
11.3
MADISON AV
E 98 ST
11.2
8.0
E 103 ST
E 102 ST
E 101 ST
7.9
E 97 ST
5 AV
10

Proposed Lenox Hill Hospital



Mount Sinai





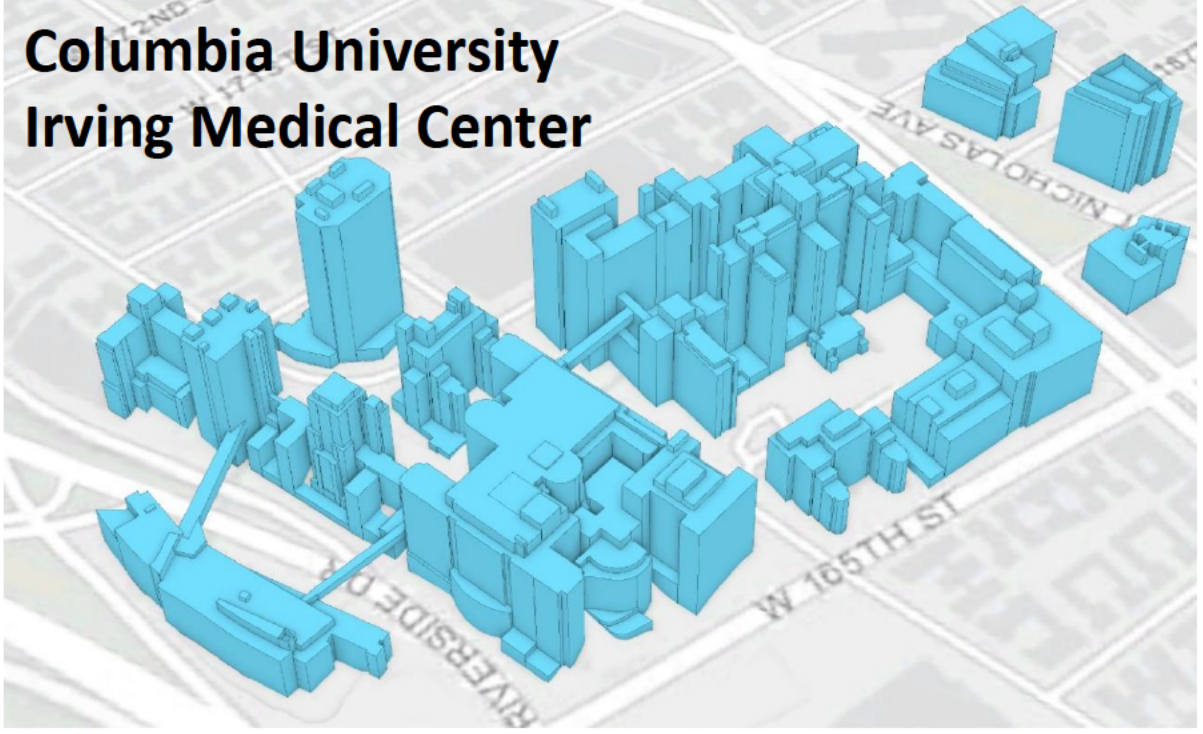
The Annenberg Building



Proposed Lenox Hill Hospital



Columbia University Irving Medical Center

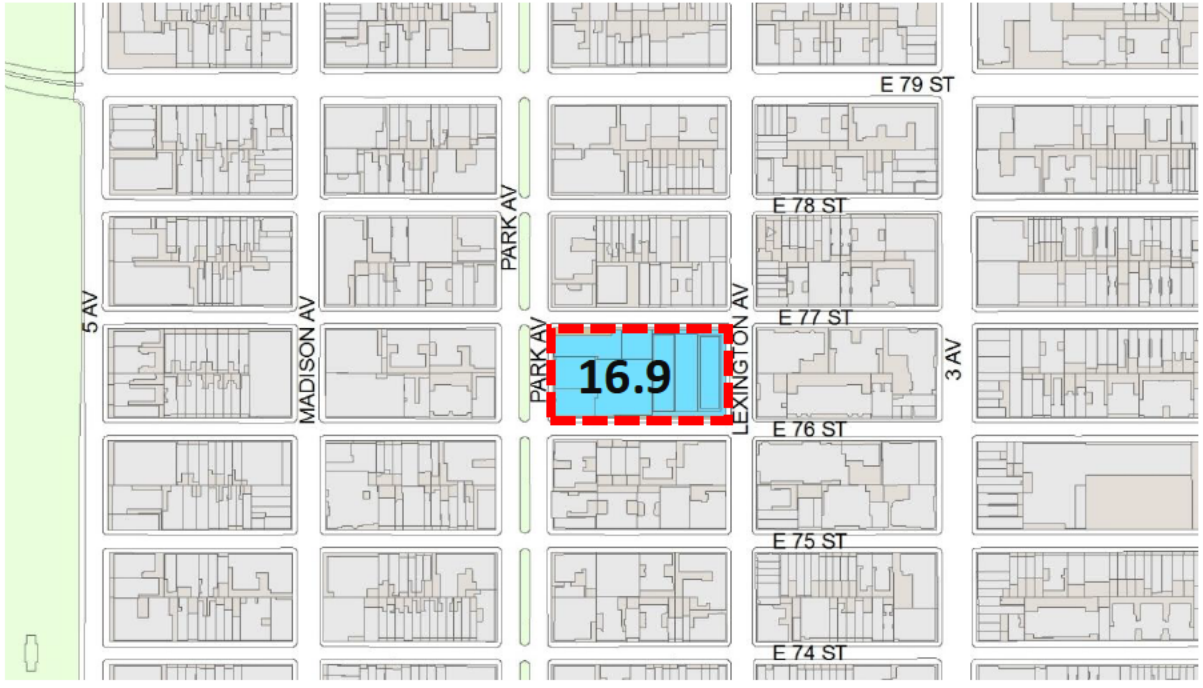







Proposed Lenox Hill Hospital
E 79TH ST
E 78TH ST
E 77TH ST
E 76TH ST
E 74TH ST
PARK AVE


NYU/
Bellevue/
VA
E 34TH ST
MARGINAL
FDR DR
E 25TH ST
E 23RD ST
20TH ST


E 79 ST
E 78 ST
E 77 ST
E 76 ST
E 75 ST
E 74 ST
5 AV
MADISON AV
PARK AV
PARK AV
LEXINGTON AV
3 AV
16.9


F D R DR
4.1
3.4
5.0
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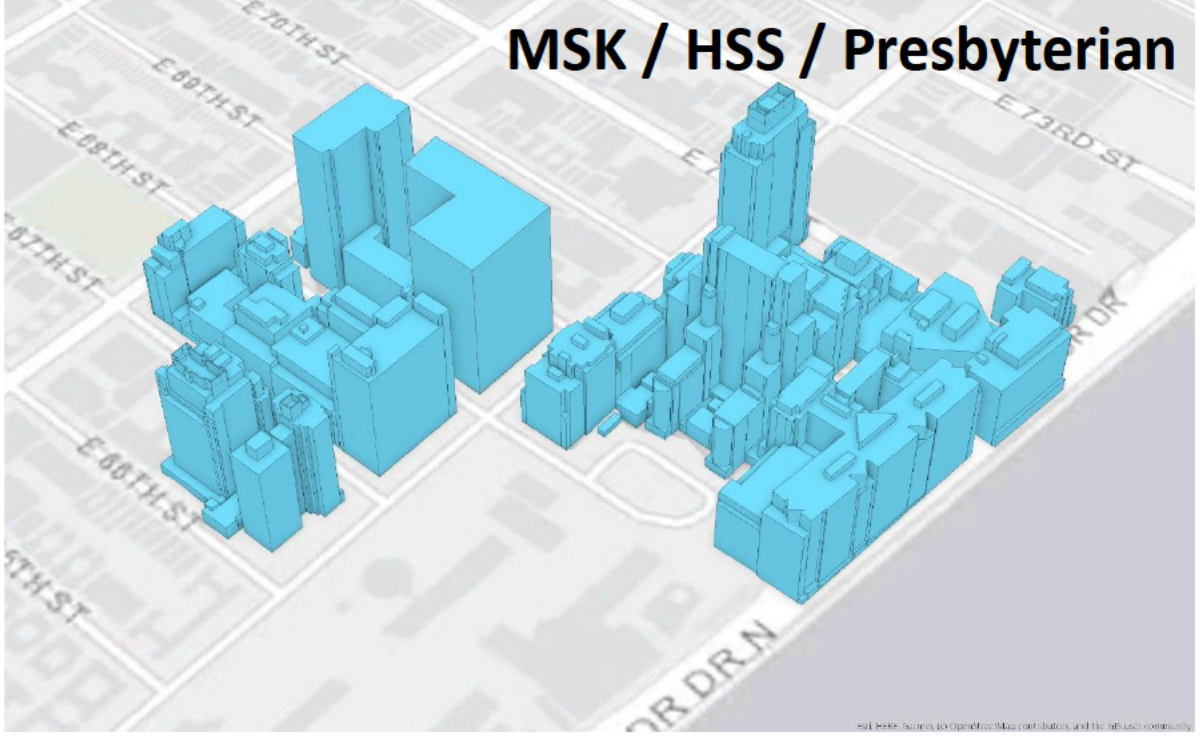
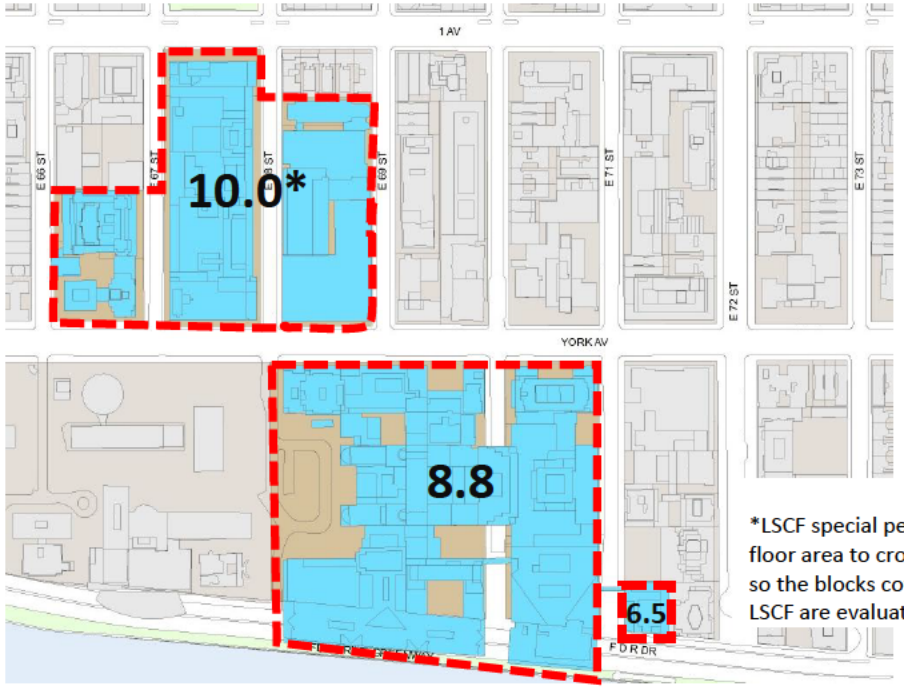
Proposed Lenox Hill Hospital



MSK / HSS / Presbyterian

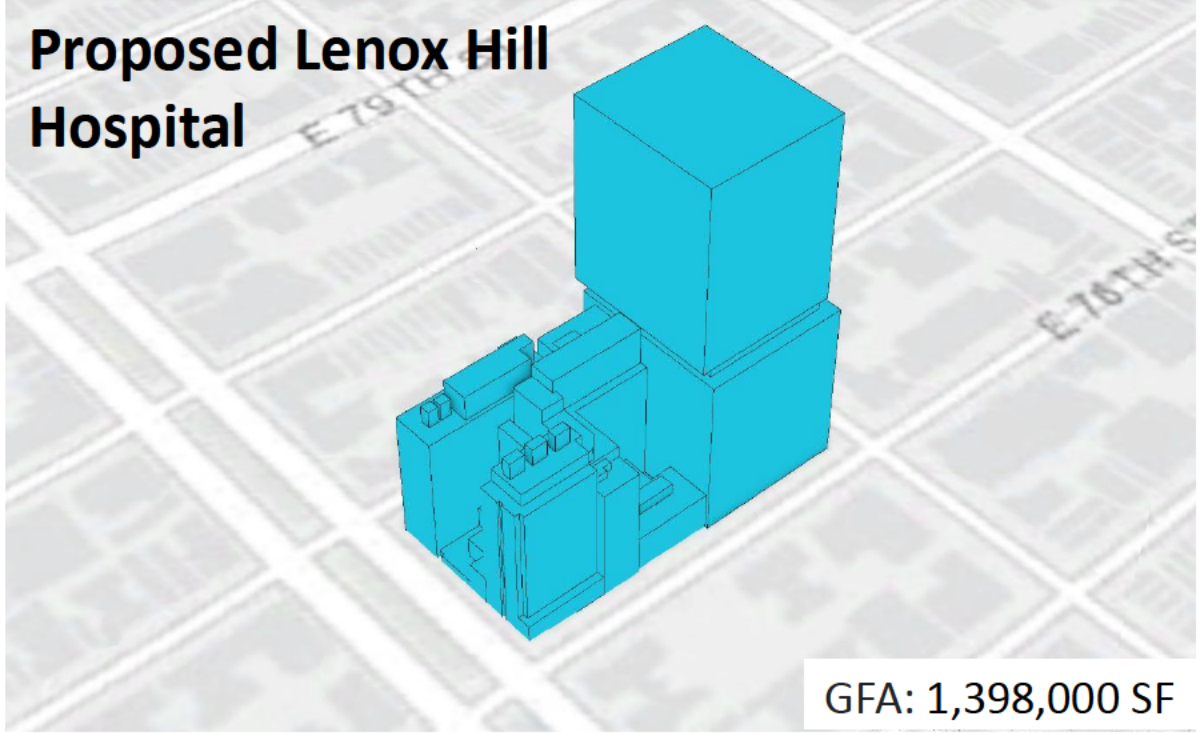




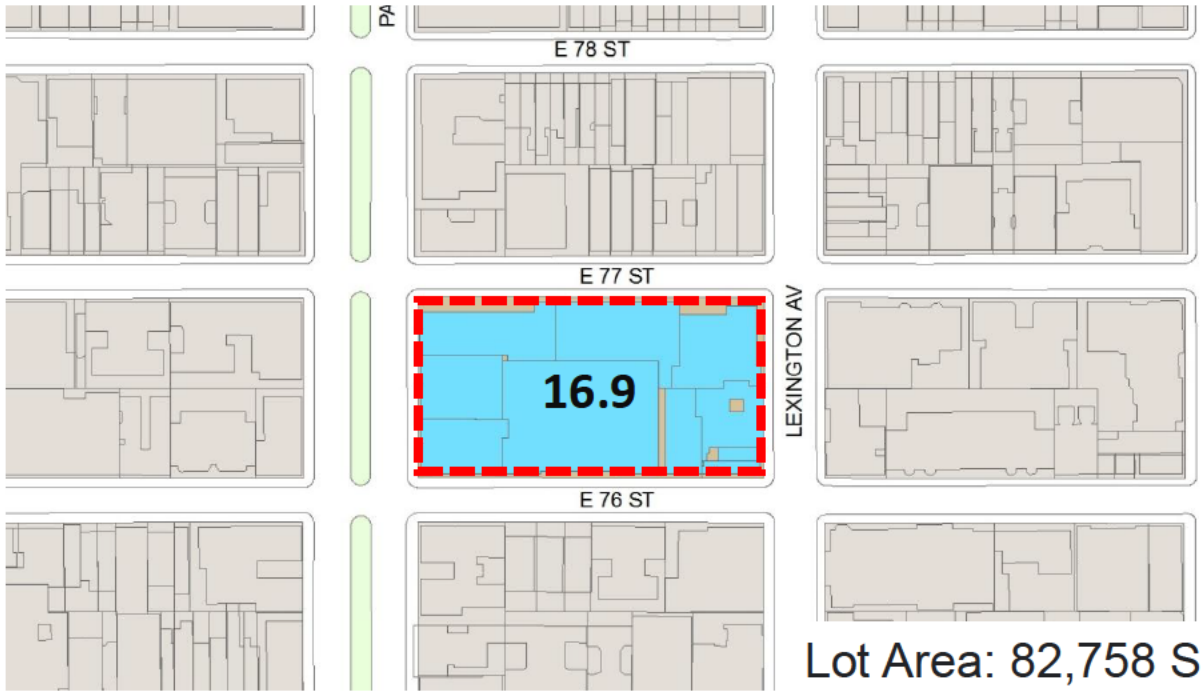


*LSCF special permit allows floor area to cross streets, and so the blocks covered by the LSCF are evaluated as one

Proposed Lenox Hill Hospital

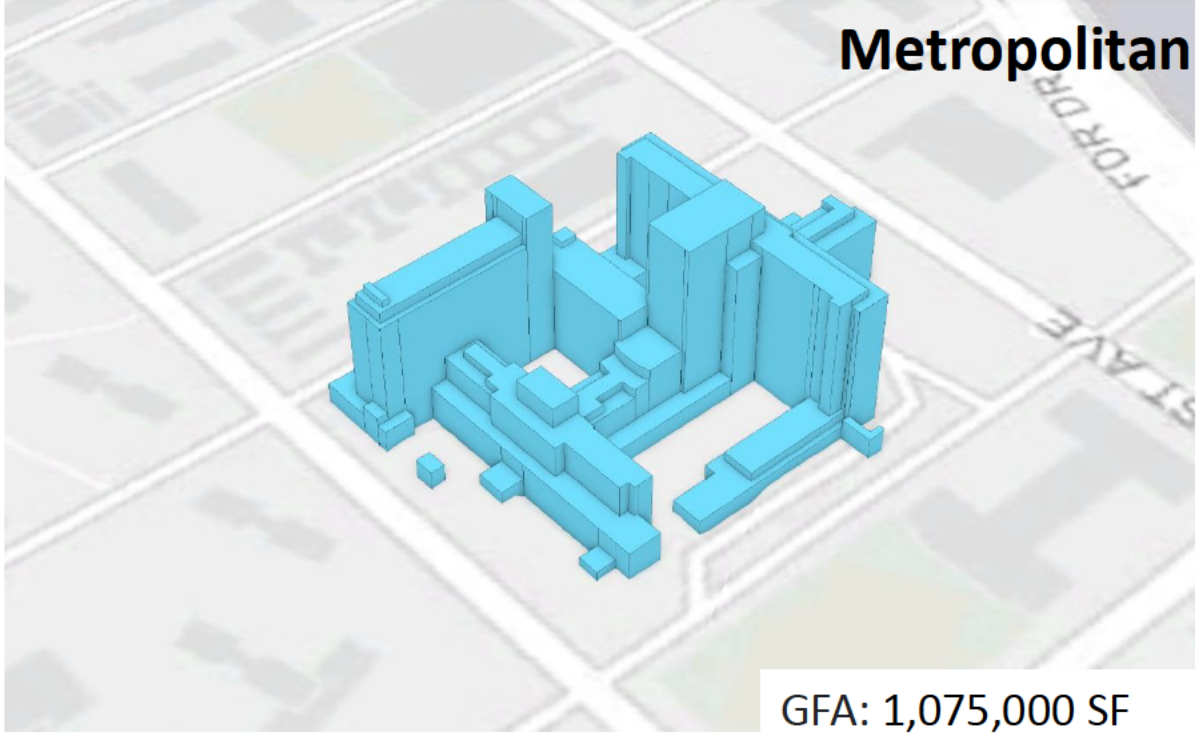


GFA: 1,398,000 SF

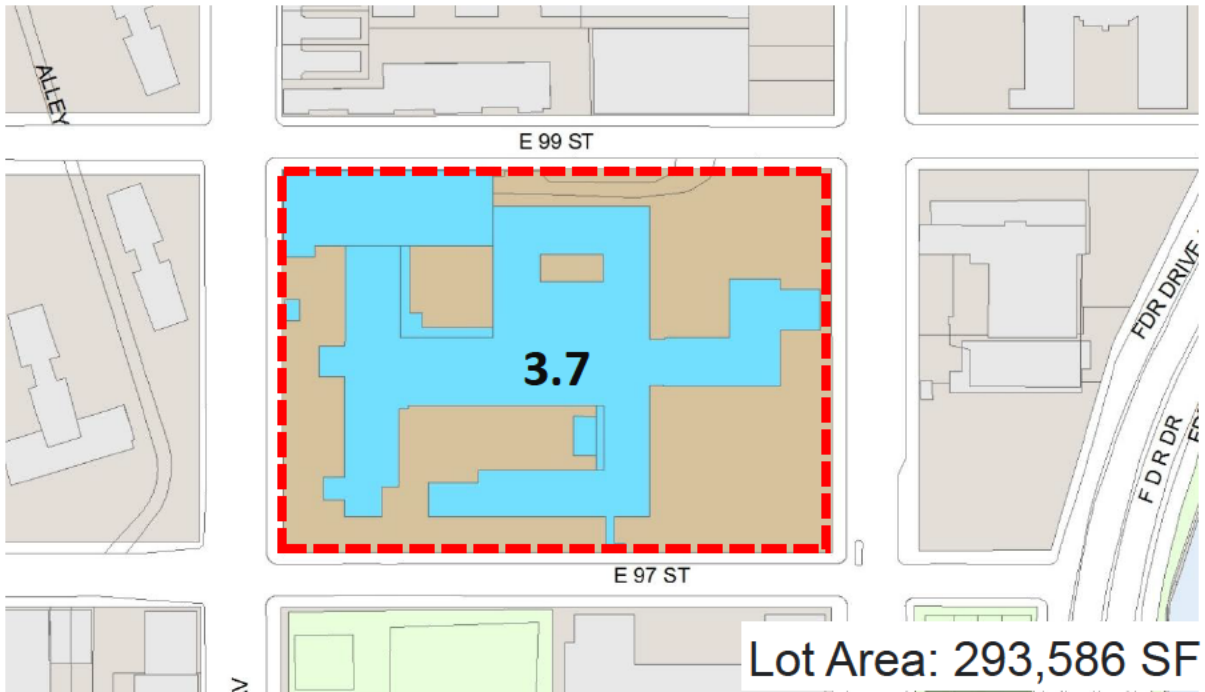


Lot Area: 82,758 SF

Metropolitan

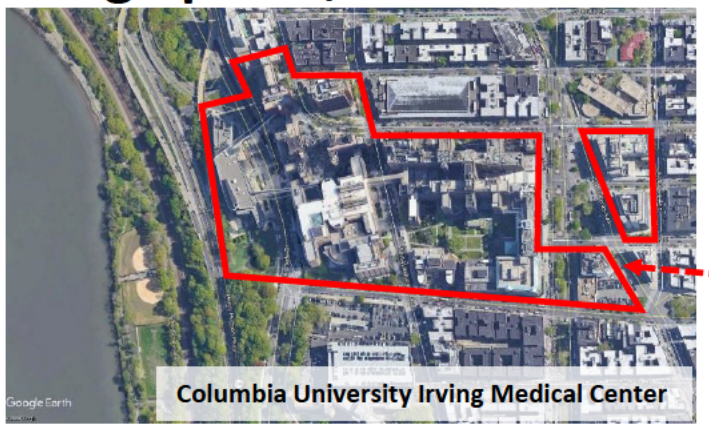


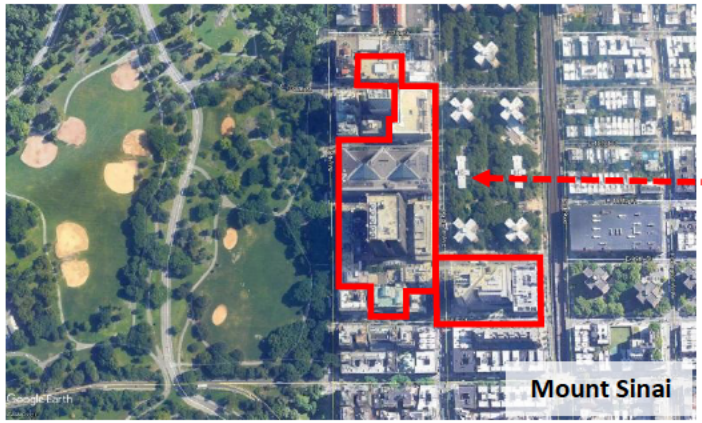
GFA: 1,075,000 SF

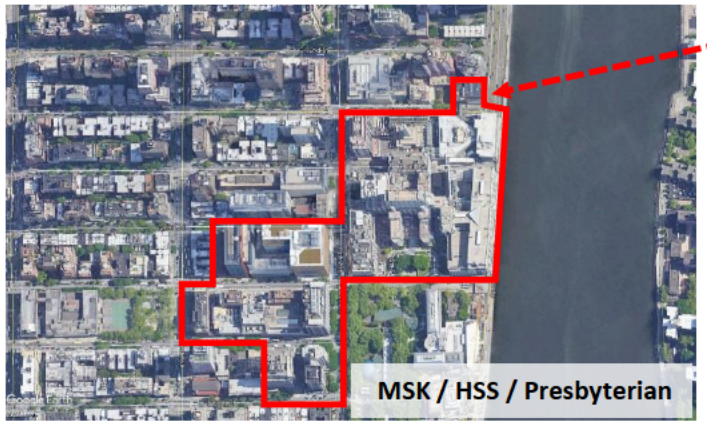


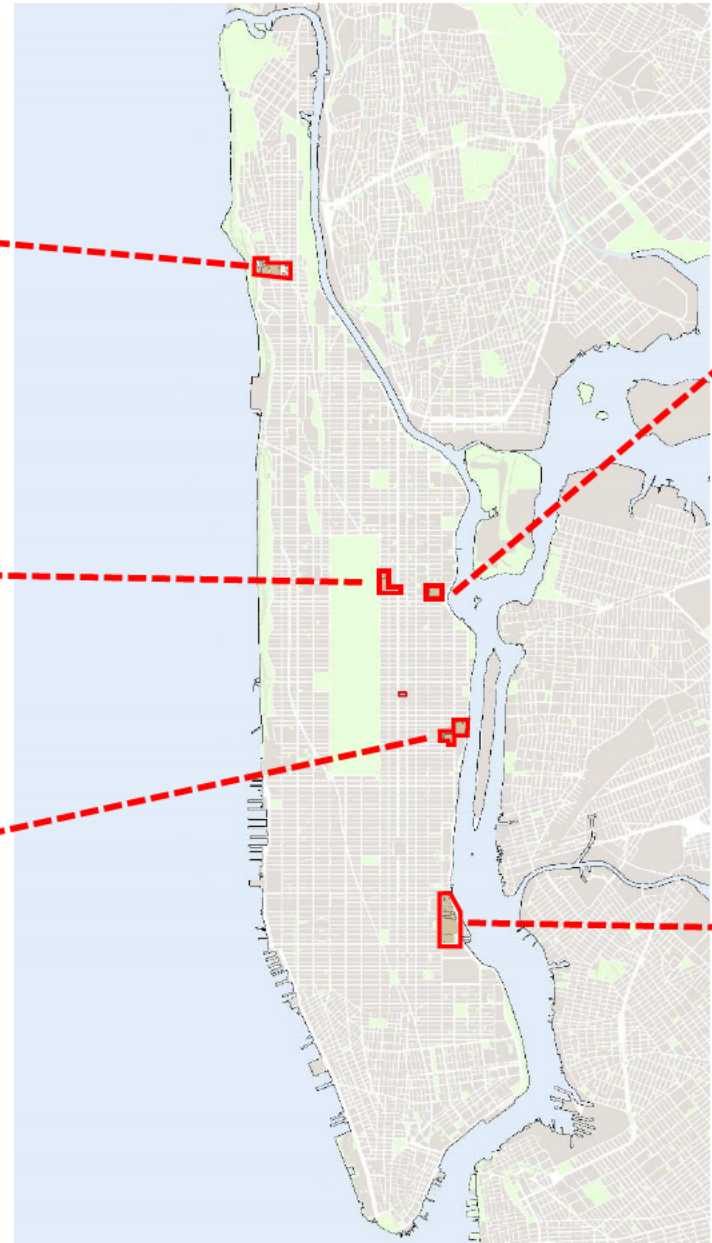
Lot Area: 293,586 SF

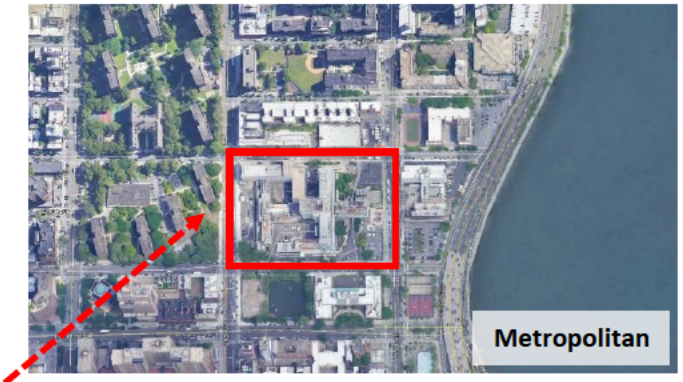
Manhattan hospitals tend to be located on superblocks at the edges: near shorelines or large parks, not in center of neighborhoods on small blocks













Lenox Hill is an institution that has served our community for generations

- But Northwell's problem is that their site is too small for their program
- They want to solve this problem by changing zoning
- This is bad planning
- There are other ways to address Northwell's problem, but it will require political will, planning, engagement and a willingness to look beyond this block

George M. Janes
& Associates
250 E. 87th Street
New York, NY 10128

Tel: 646.652.6498
george@georgejanes.com

Lenox Hill Hospital Proposal

Prepared for:
COMMITTEE TO PROTECT OUR
LENOX HILL NEIGHBORHOOD, INC.

George M. Janes, AICP
2025 update

Outlook

[EXTERNAL] Comment on the DEIS of the Lenox Hill Hospital proposed project

From Meyer, Peter <pbmeyer@louisville.edu>
Date Sun 5/18/2025 1:18 PM
To 23DCP079M_DL <23DCP079M_DL@planning.nyc.gov>

2 attachments (316 KB)
Comment on Northwell Health's LHH DEIS.pdf; PBM -signature.docx;

Some people who received this message don't often get email from pbmeyer@louisville.edu. Learn why this is important

CAUTION! EXTERNAL SENDER. Never click on links or open attachments if sender is unknown, and never provide user ID or password. If **suspicious**, report this email by hitting the **Phish Alert Button**. If the button is unavailable or you are on a mobile device, forward as an attachment to phish@oti.nyc.gov.

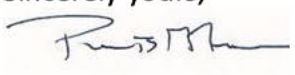
.Stephanie Shellooe, AICP, Director,
Environmental Assessment and Review Division
New York City Department of City Planning

Dear Ms. Shellooe,
Please see the attached document. (In case you don't accept attachments, the document text follows my signature below.)
The submission is with reference to:

- Application Number: **C 250151 ZMM**
- Project: **Lenox Hill Hospital**
- Public Hearing Date: **05/21/2025**
- Borough: **Manhattan**
- Community District: **8**

I thank you for your attention.

Sincerely yours,



Peter B. Meyer, PhD
Professor Emeritus of Urban Policy and Economics, U. of Louisville
President and Chief Economist, The E.P. Systems Group, Inc.
Council Member, Borough of New Hope
228 Riverwoods Dr., New Hope, PA 18938 USA
+1-502-435-3240

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THE E. P. SYSTEMS GROUP, INC.
228 Riverwoods Drive
New Hope, PA 18938

502-435-3240
<EPSGonline@gmail.com>

Comment on the

Notice Of Completion and Notice of Availability of a Draft Environmental Impact Statement and the Lenox Hill Hospital Development Draft Environmental Impact Statement

Prepared March 12, 2025, by Peter B. Meyer, PhD

DISCUSSION OF NEED AND FEASIBILITY

The need for this massive new development is never clarified by the applicant or in the DEIS other than the claim that it needs to assure "475 single-bedded patient rooms, 30 operating suites, and a right-sized emergency department." Northwell Health apparently needs this construction to serve some of its (unspecified) objectives, but there is no documentation of need from the perspective of the neighborhood in which the hospital is located, from that of Community Board 8 that is being asked to approve this project, nor from that of the City of New York itself.

A number of questions need to be answered to establish need:

- Does the claim that " current standards of healthcare delivery, including single-bedded patient rooms" require this expansion stand? Are single-bedded rooms the norm in New York or nationally?
- What is "right sized" when it comes to the appropriate size of an emergency room?
- How does the addition of 25 beds necessitate an ED expansion of 14 treatment units from the current 34 to the proposed 48
- Similarly, where is the evidence that 5 additional ORs are needed in this part of the city – or the city as a whole?
- Where is the evidence that justifies a "new off-street ambulance bay with six berths" and " Four new and longer truck loading bays" when three truck bays already exist and the proposed construction would impede local traffic, cross pedestrian walkways and intrude on the streetscape of the neighborhood? Granting that the new vehicular access facilities may be an improvement over those that exist, are they needed? Where is the evidence that demand for services at this location warrants six ambulance bays and seven truck bays?
- Why do any of these new facilities necessitate a new "46,000-gsf, six-story, 75-foot-tall building to house hospital support functions"? What are those functions and aren't they already housed in existing buildings that could be rehabilitated or modernized?
- Even granting the need for all of the above can be empirically demonstrated to serve the immediate neighborhood, broader local community, and the city as a whole, what justifies the construction of two towers, one 21 stories and the other 26 stories tall to accommodate the expansion in facilities that are proposed?

Part of the apparent answer from Northwell Health to this last question is their claim that

> "the buildings to be demolished cannot be used for inpatient care because their structures cannot accommodate the necessary heating, ventilation, and air conditioning (HVAC) infrastructure, sensitive modern imaging equipment, or patient transport between buildings."

But those buildings are in use now. If they are used for inpatient care, then the hospital is acknowledging that it is not providing a high quality of care. If they serve other hospital purposes and functions than inpatient care, why do they need to be demolished?

There is simply no rationale provided for the intended demolitions and the construction of proposed structures are substantially taller than any other buildings around the project sites – towers that will substantially change the character of the neighborhood.

There may be a need for the *proposed Subway Station Access and Sidewalk Improvements* but those are not hospital functions and there is no evidence offered to show that improvements are not in the MTA's workplan.

An upgraded subway entrance is a function of the MTA – but there apparently has been no contact with the MTA about whether the site improvements are not already in their workplan, and Northwell's contribution is not required.

This failure to communicate with the MTA is reflected in the plans for the tunnel proposed for access between the two development sites. According to Northwell, that tunnel "would require a revocable consent from DOT." But the applicant for permission to undertake a massive project has apparently had as much contact with DOT as it has had with the MTA.

Any plans developed without needed consultations – not to mention those dependent on a "revocable consent" that has no permanence – really aren't plans. They fail the fundamental standard of demonstrated feasibility.

Some facets of that limited feasibility are evident in the flaws in the DEIS discussion of the anticipated impacts of the proposed project.

PROJECT IMPACTS DESCRIBED AND OVERLOOKED

The DEIS starts by defining its study area as within 400 feet of the Project Site. The definition on which the entire analysis stands, however, is an area defined by distance from the midpoint of the project site, not the borders of the site. When a site is as large as this one – a whole city block – the boundary of the study area is far greater when the distance to boundary is used. That is warranted, since that includes the properties within 400 feet of the proposed construction site and the proximity is a measure of the expected spillover risk.

Thus the entire statistical and architectural context discussions may be off by a significant measure. Looking at Figure ES-1, the more appropriate study area based on distance to project boundaries would not be the limited area defined by the dotted red line, but one that probably reaches to the far side of Madison Avenue, 76th Street, the far side of Third Avenue and the far side of 79th Street.

If the study area really were defined by a distance of 400 feet from the center of the project site, it would be a perfect circle; the distorted dotted line shape may involve some allowance for the second development site, but it is still inexplicably different from a circle and its shape is never explained. An explanation is needed or the area defined would seem to have been selected to serve the case for the project.

Land Use and Zoning, and Public Policy

The DEIS claims that the

> "proposed bulk would be consistent in scale with other institutions and medical facilities in the area."

But the description of proposed construction involves structures far taller than those in the neighborhood as a whole, so that claim is false.

The reference to other medical facilities suggests that the neighborhood-specific impacts are ignored. (That reference, including enumeration of many competing hospitals on the East side of Manhattan is repeated in the chapter nominally about "Neighborhood Character" which leads the reader to wonder if the assessment is paying any real attention to the people and premises in its immediate proximity.)

Contribution of project to OneNYC's goals is irrelevant since courts by and large have ruled that comprehensive plans have no legal standing as a guide to action.

Community Facilities and Services

Claim that the project "would not directly affect other types of public community facilities" totally fails to consider what impact the nine-year construction process would have on those facilities, businesses in the area, and/or the amenity values of the residences in the neighborhood.

Further fails to consider what impact the supposed improvements in traffic flow due to better ER-ambulance interactions or improvements in subway access would have on the viability of local businesses and other community facilities. (They could improve conditions, not contribute to deterioration; the failure to consider even such positive effects is a measure of how shallow the review has been to date.)

Open Space

The issue of "increased population" is limited to consideration of the number of new employees when the intent of the proposed project is to increase the number of patients served, thus the transient population of the neighborhood. Those transients DO constitute a "new user population" for the limited immediately available open space.

There is no basis for the claim that the additional shadow would not affect use of the garden cited.

Shadows

Admitted that "the significant adverse shadow impacts to the church garden would be unavoidable." -- thus being thoroughly inconsistent with the prior claim.

Historic and Cultural Resources

Acknowledging the existence of historic architectural resources, the impact assessment makes the untenable assumption that the Construction Protection Plan prepared as required will be fully successful in protecting those resources from damage due to vibration and other impacts from demolition and construction. This certainly is not viable as part of a worst case assessment.

The DEIS itself notes that "The NYC Building Code, in Section BC 3309: Protection of Adjoining Property, provides some measures of … they do not afford special consideration for historic structures." Thus there is no basis for assuming there would be no adverse impacts from the demolition, excavation and construction elements of the proposed project.

Urban Design and Visual Resources

While further justifying the proposed building heights, the discussion of design impacts remains superficial at best despite the minimal commitments to conform to neighborhood exterior color and cladding character.

Typical is the meaningless claim that "the buildings on the western portion of Projected Development Site 1 … would provide transparency and activate uses on the adjacent sidewalks on Park Avenue." What "transparency' relative to what, and what uses of the sidewalk are considered and how do either affect – or are affected by – design or visual resources?

Hazardous Materials

The fact that the Phase II hazardous materials investigation was incomplete is not acknowledged in the Notice of Completion and Notice of Availability of the DEIS. The DEIS itself, however, notes that,

> "Due to physical limitations encountered during the field investigation, including intervening subsurface utilities, active electrical systems for critical hospital care systems, and ongoing hospital operations, the advancement of soil borings with a Geoprobe® direct-push drill rig was not possible as hospital operations prohibited the use of fuel-powered drilling equipment with exhaust inside the building and limited the use of electrical power to standard outlets. As such, borings were advanced manually with hand tools consisting of a core drill and a hand auger, which precluded the installation of soil borings to significant depths below the sub-basement and basement floor slabs and limited subsurface sample collection."

There is no consideration given in the DEIS to the potential future discovery of contamination that was missed by using only the manual borings and its impact on the project budget or on the already long time period specified as

needed for construction. Such discovery could stop construction – and could also release substantial contaminated gasses or dust in the period before an excavated hazard could be identified and contained.

This risk could be alleviated to some extent by assuring that there be hazardous waste management personnel and equipment on site continuously during any excavation activity. It could not, however, be completely eliminated.

The failure to acknowledge this risk associated with the proposed project stands in stark contrast to the hazardous waste warning inserted into the description of The Future Without the Proposed Project in the DEIS:

> "The No Action condition may entail demolition of certain existing buildings/foundations and limited excavation. Demolition could disturb hazardous materials within buildings and excavation could increase pathways for human exposure if performed without appropriate controls."

The identical phrase could have been used in describing the future WITH the proposed project with one minor edit, substituting the word "will" for the word "may" in the first sentence.

Since this risk is noted only for the do nothing alternative, the language of the supposedly objective assessment of hazardous material risks demonstrates a clear bias in favor of the proposed project.

Water and Sewer Infrastructure

There is little to be said about water and sewer infrastructure since the flow volumes would not change that much under the proposed project.

What is, however, notable, is that there is no indication that any effort will be committed to any form of water reuse or conservation, which would be desirable for a development that could take advantage of new technologies and is facing an uncertain future with respect to rainfall changes and possible drought conditions associated with climate change effects.

Transportation

It is notable that the traffic problem condition described as a flaw in the current ER and ambulance interaction is never addressed in the EIS. Some discussion of improved through-flow might have been warranted.

On the other hand, the elimination of ambulance double parking and congestion around truck deliveries and loading may generate more traffic in an area previously avoided due to the disamenities the proposed project would eliminate. That vehicular traffic is never addressed as the DEIS focuses only on the vehicles associated with the movement of people.

That is a gap in the DEIS coverage. However, the transportation issue is one of several impacts that are understated due to the strict comparison of a "do nothing" to "do this project" comparison. No consideration is given to the negative transportation impacts associated with what is likely to be over a decade of construction in the neighborhood and the effects on livability and attractiveness associated with that disruption. Those disamenities are real and pote ntiallysubstantial, but totally ignored in the DEIS.

Air Quality

This impact analysis contains the same obvious gap as that for Transportation – no consideration of any neighborhood air quality impacts over a decade of construction.

But it does contain a statement about traffic and emissions for which no evidence is provided:

> "Traffic around the Project Site is not expected to increase between existing and No Action conditions. "

Given the claim that vehicular flow is currently impeded around the hospital that exists would be ameliorated by the proposed project, this seems to be a contradictory statement warranting some explanation.

There is a further unwarranted assertion in the DEIS that appears to ignore the potential for advancements in medicine and medical care:

> "The Proposed Project would not introduce new laboratory chemicals or affect the types and quantities of materials used in the existing laboratories. Therefore, no analysis of such chemicals or materials was

performed."

The argument for the proposed project contains repeated references to the need for an expanded facility in order to accommodate advances in medicine and hospital practices and services. Implicit in that statement is the presumption that those advances could not be accommodated in the existing premises.

Thus, the construction of the proposed facility WOULD be expected to introduce new laboratory chemicals as needed for the services the existing hospital could not accommodate should medical advances call for such new chemicals. Presumably that would be a benefit to residents in the service area of the hospital, but only if potentially dangerous emissions from the laboratories are under control.

Greenhouse Gas Emissions and Climate Change

The measures taken to assure that the construction under the proposed project results in energy efficient buildings are appropriate, admirable, and the minimum required.

Two glaring omissions must be noted:

1. The proposed project contains buildings that will be taller than those around them and thus will have unimpeded sunlight but no consideration is given to construction of on-site solar power that could both reduce the hospital's power costs and GHG generation. (There is, admittedly, passing reference to pursuit of LEED certification and possible solar power generation, but there is no sign it has bene part of any substantive planning to date.)
2. The proposed project apparently has given no consideration to limiting demolitions which, by definition, require new steel and cement and other materials be used for the buildings which replace them. Building over existing structures could be far more energy efficient than demolition and new construction, as could raising the height of buildings that have foundations and walls that are sufficiently strong to support the weight of additional stories.

Neither action is necessarily required by law but both should logically be considered for any project claiming to contribute to improve population health standards when the globe is facing a growing problem associated with CO2-equivalent emissions and the ways in which they drive climate change.

The DEIS section on this topic does – finally – address issues associated with construction activities. It is notable that much of this discussion describes emissions reduction and energy consumption activity that "may" occur or actions that are "likely." Those terms are not typically found in construction plans that constitute hard commitments.

Noise

It would appear that the existence of ambulances was overlooked in the process of the preparation of the DEIS. The discussion of noise never touches on whether the construction of six ambulance bays in the proposed project would significantly increase the volume of ambulance traffic in the neighborhood over the present level.

Neighborhood noise during nine or more years of construction was also ignored in this chapter.

Public Health

The years of construction were definitely acknowledged in consideration of public health: "… the construction analysis determined that construction activities would result in unmitigated temporary significant adverse noise impacts on the façades of multiple residential buildings either adjacent to or with a direct line of sight to the construction work areas and various portions of LHH …" Those noise impacts were found to "not generate significant adverse public health impacts."

The construction noise may not affect auditory health, but there is no consideration given at all to its mental health impacts. The DEIS dwells at some length on the physical vulnerabilities of the aging population in the hospital's service area but pays no attention at all to the effects of noise – especially unexpected loud outbreaks – on the emotional state of the elderly and others in the population (notably those on any autism spectrum).

Those impacts constitute a public health effect that is ignored.

Neighborhood Character

The impact of any project on neighborhood character depends on the character prior to the initiation of the project – and thus on the boundaries of the affected neighborhood.

The DEIS notes that:

> "The neighborhood character of the 400-foot study area is primarily defined by its mix of institutional, residential, and ground floor retail uses, as well as the diverse urban and architectural context of the area. The Proposed Project would reinforce the existing institutional nature of the Project Site and neighborhood and would contribute to the mix of land uses in the area and the diverse urban and architectural context."

The study area defined in the DEIS, based in some measure on distance from the center of a site that exceeds a city block in size, is questionable, as stated at the outset of this discussion of Impact. If the 400-foot study area were defined as within 400 feet of the boundary of the project then the neighborhood would have a substantially different character than what is asserted. Most notably, the extension of the study area to the west would include residential uses on both sides of Park Avenue, and all the extensions would add more residential uses on the side streets. In that case, the mix of uses would tilt far more towards residential, and that would require far more consideration of effects on the residents than is given in the DEIS.

Even if the neighborhood is characterized as a "mix of institutional, residential, and ground floor retail uses," there is a need to systematically analyze the effect of the reinforcement of the "institutional nature of the Project Site." The proposed intensity of land use and scale of new buildings proposed may well change the neighborhood from a mix of land uses to an area dominated by a single overwhelming institutional use where the institution had previously fit into the neighborhood mix.

In defining the features of the neighborhood, the DEIS actually goes well beyond the 400-foot boundary and drags in a laundry list of institutional uses "located on Manhattan's Upper East Side" as if they defined the affected area. It is ironic in the extreme that this narrative, irrelevant as it is to the issue of Neighborhood Impact, raises questions about the need for another major hospital center in that part of New York City.

The DEIS cites the physical characteristics of the neighborhood, but totally ignores the population characteristics and property values in the area. Yet it is those features of the area surrounding the proposed project that will be most immediately affected by the nine-year construction process and the resulting change in the neighborhood character. It claims that,

> "Benefits of the Proposed Project would include the activation of the streetscape, the strengthening of an existing neighborhood community facility institution, and access improvements to the local subway station."

This claim is dubious at best.

1. "Activation of the streetscape" is ambiguous and no consideration is given to the effects of a change in the characteristics of neighborhood residents or property values on retail activity when the nine-year construction period and change in physical appearance of the area might generate such a change.
2. The Hospital has claimed its need to expand is a function of demand from a service area that extends into Brooklyn and Queens and the DEIS apparently accepts that rationale, but then describes it as "an existing neighborhood community facility." Some modicum of consistency in argument should exist in the DEIS.
3. Access improvements to the local subway station are likely to be undertaken by the MTA over the next decade with or without the project – and subway access is not an integral concern of a hospital. (The history of the construction of the Second Avenue subway is also germane here: that street disruption drove many local stores into bankruptcy so any subway improvements would come at some cost to local retail.)

Construction

The DEIS assessment of the construction impacts opens with the assertion that:

> "Construction associated with the Proposed Actions would result in temporary disruptions in the surrounding area."

There may be a world in which nine years is considered "temporary," but New York is not in such a world. Given the overall tenor of the DEIS, we should acknowledge that it admits there will be disruptions altogether.

The discussion of traffic on streets adjacent to the proposed construction site is remarkable for its failure to so much as admit that there is, at present, on-street curbside parking. There is no question that the availability of that parking, on the East side of Park Avenue, South side of 77th street, West side of Lexington Avenue and North side of 76th street, WILL be affected by the construction which will need, at a minimum, space for staging construction elements at loading docks while buildings are erected as well as for cranes and two exterior hoists, even in the years when interior work is being done. That space will be taken from curbside parking.

Any reduction in curbside parking space will increase the likelihood of double parking and that double parking will reduce the number of passable travel lanes. The increased frequency of that double parking will have an impact on traffic volume that is completely ignored in the DEIs. It is notable that the loss of the single passable lane on 77th street would effectively block ambulance access to the hospital. Double parking on 76th street could make it difficult for trucks to turn into the proposed truck bays. Neither of these impacts on hospital operations during the construction phase are considered at all in the DEIS but need to be addressed.

Double parking on the avenues will create bottlenecks, reducing traffic speed and volume. (Bottlenecks typically increase the likelihood of honking, a noise impact that is ignored.) And such double parking will be substantial, occurring whenever construction materials are delivered to holding areas unless curbside parking is virtually eliminated in order to permit trucks to back up adjacent to holding along the curbs.

Since parking is ignored in discussion of traffic, it is not surprising that reduction of parking available to neighborhood residents is ignored in the DEIS that makes reference only to the parking needs of construction personnel. The failure to acknowledge residents and their needs in the discussion of the nine-year construction period is all too obvious:

1. Discussion of pedestrians relies only on data on current patterns and never considers that residents might change their walking habits. To some degree, construction noise may drive away those walking for exercise. On the other hand, vehicular congestion and reduced on-street parking might mean more people walking from near the construction to access mass transit, to the parked cars, or to access taxis and ride-share vehicles. These issues warrant consideration.
2. The unavoidable impact of the needed construction materials and staging operations on sidewalk access and pedestrian detours is ignored completely, consistent with the DEIS' failure to recognize the project area contains resident human beings.
3. The proposed project includes provision of an improved subway station but the DEIS discussion of construction impacts on transit never mentions that aspect of the project or its impacts during and after construction. At a minimum, the timing of those improvements could be considered o minimize the combined disruptions of sidewalk-adjacent excavations and construction materials staging.
4. *Street User Safety* is specifically identified as a consideration but the effects on accident rates and the like of more people crossing streets and avenues to avoid walking adjacent to the construction sites addressed. (This section of the DEIS acknowledges "heavy volumes at high crash locations in the study area" as if that condition makes it unnecessary to consider increased risks or the extent to which construction will impede efforts to reduce crashes, a measure that might otherwise improve neighborhood quality of life as well as health.
5. The diagram of the construction site indicating building and construction stages notes multiple "sidewalk sheds" and gates that unquestionably will affect pedestrian traffic along the impacted sidewalks. On Lexington Avenue, it appears that the entire West side sidewalk will have to be closed at times (it is also marked as a vehicular lane). Those impacts on pedestrians and safety are ignored.
6. The description of Construction Practices notes that the average number of trucks accessing the construction site is expected to be 27 per day. Assuming a 7:00 AM to 3:30 PM workday, that averages out to one large truck arriving every 19 minutes for nine years. (in 2030, 33 trucks are expected per day, or one every 15 minutes.) And yet there is complete denial of any significant construction impact on the neighborhood.
7. Following p. 16-26 on the DEIS Construction chapter there are 15 pages diagramming construction worker pedestrian flows at neighborhood corners under the existing, no action and proposed project scenarios. There is no analysis of any sort of the residents' pedestrian flows and how they might change in response to noise, rerouting onto special walkways or other Impediments associated with the construction project, including temporary or extended sidewalk closures.

The discussion of construction noise included detailed data on impact projections for over 200 noise receptors. Serious noise impacts, however, were discussed only for those few locations at which the increase in noise led to a volume increase that exceeded 10 dBA above the interior noise level threshold of 45 dBA considered acceptable. That 10dBA increase, it must be noted, constitutes a doubling of noise volume since the measurement scale is logarithmic. There is no determination of the extent to which construction will generate a 10, 20, or 30% increase in the daytime

noise volume experienced by neighborhood residents during the nine years of active construction. Without those data, the DEIS cannot in any way determine the negative effects on the neighborhood property values, not to mention the quality of life of the current residents.

Alternatives

This DEIS chapter purports to discuss alternatives to the massive construction project proposed. It fails to do so in any constructive manner.

It compares the No Action Alternative, a "No Significant Adverse Impact Alternative" and the Proposed Project. These are far from the only alternatives available for a project to improve and upgrade the current historic Lennox Hill Hospital. The first two alternatives are effectively straw men, inserted as required by law but not offered as real options to the neighborhood, Community Board 8, or the City of New York.

There is no constituency for taking no action at all. The neighborhood would welcome an upgrading of facilities at the hospital that did not change the architectural character of the neighborhood and the balance between the diverse uses that it now encompasses.

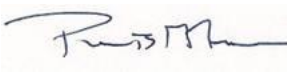
The option of a project with no significant adverse impacts that the DEIS reviews looks for a project with no shadowing of a garden and no temporary construction noise. That option is rejected because,

> "… there is no alternative that would avoid a significant adverse temporary construction noise impact and produce a project that would satisfy the goals and objectives of the Proposed Project."

The question is whether the goals of the proposed project, which are those of Northwell Health, a nonprofit corporate entity with over 900 locations, are consistent with the goals of the neighborhood in which Lenox Hill Hospital is located. If they are not, then the realistic alternatives to the proposed project are alternative developments that provide needed upgrades to the quality of healthcare at the hospital while simultaneously "advancing public policy goals such as One NYC's goal for growth in emerging fields, promoting access to health care, and modernizing key infrastructure."

Such alternatives have not been considered by Northwell Health and are thus not included in this DEIS. They should be if there is to be an objective, consistent, and complete Environmental Impact Statement that serves the residents and taxpayers of the neighborhood, community and city.

Respectfully submitted,



Peter B. Meyer, PhD
President and Chief Economist

Peter B. Meyer is Professor Emeritus of Urban Policy and Economics and Director Emeritus of the Center for Environmental Policy and Management at the University of Louisville, and previously served as Director of the Local Economic Development Assistance Center at The Pennsylvania State University. He spent 15 years as an Expert Witness for EPA's Environmental Finance Advisory Board and then served on the Sustainable and Healthy Communities subcommittee of its Board of Scientific Counselors. He has an international reputation for his work on contaminated land (brownfield) reclamation and development and for his work on climate change mitigation and adaptation finance. Dr. Meyer's prior experience reviewing Environmental Impact Statements includes those for new road systems, bridges, waste management projects, and other construction plans.

THE E. P. SYSTEMS GROUP, INC.
228 Riverwoods Drive
New Hope, PA 18938

502-435-3240
<EPSGonline@gmail.com>

Comment on the

Notice Of Completion and Notice of Availability of a Draft Environmental Impact Statement
and the
Lenox Hill Hospital Development Draft Environmental Impact Statement

Prepared March 12, 2025, by Peter B. Meyer, PhD

Peter B. Meyer, PhD, is Professor Emeritus of Urban Policy and Economics and Director Emeritus of the Center for Environmental Policy and Management at the University of Louisville, and previously served as Director of the Local Economic Development Assistance Center at The Pennsylvania State University. He spent 15 years as an Expert Witness for EPA's Environmental Finance Advisory Board and then served on the Sustainable and Healthy Communities subcommittee of its Board of Scientific Counselors. He has an international reputation for his work on contaminated land (brownfield) reclamation and development and for his work on climate change mitigation and adaptation finance. Dr. Meyer's prior experience reviewing Environmental Impact Statements includes those for new road systems, bridges, waste management projects, and other construction plans.

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DISCUSSION OF NEED AND FEASIBILITY

The need for this massive new development is never clarified by the applicant or in the DEIS other than the claim that it needs to assure "475 single-bedded patient rooms, 30 operating suites, and a right-sized emergency department." Northwell Health apparently needs this construction to serve some of its (unspecified) objectives, but there is no documentation of need from the perspective of the neighborhood in which the hospital is located, from that of Community Board 8 that is being asked to approve this project, nor from that of the City of New York itself.

A number of questions need to be answered to establish need:

- Does the claim that " current standards of healthcare delivery, including single-bedded patient rooms" require this expansion stand? Are single-bedded rooms the norm in New York or nationally?
- What is "right sized" when it comes to the appropriate size of an emergency room?
- How does the addition of 25 beds necessitate an ED expansion of 14 treatment units from the current 34 to the proposed 48
- Similarly, where is the evidence that 5 additional ORs are needed in this part of the city – or the city as a whole?
- Where is the evidence that justifies a "new off-street ambulance bay with six berths" and " Four new and longer truck loading bays" when three truck bays already exist and the proposed construction would impede local traffic, cross pedestrian walkways and intrude on the streetscape of the neighborhood? Granting that the new vehicular access facilities may be an improvement over those that exist, are they needed? Where is the evidence that demand for services at this location warrants six ambulance bays and seven truck bays?
- Why do any of these new facilities necessitate a new "46,000-gsf, six-story, 75-foot-tall building to house hospital support functions"? What are those functions and aren't they already housed in existing buildings that could be rehabilitated or modernized?

- Even granting the need for all of the above can be empirically demonstrated to serve the immediate neighborhood, broader local community, and the city as a whole, what justifies the construction of two towers, one 21 stories and the other 26 stories tall to accommodate the expansion in facilities that are proposed?

Part of the apparent answer from Northwell Health to this last question is their claim that

> "the buildings to be demolished cannot be used for inpatient care because their structures cannot accommodate the necessary heating, ventilation, and air conditioning (HVAC) infrastructure, sensitive modern imaging equipment, or patient transport between buildings."

But those buildings are in use now. If they are used for inpatient care, then the hospital is acknowledging that it is not providing a high quality of care. If they serve other hospital purposes and functions than inpatient care, why do they need to be demolished?

There is simply no rationale provided for the intended demolitions and the construction of proposed structures are substantially taller than any other buildings around the project sites – towers that will substantially change the character of the neighborhood.

There may be a need for the *proposed Subway Station Access and Sidewalk Improvements* but those are not hospital functions and there is no evidence offered to show that improvements are not in the MTA's workplan.

An upgraded subway entrance is a function of the MTA – but there apparently has been no contact with the MTA about whether the site improvements are not already in their workplan, and Northwell's contribution is not required.

This failure to communicate with the MTA is reflected in the plans for the tunnel proposed for access between the two development sites. According to Northwell, that tunnel "would require a revocable consent from DOT." But the applicant for permission to undertake a massive project has apparently had as much contact with DOT as it has had with the MTA.

Any plans developed without needed consultations – not to mention those dependent on a "revocable consent" that has no permanence – really aren't plans. They fail the fundamental standard of demonstrated feasibility.

Some facets of that limited feasibility are evident in the flaws in the DEIS discussion of the anticipated impacts of the proposed project.

PROJECT IMPACTS DESCRIBED AND OVERLOOKED

The DEIS starts by defining its study area as within 400 feet of the Project Site. The definition on which the entire analysis stands, however, is an area defined by distance from the midpoint of the project site, not the borders of the site. When a site is as large as this one – a whole city block – the boundary of the study area is far greater when the distance to boundary is used. That is warranted, since that includes the properties within 400 feet of the proposed construction site and the proximity is a measure of the expected spillover risk.

Thus the entire statistical and architectural context discussions may be off by a significant measure. Looking at Figure ES-1, the more appropriate study area based on distance to project boundaries would not be the limited area defined by the dotted red line, but one that probably reaches to the far side of Madison Avenue, 76th Street, the far side of Third Avenue and the far side of 79th Street.

If the study area really were defined by a distance of 400 feet from the center of the project site, it would be a perfect circle; the distorted dotted line shape may involve some allowance for the second development site, but it is still inexplicably different from a circle and its shape is never explained. An explanation is needed or the area defined would seem to have been selected to serve the case for the project.

Land Use and Zoning, and Public Policy

The DEIS claims that the

> "proposed bulk would be consistent in scale with other institutions and medical facilities in the area."

But the description of proposed construction involves structures far taller than those in the neighborhood as a whole, so that claim is false.

The reference to other medical facilities suggests that the neighborhood-specific impacts are ignored. (That reference, including enumeration of many competing hospitals on the East side of Manhattan is repeated in the chapter nominally about "Neighborhood Character" which leads the reader to wonder if the assessment is paying any real attention to the people and premises in its immediate proximity.)

Contribution of project to OneNYC's goals is irrelevant since courts by and large have ruled that comprehensive plans have no legal standing as a guide to action.

Community Facilities and Services

Claim that the project "would not directly affect other types of public community facilities" totally fails to consider what impact the nine-year construction process would have on those facilities, businesses in the area, and/or the amenity values of the residences in the neighborhood.

Further fails to consider what impact the supposed improvements in traffic flow due to better ER-ambulance interactions or improvements in subway access would have on the viability of local businesses and other community facilities. (They could improve conditions, not contribute to deterioration; the failure to consider even such positive effects is a measure of how shallow the review has been to date.)

Open Space

The issue of "increased population" is limited to consideration of the number of new employees when the intent of the proposed project is to increase the number of patients served, thus the transient population of the neighborhood. Those transients DO constitute a "new user population" for the limited immediately available open space.

There is no basis for the claim that the additional shadow would not affect use of the garden cited.

Shadows

Admitted that "the significant adverse shadow impacts to the church garden would be unavoidable." -- thus being thoroughly inconsistent with the prior claim.

Historic and Cultural Resources

Acknowledging the existence of historic architectural resources, the impact assessment makes the untenable assumption that the Construction Protection Plan prepared as required will be fully successful in protecting those resources from damage due to vibration and other impacts from demolition and construction. This certainly is not viable as part of a worst case assessment.

The DEIS itself notes that "The NYC Building Code, in Section BC 3309: Protection of Adjoining Property, provides some measures of ... they do not afford special consideration for historic structures." Thus there is no basis for assuming there would be no adverse impacts from the demolition, excavation and construction elements of the proposed project.

Urban Design and Visual Resources

While further justifying the proposed building heights, the discussion of design impacts remains superficial at best despite the minimal commitments to conform to neighborhood exterior color and cladding character.

Typical is the meaningless claim that "the buildings on the western portion of Projected Development Site 1 … would provide transparency and activate uses on the adjacent sidewalks on Park Avenue." What "transparency' relative to what, and what uses of the sidewalk are considered and how do either affect – or are affected by – design or visual resources?

Hazardous Materials

The fact that the Phase II hazardous materials investigation was incomplete is not acknowledged in the Notice of Completion and Notice of Availability of the DEIS. The DEIS itself, however, notes that,

> "Due to physical limitations encountered during the field investigation, including intervening subsurface utilities, active electrical systems for critical hospital care systems, and ongoing hospital operations, the advancement of soil borings with a Geoprobe® direct-push drill rig was not possible as hospital operations prohibited the use of fuel-powered drilling equipment with exhaust inside the building and limited the use of electrical power to standard outlets. As such, borings were advanced manually with hand tools consisting of a core drill and a hand auger, which precluded the installation of soil borings to significant depths below the sub-basement and basement floor slabs and limited subsurface sample collection."

There is no consideration given in the DEIS to the potential future discovery of contamination that was missed by using only the manual borings and its impact on the project budget or on the already long time period specified as needed for construction. Such discovery could stop construction – and could also release substantial contaminated gasses or dust in the period before an excavated hazard could be identified and contained.

This risk could be alleviated to some extent by assuring that there be hazardous waste management personnel and equipment on site continuously during any excavation activity. It could not, however, be completely eliminated.

The failure to acknowledge this risk associated with the proposed project stands in stark contrast to the hazardous waste warning inserted into the description of The Future Without the Proposed Project in the DEIS:

> "The No Action condition may entail demolition of certain existing buildings/foundations and limited excavation. Demolition could disturb hazardous materials within buildings and excavation could increase pathways for human exposure if performed without appropriate controls."

The identical phrase could have been used in describing the future WITH the proposed project with one minor edit, substituting the word "will" for the word "may" in the first sentence.

Since this risk is noted only for the do nothing alternative, the language of the supposedly objective assessment of hazardous material risks demonstrates a clear bias in favor of the proposed project.

Water and Sewer Infrastructure

There is little to be said about water and sewer infrastructure since the flow volumes would not change that much under the proposed project.

What is, however, notable, is that there is no indication that any effort will be committed to any form of water reuse or conservation, which would be desirable for a development that could take advantage of new technologies and is facing an uncertain future with respect to rainfall changes and possible drought conditions associated with climate change effects.

Transportation

It is notable that the traffic problem condition described as a flaw in the current ER and ambulance interaction is never addressed in the EIS. Some discussion of improved through-flow might have been warranted.

On the other hand, the elimination of ambulance double parking and congestion around truck deliveries and loading may generate more traffic in an area previously avoided due to the disamenities the proposed project would eliminate. That vehicular traffic is never addressed as the DEIS focuses only on the vehicles associated with the movement of people.

That is a gap in the DEIS coverage. However, the transportation issue is one of several impacts that are understated due to the strict comparison of a "do nothing" to "do this project" comparison. No consideration is given to the negative transportation impacts associated with what is likely to be over a decade of construction in the neighborhood and the effects on livability and attractiveness associated with that disruption. Those disamenities are real and pote ntiallysubstantial, but totally ignored in the DEIS.

Air Quality

This impact analysis contains the same obvious gap as that for Transportation – no consideration of any neighborhood air quality impacts over a decade of construction.

But it does contain a statement about traffic and emissions for which no evidence is provided:

> "Traffic around the Project Site is not expected to increase between existing and No Action conditions. "

Given the claim that vehicular flow is currently impeded around the hospital that exists would be ameliorated by the proposed project, this seems to be a contradictory statement warranting some explanation.

There is a further unwarranted assertion in the DEIS that appears to ignore the potential for advancements in medicine and medical care:

> "The Proposed Project would not introduce new laboratory chemicals or affect the types and quantities of materials used in the existing laboratories. Therefore, no analysis of such chemicals or materials was performed."

The argument for the proposed project contains repeated references to the need for an expanded facility in order to accommodate advances in medicine and hospital practices and services. Implicit in that statement is the presumption that those advances could not be accommodated in the existing premises.

Thus, the construction of the proposed facility WOULD be expected to introduce new laboratory chemicals as needed for the services the existing hospital could not accommodate should medical advances call for such new chemicals. Presumably that would be a benefit to residents in the service area of the hospital, but only if potentially dangerous emissions from the laboratories are under control.

Greenhouse Gas Emissions and Climate Change

The measures taken to assure that the construction under the proposed project results in energy efficient buildings are appropriate, admirable, and the minimum required.

Two glaring omissions must be noted:

1. The proposed project contains buildings that will be taller than those around them and thus will have unimpeded sunlight but no consideration is given to construction of on-site solar power that could both reduce the hospital's power costs and GHG generation. (There is, admittedly, passing reference to pursuit of LEED certification

and possible solar power generation, but there is no sign it has bene part of any substantive planning to date.)

2. The proposed project apparently has given no consideration to limiting demolitions which, by definition, require new steel and cement and other materials be used for the buildings which replace them. Building over existing structures could be far more energy efficient than demolition and new construction, as could raising the height of buildings that have foundations and walls that are sufficiently strong to support the weight of additional stories.

Neither action is necessarily required by law but both should logically be considered for any project claiming to contribute to improve population health standards when the globe is facing a growing problem associated with CO2-equivalent emissions and the ways in which they drive climate change.

The DEIS section on this topic does – finally – address issues associated with construction activities. It is notable that much of this discussion describes emissions reduction and energy consumption activity that "may" occur or actions that are "likely." Those terms are not typically found in construction plans that constitute hard commitments.

Noise

It would appear that the existence of ambulances was overlooked in the process of the preparation of the DEIS. The discussion of noise never touches on whether the construction of six ambulance bays in the proposed project would significantly increase the volume of ambulance traffic in the neighborhood over the present level.

Neighborhood noise during nine or more years of construction was also ignored in this chapter.

Public Health

The years of construction were definitely acknowledged in consideration of public health: "… the construction analysis determined that construction activities would result in unmitigated temporary significant adverse noise impacts on the façades of multiple residential buildings either adjacent to or with a direct line of sight to the construction work areas and various portions of LHH …" Those noise impacts were found to "not generate significant adverse public health impacts."

The construction noise may not affect auditory health, but there is no consideration given at all to its mental health impacts. The DEIS dwells at some length on the physical vulnerabilities of the aging population in the hospital's service area but pays no attention at

all to the effects of noise – especially unexpected loud outbreaks – on the emotional state of the elderly and others in the population (notably those on any autism spectrum).

Those impacts constitute a public health effect that is ignored.

Neighborhood Character

The impact of any project on neighborhood character depends on the character prior to the initiation of the project – and thus on the boundaries of the affected neighborhood.

The DEIS notes that:

> "The neighborhood character of the 400-foot study area is primarily defined by its mix of institutional, residential, and ground floor retail uses, as well as the diverse urban and architectural context of the area. The Proposed Project would reinforce the existing institutional nature of the Project Site and neighborhood and would contribute to the mix of land uses in the area and the diverse urban and architectural context."

The study area defined in the DEIS, based in some measure on distance from the center of a site that exceeds a city block in size, is questionable, as stated at the outset of this discussion of Impact. If the 400-foot study area were defined as within 400 feet of the boundary of the project then the neighborhood would have a substantially different character than what is asserted. Most notably, the extension of the study area to the west would include residential uses on both sides of Park Avenue, and all the extensions would add more residential uses on the side streets. In that case, the mix of uses would tilt far more towards residential, and that would require far more consideration of effects on the residents than is given in the DEIS.

Even if the neighborhood is characterized as a "mix of institutional, residential, and ground floor retail uses," there is a need to systematically analyze the effect of the reinforcement of the "institutional nature of the Project Site." The proposed intensity of land use and scale of new buildings proposed may well change the neighborhood from a mix of land uses to an area dominated by a single overwhelming institutional use where the institution had previously fit into the neighborhood mix.

In defining the features of the neighborhood, the DEIS actually goes well beyond the 400-foot boundary and drags in a laundry list of institutional uses "located on Manhattan's Upper East Side" as if they defined the affected area. It is ironic in the extreme that this narrative, irrelevant as it is to the issue of Neighborhood Impact, raises questions about the need for another major hospital center in that part of New York City.

The DEIS cites the physical characteristics of the neighborhood, but totally ignores the population characteristics and property values in the area. Yet it is those features of the area surrounding the proposed project that will be most immediately affected by the nine-year construction process and the resulting change in the neighborhood character. It claims that,

> "Benefits of the Proposed Project would include the activation of the streetscape, the strengthening of an existing neighborhood community facility institution, and access improvements to the local subway station."

This claim is dubious at best.

1. "Activation of the streetscape" is ambiguous and no consideration is given to the effects of a change in the characteristics of neighborhood residents or property values on retail activity when the nine-year construction period and change in physical appearance of the area might generate such a change.
2. The Hospital has claimed its need to expand is a function of demand from a service area that extends into Brooklyn and Queens and the DEIS apparently accepts that rationale, but then describes it as "an existing neighborhood community facility." Some modicum of consistency in argument should exist in the DEIS.
3. Access improvements to the local subway station are likely to be undertaken by the MTA over the next decade with or without the project – and subway access is not an integral concern of a hospital. (The history of the construction of the Second Avenue subway is also germane here: that street disruption drove many local stores into bankruptcy so any subway improvements would come at some cost to local retail.)

Construction

The DEIS assessment of the construction impacts opens with the assertion that:

> "Construction associated with the Proposed Actions would result in temporary disruptions in the surrounding area."

There may be a world in which nine years is considered "temporary," but New York is not in such a world. Given the overall tenor of the DEIS, we should acknowledge that it admits there will be disruptions altogether.

The discussion of traffic on streets adjacent to the proposed construction site is remarkable for its failure to so much as admit that there is, at present, on-street curbside parking. There is no question that the availability of that parking, on the East side of Park Avenue, South side of 77th street, West side of Lexington Avenue and North side of 76th street, WILL be affected by the construction which will need, at a minimum, space for

staging construction elements at loading docks while buildings are erected as well as for cranes and two exterior hoists, even in the years when interior work is being done. That space will be taken from curbside parking.

Any reduction in curbside parking space will increase the likelihood of double parking and that double parking will reduce the number of passable travel lanes. The increased frequency of that double parking will have an impact on traffic volume that is completely ignored in the DEIs. It is notable that the loss of the single passable lane on 77th street would effectively block ambulance access to the hospital. Double parking on 76th street could make it difficult for trucks to turn into the proposed truck bays. Neither of these impacts on hospital operations during the construction phase are considered at all in the DEIS but need to be addressed.

Double parking on the avenues will create bottlenecks, reducing traffic speed and volume. (Bottlenecks typically increase the likelihood of honking, a noise impact that is ignored.) And such double parking will be substantial, occurring whenever construction materials are delivered to holding areas unless curbside parking is virtually eliminated in order to permit trucks to back up adjacent to holding along the curbs.

Since parking is ignored in discussion of traffic, it is not surprising that reduction of parking available to neighborhood residents is ignored in the DEIS that makes reference only to the parking needs of construction personnel. The failure to acknowledge residents and their needs in the discussion of the nine-year construction period is all too obvious:

1. Discussion of pedestrians relies only on data on current patterns and never considers that residents might change their walking habits. To some degree, construction noise may drive away those walking for exercise. On the other hand, vehicular congestion and reduced on-street parking might mean more people walking from near the construction to access mass transit, to the parked cars, or to access taxis and ride-share vehicles. These issues warrant consideration.
2. The unavoidable impact of the needed construction materials and staging operations on sidewalk access and pedestrian detours is ignored completely, consistent with the DEIS' failure to recognize the project area contains resident human beings.
3. The proposed project includes provision of an improved subway station but the DEIS discussion of construction impacts on transit never mentions that aspect of the project or its impacts during and after construction. At a minimum, the timing of those improvements could be considered o minimize the combined disruptions of sidewalk-adjacent excavations and construction materials staging.

4. *Street User Safety* is specifically identified as a consideration but the effects on accident rates and the like of more people crossing streets and avenues to avoid walking adjacent to the construction sites addressed. (This section of the DEIS acknowledges "heavy volumes at high crash locations in the study area" as if that condition makes it unnecessary to consider increased risks or the extent to which construction will impede efforts to reduce crashes, a measure that might otherwise improve neighborhood quality of life as well as health.
5. The diagram of the construction site indicating building and construction stages notes multiple "sidewalk sheds" and gates that unquestionably will affect pedestrian traffic along the impacted sidewalks. On Lexington Avenue, it appears that the entire West side sidewalk will have to be closed at times (it is also marked as a vehicular lane). Those impacts on pedestrians and safety are ignored.
6. The description of Construction Practices notes that the average number of trucks accessing the construction site is expected to be 27 per day. Assuming a 7:00 AM to 3:30 PM workday, that averages out to one large truck arriving every 19 minutes for nine years. (in 2030, 33 trucks are expected per day, or one every 15 minutes.) And yet there is complete denial of any significant construction impact on the neighborhood.
7. Following p. 16-26 on the DEIS Construction chapter there are 15 pages diagramming construction worker pedestrian flows at neighborhood corners under the existing, no action and proposed project scenarios. There is no analysis of any sort of the residents' pedestrian flows and how they might change in response to noise, rerouting onto special walkways or other Impediments associated with the construction project, including temporary or extended sidewalk closures.

The discussion of construction noise included detailed data on impact projections for over 200 noise receptors. Serious noise impacts, however, were discussed only for those few locations at which the increase in noise led to a volume increase that exceeded 10 dBA above the interior noise level threshold of 45 dBA considered acceptable. That 10dBA increase, it must be noted, constitutes a doubling of noise volume since the measurement scale is logarithmic. There is no determination of the extent to which construction will generate a 10, 20, or 30% increase in the daytime noise volume experienced by neighborhood residents during the nine years of active construction. Without those data, the DEIS cannot in any way determine the negative effects on the neighborhood property values, not to mention the quality of life of the current residents.

Alternatives

This DEIS chapter purports to discuss alternatives to the massive construction project proposed. It fails to do so in any constructive manner.

It compares the No Action Alternative, a "No Significant Adverse Impact Alternative" and the Proposed Project. These are far from the only alternatives available for a project to improve and upgrade the current historic Lennox Hill Hospital. The first two alternatives are effectively straw men, inserted as required by law but not offered as real options to the neighborhood, Community Board 8, or the City of New York.

There is no constituency for taking no action at all. The neighborhood would welcome an upgrading of facilities at the hospital that did not change the architectural character of the neighborhood and the balance between the diverse uses that it now encompasses.

The option of a project with no significant adverse impacts that the DEIS reviews looks for a project with no shadowing of a garden and no temporary construction noise. That option is rejected because,

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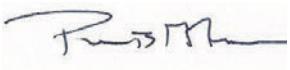
Respectfully submitted,



Peter B. Meyer, PhD
President and Chief Economist

My name is Michael Piccirillo, and I'm the Area Standards Director for the New York City District Council of Carpenters. Before I took on this role, I was a union carpenter—boots on the ground, doing the work. And I still carry that perspective with me every day.

I'm here today to speak in strong support of the new Lenox Hill Hospital project, because this isn't just another job—it's a project that's going to make a real difference in people's lives.

Let's be honest—the current hospital is outdated. It's been patched together over the years, and it just doesn't meet the needs of modern healthcare anymore. We've got the best doctors and nurses in the world working in a building that was never designed to handle today's technology, patient volume, or emergency care standards.

New Yorkers deserve better. We deserve world-class care in a modern facility that's built for the future. This new hospital will deliver just that—with more beds, better equipment, and the kind of space and layout that helps save lives.

And just as importantly, it's going to create hundreds of good union jobs. Jobs for carpenters, electricians, laborers—all of us who take pride in building this city with our hands. We're not talking about low-road, corner-cutting work. We're talking about skilled tradespeople making sure this hospital goes up safe, solid, done right and completed as quickly as possible.

Northwell's shown they understand that. They're committed to using union labor, and that means a lot—not just to our members, but to the quality and integrity of the job itself.

So I'm asking the Commission: approve this project. Let's give New Yorkers the hospital they deserve and the working people of this city the opportunity to build it. Together, we can lift up this neighborhood and deliver something that'll serve generations to come.

GENERAL PUBLIC

Dear Esteemed Government Officials,

I am writing as a deeply concerned and distressed member of the Upper East Side community who will be directly impacted by the proposed Lenox Hill Hospital renovation. But more importantly, I write as a New Yorker alarmed by what I see as a glaring example of corporate interests overwhelming the public's well-being in one of the world's most densely populated cities.

I have closely followed Lenox Hill's expansion plans, and at their core, they represent an attempt to rewrite established laws, not for the benefit of the community, but purely for the financial gain of Lenox Hill Hospital. This plan disregards the needs of the local population and, more significantly, fails to take a holistic approach to healthcare in Manhattan and the other boroughs. The hospital's proposal, dressed up as an effort to "enhance healthcare for the community," is nothing more than an effort to bypass regulations and maximize profit on a plot of land that was never intended to support a building of such enormous scale, and in the process, does nothing to address the city's pressing healthcare disparities. It also fuels a troubling pattern of "one-upmanship" among hospitals on the Upper East Side, as seen in MSKCC's proposal to build a massive tower on York Avenue. These projects, focused on scale and prestige rather than addressing community needs, are turning our neighborhoods into a battleground for corporate healthcare giants—leaving residents to bear the costs.

Let us take a closer look at how the proposed hospital expansion will truly "benefit the local community," especially its underserved members.

The plan includes a sprawling obstetrics/labor & delivery center. This is puzzling, given that Lenox Hill's maternity ward is already highly regarded. In 2024, the hospital earned a four-ribbon rating— nearly the highest possible— for its maternity services. What problem does a larger facility with private rooms actually solve? The reality is, it doesn't improve the care for expectant mothers—it merely intensifies competition with the newly built Alexandra Cohen Hospital for Women at NYP, a 246,500-square-foot facility that received a five-ribbon rating. In a recent statement, long-time doula and educator Bonu deCaires succinctly captured the issue: "With this new hospital, the competition is going to be all about how much hospitals can make themselves like hotels," she said. "Are there private rooms? What is the food like? How plush is it? But what really matters is the care that you receive, not the thread count." Lenox Hill officials claim this expansion won't increase patient costs, but that is patently untrue. Insurance companies will either be forced to pay more to Lenox Hill or, in a worst-case scenario, patients themselves will bear the financial burden. In either scenario, the primary winner is Northwell Health—not the patients who are supposed to benefit from these changes. The luxury of private rooms, perched at the top of their new tower with Central Park views, will no doubt attract wealthier patients, but this business model has little to do with improving health outcomes for the greater community. In fact, one must wonder which celebrity birth at Lenox Hill will take precedence over the care of other patients, further disrupting services for the surrounding community—a pattern Lenox Hill has already demonstrated.

Another troubling aspect of the proposal is the planned state-of-the-art neurosurgery suite. While primary care and pediatrics are desperately needed, neurosurgery seems an odd priority. However, a closer look reveals the financial incentives at play. According to a Merritt Hawkins Revenue Survey, neurosurgeons generate up to five times their salary in revenue for the hospital. "On average, a neurosurgeon generates more revenue for a hospital than all other specialties but

invasive cardiology and orthopedic surgery. According to Irving-based physician recruitment firm Merritt Hawkins, a single neurosurgeon produced his or her hospital an average revenue of $2.45 million in 2015" (reference). With neurosurgery generating more revenue than most other specialties, it is clear why this specialty is a focus. But does Manhattan really need another top-tier neurosurgery center? Fortunately, we already have three of the top 10 neurosurgery hospitals in the world—none of which are Lenox Hill.

Now let's address how the construction itself will impact the local community. The disruption caused by this project will be felt by residents and visitors alike. Any patient attempting to reach the hospital—especially in an emergency—will face significant obstacles, and the chaos may last well beyond the projected 10+ years of construction. Lenox Hill has proposed upgrades to the nearby subway entrance at 76th Street, which, while beneficial in the long term, will only add to the congestion and gridlock during the construction phase. The reality is, these upgrades would exacerbate traffic during hospital construction, especially for workers, patients, and emergency vehicles, leading to even more chaos along already congested streets.

Lexington Avenue, which is just two lanes wide (with one lane dedicated to buses), and the narrow one-way streets at 76th and 77th Streets will struggle to handle the surge of vehicles—from patient visitors, Uber/taxi services, public transit, and deliveries—once the expanded hospital is built. The area is already overburdened with hospitals, including Cornell, MSKCC, HSS, and Mount Sinai. The impact of this construction and eventual expansion will be unbearable, with the ongoing burden of traffic, waste disposal, and noise. Remember, during the pandemic, Lenox Hill even parked a mobile morgue on 76th Street, shutting down the street for nearly a year.

Lenox Hill also plans to convert all existing double rooms into private, single-occupancy rooms. While there may be a valid argument for modernizing rooms, the proposed size of the single rooms far exceeds code requirements (code 467.4.1, reference), raising a troubling question: why request rooms that are large enough to accommodate two patients? This move isn't about providing better care; it's about giving Lenox Hill the ability to later convert these large rooms back into double rooms—maximizing revenue at the expense of the community and ultimately crowding an already saturated healthcare neighborhood.

Given all of these considerations, one must ask: why would officials approve such a plan? Is it because Northwell Health is a major employer in the state? Because the project includes subway upgrades that the city cannot afford? Or perhaps because it will attract wealthy, insured patients? The truth is, no one has offered a better vision for the area—until now.

True city planning should not begin with corporate interests. Despite what Lenox Hill claims, their primary concern is profit, not the health of the public. What we need is a bold, visionary plan that prioritizes the health and well-being of New Yorkers, independent of corporate agendas. The plan, the vision—they come first--independent of corporate input, and *then* city leaders convince corporations to make concessions that follow the vision (one such example here). It's time to move beyond the corporate playbook and envision a healthcare system that genuinely serves all New Yorkers.

What does this vision look like? Lenox Hill Hospital should relocate to Hudson Yards, transforming into Hudson Yards Hospital. Located in the heart of a burgeoning biotech/pharma corridor, this new

facility would serve a broader swath of New Yorkers, meeting healthcare needs that are sorely lacking on the west side since the closure of St. Vincent's. The location, with its proximity to the Lincoln Tunnel, the Javits Center, and the Hudson River, would not only serve local residents but also provide critical emergency care for the many events and gatherings in the area.

Lenox Hill insists it wants to serve the "local community," but if that were truly the case, they would focus on providing more holistic care, not just expanding maternity services and neurosurgery. If they were truly dedicated to serving Queens or Long Island, they could build hospitals in those areas instead of capitalizing on the Upper East Side's "high-end" reputation to attract wealthier patients from outside the city.

I leave you with this quotation from a research paper in Nature Urban Sustainability (26 (2021), Pearsall *et al*.), on infrastructure in urban and rural systems. Though ostensibly about the rural-urban divide, within it there is a lesson in urban planning:

"Decisions on how to build infrastructure are made on the basis of technical and engineering considerations. While these decisions involve mostly policymakers and professionals, they in turn reflect existing economic and political structures and interests and can shape or exacerbate social and racial inequities and historical biases, which can contribute to health disparities[12,13,14,15]. By political, we are referring to "the contestations, collaborations, and negotiations through which collectives govern their everyday affairs"[16] (p 527). Such a blend of political and technical considerations influences who benefits from or bears the costs of infrastructural development, who participates in decision-making, and how stakeholder participation affects the short- and long-term trade-offs of infrastructure.

We argue that the development and management of sustainable urban infrastructure must focus on interactions across urban–rural systems to ensure that the benefits and burdens of different types of infrastructure are equitably distributed, including across distant constituencies and environments. For this purpose, it is necessary to understand how decisions about infrastructure systems are made at different levels, who participates and in what position, as well as the extent to which normative decisions consider trade-offs and disparities in health and well-being across as well as within urban and rural places. We call for a transdisciplinary research agenda that addresses the following four points, with an explicit focus on urban-rural systems: (1) How trade-offs and synergies between services that are provided by infrastructure impact health and well-being, (2) How decisions are made about the short- and long-term trade-offs created by infrastructure, (3) How different institutional arrangements that govern the appropriation and provisioning of infrastructure systems interact, either aligning or conflicting across jurisdictions, and (4) How governance, including planning, development, and management, can facilitate or constrain effective co-production of knowledge for sustainable infrastructure across diverse places and communities"

Lenox Hill's true motivation is clear: it wants to expand its customer base, not its commitment to the public health of New Yorkers. We cannot expect them to prioritize the city's healthcare needs, nor can we rely on them to consider the long-term effects of their construction plans. As New Yorkers, we must demand more from our elected officials. It's time for a new approach—one that serves the health of all New Yorkers, not just the financial interests of a corporate giant.

From: [redacted]
To: [redacted]
Subject: Comments re: C 250151 ZMM - Lenox Hill Hospital
Date: Tuesday, May 27, 2025 3:18:59 PM

Re. Project: **C 250151 ZMM - Lenox Hill Hospital**

Submitted by:

Name: **Ann Goodbody**
Zip: [redacted]

I represent: **Myself**

Details for "I Represent": **Resident f the UES at 815 Park Ave.**

My Comments:

Vote: I am **opposed**

Have you previously submitted comments on this project? **Yes**
If yes, are you now submitting new information? **Yes**

I have attended or will attend the City Planning Commission's Public hearing on this project: **Yes**

Additional Comments:
I listened carefully to Dr, Baker's explanation of the need for the size of rooms and felt they were disingenuous. To have 475 rooms ICU ready is not feasible since that requires storing additional equipment and maintaining necessary staff levels. Clearly, smaller single occupancy rooms as well as a mix of rooms would be warranted, and in fact, that is what they are doing at their other hospitals. I can't help feeling that they either want luxurious rooms for the wealthy, assuming they can attract them, or they have other plans todosomethuing to make more money through the upzonnng. Thank you for all the time you are putting into this review.

From: [redacted]
To: [redacted]
Subject: Comments re: C 250151 ZMM - Lenox Hill Hospital
Date: Monday, May 19, 2025 6:59:26 PM

Re. Project: **C 250151 ZMM - Lenox Hill Hospital**

Submitted by:

Name: **Mitchell Grubler**
Zip: [redacted]

I represent: **Myself**

Details for "I Represent":

My Comments:

Vote: I am **opposed**

Have you previously submitted comments on this project? **No**
If yes, are you now submitting new information?

I have attended or will attend the City Planning Commission's Public hearing on this project: **No**

Additional Comments:
Chair Garodnick and Commissioners, I am writing to voice my strong opposition to Northwell Health's proposed redevelopment of Lenox Hill Hospital. While the modernization of healthcare facilities is important, this plan requires a massive and inappropriate upzoning that contradicts the Upper East Side's historic character, human scale, and established zoning protections. The proposal—which spans from Park to Lexington Avenues between East 76th and 77th Streets—calls for a 436-foot tower that would be grossly out of scale with the surrounding neighborhood. This unprecedented height and bulk would disrupt Lexington Avenue's unique, pedestrian-friendly character. The Department of City Planning itself recognized this stretch in 1983 as having a "very special neighborhood character" due to its narrow width and vibrant street life. The proposed tower would cast long shadows and overwhelm the streetscape. Equally concerning is the alternate scheme that places a large high-rise midblock on East 76th Street. These midblocks are defined by low-rise residential buildings that contribute to the area's historic rhythm. Introducing a tall structure here would shatter that continuity and undermine zoning regulations specifically designed to protect neighborhood scale. It would also set a troubling precedent for future out-of-context developments. The project would also demolish several historic hospital buildings, including the Achelis and West buildings (1916, I.E. Ditmars) and the Einhorn building (1937, York & Sawyer). These structures represent the hospital's evolution since its founding in 1869 as the

German Hospital and are integral to the Yorkville neighborhood's architectural and cultural heritage. Their loss would be a significant blow to the city's historical fabric. Despite the project's scale, its specific medical benefits remain unclear—it appears that the 80% increase in building density would yield just 25 additional beds. This disproportionate trade-off raises serious concerns about the necessity and intent behind the expansion. The plan threatens to strain infrastructure, degrade environmental quality, and erode community character. I respectfully urge the City Planning Commission to reject this proposal and require Northwell to return with a more balanced plan—one that meets healthcare needs without sacrificing the neighborhood's integrity, history, and quality of life. Thank you for your attention and your commitment to thoughtful, community-centered planning.

GAIL J. HUPPER
[redacted]

May 18, 2025

City Planning Commission
City of New York
120 Broadway
New York, NY 10271

Re: Proposed Lenox Hill Hospital Expansion

Ladies and Gentlemen:

The purpose of this letter is to urge you to REJECT Northwell Health's current application to expand Lenox Hill Hospital (LHH). In my view, New York City public officials need to engage Northwell Health and Lenox Hill Hospital (LHH) in a much more robust discussion of why the needs of both LHH and the community cannot be met within the existing zoning framework. There has been all too little attention to this question in the public discussions of the proposed LHH expansion.

The neighborhood around LHH is my home town. I was born and lived within a 10-block radius of the hospital almost continuously for over 30 years. Though I moved to the Boston area in 1989, I continued to visit my parents at their home on East 67th Street. And I was thrilled when my husband and I purchased our apartment at 120 East 79th Street in 2019. It was, quite literally, a homecoming for me.

So you can imagine my horror when, shortly after closing on the purchase of our apartment, I learned of Northwell Health's plans for a massive expansion of the hospital. Like many other residents, I dread the impact such an expansion would have on the neighborhood, both during and after the construction period. I fully accept that LHH needs to modernize its facilities. But why is this massive expansion necessary in order to do so? Indeed, why is *any* expansion necessary?

The public discussion following Northwell's announcement has focused almost entirely on the benefits of the proposed expansion vis-a-vis LHH's *current* facilities. There has been almost no attention to LHH's redevelopment plans if the zoning amendments required for its expansion plans were turned down. The January 31, 2025 *Final Scope of Work for a Draft Environmental Impact Statement for the Lenox Hill Hospital Redevelopment* (the "Scope of Work"), which runs hundreds of pages, contains all of one page on the subject, as follows:

> **THE FUTURE WITHOUT THE PROPOSED PROJECT (NO ACTION CONDITION)**
>
> Absent the Proposed Project, the main hospital complex on Projected Development Site 1 would will remain in its current form, with most ambulatory

(outpatient) uses on the main hospital block relocating to other facilities (including Projected Development Site 1a). Approximately 650 daily outpatients, 944 daily visitors (associated with those outpatients), and 257 staff members will be relocated (see **Table 1**) to off-site facilities, including Northwell's as-of-right Third Avenue project, which is currently in construction. In the No Action condition, these relocations will make approximately 13,500 sf within the existing hospital available to convert a limited number of double-bedded rooms to single-bedded rooms without any effect on the total number of beds, and will allow for reconfiguration of certain suboptimal spaces. There are also a series of smaller renovation and space repurposing projects that are planned for the existing hospital that will occur independent of the Proposed Project. Under the No Action condition, the Applicant may redevelop Projected Development Site 1a. However, the No Action condition conservatively assumes that it will continue to be used as- is, other than the above-mentioned relocations from the main hospital complex on Projected Development Site 1.

Table 1

Project Population – Typical Average Weekday Daily Persons

Population	Existing	No Action	With Action	Project Increment
Projected Development Site 1 (Hospital Block)				
Staff*	**2,990**	**2,733**	**3,070**	**337**
Inpatient	*2,558*	*2,582*	*2,930*	*348*
Ambulatory	*432*	*151*	*140*	*-11*
Patients	**1,262**	**612**	**633**	**21**
Inpatient	*450*	*450*	*475*	*25*
Ambulatory	*812*	*162*	*158*	*-4*
Visitors	**2,191**	**1,247**	**1,298**	**51**
Inpatient	*1,013*	*1,012*	*1,069*	*57*
Ambulatory	*1,178*	*235*	*229*	*-6*
Projected Development Site 1a (East 77th Street Site)				
Staff*	**108**	**108**	**110**	**2**
Inpatient	*33*	*33*	*35*	*2*
Ambulatory	*75*	*75*	*75*	*0*
Patients	**4**	**4**	**0**	**-4**
Inpatient	*0*	*0*	*0*	*0*
Ambulatory	*4*	*4*	*0*	*-4*
Visitors	**6**	**6**	**0**	**-6**
Inpatient	*0*	*0*	*0*	*0*
Ambulatory	*6*	*6*	*0*	*-6*
Total – Projected Development Sites 1 and 1a				
Staff*	**3,098**	**2,841**	**3,180**	**339**
Inpatient	*2,591*	*2,615*	*2,965*	*350*
Ambulatory	*507*	*226*	*215*	*-11*
Patients	**1,266**	**616**	**633**	**17**
Inpatient	*450*	*450*	*475*	*25*
Ambulatory	*816*	*166*	*158*	*-8*
Visitors	**2,197**	**1,253**	**1,298**	**45**
Inpatient	*1,013*	*1,012*	*1,069*	*57*
Ambulatory	*1,184*	*241*	*229*	*-12*
Note: * Staff includes physicians (employed and voluntary), nurses, other clinical, administrative, and building operations employees, students, and volunteers.				

That's it. The remaining pages of the Scope of Work focus exclusively on the improvements the massive expansion would make over the *existing hospital*, and not over the hospital that LHH could become within the existing zoning framework.

It seems to me that New York City public officials need to engage LHH in a much more robust discussion of why the needs of the both the hospital and the community cannot be met within that existing framework. As Table 1 suggests, the primary increase that the proposed expansion would bring would be in *staffing levels*, not patient and visitor volume. Moreover, at the inpatient level, Table 1 focuses on total beds without regard to whether those beds are occupied. But for the past three years LHH's bed occupancy has averaged well under 70%, and at times lower than 50%. See https://data.lohud.com/hospital-capacity/facility/lenox-hill-hospital/330119/ . That statistic suggests that the hospital might meet its goal of offering patients single-bedded rooms, without compromising its ability to serve prospective inpatients, simply by reducing the total number of beds.

I leave to the experts on hospital economics and administration (of which I decidedly am not one) the job of examining questions like this more closely. My point is simply that *they need to be examined* rather than be casualties of the battle over the proposed expansion.

Finally, when considering Northwell's proposal, I urge you to keep in mind: LHH is not a world-class hospital, despite its claims in the Scope of Work and marketing releases. According to Newsweek's 2025 U.S. Hospital rankings, Lenox Hill ranks #357, right up there with HonorHealth - Scottsdale Thompson Peak Medical Center in Scottsdale, Arizona (#356) and ProHealth - Waukesha Memorial Hospital in Waukesha, Wisconsin (#358). Northwell and LHH management may *aspire* to achieving world-class status, but helping them in this quest (particularly given the costs to the community) should not be the concern of New York City public officials.

Very truly yours,



Gail J. Hupper

From: [redacted]
To: [redacted]
Subject: Comments re: C 250151 ZMM - Lenox Hill Hospital
Date: Monday, May 19, 2025 4:02:03 PM

Re. Project: **C 250151 ZMM - Lenox Hill Hospital**

Submitted by:

Name: **Helaine Lerner**
Zip: [redacted]

I represent: **Myself**

Details for "I Represent":

My Comments:

Vote: I am **opposed**

Have you previously submitted comments on this project? **Yes**
If yes, are you now submitting new information? **No**

I have attended or will attend the City Planning Commission's Public hearing on this project: **No**

Additional Comments:
There is no need to expand Lenox Hill Hospital at the present site. The existing buildings either should be upgraded or torn down and converted into a modern specialized boutique hospital within the present footprint that will be of value to the neighborhood. There is certainly no need for 25 more beds, as we hear that many of the existing beds are unused. There are a number of other hospitals and plenty of urgent care facilities nearby. The planned commercial building is ridiculously out of character with surrounding buildings in style and scale and will overwhelm the neighborhood. The statement that it will be only 25 floors is misleading, as the height of 400 feet is really more like 40 stories since each floor will be 15 feet high to allow for equipment between floors. If it will take nearly a decade to build because the hospital will be kept open also raises the likelihood that with the rapid advance of technology and miniaturization and AI, the equipment will be obsolete by the time the new building is finished. To keep the hospital open and impose so many years of construction on the neighborhood will create an unhealthy and dangerous traffic situation on Lexington Avenue and will interfere with the existing subway as well. And there are no plans to provide any additional parking! Northwell has totally disregarded the community's interests and valid concerns and is continuing with this folly despite the massive community opposition. I can understand that Northwell wants to build a state of the art new hospital but we understand that there are several other neighborhoods with available sites that would

welcome one. Please deny Northwell the requested zoning changes. Thank you.

Outlook

[EXTERNAL] Comment on the DEIS of the Lenox Hill Hospital proposed project

From Meyer, Peter [redacted]
Date Sun 5/18/2025 1:18 PM
To 23DCP079M_DL <23DCP079M_DL@planning.nyc.gov>

2 attachments (316 KB)
Comment on Northwell Health's LHH DEIS.pdf; PBM -signature.docx;

Some people who received this message don't often get email from pbmeyer@louisville.edu. Learn why this is important

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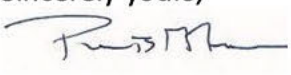
.Stephanie Shellooe, AICP, Director,
Environmental Assessment and Review Division
New York City Department of City Planning

Dear Ms. Shellooe,
Please see the attached document. (In case you don't accept attachments, the document text follows my signature below.)
The submission is with reference to:

- Application Number: **C 250151 ZMM**
- Project: **Lenox Hill Hospital**
- Public Hearing Date: **05/21/2025**
- Borough: **Manhattan**
- Community District: **8**

I thank you for your attention.

Sincerely yours,



Peter B. Meyer, PhD
Professor Emeritus of Urban Policy and Economics, U. of Louisville
President and Chief Economist, The E.P. Systems Group, Inc.
Council Member, Borough of New Hope
[redacted]

==========



THE E. P. SYSTEMS GROUP, INC.

[redacted]

Comment on the

Notice Of Completion and Notice of Availability of a Draft Environmental Impact Statement and the Lenox Hill Hospital Development Draft Environmental Impact Statement

Prepared March 12, 2025, by Peter B. Meyer, PhD

DISCUSSION OF NEED AND FEASIBILITY

The need for this massive new development is never clarified by the applicant or in the DEIS other than the claim that it needs to assure "475 single-bedded patient rooms, 30 operating suites, and a right-sized emergency department." Northwell Health apparently needs this construction to serve some of its (unspecified) objectives, but there is no documentation of need from the perspective of the neighborhood in which the hospital is located, from that of Community Board 8 that is being asked to approve this project, nor from that of the City of New York itself.

A number of questions need to be answered to establish need:

- Does the claim that " current standards of healthcare delivery, including single-bedded patient rooms" require this expansion stand? Are single-bedded rooms the norm in New York or nationally?
- What is "right sized" when it comes to the appropriate size of an emergency room?
- How does the addition of 25 beds necessitate an ED expansion of 14 treatment units from the current 34 to the proposed 48
- Similarly, where is the evidence that 5 additional ORs are needed in this part of the city – or the city as a whole?
- Where is the evidence that justifies a "new off-street ambulance bay with six berths" and " Four new and longer truck loading bays" when three truck bays already exist and the proposed construction would impede local traffic, cross pedestrian walkways and intrude on the streetscape of the neighborhood? Granting that the new vehicular access facilities may be an improvement over those that exist, are they needed? Where is the evidence that demand for services at this location warrants six ambulance bays and seven truck bays?
- Why do any of these new facilities necessitate a new "46,000-gsf, six-story, 75-foot-tall building to house hospital support functions"? What are those functions and aren't they already housed in existing buildings that could be rehabilitated or modernized?
- Even granting the need for all of the above can be empirically demonstrated to serve the immediate neighborhood, broader local community, and the city as a whole, what justifies the construction of two towers, one 21 stories and the other 26 stories tall to accommodate the expansion in facilities that are proposed?

Part of the apparent answer from Northwell Health to this last question is their claim that

> "the buildings to be demolished cannot be used for inpatient care because their structures cannot accommodate the necessary heating, ventilation, and air conditioning (HVAC) infrastructure, sensitive modern imaging equipment, or patient transport between buildings."

But those buildings are in use now. If they are used for inpatient care, then the hospital is acknowledging that it is not providing a high quality of care. If they serve other hospital purposes and functions than inpatient care, why do they need to be demolished?

There is simply no rationale provided for the intended demolitions and the construction of proposed structures are substantially taller than any other buildings around the project sites – towers that will substantially change the character of the neighborhood.

There may be a need for the *proposed Subway Station Access and Sidewalk Improvements* but those are not hospital functions and there is no evidence offered to show that improvements are not in the MTA's workplan.

An upgraded subway entrance is a function of the MTA – but there apparently has been no contact with the MTA about whether the site improvements are not already in their workplan, and Northwell's contribution is not required.

This failure to communicate with the MTA is reflected in the plans for the tunnel proposed for access between the two development sites. According to Northwell, that tunnel "would require a revocable consent from DOT." But the applicant for permission to undertake a massive project has apparently had as much contact with DOT as it has had with the MTA.

Any plans developed without needed consultations – not to mention those dependent on a "revocable consent" that has no permanence – really aren't plans. They fail the fundamental standard of demonstrated feasibility.

Some facets of that limited feasibility are evident in the flaws in the DEIS discussion of the anticipated impacts of the proposed project.

PROJECT IMPACTS DESCRIBED AND OVERLOOKED

The DEIS starts by defining its study area as within 400 feet of the Project Site. The definition on which the entire analysis stands, however, is an area defined by distance from the midpoint of the project site, not the borders of the site. When a site is as large as this one – a whole city block – the boundary of the study area is far greater when the distance to boundary is used. That is warranted, since that includes the properties within 400 feet of the proposed construction site and the proximity is a measure of the expected spillover risk.

Thus the entire statistical and architectural context discussions may be off by a significant measure. Looking at Figure ES-1, the more appropriate study area based on distance to project boundaries would not be the limited area defined by the dotted red line, but one that probably reaches to the far side of Madison Avenue, 76th Street, the far side of Third Avenue and the far side of 79th Street.

If the study area really were defined by a distance of 400 feet from the center of the project site, it would be a perfect circle; the distorted dotted line shape may involve some allowance for the second development site, but it is still inexplicably different from a circle and its shape is never explained. An explanation is needed or the area defined would seem to have been selected to serve the case for the project.

Land Use and Zoning, and Public Policy

The DEIS claims that the

> "proposed bulk would be consistent in scale with other institutions and medical facilities in the area."

But the description of proposed construction involves structures far taller than those in the neighborhood as a whole, so that claim is false.

The reference to other medical facilities suggests that the neighborhood-specific impacts are ignored. (That reference, including enumeration of many competing hospitals on the East side of Manhattan is repeated in the chapter nominally about "Neighborhood Character" which leads the reader to wonder if the assessment is paying any real attention to the people and premises in its immediate proximity.)

Contribution of project to OneNYC's goals is irrelevant since courts by and large have ruled that comprehensive plans have no legal standing as a guide to action.

Community Facilities and Services

Claim that the project "would not directly affect other types of public community facilities" totally fails to consider what impact the nine-year construction process would have on those facilities, businesses in the area, and/or the amenity values of the residences in the neighborhood.

Further fails to consider what impact the supposed improvements in traffic flow due to better ER-ambulance interactions or improvements in subway access would have on the viability of local businesses and other community facilities. (They could improve conditions, not contribute to deterioration; the failure to consider even such positive effects is a measure of how shallow the review has been to date.)

Open Space

The issue of "increased population" is limited to consideration of the number of new employees when the intent of the proposed project is to increase the number of patients served, thus the transient population of the neighborhood. Those transients DO constitute a "new user population" for the limited immediately available open space.

There is no basis for the claim that the additional shadow would not affect use of the garden cited.

Shadows

Admitted that "the significant adverse shadow impacts to the church garden would be unavoidable." -- thus being thoroughly inconsistent with the prior claim.

Historic and Cultural Resources

Acknowledging the existence of historic architectural resources, the impact assessment makes the untenable assumption that the Construction Protection Plan prepared as required will be fully successful in protecting those resources from damage due to vibration and other impacts from demolition and construction. This certainly is not viable as part of a worst case assessment.

The DEIS itself notes that "The NYC Building Code, in Section BC 3309: Protection of Adjoining Property, provides some measures of … they do not afford special consideration for historic structures." Thus there is no basis for assuming there would be no adverse impacts from the demolition, excavation and construction elements of the proposed project.

Urban Design and Visual Resources

While further justifying the proposed building heights, the discussion of design impacts remains superficial at best despite the minimal commitments to conform to neighborhood exterior color and cladding character.

Typical is the meaningless claim that "the buildings on the western portion of Projected Development Site 1 … would provide transparency and activate uses on the adjacent sidewalks on Park Avenue." What "transparency' relative to what, and what uses of the sidewalk are considered and how do either affect – or are affected by – design or visual resources?

Hazardous Materials

The fact that the Phase II hazardous materials investigation was incomplete is not acknowledged in the Notice of Completion and Notice of Availability of the DEIS. The DEIS itself, however, notes that,

> "Due to physical limitations encountered during the field investigation, including intervening subsurface utilities, active electrical systems for critical hospital care systems, and ongoing hospital operations, the advancement of soil borings with a Geoprobe® direct-push drill rig was not possible as hospital operations prohibited the use of fuel-powered drilling equipment with exhaust inside the building and limited the use of electrical power to standard outlets. As such, borings were advanced manually with hand tools consisting of a core drill and a hand auger, which precluded the installation of soil borings to significant depths below the sub-basement and basement floor slabs and limited subsurface sample collection."

There is no consideration given in the DEIS to the potential future discovery of contamination that was missed by using only the manual borings and its impact on the project budget or on the already long time period specified as

needed for construction. Such discovery could stop construction – and could also release substantial contaminated gasses or dust in the period before an excavated hazard could be identified and contained.

This risk could be alleviated to some extent by assuring that there be hazardous waste management personnel and equipment on site continuously during any excavation activity. It could not, however, be completely eliminated.

The failure to acknowledge this risk associated with the proposed project stands in stark contrast to the hazardous waste warning inserted into the description of The Future Without the Proposed Project in the DEIS:

> "The No Action condition may entail demolition of certain existing buildings/foundations and limited excavation. Demolition could disturb hazardous materials within buildings and excavation could increase pathways for human exposure if performed without appropriate controls."

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That is a gap in the DEIS coverage. However, the transportation issue is one of several impacts that are understated due to the strict comparison of a "do nothing" to "do this project" comparison. No consideration is given to the negative transportation impacts associated with what is likely to be over a decade of construction in the neighborhood and the effects on livability and attractiveness associated with that disruption. Those disamenities are real and pote ntiallysubstantial, but totally ignored in the DEIS.

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Given the claim that vehicular flow is currently impeded around the hospital that exists would be ameliorated by the proposed project, this seems to be a contradictory statement warranting some explanation.

There is a further unwarranted assertion in the DEIS that appears to ignore the potential for advancements in medicine and medical care:

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Neighborhood noise during nine or more years of construction was also ignored in this chapter.

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The years of construction were definitely acknowledged in consideration of public health: "… the construction analysis determined that construction activities would result in unmitigated temporary significant adverse noise impacts on the façades of multiple residential buildings either adjacent to or with a direct line of sight to the construction work areas and various portions of LHH …" Those noise impacts were found to "not generate significant adverse public health impacts."

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The DEIS notes that:

> "The neighborhood character of the 400-foot study area is primarily defined by its mix of institutional, residential, and ground floor retail uses, as well as the diverse urban and architectural context of the area. The Proposed Project would reinforce the existing institutional nature of the Project Site and neighborhood and would contribute to the mix of land uses in the area and the diverse urban and architectural context."

The study area defined in the DEIS, based in some measure on distance from the center of a site that exceeds a city block in size, is questionable, as stated at the outset of this discussion of Impact. If the 400-foot study area were defined as within 400 feet of the boundary of the project then the neighborhood would have a substantially different character than what is asserted. Most notably, the extension of the study area to the west would include residential uses on both sides of Park Avenue, and all the extensions would add more residential uses on the side streets. In that case, the mix of uses would tilt far more towards residential, and that would require far more consideration of effects on the residents than is given in the DEIS.

Even if the neighborhood is characterized as a "mix of institutional, residential, and ground floor retail uses," there is a need to systematically analyze the effect of the reinforcement of the "institutional nature of the Project Site." The proposed intensity of land use and scale of new buildings proposed may well change the neighborhood from a mix of land uses to an area dominated by a single overwhelming institutional use where the institution had previously fit into the neighborhood mix.

In defining the features of the neighborhood, the DEIS actually goes well beyond the 400-foot boundary and drags in a laundry list of institutional uses "located on Manhattan's Upper East Side" as if they defined the affected area. It is ironic in the extreme that this narrative, irrelevant as it is to the issue of Neighborhood Impact, raises questions about the need for another major hospital center in that part of New York City.

The DEIS cites the physical characteristics of the neighborhood, but totally ignores the population characteristics and property values in the area. Yet it is those features of the area surrounding the proposed project that will be most immediately affected by the nine-year construction process and the resulting change in the neighborhood character. It claims that,

> "Benefits of the Proposed Project would include the activation of the streetscape, the strengthening of an existing neighborhood community facility institution, and access improvements to the local subway station."

This claim is dubious at best.

1. "Activation of the streetscape" is ambiguous and no consideration is given to the effects of a change in the characteristics of neighborhood residents or property values on retail activity when the nine-year construction period and change in physical appearance of the area might generate such a change.
2. The Hospital has claimed its need to expand is a function of demand from a service area that extends into Brooklyn and Queens and the DEIS apparently accepts that rationale, but then describes it as "an existing neighborhood community facility." Some modicum of consistency in argument should exist in the DEIS.
3. Access improvements to the local subway station are likely to be undertaken by the MTA over the next decade with or without the project – and subway access is not an integral concern of a hospital. (The history of the construction of the Second Avenue subway is also germane here: that street disruption drove many local stores into bankruptcy so any subway improvements would come at some cost to local retail.)

Construction

The DEIS assessment of the construction impacts opens with the assertion that:

> "Construction associated with the Proposed Actions would result in temporary disruptions in the surrounding area."

There may be a world in which nine years is considered "temporary," but New York is not in such a world. Given the overall tenor of the DEIS, we should acknowledge that it admits there will be disruptions altogether.

The discussion of traffic on streets adjacent to the proposed construction site is remarkable for its failure to so much as admit that there is, at present, on-street curbside parking. There is no question that the availability of that parking, on the East side of Park Avenue, South side of 77th street, West side of Lexington Avenue and North side of 76th street, WILL be affected by the construction which will need, at a minimum, space for staging construction elements at loading docks while buildings are erected as well as for cranes and two exterior hoists, even in the years when interior work is being done. That space will be taken from curbside parking.

Any reduction in curbside parking space will increase the likelihood of double parking and that double parking will reduce the number of passable travel lanes. The increased frequency of that double parking will have an impact on traffic volume that is completely ignored in the DEIs. It is notable that the loss of the single passable lane on 77th street would effectively block ambulance access to the hospital. Double parking on 76th street could make it difficult for trucks to turn into the proposed truck bays. Neither of these impacts on hospital operations during the construction phase are considered at all in the DEIS but need to be addressed.

Double parking on the avenues will create bottlenecks, reducing traffic speed and volume. (Bottlenecks typically increase the likelihood of honking, a noise impact that is ignored.) And such double parking will be substantial, occurring whenever construction materials are delivered to holding areas unless curbside parking is virtually eliminated in order to permit trucks to back up adjacent to holding along the curbs.

Since parking is ignored in discussion of traffic, it is not surprising that reduction of parking available to neighborhood residents is ignored in the DEIS that makes reference only to the parking needs of construction personnel. The failure to acknowledge residents and their needs in the discussion of the nine-year construction period is all too obvious:

1. Discussion of pedestrians relies only on data on current patterns and never considers that residents might change their walking habits. To some degree, construction noise may drive away those walking for exercise. On the other hand, vehicular congestion and reduced on-street parking might mean more people walking from near the construction to access mass transit, to the parked cars, or to access taxis and ride-share vehicles. These issues warrant consideration.
2. The unavoidable impact of the needed construction materials and staging operations on sidewalk access and pedestrian detours is ignored completely, consistent with the DEIS' failure to recognize the project area contains resident human beings.
3. The proposed project includes provision of an improved subway station but the DEIS discussion of construction impacts on transit never mentions that aspect of the project or its impacts during and after construction. At a minimum, the timing of those improvements could be considered o minimize the combined disruptions of sidewalk-adjacent excavations and construction materials staging.
4. *Street User Safety* is specifically identified as a consideration but the effects on accident rates and the like of more people crossing streets and avenues to avoid walking adjacent to the construction sites addressed. (This section of the DEIS acknowledges "heavy volumes at high crash locations in the study area" as if that condition makes it unnecessary to consider increased risks or the extent to which construction will impede efforts to reduce crashes, a measure that might otherwise improve neighborhood quality of life as well as health.
5. The diagram of the construction site indicating building and construction stages notes multiple "sidewalk sheds" and gates that unquestionably will affect pedestrian traffic along the impacted sidewalks. On Lexington Avenue, it appears that the entire West side sidewalk will have to be closed at times (it is also marked as a vehicular lane). Those impacts on pedestrians and safety are ignored.
6. The description of Construction Practices notes that the average number of trucks accessing the construction site is expected to be 27 per day. Assuming a 7:00 AM to 3:30 PM workday, that averages out to one large truck arriving every 19 minutes for nine years. (in 2030, 33 trucks are expected per day, or one every 15 minutes.) And yet there is complete denial of any significant construction impact on the neighborhood.
7. Following p. 16-26 on the DEIS Construction chapter there are 15 pages diagramming construction worker pedestrian flows at neighborhood corners under the existing, no action and proposed project scenarios. There is no analysis of any sort of the residents' pedestrian flows and how they might change in response to noise, rerouting onto special walkways or other Impediments associated with the construction project, including temporary or extended sidewalk closures.

The discussion of construction noise included detailed data on impact projections for over 200 noise receptors. Serious noise impacts, however, were discussed only for those few locations at which the increase in noise led to a volume increase that exceeded 10 dBA above the interior noise level threshold of 45 dBA considered acceptable. That 10dBA increase, it must be noted, constitutes a doubling of noise volume since the measurement scale is logarithmic. There is no determination of the extent to which construction will generate a 10, 20, or 30% increase in the daytime

noise volume experienced by neighborhood residents during the nine years of active construction. Without those data, the DEIS cannot in any way determine the negative effects on the neighborhood property values, not to mention the quality of life of the current residents.

Alternatives

This DEIS chapter purports to discuss alternatives to the massive construction project proposed. It fails to do so in any constructive manner.

It compares the No Action Alternative, a "No Significant Adverse Impact Alternative" and the Proposed Project. These are far from the only alternatives available for a project to improve and upgrade the current historic Lennox Hill Hospital. The first two alternatives are effectively straw men, inserted as required by law but not offered as real options to the neighborhood, Community Board 8, or the City of New York.

There is no constituency for taking no action at all. The neighborhood would welcome an upgrading of facilities at the hospital that did not change the architectural character of the neighborhood and the balance between the diverse uses that it now encompasses.

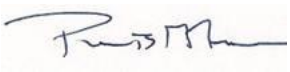
The option of a project with no significant adverse impacts that the DEIS reviews looks for a project with no shadowing of a garden and no temporary construction noise. That option is rejected because,

> "… there is no alternative that would avoid a significant adverse temporary construction noise impact and produce a project that would satisfy the goals and objectives of the Proposed Project."

The question is whether the goals of the proposed project, which are those of Northwell Health, a nonprofit corporate entity with over 900 locations, are consistent with the goals of the neighborhood in which Lenox Hill Hospital is located. If they are not, then the realistic alternatives to the proposed project are alternative developments that provide needed upgrades to the quality of healthcare at the hospital while simultaneously "advancing public policy goals such as One NYC's goal for growth in emerging fields, promoting access to health care, and modernizing key infrastructure."

Such alternatives have not been considered by Northwell Health and are thus not included in this DEIS. They should be if there is to be an objective, consistent, and complete Environmental Impact Statement that serves the residents and taxpayers of the neighborhood, community and city.

Respectfully submitted,



Peter B. Meyer, PhD
President and Chief Economist

Peter B. Meyer is Professor Emeritus of Urban Policy and Economics and Director Emeritus of the Center for Environmental Policy and Management at the University of Louisville, and previously served as Director of the Local Economic Development Assistance Center at The Pennsylvania State University. He spent 15 years as an Expert Witness for EPA's Environmental Finance Advisory Board and then served on the Sustainable and Healthy Communities subcommittee of its Board of Scientific Counselors. He has an international reputation for his work on contaminated land (brownfield) reclamation and development and for his work on climate change mitigation and adaptation finance. Dr. Meyer's prior experience reviewing Environmental Impact Statements includes those for new road systems, bridges, waste management projects, and other construction plans.

THE E. P. SYSTEMS GROUP, INC.
228 Riverwoods Drive
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502-435-3240
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and the
Lenox Hill Hospital Development Draft Environmental Impact Statement

Prepared March 12, 2025, by Peter B. Meyer, PhD

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DISCUSSION OF NEED AND FEASIBILITY

The need for this massive new development is never clarified by the applicant or in the DEIS other than the claim that it needs to assure "475 single-bedded patient rooms, 30 operating suites, and a right-sized emergency department." Northwell Health apparently needs this construction to serve some of its (unspecified) objectives, but there is no documentation of need from the perspective of the neighborhood in which the hospital is located, from that of Community Board 8 that is being asked to approve this project, nor from that of the City of New York itself.

A number of questions need to be answered to establish need:

- Does the claim that " current standards of healthcare delivery, including single-bedded patient rooms" require this expansion stand? Are single-bedded rooms the norm in New York or nationally?
- What is "right sized" when it comes to the appropriate size of an emergency room?
- How does the addition of 25 beds necessitate an ED expansion of 14 treatment units from the current 34 to the proposed 48
- Similarly, where is the evidence that 5 additional ORs are needed in this part of the city – or the city as a whole?
- Where is the evidence that justifies a "new off-street ambulance bay with six berths" and " Four new and longer truck loading bays" when three truck bays already exist and the proposed construction would impede local traffic, cross pedestrian walkways and intrude on the streetscape of the neighborhood? Granting that the new vehicular access facilities may be an improvement over those that exist, are they needed? Where is the evidence that demand for services at this location warrants six ambulance bays and seven truck bays?
- Why do any of these new facilities necessitate a new "46,000-gsf, six-story, 75-foot-tall building to house hospital support functions"? What are those functions and aren't they already housed in existing buildings that could be rehabilitated or modernized?

- Even granting the need for all of the above can be empirically demonstrated to serve the immediate neighborhood, broader local community, and the city as a whole, what justifies the construction of two towers, one 21 stories and the other 26 stories tall to accommodate the expansion in facilities that are proposed?

Part of the apparent answer from Northwell Health to this last question is their claim that

> "the buildings to be demolished cannot be used for inpatient care because their structures cannot accommodate the necessary heating, ventilation, and air conditioning (HVAC) infrastructure, sensitive modern imaging equipment, or patient transport between buildings."

But those buildings are in use now. If they are used for inpatient care, then the hospital is acknowledging that it is not providing a high quality of care. If they serve other hospital purposes and functions than inpatient care, why do they need to be demolished?

There is simply no rationale provided for the intended demolitions and the construction of proposed structures are substantially taller than any other buildings around the project sites – towers that will substantially change the character of the neighborhood.

There may be a need for the *proposed Subway Station Access and Sidewalk Improvements* but those are not hospital functions and there is no evidence offered to show that improvements are not in the MTA's workplan.

An upgraded subway entrance is a function of the MTA – but there apparently has been no contact with the MTA about whether the site improvements are not already in their workplan, and Northwell's contribution is not required.

This failure to communicate with the MTA is reflected in the plans for the tunnel proposed for access between the two development sites. According to Northwell, that tunnel "would require a revocable consent from DOT." But the applicant for permission to undertake a massive project has apparently had as much contact with DOT as it has had with the MTA.

Any plans developed without needed consultations – not to mention those dependent on a "revocable consent" that has no permanence – really aren't plans. They fail the fundamental standard of demonstrated feasibility.

Some facets of that limited feasibility are evident in the flaws in the DEIS discussion of the anticipated impacts of the proposed project.

PROJECT IMPACTS DESCRIBED AND OVERLOOKED

The DEIS starts by defining its study area as within 400 feet of the Project Site. The definition on which the entire analysis stands, however, is an area defined by distance from the midpoint of the project site, not the borders of the site. When a site is as large as this one – a whole city block – the boundary of the study area is far greater when the distance to boundary is used. That is warranted, since that includes the properties within 400 feet of the proposed construction site and the proximity is a measure of the expected spillover risk.

Thus the entire statistical and architectural context discussions may be off by a significant measure. Looking at Figure ES-1, the more appropriate study area based on distance to project boundaries would not be the limited area defined by the dotted red line, but one that probably reaches to the far side of Madison Avenue, 76th Street, the far side of Third Avenue and the far side of 79th Street.

If the study area really were defined by a distance of 400 feet from the center of the project site, it would be a perfect circle; the distorted dotted line shape may involve some allowance for the second development site, but it is still inexplicably different from a circle and its shape is never explained. An explanation is needed or the area defined would seem to have been selected to serve the case for the project.

Land Use and Zoning, and Public Policy

The DEIS claims that the

> "proposed bulk would be consistent in scale with other institutions and medical facilities in the area."

But the description of proposed construction involves structures far taller than those in the neighborhood as a whole, so that claim is false.

The reference to other medical facilities suggests that the neighborhood-specific impacts are ignored. (That reference, including enumeration of many competing hospitals on the East side of Manhattan is repeated in the chapter nominally about "Neighborhood Character" which leads the reader to wonder if the assessment is paying any real attention to the people and premises in its immediate proximity.)

Contribution of project to OneNYC's goals is irrelevant since courts by and large have ruled that comprehensive plans have no legal standing as a guide to action.

Community Facilities and Services

Claim that the project "would not directly affect other types of public community facilities" totally fails to consider what impact the nine-year construction process would have on those facilities, businesses in the area, and/or the amenity values of the residences in the neighborhood.

Further fails to consider what impact the supposed improvements in traffic flow due to better ER-ambulance interactions or improvements in subway access would have on the viability of local businesses and other community facilities. (They could improve conditions, not contribute to deterioration; the failure to consider even such positive effects is a measure of how shallow the review has been to date.)

Open Space

The issue of "increased population" is limited to consideration of the number of new employees when the intent of the proposed project is to increase the number of patients served, thus the transient population of the neighborhood. Those transients DO constitute a "new user population" for the limited immediately available open space.

There is no basis for the claim that the additional shadow would not affect use of the garden cited.

Shadows

Admitted that "the significant adverse shadow impacts to the church garden would be unavoidable." -- thus being thoroughly inconsistent with the prior claim.

Historic and Cultural Resources

Acknowledging the existence of historic architectural resources, the impact assessment makes the untenable assumption that the Construction Protection Plan prepared as required will be fully successful in protecting those resources from damage due to vibration and other impacts from demolition and construction. This certainly is not viable as part of a worst case assessment.

The DEIS itself notes that "The NYC Building Code, in Section BC 3309: Protection of Adjoining Property, provides some measures of ... they do not afford special consideration for historic structures." Thus there is no basis for assuming there would be no adverse impacts from the demolition, excavation and construction elements of the proposed project.

Urban Design and Visual Resources

While further justifying the proposed building heights, the discussion of design impacts remains superficial at best despite the minimal commitments to conform to neighborhood exterior color and cladding character.

Typical is the meaningless claim that "the buildings on the western portion of Projected Development Site 1 … would provide transparency and activate uses on the adjacent sidewalks on Park Avenue." What "transparency' relative to what, and what uses of the sidewalk are considered and how do either affect – or are affected by – design or visual resources?

Hazardous Materials

The fact that the Phase II hazardous materials investigation was incomplete is not acknowledged in the Notice of Completion and Notice of Availability of the DEIS. The DEIS itself, however, notes that,

> "Due to physical limitations encountered during the field investigation, including intervening subsurface utilities, active electrical systems for critical hospital care systems, and ongoing hospital operations, the advancement of soil borings with a Geoprobe® direct-push drill rig was not possible as hospital operations prohibited the use of fuel-powered drilling equipment with exhaust inside the building and limited the use of electrical power to standard outlets. As such, borings were advanced manually with hand tools consisting of a core drill and a hand auger, which precluded the installation of soil borings to significant depths below the sub-basement and basement floor slabs and limited subsurface sample collection."

There is no consideration given in the DEIS to the potential future discovery of contamination that was missed by using only the manual borings and its impact on the project budget or on the already long time period specified as needed for construction. Such discovery could stop construction – and could also release substantial contaminated gasses or dust in the period before an excavated hazard could be identified and contained.

This risk could be alleviated to some extent by assuring that there be hazardous waste management personnel and equipment on site continuously during any excavation activity. It could not, however, be completely eliminated.

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The DEIS notes that:

> "The neighborhood character of the 400-foot study area is primarily defined by its mix of institutional, residential, and ground floor retail uses, as well as the diverse urban and architectural context of the area. The Proposed Project would reinforce the existing institutional nature of the Project Site and neighborhood and would contribute to the mix of land uses in the area and the diverse urban and architectural context."

The study area defined in the DEIS, based in some measure on distance from the center of a site that exceeds a city block in size, is questionable, as stated at the outset of this discussion of Impact. If the 400-foot study area were defined as within 400 feet of the boundary of the project then the neighborhood would have a substantially different character than what is asserted. Most notably, the extension of the study area to the west would include residential uses on both sides of Park Avenue, and all the extensions would add more residential uses on the side streets. In that case, the mix of uses would tilt far more towards residential, and that would require far more consideration of effects on the residents than is given in the DEIS.

Even if the neighborhood is characterized as a "mix of institutional, residential, and ground floor retail uses," there is a need to systematically analyze the effect of the reinforcement of the "institutional nature of the Project Site." The proposed intensity of land use and scale of new buildings proposed may well change the neighborhood from a mix of land uses to an area dominated by a single overwhelming institutional use where the institution had previously fit into the neighborhood mix.

In defining the features of the neighborhood, the DEIS actually goes well beyond the 400-foot boundary and drags in a laundry list of institutional uses "located on Manhattan's Upper East Side" as if they defined the affected area. It is ironic in the extreme that this narrative, irrelevant as it is to the issue of Neighborhood Impact, raises questions about the need for another major hospital center in that part of New York City.

The DEIS cites the physical characteristics of the neighborhood, but totally ignores the population characteristics and property values in the area. Yet it is those features of the area surrounding the proposed project that will be most immediately affected by the nine-year construction process and the resulting change in the neighborhood character. It claims that,

> "Benefits of the Proposed Project would include the activation of the streetscape, the strengthening of an existing neighborhood community facility institution, and access improvements to the local subway station."

This claim is dubious at best.

1. "Activation of the streetscape" is ambiguous and no consideration is given to the effects of a change in the characteristics of neighborhood residents or property values on retail activity when the nine-year construction period and change in physical appearance of the area might generate such a change.
2. The Hospital has claimed its need to expand is a function of demand from a service area that extends into Brooklyn and Queens and the DEIS apparently accepts that rationale, but then describes it as "an existing neighborhood community facility." Some modicum of consistency in argument should exist in the DEIS.
3. Access improvements to the local subway station are likely to be undertaken by the MTA over the next decade with or without the project – and subway access is not an integral concern of a hospital. (The history of the construction of the Second Avenue subway is also germane here: that street disruption drove many local stores into bankruptcy so any subway improvements would come at some cost to local retail.)

Construction

The DEIS assessment of the construction impacts opens with the assertion that:

> "Construction associated with the Proposed Actions would result in temporary disruptions in the surrounding area."

There may be a world in which nine years is considered "temporary," but New York is not in such a world. Given the overall tenor of the DEIS, we should acknowledge that it admits there will be disruptions altogether.

The discussion of traffic on streets adjacent to the proposed construction site is remarkable for its failure to so much as admit that there is, at present, on-street curbside parking. There is no question that the availability of that parking, on the East side of Park Avenue, South side of 77th street, West side of Lexington Avenue and North side of 76th street, WILL be affected by the construction which will need, at a minimum, space for

staging construction elements at loading docks while buildings are erected as well as for cranes and two exterior hoists, even in the years when interior work is being done. That space will be taken from curbside parking.

Any reduction in curbside parking space will increase the likelihood of double parking and that double parking will reduce the number of passable travel lanes. The increased frequency of that double parking will have an impact on traffic volume that is completely ignored in the DEIs. It is notable that the loss of the single passable lane on 77th street would effectively block ambulance access to the hospital. Double parking on 76th street could make it difficult for trucks to turn into the proposed truck bays. Neither of these impacts on hospital operations during the construction phase are considered at all in the DEIS but need to be addressed.

Double parking on the avenues will create bottlenecks, reducing traffic speed and volume. (Bottlenecks typically increase the likelihood of honking, a noise impact that is ignored.) And such double parking will be substantial, occurring whenever construction materials are delivered to holding areas unless curbside parking is virtually eliminated in order to permit trucks to back up adjacent to holding along the curbs.

Since parking is ignored in discussion of traffic, it is not surprising that reduction of parking available to neighborhood residents is ignored in the DEIS that makes reference only to the parking needs of construction personnel. The failure to acknowledge residents and their needs in the discussion of the nine-year construction period is all too obvious:

1. Discussion of pedestrians relies only on data on current patterns and never considers that residents might change their walking habits. To some degree, construction noise may drive away those walking for exercise. On the other hand, vehicular congestion and reduced on-street parking might mean more people walking from near the construction to access mass transit, to the parked cars, or to access taxis and ride-share vehicles. These issues warrant consideration.
2. The unavoidable impact of the needed construction materials and staging operations on sidewalk access and pedestrian detours is ignored completely, consistent with the DEIS' failure to recognize the project area contains resident human beings.
3. The proposed project includes provision of an improved subway station but the DEIS discussion of construction impacts on transit never mentions that aspect of the project or its impacts during and after construction. At a minimum, the timing of those improvements could be considered o minimize the combined disruptions of sidewalk-adjacent excavations and construction materials staging.

4. *Street User Safety* is specifically identified as a consideration but the effects on accident rates and the like of more people crossing streets and avenues to avoid walking adjacent to the construction sites addressed. (This section of the DEIS acknowledges "heavy volumes at high crash locations in the study area" as if that condition makes it unnecessary to consider increased risks or the extent to which construction will impede efforts to reduce crashes, a measure that might otherwise improve neighborhood quality of life as well as health.
5. The diagram of the construction site indicating building and construction stages notes multiple "sidewalk sheds" and gates that unquestionably will affect pedestrian traffic along the impacted sidewalks. On Lexington Avenue, it appears that the entire West side sidewalk will have to be closed at times (it is also marked as a vehicular lane). Those impacts on pedestrians and safety are ignored.
6. The description of Construction Practices notes that the average number of trucks accessing the construction site is expected to be 27 per day. Assuming a 7:00 AM to 3:30 PM workday, that averages out to one large truck arriving every 19 minutes for nine years. (in 2030, 33 trucks are expected per day, or one every 15 minutes.) And yet there is complete denial of any significant construction impact on the neighborhood.
7. Following p. 16-26 on the DEIS Construction chapter there are 15 pages diagramming construction worker pedestrian flows at neighborhood corners under the existing, no action and proposed project scenarios. There is no analysis of any sort of the residents' pedestrian flows and how they might change in response to noise, rerouting onto special walkways or other Impediments associated with the construction project, including temporary or extended sidewalk closures.

The discussion of construction noise included detailed data on impact projections for over 200 noise receptors. Serious noise impacts, however, were discussed only for those few locations at which the increase in noise led to a volume increase that exceeded 10 dBA above the interior noise level threshold of 45 dBA considered acceptable. That 10dBA increase, it must be noted, constitutes a doubling of noise volume since the measurement scale is logarithmic. There is no determination of the extent to which construction will generate a 10, 20, or 30% increase in the daytime noise volume experienced by neighborhood residents during the nine years of active construction. Without those data, the DEIS cannot in any way determine the negative effects on the neighborhood property values, not to mention the quality of life of the current residents.

Alternatives

This DEIS chapter purports to discuss alternatives to the massive construction project proposed. It fails to do so in any constructive manner.

It compares the No Action Alternative, a "No Significant Adverse Impact Alternative" and the Proposed Project. These are far from the only alternatives available for a project to improve and upgrade the current historic Lennox Hill Hospital. The first two alternatives are effectively straw men, inserted as required by law but not offered as real options to the neighborhood, Community Board 8, or the City of New York.

There is no constituency for taking no action at all. The neighborhood would welcome an upgrading of facilities at the hospital that did not change the architectural character of the neighborhood and the balance between the diverse uses that it now encompasses.

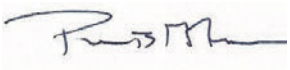
The option of a project with no significant adverse impacts that the DEIS reviews looks for a project with no shadowing of a garden and no temporary construction noise. That option is rejected because,

> "… there is no alternative that would avoid a significant adverse temporary construction noise impact and produce a project that would satisfy the goals and objectives of the Proposed Project."

The question is whether the goals of the proposed project, which are those of Northwell Health, a nonprofit corporate entity with over 900 locations, are consistent with the goals of the neighborhood in which Lenox Hill Hospital is located. If they are not, then the realistic alternatives to the proposed project are alternative developments that provide needed upgrades to the quality of healthcare at the hospital while simultaneously "advancing public policy goals such as One NYC's goal for growth in emerging fields, promoting access to health care, and modernizing key infrastructure."

Such alternatives have not been considered by Northwell Health and are thus not included in this DEIS. They should be if there is to be an objective, consistent, and complete Environmental Impact Statement that serves the residents and taxpayers of the neighborhood, community and city.

Respectfully submitted,



Peter B. Meyer, PhD
President and Chief Economist

[redacted]

Outlook

[EXTERNAL] ATT: Stephanie Shellooe-Lenox Hill Hospital Expansion

From Corinne Pulitzer [redacted]
Date Mon 3/24/2025 1:05 AM
To 23DCP079M_DL <23DCP079M_DL@planning.nyc.gov>

[Some people who received this message don't often get email from cp10021@aol.com. Learn why this is important at https://aka.ms/LearnAboutSenderIdentification] CAUTION! EXTERNAL SENDER. Never click on links or open attachments if sender is unknown, and never provide user ID or password. If suspicious, report this email by hitting the Phish Alert Button. If the button is unavailable or you are on a mobile device, forward as an attachment to phish@oti.nyc.gov. Dear Director Shellooe; I am writing to you in an effort to discourage your support for Northwell's proposal to expand Lenox Hill Hospital for many reasons starting with the disruption to the neighborhood over an estimated nine year period which doesn't justify the hospital's stated goal to modernize its facilities & only add an additional 75 single rooms for patients to a total of 475 from 450. The current facility could most certainly be updated if many of the services provided are temporarily relocated to the new facilities on Third Avenue or to other Northwell facilities as needed. Further, the plan presented at the Community Board Meeting on 3/12, includes an extremely tall tower on the narrowest avenue, in addition to extreme heights mid-block on residential streets affecting light & air! The floor plate is so extreme, it's larger than the Empire State Building! This zoning increase is unjustified for a residential neighborhood where many of the existing structures are landmarked or are in the landmark district. This neighborhood has co-existed with Lenox Hill Hospital before and after its coming under the Northwell umbrella and while many of the hospital's services can be disrupted, the neighborhood has been supportive. The current proposal makes support no longer possible. The Community opposition unanimously outweighs the voices of employees, vendors and paid advocates! The plans to expand the hospital at the expense of our neighborhood, would not only have a negative impact on our ny, it would, if approved, set precedents for other neighborhoods like ours impacting property values for private owners and landlords. For these reasons and many more, I urge you to VOTE NO! Sincerely yours, Corinne Pulitzer Cooperative Owner 815 Park Avenue New York, NY 10021 Please excuse all typos Sent from my iPhone

AMIE RAPPOPORT MCKENNA
[redacted]

May 14, 2025

Department of City Planning
Chairperson Office
Received
MAY 19 2025

Mr. Dan Garodnick
Chair, NYC Planning Commission
120 Broadway, 31st Floor
New York, NY 10271

Re: Lenox Hill Hospital ULURP Application

Dear Chair Garodnick:

I am writing to express my strong opposition to Northwell Health's proposed expansion of Lenox Hill Hospital. I urge you to reject this application unless all modifications recommended by Community Board 8 are incorporated. I am and have been a resident in the community, living within 6 blocks of Lenox Hill my whole life and my children were born in the hospital. No one disagrees that Lenox Hill deserves an upgrade, but the community should not be burdened like this.

CONSTRUCTION TIMELINE AND LEADERSHIP CONCERNS

The actual construction will take a minimum of 12 years as they propose to stay open during construction, unfairly burdening residents, businesses, and traffic – longer if there are financial issues, material delays, or change orders – all for larger private rooms. The burden to the community is not justifiable for this long, for a hospital that is not needed.

With Northwell's CEO Michael Dowling announcing his retirement this fall, there is additional uncertainty about leadership continuity for this massive, decade-long project. This transition raises serious questions about the project's oversight and vision going forward.

EXCESSIVE SCALE AND ZONING CONCERNS

The proposed expansion is excessive and unjustified:

- The project requests an unprecedented FAR of 12.5 for a hospital campus in Manhattan
- It seeks 9 zoning actions with variances of 250-500% above current limits

AMIE RAPPOPORT MCKENNA
[redacted]

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- It seeks 9 zoning actions with variances of 250-500% above current limits

- The proposed tower would reach a staggering 436 feet (equivalent to a 44-story building) in a residential neighborhood where zoning limits height to 170 feet
- The expansion would inflict more than a decade-long construction burden on a densely populated residential area
- The environmental and health impacts of construction dust, noise, and disruption would pose serious threats to neighborhood residents, especially children and seniors forced to live in a construction zone for a decade

HEALTHCARE NEEDS AND FINANCIAL IMPLICATIONS

This project fails to address real healthcare needs:

- The Upper East Side already has the lowest patient-to-bed ratios in NYC
- Lenox Hill currently reports 40% bed vacancy rates
- The project adds only 25 beds while drastically increasing the hospital's footprint
- The $2+ billion price tag estimated three years ago has grown significantly due to inflation and tariffs, with approximately $100 million per year needed just to cover debt service and increased operating expenses
- This will inevitably lead to higher healthcare costs for patients
- Other parts of Manhattan and the outer boroughs are "hospital deserts" desperately needing new facilities, making this project a misallocation of healthcare resources

STRONG COMMUNITY OPPOSITION

The community has spoken clearly against this proposal:

- In April 2025, Manhattan Community Board 8 overwhelmingly voted NO against the ULURP application
- Thousands of residents have signed petitions opposing the project
- 720 out of 878 public testimonies to CB8 expressed opposition
- Multiple community groups, nonprofits, and residential buildings have organized against it
- Until early April 2025, Northwell made little effort to meet with the community and address our opposition
- The proposal will permanently alter the character of a thriving residential neighborhood
- State Senator Liz Krueger has submitted a detailed letter opposing this project, highlighting both neighborhood and citywide concerns

CONCLUSION

While I, along with many, support necessary modernization of Lenox Hill Hospital, this application represents a misguided attempt to expand dramatically beyond what the community needs or can reasonably accommodate. The community should not pay the price for a private hospital's profit and likely interest in becoming a fly-in health center for the global wealthy. More moderate upgrades within current zoning limits would allow the hospital to meet modern healthcare standards without devastating the neighborhood's residents and businesses.

I urge you to prioritize community needs and health equity by rejecting this application in its current form.

Sincerely,



Amie Rappoport McKenna

[redacted]

LIZ KRUEGER
SENATOR, 28TH DISTRICT

ALBANY OFFICE
STATE CAPITOL BUILDING
ROOM 416
ALBANY, NEW YORK 12247
(518) 455-2297
FAX (518) 426-6874

DISTRICT OFFICE
211 EAST 43RD STREET, STE. 2000
NEW YORK, NEW YORK 10017
(212) 490-9535
FAX (212) 499-2558

E-MAIL
LKRUEGER@NYSENATE.GOV

NEW YORK
STATE
SENATE
ALBANY, NEW YORK 12247

CHAIR, MAJORITY MEMBER
FINANCE

COMMITTEES:
RULES
BUDGET & REVENUE

May 14, 2025

Hon. Mark Levine
Manhattan Borough President
One Centre Street
New York, NY 10007

Re: Lenox Hill Hospital (ULURP Nos. N250152ZRM, C250153ZSM, N250155ZCM, N250154ZAM, and C250151ZMM)

Dear Borough President Levine:

Thank you for the opportunity to comment on the private application by Lenox Hill Hospital/Northwell Health to rezone its site to upgrade the hospital facilities and add patient rooms. I represent the 28th State Senate District, which includes the Upper East Side, East Midtown, and Lenox Hill neighborhoods of Manhattan, the latter of which is the subject of the proposed zoning changes.

I join Community Board 8, Committee to Protect Our Lenox Hill Neighborhood, Inc., Friends of the Upper East Side Historic Districts, the New York Landmarks Conservancy, Carnegie Hill Neighbors, CIVITAS, and thousands of community members in strongly urging you to reject Lenox Hill Hospital's application unless all of the modifications recommended by Community Board 8 are made. Due to the extensive scope of the proposed hospital expansion project under Envelope 1 or Envelope 2, there are significant impacts to the community and to city hospital infrastructure that must be considered when evaluating the rezoning application before you.

I am proud to have included in my district the incredibly talented and dedicated members of Community Board 8, in whose boundaries this rezoning is being proposed. The board has worked diligently to analyze and assess this rezoning proposal, including Envelopes 1 and 2, since it was first proposed in 2019, which has included holding public meetings and considering testimony from hundreds of community members and stakeholder groups. With a unique understanding of the character of the neighborhood, as well as of the district that is home to multiple hospital facilities, the determination of the board to disapprove the zoning application as presented should carry significant weight moving forward in the Uniform Land Use Review Procedure (ULURP) process.

The zoning application would authorize a protracted hospital expansion project that proposes to modernize and enlarge Lenox Hill Hospital far beyond what is permitted under current zoning. My opposition to this zoning application does not reflect the integral role that Lenox Hill Hospital has served for decades, providing critical hospital care to New Yorkers and working tirelessly during the

Coronavirus pandemic. The hospital has provided care in its current location since approximately 1905 and under the name of Lenox Hill Hospital since 1918. I appreciate the need for renovation in order to meet current standards of healthcare delivery, as well as Northwell Health's efforts to modify the proposed project in response to the concerns of community members. Adoption of this expansive proposal, however, is not justified and could have detrimental implications. Below, I highlight some of my primary concerns about the proposed hospital expansion project.

Scope of the Hospital Expansion Project

The Lenox Hill Hospital expansion project is extensive, in that it aims to upgrade the hospital's emergency department, surgical suites, clinical spaces, and patient rooms, as well as make additional renovations to the ambulance bay and maternity unit. Envelopes 1 and 2 would both involve prolonged periods of construction during and outside of business hours, as well as adding an uncharacteristically and excessively high tower, as per community zoning standards, to the current hospital facility. As Community Board 8 concluded in its resolution, the applicant's proposed FAR of 12.5 is unprecedented for a hospital campus in Manhattan.

The plan to upgrade patient rooms warrants particularly close scrutiny, as the size of the upgraded patient rooms significantly impacts the scope of the expansion project. The full complement of single- and double-bedded patient rooms would be modified, resulting in 475 larger sized single-patient rooms, all of which could be converted to critical care units. Although Lenox Hill Hospital would only gain 25 additional hospital beds, authorization to upzone has been requested to accommodate the additional space needed for these larger single-patient rooms.

The most recently available *Facility Guidelines Institute's (FGI) Guidelines for Design and Construction of Health Care Facilities* provides recommended dimensions for two types of single-bedded rooms: single-patient rooms and patient/family-centered care rooms. While both types of patient rooms are single-bedded, patient/family centered care rooms are notably larger. Recommended dimensions are also provided for intermediate care units (ICUs) and critical care units, the latter of which are larger in size. Based on my understanding from review of the guidelines and consultation with public health experts, the upgraded patient room size under the Lenox Hill Hospital expansion plan would be close to the maximum recommended size for single-bedded and critical care units.

Based on the high volume of hospital beds and low patient-to-bed ratio on the Upper East Side, the plan to upgrade all patient rooms to meet recommendations for patient/family-centered care rooms and critical care units is ambitious but may also be viewed as extravagant and unwarranted. Lenox Hill Hospital should reconsider this aspect of the proposed expansion project and opt for a more moderate patient room configuration.

How Would the Hospital Expansion Project Improve Health Equity?

The purpose of the ULURP process is to provide a standardized and transparent review process for important land use decisions. In the case of this application, at a time when health equity is an issue of significant concern, and because Northwell Health seeks rezoning authorization to undertake an extensive hospital expansion project that would be detrimental to the Lenox Hill community, as well as impact city hospital infrastructure, it is imperative to consider whether the requested land use would improve health equity in New York City.

New York City is home to world-renowned, highly-reputable hospitals that excel in providing emergency, surgical, OB-GYN, and specialized health care services; yet, there are residents of New York City who have inequitable access to hospital care due to where they live or their health insurance. Health inequities are further exacerbated by the current state of our citywide hospital

infrastructure; namely, that as a result of hospital consolidation, closures, and bed de-certifications, there is a citywide shortage of hospital beds. Although we are fortunate to have quality hospitals, there are gross disparities in where hospitals are situated throughout the five boroughs, which is due in part to hospital closures. A prime example of this exists in my district, where there is a conglomeration of community and specialty hospitals located on the Upper East Side, while there are individuals and families living throughout the city who must travel long distances to receive the hospital care they need.

We need more hospital beds in New York City, but not on the Upper East Side, which has the lowest patient-to-bed ratios in the city. There are shortages of hospital care in Brooklyn, Queens, and the Bronx, and the recent closure of Mount Sinai Beth Israel left residents of the Lower East Side of Manhattan and parts of Brooklyn without a full service hospital in their communities.
Under these circumstances, the scope and duration of this rezoning application cannot be justified. The hospital expansion project will not address a critical unmet public health need on the Upper East Side or make needed hospital services more accessible. Ultimately, upgraded patient rooms would increase the costs and decrease accessibility of receiving inpatient services at Lenox Hill Hospital for uninsured and underinsured New Yorkers.

I do support necessary upgrades being made to the hospital's emergency department, surgical suites, and clinical spaces, as well as moderate patient room upgrades that would adequately decrease the construction period and keep Lenox Hill Hospital within the zoning limits recommended by Community Board 8.

Impacts of a Protracted Hospital Expansion Project Timeline

Under Envelope 1 or 2, the Lenox Hill Hospital expansion project would have a minimum duration of at least nine years. Such a prolonged project timeline would be highly disruptive to the community and could have implications for citywide hospital infrastructure.

Community members surrounding Lenox Hill Hospital have voiced strong opposition to the hospital expansion project, as devised under Envelopes 1 and 2, based on concerns about the impacts of such a prolonged project timeline on residents and businesses in the community. Some of these include: prolonged noise pollution, including outside of usual permit work hours, caused by project construction, air pollution due to dust and debris from construction, traffic congestion, loss of natural light, and loss of revenue for local businesses.

We learned many lessons from the COVID-19 pandemic, including the crucial role of hospitals in treating large volumes of patients, and the importance of their ability to quickly implement hospital surge protocols. Even the Hospital for Special Surgery treated Coronavirus patients, and the former Mount Sinai Beth Israel Hospital, which had been providing inpatient care to a lower daily patient census, opened up beds out of necessity. Furthermore, it became necessary to direct all hospitals in the State to increase their bed capacity by 25%. Should another pandemic or epidemic strike, such as influenza A subtype H5N1 or measles, a protracted project timeline could compromise NYC hospital infrastructure, decreasing citywide hospital capacity to treat a large scale of infected patients, in addition to patients with other health issues. Even though Lenox Hill Hospital would remain open, prolonged work on patient rooms and surgical suites would reduce hospital capacity for a concerning period of time.

We must also consider the current status of hospital capacity in New York City when evaluating the appropriateness of the rezoning application and project timeline at hand. Since the COVID-19 public health emergency expired, there have been reports of long waiting periods to be seen at many/most hospital Emergency Departments and to be admitted, as well as high inpatient occupancy rates. Even

though Lenox Hill Hospital's inpatient occupancy rates have been trending lower than rates of other Manhattan hospitals, when one hospital's bed capacity decreases, this causes the inpatient occupancy rates of other hospitals to increase, especially for those hospitals that are in closer vicinity. Most recently, Bellevue and NYU Langone have experienced increases in Emergency Department visits as a result of Mount Sinai Beth Israel closing.

Implications for Health Care Costs

Healthcare affordability is an issue of increasing concern as commercial and Medicare health insurance premiums, as well as out-of-pocket health care costs continue to rise. The primary cause of this trend are increases in hospital costs.

Northwell Health representatives have asserted that health care costs will not increase as a result of the conversion to a full complement of larger sized single-patient rooms: currently, single-bedded patient rooms are not billed differently than double-bedded rooms unless a patient requests a single-bedded room without there being medical necessity.

While this billing policy could remain in effect throughout the duration of the proposed expansion project, there most certainly would be implications for health care costs upon its completion if not sooner. A full complement of larger sized single-patient rooms would provide added leverage to negotiate higher inpatient reimbursement rates with insurance providers and to raise the cost of inpatient care for patients who are paying out of pocket.

When speaking about rising health care costs, people in the industry frequently say that patients will not be impacted. I must respectfully disagree. As hospital and other health care costs increase, so do health insurance premiums. My office receives calls every year from constituents who are deeply concerned about the premium rate increases they face and whether they will be able to maintain their health insurance coverage. These concerns are further exacerbated by the massive federal funding cuts that are looming. The implications for health care costs is yet another reason that I am opposed to such an extensive rezoning and expansion project. The current application should be rejected, with the recommendation that Northwell Health modify the project to conduct more moderate upgrades to Lenox Hill Hospital.

The application before you today addresses the need for renovations at Lenox Hill Hospital in order to meet current standards of healthcare delivery. However, the proposed expansion project is unjustifiably extensive, would negatively impact city hospital infrastructure, and would unnecessarily disrupt the neighborhood for a decade. Although Lenox Hill Hospital representatives have made some project modifications in response to community concerns, the modifications do not adequately address concerns related to the project duration and community impact, including protracted disruption to the community and the addition of a high tower that is inappropriate given the zoning in the surrounding community. I strongly urge you to reject Lenox Hill Hospital's application unless all of the modifications recommended by Community Board 8 are made.

Thank you for your time and consideration of my comments.

Sincerely,

Liz Krueger

Liz Krueger
State Senator

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May 14, 2025 10:07 AM | 29 MINUTES AGO

Northwell CEO Michael Dowling to step down this fall

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MH Illustration/Northwell Health

Michael Dowling has served as Northwell's president and CEO for 23 years.

After more than two decades at the helm, Northwell President and CEO Michael Dowling is planning to retire this fall.

Dowling will transition to CEO emeritus starting Oct. 1 and will continue to advise the health system while focusing on teaching and writing, Northwell said Wednesday. He will be succeeded by Dr. John D'Angelo, executive vice president of Northwell's central region and a 25-year veteran of the organization.

RELATED



Northwell completes merger with Nuvance Health



Northwell spends big on lobbyists as it seeks Upper East Side expansion



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The change of command comes as Northwell Health has solidified itself as the region's largest hospital system. The New Hyde Park-based organization completed a merger with Nuvance Health last week, expanding its footprint to 28 inpatient hospitals, 1,050 ambulatory clinics and 73 urgent care centers in New York and Connecticut. Northwell has gradually grown its reach in and outside of the city, serving more than 2 million patients each year.

Dowling oversaw the bulk of that growth. After a 12-year stint as a top health adviser to former Gov. Mario Cuomo, Dowling began his tenure at Northwell in 1995, serving as the chief operating officer of North Shore University Hospital in Manhasset, which was then a standalone hospital. Dowling became CEO in late 2001, shortly after North Shore University Hospital merged with Long Island Jewish Medical Center to become what's now known as Northwell Health. The system has expanded from a few hospitals on Long Island to 28 hospitals across two states, and now employs 104,000 workers in the region.

During his 23 years on the job, Dowling has invested in biomedical research to expand the Feinstein Institutes of Medical Research as well as Northwell's Zucker School of Medicine and Hofstra School of

Nursing. He has also invested in efforts to combat gun violence, mobilizing hospital CEOs nationwide to help elevate firearm safety into a public health issue.

Dowling said in a statement that he's had the "extraordinary privilege to lead Northwell through a period of unprecedented growth and clinical transformation," enabling the team to improve the lives of tens of millions of patients.

"I look forward to partnering with Dr. D'Angelo in the coming months to help ensure a seamless transition to what will be an exciting new chapter in the 33-year history of Northwell," Dowling said in the statement.

D'Angelo, an emergency physician by training, was named Northwell's incoming CEO after a nationwide search and unanimous vote by the board of trustees, the health system said. He will take over the health system after spending more than three years overseeing six hospitals in western Nassau County and Queens.

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At a Glance: May 14

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From: [redacted]
To: [redacted]
Subject: Comments re: C 250151 ZMM - Lenox Hill Hospital
Date: Thursday, May 15, 2025 1:53:23 PM

Re. Project: **C 250151 ZMM - Lenox Hill Hospital**

Submitted by:

Name: **Brandon Rose**
Zip: [redacted]

I represent: **Myself**

Details for "I Represent": **I live at 106 East 78th Street, 1 block from proposed project**

My Comments:

Vote: I am **opposed**

Have you previously submitted comments on this project? **No**
If yes, are you now submitting new information?

I have attended or will attend the City Planning Commission's Public hearing on this project: **No**

Additional Comments:
Dear NYC Department of City Planning, I live on East 78th Street and I am very strongly opposed to the development plan currently proposed by Northwell Health for Lenox Hill Hospital between 76th and 77th Streets. The proposed building dramatically exceeds current zoning standards, and would irreversibly DESTROYthe character and nature of residential neighborhood if the building was to be built. The enormous condominium and hospital tower do NOT comply with current zoning and if allowed will permanently destroy the primarily residential character of the neighborhood, while further congesting and overwhelming the resources available in the community. The area wold no-longer be a quiet residential neighborhood and instead would grow to resemble a bustling, high-density, mid-town business district. Increasing the size of the hospital will not benefit residents, but will attract patients and visitors from outside the neighborhood, and outside the city. The increase in visitor activity will result in significantly increased congestion, related traffic, noise, and trash, all of which would negatively impact the environment. This primarily residential neighborhood cannot sufficiently sustain the increased congestion, and increased activity which would result from this gross over-development. The existing zoning laws were developed and implemented to prevent these exact problems by discouraging too much density and congestion, and should not now be ignored or re-written to promote excessive density and congestion in our neighborhood. While the entire City is actively taking steps to reduce congestion, increase

open space and improve quality of life, Northwell Health is asking this neighborhood to increase density and congestion for the hospital's benefit, while ignoring the impacts to and rights of it’s neighbors. This plan ignores all of the stated goals of the NY City Council in the the "Speaker’s Planning and Land Use Guidelines”, which states the City is seeking to “elevate the role of planning in the land use process”, and wants to "ensure equitable economic development, increased affordable housing, while improving open space and streets, and ensure equitable access to health care in all neighborhoods". By enlarging the existing hospital in an already privileged neighborhood, that is already over-saturated with medical services, and experiencing robust economic activity, other disadvantaged neighborhoods are loosing out. This proposal fails to further these stated objectives of the CIty Council, neglecting other disadvantage neighborhoods in need, and will simultaneously result in permanent damage to the existing historic residential neighborhood. In this regard, I do not know who this project will benefit other than Northwell Health. Please reject Northwells’ request for re-zoning, and in doing so further the City Council’s stated objective to “ensure equitable access to healthcare in all neighborhoods” while helping to prevent further congestion in the city. Norhtwell already added 200,000 square ft of medical space at 77th and 3rd avenue, the area is already too densely populated and doe snot need more medical facilities and more congestion. STOP THE EXPANSION! Sincerely, Brandon Rose [redacted]

From: [redacted]
To: [redacted]
Subject: Comments re: C 250151 ZMM - Lenox Hill Hospital
Date: Tuesday, May 20, 2025 2:05:02 PM

Re. Project: **C 250151 ZMM - Lenox Hill Hospital**

Submitted by:

Name: **Edward Samek**
Zip: [redacted]

I represent: **Myself**

Details for "I Represent": **I am a knowledgeable individual.**

My Comments:

Vote: I am **opposed**

Have you previously submitted comments on this project? **No**
If yes, are you now submitting new information?

I have attended or will attend the City Planning Commission's Public hearing on this project: **No**

Additional Comments:
As a scheduling conflict means I cannot attend the City Planning Commission's Public Hearing. I am submitting the following comments, concerns, and fears regarding the proposed expansion of NORTHWELL aka LENOX HILL HOSPITAL. There are two highly significant reasons for objection and rejection: 1-huge public health risk! 2- a textbook example of backroom deals and influence peddling, ***** SUBJECT: STRONGLY RECOMMEND AGAINST PROPOSED EXPANSION OF NORTHWELL aka LENOX HILL HOSPITAL 1- The proposed expansion of Northwell Health (Lenox Hill Hospital) Poses Serious Health Risks in NYC Residential Area ??PATHOGEN ALERT- -PUBLIC HEALTH WARNING?? Northwell Health's proposed expansion of Lenox Hill Hospital—located in the heart of a densely populated Manhattan neighborhood—could easily trigger a serious public health crisis in New York City (population: 8,804,190 as of 2020). This expansion will inevitably involve the testing, treatment and research of pathogens in close proximity to residential buildings, schools, NYC MTA Subway & Bus Stops and businesses—in one of the most densely populated and globally connected cities in the world. The potential consequences include local outbreaks or, in the worst-case scenario, a global pandemic. These risks are real, not hypothetical, no matter what Northwell executives or their hired consultants claim. Let's remember: "Humans think they can predict the future—but they cannot." "Sometimes people lie—and some do it well." 2-If approved, this project would resemble a textbook example of

backroom deals and influence peddling, prioritizing profit over public safety. The approval process would effectively disregard both public opinion and the democratic voice of the local community. Ignoring the Will of the People: Two recent examples highlight the public's rejection of this proposal: Widespread opposition documented through signed petitions and surveys conducted among Lenox Hill residents and other local stakeholders. A decisive "NO" vote by Community Board 8 Manhattan on Northwell Health's ULURP application. CB8's resolution, communicated in an official letter dated April 10, 2025, was addressed to Daniel R. Garodnick, Chair of the City Planning Commission. The subject: Lenox Hill Hospital (N250152ZRM, C250153ZSM, 250155ZCM, N250154ZAM, and C250151ZMMM). Bottom Line: Building a potential hub for dangerous pathogens in a dense residential district is irresponsible and dangerous. The project must be stopped or fundamentally reconsidered with real transparency, accountability, and community input. Public health should never take a back seat to corporate expansion. There are many other reasons for stopping this project and I will leave those thoughts for others to address.

JORDAN SAUNDERS

Written Testimony Opposing Lenox Hill Hospital Expansion

May 2025

I was a longtime Trustee of Northwell Health and am one of only 11 of its Life Trustees, and I strongly oppose Northwell's plans for expanding Lenox Hill Hospital.

For more than 50 years I lived in the neighborhood and currently own property at 130 East 75th St and 812 Park Avenue. Lenox Hill was our community hospital and has been important in my family's history. My long-standing leadership of and devotion to this hospital must first be noted to fully appreciate that I do not make these comments lightly.

Lenox Hill's proposed expansion plans are fiscally irresponsible, will cause permanent harm to this iconic neighborhood, are violative of zoning laws, and will have a detrimental impact on the environment. In short—these plans must be halted.

Borrowing more than a billion dollars and investing more than $1.5 billion on the Upper East Side of Manhattan is reckless overreach which raises serious questions about the ability of Northwell to service its debt and will be an onerous burden on patients, insurers, and the City. The staggering cost will make it impossible to deliver adequate return on investment. It is a poor and imprudent value proposition.

The Hospital proposes doubling in size to create the type of footprint that Level 1 Trauma Centers and academic health centers have, but Lenox Hill Hospital is neither. It seeks to add operating rooms despite empirical evidence that fewer operating rooms are required and has wildly underestimated the cost per square foot of its nearly 640,000 new square feet!

Compounding the bad investment decision is the chaos this project would leave in its wake.

Northwell is singularly focused on building big and offers no environmental mitigation measures to the inevitable damage it will do. No green roof to ameliorate the gasses the building will generate. Then there are the more common, and equally legitimate concerns of neighborhood residents—blocked sunlight, impeded viewsheds and material diminishment of residents' use and enjoyment of their properties. Many years of construction-related detours, and traffic jams. Construction will bring attendant noise pollution day and night, and air polluting particles will make even breathing difficult. A huge influx of people and garbage mean more garbage trucks, more sirens and permanent traffic issues— round the clock neighborhood disturbance.

Worst by far is the irreparable harm that the proposed expansion will do to the character of this iconic neighborhood. It will change the core of this historic residential New York Community into little more than a behemoth sterile medical complex with some adjacent housing.

Northwell's initial modernization and renewal plan, which may have been appropriate, is gone, replaced by expansion plans that cut against the best interests of both Northwell and the Lenox Hill neighborhood. They are plans that must be stopped.

Sincerely,

Jordan Saunders

M. Barry Schneider
[redacted]

Wednesday May 21, 2025

Hon. Dan Garodnick

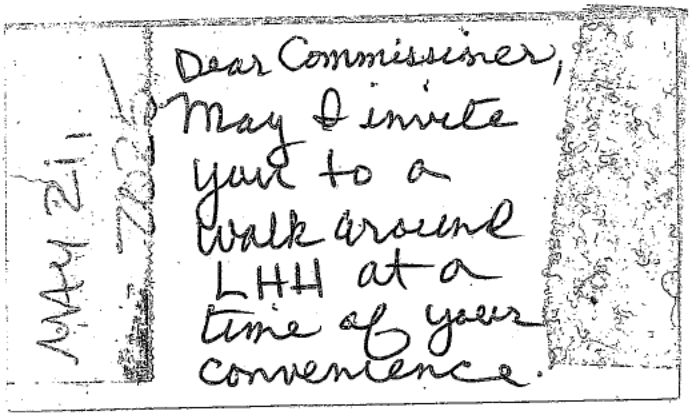
Director, New York NYC Planning Commission

I strongly support the Lenox Hill Hospital application that is before you today.
Having been a member of Manhattan Community Board 8 since the Hospital first planned its expansion in 2019 and, more recently, as an interested former Board Chairman, I have a broad knowledge of the institution's needs and the plan to achieve its goal.

Institutions like Lenox Hill that have faithfully served communities across Manhattan and New York City for generations, modernization represents not expansion but continuation—a commitment to remain steadfast in their historic mission while adapting to contemporary healthcare challenges
I hope you will find Lenox Hill Hospital up to the challenge of the next 60 years.

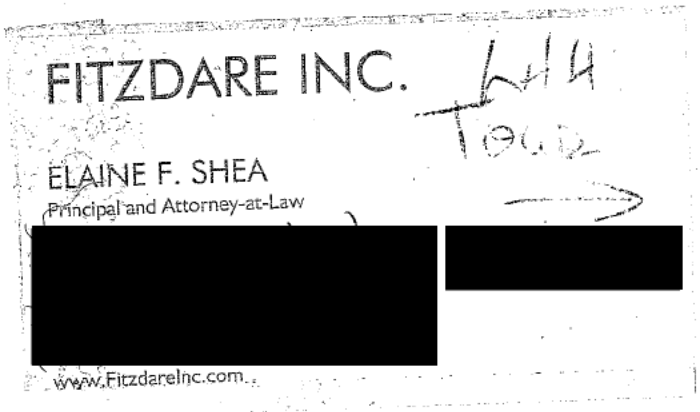
All the best,

M. Barry Schneider



May 21

Dear Commissioner,
May I invite you to a walk around LHH at a time of your convenience.



FITZDARE INC.

LHH
1962

ELAINE F. SHEA
Principal and Attorney-at-Law

[redacted]

[redacted]

www.FitzdareInc.com

From: [redacted]
To: [redacted]
Subject: Comments re: C 250151 ZMM - Lenox Hill Hospital
Date: Sunday, May 18, 2025 2:57:31 PM

Re. Project: **C 250151 ZMM - Lenox Hill Hospital**

Submitted by:

Name: **Sarah Stackpole**
Zip: [redacted]

I represent: **Myself**

Details for "I Represent": **I am a physician trained at Lenox Hill Hospital**

My Comments:

Vote: I am **opposed**

Have you previously submitted comments on this project? **Yes**
If yes, are you now submitting new information? **Yes**

I have attended or will attend the City Planning Commission's Public hearing on this project:

Additional Comments:
As a person who lives in the neighborhood of Lenox Hill Hospital, as well as a physician who trained there, I am appalled at the projected disruption of the neighborhood by unnecessary construction. In particular, I am dismayed at the projection of damage to the subway stop at 77th St, which will doubtless cause disruption of service as well. The 6 train is very important to people who live in this neighborhood, and many take the 6 to work further downtown, and some to further uptown (which I did for some time in the 1990s while working part time in Harlem). I respectfully urge the Planning Commission to deny the request for this projected construction. Signed: Sarah Stackpole MD

To: The New York City Planning Commission May 21, 2025

From: Thomas R. Trowbridge, III

I speak in opposition to Northwell's proposed expansion of Lenox Hill Hospital.

This Commission's purpose is to "guide the City's growth and development, ensuring its long term sustainability, economic vibrancy and inclusivity." If approved, Northwell's plan would be destructive of that purpose.

Current zoning in the neighborhood limits building heights to 170 feet. Northwell's proposal is for a building 436 feet high – the equivalent of a 44 story building. In this residential neighborhood of brownstones and apartment buildings that generally don't exceed 15 stories, such a structure would dominate the area, casting shadows that would deny light to broad swaths of the area.

The height of this proposed eyesore aside, there is the issue of density. Currently, Lenox Hill Hospital exceeds the zoning limits of 7.5 FAR. Nothwell's proposal would propel this to about 12.5 FAR, which would overwhelm the neighborhood.

I would, though, like to focus on the Commission's purposes of sustainability and economic vibrance. The Hospital's main building, the one that's the subject of this proposal, is bounded on the east by Lexington Avenue, between 76th and 77th streets. That section of Lexington is a warren of small businesses – a couple of eyeglass stores, a hardware store, a pizza parlor, bagel shop, etc. With a bus lane on the west and parking on the east side of the avenue, this area is always congested, and traffic inches through it. The construction apparatus and vehicles for the project would presumably use Lexington Avenue, which can barely handle the current traffic load. A multi (ten?) year construction project would be a nightmare there. The congestion and disruption both during the project and after its completion would be exacerbated by the planned relocation of the hospital's main entrance from 77th Street to Lexington Avenue. Many businesses would doubtless be unable to survive in the chaos of this environment. (Would the Lexington Avenue bus be able to fight its way through the mess or would it be rerouted?) *

It, moreover, goes without saying that the value of real estate in the area, coops, rental units and businesses would take a dramatic hit. And so, as noted, Nothwell's proposal would be counter to the Commission's purpose of ensuring sustainability and economic vibrancy.

In a separate point, I note that Northwell's Mission Statement begins: "To improve the health and quality of life for the people and communities we serve by providing world class service and patient-centric care." I understand that Northwell's proposal would add a modest number of beds to a facility which has a 40% bed vacancy rate, in an area that is already overserved by hospitals. And so, health care-wise, the area is covered. By contrast, the "quality of life" in the community it serves, which Northwell professes to be concerned about, would be negatively impacted, and severely so, by their proposal.

* Bell mgt R.

Department of Health

Hospital Bed Capacity Dashboard

Hospital Survey Data as of: 5/19/2025
Hospital Survey Data last updated on: 5/20/2025
Dashboard Updated on: 5/20/2025

Region	County	Hospital
(All)	(All)	(All)

Region	Total Hospital Beds (Prior Day)	Hospital Beds Available (Prior Day)	% Available Beds (Prior Day)	% Available Beds (7-day Avg)	Total ICU Beds (Prior Day)	ICU Beds Available (Prior Day)	% Available ICU Beds (Prior Day)	% Available ICU Beds (7-day Avg)
Statewide	36,777	6,893	19%	18%	4,289	1,103	26%	23%
Capital Region	1,950	298	15%	14%	156	42	27%	17%
Central New York	1,335	137	10%	12%	221	30	14%	12%
Finger Lakes	2,433	226	9%	9%	247	25	10%	11%
Long Island	6,050	1,456	24%	23%	794	266	34%	33%
Mid-Hudson	4,002	813	20%	21%	469	122	26%	25%
Mohawk Valley	691	71	10%	10%	80	16	20%	16%
New York City	16,360	3,183	19%	18%	1,897	491	26%	22%
North Country	593	104	18%	24%	39	8	21%	31%
Southern Tier	997	223	22%	24%	83	17	20%	23%
Western New York	2,366	382	16%	16%	303	86	28%	30%

Region	County	Hospital	Total Hospital Beds (Prior Day)	Hospital Beds Available (Prior Day)	% Available Beds (Prior Day)	% Available Beds (7-day Avg)	Total ICU Beds (Prior Day)	ICU Beds Available (Prior Day)	% Available ICU Beds (Prior Day)	% Available ICU Beds (7-day Avg)
		Mount Sinai Brooklyn								
		Woodhull Medical and Mental Health Center								
	New York	Total	6,046	1,248	21%	16%	804	206	26%	20%
		New York-Presbyterian/Lower Manhattan Hospital	164	44	27%	26%	19	5	26%	25%
		Bellevue Hospital Center	531	111	21%	16%	101	27	27%	18%
		Harlem Hospital Center	138	6	4%	2%	23	1	4%	15%
		Hospital for Special Surgery	146	97	66%	30%	4	3	75%	79%
		Lenox Hill Hospital	344	112	33%	24%	48	22	46%	32%
		Memorial Hospital for Cancer and Allied Diseases	514	64	12%	9%	20	1	5%	8%
		Metropolitan Hospital Center	266	68	26%	19%	17	9	53%	41%
		Mount Sinai Hospital	860	171	20%	17%	125	30	24%	14%
		New York-Presbyterian Hospital - New York Weill Cornell Center	793	174	22%	19%	112	27	24%	20%
		NYU Langone Hospitals	797	147	18%	14%	136	36	26%	18%
		New York-Presbyterian Hospital - Columbia Presbyterian Center	774	94	12%	11%	115	14	12%	10%
		Mount Sinai West	261	55	21%	19%	33	18	55%	42%
		Mount Sinai Morningside	304	86	28%	25%	42	13	31%	36%
		New York-Presbyterian Hospital - Allen Hospital	154	19	12%	11%	9	0	0%	10%
	Queens	Total								

From: [redacted]
To: [redacted]
Subject: Comments re: C 250151 ZMM - Lenox Hill Hospital
Date: Monday, May 19, 2025 7:39:23 AM

Re. Project: **C 250151 ZMM - Lenox Hill Hospital**

Submitted by:

Name: **Bryan Verona**
Zip: [redacted]

I represent: **Myself**

Details for "I Represent":

My Comments:

Vote: I am **opposed**

Have you previously submitted comments on this project? **No**
If yes, are you now submitting new information?

I have attended or will attend the City Planning Commission's Public hearing on this project: **Yes**

Additional Comments:
As a resident of the Upper East Side and president of the 78th Street Block between Park & Lexington Association, I strongly oppose Lenox Hill Hospital's application for a zoning variance to facilitate their proposed redevelopment. This project threatens the quality of life in our primarily residential neighborhood, which is already strained by existing infrastructure and recent disruptions. Our community recently endured significant disturbance from a construction project just 1/20th the size of the hospital's proposed redevelopment. That smaller project caused prolonged noise, traffic congestion, and disruptions to daily life, leaving residents wary of another, far larger undertaking. The hospital's plan would impose years of construction-related chaos—dust, noise, and heavy machinery—in a neighborhood ill-equipped to absorb such impacts. Lexington Avenue, a critical artery, is already stretched to capacity with traffic, garbage accumulation, and noise. Adding construction vehicles and activity would exacerbate these issues, further degrading the pedestrian experience and straining local infrastructure. The proposed utility building, to be situated adjacent to a school, a church, and residential buildings, is particularly concerning. Schools and places of worship are sanctuaries for learning and reflection, and residents deserve peaceful homes. A utility structure, with its potential for noise, vibrations, and visual blight, is incompatible with these sensitive uses. The hospital's disregard for the neighborhood's character and needs is evident in this poorly conceived plan. Lenox Hill Hospital claims the redevelopment is necessary, but

the Upper East Side already has a high density of hospital beds. The community's healthcare needs are adequately met, and this expansion appears driven by institutional ambition rather than public necessity. No residents are clamoring for this project; it serves the hospital's interests, not ours. Instead of pursuing an invasive expansion, the hospital should focus on renovating and optimizing its existing facilities. Modernization within the current footprint would minimize disruption and demonstrate respect for the neighborhood that has long supported its presence. Granting this variance would set a dangerous precedent, prioritizing institutional overreach over community well-being. The zoning regulations exist to protect neighborhoods like ours from precisely this kind of incompatible development. Approving the variance would undermine the residential character of the area, erode trust in the planning process, and burden residents with years of avoidable hardship. I urge the Commission to deny Lenox Hill Hospital's zoning variance application. The hospital must pursue alternatives that respect the neighborhood's residential nature, infrastructure limitations, and the well-being of its residents, students, and worshippers. We cannot bear the cost of an expansion that offers no benefit to the community and threatens the livability of our home.

TRANSCRIPT

NEW YORK CITY

DEPARTMENT OF CITY PLANNING

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CALENDAR NOS:

12 C 250151 ZMM 8 Lenox Hill Hospital

13 N 250152 ZRM 8

14 C 250153 ZSM 8

----------X

MAY 21, 2025

CPC Hearing Room

120 Broadway, Lower Concourse

New York, NY

10:00 A.M.

B E F O R E:

DAN GARODNICK,

THE CHAIR

APPEARANCES COMMISSIONERS:

Daniel R. Garodnick, Esq., Chair
Kenneth J. Knuckles, Esq., Vice Chair
Gail Benjamin
Alfred C. Cerullo, III
Anthony Crowell, Esq.
Joseph Douek
David Gold, Esq.
Leah Goodridge, Esq.
Rasmia Kirmani-Frye
Raju Mann
Orlando Marín
Juan Camilo Osorio
Raj Rampershad

APPLICANTS:	ORGANIZATION
Melanie Meyers	Fried Frank
Daniel Baker	Lenox Hill Hospital
Lisa Lau	AKRF
Jonathan Cogswell	
Lucy Benak	
Robert Mele	
Thomas Rosant	
Tonny Mack	

Kenny Mui		
Daniel Abate Marco		
Matthew Carmody		
Ann Locke		
PUBLIC MEMBERS:	ORGANIZATION	
Vanessa Aronson		
Nuha Ansari	Friends of the Upper East Side	
Andrea Goldwyn	New York Landmark Conservancy	
Andrew Soflof		
Alita Camp		
Chad Purkey	Better New York	
Paul Newerski		
Jean Rodd		
Peter Meyer		
Stacy Krush		
Simcha Silverman		
Arlene Asano-Henry		
Nadja Valera		
Ellen Goldstein		
Layla Law-Gisiko	City Club of New York	
Walter Dean		

Barbara Zin Moore	
Elizabeth Crowley	Building Traders Employees Association
Kathleen Flynn	NYPNU
Eric Farbman	Local 3 IBEW
Phyllis Cohen	
Pierre Von Boxdale	
Stephanie Reckler	
Alexander Hodas	
Valerie Mason	
Nora Ryan	
Michael Piccirillo	New York City District Council of Carpenters
Frank Clarke	New York Building Congress
Virginia Maloney	
Evelyn Finster	
Ann Nam	
Thomas Crowbridge	
Margarita Campin	
Eileen Toback	New York Professional Nurses Union
Mary Chan	
Neil Selkirk	
Dune Arbus	

John Oxman
Reya Sinha
Gail Scovell
Alan Harris
William Heckelrath
George Janes
Kathy Fogarty
Richard Hymes
Robert Mele
Ruth Holzer
Vanessa Lily
Elaine Shea
Benjamin Marcus
Hannah Newman
Elizabeth Rose
Karen Mira
Kosovar Januzzi
Sharon Pope Marshall
Sean Grofekowski
Lenore Passavanti
Ann Goodbody
Lo Vanderwock Carnegie Hill Neighbors
Amy Rappaport
Evelyn Finster

Anthony Cohn

Bernard Seltz

Patricia Rossetti

Michael Byowitz

Jill Schlesinger

P R O C E E D I N G S

CHAIRMAN GARODNICK: Okay. We are back in session. Thank you, all, very much for your patience. The next item of the day is -- well, I'm not going to preempt you, Madam Secretary. Why don't you call the item then we'll get right into it.

MADAM SECRETARY: Borough of Manhattan, calendar numbers 12, 13, and 14, Lenox Hill Hospital, CD 8, Calendar number 12, C 250151 ZMM, Calendar number 13, N 250152 ZRM, Calendar number 14, C 250153 ZSM, Public hearing in the matter of applications for Zoning Map and Zoning Tax Amendments and a Special Permit concerning Lenox Hill Hospital.

Notice. A public hearing is being held by the City Planning Commission in conjunction with the above actions to receive comments related to a Draft Environmental Impact Statement. This hearing is being held pursuant to the State Environmental Quality Review Act and the City Environmental Quality Review.

CHAIRMAN GARODNICK: Okay. Now, with that as an intro, and before I call the

applicant team, I know there are a number of folks who are here with us and on Zoom to testify on this item. So welcome.

I would be remiss if I did not give a special shout-out to my former constituents in the 4th Council District who I had the honor of representing for 12 years, the people as well as the hospital, I will note. And we're all glad that you are here with us today.

So with that, I'm going to turn to the applicant team which includes Melanie Meyers, Lucy Benak, Robert Mele, Daniel Baker, Lisa Lau, Jonathan Cogswell, Thomas Rosant, Tonny Mack (phonetic) Kenny Mui, Daniel, Abate Marco (phonetic), Matthew Carmody, and Ann Locke.

Ms. Meyers, welcome. Whenever you are ready. You have 10 minutes.

MS. MEYERS: Great. And this is how I'm supposed to advance? Okay. Thanks. We are not all speaking, just so you know.

CHAIRMAN GARODNICK: Understood.

MS. MEYERS: There we go.

MADAM SECRETARY: And we'll get a presentation on the podium. One second.

MS. MEYERS: Great. Thank you for having us. My name is Melanie Meyers. I'm with Fried Frank, and I'm land use counsel for the applicant. I will be joined today by Dr. Daniel Baker, who's the executive director of Lenox Hill Hospital, and Lisa Lau of AKRF.

The application before you is for a series of land use actions to secure the future of Lenox Hill Hospital. It is an application that has been a long time in the making, and we're very happy to be able to present it to you today.

In this presentation, Dr. Baker will discuss the programmatic needs of the hospital as well as the evolution of the proposal. I will speak to the precedents in forming the land use decisions and requests that we are making. And finally, Lisa will speak to the DEIS findings.

We also have representatives from the team in terms of including architects, building operations, and environmental to answer the commission's questions.

And with that, I will turn it over to, Dr. Baker. There you go.

MR. BAKER: Thank you, Melanie.

Good morning. Thank you for the opportunity to be here to present to you all today. A question that we need to ask ourselves as we consider this project is the value and importance that we place on one of the most impressive and innovative healthcare systems.

New York City has long been home to a bastion of clinical firsts, of academic fortitude, and empowering research. And Lenox Hill Hospital is very proud to have been part of that for the past 160 years.

Yet with that said, the system remains fragile as we have seen with the recent closure of Mount Sinai Beth Israel Hospital. And in order for Lenox Hill Hospital to continue for generations to come, we need to modernize and renew our facilities.

We are very proud at Lenox Hill of our mission statement of putting the patient at the center of everything we do to create world-class service. We're equally proud of our clinical services with multiple, including six ranked in the top 50 nationally, and a consistent ranking as a top 50 US hospital by Healthgrades for the past

four years.

We're equally very proud of the community partnerships that we have created over the course of many years, whether that's Harlem Grown, God's Love We Deliver, Carter Burden, or through the services that we offer with vaccinations, cancer and blood pressure screenings or pulmonary function testing, as well as our HouseCalls Program.

I want to talk a little bit about the importance of the patient population that we serve. We have over 144,000 patient visits annually. This includes some 4,000 deliveries as well as some 14,000 surgeries. We see upwards of 50,000 plus in our emergency department annually. Our occupancy rate for our average daily census is about 80 percent, which is in line with benchmarks for our healthcare. And equally, when we take a look at our patient population, you can see that while 46 percent of our patients come from Manhattan, over a third of our patients come from the outer boroughs, and then further and beyond.

60 percent of our patients use public insurance and a higher proportion of

Medicare patients compared with other NYC hospitals. Equally, 55 percent of our patients are non-white. Our demographics and our geography are larger than the Upper East Side where we sit today.

We need to renew because, over the past 160 years, we have cobbled together 10 buildings that stem from the 1800s to the 1970s. Our most recent building is exactly that. In the '60s and '70s, we demolished the -- one of the last remaining 19th-century building on Park Avenue and rebuilt the Uris Pavilion that still stands today.

Unfortunately, it has been some 50 years, and now we need to modernize again. We have physical limitations in terms of the size, configuration, ceiling heights, which limit our ability to improve the current existing facilities. The majority of our beds are in shared patient rooms, which is no longer the standard for healthcare. Our operating rooms are undersized and poorly configured, and equally, our emergency department is unfortunately undersized for the current and projected needs.

When we took a look at how we would rebuild Lenox Hill, we started with what we

already know about the clinical need. We know this clinical need because we live it each and every day in the services that we provide to the community, whether that's through our behavioral health, both inpatient and outpatient, our maternal child and the birth that we have every day, our emergency department, our surgical departments, again, ranked nationally and on and on.

We took that idea these services are continuing these services, looking at population growth, looking at the aging population and the rising demand for specialized services, and then understood what we think we need in terms of bed counts and how we can really create the -- continued clinical programming that we have.

Without this proposed rezoning, unfortunately, we will have a failure to modernize, which -- will have an impact on the clinical services that we're able to provide as we do today.

Some of the key drivers with this project is really again, putting the patient in the center of what we're doing, and that's right at home with our mission statement. Single-bedded rooms are what patients deserve. They're better

for outcomes, they're better for privacy, they're better for compassion, and they're better for the care that we can provide both to the patients, their families, and as well our care teams.

There will be the equitable assignment of these rooms at no increased cost to any patient who comes in our doors, whether they have ability to pay or not.

We need to modernize our ORs because modern ORs are much bigger, they house much more equipment, and they need more space for the people in them. And equally, we need to right-size our emergency department.

So as you can see on the right, our proposal is to go to a total of 475 beds, up from 450 beds. But that 450 beds currently is in two-thirds of shared rooms. So we're going from 450 beds to 475 rooms.

As a summary, again, the important pieces of what we're trying to do with putting the patient first in the rooms, putting the patient first in the OR, putting the patient first in the emergency department, and putting the community first in how we interact with the block, improving

the 77th Street subway station, improving our ambulances taking them off the street, improving the pedestrian and vehicular traffic.

Our project development has been quite long. We have probably, I think, one of the longest task forces preceding a ULURP process. We started in 2019. We had a task force with the Manhattan Borough president and council members at that time, which included multiple community members. Unfortunately, the pandemic shuttered our project for many years, and as we came back out, we went again to the Community Board both at their behest as well as ours. And we finally had a scoping hearing and we have continued to develop our application and it leads us to today.

Our project development started with a building that was 516 feet in 2019 and has shrunk to under 400 feet in the current proposal of 2025. This is important to remember because of the length of time that is ongoing.

Our ground floor plan will redesign the entrances to improve again the vehicular and pedestrian traffic and bring in the ambulances off the street.

Just a quick look at the stacking of what option one and option two in terms of the envelopes will look like with the building housing patient rooms on the top and our other services such as the emergency department OR below.

And just a quick few renderings so that you can understand what the possibility of what this project can look like. These, however, remain illustrative. This is looking south from 79th. That was option one into option two. This is looking at the new entrance on 77th at Lexington. The new subway entrance brought into our property. And then again, what it would look like from Park Avenue, both looking Northwards on option one and option two.

And now I'm going to pass it back to Melanie Meyers.

MS. MEYERS: Thank you, Dr. Baker.

So the application requests a series of land use approvals that will allow the program that Dr. Baker described. They're consistent with the types of approvals that other hospitals have received from this Commission, including all of the other hospitals on the Upper

East Side. Lenox has not expanded and it has not received any land use approvals for more than 50 years. And at this point is by far the smallest full-service hospital among its peers.

Just a couple of bar graphs to demonstrate that. With the proposal, Lenox will be able to achieve its objectives of ensuring the highest quality of care, but it will still remain the smallest full-service hospital substantially smaller than its peers. Similarly, in terms of the tallest element of the proposal is consistent with the heights of the other medical facilities, including with the other hospital located in the Park Improvement District.

Hospitals need to expand to provide state-of-the-art healthcare and to adapt to new technologies. And with these actions, Lenox will be able to do so and ensure the future of the hospital.

I will turn it over to Lisa Lau.

MS. LAU: Thanks, Melanie. Good morning commissioners. I'm Lisa Lau, DEIS project manager with AKRF. I just wanted to make two quick points. DEIS was --- or three. DEIS was prepared

in accordance with SEQRA and identified as significant adverse impacts in two analysis areas. Shadows on the Eighth Church of Christ, Scientist, garden vegetation, and temporary construction of noise impacts on certain facades of buildings on East 76th and 77th Streets, as well as rear-facing facades of buildings along East 78th Street. No other significant adverse impacts were identified.

Thank you for your time today, and we welcome your questions.

CHAIRMAN GARODNICK: Great. Thank you very much. I recognize the challenge of summarizing zoning actions and the CEQR technical points in the final two minutes of the thing. I'm sure there will be questions for you all.

Let me just start by setting the table here a little bit for the day. I think there's a general recognition of the need for model -- modernization here. And 77th Street is incredibly difficult as it relates to community and hospital today. It just is a mess and it is worthy of revisiting how to do that better. And of course, you have expressed the need for the hospital to grow and to evolve over time.

So let's focus -- or I'm going to focus, everybody else will focus on whatever they wish to focus on, on the relationship between what you're asking for and what your need is. You cited, and that we went really quickly through it, but you cited the difference in the number of rooms that were going to be enabled here.

Let's start with that. How many additional patient rooms are you going to get out of this if approved as you as you've proposed it?

MR. BAKER: The additional patient rooms will be a total of 25. Again, it's a little bit challenging because we're going from beds to rooms. We usually use bed counts with our occupancy in understanding of the majority of our beds, which we currently staff and utilize 450 of, two-thirds of which are in shared rooms, and then about a third, which are in single-bedded rooms. The proposal goes to -- from 450 beds to 475 beds. So it's an addition of 25 beds, but it becomes 475 rooms because each bed will be in its own room.

CHAIRMAN GARODNICK: Okay. So you got a 25 additional rooms.

MR. BAKER: Correct.

CHAIRMAN GARODNICK: And --

FEMALE VOICE 1: Beds.

CHAIRMAN GARODNICK: Beds, I'm sorry, 25 additional beds --

MR. BAKER: Correct.

CHAIRMAN GARODNICK: -- is what you get.

Okay. All right. And then -- I think that one of the questions that people will rightly ask today is, you know, the size of the building is -- it's significant as proposed.

Why do you not -- why does it not enable more beds? Why -- how does -- how should the community, how should the commission think about that question about the relationship between the size of the building and the 25 beds that it's going to get.

MR. BAKER: So again, it's a great question, and I think we have to think about this as the fact that we're not trying to have a great expansion project. There's a lot that's authored in the press and in the discussion that this is a massive expansion.

While it's an -- it is definitely

an increase in the size and the zoning and the square footage, we are trying to continue the current clinical needs with the addition of 25 beds. It's a modest increase in terms of our total beds, but that we spent a lot of time with strategic planning internally, looking at, again, what is going to be continued inside the hospital, what would come outside the hospital, how do our services ebb and flow with time projecting out multiple years from now, including a multiple decades to better understand what we think the bed count need will be.

We could certainly increase that further going into 550, 600-some beds. There's always a possibility that that may actually be necessary that, however, would add substantial volume, square footage, and massing to the project, which we did not feel was necessary based on the -- the projected clinical needs. Does that make sense?

CHAIRMAN GARODNICK: It does, I think, although it sounds like you believe that the scale of the building as proposed is needed to accommodate essentially the population that you

have today.

MR. BAKER: Correct.

CHAIRMAN GARODNICK: Is that correct?

MR. BAKER: Correct.

CHAIRMAN GARODNICK: And what will be different for a patient experience --

MR. BAKER: Okay.

CHAIRMAN GARODNICK: -- let's just say we were to fast forward from today down the line for a patient experience between the building today, and as you have envisioned it.

MR. BAKER: The patient experience is unparalleled different. To come into the hospital through the emergency department as an example, and to await a bed because of your gender, or because of the nature of your illness. Because we have to match gender in order to put patients in shared rooms, we have to match illnesses in order to put patients in shared rooms. We have to ensure that there aren't communicable diseases that can be passed from one patient to the other while in shared rooms. And all of that is eliminated. The wait for that goes away. We can immediately assign

the next available room to the next available patient. It becomes equitable equally because it is not now because right now, due to the paucity of single-bedded rooms, we have a system of discussing with patients and charging them for the ability to have a single-bedded room.

The room itself, again, you have incredible privacy. I always hearken this to imagine you show up to the hotel in a city of which you're unfamiliar and they say, "This is the person who's staying in the hotel room with you. This is their family and this is the closest you will share. This is the bathroom you will share," at a time period where you are so incredibly overwhelmed and anxious due to the disease, due to what's ongoing, due to the potential surgery that you may be having. That all dissipates.

We have the ability to bring care to the patient where we wouldn't before because the room now allows for things like ultrasound to come directly to the patient, echocardiogram to come directly to the patient, procedures to be done directly to the patient.

And equally, it allows for

patient's families to stay with them. That is one of the most important and one of the most challenges that we have right now. Patients very rarely say, "I would like all of my family to go home tonight. I'd like to be alone." They want their loved ones with them. And right now, that's a challenge again, from the multitude of individuals because you have two families sharing that room.

So the patient experience becomes unprecedentedly improved, and again, really, really putting them at the focus of what we're attempting.

CHAIRMAN GARODNICK: Okay. Thank you for that. We've heard from the community suggesting that the 436 or 395 is too much and that there should be a limit of 215 across the entire site.

MR. BAKER: Yeah.

CHAIRMAN GARODNICK: Since you -- we're -- we're going to be talking about at the rest of the afternoon, but you probably will not be at the podium. Just I'd like you to address that point as to what the meaning of that would be and what would -- what a -- why you could not, or could

you --

MR. BAKER: Yeah.

CHAIRMAN GARODNICK: -- accomplish a 215 height limit across the site.

MR. BAKER: Yes. Unfortunately, a 215 height limit is -- it's just not a challenge that we can meet. It would not allow us to actually renew the facilities. It wouldn't allow us to do it in a way that allows clinical operations during the build that allows for us to maintain the clinical services that we have for the community once the build and the modernization is accomplished.

We'd have to think about looking at these stacks and say, "What do we take out?" Is it patient rooms, which then takes out clinical services? Do we eliminate inpatient psychiatry? Do we eliminate maternal-child beds? What beds and what group of care that we offer today do we have to take out in order to get to a height of 210 or 215?

210 to 215 is incongruent with -- we look around in the neighborhood, we see multiple buildings, which are much taller than that. And

I'm -- I'm fairly certain we will continue to see much -- more buildings that will be taller than that.

And so what we've been trying to do is compromise. We've come down 120 feet since our initial proposal down to under 400 feet with option two. But again, further than this makes us have to decide what of the clinical care that we offer on a daily basis do -- we no longer when we reopen the new building.

CHAIRMAN GARODNICK: Okay. Remind us of the height of the building today.

MR. BAKER: The height of the building today --

MS. MEYERS: The maximum height is about 200 feet.

MR. BAKER: Yeah, it's -- at just at 200 feet.

CHAIRMAN GARODNICK: So you're at 200 today at the -- at the highest but I recognize there's a whole patchwork of buildings --

MR. BAKER: Yeah.

MS. MEYERS: Yeah.

CHAIRMAN GARODNICK: -- on this

site, but the highest one is at 200, is that correct?

MR. BAKER: Correct.

MS. MEYERS: Yeah, in the mid-block.

CHAIRMAN GARODNICK: Okay. Can you give us a sense of the vacancy rate of the hospital today? Like how many open beds do you have?

MR. BAKER: Yeah. So our occupancy rate is 80 percent when we look year over year so that puts the vacancy rate at about 20 percent. That is a very good benchmark particularly when you have multiple patients in shared rooms because as I spoke to you, it becomes very difficult based on how you have to block beds, isolation, gender, clinical disease.

So you need some vacancy in order to actually expedite patients coming through the emergency department so they don't overcrowd the emergency department, they don't cause long wait times and holding in our emergency department. We're very proud of the fact that we have very few patients holding in our emergency department.

Equally, we have 14,000-some surgeries who compete with our emergency department for the beds as a majority of our patients undergoing surgery stay the night. And so we have to have an ability to have a certain vacancy rate that we can continue to allow the flow of the OR.

When you see hospitals, they get upwards of 90 plus occupancy rates. They have challenges that are not patient-centric. Their ORs go on hold, their EDs hold patients overnight, their ED wait times get longer, and it becomes, again, a non-patient-centric approach.

CHAIRMAN GARODNICK: How does -- just to orient that, how does that compare to other peer hospitals in Manhattan? That's, again, the reason I'm asking this, is this a point that we've heard from community advocacy and so I just want to make sure that you address it.

MR. BAKER: Yes. So I think one of the things -- and we thank the community for bringing this to our attention -- one of the things that highlighted this was, unfortunately, the statistics that we were reporting were not the correct statistics originally to the New York State

Department of Health and HERDS, which is when the community started citing vacancy rates, which were very low.

Those were not vacancy rates that we were experiencing. They're also incongruent with actually being able to operate the hospital. It happened to do with a denominator error. We have corrected that, which is now showing again, the 80 percent occupancy rate that we had all along.

When we compare that across hospitals, there are hospitals in New York City, which are higher, there are hospitals that can get to 90 percent or 95 percent, and there are hospitals that are lower.

The hospitals, again, that are experiencing anything in this ebbs and flow on a regular basis. We will start the week on a Monday with a lower occupancy rate than we will have on a Friday. Much of that is due to OR scheduling and the way in which patients receive care. But the upwards of 90 percent, 95 percent, those hospitals, again, are struggling from operational components that they would otherwise not like to.

CHAIRMAN GARODNICK: Okay. Thank you. I have two more questions for me and then I'm going to go to Commissioner Benjamin and others. The -- one of the land use actions enables the hospital Special Permit to be used with the transportation improvement bonus. And as part of that, there is a new entrance with an elevator on 77th Street, correct?

MR. BAKER: Correct.

CHAIRMAN GARODNICK: And one of the points that was made to us was that the elevator goes down to the toll booth level and then it has a ramp to the platform. That does not necessarily seem like something that is wrong, but I did want to ask --

MR. BAKER: Sure.

CHAIRMAN GARODNICK: -- just to make sure that that is an ADA-accessible ramp at the proper incline so as to be compliant with the law?

MR. BAKER: It most certainly is. I'm going to turn to my colleague, but it was actually enforced by the MTA rather than our design.

CHAIRMAN GARODNICK: Okay. Now you can, that's -- that's --

MR. BAKER: We need to be very -- a transparent -- we wanted a dual elevator system. The MTA refused and said that we had to do the ramp.

CHAIRMAN GARODNICK: Okay. Got it. The last question from me, the construction timetable. A lot of concern here about a major construction project right here on this site. A lot of people live in the area. Tell us about the construction timetable that you anticipate and what you are thinking about as ways to potentially mitigate that.

MR. BAKER: Sure. So, at the current construction duration per the application is nine years. That's six years of an external internal mix and then three years of an internal. Both options have about that ratio of the external to internal construction.

I am very well aligned with the community here that we would like to expedite this construction as quickly as possible. There are challenges that we face that we're trying to

address in an ongoing manner and as this project continues. We have decreased the length of time so far. We were at 11 down to 9. I know the community's not happy with that, but that is still a good percentage change and two years off the cost of the project.

We will continue to look at this and I think one of the things that's going to be -- the most important is once an envelope is decided upon through this process, we can create the basis of design, understand the true construction time frame, and continue to work to bring that down.

CHAIRMAN GARODNICK: Thank you. So if I heard you correctly, you said six years external and internal and then three years that would follow that would be exclusively internal, is that correct?

MR. BAKER: That is correct.

CHAIRMAN GARODNICK: Okay. All right. Commissioner Benjamin. Thank you.

COMMISSIONER BENJAMIN: And thank you very much, Dr. Baker. I have some questions about the medical needs.

One, I think you do yourself a

disservice when you had the prior chart up that showed beds versus beds because it makes it seem like it's negligible.

My numbers say that right now you have basically 311 rooms for patients, however, if you use them, and that you're going to 475 rooms. I think that's a better comparison and you may want to use that instead of the beds because the beds looks really --

MR. BAKER: Sure.

COMMISSIONER BENJAMIN: -- negligible. Like why bother?

MR. BAKER: Thank you for that. I appreciate that.

COMMISSIONER BENJAMIN: But it goes to the heart of the need, and I know that state, federal, all your insurers are trying to reduce the number of med-surg beds in hospitals around the country, not just yours.

So, have you had a reduction, or are you looking to reduce the number of med-surg beds? And can you tell us your projections for both med-surg beds and in other documents you've also pointed to the growth in cancer -- the need

for beds for patients with cancer. If you could go over kind of by service - .

MR. BAKER: Okay.

COMMISSIONER BENJAMIN: -- where the increased beds are going? Or increased rooms. Let's not confuse the two.

MR. BAKER: Sure, the increased -- I appreciate the question. I won't be able to go into as much details. I think you might want without a full analysis in front of me in terms of exactly what bed is demarcated to what.

We have seen a reduction in occupancy that happened post-COVID that we have continued to increase in our occupancy since then. As many hospitals did see that, as the face of New York City changed, as many New Yorkers left, we equally saw a reduction in terms of our occupancy from a pre-2019 time period to where we stand today. But it has been, again, on a growth curve since.

We took that into account again with the aging population, that understanding for what the Department of Health and many healthcare agencies look like in terms of projected hospital

need, which is where we came up with a total of 475.

Of that, there will be 72 -- I don't think I have it in the presentation -- 72 of which will be earmarked as ICU beds. So that is an increase in the 48 that we have today. And I don't have the total maternal-child beds at the top of my mind.

The remainder of the beds is -- it's probably going to be in the -- in the 70 marks in terms of the maternal child. And the remainder of the rooms would be for med-surg.

COMMISSIONER BENJAMIN: And part of the reason I ask is I know that in terms of the med-surg beds, so many procedures that used to involve a hospital stay no longer involve a hospital stay their day treatment or close to it.

MR. BAKER: Yes.

COMMISSIONER BENJAMIN: I mean, even open heart surgery. And I was saying to someone, my husband had open heart surgery recently and when his friend had it 20 years ago, they were in the hospital for almost three weeks. He was in the hospital for four nights.

MR. BAKER: Yeah.

COMMISSIONER BENJAMIN: So there's been a reduction in the procedures that require hospital stays or the length of each hospital stay. How does your projections account for those reductions and presumably in the future, those reductions and the need for med-surg beds will continue?

MR. BAKER: Okay. So, I don't have it for us today, but we have a large projection and set of assumptions that we worked from that looked at all of the different pieces. We worked again, with our strategic planning department, which is filled with experts that are looking at this, that are consulting with other groups of healthcare companies looking to say, what does the future look like?

You're absolutely correct. Some things that are part of the hospital today won't be part of the hospital tomorrow. But equally, we start with different innovative techniques that -- that then need to be done in the hospital.

So there's an ebb and flow that has continued over the course of time. We've

looked at that, so when you parse that all out, it looks a bit -- a little bit like a waterfall. These are the projected beds we think will go up such as ICU as the population ages their likelihood of requiring ICU as they have complicated multi-chronic diseases while the population of orthopedics will decrease because what a knee replacement used to be a mandatory in-hospital and now you can walk out the same day.

So we have thought about all of those. I just don't have the document for you today, but that is how we arrived at the number of 475.

COMMISSIONER BENJAMIN: Okay. If you could get those to me. I'm very interested in the kind of justifications for the size based on what's going to occur inside. You also mentioned that the size of the operating rooms themselves --

MR. BAKER: Mm-hmm (affirmative.)

COMMISSIONER BENJAMIN: -- have increased because of the number of equipment and the need for new technologies to be woven into what is essentially an aging physical plan. So are there more operating rooms within the plan --

MR. BAKER: There are.

COMMISSIONER BENJAMIN: -- or is it that each operating room is getting larger?

MR. BAKER: Both.

COMMISSIONER BENJAMIN: Okay.

MR. BAKER: So we go from 25 operating rooms to 30 and all of the operating rooms get larger. All right. Operating rooms are just drastically different. If you look again, I've gotten a great opportunity in this position to spend a lot of time looking at through the history of healthcare not just at Lenox, but in New York City, and what an operating room and operating theaters used to look like compared to now.

COMMISSIONER BENJAMIN: Okay.

MR. BAKER: We outstripped easily what were the projections in 1970 of power that would be needed because so many more things need to be plugged in than they ever did before. You have so much more technology where it looks much more like a modern office than it does what you might imagine an OR actually looking like because there are giant screens so that everybody can see what's actually happening so that you can be mindful of

all of the different data points, whether it's blood pressure, pulse, all of these different pieces. And where we can actually bring in components of AI to help the surgeons as well as the robotics.

So we have a large percentage of our surgery, which is done robotically. Walking out of the hospital in three or four days after bypass surgery is usually a minimally invasive robotic surgery.

That robot is big. That robot takes up space. You need space for the robot, for the console, for the people, and for all of the technology in the room. And that's why these rooms need to be bigger.

COMMISSIONER BENJAMIN: Okay. And as I said before, if you could kind of give me that analysis that shows which services are increasing and why, I would really appreciate it.

MR. BAKER: Okay.

COMMISSIONER BENJAMIN: And thank you for your service. I mean, hospitals are so important to the livelihood of so many, and as one of the seniors you're talking about who's going to

be one of the hospitals, I appreciate the concern that hospitals have for us. Thank you.

MR. BAKER: Thank you, commissioner.

CHAIRMAN GARODNICK: Thank you, commissioner.

Commissioner Mann?

COMMISSIONER MANN: Great. Just a couple of quick questions. One, I was - I was just curious of overall population served in the current facility versus in the future, just from a number of people in a year standpoint. Do you have a sense of what the sort of more efficient adding room layout would do in terms of the number of people who could seek healthcare?

MR. BAKER: I'm not certain I understand.

COMMISSIONER MANN: So the facility today --

MR. BAKER: Yeah.

COMMISSIONER MANN: -- and we've talked about beds and rooms --

MR. BAKER: Yeah.

COMMISSIONER MANN: -- but I was

just curious about people --

MR. BAKER: Yes.

COMMISSIONER MANN: -- the number of people who actually can seek care in the facility today versus, you know, in a construction -- post-construction world. Do you have a sense of over the course, you know, a year or a month or a week of what that delta is?

MR. BAKER: So as far as patients, we're not expecting a great change. Again, that is where we get to the number of 475. It's not a huge change from where we are today. So we're not expecting massive growth in our clinical services. We want to continue all of our clinical services more than anything else. The different changes operationally from the floor plate are immeasurably helpful from a couple of different place -- pieces.

One is the team members. We don't have adequate spots for the nurses and the techs and the medical assistants and everybody to sit on a regular basis. We push into corners. We have, again, as you might imagine, in 1930 when one of our buildings was built, there was no computer. And now there are computers everywhere throughout

the floor and so how you create space for that is important, and this layout allows for that.

Equally, the layout allows for a better staffing ratio. So we may look at how a nurse ratio of patients occurs. The way that our buildings are set up, they create units that have different-sized beds. So one unit may have 12, another 17, another 24, and 36. Whereas this standardizes the floors to ratios that are much more commensurate with being allowing the patients that have immediate access to their care and can -- and for that to be equitable.

COMMISSIONER MANN: Okay. And then just another question on the -- on the patients themselves. Do you have a sense of where your patients are coming from geographically in the city or in the region?

MR. BAKER: So it's about 46 percent from Manhattan County.

COMMISSIONER MANN: I'm sorry, I missed that slide.

MR. BAKER: You see then the 12.8 from the Bronx, 11.3 from Brooklyn, and 10.9 from Queens. You see a small piece from Westchester

that's mostly driven with our association with Northwell and Phelps and Northern Westchester Hospitals.

COMMISSIONER MANN: At any --

MR. BAKER: A small New Jersey and Connecticut and the all other tends to be other areas of New York.

COMMISSIONER MANN: Yeah, apologies for missing this one. Do you have a sense of within the Manhattan slice where what neighborhoods are?

MR. BAKER: Yeah, so in New York City, it's about 240 different zip codes we -- if you -- for all the 6 train is where you will see the most light up of a heat map in terms of where the patients come from. They -- it stems right from the proximate vicinity of the hospital and goes north through to 6th into Harlem. There is a western Manhattan component piece equally across the park due to the cut-through --

COMMISSIONER MANN: Right.

MR. BAKER: -- of Central Park. And there is a portion in Greenwich Village where we have our Northwell Greenwich Village Hospital

centered there.

COMMISSIONER MANN: Got it. Okay. And then just to drill down on some of the site planning questions, I don't if you have a ground floor plan in the presentation.

Just to the Chair's earlier comment about kind of the existing traffic flows and pedestrian flows there today, I think, most would acknowledge are not great to be generous. But understanding that the two loading docks on 76th Street here.

And one, the reason for two as opposed to a consolidated loading dock. And then two, what about a turnaround cable in the building so that we don't have the back-in, back-out condition, which compromises the 76th Street sidewalk and also traffic flows on 76th Street?

I appreciate the need to segregate the ambulances from the receiving function of the hospital, but I'm just curious about the thinking there.

MR. BAKER: Yes. So the total number we got to, again, at looking at the deliveries that we currently have. Our loading

dock right now is terribly undersized for the materials that we need and we're not good neighbors because of it.

We've tried very hard to change a lot of different pieces. Some five years ago, we routinely blocked the sidewalk fully with semi-trucks. We tend to no longer do that because we have asked all of our vendors to use smaller trucks which increases, unfortunately, the frequency of deliveries, but at least gets them in, so it's not blocking the pedestrian traffic.

The idea of having the seven different receiving stations here is that we can bring in very quickly. The door comes down and you see sight unseen to the community what's happening with the loading. Right now, there's often a queue from trying to get in because of, again, the undersized nature to what we have. This accounts for that.

As far as the turntable, I don't believe that it was feasible to be able to do in terms of putting an actual turntable so that there was not a backing in phenomenon. But this is our best alternative and best solution to making it as

safe and as unseen to pedestrians and the community.

COMMISSIONER MANN: Okay. Just to drill down on a little bit more, help me understand the reason for the two separate loading facilities on 76th Street.

MS. MEYERS: Okay. Jonathan mentioned of those are sterile or non-sterile.

MR. BAKER: I'm going to -- I'm going to phone a friend. Okay. Great. Dan needs a break.

MR. COGSWELL: Good morning. My name is Jonathan Cogswell, I'm the Vice President of Design and Construction for the Manhattan Region of Northwell. Thanks for having us here this morning.

So, just to build on what Dr. Baker was talking about, one of the reasons we have bifurcated the loading docks is soiled to clean. So the dock closer to Park Avenue would be our soil dock that we could -- remain closed and only open when we need to remove and deliver trucks, et cetera.

The loading dock in the center of

the block would be our clean docks. That would be where we would receive our sterile supplies and food, et cetera into the facility. It gives the ability to bifurcate those two streams.

And you will see that what we're showing in that middle dock, in an effort to try to mitigate the -- not being able to do a turntable, is we canted the loading docks so that we're -- we don't have as much of that problem with the trucks trying to get in at a 90-degree angle. They can pull up the block and kind of just slide in, close the doors, and then pull right out and keep driving without having to go through that turn procedure on this -- on this street.

COMMISSIONER MANN: And again, just understand this a little better I'm far from an expert, but do most hospitals have separate facilities for soiled and sterile (unintelligible)?

MR. COGSWELL: It's definitely a best practice.

COMMISSIONER MANN: Okay.

MR. COGSWELL: It really gives you that ability to maintain that differentiation and make sure that there's no cross-contamination.

COMMISSIONER MANN: Got it. Okay. And then just the last question here on that kind of sidewalk spacing, just kind of trying to focus on the ground floor condition, you know, Lexington is one of the narrower sidewalks that has this kind of pedestrian volume of dust today. And I -- as far as I understand, Lexington will still be the primary entrance. It's the mother and baby entrance on Park Avenue, I imagine will be much quieter than --

MR. COGSWELL: Yes.

COMMISSIONER MANN: -- than the -- and so and there's subway grates along Lexington Avenue and the Great's (phonetic) pinch points for pedestrians. And imagine there'll be a busy swirl of activity depending on the time of day with, you know staff shifts and all of that.

So I'm just curious about setting building back further. I asked about this at the beginning of the process, but to create a little more relief on Lexington Avenue. So there's a little more space, not just for patients and staff and visitors, but also just the general public.

MR. COGSWELL: So what we're

showing now is at -- I believe it's 12 foot -- currently at a 12-foot sidewalk from building to curb. We're currently showing at the street level doubling the width of that to a 24-foot wide. That actually will be -- if you see that red dotted line square that kind of goes around the building there, that's the building above. So there will actually be a 12-foot-deep colonnade there that goes from the subway entrance all the way down to the corner of 76 down to the main entrance. That will be a covered walkway that would -- is also available for the public.

COMMISSIONER MANN: Right. So to your understanding of it that will be primarily for hospital staff visitors and then -- and then the sort of sidewalk of 12 foot would be the sort of the fast lane to use a New Yorker cartridge.

MR. COGSWELL: Okay. It's -- it's --

COMMISSIONER MANN: Yeah.

MR. COGSWELL: -- it's really not bifurcated.

COMMISSIONER MANN: Yeah.

MR. COGSWELL: You know, it's --

it's available to anyone.

COMMISSIONER MANN: Yeah. Okay. And then the last question, just on the two different options for the building, can you just spend a little bit more time explaining how you intend to make the decision there about option one versus option two?

MS. MEYERS: Do you want to talk about it, or I can go?

MR. BAKER: Go.

MS. MEYERS: Yeah. So, you know, the reason why we have two options, I mean, certainly, we had a long conversation with the community board and understood that height was a concern, changed the model that we even started with over that time, and looked at -- and so when we presented the first option, the 436-foot-high with the mechanical option, we were still -- there were still people who were saying we need to try to think about it becoming a lower building.

So we spent, frankly, another year working on that as well as trying to work on the construction schedule. And so the reason for option two, both of them work, but we wanted to try

to address the comments that we were hearing over the course of the review by thinking about how to accommodate the program in two different ways.

COMMISSIONER MANN: Yeah. So, Northwell is sort of neutral on the outcome here?

MS. MEYERS: Both of them work.

COMMISSIONER MANN: Got it. Thank you.

CHAIRMAN GARODNICK: Thank you, commissioner. Commissioner Marín?

COMMISSIONER MARÍN: Thank you, Chair. Some of the questions that my fellow commissioners have asked were of concern to me as well, but I'd like to kind of dig a little deeper.

So we talked about -- Commissioner Benjamin talked about, which I think is very prudent for you guys to do, to talk in one language. It's either beds or rooms because it's hard to understand beds to rooms without really identifying the impact that that has going from single-bedded rooms -- that is from double-bedroom to single-bedded rooms.

So along those lines, what are the size of the -- of your existing rooms, what are the

size of the new rooms and what's the difference in those two? Is that a state-mandated up like a square footage? Can you talk to that?

MR. BAKER: Yes. I'm going to need help on, I believe --

COMMISSIONER MARÍN: You're good.

MR. BAKER: -- our current size in our -- I'm just going to get the current sizes for you. But I can speak to a little bit of pieces. There is a Department of Health component about moving to single-bedded rooms with new builds.

So while that is adopted regulation that we intend to adhere to, there isn't a necessary this is the amount of square footage that this has to be; there is variation in that.

We are going for really kind of a middle-of-the-road option in terms of allows us a fluency with the use of rooms. COVID is a perfect example of why that's important. So in COVID, as we discovered what this disease could do and how it clinically affected individuals, it acted much more rapidly than so many of our other respiratory illnesses where a patient could come in and seem to need no oxygen and really no monitoring, and then

within six to 12 hours, suddenly need ICU level care.

That requires a complete movement of the patient, changing where they are, bringing a bunch of equipment into a small room to get them monitored during the time period before you can get to them to the ICU.

The new build would allow an ICU capable room in all rooms so that you wouldn't have that problem, that you could render all levels of care, whether it's no monitoring, heart monitoring, or full ICU from that.

The actual numbers in terms of the square footage are comparable across our contemporaries in Manhattan are on par. We are not bigger than what is being built on a regular basis by any demonstrable nature to the Kimmel Pavilion, NYP, Mount Sinai, or any of the other new builds. Our current room dimensions for a single-bedded room at the moment is 190 and the current proposal will be 234 square feet.

COMMISSIONER MARÍN: Okay. Thank you for that. One of the -- one of the concerns of the community is height. And understanding that

new equipment takes up more space, understanding that the ICU capable rooms bring in more equipment, is there any way of reducing the size of the plenum in between the drop ceiling and the structural slab?

MR. BAKER: Yeah. That's a great question, and while I've learned a lot in this process, I'm not an expert enough to answer that question. I understand a little bit of difference between concrete and steel buildings more than I ever anticipated, but I'm going to --

COMMISSIONER MARÍN: It is found in the front end.

MR. BAKER: -- turn it over to Jonathan.

MR. COGSWELL: So the challenge that we always have with the plenum is more than just air. So we are bringing a multitude of services through the ceiling into the space. So -- and also as we look towards local law 97 compliance and all air systems, that's also giving us additional challenge to this.

We are in complete agreement that we want to make this building as tight as we can

and we will continue. We actually have already brought the building a little bit lower than what is the benchmark standard across the country from a floor-to-floor height perspective, working with our engineers to try to cram it in as much as we can, but between the air, the medical gas systems, the plumbing systems, the IT systems, everything that has to run through that ceiling, it just becomes very challenging to squeeze it as much as we can. But we continue to look and we will continue to strive as we learn more about emerging technologies in the mechanical systems et cetera, and what we can do to try to condense that.

COMMISSIONER MARÍN: Thank you. And in the scenario -- well, before I go to beds per floor. Now, let me go to --let me stay with that.

So how many beds per floor, bed/rooms because at this point, the number of rooms equals the number of beds because they're single-bedded. How many beds per floor are you projecting?

MR. BAKER: It will be variable. So if we just look at the diagram on the left, you

will see in the in the blue, it's hard to read. I can -- but on your left --

COMMISSIONER MARÍN: To right.

MR. BAKER: Well, both of our left there are patient beds that remain on the Park Avenue side of the campus. There are patient beds that will exist on the Lexington side of the campus, those floor numbers will be different. The layout of the floors in the new build is approximately 40 beds per floor.

MS. MEYERS: A little less than.

MR. BAKER: Sorry.

MS. MEYERS: I think it's a little less than (unintelligible.)

MR. COGSWELL: Yeah, 24.

COMMISSIONER MARÍN: And out of the 450 beds/rooms that you are projecting, how many are staying in the existing building?

MR. BAKER: Less than half.

COMMISSIONER MARÍN: And when you talk to the ratio of nurses per patient, what is your ideal ratio because that also will determine the number of nurses' stations, the amount of computers on the floor, the amount of meeting

rooms.

MR. BAKER: The ideal nursing-to-patient ratio, that's a conversation worthy of probably a week, but --

COMMISSIONER MARÍN: If you don't have an answer we can -- we can get it later.

MR. BAKER: Right. We have -- we have worked very closely with our nurses and our nurses' union and as well as the state guidelines. And so currently we have a 6 to 1 ratio for our med-surg beds. There's a 4 to 1 ratio for our telemetry beds and a 2 to 1 ratio for our ICU. That's very consistent with standards across the United States actually, a very good standard that we're very proud of --

COMMISSIONER MARÍN: Yeah.

MR. BAKER: -- as compared to other life-size facilities.

COMMISSIONER MARÍN: Thank you.

Thank you, Chair.

CHAIRMAN GARODNICK: Thank you. Commissioner Vice chair Knuckles.

VICE CHAIR KNUCKLES: Thank you. Dr. Baker, thank you for your testimony and your

service of course.

Could we go back to the slide where you had the -- the existing number of beds and the projected number? So the proposed number is that option one or option two?

MR. BAKER: Both.

VICE CHAIR KNUCKLES: So they're the same.

MR. BAKER: Correct.

MS. MEYERS: Programmatic.

MR. BAKER: The clinical program built for both options remains the same.

VICE CHAIR KNUCKLES: Okay. I think that's significant. Thank you.

CHAIRMAN GARODNICK: Thank you, Vice Chairman.

Commissioner Gold on Zoom.

COMMISSIONER GOLD: Hi. First thank you certainly for the service and for the efforts in the neighborhood. I have just a couple of points of follow-up there.

The first is -- so on the question of decreasing construction time, you know, I heard you say six years external and internal and then

some period of internal. And I think you commented, I think you said once you know a little better, you can see what you can do tighter.

Just given that's a big concern both for the neighborhood and of the borough president, can you speak a little bit to what can we do to tighten that timeline? You know, what are the -- I imagine you must have a very tight plan right now and it sounds like it's, you know, 6 to 10 years.

MR. COGSWELL: Absolutely. I think what will really help us try to drive that schedule down is when we truly can get into the detailed design of the facility. We will continue to look at modularity in the current, you know, construction climate, how can we build more off-site to reduce the amount of time it takes to build it on-site? We will continue to drive with -- as I said before, the mechanical systems and the modularity of mechanical rooms that can be built offsite and brought in. There's a lot of stuff that we will continue to look at as we go into the detailed design of the facility to try to continually reduce that timeframe because as Dr.

Baker said, that's one thing that we're aligned on. We want to build this as quickly as we can.

COMMISSIONER GOLD: Right. I get that. But you know, I mean, at the same time there are, you know, certain things, I listen I think the stat that I heard yesterday was the Empire State Building was built in 410 days, right? So, you know, when there's a will, there's a way. And you know, not -- it was an interesting statistic and that was many years ago, but, you know, and candidly, you know, 6 to 10 years, you know, you can certainly see why the community is concerned about this. You know, we've seen other facilities go up quite quickly. So one, you know, would be helpful to have, you know, perhaps maybe some more formal ideas than just modular mechanical rooms. You know, we would ask you to think about that pretty specifically.

The second question in there which, you know, we haven't spoken a ton about, but also seems to be an issue raised by both the community and the borough president is parking, right? Yeah, how are we thinking about that? I know it's a transit-rich environment, but also

expansion does create some additional needs both for staff and for patients.

MS. MEYERS: Thank you for that question. The program, as Dr. Baker said, is really to ensure that the -- there's a continuation of services at the hospital. So we do not expect, and the environmental review does not anticipate that there's going to be a substantial increase in the number of patients, the number of employees, and there won't be a significant need for additional parking.

Having said that, during construction we did, there has been, and the EIS includes an analysis of the parking facilities in the area. There are many something on the order of 26 within a five-minute walk. There are about 2,800 spaces within those facilities, and there's a capacity at this point of about 12 percent.

So there's plenty of space for an increase. And, you know, that -- those are the -- those are the statistics that we can provide,.

COMMISSIONER GOLD: Right. So one of -- one of the things -- so I live in the neighborhood and one of the things that I see very

readily, particularly around your facility and some of the others including Sloan, are really long lines of cars each morning waiting to go into facilities and sometimes getting turned away. So, you know, I would say, you know, I know that's incremental, but the incremental view is one that there's -- there definitely are some challenges that are creating some traffic on the parking side. So, you know, hard to believe, we could just rely on what's out there.

But two, if we're increasing the number of rooms, and granted, I mean, 475 is not huge, but it's, but it is a big increase, you know, on a relative basis, we don't think that we'll have more staff or more patients using the facility. We think it's just the same number.

MR. BAKER: It will be approximately very close to the same number. We're not anticipating, again, a great increase in the staff in terms of what we will need. It -- you know, even to continue 24/7 operations.

COMMISSIONER GOLD: Got it -- got it. So we think the larger facility is really just the status quo, right?

MR. BAKER: I'm sorry. I didn't -- I didn't hear what you said.

COMMISSIONER GOLD: Yes, we're -- we're saying that we think that the lot -- that despite, you know, redoing the facility, increasing the number of rooms, that it's just going to be status quo, that it's the same number of staff and same number of -- so we're saying we're -- we're serving the same number of people. We're not actually increasing our capacity by doing this?

MR. BAKER: So we're not -- we're not anticipating, again, we're going an additional 25 does not cause a massive staffing upheaval for the hospital in terms of what we need to be able to supply, both from ancillary services as well as direct patient care.

We aren't trying to cause a need to have a staff increase that is marketed. We're not trying to outgrow what we think we need to continue the clinical services that we currently provide to the community. That's a pennant of what we're trying to do is to preserve our services rather than cut them to remain in where we are in providing world-class care for generations to come,

but not at an expense of a massive expansion in terms of the total patients that we would see that the services that we offer or the staff that we would employ.

COMMISSIONER GOLD: Got it. Got it. Okay. That's helpful. Thank you.

And then, you know, just the one last point to follow-up, and it's come up already, but the concept of not having the turntable does not feel like the ideal, you know, design given the challenges to -- to traffic and traffic flow that can create.

So, I know it sounds like you get -- you've thought about it and it sounds like -- it feels like it would be too much of a giveaway to figure something out there, but would certainly encourage more thinking there because it does seem like a solution, you know, a problem that you guys can solve internally, right?

MR. BAKER: Certainly. Thank you. Perfect.

COMMISSIONER GOLD: Okay. Thanks.

CHAIRMAN GARODNICK: Thank you, Commissioner Gold.

Commissioner Goodridge?

COMMISSIONER GOODRIDGE: I have a follow-up because I think a lot of us are thinking of this as one of the justifications, right? Is that the improvements and the upgrades will reach more people, and not necessarily the staff, but mainly patients; you know, the upgrades in more patient beds, in more rooms, the whole purpose would be to reach a larger segment.

I think we're at one -- at one point I was -- I'm -- I'm glad that Commissioner Benjamin clarified because I thought at one point it was only 25 additional beds or rooms. But I'm glad to hear it's 300, but --

(Chorus of "it is not.").

COMMISSIONER GOODRIDGE: It is not. Okay. So let me clarify, is it only 25?

MR. BAKER: We're -- we're not -- we're not -- we're not trying to greatly increase the capacity of our ability to provide inpatient services at the hospital. We currently -- the reason that we did beds is because it's 450 and the room's piece is a change because the -- while the room number goes so drastically, the bed number

does not. So it's not showing a massive attempt at trying to increase the inpatient services that we offer.

COMMISSIONER GOODRIDGE: Okay. So the goal is not to reach more people, it's more about the -- it's more about improving the patient experience?

MR. BAKER: The goal is to improve the services for the patients in the community that we serve currently. There will be some more people that are going to be affected by this. That's always the goal is to affect the healthcare for any patient that you can. We're not, however, trying to outgrow what we think we need to provide to the patient population that we have. We're not trying to take on a larger portion by growing outside the scope of the block. We would need, frankly, more room, we would need a much bigger campus like we see at NYU, at NYP, or at Mount Sinai.

COMMISSIONER GOODRIDGE: Okay. And so please clarify for me exactly how many additional beds or rooms this will be because I was confused about that part.

MR. BAKER: It is 25 additional

beds.

MS. MEYERS: And 300 -- and 200. I'm looking at the map. And 302 additional single rooms. Additional single bed, correct.

CHAIRMAN GARODNICK: Okay. Let's have the applicant say it in response and to the -- into the microphone so everybody can hear it. Thank you.

MS. MEYERS: So in terms of the number of beds, the answer is it will be 25 additional beds. However, in terms of the number of single-bedded rooms, which is industry standard, which allows for your loved ones to be as part of it to be with you to address issues and concerns about infection and things like that, the number of single-bedded rooms will increase from 172 to 475, which I always worry about my math, but I think that is 302 additional single bedded rooms.

COMMISSIONER GOODRIDGE: Oh,.

MS. MEYERS: Is that clear?

COMMISSIONER GOODRIDGE: So it would be 302 additional rooms.

MS. MEYERS: Single bedded rooms.

COMMISSIONER GOODRIDGE: Single

bedded room?

FEMALE VOICE 2: No, it will not.

COMMISSIONER GOODRIDGE: No, it will not.

MS. MEYERS: Okay. It will be -- it'll be 302 additional single-bedded rooms.

FEMALE VOICE 2: (Unintelligible).

CHAIRMAN GARODNICK: No, sorry. Sorry. We cannot have interruptions from the audience even if they were members of my college class from the same graduating year. So everybody will have a chance to be heard, but please don't interrupt the applicant. Applicant will answer, and then members of the public, we're going to get to you, I promise. And I know there are a lot of you who want to be heard today.

Melanie, would you like to answer that?

MS. MEYERS: I'm sorry. It's -- I said 302. It's actually 303.

CHAIRMAN GARODNICK: Okay.

COMMISSIONER GOODRIDGE: 303. So this project will result in an additional 303 single bedded rooms.

MS. MEYERS: Correct.

COMMISSIONER GOODRIDGE: Is that correct?

MS. MEYERS: As well as an enlarged emergency room, as well as state-of-the-art operating rooms for the patients.

COMMISSIONER GOODRIDGE: Is there -- can you provide some insight into why there seems to be some mistrust of that, like from the com -- clearly I was there a back and forth about the number with the community board or?

MS. MEYERS: We had a quite long -- I mean, again, this has been a long process.

COMMISSIONER GOODRIDGE: Right?

MS. MEYERS: We had a working group and task force, and actually went through with some level of detail about the needs about -- for each of the individual components. And the program -- well, the project has changed over time in terms of the size of the building in terms of thinking about a residential component to finance it, the program has not changed. We started with an intention to create highest quality healthcare for our patients knowing that there was an obsolete

building or growing obsolete hospital. And this is the program that would ensure that future.

COMMISSIONER GOODRIDGE: Question, the community board says that the FAR of 12.5 is unprecedented for a Manhattan and for a hospital of that size and that it exceeds at least for the following St. Luke's, Mount Sinai, New York Presbyterian on NYU Langone. There was a slide, however, there was a slide before that you say that --

MS. MEYERS: Yeah, we'll move it to that. So I think one of the questions that was asked at the last community board meeting was, why does the hospital need a million square feet? And there's actually another ambulatory building that Northwell is building, which is another 200,000. So the question was, why would a hospital need 1.2 million square feet? And the answer is, they do. Every hospital has need to grow. Every hospital has gotten approvals, and in the course of every other hospital asking for approvals, they've increased enormously and have been able to survive and thrive as a result. So we are asking for waivers and heights and densities that are

consistent with others.

You asked about FAR, so which is the 12.5? So every hospital that's on the Upper East Side is located primarily in a zone that allows for 10 FAR. And most of them are built to that. And some of them are built to higher. MSK went through the process two months ago, three months ago. The southern development that they're proposing has an FAR on that block of -- north of 14. A hospital like Mount Sinai currently has an FAR of 9, but it also has floor area generated by the DMAP streets. So if you think about what that means from -- if you take that space that we don't get to count and you add it to their site, they're at about 11.2.

So all of the hospitals need density. All of the hospitals except NYU because it has a very large footprint, is north of 10. Hospitals like Hospital for Special Surgery, New York Presbyterian, they're built to, depending on where, between 10 and 12 FAR, but they also get the benefit of land that was created out over a street. So again, got additional FAR through other means. What we're doing -- we're the only hospital that's

doing a subway improvement and we think the density that we're talking about is well in line with those others.

COMMISSIONER GOODRIDGE: I don't want to prolong it too much.

MS. MEYERS: Yeah.

COMMISSIONER GOODRIDGE: So let me just get to the next question. You mentioned the subway improvement; the Manhattan Borough President, there's two, the Northwell entrance, and the Manhattan borough president recommended that there be some recommendations there. I think that there was a little bit of a back and forth because it said private property owner and I guess would mean less retail space. What is your response to that?

MS. MEYERS: I think there's two things. One is the bonus that we're asking for on our site has a -- changes the sidewalk, removes elements from the sidewalk, creates a new stairwell, which increased -- is one and a half times the capacity of what exists today, and there's an elevator. We're asking for a half -- I promise I'll get to your question. We're asking

for a half FAR for that, which is about 40,000, 41,000 square feet of bonus.

Under city planning standard metrics, that is an improvement that would generate closer to one FAR. So we're doing a lot on our site. We have had early conversations, you know, way back when we first started looking at this with the MTA and sort of what came out of that. Jonathan can add a little bit more, but when did that -- the MTA thought that any improvement would require private property and which we are not in control of. So it would be great if there was an upnorthbound ADA-accessible subway station, but we're not in a position to deliver that. Certainly, we would be happy to be part of conversation.

COMMISSIONER GOODRIDGE: Okay. So, for that other -- for the Manhattan President's recommendation for that other one, you're saying it won't be able; it's not feasible?

MS. MEYERS: Again, we would be happy to be part of the conversations, but we can't do it on our own.

COMMISSIONER GOODRIDGE: Traffic.

I know, you know, Commissioner Gold addressed this one, and I just want to circle back on it.

Community Board recommended parking?

MS. MEYERS: Correct, yes. Yes, they did.

COMMISSIONER GOODRIDGE: Right. What is your response?

MS. MEYERS: We don't see a need for additional parking. It's not part of the proposal. And again, the -- we can provide the statistics.

MR. BAKER: Yeah, we don't have the ability to put parking into the build of what we're currently structuring. It doesn't allow us to -- it would cause the building to get higher, cause the building to have a longer duration of parking. So we -- or excuse me, longer duration of construction because we have to go deeper into the bedrock, It would be louder and longer, and again, would cause an increase in terms of what we would have to do with height. So we don't have the ability to put parking in the site that we have and that we own.

Through our analysis that Melanie said, we haven't anticipated a need that is going to greatly cause a change in terms of what the current Upper East Side has. I understand as being on the Upper East Side each and every day that there is a feeling the community that we need more parking. I think there's a community feel across Manhattan that we need more parking. But we don't have a proposal to add additional parking within this current proposal.

COMMISSIONER GOODRIDGE: Okay. My last question is more of a broader question. You know, I want to go back to the slide where you talked about who it will serve, you know, the demographics how many patients that don't have health insurance. We have had a bunch of hospitals who come before us, and oftentimes the community pushback at the end of the day, it's more or less, you know, this is a Ritzy hospital, I'm not going to benefit, it's not really serving, it's serving, you know, well, to do rich patients, you don't need health insurance, but it's going to cause me 10 years of construction living next door and ruin the neighborhood.

I would love -- my question is twofold. I would love to hear a bit about your reach to the community, how that process has been since there has been a lot of community pushback. From my standpoint, you know, the answer -- I think there probably has been a lot of tension. Maybe they're not getting answers that they want. It's a lot of convoluted answers. And so I would love to hear about how you've been engaging with the community. And then just answer the larger question of -- but then, you know, if it's not -- you know, if we're not reaching the number if we're not substantially increasing the number of people that the hospital will serve, and it's more about just an internal, you know, improving patient experience, which is great, you know, the community's larger question is, but it's going to lead to nine years of construction traffic noise.

MR. BAKER: I mean it - so --

COMMISSIONER GOODRIDGE: How -- so what is the overall benefit here?

MR. BAKER: I think there's multiple questions within that. So I would say it's more than great. I mean, you -- we cannot

discount this idea that somehow we're only improving the patient experience. We're improving patient outcomes with this. We're improving the ability for Lenox Hill Hospital and the New York City healthcare ecosystem to continue to modernize and offer care to all New Yorkers.

We do not turn people away based on anything; whether that's the -- the geographic location in which they live, whether that's the ability to pay, whether that is their gender, whether that is their race. We do not look like the Upper East Side in terms of our patient population. We are far more diverse.

And we have made inroads in creating healthcare equity and diversity with regard to that. We have pushed clinics into Harlem. We have pushed clinics into Greenwich Village. We have over some hundred plus ambulatory sites throughout Manhattan in an attempt to reach all of Manhattanite.

And then when you add to the bigger, broader aspect of Northwell, we have hospitals and ambulatory facilities in every single borough understanding that there's a bigger piece

at play here. And that's what we're very proud to be part of Northwell from that.

We're not trying to increase the proportion that Lenox Hill owns within that ecosystem. We're trying to make certain that the proportion that we currently have has the ability to have the best level of care that they deserve. 60 percent of our patients are on government insurers. That's not a luxury hospital. That's not something that has 60 percent commercial, 70 percent commercial, something from that perspective. That's a hospital that's looking at this.

And again, our demographics here are skewed more towards, again, a different patient population and different governmental payer than most of our competitors. So we're not trying to be only to the vicinity of the Upper East Side. We're trying to be to the patients that we have always served and we hope to continue to serve.

COMMISSIONER GOODRIDGE: And the community engagement?

MR. BAKKER: Yeah. So I think, again, when we go back. We've been -- we've been

talking with the community for quite some time. I understand and as I hear the murmurs from the community behind me consistently, that we're never going to be able to communicate with them enough. I understand that. That is something that they, you know, have made very clear as they continue to. That's not for the fact that we don't value them, and it's not for the fact that we don't value their voices, and we have continued to utilize their improvement. We've come down from a height of 516 to a height of 436 because of the community. We changed the pace of the project because of the community.

They may still not like exactly what it looks like in terms of the height and the duration and I understand and respect that, but it's not for want of not attempting to listen. We've been with Community Board 8 multiple times throughout the process of 2019 onwards. We had a task force, again with Gale Brewer and Keith Powers originally when we launched this. We continued to go to the community board. We went to the community board with our site on Third Avenue, which was an as-of-right build, but we wanted to

make certain that we were transparent with them, with what we were doing, and what we were trying to achieve. And we've been trying to work with the community. We may not see eye to eye on all aspects of the project. That part is clear to me, but it's not, again a lack of attempt of trying to listen and trying to participate with the community.

COMMISSIONER GOODRIDGE: Thank you.

CHAIRMAN GARODNICK: All right. Thank you.

Commissioner Cerullo?

COMMISSIONER CERULLO: I hope this is just a quick question. It's really a thought and perhaps less about the direct sort of land use implications of the proposal, but I found it interesting the idea of the rooms being designed in order to actually accommodate ICU purposes. And the one thing that I thought about at that moment, but then it sorts of was followed up, I don't remember who asked the question, but in terms of your nursing-to-patient ratios, the ICU component was two to one.

MR. BAKER: Mm-hmm (affirmative).

COMMISSIONER CERULLO: Do you envision, and I guess this is an impact question in terms of staff size and access in and out of the neighborhood to the facility, that in creating an ICU capable room, it's not just about the machinery that can come in. Obviously, there's a different level of care in an ICU circumstance.

How do you envision, or is there planning that you know, that's been determined or underway to figure out how to support on the staffing level some of the things you're proposing to be -- for the hospital to be capable of in the future? And then what implications does that have on the community with people coming in and out on a daily basis, whatever the scheduling may be?

MR. BAKER: Yeah, it's an excellent question. The answer is yes, that we have taken a look at what the staffing needs would be in the proposal with the 475 beds, 72 of which would be ICU. So there's a standard that we're adhering by, to begin with to create a general staffing plan. We change our staffing plan each and every day for the next day based on the

clinical need of the building, the occupancy of the building, and every -- from that standpoint.

And so the ability to do that will continue throughout that project. It's not just about the room being capable of providing ICU and then it just, we increase the total number of ICUs, which would then increase the total number of staff from that perspective. It's about the care being able to be rendered within that room as you change what's actually being done. So there's two components there.

We're not anticipating a situation where we would go up so markedly in ICU count that we would affect total staffing to a detriment of the community, to a detriment of environment or parking or anything from that perspective.

COMMISSIONER CERULLO: Okay.

MR. BAKER: That's not an anticipation. That being said, it is smart always to plan for the possibility that things may be completely outside of what you imagined as we experienced in the pandemic and with other events. So the planning on the facility side is important to allow for that, and then we can continue to

monitor that on a regular basis day over day.

COMMISSIONER CERULLO: Okay. Thank you.

MR. BAKER: Thank you.

CHAIRMAN GARODNICK: Thank you, Vice Chair.

Commissioner Osorio?

COMMISSIONER OSORIO: Thank you, Vice Chair Knuckles, and thanks so much for what you do. I associate myself with some of my colleagues who expressed that. And thank you again for addressing our questions. I appreciate the effort to try to understand what is the balance that you're trying to achieve and helping us understand the land use rationale behind it.

I think one first quick comment is a recommendation that you know, based on hearing the questions and hearing your responses, I think it'll be useful to maybe succinctly in writing and publicly clarifying where you see that public benefit in terms of the quality, but also in terms of the medical outcomes that you listed. Right? It's as much as with the -- it has to do as much with the beds as it -- as it does with the ICUs and

the -- the surgery room. So I think that would useful. The same thing goes for the pedestrian experience, height of the building, et cetera.

So the second question, and now specifically in terms of, you know, the environmental impact of the building because You know, what we have to evaluate is basically, you know, what is the no action and then what is the impact of the action? And so I'm wondering if in the presentation, you quickly mentioned this, but when do you anticipate to have the mitigation strategies for the shadow impacts specifically?

MR. BAKER: Yeah, so we actually met with the church, I want to say two months ago. Really exceptional meeting. And I think we all walked out of there very happy with each other in terms of what we'll be able to do. We presented to them a myriad of options in terms of the mitigation. They're obviously very concerned about their organ. They have a beautiful organ that needs preservation. They're concerned about the park in terms of preserving the park. And we've talked about how we can achieve that during the construction time period as well as for the future.

And then we offered a lot of potential options for what the park could look like. While there will be shadows, there is still great opportunity for plant life. There's still great opportunity for respite, there's still great opportunity for the reflection and the downtime that occurs on there.

And so I think if you ask them, you would find that it was a very positive meeting of our attempt. We plan to, as soon as approval would be achieved, we would sit down with them and start talking about -- about how the timeframe of when these would happen.

COMMISSIONER OSORIO: Well, thank you that sounds useful. But the thing is, you know, you're going to have to report on them on the final EIS before we vote. And so I'm just -- my question is really when do you think whether you think you can share some of that, those drawings and those proposals with us, just so we can understand, you know, how you're planning to mitigate those? Because that's, in my mind, the most significant adverse impact.

MS. MEYERS: Yeah. And I appreciate the question. And again, the -- there

are a number of concepts and I think if the hospital is comfortable, that is something that we can share --

COMMISSIONER OSORIO: I appreciate.

MS. MEYERS: -- so you can get a sense of what's here.

COMMISSIONER OSORIO: Great. Thank you. Thank you. So the last question that I have, and I plan to be really brief, I'm also concerned with the energy use and the air quality. And so maybe kind of like on the energy use, you don't have to do it now, but if you can share, expand a little bit on what the plan is exactly. I read some interesting things, but you know, I wasn't clear in terms of the energy matrix, whether you're, and how much you know, better is the plan to what it exists.

So if you can provide some maybe detailed information in terms of how much renewables and exactly what is the type of energy efficiency that you are proposing, that would be great. I read, and it sounds like you have a plan to comply with the law, but you know, that's the

bare minimum. So I want to understand really what's the public benefit again, of the action.

MS. MEYERS: Can I ask just one question? Are you -- you're asking about the future --

COMMISSIONER OSORIO: Yes.

MS. MEYERS: -- or asking about today as well?

COMMISSIONER OSORIO: Well, it would be great to understand both. Because, you know, we've been focused on the proposed, but I actually want to understand as a campus, how are you planning to work? Like, for example, with, on the energy side, this is a, you know, textbook opportunity to create a microgrid, you know, to be able to create a little bit of an economy of scale in terms of sharing clean, redundant energy in the case of an emergency. Because you're also relying on steam and energy -- and electricity from the utility. If that goes out, I think you're saying you're going to rely then on filtered oil burners.

And so, you know, I now want to understand the impacts on our quality. So in terms of energy, if you can share additional information,

I would appreciate it. In terms of air quality, you're the largest source in the neighborhood, right? You're -- the EIS is clear on that, and that's great, but it also doesn't report any significant adverse impacts on air quality because you're going to stay the same.

And so if we go back to where we started today, that there isn't really an increase in the amount of services, but in the quality of it, you know, I want to understand, you know, what is it that you're doing to improve your quality of the existing operations? Because you know, I sense that that's another important con point here.

I mean, and I want be clear, it's not a significant adverse impact in the environmental impact study because you know, you are the main source. In other words, you're not necessarily making the air quality worse. But my question is, how are you making it better?

MR. COGSWELL: I mean, we can certainly --

COMMISSIONER OSORIO: Fair enough.

MR. COGSWELL: -- get back to you with a little.

COMMISSIONER OSORIO: Yes, appreciate.

MR. COGSWELL: -- a little more detailed information, but I will say that, you know, we're very much aligned in that.

COMMISSIONER OSORIO: Thank you.

MR. COGSWELL: It -- we believe, I mean, we're a healthcare facility, right? And we believe in promoting the health of the community. So what we want to do is make this facility as healthy as we possibly can.

COMMISSIONER OSORIO: Thank you.

MR. COGSWELL: Thank you.

COMMISSIONER OSORIO: I appreciate that.

CHAIRMAN GARODNICK: Thank you, commissioner.

Commissioner Rampershad?

COMMISSIONER RAMPERSHAD: Thank you. Thank you for your service. I know you've been out there for a while, so, and a lot of the questions I had were asked by my fellow commissioners, so I'm just going to narrow it down. You mentioned about the ER. What is the current

square footage of the ER now and what will it be in the proposed and sticking with the ER, with the ambulance base? I know, and you referenced there's none now.

So in terms of just walk me through, an ambulance comes in, does it stay out in the street and they bring the people in? And in terms of with the new proposal sign with the six days, do you anticipate eliminating having any ambulances outside on the sidewalk?

MR. BAKER: Yeah. So if someone could find me the proposal of the new square footage, I know the current square footage, having lived in there for many years, I'm an emergency physician. We operate about 14,000 square feet. And we see some 55,000 patients a year. It's not enough by any means. It doesn't offer the privacy that is needed for patients.

Again, when you are in an emergency, and it doesn't offer us to be able to provide the care in each one of the different bays that we should be able to provide. From an ambulance perspective, we equally -- our ambulance bay is currently 77th Street. It's nowhere near

ideal. It's a disaster for vehicular traffic, and it's really not patient-centric. So that when patients currently come out of the ambulance they come out parked on 77th Street and they will come in a separate ambulance entrance to the hospital. And that's the current state today. There isn't -- there is a small awning over the entrance, but that doesn't cover the time from the ambulance into that awning. So often inclement weather is with a sheet covering.

The proposal greatly expands emergency department to --

MR. COGSWELL: 36,500 from 14.

MR. BAKER: -- 36,500 square feet. And we go up to 48 treatment bays, which really allow for, again, a much better and comfortable environment for the patients as well as the clinicians.

The ambulance will be brought off the street, so there's no intent on having the ambulances on the street. They would pull into the building so that they are no longer faced with implement weather. They also will have faster access to the emergency department because of that,

because they don't have to deal with the traffic, they don't have to deal with the double parking and everything from that perspective by coming directly in.

The intent then would be that it's, again, unseen to the community with nothing that we're planning on having ambulances parked outside. And they would then exit and then go about to either bring another patient or their stations throughout the city.

COMMISSIONER RAMPERSHAD: Right. Two more quick questions. Commissioner Marín brought it up earlier in terms of the design and the height. How do you -- and you use the other hospitals in comparison with square footage, how does this compare in terms of floor-to-floor heights with the other hospitals?

MR. COGSWELL: The floor-to-floor heights? I don't know that answer.

MR. BAKER: Know if we can compare it to other property.

COMMISSIONER RAMPERSHAD: Well, yeah, if you can get back to us because I'm just curious.

MR. BAKER: Yeah.

COMMISSIONER RAMPERSHAD: And the reason I bring that up is I know you've been through this process for a number of years; you went from 536 feet to what it is now. I know the program would've changed, but from the, the original design does your four-to-four height change, and I understand the design intent in terms of what's needed. So I'm just trying to wrap my head around that.

The other thing I'm trying to wrap my head around is also the timeframe. I understand you talked about it, commissioner Gold brought it up. What are the long lead items to get in terms of, I understand design takes a while to get done but also to his point also, and I know this is not the Empire State Building, you're not going to build in 410 days, but the longer the job takes to build, the more money it costs, obviously? And I know you said you cut down on the budget, so I'm just trying to understand why would it still take six to nine years to build out this project?

MR. COGSWELL: So a lot of the challenge in constructing this facility is its

location, right? We're building immediately adjacent to the current hospital in a dense community. So we're not looking to, you know, the Empire State Building. They work 24/7. We're not going to work nights; we're not going to work overnights. We're going to greatly limit our weekend work.

We're going to try to keep this to daytime work during the week so that we can be as respectful as a construction project can be of our community. And it's not an insignificant building in its connection point to the existing facility, which is a little more surgical in how that work has to be done, as we're looking at the superstructure work of the building.

We also sit directly on Bedrock. So where we have some excavation that we're going to need to do for the foundation, and we are also share a wall with the MTA subway system station, with the track platform and what will be the foundation of this building, which is going to make that work a little more surgical as well.

So there are a lot of mitigating factors along because of the location of this

facility that will drive help to drive the schedule.

We continue to work with our partners at Con Sigley, to find -- to try to find ways that we can, we can reduce schedule down to try to shorten phase times. And that will continue throughout the design as they will partner with the architects to make suggestions on, you know, if we did it this way, we could cut a couple months off schedule.

COMMISSIONER RAMPERSHAD: Okay. Thank you.

CHAIRMAN GARODNICK: Thank you.

Commissioner Benjamin, brief follow-up.

COMMISSIONER BENJAMIN: Yes. Following up on Commissioner Rampershad's question about the Florida floors, if you could get back to us with how much the percentage of the Florida floors that are occupied by the Plenums and how much square foot -- how much footage that is totally.

The second question is, are you increasing the kinds of ambulatory services that

will be available to people, the number of labs, and the work that will go on in those labs?

MR. BAKER: So ambulatory services which is traditionally outpatient, we are constantly working on equally. We have a new building designed just to do that again, trying to put the patient to the center of that building. So we're going to continue to make certain that we push out into the communities equally and offer services in the communities that don't need to be in the hospital. We don't want things in the hospital that don't need to be.

We're not anticipating that there will be a change in -- a large change in terms of the ancillary services, whether it's imaging or laboratory that will occur within the building itself. We are anticipating that that will get much more technologically advanced with the use of digital pathology, digital radiology, the use of AI, and these component pieces. But that shouldn't cause any kind of space or change to the programming of the building. Just allows for an improvement in terms of the services that we can provide.

COMMISSIONER BENJAMIN: Okay. And I asked that question because one of the hospitals that was here before, you talked about the increase in cancer patients and increasing the number of ambulatory care options available to service that increase.

MR. BAKER: Yeah, we are going to continue to increase the ambulatory options equally. This project doesn't do that because this is our inpatient build, but we will continue. We have multiple different places where we just opened a center at Hudson Yards. We are changing the face of what the Greenwich Village facility does by opening up inpatient beds there and a cardiac catheterization lab. We are building a spine center, which is all ambulatory, so you need not come to the hospital. So, and again building on Third Avenue, which will be centered around cancer care.

COMMISSIONER BENJAMIN: Okay.

MR. BAKER: So we're trying to push out equally understanding that you shouldn't have to go to one place and only one place.

COMMISSIONER BENJAMIN: Okay.

Thank you very much.

CHAIRMAN GARODNICK: Thank you. Okay. We will now turn to public testimony. We are going to start -- thank you for your presentation, Lenox Hill.

We're going to start with Vanessa Aronson, who will be followed by Nuha Ansari, and then Andrea Goldwyn.

Ms. Aronson?

MS. ARONSON: All right, I'm here. Hi. Thank you so much for having me. I'm Vanessa Aronson. I live on East 74th Street and I'm a local community leader and advocate. I joined Community Board 8, the Committee to protect our Lenox Hill neighborhood, Friends of the Upper East Side historic districts, the New York Landmarks Conservancy, Carnegie Hill Neighbors, Stevie Toss, and thousands of community members in strongly urging you to reject Lenox Hill Hospital's application unless all of the modifications recommended by Community Board 8 are made.

Due to the extensive scope of the proposed hospital expansion, there are significant negative impacts to the community and to city

hospital infrastructure. Along with members of Community Board 8, I have worked diligently to analyze and assess this rezoning proposal since it was first proposed in 2019.

The zoning application would authorize a protracted hospital expansion project to enlarge Lenox Hill Hospital far beyond what is permitted under current zoning, all for a poultry increase of just 25 additional patient beds. As a Lenox Hill patient myself, who delivered my son there almost exactly one year ago, I appreciate the need for renovation and do support necessary hospital upgrades within the zoning limits recommended by Community Board 8.

However, the scope of this application is not justified and would have detrimental implications, the applicant's proposed FAR of 12.5 is unprecedented for a hospital campus in Manhattan.

Furthermore, this project would involve prolonged periods of construction during and outside of business hours for at least 9 to 11 years, which would be highly disruptive to the community and could have implications for citywide

hospital infrastructure, including prolonged noise pollution, air pollution, traffic congestion, loss of natural light, and loss of revenue for local businesses.

The hospital expansion project will not address a critical unmet public health need on the Upper East Side or make the needed hospital services more accessible. A full complement of needlessly large, single-patient rooms would provide extra leverage for Lenox Hill to negotiate higher inpatient reimbursement rates with insurance providers and raise the cost of inpatient care for patients who are paying out of pocket.

Ultimately, upgraded patient rooms will increase the costs and decrease accessibility of receiving inpatient services at Lenox Hill Hospital for uninsured and underinsured New Yorkers. The proposed expansion project is unjustifiably extensive, would negatively impact city hospital infrastructure, and would unnecessarily disrupt the neighborhood for a decade. I strongly urge you to reject Lenox Hill Hospital's application. Thank you for your time

and consideration of my comments.

CHAIRMAN GARODNICK: Thank you, Ms. Aronson.

Nuha Ansari?

MS. ANSARI: Hello, commissioners. My name is Nuha Ansari. I'm speaking on behalf of Friends of the Upper East Side. Friends believes that at its core this redevelopment proposal for Lenox Hill Hospital is a zoning issue even more than it's a healthcare matter. Northwell is requesting an enormous upzoning of the hospital site that would completely upend the carefully balanced zoning framework that has long protected the character of Lexington and Park Avenues and their low-rise midblock.

The City's own planning documents underscore this. A 1983 Department of City Planning report describe Lexington Avenue as a uniquely narrow avenue with congested retail-oriented sidewalks and a very special neighborhood character. This character has been preserved for decades by zoning tools designed by your agency that have helped ensure livable contextual development in one of the city's most

densely populated neighborhoods. Northwell's current proposal includes a 436-foot-tall tower with oversized floor plates, a building that's wildly out of scale with anything else in the area.

This is poor planning and a clear violation of the zoning principles that have served this neighborhood well for decades. We support the goal of modernizing hospital facilities. Lenox Hill Hospital has a long and storied past on this block, and we recognize their need for updated facilities, but they have not presented an alternative approach. There's been little effort to consider the hospital's role within the broader context of New York City's Healthcare Network or its impact on the surrounding neighborhood.

Whether the proposed bulk is placed on Lexington Avenue or shifted mid-block, both options disregard the urban fabric of the Upper East Side and set a dangerous precedent for zoning and for institutional expansion across the city. We urge the Commission to stand with us and stand with your own history and call on Northwell to return with a plan that stays closer to as of right zoning and respects the longstanding

character of the neighborhood. Thank you.

CHAIRMAN GARODNICK: Thank you.

Andrea Goldwyn?

MS. GOLDWYN: Good afternoon, commissioners. I'm Andrea Goldwin speaking on behalf of the New York Landmarks Conservancy. The Conservancy is a 52-year-old organization dedicated to preserving, revitalizing, and reusing New York's historic buildings and neighborhoods. We want to ensure that New York's rich diversity of architecture continues to enhance the city, creating jobs, housing New Yorkers, encouraging sustainability, and welcoming visitors from around the world.

The Conservancy opposes Lenox Hill Hospital's redevelopment plan, which would radically change zoning on Lexington Avenue. Although this site is not a designated landmark, it contains several historic buildings designed by notable architects York and Sawyer and then is surrounded by historic districts. This proposal calls for the demolition of those buildings and would drastically disrupt the relationship of the hospital and its neighbors.

The city deserves world-class medical institutions. Everyone who's been in the hospital or had a loved one in the hospital can appreciate the interest in upgrading services. But there are experts who disagree with Lenox Hill's insistence that this is the only sized building that can meet their needs. There must be a way to do that without such a negative impact on the character and quality of life of the neighborhood. We urge you to demand a revised proposal that's closer to as of right. The proposal is not a minor change to the zoning.

The new building would be three times larger than what zoning currently allows. The hospital tower would have massive floor plates rivaling the Freedom Tower and exceeding those of any other hospital tower in the area. This upzoning of the Lexington Avenue site and the midblock on East 76th Street threatens the carefully calibrated zoning protections that have maintained the character of Park Avenue and Lexington Avenue and their low-rise midblock corridors.

It disregards Lexington Avenue's

historic constraints as a narrow pedestrian heavy retail oriented corridor with special neighborhood care character. The proposed tall building additions along 76 would disrupt hard-won low-rise character of the mid-block, which are largely residential.

If the proposal is approved, it would set a precedent for upzoning throughout the neighborhood and across the city. Thank you for the opportunity to express the Conservancy's views.

CHAIRMAN GARODNICK: Thank you. Andrew Soflof (phonetic), who will be followed by Alida Camp, and then Susan Holiday (phonetic).

MR. SOFLOF: Thank you. I'm Andrew Soflof and I'm the board president of a two-building cooperative 830 and 840 Park Avenue at 76th Street directly across from the hospital. Our buildings were constructed in 1911, so we had been neighbors of Lenox Hill for more than 100 years.

The massive tower proposed by Northwell simply shouldn't be approved to be built in this location. Northwell is requesting zoning law changes to construct a tower that exceeds the current zoning limitations by 250 percent. The

mass of an effective FAR of 12.5 as you've heard from others, it's unprecedented in any other hospital campus. And I note that in their chart, they're comparing hospital campuses to their building which is why it looks like they have less space than others, but that's comparing it to New York Hospital or NYU Langone, which are spread out over a large area.

As you've heard, I mean this is a structure that's comparable in mass to some of the largest buildings in the city, like the Empire State Building or one Vanderbilt. And there's nothing like it in any residential neighborhood of the city.

I really think it's just a land grab by a powerful institution and we don't need another palatial hospital on the Upper East Side. We have the best access to healthcare of anyone in the city. There are other neighborhoods in Manhattan where Northwell could build a state-of-the-art hospital or an entire medical campus in a neighborhood that needs healthcare services. On many of these sites, they could build a tower this size or even larger as of right

without the need for your approval or city council approval. And it would be at a lower cost and less disruptive than trying to shoehorn this building into the narrow streets surrounding 77th and Lexington.

The City Planning Commission should uphold the zoning laws that have been effect for more than 50 years or longer, and that have shaped the growth of a vibrant residential community. This project puts that community at risk and we ask the community -- the community ask the Commission to deny this application. Thank you.

CHAIRMAN GARODNICK: Thank you, sir.

Alita Camp. I'm sorry. Oh, okay.

MS. CAMP: Hello, sorry. Thank you for hearing my testimony. My name is Alita Camp. I'm a member of CB 8, but I'm speaking individually. However, I was the board chair when the hospital first revealed its plans. This plan is not the way for modernization of Lenox Hill for the following reasons:

It need not be all or nothing. If

it closed during construction, the modern hospital would be smaller and would give the hospital the community and the patients exactly what they need.

Lenox Hill has not been forthcoming about the effect on hospital size if it were to close during construction. Hospital beds are needed in New York's hospital deserts. We saw this during the pandemic, and it's gotten worse as Beth Israel closed downtown. Beth Israel would be a suitable envelope for a new or temporary hospital if Lenox Hill closed while it undergoes modernization.

Tellingly, Lenox Hill brings patients from the emergency room at the old St. Vincent's location downtown to the Uptown Hospital on 77th Street to be admitted. Elevator shafts are expressways for pathogens. A 43-story elevator is asking for trouble. Lenox Hill intends to be a luxury destination. The community should not be irrevocably harmed for a luxury hospital. On its original website, when it unveiled the plans, it noted crystal chandeliers, spa-like amenities, a Michelin chef, and a quoted patient who liked being in the hospital so much that she didn't want to

leave. Even now, it talks about the views from the tower.

Would you want to be admitted to a hospital undergoing construction? If it closed during modernization, it would be a lot smaller and construction would be faster. But the hospital wouldn't say any -- would not provide any specifics in response to my inquiry. It has been impossible to gauge how much smaller it would be. At the least, there should be specifics about the size, where it to close during renovations to assess the proper path forward.

The community has opposed. Plan approvals were almost all from unions and hospital employees. The plan size is staggeringly inappropriate for residential neighborhoods. We're full of hospitals and doctor's offices. Modernize, but not to build a tower that the neighborhood rejects. Zoning must mean something and context matters.

Not much outreach to the community has been forthcoming as one of the commissioners asked. When the hospital first unveiled its plans, the community board was not invited to the

presentation. Hospitals and doctors swear to do no harm. The building will harm the residential community for as long as this 43-story building exists, but the hospital could do much better if it were to close during modernization or by building in a hospital desert. Thank you very much for listening.

CHAIRMAN GARODNICK: Thank you. Susan Holiday who will be followed by Chad Purkey and then Paul Nowerski.

MADAM SECRETARY: Vice Chair, we do not have a phone number in the Zoom that matches Susan's administration.

CHAIRMAN GARODNICK: Okay. Chad Perky. Is he here?

MADAM SECRETARY: We're going to promote Chad. Mm-hmm (affirmative.)

MR. PURKEY: Hello? Can you hear me?

CHAIRMAN GARODNICK: Yes.

MR. PURKEY: Great. Good afternoon. In an interest of time, I'll be brief and submit fuller comments in writing. But my name is Chad Purkey and I'm speaking on behalf of the

association -- behalf of the Association for Better New York known as ABNI. I wish to express our strong support of the requested actions, which would allow for the first comprehensive investment in this critical healthcare facility in over 50 years.

We believe the requested actions in the current modified plan, the result of incredible lengthy engagement offers an appropriate balance between the hospital's needs and the site's use within one of the city's densest neighborhoods.

We echo comments from the borough president and I point to those from the Borough President's recommendations which point to the modifications that the applicant has made to their original plan; they've reduced the overall height, reduction of the construction timeline, and commitments and healthcare services. We commend the applicant for having spent years and making these important improvements to their proposal. The one that you're reviewing today.

After thorough review of the plans, we believe the current proposal and requested actions again reflected much improved and

the best balance between the hospital's operational needs and its physical footprint. Because of that, we encourage the Commission to support the requested actions. Thank you.

CHAIRMAN GARODNICK: Thank you. Paul Nowerski.

MR. NOWERSKI: Hi, good afternoon. Thank you for listening to me. My name is Paul Nowerski. I am the Senior Director of Pharmacy Services at Lenox Hill Hospital. I have been there for 22 years, and I think everyone on the council can agree that in the last 22 years, healthcare has dramatically changed and the use of pharmaceuticals has also dramatically changed.

We talk briefly about COVID and what happened during COVID, but when we take a look at space and changes, we learned the concept of ultra-low temperature re-freezers and what was the space requirements. We still keep those and we still look at the future of what that is going to look like in terms of what we need in space.

We take a look at federal regulations and things like USP 797 and USP 800, and 795. These are regulations that everyone knows

about and it expanded the space needed within a pharmacy.

So I'm talking about -- so when I first started there, we had maybe 40 square feet per hood and two hoods. We now need three hoods. The future with biologicals will say that we need more. And in the planning of this building, there's room to be able to expand it, to have better refrigeration and better storage. When I first started, we started with three refrigerators. I'm now at nine within my pharmacy.

If we take a look at my square footage for those USP 797, 800, I now have more than 500 square feet, where before I had less than a hundred. When we take a look at NIOSH regulations and hazardous medications, how many more hazardous medications do we have recognized today in the last 20 years? It's enormous. How do we store them? How do we distribute them? How do we compound them? What are the devices that we use? How do we store those devices? 10 years ago, we went to closest system transfer devices in our hospital to safeguard the people that compound and the nurses that administer. This takes space. I'm

sorry. I talk about my profession and the things that matter to us. We've added 10 clinical pharmacists, advanced practice that rounded ICU units, and in medical floors. These people need space to work and to operate.

They stand most of their day now on nursing units because they have no place to stand or they sit in a cramped office space to be able to handle off-hour items. We have services that last 24 hours a day by these groups versus having people on site because we can't do it on-site.

So just as a community of pharmacy, we sat through our hurricane and our snow storms. We hunkered down in the pharmacy to be able to service the Upper East Side of Manhattan. We've done so very admirably and I, you know, gratefully appreciate the staff that I've had and the time that I've had to do it. So I appreciate that the magnitude of this project may not be, but please consider some of those little nuances that we accept.

MS. RODD: Hello.

CHAIRMAN GARODNICK: Ms. Rodd, can

you hear us?

MS. RODD: Now I can. Can you hear me?

CHAIRMAN GARODNICK: Yes.

MS. RODD: Perfect.

CHAIRMAN GARODNICK: Proceed.

MS. RODD: Thank you. Sorry, it took a second. Good afternoon, everybody. My name is Jean Rodd. I am a 40-plus-year nurse from Lenox Hill Neonatal Intensive Care. I'm currently the secretary of the New York Professional Nurses Union. And I'm going to speak for a second about the -- in behalf of the redevelopment project. I'll speak to the NICU because it's what I know.

We are way too small and spatially we are a logistical nightmare. Despite small updates and refreshes, our footprint is from 1999 and it's my understanding that it cannot be changed without the addition of a lot of square footage. And now with a larger equipment -- larger lifesaving equipment and larger isolates to keep the infants in, it's almost impossible to navigate.

When a sick infant enters the NICU we have to move everybody around to make room for

the next admission; kind of feels like a volleyball game. In order to keep open areas for new admissions, parents have very little space and sometimes they have to wait for the staff to make room for them so that they can hold their infants. And there is no privacy for grieving parents, the families of babies that are sick or dying, or in the same waiting room as the families that are having healthy babies and celebrating. We have an amazing staff of providers, nurses, ancillary staff techs, et cetera. And we need an appropriate space so we can provide the best medical and emotional care that Lenox Hills' littlest patients and their and their families deserve.

Just as a side, I was born at Lenox Hill 62 years ago. My parents lived in Astoria. They came over the bridge so they could get the best prenatal care and I interviewed at Lenox Hill because of that and I'm still here. And I would like to see that amazing care continue in this place where it stood for the last 160 years or so. I thank you for your time.

VICE CHAIR KNUCKLES: Thank you. Troy Watt?

MADAM SECRETARY: Troy is no longer in the Zoom.

VICE CHAIR KNUCKLES: Thank you. Anthony Cohen?

MADAM SECRETARY: Anthony has left the Zoom.

VICE CHAIR KNUCKLES: Thank you. Bernard Seltz?

MADAM SECRETARY: And vice chair, we just were rejoined by Anthony Cohen who just called.

VICE CHAIR KNUCKLES: Okay. Can you go immediately to him?

MADAM SECRETARY: Yes. Anthony, we're going to promote you. Bernard, you'll be next.

CHAIRMAN GARODNICK: Mr. Cohen, are you there?

MADAM SECRETARY: Anthony, you have the ability to unmute in Zoom. Anthony, you should be able to unmute in Zoom.

Vice Chair, Anthony has left the Zoom again.

VICE CHAIR KNUCKLES: Okay.

MADAM SECRETARY: So we'll move on to Bernard.

VICE CHAIR KNUCKLES: Mr. Seltz?

MADAM SECRETARY: I think he's having trouble getting on. He's going to try to come back in.

VICE CHAIR KNUCKLES: He can try to reenter and we'll admit him.

MADAM SECRETARY: Bernard, you should be able to unmute in Zoom.

Bernard, you should be able to unmute in Zoom. Okay, Bernard is not unmuting, so we can move on to --

VICE CHAIR KNUCKLES: Okay. Patricia Rossetti?

MADAM SECRETARY: We have Patricia.

VICE CHAIR KNUCKLES: Or do we?

MADAM SECRETARY: Patricia you should be able to unmute in Zoom. Patricia has declined promotion but you should be able to unmute in Zoom, Patricia.

VICE CHAIR KNUCKLES: Should move on then. Let's have Peter Meyer.

MADAM SECRETARY: We have Peter in Zoom. And just a general Zoom note, for those on Zoom, you will get a prompt to be promoted. We can also unmute you from the attendee column.

Peter, you should be able to unmute.

MR. MEYER: I have just unmuted myself. I think I'm available.

VICE CHAIR KNUCKLES: Thank you. We can hear you. Thank you.

MR. MEYER: Just somebody finally made it through. I'm glad that I was able to do that.

VICE CHAIR KNUCKLES: Yes.

MR. MEYER: By way of quick introduction, I'm an economist. I've had about 50 years experience doing local economic development and conducting regulatory and construction cost-benefit analysis and EIS reviews. I'm really speaking for myself, but also with the encouragement of the committee to protect our Lenox Hill neighborhood. And I've looked over the proposals and the draft EIS and my comments today focus on the project scale and the duration of the

construction period.

We've got both the breadth and the scale and the height of the proposal and serious issues that we need to pay attention to. We're talking about the demolition of a virtually an entire city block of otherwise functional buildings to provide 25 additional beds and additional emergency bays and operating rooms where none of which is justified in the plans that I've seen with any demonstration of medical need in this particular neighborhood or the Upper East Side. Others have already spoken at that point.

Buildings that are now serving Lenox Hill Hospital are designated for elimination, apparently because they're in the way of the massive tower that is proposed. The tower itself, whether built for whatever reasons, and it's not clear to me that it's going to require that the proposed new beds and offices and surgical suites are going to require that much space, are inconsistent with the character of the neighborhood. I don't need to dwell on that. But the impact falls not merely on the immediately adjacent blocks, which is all that the DEIS refers

to but also on the aesthetic and urban aesthetic, quality of life of resonance in adjacent blocks, up and down both sides of Lexington and Park Avenues.

The proposed heights can't be justified as I suggested. There appears to be no real public interest served by adversely affecting the neighborhood. But the impact is dwarfed by the size of the project in terms of its timeline. Nine years is ridiculous.

Nine years of noise, fumes, dust project-generated congestion diverted and limited vehicular and pedestrian traffic flows, and loss of available street parking is going to undermine property values and impair the viability of a whole range of businesses on Lexington Avenue as well as all those residential properties, decade -- decline over a decade is going to add -- is going to be very, very difficult to overcome and the rationale for this is nothing more than the need to keep the hospital open when in fact there is a surplus of hospitals on the Upper East Side. I'll stop there. There's a 14-page document reviewing the DEIS that I've already submitted. Thank you.

VICE CHAIR KNUCKLES: Thank you,

Mr. Meyer. Thank you.

Stacy Krush (phonetic.)

MS. KRUSH: So I just want to start off with thanking you. But no increase in patients or staff. It just doesn't fit in the space. For the last five years, I've been involved in trying to make sense of the Lenox Hill Project. I've been on the task force with Gale Brewer. While the players of the hospital have changed several times over during that time, I have been here the whole time as have my Upper East Side neighbors and community steadfast in our opposition. Why? Because we're the people who live here. We're not the hospital staff that come and go to work and then go home somewhere else or the transient patients or visitors. This is our home. We are the actual community who have to live with a massive, oversized, unnecessary structure in our residential community forever. Most of the hospital staff, I'd ventures say, won't even be there 10 plus years from now after construction but they will have had to work in a dangerous construction zone all the while.

And this is an abstract. I invite

each of you to join me on the corner of 76 and Lex to see firsthand in reality not in a glossy presentation what this looks like. Yes, the hospital is outdated and dilapidated. In fact, it's crumbling and it's a shame that Lenox Hill's let their facility fall into such disrepair for decades now. They're trying to make it the community's problem. The city's problem. It's not.

Lenox Hill yes, renovate, modernize. Bring your facility up to the 21st century standards at least before the century is half over but not at the size and scale in this neighborhood. It's a residential neighborhood. 12.5 FAR, 250 to 500 percent zoning increase on the Narrowest Avenue, I don't know why we just don't stop at that. No more staff, no more patients, 25 more beds, shoehorning a 40-story midtown size building in a residential neighborhood, seven loading bays, six ambulance bays. Really? When they started with a 516-foot tower and then came back with a 436-foot tower, it's veiled as a compromise. It is not. We all know that trick.

Let's be clear. These massive

heights in bulk buildings have no place in Lenox Hill or any residential neighborhood. A structure of this magnitude will overwhelm the area and set dangerous precedents across the city. And here's the irony we've talked about. They don't even need this kind of expansion. There's a platitude of beds and they have a high vacancy rate. With thoughtful urban planning and maintaining the sanctity of zoning, residents can plan our futures in this city but not if it's all up for grabs to companies with the deepest pockets.

Please stand up for our city and our sacred zoning as it should be upheld as intended to protect us. The people who make these communities our homes. We won't be steamrolled by corporations building for their profit at our expense. You are responsible for shaping the city's future, not Northwell Health. The community has spoken loudly and clearly. You must say no. Thank you.

CHAIRMAN GARODNICK: Thank you. Simcha Silverman, to be followed by Crystal LeBron (phonetic).

MR. SILVERMAN: Good afternoon.

Thank you for --

CHAIRMAN GARODNICK: Hello. Is this Mr. Silverman?

MR. SILVERMAN: Yes, it is. Thank you.

CHAIRMAN GARODNICK: Thank you. You may proceed.

MR. SILVERMAN: Thank you. My name is Simcha Silverman. I'm very proud employee of Lenox Hill Hospital for over a dozen years, I serve as the Director of Spiritual Services. I'm here today to strongly encourage the Commission to support the redevelopment plan of Lenox Hill Hospital. In my capacity, I see many, many patients and families from all the communities that Lenox Hill Hospital serves and the entire trajectory of their hospitalization and course of illness. I look forward to these patients and their families receiving top-quality medical care in an optimized facility in a place where the most up-to-date medical care can be delivered, where life transitional moments can be marked in the most appropriate fashion, and so therefore, in advance, I thank the Commission for standing with patients

and families, standing with -- in delivering best quality medical care and supporting the redevelopment plan of Lenox Hospital. Thank you.

CHAIRMAN GARODNICK: Thank you, sir. Arlene Asano-Henry (phonetic), who will be followed by Nadja Valera (phonetic), who will be followed by Deger Blunt.

MS. LEBRON: Hello I am Crystal LeBron. Good morning. Well, actually good afternoon. I am a local 79 laborer and I am in support of the Lenox Hill Project. As a lifelong New Yorker and a mom, I know there's a lot of challenges of finding quality healthcare for families in the city and this would be a major upgrade for that. We need high-quality care and good-paying jobs and construction. Building with union labor provides family health benefits and family-sustaining wages for people like myself. Frontline nurses and healthcare workers as well deserve to work through better medical facilities in order to support their patients. Thank you.

CHAIRMAN GARODNICK: Thank you. It's now Arlene Asano-Henry.

MADAM SECRETARY: Arlene isn't

here. Looks like.

CHAIRMAN GARODNICK: Okay.

MADAM SECRETARY: Can we move to the next?

CHAIRMAN GARODNICK: Nadja Valera.

MS. VALERA: Hello, my name is Nadja. I'm actually reading a statement on behalf of a local 79 member Khalil Vasquez. He's working right now, so he couldn't be here.

"I said, good afternoon. My name is Khalil. I'm an East Harlem resident and a member of Labor's Local 79. I'm here to support the Lenox Hill Project. I have to work today as do many of my 10,000 brothers and sisters so they can't attend long hearings like this. Our entire city will benefit from family-sustaining jobs, career opportunities for New Yorkers of color and low-income households, and expanded medical facilities.

We need more services at Lenox Hills, like single-patient rooms. Leaving things as they are would be a huge disservice to my community and we cannot afford that. Opposition to this project is narrow but Lenox Hill can uplift

hundreds of families from surrounding areas like Harlem, South Bronx, and the whole east side of Manhattan through union jobs in construction. I joined Local 79 through the apprenticeship program and it changed my life. Now more than ever, we need to make sure that everyone has access to top-tier healthcare facilities and family-sustaining jobs. Thank you."

CHAIRMAN GARODNICK: Thank you. Deger Blunt?

MADAM SECRETARY: I don't see her in the Zoom.

CHAIRMAN GARODNICK: Okay. Ellen Goldstein, to be followed by Layla Law-Gisiko.

MS. GOLDSTEIN: Good afternoon. I'm Ellen Goldstein. I'm a resident in the area for 40 years. The outrageous zoning variance request is not justified. Even Northwell Health's longstanding CEO Michael Dowling said recently on numerous occasions and I quote, "The hospital is only one part of the continuum of care. The hospital is not as centric anymore as it used to be."

The hospital is not the center of

the universe anymore, yet Northwell certainly wants to make themselves the center of the Upper East Side. And they just built a 200,000-square-foot building on the same streets between 76 and 77th Street just one block away. How does that figure in?

Now with the recent announcement of Michael Dowling retiring this fall, it's a great time to say no and kick this proposal back to Northwell. I can't imagine that it's impossible to figure out a way to build a great community hospital reducing the size and construction timeline that's in keeping with the scale of the neighborhood. Thank you.

CHAIRMAN GARODNICK: Thank you. Layla Law-Gisiko.

MS. LAW-GISIKO: Thank you. Good afternoon commissioner and members of the group. My name is Layla Law-Gisiko. I am the president of the City Club of New York. We stand in unequivocal opposition to the Northwell Health proposed expansion of Lenox Hill Hospital. This proposal is a textbook example of zoning creep disguised as institutional necessity. The requested of zoning

would enable the construction of the 436-foot medical tower with four plates that grossly exceed both the neighborhood norms and the functional requirements of contemporary hospital design.

The proposed FAR increase from 6.5 to 12 FAR would obliterate the carefully calibrated bulk height and sky exposure plain regulation that have preserved midblock and avenue scales. In land use term, this is not a desired modernization, it is a spot zone institutional incursion into a district governed by contextual zoning precisely to prevent this sort of vertical leapfrogging.

We recognize the importance of medical infrastructure but the floor area increase and the net -- for a net gain of only 25 beds is simply inadequate. This is not planning. It is an FAR distortion algorithm operating in defiance of logic, need, and neighborhood fabric.

Lenox Hill admitted that they do not intend to outgrow their capacity. I guess they only want to outgrow their zoning envelope and this is not okay. Even if one were to entertain the idea of a strategic expansion, Northwell's proposal fails to the basic test of contextual fit. The

existing 1916 and 1937 buildings present significant examples of 20th-century institutional architecture and their eraser would amount to architectural amnesia. Something Northwell cannot treat.

Furthermore, this application is part of a troubling city trend. Institutionalization -- institutions pursuing zoning tailor-made for their ambitions, not their surroundings or not the patient's needs. The City Club has long has long advocated for incremental, transparent, and context-sensitive planning. This proposal violates all three.

So we respectfully and strongly urge the Commission to reject this application as currently constituted and call upon Northwell Health to return with a revised scheme that conforms to the underlying R-10 zoning envelope and also listen to the community. There is a better building, there is a better hospital; the proposed one is not one of those. This neighborhood and this city deserve better than a 436-foot loophole. Thank you.

CHAIRMAN GARODNICK: Thank you.

Ann Goodbody (phonetic).

MADAM SECRETARY: Ann is not in the Zoom room.

CHAIRMAN GARODNICK: Okay. Walter Dean to be followed by Lois Utley.

MR. DEAN: Thank you very much. Good afternoon. My name is Walter Dean and I appreciate everything you do on the Planning Commission. Please know that despite what the hospital leadership, whose chairman is purportedly earning $7.7 million a year and their highly paid consultants have said, the hospital has not reached out to even one neighboring building and does not have the support of any community-based organizations. The hospital is surrounded by several landmark districts and not one landmark organization endorses this project.

The proposal is three times the size of what is permitted and would be one of the largest and I would say ugliest buildings for a two-mile radius. Their photoshopped slides of the 1 million square foot model are attempts to gaslight us all and do not represent reality. The hospital has also not worked with neighbors on the

current Third Avenue, 200,000 square-foot construction project, which has caused massive traffic delays every day for more than half a mile.

They are also not just working Monday through Friday for eight hours and I'm told they have permission for 24 hours construction. They are warehousing apartments on East 76th Street that could be lived in and they are not good neighbors and they are not good landlords according to many of their residential tenants. Their subway improvements very importantly do not include direct access to the hospital. With pedestrians still having to exit onto the already congested sidewalk.

Their proposed covered colonnade is nothing more than a permanent scaffold, which no serious urban architect would ever propose for New York City. Their timeline is three times longer than it took to build LaGuardia Airport, which was constructed with planes taking off and landing and millions of passengers coming and going.

All of my neighbors join me in urging you to reject this ridiculous proposal. We understand that our hospital needs to be renovated, but this is the wrong tower with a timetable which

will destroy our neighborhood. A new plan is needed with unified height from Lexington to Park avenues with dramatically shortened timetables.

The hospital needs to start working with its neighbors and with its neighborhood. They also may want to consult with HOK, which has built several beautiful hospitals around the world that have not faced significant community opposition. Also, there have been several magnificent tall towers that have been constructed in our neighborhood, including a 36-story tower down 77th Street that have been supported by many of our neighbors and each has been built in under two years.

So this is not about NIMBY, but our issues are with the timetable, the horrific design, and the non-contextual spot zoning that the current hospital leadership is trying to force on all of us.

CHAIRMAN GARODNICK: Thank you, Mr. Dean.

MR. DEAN: Thank you.

CHAIRMAN GARODNICK: Lois Utley.

MS. UTLEY: Good afternoon.

Thanks for sticking in with us and listening. We really appreciate your patience. I'm Lois Utley. I'm a Manhattan resident and I'm advocate for health equity. I coordinate a statewide network of advocates dedicated to ensuring that access to hospitals and other health facilities is equitable and affordable for all New Yorkers.

So Lenox Hill Hospital is asking you really for some significant changes to the zoning and the question is whether the benefits justify those significant changes. You know, certainly, they do need to modernize that hospital. It's an old, I would call it beat-down hospital. It does need modernizing, but there are several compelling reasons why you should not approve it from a health equity standpoint.

First, this project would add hospital capacity where it is not needed while other New York City neighborhoods are losing their community hospitals or already have too many -- too few hospital beds leading to overcrowding and long waits.

The Upper East Side of Manhattan, this district, has five hospitals, including Lenox

Hill, which provide 10.5 hospital beds for every 1000 residents. That is nearly four times the citywide average of 2.7 hospital beds per thousand residents. So they're oversaturated with hospitals and beds in that neighborhood.

Other areas within the city are in much greater need of more hospital capacity. The Borough of Queens, for example, has only 1.65 hospital beds for every thousand people. Brooklyn has only 2.1. The Lower East Side just lost its longtime community hospital and now has less than a -- one bed per thousand people below 14th Street. Moreover, Lenox Hill Hospital can't even fill all the beds it has now.

State DOH data show that last week nearly 30 percent of the beds at Lenox Hill Hospital were vacant. And I want you to note that they were counting from 344 beds, not 450. They reduced the denominator, as the president mentioned, they changed the denominator and now it's 30 percent of 344 beds instead of previously it was 40 percent of 450 beds. Compare that to Harlem Hospital, 2 percent vacant, New York Presbyterian, 11 percent, NYU Langone, 13 percent,

Woodhull 7 percent.

CHAIRMAN GARODNICK: Thank you, Ms. Utley. Thank you. You can submit if you have written. Yes. Okay.

MS. UTLEY: I submitted a written testimony that goes into this in more detail.

CHAIRMAN GARODNICK: Okay. And we do have a question.

MS. UTLEY: Okay.

CHAIRMAN GARODNICK: Commissioner Goodridge.

COMMISSIONER GOODRIDGE: I was actually interested in hearing the rest of the comparisons of the vacancies.

MS. UTLEY: Okay. Jamaica Hospital Center, 11 percent. And I had an additional comparison statistic, which is, what is the percentage of discharges at Lenox Hill Hospital that are Medicaid insured? According to Spark's data, that's the state website, 18 percent, Manhattan Hospitals as a whole, 29 percent, New York City Hospitals, 39 percent. So they're serving a far smaller percentage of their patients are Medicaid insured, in other words, low income

than is true across Manhattan and across New York City.

CHAIRMAN GARODNICK: Thank you, Ms. Utley.

Elizabeth Crowley should be followed by Barbara Zinn Moore, and then Kathleen Flynn.

Elizabeth Crowley.

MS. CROWLEY'S ASSISTANT: Hi, folks. We're -- we're just getting set up here. Could we come on after the next speaker, please?

CHAIRMAN GARODNICK: Who is speaking?

MS. CROWLEY'S ASSISTANT: This is her assistant. She's just coming on right now in a moment. Would it be okay for us to come on after the next speaker?

MADAM SECRETARY: We could call up the next speaker and then return to Elizabeth after.

CHAIRMAN GARODNICK: Okay. Barbara Zinn Moore.

MS. ZINN MOORE: Hi, can you hear me?

CHAIRMAN GARODNICK: Yes.

MS. ZIN MOORE: Okay. My name is Zinn Moore and I'm honored to serve as the Chair of the Auxiliary of Lenox Hill Hospital. I've seen firsthand how this hospital touches people's lives every day from teaching new parents infancy PR to giving local students their first experience working in healthcare through summer internships. But more than that, I'm here today as a member of this community, as a New Yorker, who like so many of you, depends on Lenox Hill not just as a hospital but as a lifeline.

For me, it's personal. My grandson was born at Lenox Hill and that will stay with me forever. When families welcome new life, when emergencies arise, or when our loved ones need world-class medical care, Lenox Hill is there. But here's the truth. While the doctors and nurses at Lenox Hill are among the best in the world, the hospital itself, the infrastructure, emergency department, ambulance access doesn't reflect that excellence.

At a time when hospitals across the city are struggling or even closing, Northwell

Health aims to reinvest in our community's health by strengthening Lenox Hill. This proposal isn't about expansion for expansion's sake. It's about ensuring that Lenox Hill can continue to service at the level we deserve. A new state-of-the-art emergency department will provide privacy and efficiency, which are critical for patients in their most vulnerable moments. An improved subway entrance will enhance safety and accessibility and a modern dedicated ambulance which will reduce congestion and delays that impact emergency response times.

I understand change can be difficult. However, what's even more challenging is needing urgent medical care in a facility that no longer meets the requirements of (unintelligible). We should not have to choose between world-class doctors in a world-class hospital. We deserve both.

Lenox Hill has served as a pillar of the community for generations. I've witnessed how much Lenox Hill means to the community. Supporting this project means advocating for better healthcare for all our neighbors. Not just for

today, but for generations of New Yorkers to come. I urge you to support it. Thank you.

CHAIRMAN GARODNICK: Thank you. Is Ms. Crowley ready?

MS. CROWLEY'S ASSISTANT: She is. She just raised her hand from her other Zoom account. Did you guys see that? If you could turn that one on. Thank you.

MADAM SECRETARY: Yes. We're going to promote.

MS. CROWLEY: Good afternoon.

CHAIRMAN GARODNICK: Good afternoon.

MS. CROWLEY: Good afternoon. My name is Elizabeth Crowley and I'd like to thank the New York Planning -- New York City Planning Commission, especially your Commissioner Dan Garodnick, my former colleague at the New York City Council. I want to thank all your board members as well as your staff for the work that you do and for allowing me the opportunity to testify today.

I'm the president and CEO of the Building Trades Employers Association, representing over 1,200 businesses from union construction

management firms to small MWBE trade contractors. I'm here today to voice our support of the Lenox Hill Hospital Redevelopment Project, .

Northwell's plan to modernize and rebuild the Lenox Hill Hospital will create thousands of good-paying union jobs with as little neighborhood interruption as possible. I'd like to emphasize two important aspects of the current plan. First, a state-of-the-art healthcare facility that will replace the 160-year-old hodgepodge of buildings we now have. This plan will take the antiquated buildings and replace them with the latest in surgical care and technology, improving experiences and outcomes for patients at Lenox Hill Hospital. And second, I'd like to highlight the tens of millions of dollars that Lenox Hill is investing in community incentives.

The plan will invest in the subway and the street infrastructure adjacent to the property with a new and improved six-train station that will finally be accessible to all. Moreover, Northwell will be taking ambulances off the street into the envelope of the building, mitigating traffic and easing congestion for local residents

and businesses in the surrounding area. The investment that Northwell is making at Lenox Hill will ensure future generations will continue to receive healthcare that is second to none.

I'd like to thank you today for allowing me to testify again and for your consideration of my testimony. Thank you.

CHAIRMAN GARODNICK: Thank you. Kathleen Flynn, to be followed by Eric Farbman and then Phyllis Cohen.

MADAM SECRETARY: Kathleen, you should be able to unmute in Zoom.

MS. FLYNN: Thank you. Good afternoon. My name is Kathleen Flynn. I'm President of the New York Professional Nurses Union, NYPNU. NYPNU represents the over 1000 registered nurses at --

CHAIRMAN GARODNICK: Wait a minute. I'm sorry, Ms. Flynn. Hold on for one second. We need a -- we've lost our quorum.

MADAM SECRETARY: Kathleen, we're going to pause your testimony real quick. We have to establish a quorum.

MS. FLYNN: Thank you.

CHAIRMAN GARODNICK: No, you're fine. You're fine. We need one more. Okay. I apologize for the interruption, Ms. Flynn. Please, proceed.

MS. FLYNN: Okay, thank you. So, as I said, NYPNU represents the over 1000 nurses at Lenox Hill Hospital and those nurses absolutely support the redevelopment plan. In addition to being president of NYPNU, I was a bedside nurse at Lenox Hill Hospital for over 38 years and I'm extremely proud of the care provided by the nurses, physicians, and ancillary staff at Lenox Hill Hospital. But the nurses do recognize they're acutely aware of the need for -- to upgrade and renovate the facility in order to provide the best possible care in the future.

I retired early from bedside nursing and one of the driving reasons for me leaving the bedside was dealing with the day-to-day obstacles of working in an outdated facility, having to search for equipment, for chairs, getting chairs for parents to sit in, having to stand up while feeding neonates because there was no place for me to sit. That does wear on nursing staff,

which is why we are totally endorsed the redevelopment plan. Thank you.

CHAIRMAN GARODNICK: Thank you. Eric Farbman.

MR. FARBMAN: Good afternoon, Commissioners. Thank you for allowing me to speak on testimony on behalf of this. My name is Eric Farbman. I'm a proud member of Local 3 IBEW. Local 3 IBEW represents 20,000 members that work in New York City and we are in favor of this project for the Lenox Hill Redevelopment Project. Projects like these create good-paying jobs for professional electricians, such as the members of this Local 3 IBEW, as well as many other building trades who are desperately in need of these jobs.

In addition, we'll be getting a new state-of-the-art medical facility that the citizens of this great city deserve so desperately. Thank you very much for your time.

CHAIRMAN GARODNICK: Thank you, sir.

Phyllis Cohen, to be followed by Pierre Von Boxdale (phonetic). I hope that's correct pronunciation.

MADAM SECRETARY: Ms. Cohen, can you hear us? Can you unmute?

MS. COHEN: Can you hear me now?

CHAIRMAN GARODNICK: Yes. Please proceed.

MS. COHEN: Thank you. My name is Phyllis Cohen and my home is the Upper East Side. I asked for time to speak today in favor of this project. I come to you not just as a member of this community, but also as an employee of the hospital. In addition, I am also someone who relies on Lenox Hill for my family's healthcare and my own. I therefore have a unique perspective on this issue.

I've experienced and witnessed firsthand the outstanding care provided by the dedicated staff at Lenox Hill. The clinical and non-clinical teams are exceptional. However, the building in which we perform these daily miracles is simply not up to par. The aging infrastructure and cramp spaces make it incredibly challenging to provide the optimal care our community deserves in a healing environment.

I hear some of the neighborhood,

my neighborhood, refer to this as a vanity project and intended to cater to the wealthy and a way to change charge higher pricing. Let me assure you, it is anything but that. This community narrative is very shortsighted, untrue, and so disheartening to hear. I collaborate with a team of social workers at Lenox Hill that screen all patients admitted to the hospital to identify non-medical factors that influence a person's health and well-being. We are serving increasing numbers of patients who are homeless, living in shelters, are food insecure, and have no support systems to support their transitions outside of the hospital.

The goal of this project is about providing the best possible experience for all and honestly, a safe and efficient work environment for the staff who dedicate their lives to caring for us. My team and I speak with patients and families daily expressing their frustrations about the care environment; that is the true community we are serving. They want the dignity of a private room and bathroom. They're understandably distressed by noisy roommates, late-day patient admissions to adjacent beds, waking them up in the middle of the

night, sharing facilities, and the lack of privacy and space for their support persons.

We often play King Solomon trying to facilitate fairly allocating limited resources. Patients and families say how mortified they are when being taken from an ambulance and displayed to all the pedestrians walking on 77 streets. These are true -- not trivial complaints.

I understand the concerns about the disruption during construction and I appreciate the change that change can be difficult. This is an investment in our community's health and future. I urge you to approve this project and allow Lenox Hill to build a facility that matches the caliber of care it provides. Thank you.

CHAIRMAN GARODNICK: Thank you. Good.

MR. BOXDALE: Good afternoon, Commissioners. My name is Pierre Von Boxdale. I'm a resident of the neighborhood on 77th and Third. My family has been there since the late sixties. I rise today to voice strong opposition to the current, outrageous, and flawed Northwell Health expansion plan for Lenox Hill Hospital.

This plan has fundamentally disregarded the input and needs of our community organizations. It proposes a flawed design that importantly was not approved by Community Board 8. Furthermore, Northwell Health is attempting to ignore the current zone footprint of Lenox Hill Hospital.

From the very beginning, Northwell's ambition has been clear; to transform Lenox Hill into a massive flagship medical facility, a destination hospital aimed at attracting national and worldwide patients. This vision takes no account of the actual neighborhood it resides in, and the impact it will have on us.

Let me be clear. Our community is not against upgrading the current hospital. We are not against local union working, but the sheer enormity of this proposed project is simply not needed in our community. There are other underserved areas of this city where new hospital facilities are genuinely and desperately needed. Northwell should look there. Therefore, I urge you to vote down this project. Thank you.

CHAIRMAN GARODNICK: Thank you,

sir. Stephanie Reckler (phonetic), be followed by Alexander Hodas (phonetic), and Nora Ryan.

MS. RECKLER: Good afternoon. I'm Stephanie Reckler. I have lived on the Upper East Side for the past eight decades and I'm one of the original members of the Committee to protect our Lenox Hill neighborhood. I've also been president of the Board of 885 Park Avenue for over 25 years. I urge you the Commissioners to examine Northwell's application for the development of Lenox Hill Hospital in terms of how it will destroy a beautiful, thriving neighborhood for no need.

During this session, you will hear many voices in opposition to the application and many in favor. Because I want to use my precious time constructively, therefore, what would've been said last in my testimony comes first. I invite you Commissioner Garodnick and your fellow commissioners to take a tour of the neighborhood and the site where Northwell would like to construct the tower in question. You'll be able to put in context everything that you have heard this morning. I congratulate you, the commissioners on your probing questions. I hope you question the

answers.

Everyone agrees, including Michael Dowling, the CEO, that healthcare is evolving and fewer patients will be treated in hospitals. Northwell has never acknowledged this evolution of healthcare needs nor has Northwell acknowledged the easy accessibility of healthcare to six world-class hospitals on the east side. How, besides Northwell says we need better healthcare on the Upper East Side. Tell me. We certainly don't need better healthcare on the Upper East Side. We are privileged to have the six world-class hospitals.

Lenox Hill Hospital has always been known as a good community hospital. My mother in the 1950s worked on the auxiliary. We appreciate the hospital as a good community hospital. Northwell, in the 15 years that they have owned this hospital, has let it fall into disrepair. Northwell should make Lenox Hill Hospital an outstanding community hospital known throughout the city as the best community hospital there can be. And they should build their signature hospital on a more appropriate site in an area that is calling out for better healthcare.

We are appalled at the entitlement that Northwell Health has shown in trying to steamroll their application through the ULURP process. Don't wait for a minute that they have listened to the 6,000 residents who belong to the Committee to protect our Lenox Hill neighborhood. I have developed the database. I know exactly who the 6,000 people are.

CHAIRMAN GARODNICK: Thank you, Ms. Reckler.

MS. RECKLER: Okay.

CHAIRMAN GARODNICK: Thank you very much.

MS. RECKLER: Thank you, Commissioners.

CHAIRMAN GARODNICK: Thank you. Alexander Hodas to be followed by Nora Ryan.

MR. HODAS: Thank you, Chairman Garodnick, vice Chair Knuckles, and members of the Commission for hearing testimony today. My name is Alex Hodas and I'm here today to speak in opposition of Northwell Health's plans to renovate Lenox Hill Hospital. Others here have spoken to the specifics around why these zoning exemptions

are completely unwarranted. So I'm just going to speak from the heart.

I'm a lifelong New Yorker. I was born in Lenox Hill Hospital. I grew up in the Upper East Side and today I lived directly across the street from the hospital on 77th and Lex with my wife and two young children. I love growing up in the Upper East Side and I've always been fond of Lenox Hill Hospital for obvious reasons, but there is no justification for these renovation plans to be approved. The neighborhood does not need it, the community overwhelmingly opposes it, the scale of the proposed project and result in construction is completely out of line with anything resembling appropriate, and the expected construction timeline would cause undue harm to the community, especially those of us that live closest to the hospital.

And let me just note, those of us that live in buildings where Lenox Hill already leases parking, can attest to the fact that the parking is completely inadequate today and will become an absolute nightmare during proposed construction timeline and beyond, especially for all those construction jobs that we brought in. So

those claims about it wouldn't be an impact are just completely wrong.

I've not met a single member of the community that wishes to see the project move ahead. If it goes forward, our lives will be forever altered for the worst. Do no harm would not be met here. My children and all the children that live in neighborhood will have their childhood -- childhood forever marred by this project should you choose to move support it and move forward.

It is telling to me and to everyone here, and it is quite obvious, that the only people in here who support this project are those that stand to benefit financially whether they be employed directly by Northwell or stand to benefit from the lengthy construction timeline and costs. I recognize, and we can all recognize the benefits of modernization but I would encourage all of you to recognize that at what cost.

If you cannot do that, then I think it is prudent to consider other alternatives, up to and including redirecting these resources to other areas that need it more, even if that comes at the expense of Lenox Hill Hospital itself up to

and including its closure. More importantly, if you cannot be responsive to the community that you purport to serve, then you are no member of the community at all.

Now, chairman Garodnick, if you were sitting there, I would say I remember meeting you when you were first running for City Council 20 years ago and you pledge to represent our interests in the Upper East Side. I urge all members of the Commission to do that today and respect the wishes of the community who will bear the brunt of the most egregious adverse impacts that will be faced by this hospital development plan. Reject Northwell's efforts to take advantage of the community. I urge you to vote "no." Thank you.

CHAIRMAN GARODNICK: Thank you. Nora Ryan, to be followed by Valerie Mason, and then Sally Shaw.

MADAM SECRETARY: Nora, you should be able to unmute on Zoom.

MS. RYAN: I -- yes. It would be easier. I'm just getting out of a car. Could I leave it to the next person and I'll come in, in person? Would that be all right?

CHAIRMAN GARODNICK: Okay. But you'll have to be quick. We have a lot of speakers.

MS. RYAN: Okay. I'm on my way in. Thank you.

CHAIRMAN GARODNICK: Okay.

MADAM SECRETARY: Okay. We'll see you in a bit.

CHAIRMAN GARODNICK: All right.

MS. RYAN: Great. Thank you.

CHAIRMAN GARODNICK: You would be Ms. Mason?

MS. MASON: I would be, yes. Thank you.

CHAIRMAN GARODNICK: Thank you.

MS. MASON: Stepping in for the lady who's not here.

CHAIRMAN GARODNICK: Okay.

MS. MASON: My name is Valerie Mason and I'm proud to say and honored as well to be the chair of Manhattan Community Board 8. And I am happy to be with all of you here today. I am -- I had prepared remarks but since so much time has passed since this hearing began, I wanted to

address a couple of points.

First, I just want to say thank you because it's been obvious to me that the members of the Commission have read our resolution in which we disapprove this application unless certain conditions were met. We have approved applications for hospitals beyond zoning limitations, most recently a couple of months ago. I believe that the charts that were shown earlier are not really representative in terms of not comparing apples to apples. I know that you all are familiar with the various different zoning limitations on the east side as well as the rest of the city. And so to compare Lexington Avenue on 76th Street with York Avenue and 68th Street, well, frankly, there is no comparison. And that's how we looked at this.

Our community board and our community, I'm so proud to have so many members here today, speaking in their individual capacities to talk about how these locations are different. There was not a lot of community engagement here. This proposal first was made in 2018, 2019 at a height of 500 feet. And I really am kind of

insulted to say, oh, we came down from 500 feet to 400 feet. Well, no one ever agreed to that. I mean, that's like saying we were originally at 10 at -- you know, 100,000 feet height. It's ridiculous. We have tried to engage with the hospital over the years and finally after repeated requests for meetings and coming to our meetings, the dialogue finally began at the end of 2024.

That's why we put our proposal in terms of a disapproval unless certain conditions were met because we felt if we went a different way, it would give a much different impression of how this has all gone on. And I think the testimony you have heard in the previous couple of hours tells you that we believe yes. I think the commissioner said there's an element of distrust here and I think you've hit the nail on the head. And that's why we operated the way we did with the disapproval that we issued.

We spent countless hours on this. We heard from everyone, 6,000 names on a petition. One over 100 members of our community and from other parts of the city testifying. I attended borough board meetings where other chairs of other

boards were saying, "You guys are hospital rich. Why is this hospital trying to do this?" Well, I don't have the answer for that but I think we did hear a commercial here today from Lenox Hill Hospital about how they want to attract the richest members of our community who need healthcare time. And I hope you will hear that too. Thank you.

CHAIRMAN GARODNICK: Thank you, Ms. Mason. We have a couple of questions.

MS. MASON: Okay.

CHAIRMAN GARODNICK: Commissioner Osorio and then Commissioner Goodridge.

COMMISSIONER OSORIO: Thank you, Vice Chair Knuckles. Thank you for your comments and thank you for being here. The -- quick question. So have you received a response from the applicant to your comments? To your formal comments?

MS. MASON: To our actual resolution? No. I think -- what we did say that we would speak, we have been having somewhat of a dialogue but I think everyone is rightly looking towards this body. We respect the process. The Manhattan Borough President weighed in. I mean, an

approval with 17 conditions is not much of a recommendation in my opinion. But --

COMMISSIONER OSORIO: But you haven't. You haven't received a written statement responding --

MS. MASON: No. No written statement. Thank you.

CHAIRMAN GARODNICK: Commissioner Goodridge. There you go.

COMMISSIONER GOODRIDGE: You had a really strong reaction to the hospital beds --

MS. MASON: Mm-hmm (affirmative).

COMMISSIONER GOODRIDGE: -- the number of hospital beds. The hospital says it'll be 303 single hospital bedrooms. I heard you say, "No." So I wanted some more insight into this. Why do you think that's not the number? What do you think is the number?

MS. MASON: Well, here's the thing. I mean, you talk -- when it suits people, they talk about additional -- I believe the attorney from Fried Frank said there will be a number of additional single rooms. Well, yes, but I believe that will be additional single rooms at

the expense of rooms that have multiple beds at them -- in them. So at the end of the day, the question is how many patients can be in the hospital at the same time and bedded in at the same time. And I think the number there is 25 more than there are today.

I mean, you can have an apartment building with 425 studios. Okay? Or you can have an apartment building with, you know, residents that have six-bedroom apartments in them or a combination of both, but I think what I hear the hospital saying, and we've gone back and forth on this but 25 beds, you also heard them say that I think there would be an additional 38 treatment bays in the emergency room.

Well, no one said how many emergency bays there are today and how many patients that means can be treated in the emergency room. And I think that's what we're talking about. Does this massive increase in height and mass really translate to more care?

And I think the other thing I'd just like to point out and I think Layla pointed this out from City -- City Club, if there is such

an urgent need for an expansive hospital, why are they leaving out such a large portion of the lot they own from this expansion? And by the way, that's the lot that's on Park Avenue. I think that should be questioned as well.

Any -- any other questions?

COMMISSIONER GOODRIDGE: Yes, my last question is -- I'm from New York City, so. I know the area but I don't live in the area and several people obviously are residents. Can you please give like a very clear example as to like literally what it's like because it seems like everyone here is aware of -- you know, I have construction in my neighborhood --

MS. MASON: Yes.

COMMISSIONER GOODRIDGE: -- so I'm sort of like --

MS. MASON: Mm-hmm (affirmative).

COMMISSIONER GOODRIDGE: -- I'm living a very busy --

MS. MASON: Mm-hmm (affirmative).

COMMISSIONER GOODRIDGE: So I'm sort of used to it, but everyone here seems to have like a very -- it seems to be something that has

happened in the neighborhood often. So I'm wondering, can you please walk me through literally exactly what it's like as a resident when you wake up? Like what -- if this hospital expansion goes through, like literally what would it actually mean?

MS. MASON: Okay. Well --

COMMISSIONER GOODRIDGE: Are you like literally hearing --

MS. MASON: Okay --

COMMISSIONER GOODRIDGE: Like, you know, what is the -- like what exactly does it mean? Like when you talk about York versus Lexington, what does it mean for the child? Like, literally, how does it literally impact your -- like an individual's day when you wake up -- when you wake up?

MS. MASON: Okay, I can answer that from a number of viewpoints. Right now, the ULURP we approved for MSK on York Avenue, I'm receiving hundreds of complaints from people who are not happy with even the pre-construction that's going on there. And that there was 24-hour day work going on. I myself live on Second Avenue and

72nd Street and I lived through the construction of the Second Avenue subway, which was 10 years and blasting underground that when my building was shaking as if we were living in an earthquake situation.

In this instance, if you come to Lexington Avenue right now with the hospital is as it is, you can barely walk down the sidewalks during rush hour in the morning. There is so much activity. Residents actually avoid that area during the morning and rush hour areas. The traffic is beyond.

And the situation of ambulances trying to get down Lexington Avenue is beyond. Let me put it this way. If the hospital wasn't there right now and someone came to this Commission and said, "Hey, we'd like to put a hospital on Lexington Avenue, the most narrow avenue on the Upper East Side. We'd like it to be 440 feet to 500 feet tall with a mass that extends the entire block. And by the way, we have a subway that's not accessible, not accessible to the disabled," would you really in this as commissioners approve that today? I would think not. I can tell by the

questions that you're asking. You're asking the same types of questions that we were asking and unfortunately, you're getting the same type of answers. You're not getting detailed responses, you're getting broad answers. And I think you should be a suspect of those answers, as Stephanie says, as we have been, over the last three or four months and actually last five years. Thank you.

COMMISSIONER GOODRIDGE: Thank you.

CHAIRMAN GARODNICK: Thank you, Commissioner. Thank you. Thanks for being with us.

MS. MASON: Nice to see you to see.

CHAIRMAN GARODNICK: Good to see you too.

Okay, next up we're going to bring Nora Ryan up. Glad we got you.

MS. RYAN: Thanks for accommodating me today. It was between get fit for the hearing aids or speak on behalf of my neighborhood. So as a good New Yorker, it's both. So I really appreciate your accommodation. So I

join all of my neighbors in requesting that you please preserve the residential quality of the Lenox Hill neighborhood. You've heard this before. It's a fabulous, diverse community; singles, seniors, families, many wonderful schools, private, public, religious. I've lived there for over 30 years. Raised my daughter there. She went to PS six. I was so happy to pay my taxes for that great school. She went to Brewerly (phonetic). She did her first communion at St. Ignatius Loyola. She did her -- she was bat mitzvahed at Temple Shaaray Tefila. So we love the neighborhood and we're hoping that generations to come will continue to raise families, grow up, grow old, continue to enjoy the comfortable connected space that it is today; warm by the sun, shaded by the trees, you can see the sky.

And this will be destroyed by the excessive and unnecessary addition of a massive tower in expanding hospital campus and 10 years of disruptive construction. Health and safety, quality of life shall be compromised, local residents will move on. They won't come back. Nearby homes will be particularly affected. Real

estate values will plummet, real estate taxes will decrease, and that's sending less tax revenue to the city. The cost-benefit balance is negative. The massive addition in this particular area of the city is unnecessary.

There are hospital campuses, top quality medical complexes within walking distance immediately south and north of the neighborhood. There's no need to expand facilities there. Modernize, absolutely, yes, but within the existing footprint and zoning parameters. Build a massive tower, a skyscraper in a historic residential community, increase zoning by 250 to 500 percent. No, no. Oversized skyscrapers should be limited to commercially zoned areas where they fit not in existing residential neighborhoods.

If there's a need for upgraded rooms, then I would say Northwell has a choice. Live within your space or go somewhere else. It's understandable. If you need to have more space, then you need to go find it in another area. Ideally, an area that's underserved and doesn't have anywhere near the same access. Thank you very much.

CHAIRMAN GARODNICK: Okay, thank you.

Okay. Next up is Sally Shaw on Zoom.

MADAM SECRETARY: We do not have Sally in the room.

CHAIRMAN GARODNICK: Okay. Next after Sally is Michael Piccirillo, Patrick Young.

Michael, are you here with us in the room?

MR. PICCIRILLO: I am.

CHAIRMAN GARODNICK: Okay. Great. Come on down. Patrick Young on Zoom, Frank Clark in queue on deck or in the circle, whatever we call it.

Okay. Go ahead. Welcome, Michael.

MR. PICCIRILLO: Good afternoon, commissioners. My name is Michael Piccirillo, and I'm an Area Standards Director for the New York City District Council of Carpenters. Before I took on this role, I was a union carpenter, boots on the ground, doing the work. And I still carry that perspective with me every day. I'm here today to

speak in strong support of the new Lenox Hill Hospital Project because it isn't just another job, it's a project that's going to make a real difference in people's lives.

Let's be honest, the current hospital is outdated. It's been patched together over the years, and it just doesn't meet the needs of modern healthcare anymore. We've got the best doctors and nurses in the world working in a building that was never designed to handle today's technology, patient volume, or emergency care standards. New Yorkers deserve better. We deserve world-class care in a modern facility that's built for the future. This new hospital will deliver just that. Better equipment and the kind of space and layout that helps save lives.

And just as importantly, it's going to create hundreds of good union jobs, jobs for carpenters, electricians, and laborers. All of us who take pride in building the city with our hands. We're not talking about low-road corner-cutting work. We're talking about skilled trades, people, making sure the hospital goes up safe, solid done right, and completed as quickly as

possible. Northwell has shown that they understand that. They're committed to using union labor and that means a lot not just to our members but to the quality and integrity of the job itself.

So I'm asking the Commission to approve this project. Let's give New York the hospital they deserve and the working people of the city, the opportunity to build it. Together we can lift up this neighborhood and deliver something that will serve generations to come. Thank you.

CHAIRMAN GARODNICK: Great. Thank You, Michael. Next is Patrick Young on Zoom, followed by Frank Clarke in the room.

MADAM SECRETARY: Patrick is not in the Zoom.

CHAIRMAN GARODNICK: Okay. So we'll move on to Frank Clark here in the hearing room.

Mr. Clarke, you here?

MR. CLARKE: Yes.

CHAIRMAN GARODNICK: Great. Next up will be Virginia Maloney, Evelyn Finster. Okay, welcome.

MR. CLARKE: Thank You. Good

afternoon. My name is Frank Clarke, Director of Government Relations at the New York Building Congress. New York Building Congress represents 500 member organizations and more than 250,000 skilled tradespeople and professionals dedicated to the growth of the New York region. New York Building Congress expresses our full support for Northwell Health's proposal to reinvest in Lenox Hill Hospital.

This initiative represents a critical opportunity to not only improve healthcare outcomes for New Yorkers but also strengthen the city's economic fabric through job creation and long-term investment in its infrastructure. New York City's healthcare system urgently requires updates to keep pace with the growing population and the evolving needs of our diverse communities.

Investing in hospital infrastructure is a critical part of ensuring that every New Yorker receives the world-class care they deserve today and in the future. Northwell Health has already demonstrated exceptional leadership in providing high-quality care across all boroughs, with significant investments made across New York.

Lenox Hill Hospital is in need of modernization to meet the challenges of the 21st century. This reinvestment will allow the hospital to enhance patient care by updating its older facilities with the latest medical technology, more efficient layouts, and larger flexible spaces designed to improve care delivery.

Specifically, this project will update infrastructure with state-of-the-art technology, create jobs in both the construction and healthcare sectors, providing high-quality well-paying union jobs, and revitalize a vital healthcare institution so that Lenox Hill can continue offering exceptional care.

This project is more than just about building, it's about ensuring that New York City has hospitals equipped for the future, so that every patient in New York City can access the care they need. The revitalization of Lenox Hill Hospital is an investment in both the health and economic well-being of our community. And the New York Building Congress respectfully urges your approval. Thank you.

CHAIRMAN GARODNICK: Great. Thank

you. All right. Next up is Virginia Maloney, followed by Evelyn Finster. Welcome. Good to see you.

MS. MALONEY: Great. Good to see you as well. I want to first off thank the City Planning Commission for giving me the opportunity to present testimony and opposition to Northwell Health's current proposed Lenox Hill Hospital Redevelopment and Chair Garodnick for hosting this conversation and for representing this community for years.

My name is Virginia Maloney. I've lived on the east side my entire life, and now I live just one block from the hospital. I love this community and I care deeply about the wellbeing of my neighbors. Today I want to join the voices of my community, that of Manhattan Community Board 8, CIVITAS, the friends of the Upper East Side, Carnegie Hill neighbors, New York Landmarks, the City Club of New York City, Temple Israel, also church, and so on, urging you to oppose Northwell Health's current proposal.

Let me be clear, I support modernizing Lenox Hill Hospital. If I ever had a

medical emergency, this is where I would go and I agree that it's sorely in need of work. Improvements that expand care and prepare us for possible future health challenges like the Coronavirus pandemic are both welcome and necessary for area residents and for the staff that work in the hospital every day.

But this is a plan that's been in development for years with minimal engagement from the community. If there had been more engagement, I'm confident that the hospital and the community would've been able to formulate a plan that works for both the hospital and its neighbors; the very people the hospital seeks to serve.

The result, a plan that's out of proportion with the surrounding area, only increasing capacity by 50 beds, and I'm especially concerned about the long construction timeline, potentially standing a decade or more. That's half of a childhood, that's a large chunk of someone's golden years, and it's not a temporary inconvenience. Years of noise, air pollution, traffic, congestion, street closures in a neighborhood where families are raising children

and seniors are aging in place.

We can't ignore the health risks posed by prolonged construction. Ironically, a project intended to improve care could end up harming residents' quality of life and health.

Modernization and community concerns do not have to be at odds. I reiterate, let's focus on the asks versus what is truly needed and ensure we work together to bring the future of Lenox Hill to reflect the needs of the hospital and the values of the community it serves in its current form. It's no wonder thousands of residents have signed petitions and 82 percent of the testimony submitted to Community Board 8 were against the project. Thank you for your attention to this matter.

CHAIRMAN GARODNICK: Great. Thank you. Thank you for being with us.

Okay, next up is Evelyn Finster on Zoom.

MADAM SECRETARY: Evelyn is not in the Zoom room.

CHAIRMAN GARODNICK: Okay. How about Ann Nam here in the room?

Ms. Nam, welcome.

I'm just going to call a few names just to get you prepped here. Thomas Crowbridge, Margarita Campin here in the room, I believe with us, and then Barbara is in on Zoom. So welcome.

MS. NAM: Good afternoon.

CHAIRMAN GARODNICK: Good afternoon.

MS. NAM: There are building codes in place for a reason. Some reasons are light and air. The Upper East Side is already overserved with hospitals, as you know. Other areas in Manhattan and outer boroughs are in hospital deserts. They desperately need of new and improved hospitals. I strongly recommend that you reconsider Lenox Hills' esque of a build. Thank you.

CHAIRMAN GARODNICK: Thank you. Okay. Thomas Crowbridge, followed by Margarita Campin.

MR. CROWBRIDGE: Good afternoon, commissioners. Thank you for the chance to address you. And I'm a long-term resident of the Upper East Side and vigorously opposed Northwell's

proposal. As the Commission well knows its purpose, and I quote, "is to guide the city's growth and development, ensuring its long-term sustainability, economic vibrancy, and inclusivity." If approved Northwell's proposal would be destructive of that purpose.

The hospital is located on Lexington Avenue between 76th and 77th Street. The section of -- the section of Lexington is a warren of small businesses. A couple of eyeglass doors, a hardware store, a pizza parlor, a bagel shop, et cetera. With a bus lane on the west side and parking on the east, traffic in this area was always congested in inches along. And I have to say, I chuckled when I saw the graphic of the supposed Lexington Avenue that Northwell put up. It looked more like the Champs-Élysées than in the street I recognize.

Anyway, the construction apparatus in vehicles for the project would presumably use Lexington Avenue, which can barely handle the current traffic load. A 10-year construction project would be a nightmare there. The congestion and disrupting -- disruption during both the

project and its aftermath would be exacerbated by the relocation of the main entrance, as I gather it's proposed, from 77th Street to Lexington Avenue. Many businesses would be unable to survive the chaos, the prolonged chaos during this construction project.

A separate question too is, what would happen to Lexington Avenue bus? How could it fight its way through all this mess? And I know too that you chairman, you asked Dr. Baker, what steps would be taken to mitigate the disruption caused during the project? Did not get an answer. And it goes without saying too that the value of the real estate in the area, rental units, co-ops, and businesses, would take a dramatic hit.

And so as noted, Northwell's proposal will be countered to the Commission's purpose (unintelligible) point. I note that the Northwell's mission statement, which we saw earlier begins to improve the health and quality of life for the people and communities we serve by providing world-class service and centric -- patient-centric -- I'm not sure what that is -- patron-centric care.

I understand that Northwell's proposal would add only 25 more beds to a facility, which has already has a 30 percent vacancy rate in an area that is already overserved by hospitals. And so healthcare-wise, the area is covered. By contrast, the quality of life, which I take from Northwell's mission statement and the community it serves, which Northwell proposes to be concern about would be negatively impacted. Thank you very much.

CHAIRMAN GARODNICK: Thank you. Thanks for joining us.

Okay. Margarita Campin, followed by Barbara Zinn on Zoom. Welcome.

MS. CAMPIN: Hi. Thank you, all, for your time and consideration. I'm Margarita Campin, a resident of the Upper East Side for 50 years. I'm particularly concerned about the major variance of the current building code and the proposed site -- height.

If this significant variance is approved, it will have a horrendous -- will be setting a really terrible and horrendous precedent. Lexington Avenue as mentioned is narrow already,

traffic around the hospital is a problem, and during construction, eliminating two lanes of traffic, at least for construction. And as former resident has said there's a bus lane for nine to 10 years will have a catastrophic impact on the neighborhood and make the area barely livable. As a former and a potential patient of Lenox Hill Hospital, I would avoid using the Lenox Hill Hospital at all costs while the hospital is under construction. How does the hospital expect to remain fully functional during this extensive construction? Which current buildings are being raised? The hospital will be functioning with less than half the space for nine to 10 years. This really to me is something that really can't be supported by the proposed plan. Thank you.

CHAIRMAN GARODNICK: Okay. Thank you. Okay. Barbara Zinn. Do we have Barbara on Zoom?

MADAM SECRETARY: I believe we heard from Barbara earlier as speaker number 32.

CHAIRMAN GARODNICK: Okay. If we did, then we do not need to return to Ms. Zinn. Let's go on to the Reverend Dr. Phillip Craig if he

is on Zoom.

MADAM SECRETARY: Just confirming with Barbara. I see you still in the Zoom.

MS. ZINN: Oh, yes, I did speak, so I'm fine. Thank you.

MADAM SECRETARY: Thank you.

CHAIRMAN GARODNICK: Great. Thank you. Is Reverend Craig there? Followed by Landy Gonzalez here in the room.

MADAM SECRETARY: Reverend Craig, you should be able to unmute in Zoom. Reverend Craig, you should be able to unmute in Zoom.

CHAIRMAN GARODNICK: Okay. Doesn't sound like we have Reverend Craig there. We'll see if you reappear.

Landy Gonzalez, are you here with us?

Landy Gonzalez?

No. Okay. How about Eileen Toback on Zoom?

Great, Ms. Toback, we're going to promote you whenever you're ready, please begin.

MS. TOBACK: Hello.

CHAIRMAN GARODNICK: Hello.

MS. TOBACK: Hello. Thank you. Good afternoon. My name is Eileen Toback and I'm the Executive Director of the New York Professional Nurses Union, representing over a thousand nurses at Lenox Hill Hospital. I'm speaking in support of the project. I'm also a local resident living a few blocks from the hospital.

Lenox Hill is a world-class hospital delivering accessible care to patients from more than 200 zip codes, but our nurses are doing heroic work in a building that's falling further and further behind the realities of modern healthcare. Staff are constantly compensating for outdated infrastructure, whether it's maneuvering state-of-the-art equipment in patient rooms that are too small, navigating tight spaces in the ER and other units, or managing patient care in spaces without proper break rooms. They do it -- they do it so patients never feel the burden, but it takes a toll on them shift by shift.

We're spending more and more time in labor-management meetings addressing issues caused by the building itself, working to maintain the highest standards for patients, their families,

and our staff despite physical constraints that make that harder every year. This plan is not a luxury. It's about keeping pace and being ready to meet the future. We've seen what happens when hospitals cannot evolve. Beth Israel's closure is the latest stark warning and Lenox Hill must not be next.

Rebuilding Lenox Hill Hospital will give us the space and infrastructure we need to keep delivering excellent care safely, efficiently, and with dignity for both the patients and our healthcare providers. I urge you to support this critical investment in our hospital's future. Thank you very much.

CHAIRMAN GARODNICK: Great. Thank you, Ms. Toback.

Mary Chan, next on Zoom. Great. Following Mary, we'll have Michael Byowitz, Nina Lesavoy, Neil Selkirk.

MS. CHAN: Hello.

MADAM SECRETARY: Mary, you should be able to unmute.

MS. CHAN: Can hear you me now?

MADAM SECRETARY: Yes, we can hear

you.

CHAIRMAN GARODNICK: Go ahead.

MS. CHAN: So my name is Mary Chan, I've been a nurse at Lenox Hill Hospital for 42 years, and I've just recently retired. It's very important for me since I've been very passionate about my profession, for my co-workers, and for my patients that live around near and far. I've been a patient there myself and the care has been excellent and we really need the space to accommodate our growing community.

If you look around us, we have buildings that are really high tall; who's going to accommodate them? How can you send patients to other institutions, other hospitals? That's an unreasonable request, and I believe that it's very important that we reach out to the community that we can help them and not just abandon them. Yes, it does take time, just like it took time for the subway and for other issues around the city, but they start from scratch. Lenox Hill is not starting from scratch; they're going to still able to stay open for the patients that they have now, and then for the incoming patients later. So, I

mean, it is a bit of an inconvenience, but in the long run, in the future, it should be one of the most beautiful updated institution hospital in Upper East Side. Thank you very much.

CHAIRMAN GARODNICK: Thank you. Okay. Next up Michael Byowitz.

MADAM SECRETARY: Michael is not in the Zoom room.

CHAIRMAN GARODNICK: Okay. Nina Lesavoy?

MADAM SECRETARY: Nina is not in the Zoom.

CHAIRMAN GARODNICK: How about do we have Neil Selkirk, here with us in the hearing room?

Mr. Selkirk, welcome. Followed by Dune Arbus and John Oxman.

MR. SELKIRK: Thank you, everybody. My name is Neil Selkirk. I am an immigrant citizen who dearly loves his home city. Community Board 8, which held hearings regarding Lenox Hill Hospital expansion matter, published the letters it received as it received them. Of over 800 letters received by the community board and

discounting letters from people financially connected to the hospital, 96 and three-quarter percent of respondents were opposed to the variances.

Daniel Baker, Chief Executive Director, the executive director of Lenox Hill, has once again emailed his staff asking them to speak on behalf of the hospital at this event, and he asked them to submit their names if they intended to participate. Coming from an employer and addressed to his employees that literally defines coercion, that list of names becomes his loyalty list.

Hospital employees here today responding to their president's email were told only that this hearing was about redevelopment. They were not told in advance about a gigantic tower that will exceed current zoning by up to 500 percent, nor of nine years of construction while the hospital attempts to stay open.

The talking points Executive Director Baker suggested all related to the word redevelopment. Everyone on both sides of the Lenox Hill Hospital matter knows that the property is in

desperate need of redevelopment and welcome it. But that concept is not honestly the issue at hand, which is in fact entirely about size and its effect on the community, and the consequently requested outrageous zoning variances. This matter has nothing whatever to do with healthcare. It is exclusively about the unnecessary destruction of a neighborhood in the face of zero established need. Zero. That is the number of informed New Yorkers other than those in the pay of Northwell Health, who have publicly stated that a 400-foot tower on 76 between Park and Lexus is a good idea. It is a lousy idea and serves no public planning purpose. It has zero support outside the confines of the Northwell Health Corporation.

We all have to ask on what grounds is it possible to justify in violation of multiple established zoning laws, the handing to a corporate behemoth of the right to build a vastly obstructive and utterly unnecessary monument, conceived principally to crown the splendid business career of its retiring chief executive officer. The proposed variances have nothing whatever to do with servicing a community in need of objectively Lenox

Hills' community has no need for more hospital space, the communities in need are all elsewhere.

MADAM SECRETARY: Time.

MR. SELKIRK: Thank you.

CHAIRMAN GARODNICK: Thank you very much. You got in a lot in that final 10 seconds. Thank you.

Let's go to Dune Arbus. Hello.

MS. ARBUS: Hi.

CHAIRMAN GARODNICK: Welcome.

MS. ARBUS: Thank you, members of the commission, each and every one of you. Renovating Lenox Hill Hospital is almost universally acknowledged to be essential, but destroying its entire precious neighborhood in the process which this proposal guarantees would be criminal and runs counter to the very essence of the mission of City Planning.

Northwell Health has completely failed to demonstrate a real need for the citizens of New York to have a new, bigger hospital in an area already teaming with some of the world's greatest hospitals. On the other hand, the city is indisputably in very serious need of increased

hospital capacity in multiple other places right now, a need to which Northwell, despite its wealth and power, appears to have remained relatively indifferent. Therefore, it is clear that this project is not about serving the sick, it is primarily about serving Northwell Health's craving for prestige.

Simply because Northwell is the largest employer in the state and serves the sick, should not entitle it to receive carte blanche from the City Planning Commission for whatever it claims to need, regardless of the permanent catastrophic effects that will inevitably result. It sounds as if the hospital is asking you to approve its proposal, and later, during the course of a decade-long construction, it will contemplate addressing the number of concerns that have been expressed. If the hospital were to throw up its hands and say, oh, sorry, there's nothing we can do, there are no penalties.

You have both the power and the obligation to protect the city and its citizens, including families, small business owners, students, the elderly, and the sick, now and in the

foreseeable future, from the ravages of greedy, irresponsible corporate giants. The people have spoken, 644 independent voices opposed versus 26 in favor, but it appears their representatives are turning a deaf ear.

The Manhattan borough president is apparently not representing his constituents, he must be representing Northwell, because none of his constituents want this enormous tower. It is impossible to comprehend how anyone driven by a sense of moral responsibility, which I hope is all of you, could consider enabling this destructive, irrational, and overwhelmingly self-serving project to proceed. Thank you.

CHAIRMAN GARODNICK: Thank you. Okay, we're going to proceed with the hearing. I do want to encourage people if they -- if they want to weigh in on the question about, there's two proposals that are before us about density that leans more toward the avenue versus midblock and things like that. If you don't want to even weigh in on it, that's your prerogative, but I do think if you wish to advise the Commission on that, this would be an appropriate time to do that. Not -- I

mean, when you get up, not right now. When you're called to testify if that is of any interest to you.

Okay, let me go to John Oxman. Welcome, Mr. Oxman.

MR. OXMAN: Thank you very much. Thanks, commissioners. I don't think there's any debate about whether or not there needs to be a renovation of the hospital. Better is not the same thing as bigger, and it's -- I hope that dawns on everybody here. And also when someone says they're going to take 10 years to completely obliterate and then rebuild a city block while simultaneously running a hospital on that site, if you believe that, good luck to you. If you believe $2 billion, good luck to you. Who's going to pay for that when it inflates to three or four? Think about the World Trade Center rebuild.

There are a lot of problems that are going on at Lenox Hill right now that the current management could work harder on to deliver a better quality of care. I believe the surveys that I got off the web from various different agencies and organizations that review hospitals,

there seems to be a communication problem between doctors and patients, and between nurses and patients. There seems to be a cleanliness problem as well. So these are behavioral aspects that if they want to make it better, those are some things to work on.

Essentially, coming back to one of the earlier questions, what has Northwell done to engage? Look around you. This is the most important project they have. Where is their CEO? Getting ready for a Memorial Day weekend out in the North Shore? He should be here. This is so important to him, he sends someone who is not even empowered to commit the corporation to any courts of action, not a vice president. This is his most important project.

I would just like to remind you to kind of put this whole thing in perspective. By my account, haven't, you know, gone to count the beds myself, but Columbia has something like 2,600 beds, Langone 2,100, Mount Sinai, 1,100, Sloan Kettering, 500, Lenox Hill 450, Special Surgery, 200.

So Lenox Hill is kind of the runt of the litter, okay. They don't need to go from

450 to 500 beds or 475. What really, really is hard to understand is how they've managed to mislead you, and no one seemed to catch it until that lady earlier today. I brought with me the sheet that she was referring to that has the actual occupancy last week. Lenox Hill has a far greater vacancy rate by a measurable gap compared to any other New York hospital. So they have lots of capacity even with their current setup. And by the way, not every hospital wants to do single-room occupancy. That's not the way it works. Go look at Columbia.

So one question that never came up in any discussion up until now is why does 475 have to be 475? Why couldn't it be some different mix that would then enable some double-bunking, if you want to call it that, but an increase in the single room if that's so darn important, although nobody else has made that a mantra, but why not kind of reduce the scope and see what they can do that way? Thank you very much.

CHAIRMAN GARODNICK: Okay. Thank you. Okay. Next up is Greg Husk on Zoom.

MADAM SECRETARY: Greg is not in

the Zoom room.

CHAIRMAN GARODNICK: Okay. How about Angela Gerraso?

MADAM SECRETARY: Angela is not in the Zoom room.

CHAIRMAN GARODNICK: Reya Sinha.

MADAM SECRETARY: Reya, you should be able to unmute in Zoom.

MS. SINHA: Hi, good afternoon.

CHAIRMAN GARODNICK: Hello.

MS. SINHA: Thank you so much for the opportunity to speak. Not only am I a proud employee of Lenox Hill and Northwell, but I'm also a proud resident of the Lenox Hill neighborhood. My husband and I live at 78th Street in Second Avenue, a mere four blocks from Lenox Hill. Our two young children go to PS 158 down the street. We've lived on the Upper East Side for over 10 years, and my husband and I have devoted our livelihoods to patient care but also built our life in this community. I've heard the passionate testimonials and I'm looking at this as an employee and a neighbor.

The Upper East Side is the

healthcare destination for not just the city, not just our community, but the state, the country, the world. I've interacted with nearly every institution on the Upper East Side, either as a patient, a caregiver, or an employee. But Lenox Hill is truly the hospital for our community. And our community deserves a more modern setting.

Our community is already changing. You can see the amount of residential development across the Upper East Side. In my own three-block radius, there are three huge residential luxury highrises in development. Where will those residents get care? We as a community, are modernizing and growing and we deserve a hospital to match this.

I also have the privilege of working for the Northwell Health Cancer Institute in Manhattan, and I have the privilege to work with the cancer patients of Lenox Hill Hospital every day. I strongly believe that the aging infrastructure in our home hospital needs to be addressed in order to provide them with the advanced treatments they need. Our patients come with all -- come from all walks of life. And

without an inpatient setting for our most vulnerable patients, we're doing a disservice to them, their families, and the community we all love.

I truly understand the difficulties that will come with this construction and development. I know that it will be myself and my children's stuck in Lexington Avenue traffic and I can truly appreciate the work that will need to be done to make these improvements. I myself have been through construction projects and I know that they take a really long time, even a simple kitchen in a small apartment can take months. Construction is never an easy process, but it's a necessary evil to bring the right services to our community. And I know the timeline is daunting. We all felt the same way about the Q Train construction. Look how amazing it has made our community and how easy it has made our Upper East Side residents getting to where they need to go across the city.

I strongly urge us to move forward with this necessary redevelopment project on the Upper East Side and I really thank you for your time and consideration on this project.

CHAIRMAN GARODNICK: Great. Thank you. Thanks for being with us.

Okay. Next up is Ronnie Rothschild on Zoom, followed by Adam Aponte on Zoom.

MADAM SECRETARY: Ronnie is not in the Zoom room.

CHAIRMAN GARODNICK: How about Adam Aponte?

MADAM SECRETARY: Adam is not in the Zoom.

CHAIRMAN GARODNICK: Okay. All right. So let us now turn to Gail Scovell on Zoom.

Gail Scovell?

MADAM SECRETARY: We do have Gale.

MS. SCOVELL: Hi. Thank you. My name is Gail Scovell. I live at 150 East 77th Street across the street from Lenox Hill Hospital. I've lived in various locations on the Upper East Side for most of the last 60 years. I have doctors at Northwell, Weill Cornell, and Mount Sinai. Still, I sincerely hope that you all pose the Northwell Health Project.

It's hard to think of anything

that will affect the quality of life of those living in our neighborhood more than 10-plus relentless years of construction, noise, dust, traffic, and general disruption or even six years, all for a hospital project in a neighborhood that already has six world-class hospitals nearby, most in walking distance in a city that has great need for hospital facilities in other neighborhoods.

Northwell acquired Lenox Hill Hospital in 2010 knowing its facilities, its neighborhoods, its footprint, and its zoning. It now seeks an increase in zoning of at least 250 percent. I don't know what zoning laws are for if such a proposal is permitted even as a starting point for negotiation. The Northwell Health Project just doesn't make sense.

I've given a lot of thought to making sure that my position is not nimbyism. However, the combination of the fact that the Upper East Side is not one of the neighborhoods that is suffering from lack of medical facilities, and the fact that the construction of other tall buildings seems to only disrupt their neighborhoods for a year or maybe two, makes me confident that this

project is unreasonable and opposition is not nimbyism.

I would also note that the chances that the construction timeline will get extended seems almost inevitable when trying to plan 10 years out. Having recently joined the remote workforce, I have a new understanding of just how many people are in my building and the streets nearby all day long.

We've all heard tell of negotiators and developers who ask for much more than what they need so that they can appear to compromise and still get everything they really wanted. Well, looking for some compromise can sometimes be the right approach. A compromise is not acceptable when the proposal is so extreme. We cannot allow Northwell Health to capitalize on the well-established cognitive bias of anchoring the negotiation with starting points that are outside the bounds of reasonableness.

You've asked about community interaction. Most of those interactions with the general public consisted of the hospital appearing without plans and saying they couldn't yet answer

questions but would do so in the future. But ratchet up a notation of we met with the community board that day.

Please think about what it will feel like for those of us who live near the project to live with the noise, dirt, traffic, lights, and congestion for 10 years of construction, or even five years. That much disruption is not a reasonable ask. Then consider that all of this will be compounded by the fact that Lexington Avenue is a particularly narrow avenue and the area around the subway stop and the -- and often the subway platforms are already very crowded.

Of course, the businesses in the area will also suffer and many will likely fail over that long a period. This is not even considering the light that will be blocked by such a large building when construction is finally finished.

MADAM SECRETARY: Time.

CHAIRMAN GARODNICK: Thank you.

MS. SCOVELL: Thank you.

CHAIRMAN GARODNICK: Thank you very much. Thank you for joining us.

Okay. Alan Harris is next.

Mr. Harris, are you with us here in the room?

Okay. Great. Take your time. You're good. Mr. Harris is here. Sharon Kahn, next on Zoom. William Heckelrath, here in the hearing room. Great. Thank you.

Okay, Mr. Harris. Welcome.

MR. HARRIS: Hi. Glad to meet all of you. Thank you for listening to me. This is my personal experience with Lenox Hill Hospital. I live across the street at 122 East 76th Street, a 27-apartment building that was a rental. Lenox Hill started taking over the building in 1969 and occupying it for, with illegal services. When they were challenged by the tenants, the city granted them a variance, which from its very inception, they have corrupted. They have populated the building with illegal people; employees. They have not rented an apartment since 1969. The apartments are all warehouse. They're allowed 18 apartments. The rest of the apartments are supposed to be for tenants, but they use them for themselves.

The empty apartments qualify as

slum landlord condition. We have not had -- we have not had water for a year. The building is illegally populated as I said. There are two tenants left, and they've experienced harassment. This conduct illustrates that the sacrifices and concerns of the community, the law, and the tenants are for their own ill-considered purposes.

The will of Community Board 8, justice, and the residents of the Upper East Side reasonably should prevail. If passed, the long-term project will infect the mental and physical health of the children of the community, making Northwell Lenox Hill Hospital the antithesis of a healthcare institution. Before Northwell Lenox Hill Hospital is allowed to proceed, Lenox Hill Hospital should be required to be brought into compliance and alignment with the zoning that has since been violated for 40 years.

Lenox Hills' history, nature, character, deceptive conduct, and lack of self-enforcement casts a dark cloud upon their request to destroy the current zoning. When you consider trustworthiness, Northwell is unwell. Thank you very much.

CHAIRMAN GARODNICK: Thank you. Stay there for one sec. I just want to make sure that I understand.

MR. HARRIS: We know each other from Costco.

CHAIRMAN GARODNICK: Good to see you. Listen. Smart shopper right there. Okay. Did I hear you say that you have not had water for a year?

MR. HARRIS: Yeah, one of our bathrooms, no water for a year.

CHAIRMAN GARODNICK: Okay.

MR. HARRIS: No toilet, no sink, no shower.

CHAIRMAN GARODNICK: Okay. And have this is -- I realize we're a field from the specifics of the land use application here, but what have -- yeah, you have raised this issue, presumably with --

MR. HARRIS: Many times with Department of Buildings. They have no enforceable power as far as I can see.

CHAIRMAN GARODNICK: Okay.

MR. HARRIS: You need a report.

Lenox Hill Hospital has been fined over $130,000, which they don't pay.

CHAIRMAN GARODNICK: And if you don't, what's is your address one more time?

MR. HARRIS: 122 East 76th Street.

CHAIRMAN GARODNICK: Okay.

MR. HARRIS: 110 East 77th is Lenox Hills Hospital.

CHAIRMAN GARODNICK: Okay. Got it. Yeah, no, I know exactly where you are. Okay. Okay. We'll have to look into that. That question. I'll see you in Costco. Thank you for being with us.

MR. HARRIS: Okay. Healthy and strong hearts.

CHAIRMAN GARODNICK: Okay. Thank you. Okay. Let's go on to Sharon Kahn on Zoom.

MADAM SECRETARY: Sharon is not in the Zoom room.

MR. HARRIS: Okay. Is William Heckelrath here? Yes, Mr. Heckelrath. Great. Welcome.

MR. HECKELRATH: Great. Thank you. As I am not a union member nor an employee of

Lenox Hill, I'm therefore standing in opposition to this plan. Look, I don't want to restate the same things you guys have heard a million times. We're all very tired. This has gone longer than I expected to. But I just want to say one more time that obviously this has nothing to do with healthcare. This is absolutely nothing to do with healthcare. We are over-served in the neighborhood. This has already been brought up. We have six beds per 1000 or something. If this institution were to disappear completely, we would still be the largest per -- as a neighborhood with the number of hospital beds we have per resident.

So this has nothing to do with healthcare. This has nothing to do with union jobs. These same jobs will exist if they build it to the existing standards of 215 feet. Or the same jobs will exist if they build it in a neighborhood that actually needs this or wants this. So it is really just about money, unfortunately, I hate to be cynical, but it really is. It's a direct transfer of capital from us to them. Our property values will be decimated. This is not a per a nine-year thing. This is -- we're talking years

and years, decades worth of an impact. That's tax dollars, of course, that go to you. But this is our livelihood. These are our apartments. This is what -- this is unacceptable, what this would have on our lives. This is money out of our pockets and it goes straight to them.

I don't begrudge them for trying. They're a corporation, they have to try. They have a fiduciary responsibility to the people that they represent, I get it. But they cannot build their business and their corporation on the backs of us.

The last point I will make is simply that, why does this bother? What is the point of having zoning rules? What is the point of having a community board? What is the point of reaching out to the community, getting thousands and thousands and thousands of testimonials where 96 percent of them from those who live in the neighborhood are saying absolutely, don't do that? What is the point of any of that if the largest corporations can simply get together with the most powerful unions and cozy up to whomever they need to in the apparatus that is New York City, and always just steamroll and get whatever they want?

It makes absolutely no sense this building has to happen here. I rescind the rest of my time. Back to you. Thank you so much.

CHAIRMAN GARODNICK: That's all right. Before you go though, wait, wait. Hold on, hold on. Hold on. And I just want to remind everybody we're five-plus hours in today. And so -- and there's still a lot of people who want to be heard. So the clapping or the reactions are not going to help us get there any faster. So if you want to do some jazz hands or something, fine, but it'll allow us to proceed.

Tell us about the -- what you said was the decades' worth of impact. The six to nine years I see, because that's clear. That's right in front of us. But tell us what you actually anticipate on that front.

Commissioner Goodridge, is that (unintelligible)?

MR. HECKELRATH: The council member in the back asked earlier.

CHAIRMAN GARODNICK: Commissioner Goodridge.

MR. HECKELRATH: Yeah, thank you.

She was not familiar with the neighborhood. This is a gilded age, pristine, historic neighborhood. Without question, the existence of a 400-plus-foot tower with a ridiculously gaudy design that will overhang and overshadow, a historic neighborhood is not going to raise values in said neighborhood. It is going to reduce values in said neighborhood, even when they are done.

CHAIRMAN GARODNICK: Okay.

MR. HECKELRATH: Call it 10, 11, 12.

CHAIRMAN GARODNICK: Okay, I understand. So you're not talking about operational impact. You're talking about concern about property value. You're talking about aesthetic --

MR. HECKELRATH: Long term (unintelligible).

CHAIRMAN GARODNICK: I understand. Okay. I got it. Thank you.

MR. HECKELRATH: Thank you so much.

CHAIRMAN GARODNICK: Thanks very much.

Okay. George Janes?

Mr. Janes, welcome.

To be followed by Kathy Fogarty on Zoom.

MR. JANES: Thank you. I'm George Janes, I'm an urban planner and I've been helping the community on this application. So, you know, Northwell has a problem, the program is simply too big for the site. They have large ambitions, but a small site that can't fit their program. So what should they do? Bigger site? That's kind of hard. The easiest thing is to change the zoning so that their site is no longer too small for their ambitions. Not enough floor area, change the zoning map. Still not enough floor area. Invent a brand new special permit that will create even more floor area. Zoning envelope too restrictive, grant and bulk waivers. Yes, the easiest thing for this applicant to do is to change the zoning so it matches their ambitions. Large and outsized.

This is how we should be doing our planning and zoning? Should we adjust our plans, our zoning in response to the ambitions of individual applicants? I'm going to guess that

most of you believe that this is not ideal, but it's what we do. It's what we do. But we do it at the detriment of the future of the city. For decades, we have witnessed the concentration of hospitals in limited areas because we respond to applicant ambitions rather than plan for the health needs of all New Yorkers as a land use issue. This concentration serves the needs of applicants, and it has created a world-class healthcare district. But this has done so by creating vast geographic inequities.

To be clear, a plan that is being implemented here, is Northwell's plan. There is no public plan for this use, and we've seen the result. A concentration of hospitals on the east side of Manhattan, which has resulted in hospital deserts elsewhere, that's not okay.

The Planning Commission has a responsibility to the people of the city of New York, and it is not in the public interest to concentrate our hospitals like this; that's in the interest of those hospitals. This is not going to change until you are Planning Commissioners start saying the status quo is unacceptable; that

hospitals are land use that must be planned to serve the public interest. You can start doing that by saying no to this applicant and their outsized ambitions, and then also start working with them and other stakeholders to develop a plan that serves the healthcare needs of all New Yorkers. Thank you very much.

CHAIRMAN GARODNICK: Thank you, Mr. Janes. Before you -- before you go, I've got a couple of questions. I know Commissioner Benjamin has a couple too. So, thank you, thank you for that. And I've heard from other folks today about the -- if you were doing it today, would you put a hospital here, or might you put hospitals where they are today?

MR. JANES: Okay. Interesting question. Theoretical question. We do have a hospital there today. It is a functioning hospital, and I think by most accounts, a hospital we would like to see succeed.

CHAIRMAN GARODNICK: So, I guess my question for you is based on your understanding of this, if the -- if Lenox Hill Hospital wanted to be able to become a -- in their definition, or

maybe your definition, a world-class hospital, whether you agree with the need to have single room beds or not, but let's just stipulate for the moment that that is a need that is a -- you know, a business need for hospitals, what would be the right size of this building? What would be the right height of this building?

MR. JANES: I would like to see a plan for the development of healthcare systems in an equitable way in New York City. First and foremost, you're -- Chair Garodnick, you're talking at the need of the applicant and I get it. That's what we do in this city.

CHAIRMAN GARODNICK: Well, it's a hospital that needs to function and needs to succeed.

MR. JANES: But if we --

CHAIRMAN GARODNICK: So I have an interest -- we have an interest in that too.

MR. JANES: Absolutely.

CHAIRMAN GARODNICK: Right?

MR. JANES: But if we care about equity in New York City and we think that that geographic equity is important, really the last

thing you want to do is invest billions of dollars in this spot at this place because all that does is it expands geographic inequity.

CHAIRMAN GARODNICK: Yeah, but nobody is asking me to invest billions of dollars into this site. It is the hospital that is actually looking to invest in their own property.

MR. JANES: It's absolutely in their interest to do that.

CHAIRMAN GARODNICK: Okay. So now -- so answer me the question from a land use perspective because this is your -- this is your field. What's the appropriate envelope here? I've seen community has said let's stick to 215 the applicant -- again, this is the applicant's desires --

MR. JANES: Yeah.

CHAIRMAN GARODNICK: -- wants something significantly higher. Like, where would you -- where would you land here? Where is an appropriate level if they want to consolidate buildings? We've got a very significant patchwork of buildings on the site. It's complicated, 77th Street is a mess. What's the right bulk and form

here?

MR. JANES: That is a question that I am not able to answer right now, but we will get back to you with a recommendation.

CHAIRMAN GARODNICK: Okay. All right. Well, that's fair enough. And I also do want, you know, if you or others would weigh in, I mean, we do have a couple of different options here and I recognize that there's probably a lot of feelings that are against anything above 215 feet but there are different designs and nobody so far, at least as far as I've heard, has said, well, if you had to be anything north of 215, or if you had to be anything north of 210, which is where they are today, we'd prefer to see density on Lexington, or we'd prefer to see density closer to Park. I haven't heard that and that would be, you know, that is the responsibility of this group. And so I'm really asking for your and the public's help to guide us a little bit, but I go back to you.

MR. JANES: One of the most difficult things for me as a land use planner is to explain to people, and this is really not so much about the height, it's about the mass. All right.

The towers footprint is 30,000 square feet. We don't have 30,000 square feet towers. We have towers that are 400 feet tall. We have lots of them. But they are all less than 8,000 square feet because of the tower-on-base rules, right? I mean, there's a form, there's a pattern that we have. We don't have 30,000 square feet towers.

The only one that's close is the Mount Sinai tower that they have, but it's one smaller in the center of a superblock, so you don't actually get it. And so that's a difficult thing to explain to people that it's really not as much about the height as it is about the mass.

And the thing about these proposals, they talk about lowering the height, but the mass of the proposal has never changed. So it was at 500 feet, they made it wider, so they got it down to 400 feet. And so they make it wider again to get it down to under 400 feet. And so it's -- you know, to me it's like, it's all the same mass, it's all the same program. It's just that it's slightly different height and it's really about the mass.

CHAIRMAN GARODNICK: Okay. I got

it. I'm going to go to Commissioner Benjamin. I guess my only observation is it is different from a lot of the other things that we see on the upper side because it is a hospital and they do need big floor plates to be able to operate. So I understand your point and I realize it's complicated what I'm asking you, but I appreciate any thoughts or follow-up --

MR. JANES: We'll will absolutely follow up.

CHAIRMAN GARODNICK: Thank you. Commissioner Benjamin?

COMMISSIONER BENJAMIN: Hi. I spent years working at HHC, so I know hospitals in the other boroughs and hospitals in the other boroughs have been closing. So your idea that even with public hospitals, we can keep them open all over the city in equity with who is there has not proven to be the case. And so residents of Brooklyn, like me, most often if they need hospital services, are forced to go to Manhattan. But my question is, you made a statement that Manhattan Hospitals' growth has resulted in a dearth of hospitals around the rest of the boroughs. Where

is that from, and can you tell me where I can --

MR. JANES: We can get you materials on that, but essentially hospitals are largely a zero-sum game. You grow in one place, I mean, you serve a population, right? And their technologies do change, right? I get that.

COMMISSIONER BENJAMIN: And the investment, if the hospital like HHCA, public hospital cannot afford to invest, the hospitals die.

MR. JANES: Oh, I get it, and you know, there have been some --

COMMISSIONER BENJAMIN: And with the not-for-profits also, I mean, we had LICH, we had Interfaith, we have any number of hospitals that were there that are not there now.

MR. JANES: Yeah. I mean, they're all not-for-profits because they -- to be a hospital --

COMMISSIONER BENJAMIN: HHC is government-run, so it's not for profit.

MR. JANES: -- or government, right. It's either --

COMMISSIONER BENJAMIN: And

downstate.

MR. JANES: It is both a financial and a land use issue. I guess it's the point you're trying to make.

COMMISSIONER BENJAMIN: I'm not saying it's a land use issue because we had plenty of land and I was involved in the expansion of NYU when they built the tall tower on their campus and made a number of the other buildings on the campus redundant.

MR. JANES: So, my question to you, I guess, Commissioner Benjamin, would be, if you're ill and you need care, is it better to be served in your neighborhood, or is it better to be served by traveling to Manhattan? We make that --

COMMISSIONER BENJAMIN: Wait, wait, you asked me a question.

MR. JANES: Yeah.

COMMISSIONER BENJAMIN: It depends if I can get the same care --

MR. JANES: Indeed.

COMMISSIONER BENJAMIN: -- which is not the case. The care at Interboro was never the same as the care at NYU. So, it's not as if

just having any hospital is the same care as having a hospital that has all the facilities that you might need, the staff that you might need, the level of expertise, and professionalism that you might need.

But my original question was still about your statement about which I'm curious that Manhattan, the concentration of Manhattan hospitals has resulted in a dearth of hospitals in the other four boroughs.

MR. JANES: That comes from the concept that the -- and we will get you back up for this, but the idea --

COMMISSIONER BENJAMIN: Okay. I appreciate that.

MR. JANES: -- is that there's a relatively stable number of beds that serves the population. It changes according to the number of beds and there's technological changes, I get it, right? But there's a --

COMMISSIONER BENJAMIN: Healthcare insurance changes.

MR. JANES: -- and insurance changes, absolutely. But if you have a system

that's largely, not entirely, but largely a zero-sum game and you increase in one area, you by definition decrease in another area.

COMMISSIONER BENJAMIN: Well, except that the state has been decreasing med-surg beds for the past 20 years.

MR. JANES: Indeed.

COMMISSIONER BENJAMIN: Not as a zero-sum game --

MR. JANES: Indeed.

COMMISSIONER BENJAMIN: -- but overall in the state and the city as a whole, they've been decreasing these beds completely.

MR. JANES: Yes.

COMMISSIONER BENJAMIN: And the beds have not been replaced when they've been closed. So it's not a zero-sum game. But we don't need to argue this now.

MR. JANES: Okay. Very good.

COMMISSIONER BENJAMIN: If you could get this from me, I'd appreciate it.

MR. JANES: Absolutely. Thank you.

COMMISSIONER BENJAMIN: Thank you.

CHAIRMAN GARODNICK: Thank you, commissioner. Thank you, Mr. Janes. Thank you. Appreciate it.

Okay. Next up is Kathy Fogerty on Zoom, followed by Barry Schneider on Zoom.

MS. FOGERTY: Good afternoon. Thank you for hearing me today. I appreciate the time. My name is Kathy Fogerty. I've been a registered nurse for 47 years. I want to tell you that I am so proud to work at a hospital that provides exceptional care despite the limitations of this old building.

I also want to say that in no way am I participating in any coercion today, and I would also like to say that the plans of this new hospital have been shared widely with the employees of the hospital by Northwell leadership. So we are all very excited about what we hope to come in the future.

I live just north of New York City and I'm happy to say that I can choose where I want to receive healthcare, and this is where I choose for myself and for my family to receive healthcare at Lenox Hill Hospital, where I know that the

quality is exceptional and the outcomes are superb. The doctors, the healthcare workers that come to this building every day who enjoy working here, enjoy providing this type of care to patients is just something that I can't even -- I can't imagine anywhere else.

I have the ability to work anywhere with the experience that I have, but I choose to work here because of the exceptional hospital that it is. Patients deserve a hospital, a state-of-the-art hospital that we all healthcare workers have the right to work in this type of an environment where we can serve our patients and our families and each other in this type of a building.

So I will tell you that, you know, I too, I'm very concerned about the Lenox Hill community. So much so that I greatly support this project to continue to provide exceptional care to the people, not only that live in this very local community, but people that come to New York City every single day. People that come from all over the world to New York City every day and choose to come to Lenox Hill because of the tremendous reputation that we have. So I thank you and I urge

you to support this project.

CHAIRMAN GARODNICK: Great. Thank you, Ms. Fogerty.

Next up is Barry Schneider.

Barry, are you there? You know, I know some of these people, that's how -- like this one in particular not just from Costco, exactly. This is --

MADAM SECRETARY: I think we lost him.

CHAIRMAN GARODNICK: Too bad. Okay. Next up is Richard Hymes on Zoom.

MR. HYMES: Can you hear me?

MADAM SECRETARY: Yeah.

CHAIRMAN GARODNICK: We can, yes.

MR. HYMES: Okay. Thank you very much to the committee. I'd also like to thank the community board which gave a very informative information. You had asked -- just to cut to the chase here, the whole issue isn't really updating the hospital. I don't think anybody's against that, and I'm sure that's happy to have them update the hospital. The issue is the giant dark tower in the middle of the block that absolutely destroys

the neighborhood and then just puts carte blanche to everyone, build a giant tower in the middle of the block and really destroying the goose that lays the golden egg.

The idea here is, is that we're fine with them expanding the hospital if it was going to be straight across or maybe a little bit more on the avenues, but the 30,000 -- the 400-foot massive tower in the middle of a residential neighborhood so that they can attract oligarch money from around the world on birthing centers with crystal chandeliers and that was what they said, is just ridiculous. I mean, it's just obscene, and we really like to save the neighborhood.

Once again, it's not about whether you go from 210 feet to 230 feet. This is about whether you go and build the giant tower in the middle of our block. We don't have any sun as it is if you get a couple seconds of sun when you're walking down the street, can we just have that, please? Thank you very much once again for the Commission and thanks to all the people who participated.

CHAIRMAN GARODNICK: Thank you, Mr. Hymes. Appreciate it.

Okay. Wen Gao Huang on Zoom?

MADAM SECRETARY: Wen, can you hear us?

CHAIR GARODNICK: Do we have Wen Gao Huang on Zoom?

MADAM SECRETARY: I've asked him to unmute.

CHAIR GARODNICK: Shall I move on?

MADAM SECRETARY: One moment. Wait. Let me just -- yes.

CHAIR GARODNICK: Yes, move on?

MADAM SECRETARY: Yes, please.

CHAIR GARODNICK: Okay. Robert Mele? Robert Mele on Zoom?

MADAM SECRETARY: I believe we have Robert.

CHAIR GARODNICK: Great. We can see you.

MR. MELE: Can you hear me?

CHAIR GARODNICK: Hi.

MADAM SECRETARY: We can hear you.

CHAIR GARODNICK: We can.

MR. MELE: Thank you all so much. Good afternoon to the members of the City Planning Commission, and thank you for the opportunity to speak. My name is Dr. Robert Mele and I'm a Neonatal Nurse Practitioner and supervisor here at Lenox Hill Hospital in the neonatal ICU. And I'm here to strongly support the proposed renovations to Lenox Hill Hospital.

As a vital healthcare provider in this community, Lenox Hill has been at the forefront of providing quality care, and these renovations will ensure that we continue to meet the growing needs of our diverse population.

One of the most exciting aspects of this renovation is the creation of a new mother-baby center. This dedicated space will offer state-of-the-art care for both mothers and newborns, providing safe, supportive, and nurturing environment, during one of the most important moments in a family's life. The new center will improve outcomes, enhance the patient experience, and ensures the families have access to the best care possible, right here in our community. With updated facilities, enhanced technology, and

expanded services, this project will not only improve patient care, but it'll also create jobs and contribute to the local economy.

In a time when healthcare is more crucial than ever, we must invest in institutions like Lenox Hill, to ensure that they remain (unintelligible). I've been on the meeting for the last couple hours. I've actually been listening to some of my constituents and neighbors. I actually live on 75th, and I have to say that, some people that said that it's not the community's problem, I find that to be a little selfish to say to be honest with you.

You know, what wasn't our problem that we anticipated? Is we didn't anticipate having a global pandemic five short years ago. But we are flexible. We are healthcare workers that showed up for all of you, and we will continue to show up for all of you when the next pandemic happens or the next crisis happens in Manhattan.

We are asking for flexibility, we are asking for your partnership, and we are simply asking to renovate and really add the -- to the quality of our building. I don't even have my own

office space and I work here to enhance our neonatal care and neonatal services. But I don't even have an office space because we are such a small and inundated building.

So once again, I am a neighbor. I am a community member. I'm a healthcare worker, proud Northwell Health Lenox Hill employee, and I proudly stand amongst other physicians, nurses, nurse practitioners, PAs, registered -- like I said, registered nurses, to support this project. Thank you, all, so much for your time.

CHAIR GARODNICK: Great. Thank you.

Okay. Next up is Brian Verona here in the hearing room.

MADAM SECRETARY: He had to leave.

CHAIR GARODNICK: Had to leave. Ruth Holzer? Ms. Holzer is coming up. Great. Next up is Vanessa Lily and Elaine Shea.

Ms. Holzer, welcome.

MS. HOLZER: Thank you very much. And thank you to everyone. I live at 800 Park, which is 74th and Park, and my three kids each live in their own apartments at 155 East 76th Street,

which is right across from this project. We love the low-rise character of this neighborhood. This project is way too big for the neighborhood, totally out of character. Lenox Hill should -- Hospital should really rethink this project.

There's a reason why zoning exists and why the community board overwhelmingly rejected this proposal. If Lenox Hill Hospital and Northwell Health truly believe in helping patients, they should put this project in neighborhoods where there is a need, as discussed before, either downtown in the outer boroughs or Midtown.

We have more than enough beds and hospitals in this neighborhood as a fact of the current occupancy rate in Lenox Hill Hospital is not completely full. If the hospital truly wants to be a better neighbor, which they claim they want to be, how is this possible if they will subject the neighborhood to nine -- to 11 years of construction? That includes huge dust and traffic nightmares, not to mention unrelenting noise and major air pollution, including on weekends, which they've already mentioned in several meetings that they would like variances for this work.

I am particularly concerned about the pollution issues for small children and the elderly in the neighborhood. All this is because they refuse to shorten the construction time by not closing the hospital completely. At various meetings that I have attended about this project, it is outrageous to me that the hospital has brought in people from a number of unions that will work on this project to say that it is a great thing.

None, absolutely none of these people live in the exact neighborhood. We are not against these Union jobs or against the staff at the hospital, we're just asking that this project be scaled down. The Union jobs will be used, no matter how big the hospital is, by renovating and upgrading the hospital's existing facility.

Medicare, by the way, will not cover these single rooms that the hospital will have, and therefore Lenox Hill is not being truthful. It will ultimately result in more double rooms and more patients and more congestion in our neighborhood. Or it will appeal only to the ultra-wealthy individuals from out of town and out

of the country. In addition, the maternity entrance will be on Park Avenue, resulting in huge traffic tie-up while spouses double and triple park along the avenue.

The hospital needs to rethink this project. Option two is a good start. Okay, but just a start. We hope that the City Planning Commission will urge them to do so and look at the recommendations that the community board made. Thank you.

CHAIR GARODNICK: Great. Thank you. And thank you for being one of the first -- not the first to weigh in on the subjective option one or two, so I appreciate that. Okay. Let me -- let me move on, as I'm digesting what the impact would be to shut Lenox Hill Hospital entirely for construction purposes. That's just a point of concern. That would be point of concern to me as a New Yorker. I recognize that it might --

MADAM SECRETARY: They might never --

CHAIR GARODNICK: -- speed up -- they might -- it might speed up construction. They might never reopen. But I will just express my

concern about that as a -- as a scenario. That's just one person's opinion.

Okay. Let's move on to Vanessa Lily and Elaine Shea. Ms. Lily, welcome.

MS. LILY: Hi. Good afternoon, commissioners. Thank you. Thank you for giving me time to speak today. I'm Vanessa Lilly. I'm a 24-year resident of 169 East 78th Street, and I'm here to voice my objection to Northwell Health's current plan for Lenox Hill Hospital.

Lenox Hill Hospital is a valued part of our Lenox Hill neighborhood. I gave birth to both my children there. I had a double room. I shared it was fine. We support its need to modernize, but not at the scale or timeframe that their plan proposes.

Northwell Health asked for multiple zoning easements to raise the height over 250 percent over the legal limit and add 80 percent more density to the hospital, but only for 25 more beds. And now we here to serve no more patients.

The hokey mass is vastly out of scale with our primarily residential neighborhood. Not only will this skyscraper ruin the feel of our

neighborhood through its size and unfriendly street-level face, it will submerge much of its neighbor -- its surrounding blocks and shadow, all day long, all year long. The design misses many possible improvements to our neighborhood.

Despite its full block plot, the design does not create a flow through ambulance or delivery exit -- entry and exit. Instead, it plans for ambulances to back out into the sidewalk and then the bike lanes and then into traffic on 77th Street and for delivery trucks to back out over the sidewalk and into traffic on 76th.

The ER is on the third floor. Surely not ideal for accessibility. If I'm, you know, bleeding and my -- at the side of my arm, I do not want to have to wait for an elevator to get to the emergency room. The subway entrance upgrade only goes to the first level and only on the southbound side. The neighborhood community is not an important part of this plan.

Furthermore, the decade-long construction schedule proposed will put our neighborhood in chaos, grime, and noise for an untenable period. Traffic on Lexington Avenue is

already often at a standstill. It will be unnavigable for years during this construction. Local shops will lose customs and close. Children will spend their entire childhoods in the dust and noise of this unnecessary construction.

We have zoning laws for a reason. Residents of our neighborhood chose it for its tree-lined streets. Its low midblock and mom-and-pop services on Lexington Avenue. All of this is threatened by Northwell Health's massive 430-foot -- five foot tall tower.

I urge the Planning Commission to reject Northwell Health's many variant requests. Please uphold zoning laws that are carefully designed to maintain cherished neighborhoods like Lenox Hill. Instead ask Northwell Health to work with its architects and neighbors to devise a more hospitable hospital. Thank you.

CHAIR GARODNICK: Thank you. Okay. Elaine Shea?

Ms. Shea, welcome. To be followed by Benjamin Marcus here in the room.

MS. SHEA: Good afternoon.

CHAIR GARODNICK: Hi.

MS. SHEA: Thank you, Chairman Garodnick and Commissioners, for this opportunity. Sorry. Okay. I had prepared remarks, I'll try to stick to them. But a lot of issues have been raised. You just raised; would it make sense to close the hospital to allow it to construct? That's an excellent idea because if it would reduce the timeframe from 10 years or more to one, that would be amazing.

Okay. Now's the time to vote no and reject in entirety Northwell Health Lenox Hill Hospital's private application to so massively change existing residential zoning laws. They obliterate them. Any yes vote, even with conditions, guarantees the massive disruption of more than a decade and the harming of every aspect of daily living, not to mention the physical destruction of everyone's investment, business, residence, you name it, hair salon, grocery store, and quality of life. And will absolutely guarantee the permanent destruction of the Lenox Hill neighborhood. It is a death warrant for the Lenox Hill neighborhood and a physical devastation of the values of everyone working, living, and residing

there.

Also, any yes, even with conditions, will ultimately doom every other unique residential zoned neighborhood in New York City from Bedford-Stuy to Chelsea, Soho, you name it. This will be the foot in the door to put a massive tower of 30,000 square feet, not existing anywhere, anywhere.

Now, much is made about the Northwell application "subway improvements." Those are air quotes for those who can't see me. It sounds good. It is not. On housing of tenants, and putting myriad small businesses out of business through eminent domain will be the inevitable consequence of Lenox Hill Hospital's subway improvements.

You also -- they also referenced transportation. Lexington Avenue was our narrowest avenue. Any lane closure briefly, results in traffic backups. To suggest that the bus stop between 76th and 77th Street, which is the most heavily trafficked by families with children and carriages, aging in-place seniors, handicapped people, students, and everybody else, it's

impossible and unthinkable that it will be closed for 10 or more years. So to the subway. The subway; it is unthinkable to imagine that the subway would be closed for that.

And I would like to offer every commissioner individually or collectively --

MADAM SECRETARY: Time.

MS. SHEA: -- a tour over the neighborhood. Every single goal that Lenox --

CHAIR GARODNICK: Thank you. Your time is up. But before you go -- before you go, I just want to understand one of the -- well, first I want to just be clear that I was expressing a certain amount of skepticism about the possibility of closing the hospital.

MS. SHEA: Okay.

CHAIR GARODNICK: But I understand that's a live conversation.

MS. SHEA: (Unintelligible).

CHAIR GARODNICK: At least it's something that's out here.

MS. SHEA: Interesting thought.

CHAIR GARODNICK: Yeah. I got it. Understood.

MS. SHEA: (Unintelligible).

CHAIR GARODNICK: Okay. But I just wanted to make sure that I was clear. On the point about eminent domain and the small businesses, what -- can you just explain what you're referring to there?

MS. SHEA: Yes. There are four subway entrances at the corners of -- four corners of 77th Street --

CHAIR GARODNICK: Right.

MS. SHEA: -- in Lexington.

CHAIR GARODNICK: Right.

MS. SHEA: Each has two separate staircases.

CHAIR GARODNICK: Right.

MS. SHEA: I live on East 77th Street, and I use those subways multiple times a day.

CHAIR GARODNICK: Right.

MS. SHEA: Frequently, some of -- there -- because there are two staircases, if one staircase is congested, you just zip around to the other staircase and maybe you're the only one there. But it is a heavily, heavily trafficked

station --

CHAIR GARODNICK: Yes.

MS. SHEA: -- both north and south, because our unions -- there will be a doorman at every hour in the day and night, the grocery workers every hour of the day and night, use the subway and the buses. And the senior -- and if you -- if the buses in subways will be disrupted for a decade --

CHAIR GARODNICK: But focus on my question about eminent domain, because you --

MS. SHEA: Yeah. Well --

CHAIR GARODNICK: -- eminent domain --

MS. SHEA: -- do a subway improvement. It just -- it's not theoretical. It happened at 72nd Street. They took residential buildings --

CHAIR GARODNICK: Are you suggesting that Lenox Hill Hospital does not own the property on which they would be creating the subway entrance?

MS. SHEA: Well, it was unclear to me because they're -- where they were going to put

it, and --

CHAIR GARODNICK: I don't think it's -- I don't think --

MS. SHEA: -- the entrance looked like 72nd and second to me where they took away people's housing and --

CHAIR GARODNICK: Well, but there's nothing -- there's this -- we're talking about the --

MS. SHEA: Then I misunderstood what I was saying.

CHAIR GARODNICK: -- the southwest corner of --

MS. SHEA: Then I was misunderstood what I was saying.

CHAIR GARODNICK: Yeah. I think you were. Anyway, I'll just ask you to take a -- take a closer look at that yourself --

MS. SHEA: Sure. I'd be happy to.

CHAIR GARODNICK: -- because it is not my understanding that there's eminent domain involved in this conversation at all. And this is a question of a subway improvement on the corner where Lenox Hill Hospital sits. Don't mean to

minimize in any way the questions about disruption or what that would mean for subway entrances during the midst of any of that happening, but it would result in a -- I mean, I think objectively a much better access point on that particular corner. But anyway --

MS. SHEA: Well --

CHAIR GARODNICK: So I just ask you to take a look at that.

MS. SHEA: Yeah. If there's a ramp in a direct entrance into the hospital, just like Lincoln Center, that would be great. But that's not what's in the plan now.

CHAIR GARODNICK: Okay. Just an accessible entrance --

MS. SHEA: By the way --

CHAIR GARODNICK: -- which would be totally brand new and modern. Thank you.

MS. SHEA: -- (unintelligible) Hudson Yards just turned down the casino and there's a huge piece of property there. Maybe they can build this magnificent edifice over there.

CHAIR GARODNICK: That's a -- thank you for that. I don't think that's a

practical suggestion, but I appreciate it. Let me move on. I thank you.

We're going to move on to Benjamin Marcus, who is next in the room.

Mr. Marcus, welcome.

MR. MARCUS: Hi. I am an architect and a neighbor. And until the public began to speak, I was thinking that the entire conversation has been and the language being used to describe the problems of the proposal are entirely too conciliatory for the drastic impact this superstructure must necessarily entail. I live just a few blocks from the site at 85th and Madison. So this matter very much to me. But it might be instructive to point out that a person who lives anywhere in Manhattan or indeed anywhere in the world, but who cherishes and looks to New York as a paradigm of successful hyperdense urban planning, is almost to have the same investment in the protection of this site as anyone next door.

We thought we had protection in the form of what are called zoning laws and regulations. And what we and this site need protection from are assaults of this kind. So

drastic are its threats to the unique, iconic, and even existential character of this famous neighborhood that so many also actually live in. But many, many more identify with the greatest city in the world.

But this proposal by a giant real estate corporation, real estate development corporation cosplaying as a healthcare provider and whose officers should know better, cynically seeks to exploit the provisions of a zoning variance application, to assert their own profit-making plans, existing historic neighborhood be damned. If a zoning variance could be conceivably considered -- be considered for a project like this, then zoning is a meaningless and empty term in purported values, illusory and its protections imaginary.

The proposed design is a monstrosity that its generic facade design plumbs the depths of finality, if not its greatest crime, though. That honor is reserved for the audacity, the affront, and the disdain that Northwell's rapacious and indifferent appetite has, for what they must laughingly call its neighbors, over whose

heads the consuming shadow.

It's preposterous and offensive proposed height would cast that we're having multiple conversations about whether it should be allowed, with its looming massiveness to blight out the daylight sky when seen close by -- close up, and by rising above the entire cohesive and civilized heights of the surrounding block and block and block and block, that are directly adjacent, and which may -- which will be made as a matter of course, to serve as visual plinth for the barreling height when seen from a distance and whether we should be allowed -- whether we should -- whether it should be allowed if it's oversized, unarticulated, and unrelenting window pattern to thumb its nose in oblivious yet loud contempt for its context.

The genteel proportions and variated accreted, yet still coherent scale of the surrounding neighborhood. The historic and renowned residential neighborhood, a fast-disappearing refinement column, and sobriety. They were having these conversations as necessary as any design critique makes them. It's only

beside the point. Contrary to the claims of the proposal, nothing is a necessary feature. As any -- a first-year student knows -- all right. Well, it should be a lot better of a building.

CHAIR GARODNICK: That's your time. Thank you very much. Appreciate it.

Okay. Next up is Hannah Newman on Zoom and Brian DeCenzo on Zoom. Great.

MS. NEWMAN: Hi. Can you hear me?

MADAM SECRETARY: Yes.

MS. NEWMAN: Okay. Hi. Appreciate it.

CHAIR GARODNICK: Yes, we can.

MS. NEWMAN: Hi. My name is Hannah Newman. I'm the Senior Director of Infection Prevention at Lenox Hill Hospital. Thank you so much for your time. And I wanted to express my enthusiastic support for this project and also give a unique perspective based on my role.

Having worked in numerous hospitals across the country before making New York City and Lenox Hill my home in 2018, both as an employee and a patient who has received care at Lenox, I recognize what a special place Lenox Hill

is. I also recognize the importance in the role that environment has on patient outcomes.

My role is fundamentally about protecting patients, workers, and visitors for acquiring infections within the hospital. Hospital-acquired infections represent a leading cause of preventable illness and death. And as we all know, through experience with recent pandemics, infectious illnesses pose a severe threat to public health and new threats continue to arise.

We note that things like air systems, new technologies, optimize room setup, et cetera, come into play. And it's important to invest in updated modern facilities to effectively mitigate infectious threats.

Some of the best practices preventing certain infectious conditions involve what we call isolation, where the literature and the guidelines call for a private room.

The current reality is that, sometimes this means blocking available beds to which otherwise would be given to another patient in need of care. A key element of this modernization from an infection prevention

perspective is as simple as the inclusion of all single-patient rooms. The current reality of having to house multiple patients in a single room is not just a matter of comfort and privacy, but also safety and prevention of exposure to avoidable contagious illnesses and pathogens.

Lenox Hill already provides world-class care, and our community deserves a world-class facility that is set up with the most modern advantages and not challenged by older infrastructure. Thank you so much, and I do urge you all to approve this project. Thanks for your time.

CHAIR GARODNICK: Great. Thank you. Thank you very much. Brian DeCenzo and then Elizabeth Rose.

MADAM SECRETARY: Brian, you should be able to unmute on Zoom.

Brian, you should be able to unmute on Zoom.

It appears Brian has declined promotion.

CHAIR GARODNICK: Okay. I see we have Elizabeth Rose, so let's bring her up.

Hello, Elizabeth.

MS. ROSE: Hello, commissioner. Another person, you know.

CHAIR GARODNICK: Good to see you.

MS. ROSE: Good to see you too. Wish we had better circumstances. My name is Elizabeth Rose. I am a member of Community Board Eight, though today I am speaking in my capacity as an individual. Thank you to the Commission for the opportunity to testify.

Let's stipulate that residents, members of Community Board Eight, all want Lenox Hill Hospital to have modern facilities. Let's also stipulate that any project at this location will be staffed by Union labor. So that focuses the questions on how big and how tall.

I'd like to highlight a comment that was made by a member of the applicant team earlier today. The applicant mentioned that a new Memorial Sloane Kettering building also on the Upper East Side will have bigger FAR, greater density and be taller than the Lenox Hill Hospital proposal. And that individual strongly implied that fairness should then provide approval for the

Lenox Hill Hospital proposal.

But let's be clear, the recently approved MSK Building allowed for a single remaining parcel of a multi-block campus to go to an FAR of 10. All of the other square footage being used, all of the other FAR being used on this new building, was from a 2001 upzoning, also to a 10 FAR, for a multi-block large-scale campus. And unfortunately, zoning rules allow MSK to transfer FAR from adjacent blocks, onto a single small portion of its campus, which is resulting in an outsized building along York Avenue, which frankly, is very different from what the community Board approved back in 2001 when it upzoned the campus to a 10.

But let's be clear, the total campus is at a 10 FAR. Lenox Hills Hospital's proposal is for a 12.5 FAR, 25 percent more dense than MSK's entire campus. Parity with other hospitals would be, at best, an FAR of 10, not 12.5. So to George Janes' point, it density and bulk is as much of an issue here as height.

I urge the Commission to disapprove this proposal with the goal of

encouraging modifications.

I encourage Lenox Hill Hospital to consider moving some operations to satellite locations in the neighborhood as other hospitals do, not increasing the patient beds, opening and expanding operations in other parts of Manhattan or other neighborhoods outside of Manhattan that lack services, and redesigning the building for greater height uniformity across the full block front, rather than concentrating the bulk into a single massive tower on the Lexington Avenue side. Any and all of these approaches would allow for modernization that is smaller (unintelligible) in height and bulk than the current proposal and better needs of the community.

CHAIR GARODNICK: Thank you, Elizabeth.

Let me just pose one quick question to you. And uniform height across the whole block, I just want to understand, the Community Board, I believe proposed 215 as the -- as the height, but am I to understand that the Community Board would've supported 215 all the way to Park Avenue?

MS. ROSE: Let's be clear, the Community Board has not had a specific discussion about what an alternative design might be. There were several people on the Community Board who suggested in the most recent hearing that a uniform height across the full block front --

CHAIR GARODNICK: Got it. Yes.

MS. ROSE: -- would be a preferable solution. I personally think that would be a preferable solution. I still think it needs to be height-limited.

CHAIR GARODNICK: So you think -- just to -- and I may have misspoken about where the notion came from my apologies, but your preference would be 215 Lexington all the way across to Park Avenue?

MS. ROSE: I genuinely don't feel that you -- we should be approving harming one side of the block and sparing the other side of the block. And to echo some of the things that Valerie Mason mentioned earlier, the notion that Park Avenue gets to retain its low density, but we're putting everything on the Lexington Avenue side, that to me is also inequitable and a bit obscene.

So I think you have to treat, even within the neighborhood, in a microcosm, all sides equitably.

CHAIR GARODNICK: Okay. I hear that. Thank you. Thanks very much. Appreciate it.

Okay. Next up is Karen Mira, who's here. Kosovar Januzzi on Zoom, will be next.

Karen, welcome.

MS. MIRA: Thank you very much and --

CHAIR GARODNICK: See you.

MS. MIRA: -- thanks, everyone for being here. What are we; five hours in? Good afternoon. I'm Karen Mira, a partner at Carter Ledyard & Milburn, and I'm environmental counsel to the Committee to protect our Lenox Hill neighborhood. And I could echo pretty much everything Elizabeth Rose said, but I will put it in the context of DEIS review.

And as one of you wisely said at the beginning of this hearing, it's really all about what is -- what are the adverse impacts and what are the benefits and weighing those. And you can't do that unless you have a complete

understanding of both. And I think some of you, by your questions, it's clear in some areas that's been lacking, but I applaud your efforts to get more clarity.

Anyway, so I'm going to start with, the DEIS for the project is incomplete and inaccurate in ways that downplay adverse impact, particularly with respect to the bulk and overstate need, and lack key information. On both controls, many have already gone over this at length, but, you know, just in short, I think we all know this would be a jarring departure from the context of the neighborhood and the Commission's longstanding practice for how you treat a residential neighborhood like this, in terms of bulk.

But you wouldn't know that from reading the DEIS. It's full of statements like, "The proposed bulk would be consistent in scale with other institutions and medical facilities in the area." But that's simply not true. If we're talking about the study area for the DEIS, which is 400 feet, there, of course, is nothing close to the enormous floor plates that George James and others have mentioned.

You know, you'd have to go quite a long way to find anything close to that kind of a building form. And to the extent that the DEIS and the applicant in their comments earlier, is implying you can evaluate the consistency of the proposal's bulk controls, by comparing them to the density of a campus like Mount Sinai or MSK. Again, many others have made this point, that even as Elizabeth Rose just said, even MSK is 10 FAR and this is proposed to be 12.5 FAR, on a much more constrained site. Or, you know, it's not York Avenue. It's a much narrower location.

Anyway, so you know, we request that the DEIS it's -- it really needs to be -- needs to be revised to reflect that. And when you downplay these impacts, what happens is, the DEIS also, it never concludes that this is an adverse impact. It never requires you to consider alternatives. And so, we urge you to correct both of those pieces.

CHAIR GARODNICK: Thanks, Karen.

MS. MIRA: I had so much else to say, which I will put in my written comment.

CHAIR GARODNICK: I'm going to

give you one more second on the DEIS point on the bulk being consistent with other hospitals in the area. You read -- you read the piece?

MS. MIRA: Yeah. My point is that the -- if you look at your own CEQR technical manual, says when you're evaluating zoning, when you're evaluating urban design, visual impacts, historic resources, neighborhood character, every one of those because it relates to how a pedestrian in the street or, you know, experiences the neighborhood, you're not -- it doesn't matter whether it's appropriate on York Avenue. It doesn't matter if it's appropriate, you know, down by the NYU campus next to the FDR, because it's a different question.

CHAIR GARODNICK: I see. So your point is --

MS. MIRA: It's context --

CHAIR GARODNICK: Your point is that maybe the bulk is appropriate, maybe it's not, but you can't say that it is appropriate because a hospital --

MS. MIRA: Because a half mile or a mile away.

CHAIR GARODNICK: Okay.

MS. MIRA: Exactly.

CHAIR GARODNICK: I understand.

MS. MIRA: That's exactly the point.

CHAIR GARODNICK: Okay. I got it.

MS. MIRA: Okay.

CHAIR GARODNICK: Thank you.

MS. MIRA: Thank you very much.

CHAIR GARODNICK: Okay. Next up is Kosovar Januzzi on Zoom.

MR. JANUZZI: Hello? Can you hear me?

CHAIR GARODNICK: Hello? We can.

MADAM SECRETARY: Yes, we can.

MR. JANUZZI: Hi. Good afternoon. Thank you, all, for hearing me out. I just want to echo a lot of what my neighbors have already mentioned. The stated goal of this project, correct me if I'm wrong, was to improve patient experience overall, not necessarily capacity. And that's why there's only 25 additional beds. I think in that respect, there are many other improvements that can be made.

With a simple Google Review search, you can see a bunch of complaints that people have that can be addressed without having to change zoning rules and things of that nature. But the project, I think is quite unreasonable and there's a tremendous amount of pushback from local residents, Community Board Eight, and even Manhattan Borough president, although he approved it, he set some conditions before, for approval. I think that it would be beneficial for Northwell Health to consider these conditions and revise their plan to accommodate the community and their vision for this renovation. Thank you.

CHAIR GARODNICK: Thank you. Okay. Kaitlyn Griffin and then Sharon Pope Marshall.

Ms. Griffin, are you here?

(No response).

CHAIR GARODNICK: Kaitlyn Griffin? Is that --

(Unintelligible background talking).

CHAIR GARODNICK: Yeah. Okay. Come on up. Welcome. Good to see you.

MS. MARSHALL: Good to see you as well, Chair Garodnick, Vice President -- I'm sorry, vice president. It's been a long night. Vice Chair Knuckles, I'll get to the long night in a minute. My name is Sharon Pope Marshall. I'm a member of Community Board Eight for more than two decades. Today, I am speaking in my capacity as the executive director of Civitas, an organization of citizens dedicated to improving neighborhood quality of life on the Upper East Side, as well as El Barrio East Harlem.

In fact, we celebrated last night, 44 years of advocacy for these two communities. I had a great time. When Manhattan Community Board Eight voted to reject Lenox Hill Hospital at -- and the vote was 2814 to one, and rejecting the proposed expansion, it signaled a vital opportunity and one for you as well, commissioners; an invitation for the institution to pause, reassess, and meaningfully reengage with its neighbors and the broader community. And I would really ask that you allow this to happen.

Although we support the modernization of the hospital facilities as

presented, Lenox Hill -- although we overall support modernization, Lenox Hill's proposal is deeply troubling. The expansion calls for a massive 30,000 square foot floor paint, which you've heard a soaring 436-foot tower. Chair Garodnick, I'm thinking 350 feet would -- or less, would be appropriate, and a -- with a build program of 10 years.

These elements taken together, will transform our community from a neighborhood into a massive hospital complex. That's what we're looking at here. That plan's bulk, height, and prolonged construction would overwhelm the Park Avenue Corridor and surrounding areas, ignoring longstanding zoning protections and jeopardizing the unique fabric of this vibrant historic community.

The proposed Tower Stark visual presence and eerie -- will irreversibly alter the iconic Park Avenue District. Thank you for the opportunity for me to speak.

CHAIR GARODNICK: Thank you. Thank you for being with us today. We appreciate it.

MS. MARSHALL: Thank you.

CHAIR GARODNICK: Okay. Next up is Sean Grofekowski on Zoom, Jill Schlesinger on Zoom, and then Lenore Passavanti, and Kenneth Anderson here in the room with us.

MADAM SECRETARY: Sean, you should be able to unmute on Zoom.

MR. GROFEKOWSKI: Yes.

MADAM SECRETARY: (Unintelligible).

CHAIR GARODNICK: We got you. We got you.

MR. GROFEKOWSKI: All right.

CHAIR GARODNICK: Yeah.

MR. GROFEKOWSKI: So thanks, everybody in the committee here and I live -- I live on -- across the street from NHL 150, East 77th Street. Have for over 25 years. And I strongly urge the commission to reject the application rule of this -- the requested zoning mod. It would -- in effect, it'd be a proclamation that the -- that the New York City zoning laws really have no meaning. And that, you know, it would, you know, disregard the justification for

the zoning designations that were -- that were established in the first place.

And I also take offense too with the fact that Northwell, in every opportunity they've -- they portray their -- the noncompliant redevelopment plan as something -- magnanimous gesture to the community, but, you know, their insistence on disregarding the Community Board recommendations and continuing to pursue the proposed redevelopment plan illustrate the fact that they do not have a genuine concern for the community desires and is a -- and it really is a self-serving alternative designed to benefit their interests.

You know, I've been living across the street now for, like I said, 26 years. I've witnessed firsthand in practice, they're -- the most -- they're poor stewards for the -- for the neighborhood. They're actually -- and they consistently demonstrate a lack of regard for the residents who live in the area, and disrupt daily and night -- and they're disrupted daily and nightly by their operations.

So impact on the community is not

theoretical, but for persistent tangible, largely ignored, and would only increase exponentially. So going -- some of this has been addressed already, but you know, a big, kind of overarching issue is that, northwest framing this as a debate in such a way that, opposition to their plan equates to being an opposition of hospitals, which is not the case.

And I don't think anybody has ever expressed that, but they've been in full control of the -- of the narrative for this, from the beginning. And they have every step along the way, chosen to pursue the redevelopment plans with grossly out of character with -- and too large for the community, and doesn't comply with existing zoning, only to then, you know, claim that they're conceding and in reducing it to something slightly less large.

And you know, there's -- they're not constrained by any technical zoning -- restrictive zoning criteria for the site, but instead, those that they're placing upon themselves, you know, they end up using the entire property and use the 12 --

MADAM SECRETARY: Time.

MR. GROFEKOWSKI: If they use the FAR as per the community board rec, then they would end up having 1.3 million square feet --

CHAIR GARODNICK: Thank you.

MR. GROFEKOWSKI: -- with 14 and a half foot floors.

CHAIR GARODNICK: Thank you, Mr. Grofekowski.

Next up, we got Jill Schlesinger on Zoom, followed by Lenore Passavanti, and Kenneth Anderson.

MADAM SECRETARY: Jill, you should be able to unmute in Zoom. It appears Jill has declined to be promoted to a panelist.

CHAIR GARODNICK: Okay. Fine.

Ms. Passavanti, welcome.

MS. PASSAVANTI: Hi. Thank you, commissioners, for your time. Good afternoon. And it's been a long day, so I thank you. My name is Lenore Passavanti, and I've been a resident of the Upper East Side for the past 21 years. I oppose the passage of this zoning variance. And I'm going to use a fairytale to illustrate this issue.

Northwell is attempting to

shoehorn too large a program into too smaller space. This is like trying to fit the wrong foot into the glass slipper. All that was, and is needed, is the right user and the right program for the site.

I'm a registered architect. I've been practicing for the past 30 years, but prior to becoming an architect, I was a registered nurse at Columbia Presbyterian Hospital where I worked in the surgical ICU for 13 years full-time, 12 years part-time, to pay for my lovely architectural intern salary. So I was there for 25 years at Columbia.

I was there during the construction of the Milstein Building and actually part of the -- and the transfer from Presbyterian Hospital to Milstein. So I know something about hospital design, I know something about the need for hospitals to modernize. And I support that.

While I was in graduate school, I worked at Skidmore, Owings, and Merrill, they did the Milstein Building, and they also did new pavilions at Roosevelt and St. Luke's and among many others. So I understand hospital design. And

then, pro-modernization and pro-construction, including new construction.

With this in mind, I believe Lenox Hill should build a new hospital that is designed with a program that the site will allow. I think Lenox Hill should then locate other programmatic elements in other -- at other sites.

As an architect, I object to the massing and style of the proposed design. Both dwarf the existing buildings and destroy the fabric of the neighborhood because the -- it is an alienating outlier that ignores the current aesthetic of neighboring buildings, some of which are part of the Upper East Side Historic District.

Recently built buildings, including those by Sofield Architects at 79th and Lex, Peter Pennoyer Architects at 78th East 78th Street and Lex, and Robert Amster Architects at East 78th Street and Lex, are appropriately scaled with facades that align with and are sympathetic to the existing structures and support the character of the neighborhood.

I don't see why Northwell Health can engage an architect that can do that.

Modernization of a hospital, yes, this proposal, no. So you asked us to comment on this; the two things. So what I would say, when I look at both of these, and I didn't study these at length, but what I would just say is on the Lexington Avenue Street, that is -- they just both stop at about 196 feet and then just step back gratuitous like two or three feet and then go back up almost straight up. So I don't think that's great.

You said about -- if it was one height all the way across, I'm -- you know, I would be in favor of like 215 all the way across -- can I finish that?

CHAIR GARODNICK: Yeah. Go ahead. You can finish this up. Yeah.

MS. PASSAVANTI: Yeah, just to articulate it with a good -- like a stern building would when you really articulate any building, so it's not a mass, I think the current design is massing and also aesthetically inappropriate.

CHAIR GARODNICK: And am I hearing you correctly and maybe others, in saying that you'd like them to change their program --

MS. PASSAVANTI: Yeah.

CHAIR GARODNICK: -- altogether and have the Lenox Hill Hospital cease to be what it is today, essentially, and be a subset of what it is; provide other services, but not be a full-service hospital in order to avoid this particular conversation. Is that a fair statement?

MS. PASSAVANTI: No. I'm not quite -- I'm not -- I don't -- I didn't study their program. I don't -- I don't get how what's working today needs to be blown up to two and a half or three times the size that it is to work today. That conversation about, you know, hoods being bigger and I need to get my robots in and all that kind of stuff. I mean, I don't know. I think that's a lot of hyperbole. I think it's a bit much. And so, I don't -- I can't speak --

CHAIR GARODNICK: Okay. I understand that. And I think it's incumbent upon Lenox Hill Hospital to make that case in this process --

MS. PASSAVANTI: Yeah.

CHAIR GARODNICK: -- as to why. And I -- this is really where I started when they were up at the podium, I don't know, five and a

half hours ago, as to show us what you're getting, show us why you need what you are asking for here, and you know -- and I think that that's going to be an important part of this conversation.

MS. PASSAVANTI: Yeah.

CHAIR GARODNICK: So I understand your point.

MS. PASSAVANTI: And when -- I mean, when I was at Columbia, okay, granted it was in 2004 is when I left, but from the hospital at Presbyterian where I worked for like 12 years and then the hospital at Milstein, I mean, the ORs didn't change that drastically. Maybe the past, you know, 10, 20 years, ORs have changed, you know, drastically. But I don't think they have, and I don't think they require a million times more or three times more space. So I would --

CHAIR GARODNICK: How about the patient -- how about the patient room experience?

MS. PASSAVANTI: Well, you know, I think hard to say. I don't think you have to have a single room. I don't think that whole argument about infectious disease and needing to need single rooms for infectious disease to have isolation

rooms is quite right. Most floors have special isolation rooms because you need a vestibule, as well as the room itself and negative pressure and all those things to have an isolation room. So you can't just convert any room into an isolation room like that. So that's not a good argument for it. I don't know what other hospitals are doing if one of single patient rooms are the benchmark now, but --

CHAIR GARODNICK: Okay.

MS. PASSAVANTI: Yeah.

CHAIR GARODNICK: Got it. Thank you.

MS. PASSAVANTI: Thanks.

CHAIR GARODNICK: Thanks very much.

Okay. Kenneth Anderson, are you here with us?

(No response).

CHAIR GARODNICK: Mr. Anderson? Okay. I don't see him here. Rosemary Fanelli on Zoom and Ann Goodbody on Zoom. Are they here or are they on the Zoom?

(No response).

MADAM SECRETARY: Rosemary is not in the Zoom.

CHAIR GARODNICK: How about Anne Goodbody?

MADAM SECRETARY: We do have Anne.

CHAIR GARODNICK: Great. And while you're promoting Anne, I'm going to just make a public service announcement that we are getting very, very close to the end of our hearing today. So if you wish to be heard on calendars 12 to 14 Lenox Hill Hospital and have not yet signed up, now's a good time to do that. And we will continue to take comments after today, of course, which we'll make an announcement about at the very end. But if you want to be heard today, now's a good time to sign up.

Okay. Ann Goodbody?

MS. GOODBODY: Yes.

MADAM SECRETARY: Ann, you should be able to unmute on Zoom.

MS. GOODBODY: Okay.

MADAM SECRETARY: We can hear you.

CHAIR GARODNICK: Hello?

MS. GOODBODY: Okay. Can you hear

me? Am I --

CHAIR GARODNICK: We can.

MS. GOODBODY: Okay. Thank you. I am strongly in opposition to this expansion and the fact that the hospital is in this location where it fit at the time does not give it a right to build something so wrong for the neighborhood and frankly, for the city. I'm not going to repeat the very important points that others have made, especially with regard to disparity. So I'll cut this short.

Northwell claims there's no alternative to staying within the zoning envelope. Not true. LaGuardia managed to rebuild an airport and keep planes flying. They say all this is necessary for quality care, but they're adding to one of their hospitals in Long Island that will not have such extravagant facilities. I'm a financial guy, and this is important.

The use argument, which Northwell says, justifies the upzoning, falls flat on its face when considering the financial aspects. Land use issues cannot be considered in a silo. Today, Medicare and Medicaid reimbursement rates cover

about one-third of related costs. And so, hospitals provide, and/or markup other expensive services to sustain profitability. They must do so.

In this case, Northwell will be spending two to two and a half billion dollars to add a few beds, ORs, and ER stations. Think about the economics of that. They will either find ways to deny patients on public insurance and market only to wealthy private payers if they can attract enough or they will be insolvent. They deny that but just do the arithmetic. And who knows what will happen to reimbursement rates over the next decade?

All hospitals are concerned about that very significant risk. They have an irrational dream, but built somewhere else in a rational way and fixed Lenox Hill for local community services. And in response to Commissioner Benjamin's questions earlier, downtown and the boroughs are not being served because residents cannot afford big, fancy hospitals, and therefore they can't afford to come here either. And that is why their healthcare outcomes are so

poor. That needs to be addressed.

I trust the commissioners will look at this with eyes wide open and deny the application and ask Northwell to return with a suitable plan within its zoning envelope. Thank you.

CHAIR GARODNICK: Thank you. We next have Lo Vanderwock (phonetic), on Zoom and Amy Rappaport here in the room. And then, we're going to see if we have any of the folks that we had called previously on Zoom, or anybody else who wishes to be heard, who has not yet come forward today. But I'm looking for you, Lo. I was hoping that I would see you today. I knew I would see you today.

MADAM SECRETARY: Lo, you should be able to unmute on Zoom.

MR. VANDERWOCK: Yes. Can you hear me?

MADAM SECRETARY: Yes, we can.

CHAIR GARODNICK: We can.

MR. VANDERWOCK: Yeah. Oh. My name is Lo Vanderwock, I'm representing Carnegie Hill Neighbors on the Upper East Side. We are

closer to Mount Sinai than to Lenox Hill, so -- but our concerns about hospital size and expansions are evident in our participation in this process. And Chair Garodnick, I want to thank you very much for the exchange you had with various people, and especially George Janes, and addressing some of the really important open questions. I think that has really added value to these hearings.

And going on with my plan testimony, the proposed hospital renovation plan for adding 436 feet is more than twice the zoning of what zoning allows and is also bulky and massing. And it's -- the bulky and massing is especially important in making this an unacceptable plan, with the midblock being invaded by 80 feet which we think is a -- is a terrible mistake.

Only Hunter College has towers on this also residential part of Lexington Avenue, but these are no more than 250 feet tall, including the canticles and they are less bulky. The nearby Carlisle Hotel between 76 and 77th Streets on Madison Avenue, is of similar height, but its tower is slender and occupies only half the block on Madison Avenue, and hence, has no great adverse

impact on the surrounding residential community.

The proposed objection to alternative for expanding into the midblock to lower the overall height, is also unacceptable, as it has already 80 feet into the midblock. And this will add to the midblock bulk and that has a major impact on the residents on both 76 and 77th Street.

A final concern should be the flow of vendor delivery trucks and ambulances. The current designs require all trucks and ambulances to back up, rather than allowing vehicles to travel from street to street. This design creates enormous curb cuts on both 76 and 77th streets that will damage the quality of life on these streets.

Finding solutions to the immediate traffic flow problems should be seen as an obligation of the hospital and it's building design team because success or failure here can have a major impact on vehicle travel flow and -- at the hospital and surrounding areas. It can also have a major impact on the permanent quality of life in terms of noise and congestion, for the -- for the residents of 76 and 77th Streets.

We ask that the planning

commission request the applicant to revise and significantly reduce the size of the project to confirm -- conform more closely to the context of the residential community. Thank you for this opportunity. I will submit written testimony.

CHAIR GARODNICK: Great. Thank you very much, Lo. Appreciate it.

Okay. Next up, is Amy Rappaport. Welcome. And then we have Evelyn Finster back on the Zoom.

MS. RAPPAPORT: Ah, I guess I'm not last batter. Well, thank you Chair Garodnick, and members of the Planning Commission, for your patience and your due diligence. I am Amy Rappaport McKenna, a lifelong Upper East Side resident, always living within a few blocks of Lenox Hill, aside from my time with Chair Garodnick in college. My children were born at Lenox Hill and I'm a patient of a Northwell physician.

I urge rejection of Northwell's proposal in its current form. No one today has disputed the need for modernization, but this proposal is misaligned and grossly burdens the community in the short and long term. Throughout

the day, you have heard about this two-plus billion dollar project for 25 new beds that requires nine zoning variances with increases of 250 to 500 percent. If approved, it sets a terrible precedent for the city.

This Commission is tasked with responsible development. The proposed plan is unjustifiable. Northwell made a bad investment, a vanity project of wanting a Park Avenue address to compete on a global scale and scale and with its New York City peer institutions. I'm appalled at Northwell for trying to push through zoning changes to achieve their interests, not the cities and not the communities.

And we've also heard about the decade-long construction and the impact, but we really heard about the fact that Northwell plans to stay operational when they don't need to. They have enough swing space to close and move elective surgeries and -- to other venues during construction. This would be better for the community, their patients, and staff. With 50 percent of all patients coming from outside of the community, this shouldn't be an issue since they

are already traveling and will get great Northwell Care.

Please reject this application and disregard Northwell's two proposals and urge them to close during construction.

And lastly, what I've heard all day is the community genuinely wants to work with Northwell for a first-class program. I genuinely believe we can find a path together. Thank you for your consideration.

CHAIR GARODNICK: Great, thank you very much. Good to see you.

Let's go to Evelyn Finster. And I'm certain that as we close here, I don't want to speak for Lenox Hill Hospital, but I'm certain that they will be enthusiastic to find ways to work with the community and should be, in the course of the next number of months that exist on this particular proposal.

Okay. Let's go to Evelyn Finster.

MS. FINSTER: Hi. Can you hear me?

CHAIR GARODNICK: Yes.

MADAM SECRETARY: We can.

MS. FINSTER: Oh, fantastic. Hi. Thank you very much. My name is Evelyn Finster as you point out. I live at 136 East 76th Street. My family has been in the building, including my almost 97-year-old mother. But don't tell her I told you that, for 45 years. I participated in almost every forum where this topic has been discussed, since the plan was revealed in 2019, including then Borough President Brewer and Council member Power's task force.

It's been a long road and we are really grateful that Community Board 8 made a thoughtful recommendation and is supporting the community so vigorously. I'm disappointed in the recommendation from our current Manhattan Borough President Levine. I think it's -- doesn't -- it reflects, unfortunately, quite a bit of the influence that Northwell has achieved through its incredible spending on lobbyists, which has been published very recently in cranes.

It is unrealistic about Northwell's potential to be a good neighbor. It understates the (unintelligible) opposition of the community that you've been hearing quite a bit of

today. And it also understates the terrible impact that the project is going to have on, not just as was pointed out during the construction period, but permanently. Not just to home values, but to the congestion and the loss of light and air that we will suffer forever.

It's very interesting that the project will not actually create a single new healthcare job. Please do not be distracted by the Union rally that the hospital has managed to encourage, they should build with union labor, wherever and whatever they construct.

A couple of other notes, in terms of the comments from Manhattan Borough President Levine, there are misstatements in his background description. The emergency department beds are not in a hallway that seems -- that connotes a certain imagery of people lying just outside of rooms. They have an open-plan emergency department where there are bays that are separated by curtains. Not optimal perhaps, but not a hallway.

He also describes significant reductions that were in response to the community. That is a tremendous overstatement. Their

willingness to throw away a residential tower that was completely nonsensical to begin with is not a great concession. The modest reductions in height are accompanied by an increase in bulk, in thickness, which has already been explained by all of the architectural experts, is very damaging. The impact it -- to it will be severe.

MADAM SECRETARY: Time.

MS. FINSTER: They actually closed our street for 12 hours recently to replace a single MRI machine. Thank you.

CHAIR GARODNICK: Thank you. Thank you, Ms. Finster.

Okay. Let me do a last-call roundup here, Madam Secretary. Do we have others in the Zoom who we called previously and who have not yet been heard?

MADAM SECRETARY: Yes. I'm going to start calling out some names --

CHAIR GARODNICK: Great.

MADAM SECRETARY: -- some second calls. Anthony Cohn, who's now joined by Zoom and possibly by phone. Anthony has joined us as a panelist.

Bernard, you'll be next.

MR. COHN: Okay. Hi. I hope you can hear me.

MADAM SECRETARY: Yes, we can.

CHAIR GARODNICK: We can.

MR. COHN: Great. Thank you for the opportunity to speak. My name is Anthony Cohn, I'm an architect and I live on East 77th Street. I've been a member of Community Board 8 since 2017, and I'm co-chair of the Landmarks and the Zoning Development and Housing Committees. I also served on the Borough President's task force on the Lenox Hill expansion in 2019, 2020. So I have been living with this project for almost as long as the applicants.

As an architect, I always engage in hypotheticals and I firmly believe in examining all the possibilities of any proposal, no matter how far-fetched they might seem. The applicant demands that Lenox Hill Hospital remain fully operational throughout the construction process. This declared imperative clearly establishes the proposed development's original sin, from which sprout all of its defects. These have been

enumerated and elaborated upon over the course of many afternoons and evenings since 2019, and especially today.

By example, the refusal to close the hospital not only extends the construction period but also precludes a distribution of the mass of the hospital across the entire site, say at a height of about 215 feet, which could more or less satisfy their entire program. In any project, the client and their professional advisors create a program consisting of what becomes a chain of demands. The expansion of Lenox Hill Hospital is no different.

If you accept that the hospital must be modernized, the ER department must be enlarged. The new single-patient rooms must be larger than the existing two-bedded rooms. The new operating rooms must be larger than the existing operating rooms, and that the hospital must remain open throughout the lengthy construction, the inconvenience to neighbors, patients, and staff be damned, then you must accept the proposal. I would, however, urge you to look more closely at the applicant's non-negotiable demands and their

consequences. Thank you.

CHAIR GARODNICK: Okay. Thank you.

Madam Secretary?

MADAM SECRETARY: Bernard Seltz, you should be able to unmute.

Bernard Seltz, you should be able to unmute on Zoom.

MR. SELTZ: I won't repeat the -- all the reasons why I am against the project, but based on all the people I've heard and I have not been able to stay tuned for the whole day, everyone who seems to be for the project, is one way or another on the Northwell payroll. And I'm just wondering what the company has done to induce all these people to be in favor of their project. Thank you.

CHAIR GARODNICK: Thank you.

MADAM SECRETARY: Okay. Next, we have Patricia Rossetti.

Patricia, you should be able to unmute.

MS. ROSSETTI: Can you hear me all?

CHAIR GARODNICK: We can.

MADAM SECRETARY: Yes, we can.

MS. ROSSETTI: Good afternoon, Chairman Garodnick and the City Planning Commissioners. And thank you so much for hearing us all out. I'm speaking as a concerned member of the Upper East Side community and more broadly, as a New Yorker, alarmed by the growing influence of corporate interests over the public good. I'm opposed to the proposed Lenox Hill Hospital expansion in all forms.

And at its core, it's not about improving patient care, it is about profit. This seeks to override zoning laws to construct a tower vastly out of scale with the neighborhood serving corporate ambitions while failing to address true healthcare disparities in Manhattan.

The proposal to expand the maternity unit is troubling. Lenox Hill already has a highly rated maternity ward. Why the need for bigger private rooms with Central Park views to compete with Cornell's Alexandra Cohen Tower or to improve maternal fair outcomes? The focus has become hotel-like amenities and not actual care.

The proposed neurosurgery suite tells the same story. Neurosurgery specifically is one of the highest revenue generators for hospitals, which is likely why it's prioritized, despite the fact that New York already hosts some of the top neurosurgery centers in the world.

Finally, we must ask why Lenox Hill insists on remaining in such a high-income area. Under Emtala, a federal law requiring hospitals to treat all emergency patients regardless of ability to pay, locating in a wealthy neighborhood helps hospitals minimize the number of uninsured patients they must treat. In short, by staying put, Lenox Hill can continue to maximize revenue while limiting its share of uncompensated care.

Beyond the medical issues, lies the vast and devastating impact of construction to everyone; residents, patients, doctors, and nurses, and all of the traffic, waste and noise, and disruption that will follow. There is a better path. By expanding rather than on the cramped Upper East Side, but potentially relocating to Hudson Yards, an area completely underserved by

hospitals, and in a burgeoning biotech and pharma corridor, Lenox Hill wins. It has the space to modernize and within established zoning laws.

If I have a heart attack now and Lenox Hill doesn't exist, I have other choices. If I live in Chelsea or anywhere between Canal and 50th Street, I have nowhere to go. This makes us all less safe. True city planning starts with vision, not with corporate blueprints. I urge you to project -- reject this expansion proposal and demand a plan that serves all of New York.

CHAIR GARODNICK: Thank you.

MADAM SECRETARY: Okay. Next for the second calls, Michael Byowitz, Barry Schneider, and Jill Schlesinger. We'll try that again.

Michael Byowitz?

MR. BYOWITZ: Yes. Can you hear me?

MADAM SECRETARY: Yes, we can.

CHAIR GARODNICK: Can.

MR. BYOWITZZ: Great. For some reason I can't -- oh, there it is. Okay. I'm Mike Byowitz. I'm a 27-year resident of the neighborhood, more than 40-year residents of the

city. I'm speaking not only for myself, I live on Park Avenue near Lenox Hill, but I have three adult children, each of whom live in the neighborhood in their own apartments in close proximity to Lenox Hill, and they're on the east side of Lex. So I cover both sides of this discussion.

This will put a tremendous burden on the community, as you've heard repeatedly. This is not just a modernization, this is a huge addition to hospital size, without adding patient capacity. We get 25 more patient beds than we would've -- we have now, with no increase in patient flow, as I heard Dr. Baker admit.

The building, even if in reduced size, would be two times taller than what we have now, at substantially taller and bigger than neighborhood buildings. And it would stand out in an unattractive way, would be applied on the neighborhood. It would cause great inconvenience and deterioration of the quality of life for neighborhood residents.

You heard about nine years of construction, external and internal, both of which are disruptive. And we've heard that once they

know better and evaluate, that may lead to a decrease in the amount of size. That isn't realistic.

What I find -- you have more experience than me, but I find that most estimates of how long something is going to take in construction, underestimates, and it often takes longer. There are other problems that have been focused on, to not as great an effect but have been mentioned here today. And it -- this includes the pick off and -- pick up and drop off from maternity ward on Park Avenue. That will exacerbate crowded conditions on Park Avenue, where there's already lots of double parking on that specific street between 76th and 77th. And traffic will grind to a standstill there.

And in terms of need, you've heard before, this is bedpan alley. There is a large number of hospital beds here. As others have said, if they want to add rooms for people in other neighborhoods, they should build them in other neighborhoods where there's room. Northwell has built elsewhere, they've indicated that they talked about Harlem in the Lower East Side and other

places, and that's where the bed should be, as well as in the outer boroughs.

I'm not saying Lenox Hill should cut back on services. I'm saying they've not made the case for why they need what they're asking for. They claim to need service for the whole city, and they can move some of that service to other parts of the city. And for those reasons, the Planning Commission should reject the proposal. Thank you.

CHAIR GARODNICK: Thank you.

MADAM SECRETARY: Okay. Jill, you should be able to mute on Zoom.

MS. SCHLESINGER: Hi.

CHAIR GARODNICK: Hello.

MS. SCHLESINGER: Hi. You know, I've been listening basically, off and on all day. And what we haven't really discussed, which is kind of unbelievable, is that they initially proposed their first thing, which was immediately changed to their second rendition, but nothing's really changed in the last six years. So they've never really listened to what the community was looking for and have changed accordingly. They have not submitted another plan in in the last five years.

That's one -- that's one contention.

The other thing is, they get an incredible amount of money for their private rooms in their maternity, and of course, they -- and their maternity is one of their biggest profit centers. And so, of course, they want to, you know, increase the number of private rooms to increase their profit center. For the community, there's no reason it needs to be, you know, having another construction project of 9 to 11 years, because number one was 11 years.

Number three, the subway, it is one way. They're going expand one side of the street. So the person that's disabled that wants to go downtown will not be able to come uptown to the same thing, to the same station. So that's not really that all that helpful. And that we've had so much construction in our area, and I realized that the city is a growing place and there's just construction sites everywhere. So to have another one on a smaller street is just insane.

And my last point is that New York Hospital renovated one floor by one floor. You know, for whatever, you know, expansion, I

understand that Sloan Kettering is expanding, but York Avenue is much wider and much less congested than Lexington Avenue and 77th Street. And you everybody talks about it's a 2 billion spend, it's a 2 billion spend for what? Not for our community. It's not going to enhance our community.

We have plenty of hospital beds and now they're going to create, instead of six bays -- I'm sorry. I'm sorry, I'm on the street -- six bays, they're going to create 38 bays. I was recently in Lenox Hill Hospital. They check you in right away and then you wait for hours, but you wait in the back. So they're going to add more jobs and they're going to add more staff?

MADAM SECRETARY: Time.

MS. SCHLESINGER: Okay. That's my whole thing. Nothing of that has been discussed.

CHAIR GARODNICK: Thank you. Thanks very much for being with us.

MADAM SECRETARY: Okay. Last call for Barry Schneider.

Barry, you should be able to unmute in Zoom.

CHAIR GARODNICK: Barry is going

to be very disappointed he didn't get to have the last word today if that's what happens. No Barry?

MADAM SECRETARY: We've tried promoting Barry and declined and --

CHAIR GARODNICK: Okay.

MADAM SECRETARY: Barry has the ability to unmute.

CHAIR GARODNICK: Okay.

MADAM SECRETARY: Not --

CHAIR GARODNICK: All right, Barry. We missed you.

MADAM SECRETARY: Sorry, Barry.

CHAIR GARODNICK: Okay. Anybody else who wishes to be heard today on this item? This is the final call, here in the room, on Zoom. I'm going to pause for one second, filibuster, just to make sure nobody else wants to be heard on calendars number 12, 13, and 14.

(No response).

CHAIR GARODNICK: Okay. With that, Madam Secretary, any announcements before I close the hearing on this item?

MADAM SECRETARY: I'll just note, before we close the hearing on calendar numbers 12,

13, and 14, the record will remain open through 5:00 p.m. on Monday, June 2nd to receive written comments on the DEIS.

CHAIR GARODNICK: Great. Let me -- let me express my appreciation to everybody who was with us for, you know, six and a half, six and three quarter hours today. Of course, to the commissioners, for your attention and commitment, to members of the public who are here with us, for many, many hours. Thank you. We appreciate it. To the applicants -- all of the applicants today who are, you know, looking to invest in New York City, we certainly appreciate that, even in the midst of obvious disagreement, among some, about what's going on. But I do want to just say thank you. It was a very interesting and productive day.

Madam Secretary, anything before we close?

MADAM SECRETARY: There is no other business before the Commission for the public meeting, but I do have some public information to share.

For those of you who are unable to, or did not wish to testify, you can submit

written testimony online by selecting this hearing on the NYC Engage Portal, through DCP's website, or by mailing your comments to City Planning Commission, Calendar information Office, 120 Broadway, 31st Floor, New York, New York, 10271.

CHAIR GARODNICK: Great. Thank you, Madam Secretary. Time is 4:47. We are adjourned.

(Whereupon, the meeting was adjourned at 4:47 p.m.)

STATE OF NEW YORK)
SS.
COUNTY OF NEW YORK)

I, MARC RUSSO, a Shorthand (Stenotype) Reporter and Notary Public within and for the State of New York, do hereby certify that the foregoing pages 1 through 297, taken at the time and place aforesaid, is a true and correct transcription of my shorthand notes.

IN WITNESS WHEREOF, I have hereunto set my name this 4th day of June 2025.

Marc Russo

MARC RUSSO

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