Appendix A

Proposed Zoning Text

Final Scope of Work - Attachment 1: Supplemental Project Information

Lenox Hill Hospital Proposed Zoning Text

Matter underlined is new, to be added;
Matter ~~struck out~~ is to be deleted;
Matter within # # is defined in Section 12-10;
* * * indicates where unchanged text appears in the Zoning Resolution.

ARTICLE VI
SPECIAL REGULATIONS APPLICABLE TO CERTAIN AREAS

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Chapter 6
Special Regulations Applying Around Mass Transit Stations

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66-50
SPECIAL APPROVALS

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66-51
Additional Floor Area for Mass Transit Station Improvements

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66-513
Additional rules and limitations, conditions, findings, and requirements

Any authorization or special permit application pursuant to the provisions of Section 66-511 (Additional floor area for mass transit station improvements by authorization) or Section 66-512 (Additional floor area for mass transit station improvements by special permit), respectively, shall be subject to the following provisions.

(a) Additional rules and limitations on bonus #floor area#

The following rules and limitations on bonus #floor area# shall apply in addition to the provisions set forth in Sections 66-511 and 66-512:

(1) Where a #zoning lot# contains multiple #uses# with different #floor area ratios#, the bonus may be applied to any individual #use#, and the total of all #floor area ratios# shall not exceed 20 percent of the greatest #floor area ratio# permitted on the #zoning lot#;

(2) The #floor area# bonus may be used in combination with other #floor area#

bonuses, provided that the maximum #floor area ratio# permitted through the combination of bonuses does not exceed 20 percent of the maximum #floor area ratio# otherwise permitted on the #zoning lot#. However, such 20 percent limitation shall not apply:

(i) where explicitly stated otherwise in a Special Purpose District; or

(ii) where explicitly stated otherwise in a special permit of the City Planning Commission; and

(3) For #MIH developments# or #UAP developments#, the requirements of Article II, Chapter 7 (Additional Regulations and Administration in Residence Districts) shall not apply to the bonus #floor area# granted under the provisions of this Section.

For the purposes of applying this paragraph to applications seeking an authorization pursuant to Section 66-511 (Additional floor area for mass transit station improvements by authorization), notwithstanding the above allowances, in no event shall the amount of bonus #floor area# exceed 200,000 square feet.

(b) Conditions

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ARTICLE VII
ADMINISTRATION

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Chapter 4
Special Permits by the City Planning Commission

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74-90
ADDITIONAL PERMITS

* * *

74-904
Non-profit or voluntary hospitals in R9 or R10 Districts and certain Commercial Districts

For a #zoning lot# occupying an entire #block# located in an R9 or an R10 District, or in #commercial districts# mapped within, or with a #residential equivalent# of an R9 or an R10 District, partially within the #Special Park Improvement District#, and containing a non-profit or voluntary hospital and related facilities, as listed in Use Group III(B), the City Planning Commission may, by special permit, allow the modifications set forth in paragraph (a) of this

Section, provided the conditions set forth in paragraph (b) and findings set forth in paragraph (c) are met.

(a) The Commission may allow an increase in the maximum #community facility# #floor area ratio# by up to a maximum of 20 percent. A #floor area# bonus pursuant to this Section may be used in combination with a #floor area# bonus permitted pursuant to Section 66-51 (Additional Floor Area for Mass Transit Station Improvements), and the combination of such bonuses may exceed 20 percent of the maximum #floor area ratio# otherwise permitted.

In connection with such #floor area# bonus, the Commission may allow modifications to applicable #bulk# regulations.

(b) In order to grant a special permit pursuant to this Section, the following conditions shall be met:

(1) a minimum #floor area# of 75 percent of any #development# or #enlargement# on such #zoning lot# will be allocated to such hospital #use#;

(2) the bonus #floor area# allowed pursuant to this Section shall be exclusively allocated to such hospital #use#; and

(3) the amount of #floor area# to be located on the portion of such #zoning lot# within the #Special Park Improvement District# shall not exceed a #floor area ratio# of 10.0.

(c) In order to grant a special permit pursuant to this Section, the Commission shall find that:

(1) the public benefit derived from such proposed hospital #development# or #enlargement# merits the additional #floor area# being granted pursuant to this special permit;

(2) where #bulk# modifications are utilized, such modifications will provide a more satisfactory physical relationship to existing hospital #buildings or other structures# on the #zoning lot#, and facilitate a more efficient and integrated site plan; and

(3) where #bulk# modifications are utilized, the distribution of #bulk# on the #zoning lot# will result in a satisfactory site plan and urban design relationships of #buildings or other structures# to adjacent #streets# and the surrounding area.

The Commission may prescribe appropriate conditions and safeguards to minimize adverse effects on the character of the surrounding area.

74-91
Modification of Public Plazas

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ARTICLE IX
SPECIAL PURPOSE DISTRICTS

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Chapter 2
Special Park Improvement District

* * *

92-20
SPECIAL BULK REGULATIONS

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92-21
Special Floor Area Regulations

The underlying #floor area# regulations shall apply except as modified in this Section.

For #developments# or #enlargements# on #qualifying transit improvement sites#, a #floor area# bonus for #mass transit station# improvements may be granted by the City Planning Commission pursuant to the provisions of Section 66-51 (Additional Floor Area for Mass Transit Station Improvements). For the purposes of this paragraph, defined terms additionally include those in Section 66-11 (Definitions). In addition, a #floor area# bonus may be granted by the Commission pursuant to the provisions of Section 74-904 (Non-profit or voluntary hospitals in R9 or R10 Districts and certain Commercial Districts). No other #floor area# bonuses shall be permitted.

* * *

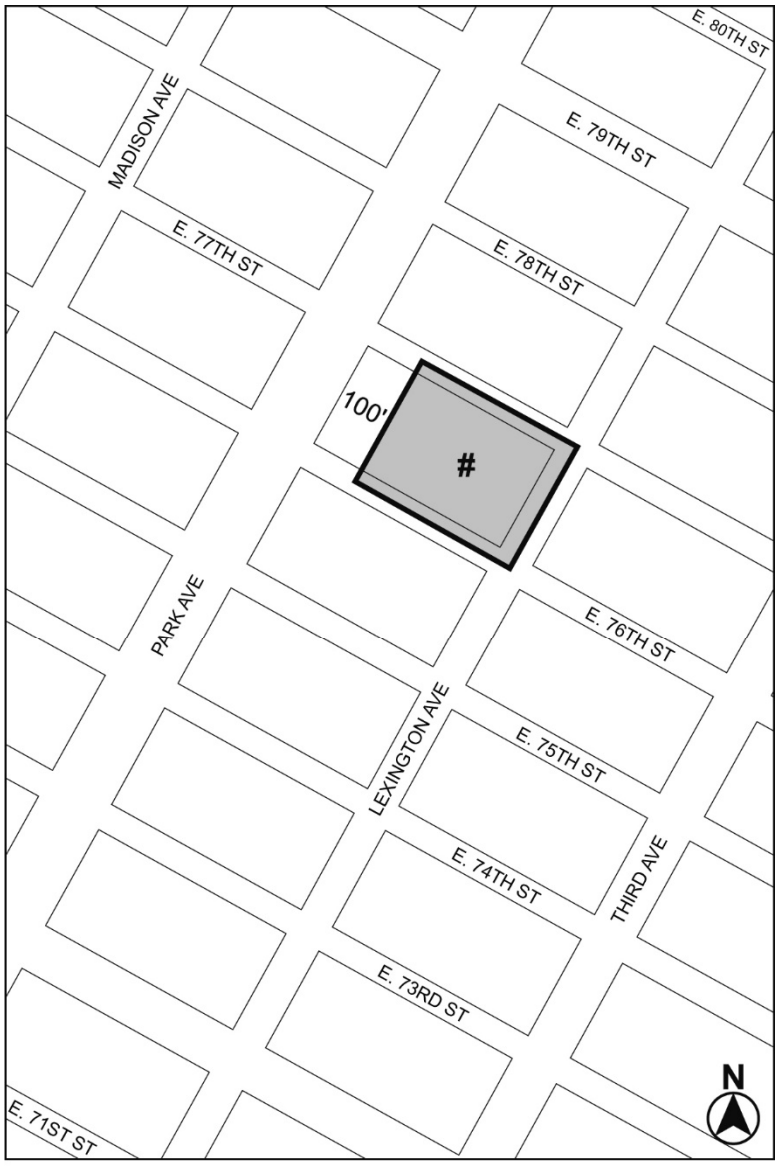
APPENDIX F
Mandatory Inclusionary Housing Areas and former Inclusionary Housing Designated Areas

MANHATTAN

* * *

Manhattan Community District 8

Map 3 – [date of adoption]



Mandatory Inclusionary Housing area
Area # — [date of adoption] MIH Option 1 and Option 2

Portion of Community District 8, Manhattan

* * *

Attachment 1: Supplemental Project Information

Attachment 1 has been created to provide additional information regarding the planning and design of the Proposed Project. It is important to note that both massings of the Proposed Project, Envelope 1 and Envelope 2, would satisfy the purpose and need of the Proposed Project. They would provide the same number of inpatient rooms, operating rooms (ORs), and emergency department (ED) positions. They would have the same ground floor plan, entrances, loading docks, and a new bay for six ambulances. They would have the same population of patients, staff, and visitors.

A. INTRODUCTION

PURPOSE AND NEED

Lenox Hill Hospital (LHH) is an academic medical center. The Proposed Project has been designed to modernize the existing LHH and create a purpose-built hospital complex to address critical infrastructure challenges and space needs. The Proposed Project would allow LHH to meet current standards of healthcare delivery, including single-bedded patient rooms, as well as address projected future needs for an expanded ED, new and larger state-of-the-art surgical suites, and other essential clinical and support spaces.

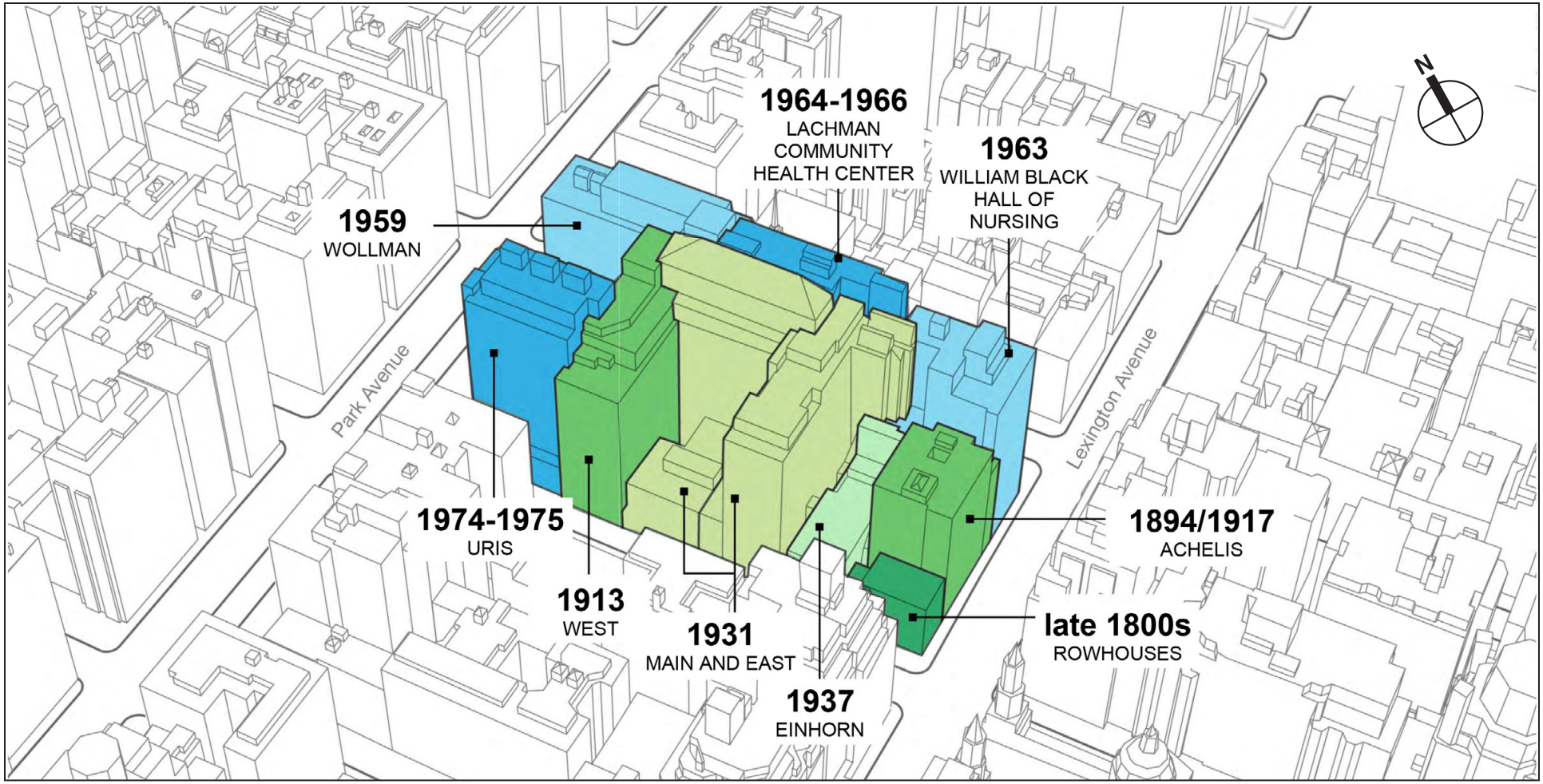
Northwell has taken into account the shift of surgery to outpatient settings and other changes in delivery of care by moving ambulatory services to outpatient settings, including the Northwell Medical Pavilion-77th Street in construction on Third Avenue, and has focused on the main campus to address the services that do require inpatient care.

The combination of projected growth in admissions and projected increases in average length of stay results in an increased need for inpatient beds over the next ten years. Therefore, LHH proposes to increase the number of beds from 450 to 475, while also transferring all of those beds into single-bedded rooms. Further, with the Proposed Project, the size and configuration of the patient rooms would be designed to provide flexibility to address the evolving nature of medical technology and patient needs as well as to assist LHH in addressing potential unanticipated events such as another public health emergency.

HOSPITAL BUILDINGS: EXISTING USES AND LIMITATIONS

Ten buildings ranging in height from 4 to 14 stories (40 to 200 feet high) and developed separately between the late 1880s and 1972 currently occupy Projected Development Site 1 (see **Figure 1-1**). The four buildings that are being demolished are not currently used to provide inpatient care and cannot be used to provide inpatient care in the future (see **Table 1-1**). The rowhouses on the corner of East 76th Street and Lexington Avenue were built in the late 1800s and house LHH's Chaplaincy and Facilities Management departments. The 1917 Achelis Building contains offices, administrative space, residency space, and on-call rooms. The Einhorn Memorial Building was constructed in 1937 and contains an auditorium. The William Black Hall of Nursing was built in

NOTE: This figure is new for the Final Scope



Source: Northwell Health

Existing Lenox Hill Hospital

1963 and houses ambulatory practices, medicine administration, and the entrance to the ED. These buildings cannot be used to provide inpatient care, now or in the future, for the following reasons: building floor-to-floor heights are inadequate for the mechanical (HVAC) infrastructure required to serve inpatient care spaces; the existing structural system(s) of the buildings is not suitable for modern imaging equipment, which is heavy and requires limited vibration in the floor to operate properly; the buildings' floors do not align with each other vertically, which has resulted in connections via stairs and prevents patient transport to and from the primary elevator core in the Main Building; a tight column grid spacing does not accommodate modern industry-standard patient rooms, imaging rooms, or ORs with appropriately sized corridor widths; and the buildings have elevators and courtyards in the center of them, which limits their use to medical offices and support rooms. The six other buildings, which serve various purposes (as outlined in **Table 1-2**) including patient care, were constructed between 1913 and 1972. The structures of these buildings pose the following challenges, which necessitate the Proposed Project: narrow building widths and the existing column grid spacing are not suitable for right-sized ORs, imaging, or procedure spaces; each building supports only a single double-loaded corridor, which prevents the separation of patients, staff, and service circulations, which is best practice in healthcare delivery and patient safety; and the buildings were designed independent of each another, which curtails flexibility and hospital growth.

Table 1-1
Existing Buildings to be Demolished

Building	Existing Uses	Constraints/Challenges
Rowhouses (late 1800s)	Chaplaincy and Facilities Management departments	Floor to floor height, narrow building width, construction type, structural capacity/vibration, inadequate means of egress, severed from all other buildings on campus, misalignment of floors to adjacent buildings
Achelis Building (1894/1917)	Offices, administrative space, residency space, and call rooms	Floor to floor height, column grid spacing, narrow building width, non-compliant means of egress, courtyard and building core elements limit floorplate efficiency, limited connection to Main Building elevators, structural capacity/vibration, misalignment of floors to adjacent buildings
Einhorn Memorial Building (1937)	Auditorium	Height (3 stories), occupancy (assembly auditorium), narrow building width, limited connection to Main Building elevators, structural capacity/vibration, misalignment of floors to adjacent buildings
William Black Hall of Nursing (1963)	Ambulatory practices, medicine administration, and the entrance to the ED	Floor to floor height, column grid spacing, narrow building width, building core elements limit floorplate efficiency, limited connection to Main Building elevators, structural capacity/vibration, misalignment of floors to adjacent buildings

Table 1-2
Existing Buildings to Remain

Building	Existing Uses
West Building (1913)	Medical/surgical inpatient units, maternal child health services, psychiatry services, pediatric services, radiology services, and ORs
Main Building (1931)	76th Street hospital entrance, radiology services, cafeteria
East Building (1931)	Intensive care units, neonatal services, nursery, post-anesthesia care units, and the ED
Wollman Pavilion (1959)	Main hospital entrance, medical/surgical/telemetry inpatient units, ORs, labor and delivery rooms, and laboratory services
Charles R. Lachman Community Health Center (1966)	Echocardiography services, nuclear stress services, maternal child health services, labor and delivery rooms, cardiothoracic surgery ORs, multiple telemetry units, the ED, and the blood bank
Percy & Harold D. Uris Building (1972)	Medical/surgical inpatient units, maternal child health services, psychiatry services, ORs, radiology services, and pediatric services

B. POPULATION FACTORS

PATIENT POPULATION, ORIGIN, AND ADMISSIONS

While LHH receives patients from all five boroughs of New York City (NYC) and beyond, its "service area," which generates the highest volume of its patients, consists of Manhattan, parts of western Queens, and parts of southern Brooklyn. These communities have a population of over 3.5 million people and have consistently shown a reliance on LHH for inpatient and ambulatory care. LHH currently treats and will continue to treat all patients regardless of their ability to pay. In the future the payer mix may shift slightly, with more Medicare patients as a result of the aging population.

Along with most hospitals in NYC, LHH experienced declining admissions over the past two decades, largely due to a shift of surgery to outpatient settings and changes in delivery of care. However, this decline is expected to change due to the aging population, programmatic growth, and increased length of stay, as discussed below. Together these trends are anticipated to result in an increased need for inpatient beds. The sizing of the future LHH is predicated on meeting the needs of the patients who rely on the hospital.

LHH's detailed analytics are based on the hospital's service area, trends in healthcare delivery, and industry-wide accepted facilities programming standards. Furthermore, LHH's sources and analytic approach have long been accepted by the New York State Department of Health (NYSDOH) for projecting statewide and regional bed need.

*EXPECTED GROWTH IN ADMISSIONS DUE TO **AGING POPULATION***

The Proposed Project focuses on the future needs and the anticipated growth in admissions due to an aging population. The population ages 65 and older (65+) is hospitalized at a significantly higher rate than the younger population due to increased incidence of diseases that are often exacerbated by chronic conditions such as heart disease, chronic obstructive pulmonary disease, diabetes, and dementia. The projected 8.5 percent growth in the 65+ population over just the next five years will result in a growth in admissions.

*INCREASE IN ADMISSIONS DUE TO **PROGRAMMATIC GROWTH***

Program development in clinical areas such as cardiac surgery and neurosurgery, which have an inpatient focus, is expected to continue to drive growth in patient volume at LHH. Programmatic growth would also include continued physician recruitment and growth in the specialty programs for which LHH is renowned such as cardiovascular, neurosciences, and women's health. Additional physicians in specialties such as cardiology, neurology, gynecology, general surgery, and cancer surgery would also drive the growth of inpatient volume.

*INCREASED INPATIENT POPULATION DUE TO **EXTENDED LENGTH OF STAY***

Concurrent with the growth in inpatient admissions is an even more significant projected increase: the average length of stay for older patients with chronic conditions and co-morbidities. According to Sg2/Vizient (a healthcare performance improvement company), inpatient days are expected to grow by 8 percent while inpatient admissions are projected to grow just 2 percent over the next 10 years. This is due to the increased complexity of cases that are expected to remain in the hospital. For tertiary services such as cancer, cardiac surgery, and neurosurgery, the inpatient days are expected to grow 17 percent.

*CHANGES IN **EMERGENCY DEPARTMENT VISITS***

NYSDOH SPARCS (Statewide Research and Planning Cooperative System)[1] admission data shows that LHH's ED volume has increased 54 percent since 2004.[2] In more recent years (2013–2023), the average annual ED volume is approximately 53,000 visits, with volume peaking in 2021 with more than 61,000 visits.

SPARCS data shows that LHH had 48,835 ED visits in 2022 and 61,058 ED visits in 2021 (17 percent higher than the 52,398 ED visits in 2011). While 2022 showed a decrease in the number of patients as compared to 2021, the overall trend over the past two decades has been an increase in ED visits of 54 percent from 2004 to 2023.

The Northwell Health Office of Strategic Planning has projected future ED needs based on national trends in ED visits and anticipated changes in the population of its service area. Specifically, there is an expectation that full-service EDs will see an increase in patient severity and complexity with the rise of retail clinics, tele-health, and other sources of care for non-emergent problems. As a result, while the number of visits may only modestly increase, the patients will require greater resources and time in the ED. Based on Northwell's population-based projection, by 2036, LHH will have approximately 62,000 ED visits. Applying industry guidance of 1,300 ED visits per patient space, the ED is expected to need 48 patient treatment spaces, as planned.

C. HOSPITAL PROGRAM FACTORS

The New York State regulations governing heath facility construction are set forth in Title 10 of the New York Codes, Rules, and Regulations (NYCRR) Subchapter C – State Hospital Code. These regulations incorporate by reference, standards and codes that have the same force and

[1] SPARCS is an all-payer data reporting system, accessed through NYSDOH, that collects information on hospital admissions.

[2] 2001–2003 SPARCS ED treat & release volume is not available.

effect as if fully set forth in the regulations. Section 712-2.4 of NYCRR Subchapter C states that general hospital construction projects constructed or approved after January 1, 2011 shall comply with Chapter 2.2, "Specific Requirements for General Hospitals," of Part 2, "Hospitals," of the 2010 edition of the Facility Guidelines Institute's (FGI's*) Guidelines for Design and Construction of Health Care Facilities* (FGI Guidelines), published by the American Society for Healthcare Engineering of the American Hospital Association, with assistance from the United States Department of Health and Human Services. This document is further referenced in 10 NYCRR § 711.2(b)(7). NYSDOH is responsible for administering these regulations and may amend them. In August 2019, NYSDOH announced that it planned to adopt the 2018 FGI Guidelines and is now conducting reviews under this edition. While there is a 2022 edition of the FGI Guidelines, NYSDOH has not announced a plan to adopt the 2022 edition, and it continues to review proposed projects under the 2018 FGI Guidelines. As a result, the Proposed Project is designed to comply with the 2018 FGI Guidelines, and any mention of "current FGI Guidelines" refers to the 2018 edition that NYSDOH currently uses to evaluate projects.

EXISTING PATIENT ROOMS

LHH currently has 311 patient rooms containing 450 beds (139 double-bedded rooms and 172 single-bedded rooms). The inpatient bed program currently occupies a total of 177,030 square feet (sf).[3] Many of the existing rooms do not comply with the current FGI Guidelines' requirements.

FGI GUIDELINES FOR PATIENT ROOMS

The FGI Guidelines provide minimum requirements for the space and contents of various types of patient rooms. The largest component of patient rooms is the "clear floor area," which is defined by the FGI Guidelines as "the floor area of a defined space that is available for functional use excluding toilet rooms, closets, lockers, wardrobes, alcoves, vestibules, anterooms, and auxiliary work areas." In addition to clear floor area, the FGI Guidelines dictate how much clearance space is required between the bed and other elements of the room (e.g., walls, fixed obstructions) for circulation, patient transfer, and medical equipment. The FGI Guidelines also require that patient rooms contain toilet facilities, which must be accessible and Americans with Disabilities Act (ADA)-compliant in NYC, and other components such as cabinets for patient storage. In addition, where a hospital's functional program includes patient/family-centered care, the FGI Guidelines indicate that this space should include movable seating with a minimum of one seat for a family member or caregiver and one seat for the patient, and space for at least one chair that can be used for extended sitting and sleeping accommodations, such as a sleeper sofa for overnight stays. Further, critical care patient rooms must have space within or immediately outside of the room that is dedicated to that room for documentation, information review, observation, and other care-related uses.

[3] The inpatient bed program square footage refers to the total area inclusive of partitions, columns, department rooms, and department corridors. The rooms in the inpatient bed program include patient rooms, nurse/supervisor offices, nurse stations, multipurpose rooms, medication safety zones/rooms, nourishment spaces, clean supply rooms, soiled workrooms/storage, equipment storage rooms, environmental services rooms, nursing and care team locker rooms and lounges, and family lounges/support.

PROPOSED FLOOR-TO-FLOOR HEIGHTS

The floor-to-floor height of levels 1 to 10 match the height of the floors in the existing hospital to allow for seamless connection between the new and existing hospital buildings. The height of OR floors 11 to 13 is approximately 18 feet. This is inclusive of a minimum ceiling height of 10 feet plus the ceiling cavity. Eighteen feet is in line with industry standard OR floor-to-floor heights (17 to 18.5 feet) and is designed to accommodate increased mechanical ductwork, allowing for the appropriate air change rates in the ORs, building structural girders, ceiling-mounted equipment and lighting booms, and large fixed or mobile imaging equipment that requires clear ceiling dimension to function within the room. The floors above the ORs are composed of primarily patient rooms. Patient rooms require significant mechanical ductwork above a minimum ceiling height of 9 feet to accommodate bedside medical equipment and/or ceiling-mounted patient handling lifts. The height of these floors is 16 feet, which is consistent with industry standard patient room floor-to-floor heights (14 to 16 feet). The Proposed Project would be served by a 35-foot mid-level mechanical floor and upper-level mechanical floors totaling 50 feet in height. The mechanical equipment area and volume allocations are consistent with benchmarking for modern day hospitals. Coordination of equipment sizes, mechanical and electrical distribution, and building structure dictates the required floor-to-floor heights for mechanical equipment.

PROPOSED PATIENT ROOMS

The Proposed Project would provide 475 single-bedded rooms in a total of 412,214 sf (including dedicated support space). The existing rooms to continue in use would be brought into compliance with the current FGI Guidelines; the 139 double-bedded rooms would be converted to single-bedded rooms; and the size of all of the patient rooms would both meet the minimum requirements of the current FGI Guidelines and reflect industry standards. Single-bedded rooms are expected to reduce transmission of infectious diseases, provide space for modern hospital equipment to be brought into the rooms when needed, provide sufficient space for family members and other visitors, and enhance patients' privacy. These factors have been shown to improve patient outcomes relative to multiple-occupancy rooms.

The Proposed Project's patient rooms are designed to meet the current FGI Guidelines' specifications for critical care rooms to allow for future flexibility of room usage in anticipation of potential changes in the patient population's needs and acuity. With the Proposed Project, all patient rooms would have a clear floor area of approximately 215 sf.[4] This size complies with the 200 sf of clear floor area required for critical care rooms, and also accommodates family/caregiver space in support of LHH's functional program, which includes patient/family-centered care. The other room elements required by the FGI Guidelines, including the patient toilet room, clinical storage, handwash sink, and storage for patient belongings, account for approximately 65 sf. Together, these components of the interior of the patient room total 280 feet. In addition, approximately 60 sf immediately outside of each room would be dedicated care team space and used for observation, documentation, information review, personal protective equipment and

[4] Room square footages are "net" square footages, meaning they do not include the square footage occupied by walls.

supply storage, and access to the patient room door. This care team space is important for patient monitoring and rounding, as it ensures that doctors and nurses can quickly identify patients in distress or discomfort. Providing this space outside of the room is industry standard and is preferred because it reduces patient disruption by allowing the care team to monitor the patient without having to enter the room.

The Proposed Project's patient rooms, including the clear floor area, the additional elements described above (i.e., toilet, storage, family/caregiver space), and the adjacent, dedicated care team space that is outside of each patient room, total approximately 340 sf.

EXISTING OPERATING ROOMS

LHH has three types of ORs: general, image-guided/specialized, and hybrid ORs.

General ORs are used for procedures that do not require large or specialized equipment; they are not designed to accommodate specialty procedures or surgeries requiring large imaging equipment or advanced technologies.

Image-guided/specialized ORs are sized to accommodate mobile imaging equipment or procedures requiring additional personnel and/or large equipment such as orthopedic, neurological, and cardio-thoracic procedures. Mobile equipment can include C-arm imaging, robotics, perfusion machines, and additional sterile equipment carts as required for specialized or multidisciplinary procedures.

Hybrid ORs are sized to accommodate permanently installed imaging equipment. Equipment is sometimes designed to move in and out of the surgical field on a floor or ceiling track that allows the technology to be parked away from the surgical zone when not in use. Other hybrid ORs may be designed with fixed imaging equipment and two surgical fields within the same room. A separate systems component room and control room for the imaging equipment, with a view of the operating field, is required. Because the design of the room depends on the capabilities of the imaging equipment, these rooms have highly specialized spatial requirements and are larger than general and image-guided/specialized ORs.

Inpatient hospitals have been increasingly planning for larger ORs, including image-guided/specialized and hybrid ORs, as patient populations become sicker and have higher acuity. General ORs are now more prevalent in outpatient settings where surgeries are less complex, and patients are healthier. The majority of the existing LHH ORs and support spaces do not comply with the current FGI Guidelines.

LHH's 21 existing general ORs have an average size of 405 sf,[5] ranging in size from 305 to 480 sf. Eight are below the 400 sf minimum in the current FGI Guidelines.

The existing image guided ORs have an average size of 523 sf, ranging in size from 470 to 625 sf. Two of the three image guided ORs are below the 600 sf minimum in the current FGI Guidelines.

[5] Room square footages are "net" square footages, meaning they do not include the square footage occupied by walls, building façade, or columns.

The one existing hybrid OR is 830 sf, which is sufficient to accommodate the equipment currently used in that OR; however, it is not large enough to accommodate larger or varied equipment that is becoming available with medical advances.

Given the increasing reliance on imaging and other types of equipment during surgical procedures, the hospital needs more than one hybrid OR to be able to offer procedures using state-of-the-art equipment.

FGI GUIDELINES FOR OPERATING ROOMS

The FGI Guidelines set forth minimum sizes and specifications for different types of ORs and support spaces. As part of the Proposed Project, the existing ORs and support spaces would be brought into compliance with the current FGI Guidelines and would reflect industry standards. As a result, the surgical department would go from 25 ORs occupying a total of approximately 55,225 sf to 30 ORs occupying a total of approximately 131,835 sf.[6]

PROPOSED OPERATING ROOMS

The Proposed Project's surgical department is designed to meet the current FGI Guidelines' specifications for image-guided/specialized and hybrid ORs to allow for future flexibility of room usage in anticipation of changes in the patient population's needs and acuity. The Proposed Project would have 30 ORs ranging in size from approximately 630 to 1,000 sf, three of which would be hybrid ORs. The average size of the proposed image-guided/specialized ORs would be 700 sf, and the hybrid ORs would be approximately 1,000 sf to ensure that advancements in equipment and technology can be accommodated. In addition, the Proposed Project would include a right-sized pre- and post-operative patient care suite[7] that meets current FGI Guidelines and includes patient cubicles, patient toilet rooms, nursing support space, and clinical supply and storage rooms. The Proposed Project's surgical department would also have appropriately sized equipment storage, clean supply and sterile core storage, soiled holding and surgical case cart storage, and staff locker rooms and workspace.

The minimum ceiling heights of the new ORs would be 10 feet with floor-to-floor heights of approximately 18 feet to accommodate this newer and larger equipment.

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[6] The departmental square footage refers to the total area of a programmed department inclusive of partitions, columns, department rooms, and department corridors. Surgical department rooms include ORs, a pre- and postoperative patient care suite (see note 7 below), staff locker rooms and lounges, nurse control stations, hand-scrub facilities, emergency equipment storage, clean linen storage, wheelchair and small equipment storage, medical gas storage, large mobile equipment storage, human specimen storage (as required), environmental services rooms, soiled workrooms/holding, OR clean equipment and supply storage, patient belonging storage, and family/caregiver waiting areas/lounges.

[7] Support rooms and spaces associated with this suite include pre- and post-operative patient care cubicles, nurse stations with documentation space, clinical sink space, medication safety zones, nourishment areas, ice-making equipment space, soiled linen and waste holding, emergency equipment storage, equipment and clean supply storage rooms, toilet rooms, and family/caregiver seating accommodations.

D. CONSTRUCTION DURATION

LHH performed extensive analyses of varied construction phasing in order to minimize the duration of construction. The projected duration has already been reduced to approximately nine years. The Proposed Project's construction schedule assumes relocation of most outpatient services on the main hospital block to other facilities, including the Northwell Medical Pavillion-77th Street site. LHH will focus on providing inpatient care on Projected Development Site 1 during and after construction. Further relocation of patients and physicians during construction is logistically impractical. Inpatient clinical teams require proximity to other programs and services in order to provide optimal interdisciplinary care, and therefore cannot be relocated to other hospitals. Even temporarily, this relocation could impact the quality of patient care.

HOSPITAL OPERATIONS DURING CONSTRUCTION

It is not feasible for LHH to simply close for a period of time in order to shorten construction time. Closing a hospital in New York State is a highly regulated process, would result in a significant disruption in care, and is only undertaken when there are significant financial strains. In terms of the population served, many of the patients treated at LHH are part of a care continuum. They see primary care physicians and specialists that are in the Lenox/Northwell network of care, and LHH is an important part of this continuum. Physicians associated with LHH, many of whom have located their offices in proximity to LHH, cannot round on patients or perform emergent interventions in a timely manner if their patients are located in a hospital that is farther away or in another neighborhood—much less outside of Manhattan. Further, the hospital cannot simply tell its doctors, nurses, staff, and other employees to find other work during the years of construction; over 4,000 people would be out of a job during the construction. ✷