Appendix A

Proposed Zoning Text

Attachment 1: Supplemental Project Information

Attachment 2: Additional Information Regarding the Proposed Project's Program

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

* * *

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

* * *

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

* * *

Chapter 2
Special Park Improvement District

* * *

92-20
SPECIAL BULK REGULATIONS

* * *

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.

* * *

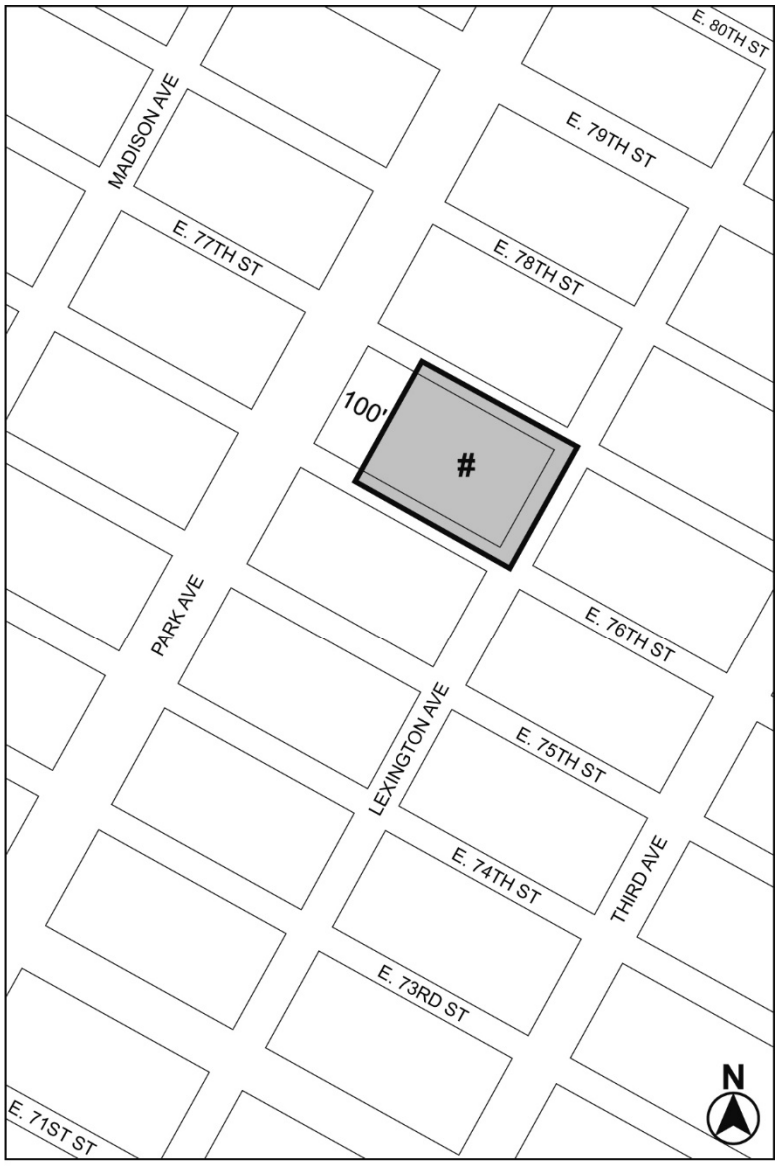
APPENDIX F
Mandatory Inclusionary Housing Areas and former Inclusionary Housing Designated Areas

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.

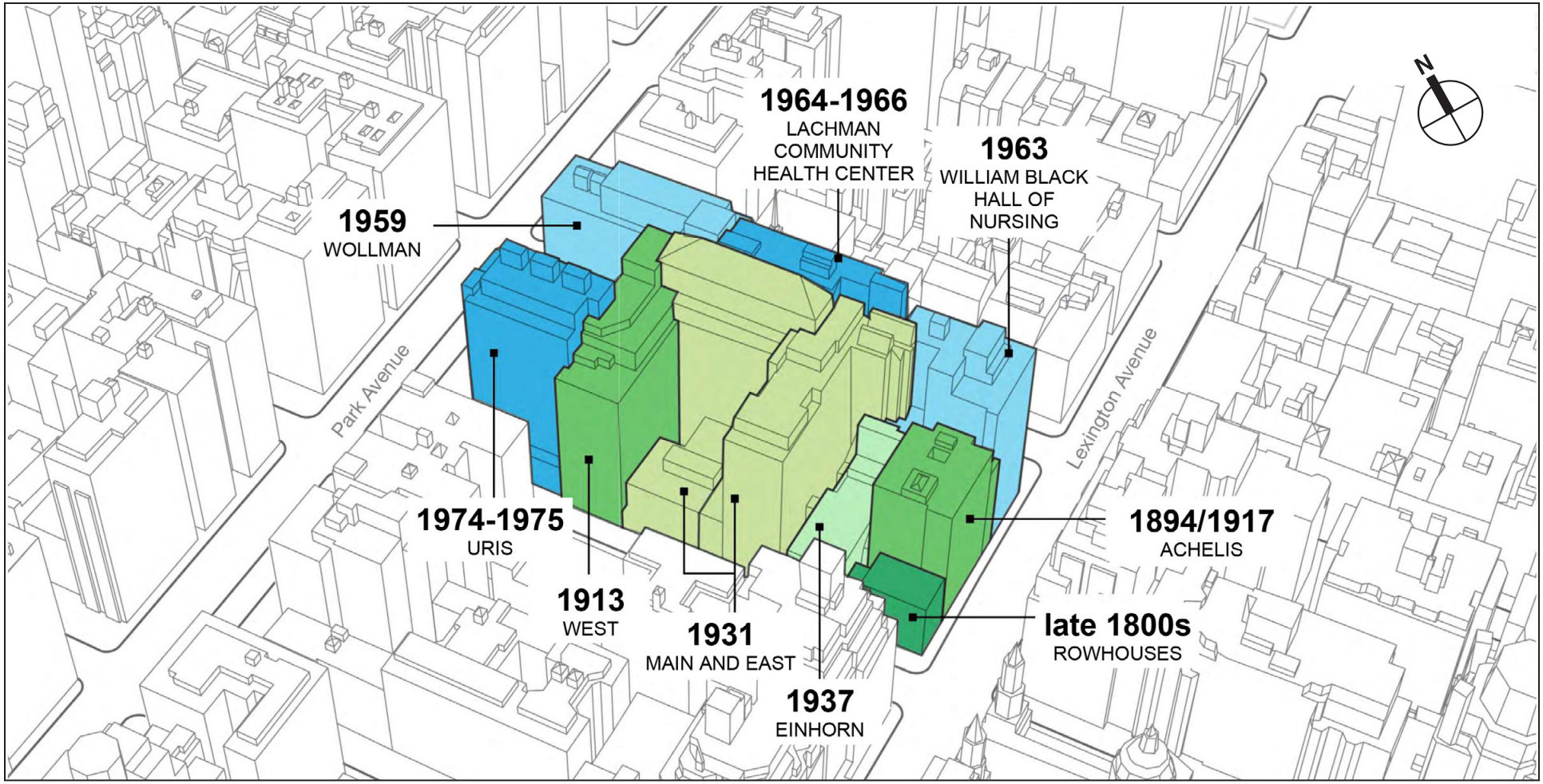
Northwell has taken into account the shift of surgery to outpatient settings and other changes in delivery of care by moving ambulatory services to outpatient settings, including the Northwell Medical Pavilion-77th Street in construction on Third Avenue, and has focused on the main campus to address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

Attachment 2: Additional Information Regarding the Proposed Project's Program

This attachment has been created to provide further detail regarding the bases for the Proposed Project's program, in response to comments received on the January 2025 DEIS, and is entirely new to the FEIS.

A. ADDITIONAL INFORMATION REGARDING THE PROPOSED PROJECT'S 475 SINGLE-BEDDED, INTENSIVE CARE UNIT (ICU)-CAPABLE PATIENT ROOMS

The Proposed Project is a targeted, evidence-based investment in long-term health system resilience, clinical quality, and equity. One component of the hospital's modernization is the modest increase from 450 to 475 beds. This proposed increase to 475 single-bedded rooms is grounded in New York State Department of Health (NYSDOH) regulatory standards and justified by population and health trends, increasing complexity of inpatient care, the potential need to respond to public health emergencies, and the hospital's anticipated programmatic growth.

BED NEED PROJECTION METHODOLOGY

The proposed size of the future Lenox Hill Hospital (LHH) is based on a data-informed assessment of the community's current and future healthcare needs. Projections incorporate detailed analysis of hospital utilization patterns, population trends, and clinical program growth. To understand future demand, LHH first evaluated current inpatient volumes, including average daily census, peak occupancy, and lengths of stay. The analysis also considered broader demographic and healthcare utilization patterns within the hospital's primary service area, which includes Manhattan and portions of Queens and Brooklyn. Population data from reputable sources, such as the U.S. Census and Claritas, show that while overall growth in the service area will remain stable, the aging population is expected to increase significantly. The 65+ age group is projected to grow by 8.5 percent over the next five years, driving greater demand for hospital services due to increased medical complexity and chronic conditions. Forecasting tools from Sg2—an industry-recognized healthcare analytics firm—were used to project future inpatient volumes by applying local market impact factors such as demographics, disease burden, and policy changes. These projections were then aligned with LHH's current market share across service lines and adjusted to include the hospital's consistent share of patients from outside its core service area. Finally, modest programmatic growth was incorporated to reflect planned investments in key specialties where LHH already has strong clinical capabilities—cardiac surgery, neurosurgery, orthopedics, and oncology.

The final projected bed need aligns with the NYS DOH occupancy standards outlined in 10 NYCRR § 709.2: 85 percent for medical/surgical beds, 70 percent for pediatrics, and 75 percent for obstetrics. These projections will be reviewed by the NYSDOH during the Certificate of Need (CON) process. Importantly, every hospital in New York State (NYS) that has adhered to this methodology—using the same regulatory framework and applying the Section 709.2 standards—has received state approval for its proposed bed counts. LHH's projections follow this same proven and accepted planning approach.

PLANNING FOR REGIONAL SHIFTS IN HEALTHCARE DELIVERY

The recent closure of Beth Israel Hospital has already reshaped the healthcare landscape in Manhattan, eliminating a major source of emergency and inpatient care. As a result, LHH and other nearby providers are absorbing displaced patient volume. Further ongoing financial pressures due to State and federal

reimbursement cuts across the hospital sector suggest that further service reductions or closures cannot be ruled out.

In this context, LHH's plan to expand to 475 beds is not simply a response to internal demand growth—it is a necessary step to ensure the hospital remains equipped to serve a broader population. As fewer institutions offer full-scale inpatient and emergency services, the burden will increasingly fall on stable, well-resourced hospitals like LHH.

OCCUPANCY STANDARDS AND THE IMPORTANCE OF FLEXIBILITY IN HOSPITAL PLANNING

Section 709.2 of the NYS Department of Health Planning guidelines indicates that hospitals should operate between 70 percent and 85 percent occupancy of their total bed capacity depending on their bed category. This standard helps ensure hospitals can manage day-to-day patient flow while also remaining prepared for unexpected events like flu surges, major accidents, or public health emergencies like the COVID-19 pandemic and climate-related events such as hurricanes, heatwaves, and winter storms. Surge capacity is a necessary and expected component of hospital preparedness; without appropriate capacity buffers, hospitals face difficult decisions: postponing elective procedures, boarding admitted patients in the emergency department (ED), or diverting ambulances, all of which carry serious consequences for patient outcomes and system-wide performance.

Patient volume at LHH fluctuates significantly throughout the day and week, often exceeding the average daily census (ADC). For 2025 (January through March), LHH is averaging 336 inpatients per day out of 450 total beds. That is a 75 percent occupancy rate—in line with the State's planning methodology. This means the hospital is not underused; it is operating at full planning capacity with room to accommodate sudden increases in demand. Indeed, between 2023 and 2024, LHH experienced multiple days with over 400 patients admitted. In 2023 and 2024, there were 65 days and 59 days, respectively, where the hospital's average daily census (ADC) exceeded 400 patients. This represents occupancy levels of 90 percent or higher based on the hospital's 450-bed capacity. Put differently, the hospital was operating near full capacity approximately every 6 days in 2023 and every 7 days in 2024. Operating at or near full capacity creates significant constraints, which in turn can reduce the hospital's ability to accept new admissions, including emergency patients. When the hospital nears capacity, the hospital can be forced into diversion status—meaning ambulances transporting critically ill patients have to be rerouted to other hospitals due to a lack of available beds. In 2024, this occurred 19 times throughout the year. Diversions such as these delay access to timely care and can contribute to poorer health outcomes, especially for patients requiring urgent interventions. Thus, in projecting future patient bed need, the hospital plans for the appropriate level of capacity set forth in Section 709.2.

SUSTAINED GROWTH IN AVERAGE DAILY CENSUS (ADC) DEMONSTRATES REBOUNDING DEMAND, AND INCREASING PATIENT COMPLEXITY IS DRIVING DEMAND FOR MORE INPATIENT ACUITY

Over the past three years, LHH has experienced a steady and measurable increase in its ADC—from 312 in 2022, to 326 in 2023 and 2024, to 336 in 2025 (January through March). This represents an 8 percent growth in just over three years, a clear indicator of rising demand and the hospital's critical role in the post-pandemic healthcare landscape. Importantly, this trajectory brings LHH's ADC close to its pre-pandemic 2018 level of 339, signaling a strong and consistent rebound in inpatient utilization. This return to pre-COVID levels is not incidental; it reflects renewed demand for inpatient services within New York City (NYC) and underscores the hospital's continued relevance to the community it serves.

Alongside growth in ADC, LHH is also seeing a significant rise in the medical complexity of its patients. As more routine care shifts to outpatient settings, the patients admitted to LHH today tend to be sicker, have more chronic conditions, and need more intensive care than in the past. In addition, LHH frequently treats patients who are referred from other hospitals for advanced surgeries or specialized care in cardiology,

oncology, and neurology; these patients often cannot be safely treated in community settings and need longer, closely managed hospital stays.

This shift to higher complexity patients is reflected in the hospital's rising Case Mix Index (CMI), a standard measure of patients' clinical complexity. LHH's medical/surgical CMI has increased from 1.9 in 2018 to 2.1 in 2024, a clear sign that the hospital is caring for more complex, higher-acuity patients. When patient complexity increases, each bed is occupied longer, reducing turnover and creating more demand for inpatient beds. This in turn increases daily occupancy and requires more beds to avoid delays, backlogs, and emergency diversions.

AGING POPULATION WILL DRIVE INCREASED UTILIZATION AND COMPLEXITY

Communities across NYS are undergoing a well-documented demographic shift toward an older population, and the service area of LHH is no exception. The 65+ age group is projected to grow by approximately 8.5 percent over the next five years. This shift is not a distant forecast—it is a structural change that is already reshaping the healthcare landscape. Older adults are the highest utilizers of inpatient services due to their greater medical complexity, higher incidence of chronic conditions, and increased susceptibility to acute health episodes such as cardiac events, strokes, and infections. As this population grows, demand for hospital-based care—particularly in tertiary care centers equipped to manage complex cases, like LHH—will rise proportionally. At LHH, this demographic shift is already materializing in the hospital's inpatient profile. Between 2022 and 2024, Medicare inpatient volume increased by 3 percent, reflecting a steady rise in the hospital's aging patient base. As of 2024, Medicare beneficiaries now comprise 45 percent of LHH's total inpatient volume, a clear indicator of the hospital's growing role in meeting the needs of older adults with complex medical conditions. With the 65+ population projected to continue rising over the next decade, this proportion is expected to grow significantly, potentially exceeding 50 percent in the coming years. This trajectory reinforces LHH's critical role as a leading tertiary care provider for high-acuity, aging populations who often require more intensive, prolonged, and multidisciplinary care. Importantly, this demographic transformation is not just about rising volumes—it signals a profound shift in the nature of inpatient care. Older patients tend to have multiple comorbidities, functional limitations, and greater post-discharge needs, all of which translate into longer lengths of stay, higher resource utilization, and more complex discharge planning. As a result, the pressure on hospital infrastructure, care teams, and bed capacity will intensify—necessitating physical environments that are adaptable, private, and designed for complex, team-based geriatric care.

STRATEGIC 25-BED INCREMENT REFLECTS PATIENT COMPLEXITY AND PROGRAMMATIC GROWTH

The projection of 475 beds by 2036 reflects two distinct and data-supported planning needs: (1) the need to maintain 450 beds based on population and complexity growth, and (2) the need for an additional 25 beds to support targeted programmatic investments. The foundation for 450 beds is the combination of factors described above: the rising ADC, driven by an aging service area where the 65+ population is expected to grow by 8.5 percent over the next five years and a rising CMI, which has moved from 1.9 to 2.1 over the past couple of years, indicating higher patient complexity and longer lengths of stay. While some volume will shift to outpatient settings due to broader healthcare delivery trends, the impact of this shift is expected to be more than offset by the growing number of patients requiring inpatient care for complex and chronic conditions. Therefore, maintaining a core capacity of 450 beds is essential to meet current and future demand without compromising quality or access.

The additional 25 beds are tied to planned clinical growth within core tertiary programs that already define LHH's identity—cardiac surgery and neurosurgery. These specialties are projected to grow over the next decade, based on historical volume, physician recruitment, and programmatic investments. Based on Sg2, for tertiary services like these, the inpatient days are expected to grow 17 percent. As a result, the hospital anticipates serving an average of 380 inpatients per day by 2036—an increase of 22 patients daily. To

maintain 70 to 85 percent occupancy and continue operating safely and efficiently, LHH would need 475 beds.

The 25-bed increase is a measured and evidence-based response to this anticipated growth. It ensures that as LHH continues to expand access to lifesaving tertiary services, it will have the physical capacity to match the clinical capability—avoiding bottlenecks in surgical scheduling, ICU backlogs, or prolonged ED boarding due to bed unavailability. In summary, the 475-bed plan is not an overreach—it is a precisely calibrated strategy to ensure LHH remains resilient, modern, and responsive to both the core capacity needs of its growing population and the programmatic evolution of its nationally recognized centers of excellence.

ICU-CAPABLE ROOMS

The COVID-19 pandemic highlighted the need for adaptable inpatient rooms that can seamlessly flex between medical/surgical and ICU-level care, enabling hospitals to scale critical care services during emergencies without relying on temporary retrofitting or makeshift arrangements. By expanding and modernizing its inpatient bed infrastructure, LHH is ensuring it can serve not only routine medical demand but also fulfill its regional responsibility during public health crises, protecting both its immediate community and the broader NYC healthcare ecosystem.

INPATIENT ROOM SIZE

Per the Facility Guidelines Institute (FGI) guidelines, a minimum of 200 clear square feet (this is exclusive of walls, columns, or any fixed item[s] in the room) is required for critical care beds and the following clearances must be provided: 5 feet on the transfer side of the bed, 5 feet at the foot of the bed, 1 foot at the head of the bed, and 4 feet on the non-transfer side of the bed. These clearances apply to the entire length/width of the patient bed. See Appendix A, Attachment 1 for additional information about inpatient rooms.

B. EMERGENCY DEPARTMENT (ED) JUSTIFICATION

Between 2022 and 2024, LHH's ED experienced a 5.2 percent increase in annual visits, rising from 50,472 in 2022 to 53,112 in 2024. This steady growth underscores sustained and growing demand for emergency care in the hospital's service area. At the same time, the demographic composition of ED patients has shifted significantly: Medicare patients increased by 7 percent during this period, and as of 2024, Medicare beneficiaries account for 54 percent of all inpatient admissions from the ED. This is notably higher than both the citywide average (46 percent) and Manhattan average (47 percent) as of 2023, indicating that LHH serves an older and more medically complex patient population than its peers.

This trend is expected to accelerate. The population aged 65 and older in LHH's service area is projected to grow by 8.5 percent over the next five years. Older patients tend to require longer, more resource-intensive ED evaluations due to higher rates of comorbidities, diagnostic complexity, and potential for admission. As a result, although overall ED volume appears to be within national treatment space benchmarks, the longer length of stay per visit among higher-acuity patients reduces turnover and increases the strain on available rooms.

This challenge is further intensified by a common issue known as boarding, where emergency department beds are occupied by patients awaiting inpatient admission. Boarding reduces the number of available treatment spaces for incoming patients, particularly during peak periods, leading to delays in care, ED overcrowding, and compromised patient experience and outcomes. Expanding the number of treatment spaces is essential to alleviating this pressure and ensuring the ED can function efficiently. When the hospital approaches full capacity, it may be forced to enter diversion status—requiring ambulances carrying critically ill patients to be rerouted to other facilities due to the lack of available beds. In 2024 alone, Lenox Hill Hospital experienced 19 such diversions. These events delay timely access to care and pose serious risks, particularly for patients in need of urgent medical attention.

Currently, LHH ED has 34 ED treatment spaces. Using industry benchmarks from the Emergency Department Benchmarking Alliance (EDBA), which recommends 1,300 to 1,700 visits per treatment space annually, LHH should currently have between 31 and 41 spaces for its 53,112 annual visits. However, these benchmarks do not account for LHH's higher-acuity patient base and aging demographic, which slow throughput and increase room utilization per visit. In fact, EDBA notes that "the trend of EDs seeing older, sicker patients… will yield a net increase in severity/complexity for full-service EDs," and that these patients require longer and more intensive evaluations.

By 2030, LHH projects approximately 62,000 annual ED visits, which would require at least 48 treatment spaces using the 1,300 visits-per-space benchmark—an appropriate standard given the aging population and complexity of patients. Simply put, planning for current conditions will not future-proof the facility. Expanding the number of ED treatment spaces is necessary to ensure timely, high-quality, and equitable care delivery for a growing and increasingly vulnerable population.

C. OPERATING ROOM (OR) JUSTIFICATION

LHH is a nationally recognized tertiary care center, known for delivering high-acuity surgical care across multiple specialties. In 2024, U.S. News & World Report ranked LHH among the best hospitals in the country in six subspecialties, including cardiology and heart surgery, ENT, neurology and neurosurgery, and thoracic surgery. These rankings reflect the hospital's longstanding reputation for clinical excellence and reinforce the community's trust in LHH as a destination for complex, lifesaving procedures. This reputation continues to drive demand. Between 2023 and 2024, total surgical volume at LHH increased by 4 percent. More notably, surgical growth in key service lines has accelerated—cardiac surgery increased by 6 percent and vascular surgery by 12 percent from 2023 to 2024 alone. These gains are the result of strategic programmatic investments, physician recruitment, and enhanced referral patterns, positioning LHH as a preferred provider for advanced surgical care in the region.

In addition to volume growth, the hospital serves an increasingly older and more medically complex population. The 65+ age cohort—already the highest users of surgical services—is projected to grow by 8.5 percent in the service area over the next five years. This demographic shift will further increase demand for time-intensive, resource-heavy surgical procedures, many of which require specialized equipment, longer OR blocks, and increased post-operative recovery support. Furthermore, planned programmatic investments in high-acuity surgical specialties—such as cardiac surgery and neurosurgery—are expected to increase operating room volume by approximately 7 percent.

At LHH, the proposed addition of five ORs is grounded to ensure the surgical platform remains flexible, responsive, and aligned with anticipated demand. The goal is not expansion for its own sake, but to proactively safeguard timely access and operational efficiency as the patient population and case mix shift.

1. **Growth in Specialized Surgical Programs**
   LHH is actively investing in core tertiary surgical specialties—particularly cardiac surgery, neurosurgery, and oncology—where case complexity is high and operating times are longer. These services are expected to grow by 7 percent over the next decade, driven by physician recruitment, patient referrals, and service-line development. Without adequate OR capacity, growth in these clinically essential programs may be constrained, potentially leading to scheduling bottlenecks or delays in care.
2. **Rising Acuity of Surgical Patients**

   The service area is aging: the 65+ population is projected to grow by 8.5 percent in the next five years, bringing a higher burden of chronic illness, frailty, and surgical risk. Older adults undergoing surgery typically require longer procedures, extended recovery time, and higher resource utilization. These dynamics place added pressure on existing OR schedules and limit the ability to accommodate unscheduled or urgent cases.

3. **Operational Flexibility and Patient Flow**

   Increasing surgical volume and complexity—without corresponding increases in OR availability—can create downstream effects, including longer wait times, postponed cases, and reduced capacity for emergency interventions. Additional ORs create buffer capacity that supports uninterrupted patient flow and avoids unnecessary disruptions to clinical operations.

4. **Resilience in a Changing Landscape**

   Given the unpredictable nature of surgical demand, the ability to absorb surges or manage delays caused by emergencies, equipment maintenance, or staffing gaps is critical. Additional ORs provide the infrastructure necessary to maintain continuity of care, even when demand fluctuates or cases run over time.

The five new operating rooms are a prudent investment to protect surgical access, support clinical excellence, and ensure the hospital is prepared to meet the needs of its community without compromise.

D. HOSPITAL INFRASTRUCTURE

The increases in non-clinical square footage are attributable to several essential operational and regulatory considerations. These include expanded requirements for mechanical, electrical, and plumbing (MEP) systems; hospital support services; general circulation; and the new building core necessary to support vertical infrastructure. The latter includes structural steel, egress stairwells, mechanical shafts, and utility risers—each critical to ensuring life safety, code compliance, and the long-term sustainability of the facility.

MEP infrastructure increases correspond directly to the overall growth in building volume, as well as the need to meet NYC energy performance standards, and applicable building and healthcare codes. The increases in supporting infrastructure are proportional to the increases in clinical infrastructure and are also necessary to address current shortcomings. The hospital's infrastructure must be positioned to support daily operations and emergency events such as COVID or future pandemic scenarios which require insolation environments and fresh outside air.

Critical logistics functions—including materials handling, loading docks, and ambulance access—have been purposefully integrated into the new building footprint. These additions are integral to the facility's operation and account for a proportional increase in square footage allocation on the first floor. The expansion of the hospital support program addresses longstanding deficiencies in the existing facility's capacity to accommodate essential back-of-house operations. Historically, patient care spaces have been prioritized, limiting the ability to expand support functions and resulting in undersized, inefficient operational workflows. The Proposed Project's strategic programmatic expansion would improve conditions; as noted, a significant portion of the support increase is due to loading and ambulance accommodations being brought from the street into the building. The existing loading bays are undersized and therefore do not comply with minimum zoning, so new berths are required to satisfy both programmatic and regulatory requirements. Other support program increases relate to Materials Management and environmental services provisions based on clinical needs including additional space for pandemic storage.

There are very strict standards to control the spread of pathogens from within the hospital. These standards include the implementation of air filtration and specific pressure relationships to control the passage of air from one space to another. These requirements drive the needs for significant infrastructure space within, and on top of, a modern hospital facility.

E. LENOX HILL HOSPITAL'S MEDICAID UTILIZATION

In 2023, 1 out of 5 cases (19.7 percent) treated at LHH were Medicaid insured. While slightly lower, this is comparable to other tertiary hospitals in Manhattan, such as NYP Cornell, and NYU Tisch, whose composition of Medicaid cases represent 21.3 percent and 24.7 percent of their respective inpatient payor mix. Additionally, between 2021 and 2023, Medicaid volume experienced a slight growth of 0.5 percent in LHH, while Manhattan hospitals overall experienced a decrease of 0.5 percent.

The same pattern is apparent when looking at LHH's ED Treat & Release (EDTR) visits. In 2023, nearly 1 out of 3 (31.4 percent) EDTR visits in LHH were Medicaid insured. While the number of Medicaid EDTR visits decreased for Manhattan hospitals by 2.6 percent (2021-2023), LHH experienced an increase by 4.8 percent during the same time period. While LHH's current proportion of Medicaid volume may be lower than other Manhattan hospitals, its rising trend in Medicaid cases, especially in the context of declining trends in Manhattan overall, reflects its strategic efforts to engage with underserved communities, and LHH remains a crucial access point for advanced healthcare services.

According to 2023 SPARCS data, LHH draws over 1/3 of patients from outer boroughs. 55 percent of Lenox Hill patients in 2023 were non-white, with a higher proportion of Black and Asian patients compared to non-Northwell Manhattan hospitals and NYS averages. In 2023, over 60 percent of Lenox Hill patients used public insurance, with a higher proportion of Medicare patients compared to non-Northwell Manhattan hospitals and NYS averages.

Northwell also offers financial assistance to patients with family incomes up to 500 percent of the federal poverty level. This includes free or discounted care at many Northwell facilities, including LHH.

The single bedded rooms in the proposed project will be covered by Medicare/Medicaid. In fact, it is only when there is an option of double-bedded rooms that Medicaid/Medicare may not cover the cost of a single bedded room – by following NYSDOH requirements and making all of the rooms single-bedded, the project will ensure that all patients will receive the same benefit.

F. LENOX HILL HOSPITAL'S TOTAL COMMUNITY BENEFIT INVESTMENT

In 2023, LHH provided over $244M in financial assistance and community benefit programs, representing 12.93 percent of the hospital's total operating expenses. Of this total community benefit, the net benefit for Medicaid patients was over $93M (4.92 percent of total operating expenses for the same year). Additionally, the hospital's costs for Medicare patients were $82.5M, and their investment in community building activities represented over $445K for the same year. In total, LHH's overall benefit to the community exceeded $327M, and represented 17.1 percent of their total operating expense. Additionally, between 2021 and 2023, LHH reported an average of $31M in charity care, representing an average of 1.8 percent of total operating expenses.

Lenox Hill Hospital			
	2023 Financial Information	Net Community Benefit	% of Total Operating Expense
1	Total Financial Assistance and Community Benefit Programs	$244,393,877	12.93%
1a	Medicaid Shortfall	$93,043,639	4.92%
2	Community Building Activities	$445,908	0.02%
3	Medicare Shortfall	$82,507,788	4.37%
	Total Benefit to the Community	**$327,347,573**	**17.32%**

Lenox Hill Hospital Charity Care at Cost	Average	2023*	2022	2021
Charity Care	**$31,308,225**	$21,714,848	$40,676,692	$31,533,134
% of total adjusted operating expenses	**1.8%**	1.15%	2.33%	1.84%

** = Calculation impacted by NYS Attorney General guidelines*

In addition, in 2024 LHH held a total of 43 events and served 9,375 members of the local community, through health screenings, educational workshops, health fairs, community events, and blood drives.

G. EXISTING VS. PROPOSED SQUARE FOOTAGE

On Projected Development Site 1, the existing gross square footage (GSF) is 781,500; in the With Action condition, the proposed square footage would be 1,398,000 GSF. With Envelope 1, the existing GSF to remain would be 571,000 (73 percent); with Envelope 2 the existing GSF to remain would be 515,000 (66 percent).

The distribution of departments is shown in **Table A2-1**, below. With the Proposed Project, there would be 155 beds in the existing structures and 320 beds in the new building in Envelope 1, and 176 beds in the existing structures and 299 beds in the new building in Envelope 2. Envelope 1 would have 21 ORs in the new building and nine renovated ORs in the existing building. Envelope 2 would have 30 ORs, all in the new building. The overall OR platform inclusive of clinical support spaces spans new and existing buildings.

The new entrance, public lobby, and pharmacy would be located in the new building. The Emergency Department and the Mother-Baby Hospital would span the new and existing building.

Table A2-1
Existing and Proposed Hospital Program

	Existing (gsf)	Proposed (gsf)
Patient Rooms (including all required support space)	177,030	415,500
Operating Rooms (including all required support space)	55,227	132,000
Emergency Department	13,832	41,500
Additional Hospital Uses and Departments*	273,343	285,000
Other**	262,068	524,000
TOTAL	781,500	1,398,000

Notes:
* Additional hospital uses and departments include hospital and clinical support space (other than patient rooms and ORs support space as noted above), public space, labor and delivery, imaging, endoscopy, catheterization and interventional radiology procedures.
** Other uses include ambulance bays, loading dock/ materials handling, MEP, shared circulation, and core/exterior envelope square footages.
All square footages in this table are approximate.

H. PROPOSED PROJECT AMBULANCE BAYS

The number of ambulances accommodated in the ambulance bay on Projected Development Site 1 was determined based on experience with the number of ambulances currently parking on East 77th Street in order to deliver patients to the hospital. This number considers the need to avoid ambulances being forced to double-park in traffic or to park on the north side of the street. LHH currently operates 8 ambulances out of the main hospital. When not on call they are posted at various cross-street locations across Manhattan. LHH also receives patients daily from non-Northwell NYC 911 ambulances, as well as transferred patients arriving by ambulance from other hospitals. The need for 6 ambulance bays is justified by LHH's current and projected ambulance arrival volume, in order to improve traffic flow on East 77th Street and increase the safety of patients and hospital staff.

As described on page 10-7 of EIS Chapter 10, “Transportation,” it is estimated that over a typical 24-hour period, there would be an increase of four ambulances per day and one ambulette per day when comparing No Action and With Action conditions. When applied to the weekday AM, midday, and PM peak hours, this would amount to either no additional trips per hour, or up to one additional trip per hour.

I. PROPOSED PROJECT TRUCK BAYS

The Proposed Project's need for four truck bays on Projected Development Site 1 is based on LHH's experience with material deliveries scheduling, the need to separate soiled materials, and the need for deeper bays so that trucks do not encroach on the sidewalk along East 76th Street. Each space on the dock platform has been engineered based on anticipated demand and storage requirements. The spaces are sized to manage peak day capacities and function flexibly in response to high-census times. The sizing of the loading dock is a multifactorial consideration of hospital program, expected truck volume, projected growth metrics, flexibility requirements, space allocation, and traffic expectations. When sizing the dock, the design team referenced a dock schedule compiled with user engagement. Given the expected number of arrivals and dwell time for each type of dock interaction, a dock with four truck bays was deemed necessary for the Proposed Project. ✷