



**RESPONSE TO QUESTIONS FROM  
THE LANDMARKS PRESERVATION COMMISSION  
REGARDING APPLICANT'S HARDSHIP STATEMENT**

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**Owner:**

**ST. VINCENT'S CATHOLIC MEDICAL CENTERS**

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**Affected Site:**

**20 Seventh Avenue  
Block 617 Lot 55  
Manhattan**

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**July 15, 2008**

**Friedman & Gotbaum LLP  
568 Broadway, Suite 505  
New York, NY 10012  
(212) 925-4545**

**Questions from the Landmarks Preservation Commission  
Regarding the Hardship Application**

**July 15, 2008**

**1. What alternative sites for the new hospital were explored?**

Alternative sites, such as the World Trade Center and Hudson Yards, were considered in the early stages of planning for a new hospital. None of the sites considered would have allowed St. Vincent's to continue to provide healthcare services to the communities making up its primary service areas, which over the course of 150 years have come to rely on St. Vincent's as the sole acute care hospital on the lower west side of Manhattan. Additional location restrictions imposed by federal Medicare regulations have come to define the reasonable boundaries for site consideration, because relocation to any site beyond 327 yards from St. Vincent's Comprehensive Cancer Center at 325 West 18<sup>th</sup> Street would result in the loss of the Cancer Center's qualification as an on-campus provider based facility for Medicare purposes. This loss would significantly impact St. Vincent's ability to continue to provide cancer treatment to thousands of Medicare patients using the Cancer Center. The inability to offer these patients needed oncology services would seriously interfere with St. Vincent's mission. Accordingly, it will not consider sites to the south or east of its current Greenwich Village location. With regard to sites north or west within the required distance from the Cancer Center, a recent survey by Massey Knakal Realty Service indicates that there are no viable sites.

**2. Did the hospital try to buy or lease other property?**

No. No viable site was identified within St. Vincent's primary service area which could satisfy the above federal mandate and accommodate the program for a new acute care hospital and trauma center.

**3. Discuss the feasibility of leasing or buying the Cabrini site. Why can't it be used for a new hospital or used while the new hospital is being built in the Village?**

When the Commission on Healthcare Facilities in the 21st Century (a/k/a the "Berger Commission") mandated the closing of Cabrini Medical Center, it cited Cabrini as being "located in "Bed Pan Alley" with one of the largest concentrations of medical/surgical acute care hospitals in the country" and "that Cabrini's patients could be readily absorbed" by neighboring facilities including Beth Israel, Bellevue, and NYU. Considering the swift subsequent adoption of the Commission's recommendation to close Cabrini by the New York State Department of Health ("NYSDOH"), it is beyond doubt that any proposal which suggests a new acute care medical/surgical hospital on the Cabrini site will not receive NYSDOH approval. Since Cabrini's mandatory closing, St. Vincent's has worked with NYSDOH for approval to use a portion of Cabrini's facility as a suitable alternative for non-medical/surgical services including the re-location of 85 inpatient psychiatric beds and the ongoing operation of inpatient hospice beds.

The use of the Cabrini site as a temporary location of certain inpatient bed units during a phased reconstruction of the existing campus is theoretically possible; however it is not possible to separate imaging, surgical and other interventional services, as well as emergency, and intensive care units from one another or the emergency room, which must remain on the West Side. Given the acuity of our patients and the need for in-house adjacencies with the ORs, interventional and diagnostic services and intensive care units, there would be too few patients to support acute care at Cabrini during a phased renovation of the 12<sup>th</sup> Street campus. Please refer to question 12 regarding the feasibility of renovation or reconstruction on site.

**4. Has St. Vincent's explored merging with another hospital? If so, explain why such a merger didn't materialize.**

Saint Vincents Catholic Medical Centers of New York ("SVCMC") was formed on August 1, 2000 as a result of the corporate consolidation of *Saint Vincents Hospital and Medical Center* with two other local Catholic healthcare systems, *Catholic Medical Centers of Brooklyn and Queens* and *Sisters of Charity Health Care Corporation*, on August 1, 2000. Because the financial difficulties of many of the acquired hospitals and other facilities which SVCMC assumed eventually proved insurmountable, SVCMC filed for bankruptcy protection on July 5, 2005. Throughout the bankruptcy process, all available options to resolve its pending financial issues were explored, including discussions with other hospitals and health systems relating to a variety of affiliations and corporate transactions. However, due to the daunting financial condition of SVCMC during the bankruptcy proceeding, no other hospitals or hospital systems were willing to entertain significant discussions regarding a merger or similar affiliation arrangement.

The Berger Commission, created to review and strengthen New York State's acute and long-term care delivery systems, delivered its final report in December 2006 which mandated the closure or restructuring of many hospitals and long-term care facilities, such as Cabrini (see above), so as to optimize the delivery of healthcare services in New York. The Berger Commission considered several potential facility mergers among area hospitals, and its final determinations mandated the merger and/or closure of a number of hospitals. Despite SVCMC's status in Chapter 11 at that time, the Berger Commission determined current needs and future demands required that St. Vincent's Hospital remain as currently organized and undertake significant capital investments so that its role as the West Side's principal acute care hospital and Lower Manhattan's and the West Side's only Level 1 Trauma Center. Since its emergence from bankruptcy in September 2007, SVCMC has discussed a variety of affiliation arrangements with various parties in order to continue to maintain its charitable purpose, including certain service-specific clinical arrangements with other health systems; however, no merger discussions with other hospitals or healthcare systems have occurred.

**5. What additional land would be required to build a new building on 6th Ave and 15th St, and the feasibility of acquiring such land? What, if any, zoning restrictions are there on the 15th St. site that limits a tall hospital at that site? Can land across the street from the 15th St. site be purchased, if not the land directly adjoining the site? Then the oxygen storage and delivery function could be removed from the 15th St. site thereby freeing up space for a larger footprint.**

St. Vincent's has evaluated the feasibility of utilizing the Staff House site (555 Sixth Avenue), as currently configured, to support construction of a new acute care hospital and trauma center. For the reasons enumerated on page 6 of the Statement of Findings filed with the application on May 19, 2008, but principally due to Staff Housing's insufficient 30,000 square foot lot size, the site is not a viable option because its footprint could not accommodate the services now located on the Triangle and provide the type of Emergency Department on a single floor. Accommodating the Emergency Department in single contiguous ground floor space is an absolute requirement. This point is made in written testimony from prominent healthcare architect Norman Rosenfeld, FAIA, FACHA and attached herein for reference [Attachment A]. Additionally, the physician in charge of St. Vincent's emergency services testified at the June 3, 2008 public hearing that a bifurcated Emergency Department is clinically inappropriate, if not simply dangerous. No hospital in the State of New York provides emergency service split between two vertically adjacent floors. In fact, after a national search, St. Vincent's identified only one 2-floor Emergency Department in the United States, and this facility is in the process of converting the department into a single story, ground floor plan.

St. Vincent's appreciates that the Landmarks Preservation Commission acknowledges this critical clinical requirement and has asked that we explore the acquisition of the necessary number of adjacent properties to achieve a sufficient ground floor emergency department. Because of the

unavailability of the Triangle as a site for loading bays and the oxygen tanks, these services would also have to be located within the assembled parcels. In response to this question, two zoning scenarios have been evaluated: (a) a site assemblage based on current FAR allowances and (b) site assemblage assuming an upzoning to C2-7 to reduce the number of lots required. The following analyses do not take into account additional zoning non-compliances such as the applicable building height, lot coverage and year requirements in these zoning districts.

(a) As currently zoned (C6-2, R8A and R8), we estimate that a 665,000 gross square foot acute care hospital and trauma center hospital would require annexing 20 adjacent tax lots (or a zoning lot area of approximately 75,000 square feet. This assemblage, including Staff House's approximately 30,000 square feet, would extend beyond Staff House more than 200 feet down 15<sup>th</sup> and 16<sup>th</sup> Streets. [Detailed illustration will be submitted into the record under separate cover.]

(b) If zoned to C2-7 (R9 equivalent, providing FAR 10 for community facilities), which is the zoning St. Vincent's will be pursuing on the O'Toole site, a zoning lot of approx. 41,750 sf would be necessary to provide FAR for the same 665,000 gross square foot hospital. With upzoning, six adjacent tax lots extending an additional 52 feet down 15<sup>th</sup> and 16<sup>th</sup> Streets would be required. [Detailed illustration will be submitted into the record under separate cover.]

Assemblages involving adjacent parcels are inherently very long-term propositions – lasting years if not decades in some cases and involving considerable risks ranging from refusals to negotiate to controversies with displacement of rent-controlled, rent-stabilized and/or market rate tenants. St. Vincent's and the patients it serves are simply not in a position to wait such a long and uncertain period before embarking on a facility replacement effort, requiring it to both invest in short term renovations and patching of infrastructure while simultaneously owning and managing properties it is in the process of assembling.

**6. Does the State certificate of need process require that St. Vincent's remain in the Village or on the West Side, or could it move elsewhere, assuming a suitable site could be found, either on the West Side or elsewhere?**

The NYSDOH certificate of need process is based in part on meeting the healthcare needs of the residents of the communities within a hospital's primary service area. The optimal provision of healthcare to the communities St. Vincent's presently serves will be the primary evaluative standard applied to any certificate of need review. St. Vincent's has been a cornerstone of healthcare for the residents of the West Side and Lower Manhattan communities for over 150 years and its range of clinical programs and services are a direct result of the demography, economic indicators and healthcare needs of the individuals residing in them. It is highly unlikely that the NYSDOH would support the relocation of St. Vincent's acute care and trauma services to another location that materially overlaps with the primary service areas of other local hospitals, including Beth Israel Medical Center, St. Luke's Hospital and New York Downtown Hospital.

**7. How would the mission of St. Vincent's be changed if the hospital moved from its current location in the Village?**

SVCMC's Articles of Incorporation state that its charitable purpose is "[t]o provide in a non-profit basis *hospital, nursing-home and other health-care facilities and services for the care and treatment of persons who are acutely ill or who otherwise require medical care, skilled nursing care, continuous care or related services of the kind most customarily furnished most effectively by hospitals* or furnished by nursing homes or other health-care facilities..." (emphasis added) The maintenance of St. Vincent's as an acute care hospital located in Greenwich Village has been at the center of SVCMC's charitable purpose since the establishment of Saint Vincent's Hospital when originally opened by the Sisters of Charity of Saint Vincent de Paul of New York in 1849. Although the delivery of health care has changed dramatically in the 150 years that St. Vincent's has been serving the West Side, the existence of an acute care hospital and trauma center in Greenwich

Village remains central to its role of providing a broad spectrum of care to all in need, especially the poor.

**8. For how long has St. Vincent's been a Level 1 trauma center? Has it always been the only one on the West Side below 96<sup>th</sup> Street?**

NYSDOH designated St. Vincent's a regional trauma center in October of 1990, when the State first introduced this category of licensure. However, the hospital has functioned as a trauma center since the early 1980's. Prior to 1990, the New York City Regional Emergency Medical Services Council designated trauma centers, using the standards set for 9-1-1 receiving hospitals. During the 1980s, St. Vincent's was one of the original 14 hospitals within the five boroughs to function as a trauma center.

St. Vincent's is the only New York State designated trauma center located on the West Side below 114<sup>th</sup> Street (St. Luke's Hospital), and the closest trauma care provider to Wall Street, the World Trade Center, Battery Park City, Penn Station, Madison Square Garden, the Javits Center, and the future Hudson Yards communities.

**9. St. Vincent's acquired the O'Toole site in 1975. What did it pay for it, and what was its intended use at that time?**

According to the deed recorded with the City of New York, St. Vincent's acquired the O'Toole site in November of 1973 for a price of \$6,000,000. Records of the Board of Trustees indicate that, in 1973, its Planning Committee approved renovations to make "it usable for the hospital".

Some in opposition to St. Vincent's hardship application have suggested that St. Vincent's now seeks freedom from the historic district rules it knowingly inherited upon purchase of the O'Toole site. On the contrary, St. Vincent's seeks the same right conferred to any owner of property within an historic district: due consideration of its case pursuant to the hardship provisions of the Landmarks Law.

**10. How did St. Vincent's stage the construction of the current emergency room and hospital in Coleman and Link? Where were the emergency rooms, etc. at the time?**

St. Vincent's vacated the Lowenstein Pavilion in 1979 through relocation of outpatient services to the O'Toole site. Demolition of the Lowenstein Pavilion allowed for construction of the Coleman Building as Phase 1 (completed in 1983), followed by demolition of the Seton Building and replacement with the Link Pavilion as Phase 2 (completed in 1987). This phasing allowed for the Seton Building - containing core hospital services such as the emergency department, surgical suites, diagnostic imaging, and patient bedrooms - to remain in operation until these programs could be relocated into the new Coleman Building. Once vacated, the Seton Building was demolished to make way for construction of the Link Pavilion.

**11. What other hospitals in NYC have undergone major upgrades of their emergency and operating facilities? How did they juggle construction of the new hospital while continuing to operate their existing facilities?**

Many hospitals in New York City have undertaken periodic renovation of various individual departments including emergency, surgical, and inpatient facilities. By way of example, Lenox Hill Hospital renovated and expanded its emergency department; Memorial Sloan-Kettering Cancer Center replaced its surgical suites, and even St. Vincent's expanded its emergency department by opening a "Fast Track" annex in 2005. Even for hospitals such as LHH and MSKCC whose facilities have been designed from the outset with common floor levels and coordinated hallways, stairways and elevators, all features which St. Vincent's lacks, these small construction projects demanded complex phasing plans to prevent or minimize reduction in service capacity or disruption to other departments, while also maintaining environmental life safety and infection control

protocols in compliance with the Department of Buildings and the Fire Department of New York. Such planning and implementation has thus far only proved manageable for isolated construction projects within a larger hospital building complex. And no other hospitals were required to maintain Level 1 trauma center status during these projects. The scope of renovation necessary to modernize St. Vincent's Hospital is so enormous, and the need to maintain emergency and trauma services so vital, that phased renovation would be cost prohibitive.

Decisions to embark on widespread renovation or to build new are principally determined by flexibility and adaptability of existing buildings. Floor alignment between buildings, centralized vertical circulation cores, widely spaced columns and perimeter walls, along with reasonable slab-to-slab heights can create an environment conducive to renovation. Not without cost, it is often possible to supplement utility infrastructure to meet the mechanical, electrical and plumbing requirements of a renovated space. It is not, however, practical or reasonable to suggest that floors throughout a multi-building campus be made taller, stronger, better aligned, or less encumbered by vertical cores, as would be necessary for a renovated St. Vincent's Hospital.

**12. You stated that the ideal hospital is horizontal, not vertical. Has St. Vincent's explored applying for a hardship to build a lower, horizontal building somewhere on the east campus? i.e., demolishing some of the low rise buildings along 11<sup>th</sup> and 12<sup>th</sup> streets, build the new hospital and then sell Coleman, Link, O'Toole and the triangle site.**

In a Greenfield setting, a new hospital's design would more likely be horizontal than vertical. In an urban environment like New York City, hospitals have no option but to be tall – as evidenced at every acute care hospital in operation here today. The height of a hospital building is, of course, determined by the program requirement and the size of the property footprint. St. Vincent's is convinced after significant study that the O'Toole site is both a suitable location for a new acute care hospital and trauma center but also its only realistic alternative. However, in conjunction with this Hardship Application, we have explored several alternative designs for the existing campus: (a) construction of a replacement hospital in the midblock and subsequent sale of the avenue buildings, (b) construction of a replacement hospital on the site of the Coleman and Link buildings and sale of the remaining midblock buildings, and (c) construction of a low rise building in the midblock and renovation of the avenue buildings. All of these options are based on the programmatic need to build an approx. 650,000 gross square foot building. Details of these analyses will be submitted into the record under separate cover and can be summarized as follows:

(a) A midblock replacement hospital would rise 274 feet and 19 stories tall. The public entrance and all ambulance activity would be concentrated into the midblock, opposite residential buildings. Unless St. Vincent's was permitted to maintain its tunnel to retain a connection to the warehousing and central gas facilities on the Triangle, these facilities would also need to be moved to the midblock. This plan would require demolition of Reiss, Nurses Residence, Spellman, and Cronin, along with the sale of Smith, Raskob, Coleman, and Link for residential development. This alternative is not viable for St. Vincent's, creates a precedent in Greenwich Village's as the first through block building in excess of 270 feet in height accessed only by narrow streets and ignores other fundamental principles of urban planning as well as hospital siting.

(b) Demolition of Coleman and Link and replacement with a new hospital on that site is simply impossible to achieve. Coleman and Link are today the 'heart' of the hospital, with more than 65% of all acute care and trauma services located within these buildings. Unlike the phased replacement of the Seton and Lowenstein buildings, the south facing windows (a code requirement) of the Coleman patient bedrooms (almost 50% of the total bed capacity) prevent construction of a new tower on top of the Link Pavilion. The only way to build a replacement facility at this site is to close the hospital and re-open years later after completion of construction, requiring distribution of medical services to other hospitals, re-alignment of primary service areas, closing of one-half of the trauma center capacity for the lower half of Manhattan, and termination and/or dispersal of medical, nursing and support staffs. There are no known precedents for intentionally creating such disorder in New York City's acute care delivery system.

(c) While construction of a low rise building on the midblock and renovation of the remaining buildings may seem appealing, this approach only partially addresses the modernization requirements of St. Vincent's. A new clinical platform in the midblock – to house new ORs, interventional procedures, diagnostic imaging, emergency services and intensive care units – can be designed efficiently; however, adaptation of the remaining campus buildings is still severely challenged by all the same structural and infrastructure limitations outlined in the "Existing Facility Condition Report" previously submitted into the record. More importantly, this 'partial replacement and renovation' plan would cost more than \$1.5 billion, thereby rendering this alternative unlikely to obtain NYSDOH approval in light of the current proposal.

**13. If there were a scheme which either closes West 12<sup>th</sup> Street (between O'Toole and the park to the south), or builds over it creating a superblock, how much lower could the new hospital building be?**

If building over 12<sup>th</sup> Street were deemed acceptable to city regulators and the community, the 650,000 gross square feet necessary program would produce a building 11 stories tall with uniform streetwalls from the southern tip of the Triangle to West 13th Street with a uniform height of 168 feet [submitted for the record under separate cover]. Before arriving at the lenticular design proposed today, St. Vincent's initially explored this building option but later abandoned the idea due to the impact to view corridors and traffic and the fact that there were no precedents for such overbuilds anywhere on the street grid of Manhattan other than at its waterfronts. Moreover, this scheme eliminates the ability to provide improved public open space on the Triangle, the improvement of which has been an almost universally acclaimed need in the plans for a new St. Vincent's.

**14. For the scheme currently proposed, what if there is not a lenticular-shaped tower, but a lower and blockier building and place the mechanical equipment on top of the oxygen building across the street. Can this make the hospital building no higher than the apartment building to the north of the church?**

A building that "packs the bulk" without setback, supported by mechanical infrastructure added on top of the warehouse building (by code, nothing can be built on top of the oxygen plant itself), would rise 250 feet and 17 stories [submitted for the record under separate cover]. 56 Seventh Avenue, the apartment building immediately north of the United Methodist Church of the Village, is approximately 226 feet tall.

**15. St. Vincent's has said that if a new hospital is not approved it will seek to upgrade the existing facilities. Describe how such an upgrade would be financed and how the resulting hospital would or wouldn't meet required standards.**

St. Vincent's respectfully disagrees with the first sentence in this question. It has not stated that it would proceed with upgrades of the existing facilities if the new hospital is not approved. Statements to that effect have been made by parties opposed to the new hospital, inappropriately attributed to statements in documents filed with the Bankruptcy Court by St. Vincent's. The accurate rendition of those statements, further explained in a memorandum from St. Vincent's General Counsel, is provided for the record under separate cover.

The theoretical but infeasible options for upgrading the existing facilities have been discussed in the original Statement of Findings filed with the application and in Question 12. With regard to financing, aside from failing to yield many of the clinical improvements afforded by a new hospital, due principally to significant structural limitations in building heights, widths, elevations and load bearing capacities that a renovation could not address, an upgrade would also limit St. Vincent's ability to leverage its current assets through a transaction with a third party, such as the Rudins, to facilitate the financing of a new hospital. In light of the difficulty of financing such an expensive renovation that still would result in facility limitations, SVCMC's Board would be forced to re-

evaluate the long-term ability of St. Vincent's Hospital to sustain its charitable purpose. Please note that this response is provided to address a specific question from the Commission regarding finances. The hardship application before the Commission is not premised on financial hardship nor is it required to be premised on financial hardship.

**16. Has the State Department informed St. Vincent's that it will not be licensed unless it significantly upgrades its facilities, either through the construction of a new hospital or upgrading of the existing facilities?**

NYSDOH, in consideration of the Berger Commission findings and recommendations that the St. Vincent's "*requires major physical and programmatic reconfiguration, including complete overhaul of its hospital once they emerge from bankruptcy*", believes that significant upgrades to St. Vincent's facilities are critical and essential for it to continue to provide technologically advanced patient care. While currently St. Vincent's is in full compliance with its NYSDOH licenses and NYSDOH has not specifically stated that the hospital could lose its license unless significant upgrades are conducted, the common working assumption in initial discussions with NYSDOH regarding the pending certificate of need application is that the St. Vincent's will not be able to continue to carry out its acute care charitable purpose without new facilities.

**17. St. Vincent's said Coleman is already obsolete after 20 years. What will happen 20 years from now when the proposed O'Toole tower is obsolete? How will St. Vincent's grow and modernize after having sold all of the property its founders have accumulated over the past 150 years?**

As a point of clarification, although construction of Coleman was completed 25 years ago, it was designed 30 years ago and its final design was more a creature of the Landmarks and land use review process than its originally proposed design. There are important reasons that the new hospital will not be obsolete in 30 years. Coleman is obsolete after 30 years because it was not a "replacement" project, but a fundamentally compromised building solution superimposed on the existing buildings which were neither considered nor built for their current uses. This is the way hospitals generally address construction projects and is one of the reasons the cycle of modernizations is so short. Another significant difference is the dramatic change in health care delivery since the late 70s when Coleman was designed. 21<sup>st</sup> Century hospital design incorporates a flexible infrastructure to adapt to re-configuration for the technologies of the future. St. Vincent's emphasis on a decentralized system of patient friendly ambulatory sites is very consistent with the planning guideline of the NYSDOH and trends across the country and allows it to grow the outpatient programs that are central to health care delivery in the 21<sup>st</sup> Century. Continued migration of inpatient services to the outpatient arena over the coming decades will provide further flexibility in the long term use of the new hospital building.

**18. What new technology has St. Vincent's been unable to utilize in its existing facilities? How have the existing floor-to-floor heights and column spacing prevented the hospital from acquiring state-of-the-art technologies?**

St. Vincent's must compensate for its early 20<sup>th</sup> Century floor-to-floor heights by allocating floor area for engineering services which might otherwise be located above the finished ceiling. This loss of usable floor area is further compounded by immovable barriers, such as stair towers or embedded demising walls between buildings of differing elevations. Wherever possible, St. Vincent's has created a workaround where building conditions permit. The result, however, has been a steadily increasing loss of usable space, to the point where the campus now has a net to gross square footage of barely over 50 percent.

**19. Over the past 5 years, what major new technology and equipment has been installed at St. Vincent's and how was this accomplished?**

Due to the high cost and complexity of programmatic and structural workarounds necessary to compensate for building deficiencies, there have been only 4 examples of major new technology or equipment installation over the past 5 years:

- (a) Development of Fast Track in the Emergency Department (2005): The work consisted largely of mechanical relocations and installation of exam rooms. Because functional adjacency is necessary for the Emergency Department and Fast Track programs, administrative departments in the Raskob Building were displaced to accommodate the expansion. Additionally, source mechanical systems serving a wider region of the building, required replacement in order to deliver the HVAC demands of this new clinical space.
- (b) Renovation of Operating Rooms 1 & 2 (2006): The work consisted of the renovation and modernization of two operating rooms. These rooms were selected for renovation because they are located on the perimeter of the Operating Suites, allowing the work area to be walled off for physical and environmental separation from the sterile environment of the adjacent space. This strategy is feasible for only a few of the 18 operating rooms in service; more than half of the Operating Suites are land-locked in the Link Building and cannot be isolated for renovation yet accessible to construction workers.
- (c) Cardiac Catheterization Lab Replacement (2007): The work consisted of the replacement of an obsolete Cath Lab. The physical plant could not accommodate the relocation of the Cath Lab from its current location in the Spellman Building to another space with adequate load bearing capacity, so the floor below was vacated to permit installation of structural steel reinforcing beams.
- (d) CT Scanner (2007): The work involved the replacement of an obsolete CT Scanner. Neighboring space had to be lost to the CT suite to accommodate the electromagnetic field and equipment control room sizing and cooling requirements,

**20. Aren't new technologies generally smaller than existing, thereby taking up less space?**

New technologies are not necessarily smaller. Advanced laparoscopic surgery involves tiny incisions for insertion of telescopic equipment. Less invasive procedures are the preferred standard of care for patients who are clinically eligible because post-operative recovery is faster and there is less risk of infection. While such procedures are less invasive, an extensive array of surgeon-operated equipment surrounds the surgical table, thereby requiring larger operating rooms.

Importantly, with these new technologies comes an ever-increasing demand for engineering infrastructure. For example, new technologies are equipped with computerized controls – greatly improving the precision of diagnostics and treatments – which demand additional heating, cooling and ventilation systems. Contemporary diagnostic imaging, such as MRIs and CTs, require structure to suspend and/or support equipment; this structure may not be obvious to the casual observer, but takes more space in ceiling and floor area.

**21. When did St. Vincent's first solicit bids for this proposed project and when did it choose Rudin to be its development partner?**

St. Vincent's initiated its Request for Proposals for a development partner in April of 2006. The St. Vincent's Board of Trustees approved the selection of the Rudin Family in March of 2007 and a Memorandum of Understanding with the Rudin Family was signed in May of 2007. The Memorandum was ratified by the US Southern District Bankruptcy Court in June of 2007.

**22. Ballinger states that phased renovation of the existing buildings “would not yield many of the clinical program improvements afforded by a new facility.” What are these improvements and why can’t they be accommodated by renovating the existing facilities?**

The "Existing Facilities Condition Report" previously submitted into the record, as well as the response to Question 12, cite numerous permanent limitations resulting from renovation of the existing buildings. Multiple elevator and stair cores - resulting in redundant vertical circulation - cannot be eliminated because adjacent buildings do not share similar floor elevations or may not even connect on each floor. Absent universal interconnectivity of buildings, public circulation vertically and horizontally is complicated and confusing – no matter how good signage may be.

Without uniform floor elevations throughout the campus, it is difficult, and in many cases, impossible to aggregate horizontally contiguous space for large program or to co-locate programs which must be adjacent to one another. Even where adjacencies may appear attainable, low floor-to-ceiling heights and narrow spacing between columns absolutely prohibits certain occupancies.

**23. The Ballinger report is dated 2007. Are there other studies or analyses of the problems with the existing facilities and/or plans for addressing the inadequacies of the existing facilities in the 10 years prior to the Ballinger study? Were the recommendations or findings of these studies consistent with Ballinger et al?**

There are no other facility wide, comprehensive studies related to the requirements for a complete modernization of the existing campus. However, many individual projects have encountered difficulties related to the limitations imposed by the existing physical plant constraints. For example:

- (a) Cardiac Catheterization Lab Expansion: Several options have been reviewed to expand and upgrade the existing Cath Lab department. However, the existing department is surrounded by (Parti) building fire separation walls which restrict the growth opportunities without major modifications to existing fire separations. The physical plant restricts the flexibility for growth and expansion of this and other departments in the hospital. Although St. Vincent’s successfully replaced one of its three Cath Lab suites in 2007, future equipment upgrades are constrained by landlock.
- (b) Emergency Generator Replacement: The cost to replace a 750 KW generator in the Coleman Tower would have exceeded \$1MM including the cost of the crane to place the unit on the 18<sup>th</sup> floor and the cost of the removal and reinstallation of the facade (the design of Coleman did not accommodate the need for replacement of the generators). After exploring several options, including a first floor room adjacent to the Emergency Room, a 1Meg generator is presently being installed in the Service Facility on the Triangle so that power could be “piped” back to the Coleman building.

Such piecemeal renovation for specific installations, requiring major workarounds (as in structural column offsets), can be considered for isolated cases but cannot be practically or reasonably implemented campus wide.