

NEW YORK CITY BOARD OF STANDARDS & APPEALS

TRANSCRIPTION

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473 -541 6th Street, Brooklyn

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MS. MATIAS: Item number nine. 289-13-BZ. 473-541 6th Street, Brooklyn. The Office of Kramer Levin Naftalis & Frankel.

MS. WAGNER: Good afternoon, Madam Chair, members of the Board, my name is Elise Wagner. I'm a member of the firm of Kramer Levin Naftalis & Frankel, and I'm here today on behalf of New York Methodist Hospital to present to you their application for a variance for a new ambulatory care center to be called the Center for Community Health.

The zoning lot for this building is located on the block bounded by 6th and 5th Street and 7th and 8th Avenues directly north of the main hospital building.

The zoning lot consists of the entire block except for a row of walk-up buildings on 5th Street.

The zoning lot includes the existing hospital buildings on the western portion of the block.

The zoning lot is located in more than one zoning district. Most of it is located in the R-6 District but the northeast corner is located in the R7-(b) district and a mid-block portion is on 5th Street is located in the R6-(b).

Our presentation today will focus the programmatic needs of the hospital and the manner in which the proposed building satisfies those needs in a way that is sympathetic to the neighborhood and also requires the minimum variance from the Zoning Resolution provisions that are applicable.

Today, our presenters will include Lauren Yedvab, Senior Vice-President of New York Methodist; Jeff Brand and Peter Cabaluci (Phonetic) of Perkins-Eastman,

architects; Philip Habeb of Philip Habeb and Associates and then I will speak again at the end.

I also want to mention that we are joined by Lynn Hill, Vice-President for Communication and External Affairs at New York Methodist; Paul Travis of Washington Square Partners; the development consultants, Steven Holley of AKRF; Environmental Consultants, Joe Mariah; (Phonetic) of Land Lease Construction Managers and John Barenello (Phonetic) of Severit Structural Engineers.

They will be available to answer any questions the Board may have so now I'd ask Lauren to come up and she will focus on the hospital's programmatic needs.

MS. YEDVAB: Good afternoon, Madam Chair and Commissioners.

My name is Lauren Yedbab. I'm the Senior Vice-President at New York Methodist Hospital and I've been at the hospital for almost twenty years.

The hospital dates back to 1881. It is a voluntary acute care teaching facility with over six hundred and fifty beds translating to the fact that it is probably in the top ten percentage in terms of size and scope of a hospital.

In fact, in terms of services, the only thing that we don't provide at this hospital is organ transplants.

We are sponsored by the New York Presbyterian Health Care System and we are affiliated with the Weill Cornell Medical College.

Today, the hospital is a healthy, growing hospital in spite of the challenging health care environment.

We're stable. We have a successful track record. Obviously, if there isn't a margin, there is no mission. We're not going to apologize for the fact that we have been very, very successful and because of this, we are able to propose this building.

We are lowest cost teaching hospital in New York State based on the Council for Teaching Hospitals and we have experienced continued growth over the years.

Most of the numbers I used started in 1990 but I will show you some numbers starting from 1993 just to give you ten year prospective - - 2003, I'm sorry.

But, in terms of our in-patient growth, since 1990, we've actually had a 99 percent increase in our in-patient activity.

Our out-patient has grown by five times since then. Our ER has doubled to more than 105,000 visits annually interestingly enough, what we found is that our out-patient hasn't replaced the in-patient so it hasn't been an experience where our in-patient activity has gone down because it's been replaced by out-patient.

What we've actually been doing in recruiting doctors over this time so we went from four hundred members of our medical staff to over thirteen hundred.

And, so what we find is that we not only transition to out-patient but we've actually back-filled and increased our in-patient activity as well with more complex services.

We have spent on average about \$30 million a year on capital investments both on technology as well as the plant facility but, at this point, we really, really need an efficient and a state-of-the-art ambulatory care facility in order to meet the needs.

In terms of health care trends, there has been, and I mentioned this before, a transition from in-patient to out-patient. A lot of this comes from technological advances.

Thirty years ago, a gallbladder operation would require a very open procedure and you'd be in the hospital over a week. Now, that can be done in several hours and you would be sent home.

Cost control measures. It is a lot less expensive to take care of a patient on an out-care basis than it is on an in-patient basis if it's done efficiently.

However, right now, we combine our in-patient and out-patient activities so you could be going for a colonoscopy at the age of fifty and you might actually be recovering to a patient who is on a ventilator who is ninety-five years old with multiple comorbidities.

Not only is it less efficient for our staff but it is also less patient centric and not as positive of a patient experience. Our emergency room is at a point where we are so busy that we actually close our surgical clinics in the afternoon in order to expand our urgent care component of an emergency department.

Programmatic need. Whereas significant growth - - I apologize. Ignore the slides. They are just pictures anyway. I'm sure whatever I have to say is more important.

We have had a tremendous growth in surgical volume. It's not typical of what you see in other hospitals. Most people (Unintelligible) experiences after in-patient transfer to out-patient or ambulatory procedures. In our case, in the past ten years, our in-patient surgery increased by forty percent.

Our ambulatory surgery grew at the same time by thirty percent. Here are the gross numbers. Ambulatory endoscopy increased considerably but what you find and what we're finding is that what doctors were doing in their offices, they're now coming to us and asking to do them in our hospital procedure in our endoscopy suite because it's less efficient for them to do it in our offices unless you have a large group of gastroenterologists there. They found that it's less efficient and it's too expensive for them to do it in their offices.

So, now we're at a point where we're having a difficult time even accommodating their requests and their needs.

Ambulatory gynecology, ambulatory orthopedics has grown by thirty-five percent. I chose these services to highlight for you because they also support the application in terms of the programs we're planning to put in.

I would give you the percentages for ambulatory urology and minimally invasive radiology except they're really silly numbers. It's over six hundred percent increase because the services simply just didn't even exist at Methodist, specifically, ten years ago.

But, to satisfy our need, we are looking to build the Center for Community Health which would contain a new ambulatory surgery center with operating rooms; the required recovery area and facilities as well as an endoscopy suite with six procedure rooms for endoscopy, bronchoscopy (sic) pain management, urology (Unintelligible).

Hospitals throughout the country have constructed or are proposing to construct these types of facilities to support consolidated out-patient services, some of them include Lenox Hill, Montefiore. I'm sure you read about these. I'm sure you actually hear about

this all the time, Memorial, NYU. These are all very vocal hospitals that have done similar things and continue to do so.

The proposed Center for Community Health will allow Methodist to remain competitive with some of these other giants in Manhattan.

Ambulatory operating rooms must be made of an appropriate size or configuration; proximity to the support services. I guess this is really answering why we need to be where we are and Jeff will certainly be talking a whole lot more about the floor plates and the requirements that we have but if you talk about minimally invasive surgery, the space that's required for all of the equipment and the staff that are required in order to use all of that technology actually commands a much larger room than what we currently have in our ambulatory surgical center in the hospital.

Imaging, robotic services, those all take up a whole lot more room and, therefore, we have to build it much larger in order to accommodate our growing needs but really what we also want to do in this building is to focus on patient centered health care.

So, rather than building a whole lot of different services around our staff or around the buildings that we have, what we've done is we've focused on the patient and what are the patient's needs and have really, really tried to prioritize the services that will go into that building revolving around the actual patient.

So, New York Methodist needs an integrated facility to accommodate the ambulatory services.

Assembling all of these necessary services and health care providers in a single location will allow the entire episode of care from diagnosis to treatment to be centered around the patient.

For an example, a woman goes to her gynecologist, has a breast exam. They identify some sort of a lump. It turns out to be breast cancer. That patient is going to go to our one building. She is going to have her ambulatory imaging. She is going to meet with her surgeon. She is going to go for pre-surgical testing. She is going to have ambulatory surgery and recover there as well.

She will have ambulatory infusion. She may even have radiation oncology. All of those services will be provided around the patient and based on the patient's need which will also promote the collaboration of all the health care partners within that team to take care of that patient.

From our experience, a patient in that scenario could actually visit that patient facility in upwards of a hundred visits per year in order to make that as convenient and patient-centric as possible that is the reason and that is just one example of why we have chosen to assemble the services that we have put together.

The hospital has several institutes and I did highlight before the growth in ambulatory surgery but really a lot of that comes from the institute so we have institutes for neurology and neurosurgery, orthopedic medicine and surgery, cancer, cardiology and cardiac surgery, woman's health, men's health and new actually - - we didn't actually update the slide, had (Unintelligible) just to give you a sense, twelve doctors came in and relocated their practice; had to enact Yancy (Phonetic) specialists relocated from a hospital that is not doing so well and will probably not be an in-patient facility in the long run.

They relocated their entire practice and all of their services to New York Methodist Hospital and came and proposed a head and neck service so I didn't even

include the statistics in terms of where we are in 2013 in terms of the activity but they're doing major, major cases that we never did at Methodist before.

We have adapted their program and built it into one of our institutes as well.

But, what we want to do is promote collaboration amongst care givers; provide the most efficient care possible in a patient focused and physician focused manner.

So, locating the center approximate to the hospital will allow for right-sizing of in-patient facilities; the efficient delivery of out-patient care for procedures and specialties.

This will be safer. There will be less duplication; access to all hospital resources and experts. So, while you have ambulatory surgery or minor procedures that are taking place across the street from the hospital, unforeseen circumstances would allow not only for a patient to be transferred immediately to the hospital but we could also relocate or adapt and get all of the experts necessary to address an emergency situation right across the street from the hospital.

It will be much less duplication in terms of not having to duplicate services like central sterile material's management. What we're able to do is actually accommodate and optimize the hospital services in order to support this building as well.

Every square inch and I've said this before has been utilized in this building that we're proposing.

For example, pre-surgical testing will exist by day and in the evenings that same, exact space is going to be used for urgent care to support the community to decrease the amount of unnecessary visits to the Emergency Department and it's using the same, exact

space. You know, we are trying to optimize every square inch that is being designed in this building.

The next two slides and we really did struggle as to which one should go first but the question came down to who do we serve and where do our patients come from?

Our patients come from all of Brooklyn, 2.7 million patients or 2.7 million people in Brooklyn.

We went and visited all of the (Unintelligible),. Karen Westerfeld (Phonetic), she is the Deputy Health Commissioner to talk about this building and to talk about whether or not this would be something that she would support.

She looked at our discharges and looked at where we were taking care of patients in terms of some of the medically underserved areas; Bed Sty, Crown Heights, East New York, Flatbush, East Flatbush and these were all check-offs in terms of their - - in terms of meeting the needs, the health care needs and health care disparities in Brooklyn. And, by the time we left, her response to us was not only should we build an ambulatory care facility but we must build an ambulatory care facility to support all of our services that we provide.

And, how did we get to this point where we are taking care of all of these patients?

In 1993, we opened up our first satellite facility in downtown Brooklyn. Since then, we've opened about ten or fifteen. Those are the blue dots that you see throughout Brooklyn through a physician alignment strategies. But, we didn't want to force everybody to come to Methodist for unnecessary reasons or unnecessary visits.

What we have been able to do is to come spread out and should provide health care services in private doctor's offices because we do promote the private practice of medicine.

So, what we have been able to do in seventy-five plus locations is to provide services on echo cardiology, cardiologists, pulmonologists. We send those specialists out to the doctor's offices so we're able to provide a lot of those services in patient's neighborhoods; that, therefore, they come to us for the more high tech or more specialized needs that are required of the hospital.

So, when talking about which came first; whether or not we were going to the communities that provided the discharges, really what I think it probably shows more so than anything is that we used to have a very out-patient - - an in-patient focus and we were always measuring by our discharges. Those are our in-patients that get discharged from the hospital.

And, what we really have transitioned to is all of the outreach that we have done and in order to bring all of that, all of the services back to the neighborhoods.

But, no matter what the results show, it's really demonstrating that we are committed in every way to take care of the patient's needs throughout Brooklyn.

We will always need state-of-the-art facilities with the best-in-class physicians and providing the best care possible.

I know there will be some discussion regarding a complying building and if we don't receive the variances that we are requesting, we will have no choice but to build a complying building.

However, we do hope that it won't be necessary because the proposed building and the proposed Center for Community Health is a much better building, in my opinion, of course, for us and for the community.

It is better to meet all of our needs. It will allow us to deliver care in a more efficient manner, both inside and out. We believe it's more attractive and will better serve the health care needs for the future.

Jeff Brand is a senior medical planner with Perkins-Eastman. New York Methodist charged Perkins-Eastman with designing a building that provides the needed facilities consolidated under one roof and that is appropriate to the site and the surrounding neighborhood.

We've used every square inch, as I've said before and then some with outstanding clinical programs. His expertise, his guidance and experience throughout this project have been a collaborative effort resulting in an outstanding plan and I look forward to you listening to his presentation. Thank you.

CHAIR SRINIVASAN: Thank you.

MR. BRAND: Good afternoon, Madam Chair, Commissioners. My name is Jeff Brand.

What I would like to do is talk to you very simply about how this building's size came about to translate the program Lauren outlined into the shape and configuration that you see and why it is so important for them and why the floor plates are the size that they are.

So, what you're seeing here is a - - excuse me, please. The site is outlined in red, obviously. It's a constrained site, in our opinion, because it's long and narrow but we are

making this work in the best way we possibly can and we are comfortable that we can fit things in this building to meet the program.

Essentially, what you're seeing is a location for a central core for all circulation for the building and you're left with two wings, left and right that maximize the area for the medical program.

What you're seeing here is the entrance drive off of 6th Street. By the way, these diagrams are very consistent with what we submitted to the BSA. They just have more detail in them. We have been working to fill in all the programmatic boxes.

So, as a patient who might come here a hundred times a year, as Lauren said, I come in. I'm dropped off here at the entrance. I can drop myself off; come into the building. At the end of the day, somebody can pick me up or I can park in the building.

It's a very one-stop shop so all arrivals are off the street, including all the truck docks; all off the street. Next, please.

What you're seeing here is the second entrance off of 6th Street. This is about ten or twelve feet higher than the main entrance so the building slopes up and this is that combined services of pre-admission testing and urgent care and imaging. It's that integrated philosophy that Lauren is talking about so we're double functioning these functions here and relying on this kind of domino to treat patients and release them.

Keep in mind that this building is a diagnostic and treatment building so, as she said, you're coming here for everything. It's all a one-stop shop.

The second floor, although we are opposite the main hospital here, the left side of the second floor is support and what you're seeing are the locker rooms and some central

sterile supply and storage for materials for surgery. All of that serves surgery, for the most part. So, surgery is really a three-stack diagram.

When I said before that this was a constrained building, normally you would have one surgery all on one floor to minimize movement of patients and materials. Here we are on three floors to make it work and we're making it work because the width and length are minimally acceptable for the dimensions we need to fit the program.

This program was designed from the inside out. We didn't fill the boxes by what we wanted. We filled the boxes by what was needed based on Department of Health Code and guidelines and life safety on best practices across North America.

So, these are very, very efficient layouts and they're meant to not be bloated in any sense of the word. There are no offices here as well.

What you are seeing on this floor is the second part of a surgery on the left. There are twelve operating rooms. They are located around sterile core which is the safest way to provide surgery in a medical environment; not a lot of extra space. You'll notice on the left all those darker grays. All those things are shafts and stairs and elevators; electrical closets; all the other things we need to make this building work.

So, in addition to the programmatic and critical need, there's actually an infrastructure need that's necessary.

We're beginning to see how the building lays out here. The yellow public elevators are here, the service elevator and the stairs; other shafts and there's that left wing and that right wing.

What you're seeing on the right are some of the institutes that Lauren talked about. This one happens to be urology which is very related to surgery and a lot of these

patients will go there for surgery or they might go to the procedure suite directly above them. But, this is designed from the perspective of efficiency and we came up with an idea to share an examine room and a console room in one space so we're not duplicating.

We don't have a lot of consoles and exam rooms. We have some and the purpose of this was to try and fit into the assigned space that we were allocated. So, again, it's a way to be very efficient here.

What you're seeing on the left is recovery for surgery. These patients that can (Unintelligible) dedicated to recover. Again, it's a sterile environment so we have to maintain these sterile agencies and very intricate staff connections. Again, that width, we're filling the whole thing out by the required number of spaces to serve the surgical volume.

The right side, all of this green, is procedural. For six procedure rooms, we need all of that and it seems to fit. These are all patient spaces, recovery; all required by guidelines. There's no extra space here. That's classic how this building is laid out. It's a very complex medical program. Next please.

What you're seeing here in these yellow diagrams are some of the institutes. There is a Neurosciences Institute here; orthopedics over here. You can see, again, they fill out the entire floor. Orthopedics, those big green boxes are x-ray rooms. We don't want these patients who have orthopedic issues to be walking long distances so, again, this is a one-stop shop designed to be very, very efficient.

This is all Neurosciences. This floor, the sixth floor, here, is the cancer center. Cancer center is a very large program. I think in your diagrams, previously, you may have seen open spaces. We're modeling this after Memorial Sloan Kettering's Cancer

Center for ambulatory care. There's also one on Atlantic Avenue that's also very similar. It allows patients to have choices. So, if you are here a hundred times a year with your family, you may some days want to be enclosed in a private room and some days you may want to socialize. That's the purpose of these boxes. There's a place to get nourishment. There's a place to have lunch with your family. There's a place to have education when you go home. There are places to socialize with other patients with the same kind of disease you're going through.

So, these are meant to be environments that are interesting and not just clinical; locking yourself in a room. It's a patient focused care is what Lauren talked about; a lot of dignity is needed here and so the model of Sloan Kettering right now is variety and that is what we are doing here.

But, every space is assigned for and there is nothing extra. These yellow spaces are exam rooms for this cancer center. Next, please.

Okay. This is the top of the building. We have women services on the left. There's a lot of imaging over there as well on those green boxes so it's a one-stop shop for women services. We also have a small clinic on the right.

The only thing I just want to talk about here is the way this building works from a separation of public and staff. All of the public always comes out towards the street and the staff and service always comes into the green car in the back.

Any modern health care facility separates the public from back of the house for many, many reasons including infection control.

We looked at a complying structure. That's where we started. What you're seeing on the left is a complying development. We tried to fit, accommodate the program

in this building. It ended up being two structures that were separate without any kind of connection but we were able to look at it; could we actually make that work?

The proposed is a one single structure.

Can we go to the next slide, please. This is the diagram to try and explain what we're talking about. This top diagram represents a complying development. What you end up getting are two independent structures that don't connect on any one of the floors.

They're very long and they're very narrow, especially the cancer center on the sixth floor would be split into two. So, we would not make that move here. We could actually move the cancer center on two or three floors.

Surgery, as an example, is all on three in this location. If it were three here, we would have to do multiple floors just for surgical O.R.'s and recovery; very inefficient; not the safest way to provide surgery moving patients up and down four or five, six floors.

So, we think the complying development fails to satisfy the programmatic needs of this client because we can't accommodate their program in a logical way that meets modern health care. We might be able to fit it but it's not the way you really want to function in that it fails on that level.

The proposed, what we tried to do with proposed was, again, maximize these widths to allow us to fit the programs as tight as we possibly could. Next, please.

What you're seeing here on the left is a complying structure. You can see how these two structures are not connected in any way. They are very, very long. You can imagine the distances an orthopedic patient might have to take themselves.

But, I think Lauren said something very interesting. She talked about this multi-disciplinary way that doctors work together. So, if you are coming here for a diagnosis and you need to talk to a radiation oncologist and a cancer center or medical expert or surgical expert, a pharmacist, by having two structures, how do you do that? It's very, very, hard to create a multi-disciplinary dynamo even on multiple floors. Having that collegial way to talk about a patient's case is very, very hard so we suggest that the proposed is a way to provide a multi-disciplinary type of care, a patient center care and accommodates the program in a way that is acceptable to them and meets it. Thank you.

MR. CAVALUZZI: Madam Chair, Commissioners, my name is Peter Cavaluzzi. (Phonetic) I'm a design partner with Perkins-Eastman and the focus of my presentation is going to really talk about the outside of the building. And, as Lauren said, every square inch of the interior has been carefully considered and programed.

I can say that every square inch of the exterior of the building has been considered in its relationship with the community and how it makes the street.

Some of the key moves that we made with this building from a massing and building shape standpoint focus on a few key steps.

First and foremost, we took setback and cutbacks on the two wings that are the most valuable parts of the building from a programmatic standpoint and we located that extra bulk in the middle of the block on 6th Street.

We did that because we viewed 8th Avenue and 5th Street as the most sensitive areas relative to the community.

We wanted to be sure that we kept a nice frontage on 8th Avenue and tried to relate to the heights of the buildings that run along 8th Avenue which, by the way, if you look at 8th Avenue, the heights on 8th Avenue can vary from a single-family home within maybe a ten block stretch all the way up to a twelve story apartment house. So, there's a lot of variety on the avenue.

But, there is a consistent four to six story height that we tried to maintain there.

The second thing that we did is we provided setbacks on 5th Street. You can see in this diagram, we have a five foot property line setback at the sidewalk level and then at the four-story level on the R7-B, we have a fifteen foot setback and at the R6-B, we have a twenty-six foot setback which dimensionally is really a low roof rather than a setback.

In the rear yard, we provided a ten foot setback from the center property line.

Next slide.

So, this is the summary building and, again, you can see we've located the greatest height on 6th Street. We have setbacks on 5th at the corner and in the middle block and then we've focused on massing the building in the middle so we could stay low on 5th.

This is a view looking north on 8th Avenue. You can see we have a four-story height on 8th with a fifteen foot setback. We also have a bay window at the corner to mark that corner.

This is a view looking down - - excuse me - - looking down 6th Street to the west. You can see the bay window at the corner; the four-story height along 8th and the taller building along 5th, another along 6th.

Another thing that we tried to do in the massing is step down along the slope and you can see that expressed in the base of the building.

This is a view of 8th Avenue and 5th. We have a four-story height at the corner with a cutback right at the corner of the building to match with the height of the buildings adjacent and then we have a twenty-six foot setback in the mid-block. This is a view looking to the east on 5th Street.

We have the high school on the left; a hospital building, medical office building on the right; the parking deck, the existing parking deck; the twenty-six foot setback and then the lower setback on 8th Avenue.

This is the view on 6th Street and you can see on 6th Street what we tried to do is create multiple buildings along the street to not make it one large building in its appearance on the block but really distinguish elements with deep reveals, vertical expression in location - - in locations to make it appear like it's a series of buildings as opposed to a single large building.

This is the complying building looking from 8th Avenue running across the screen and 6th Street looking towards the west.

This building height is the same height that we reach with the proposed building but there is a more significant setback along 8th and along 6th and then this is the view on 8th Avenue and 5th Street looking towards the west. We are the same level of height at that intersection but, again, you see that there is a longer setback along the avenue along the block frontage.

This is looking on 5th Street to the east and this is showing the complying building. This is as if we were to build on the parking deck and you can see a significant

amount of building activity, entrances and circulation would be located on 5th Street if we followed a complying building configuration.

From a circulation standpoint, we spent a lot of time with the community trying to be sure that we disrupted the - - or did not disrupt the circulation pattern that surrounds the neighborhood and to do that, we created a cul-de-sac underneath the proposed building with four hundred feet of curb frontage so we can drop patients off under cover and once they drop off, they can go down to parking or return to 6th Street so they don't impact the traffic as much on the adjacent streets that surround the building.

MS. WAGNER: Hi. Elise Wagner, again. I think we're going to move along in the interest of time so what I'm going to do is just briefly talk about the waivers that are being requested and the findings for the variance and I just want to note just one footnote to Peter's presentation. I think it's important to understand that over a period of seven months, we had a number of meetings with the community and the Community Board and several of the changes that were made to the building in terms of the setbacks on 8th Avenue and 5th Street were in response to comments made and consultation, very positive consultation with the community and the Community Board.

So, as the architects have explained, what's really important here is these large floor plates for the building and I want to talk very briefly about how that relates to the waivers that are being requested here.

So, first, let's talk about - - there are basically five types of waivers. Let's go right to floor area.

In terms of floor area, the floor area that is being requested here is we are not asking for any additional floor area. In fact, the building is about sixty-five thousand square feet less than what would be permitted on the site but what we are doing is moving the floor area from the R-6 to the R6-(b) and R7-(b) districts which is represented on the slide by those arrows.

About 37,800 square feet is being transferred as an aggregate into the R7-(b) and the R6-(b).

The next waiver has to do with lot coverage. As we've said, what's really important here is the large floors.

The permitted lot coverage would be between sixty-five percent and eighty percent depending on the part of the site. Most of the building has a ninety percent lot coverage to create the large floors except for the area that is adjacent to the out parcels and that portion has a lot coverage of sixty-six percent to be respectful of the buildings to the north.

The next series of waivers relate to rear yard and rear yard equivalent. You can see the rear yard equivalent required through the center of the lot.

In addition, a thirty foot rear yard is required in the interior portion of the lot where there is a - - there's a twenty-three foot tall portion of the building here with a ten foot setback, as Peter says, from the adjacent properties and I would note that we received a copy of the submission to the Board from Stuart Klein, which among other things, noted that the one-story structure containing this ambulatory care use is not a permitted obstruction beyond a hundred feet from a wide street.

We acknowledge that he is correct and we have already received an updated set of Department of Building objections noting this non-compliance and we are already preparing revised application materials to the Board to reflect that additional waiver.

Height and setback. This shows the R-6 zone. In fact, on 8th Avenue, we are in compliance in the R-6 zone but - - go to the next slide - - along 6th Street, the building does go straight up to provide those large floors so height and setback waivers, if you look at the left side of the screen, that's the non-compliance in the R-6.

Moving to the right, the R6-(b) is a - - has a maximum building height of forty feet - - excuse me - - fifty feet so clearly there's a significant waiver required in the R6-(b) and, in addition - - go back, go back, the blue area shows not only the height and setback non-compliances but also the rear yard setbacks that are required are represented in that blue area.

And then if you go to the right-hand side, as we noted, we had made some changes in the R7-(b) after consultation with the community and now the R7-(b) portion on 8th Avenue, in fact, is pretty much - - which is in compliance with the R7-(b) except for a small area that goes up to 89 feet but the rest of that frontage on 8th Avenue and the R7-(b) is in compliance.

The last waiver that is being requested is signage. In this district an ambulatory care center would only allow - - would only be allowed to have one identification sign and the building directory. We are simply asking for four signs all together in order - - basically to have signage at the two entrances to the building.

Briefly, I'll talk about the findings required under the Zoning Resolution.

In terms of the first finding, Jeff Brand talked about the fact that this is a u-shaped site on a slope and, also, as we've discussed, as I mentioned at the beginning, the zoning lot includes the entire block and we have the existing garage and the existing building so when you take together the u-shape, the slope and the existing buildings, those unique physical conditions make it very difficult to design a complying building that satisfies the programmatic needs of the hospital, as we've explained.

And, because this is a non-profit teaching hospital, the finding (a) is also satisfied by the showing of programmatic need that we discussed and that Lauren went into detail on.

Finding (b) is not applicable since this is a non-profit.

Finding (c) related to the relationship to the neighborhood. This building would be located on the Methodist campus adjacent to existing hospital buildings so it's not a new use in the neighborhood.

As Peter Cavaluzzi (Phonetic) described, the massing and architectural features have been designed to be compatible with the surrounding buildings incorporating feedback from the community.

And, as I said, we shifted bulk from 8th Avenue to the middle of the block. The vehicular driveway which keeps all the cars internal to the site is something that really is important, I think, in terms of minimizing traffic in the neighborhood and, in fact, originally there was a vehicular entrance on 5th Street.

And, after meeting with people who lived on 5th Street, that side of the building, the building was modified to eliminate the vehicular entrance on 5th Street.

I would also note with respect to the relationship to the neighborhood that the environmental assessment found no significant adverse impacts.

It compared the building to the complying building. As Lauren said, Methodist would build a complying building if the variances were not granted and, therefore, that comparison is appropriate. And, in some cases, the complying building, in fact, is worse in terms of environmental effects than the proposed building.

Because of its inefficient floor plates, there is duplication of support spaces and more staff is needed which would result in more worker trips in the complying building.

As I said, the complying building does not create - - does not include an internal driveway so it would require a visitor entrance on 5th Street resulting in more traffic on 5th Street. And, the complying building also builds over the garage which would lengthen the construction period for the building by about seventeen months and would also require the garage to be closed for about seventeen months which would be a significant - - which would create significant traffic problems in the neighborhood.

Finding (d), the practical difficulties and unnecessary hardship are related to the configuration of the site as they relate to the programmatic needs.

And, finally, in terms of the minimum variance finding.

Methodist and their architects and all of us on the team have consulted with the community over the past seven months to design a building that satisfies the hospital's programmatic needs while maintaining an appropriate relationship to the neighborhood.

This has required the hospital and the architects to identify those zoning waivers that are truly necessary and, as described in the presentation, we have made some

changes so that we really think that this building is satisfying those needs and really using every square inch as demonstrated in the floor plans that Jeff showed you.

I would also note that in terms of minimum variance, we're not exceeding the permitted floor area and the building really encroaches beyond the envelop in areas that are internal to the hospital campus.

In the areas that are outside the hospital campus, the hospital has, in consultation with the community, reduced those encroachments so as to minimize the encroachments in those areas in the context of the hospital's programmatic needs. That's our presentation.

We would be more than happy to answer any questions that the Board might have.

CHAIR SRINIVASAN: All right. We did have a few questions yesterday. Commissioner Montanez.

COMM. MONTANEZ: Right. My question had to do with why didn't you utilize the existing foundation system above the garage and it's my understanding from the engineer's letter that if you went more than five floors, you would have to do structural retrofits but it could support a few floors.

And, you know, especially in looking at your second floor plan, which is basically building support and the fact that your loading dock is on that side of the building like moving, say, your materials management to an area above the garage and just bringing - - basically the goal would be to bring down the height in the R6-(b).

MS. WAGNER: Understood. I'm going to ask Paul Travers from Washington Square Partners to respond to that question.

MR. TRAVERS: Hi. Paul Travers, Washington Square Partners. So, yes, you are correct. You could build up to five floors above the garage. You need some structural reinforcement.

The garage in that circumstance is probably closed for about two months which is not the end of the world, obviously.

Anything above that, as we said before, would take seventeen months.

The issue with using the garage is because of where it's located, in effect, you go back to something very similar to a complying building. You don't have two separate buildings.

The reason for that is because of the way the site is set up. The only place you can put the surgical floor and the recovery floor is in the west wing. That, in effect, means you cannot break through so the only way to access the garage would be to go back to grade and go up through a separate core.

So, you could create a separate building on the garage site and you could, as you said, move some activities into that separate building but it goes back to the same type of issue we have with a complying building as you are no longer meeting the modern, efficient model that we're trying to do.

The other issue that I would mention, just as a side issue, is you actually need another waiver to create an efficient floor plate on the garage site because you're right in back of Wesley House which has a residential use.

So, you would actually have to get a waiver to build the building. You would want to build on the garage site, albeit, it would still, in effect, operate as a separate building in effect.

COMM. MONTANEZ: So, the Wesley House doesn't have a rear yard?

MR. TRAVERS: It does but just to create a big enough floor plate on the garage, you would want to go into the sixty foot rear yard.

COMM. MONTANEZ: I'm not talking about putting activities over the garage. I'm talking about putting support areas over the garage; like the building's - - the material's management.

MR. TRAVERS: Right.

COMM. MONTANEZ: Your whole second floor is all support activities.

MR. TRAVERS: Right. They are support activities, though. But, all that activity is going up and down. See, I think the key for us is all that activity that is on the second floor is allowing things to go up and down in a single elevator to either the West Wing or to the East Wing.

Once you separate it into a separate, they will be building - - what you are in effect doing is replicating the current hospital where goods and services are constantly being moved from one building to another. It's under cover, obviously, which is nice but there's no way to create a space where you can connect in the first five floors.

Ironically, if you build a taller building and decide you are going to close the garage for seventeen months, you could connect on a higher floor from the building we propose into the garage.

COMM. MONTANEZ: So, with the loading dock over on the west wing - -

MR. TRAVERS: Right.

COMM. MONTANEZ: - - you have to move all your materials all over to the east wing, how do they get there?

MR. TRAVERS: They go underneath. Jeff.

MR. BRAND: The beauty of the West Wing is that all the heavy duty things are there like surgery and the infusion centers on that side of the building. So, really, you - - and the clinics, the institutes which are on both wings, don't have a lot of things to them. They really don't have much clean linen. There's not much medication. There's not much supplies. It's really about surgery in the lockers. So, the lockers, the prep and the surgery all work together and that's the biggest user of material's management in the building. Is that answering your question?

COMM. MONTANEZ: I still have some questions regarding - - say you put one floor above the garage and you use that for materials services, you're not able to transport that material over to the east wing?

MR. TRAVERS: You could. You could. But just understand there's now three issues. Number one is you're going to have to go down to grade and come back and then go over time. It's amount of time and time is obviously money.

The second issue is that you have to close the garage, albeit for a small period of time but still it's very disruptive to both the operation of the hospital and to the neighborhood as a whole. And, the third is it's more expensive. In other words, now you're building another building. You have more floor area. You have more surface to cover. You have more façade. You are just building a more expensive building. I think

the goal of this building is to try to be as efficient and inexpensive as we can within the constraints of what is already a U-shaped site. But, I think the real goal here is to be efficient in every way that we can.

MR. BRAND: I would just add that the surgical suite is really a sterile barrier so you really have three levels of that; recovery, surgery and the locker room. You really can't go across it because then you're - -

COMM. MONTANEZ: I'm not talking about going across it.

MR. BRAND: Right. Okay.

COMM. MONTANEZ: All right. Any other questions?

CHAIR SRINIVASAN: I thought the presentation was very helpful. I think with the color coding and the fuller explanation about the uses on each floor, at least for me, I thought that answered quite a few questions that I had.

And, I had noted an issue about the - - I think the sixth and the seventh floor and I think Commissioner Hinkson had noted that as well and I think that in this presentation and explaining that's really - - I think on the 6th floor it's the Cancer Center - -

MS. WAGNER: Cancer Center.

CHAIR SRINIVASAN: And, the 7th floor is - -

MS. WAGNER: Woman's health.

CHAIR SRINIVASAN: Woman's health. That at least, now, I have a better idea why you have those dimensions at that level.

But, I had a very - - it's a small question; sort of minor in the scheme of this fairly elaborate project is just on the mechanicals because that takes up, I think, about maybe

about twenty or thirty feet and it seems the mechanical is actually set back and I was wondering - - it's a screening wall and whether one needs that because it does - - maybe Peter can answer that question but it seems to create bulk at street level but it's not really space behind that.

MS. WAGNER: You're talking about the mechanical screens at the top of the building.

CHAIR SRINIVASAN: Yes, exactly.

MS. WAGNER: Okay. Very good.

MR. CAVALUZZI: So, we've located the mechanical spaces on 6th Street as far as we can from the adjacent neighbors and then they are screened all the way around and it does create additional height but there are setbacks from the building edge that mitigate the visibility.

CHAIR SRINIVASAN: Right. I'm just looking at the drawing, too. Yes. So, in the R6-(b) portion, there are those buildings that - - the footprints of those buildings at the higher level are much smaller but you have the screening wall that extends over the perimeter, right. And, I'm just wondering whether the screening wall can be set back further because in some of the other renderings, that screening wall is almost flush with the sixth and seventh floor even though it's setback but it creates a lot more bulk and if, in fact, that sets back maybe, I don't know, how many feet - -

MR. CAVALUZZI: Right.

CHAIR SRINIVASAN: And, this becomes evident, the grade portion right on top where the back can be set back.

MR. CAVALUZZI: So, where it's possible what we're showing you is we're at schematic design and all the mechanical equipment has not yet been fully designed but usually you end up needing more space rather than less space but we will certainly look at ways to tighten that up to the extent that we have.

CHAIR SRINIVASAN: Yes.

MR. CAVALUZZI: I did want to point out, again, the total setback from the street property line is twenty-six feet here and then this is an additional ten feet so the illustration shows that street wall thirty-six feet back from the property line.

CHAIR SRINIVASAN: Okay. And, I think you said the also building sets back. Doesn't it set back five feet?

MR. CAVALUZZI: Yes, five feet in the back.

CHAIR SRINIVASAN: So, we're talking about - -

MR. CAVALUZZI: The five feet is included in the twenty-six. So, it's twenty-one feet plus five.

CHAIR SRINIVASAN: Okay. Commissioner Hinkson and then Vice-Chair.

COMM. HINKSON: Yes, just to echo a question and, I think, Peter, you can answer this for me. In your description of the ground floor entry, it wasn't clear to me. Are you saying that cars can pull up and if they so choose they can go to the garage internally on that level or do they have to exit and then enter the garage in a different manner?

MR. CAVALUZZI: (Inaudible). So, a visitor would come in and drop in along this edge and once they're dropped off, they can either exit and go back home or go down into the garage.

COMM. HINKSON: And, is that the only entry to the garage or is there an external - -

MR. CAVALUZZI: There's another entrance to the garage that currently exists and the garages are connected.

COMM. HINKSON: Right.

MR. CAVALUZZI: So, it's possible to enter in that other location but, you know, the way this is laid out - -

COMM. HINKSON: But, that's the predominant entry into the garage?

MR. CAVALUZZI: Right.

COMM. HINKSON: All right. Thank you.

VICE-CHAIR COLLINS: I just had a brief question. You conducted the rear yard waivers. If you can just briefly take me through it. I know in one part, you're really only impacting on yourself, if you will, but I wanted to - - yes, there we go. But, the lots that are outside the project, those residences there, what is the current rear yard situation and what's it going to be with the construction of the building?

MS. WAGNER: On those lots or on the hospital property?

VICE-CHAIR COLLINS: On the hospital property.

MS. WAGNER: On the hospital property, if someone knows the answer to that come up. I'll tell you about the proposed.

VICE-CHAIR COLLINS: Okay.

MS. WAGNER: Because we acknowledge that on those lots, themselves, they do not have much rear yards.

VICE-CHAIR COLLINS: They don't have complying rear yards.

MS. WAGNER: They do not have complying rear yards. As a result of that, a decision was made early on to provide a ten foot setback there in any case for those buildings.

VICE-CHAIR COLLINS: Okay.

MS. WAGNER: And, then, the portion that is to the south of that is a twenty-three foot portion of the building and above that, the building then sets back to the south of that.

VICE-CHAIR COLLINS: Right. So, the twenty-three foot - -

MS. WAGNER: Is within the rear yard.

VICE-CHAIR COLLINS: Okay. All right. Thank you.

CHAIR SRINIVASAN: So, we'll open up the testimony. I believe. Are there speakers here from the elected official's office? Yes.

MS. WAGNER: I believe, as I understand it, there's no one here actually from the elected officials although we have some letters from them but if we could have the Chair of the Community Board speak since he's here.

CHAIR SRINIVASAN: Yes, please.

MR. KUMMER: Good afternoon, Madam Chair and Commissioners. My name is Daniel Kummer. I'm the Chair of Community Board #6.

We submitted a lengthy letter to the Board and that states our position in detail with respect to our conditional recommendation of approval. I just want to stress a few sort of more overarching points and focus on what I see as the principal remaining outstanding issue which is the first thing I want to stress is that our recommendation of approval is conditioned. It should not be interpreted as an outright blessing of the project by the Community Board.

It was burdened by a total of eleven conditions. I'm not going to go over those conditions in detail. I'm happy to answer any questions that there may be about them. I want to stress really with respect to the first three conditions that pertain to the zoning lots, the overarching principal that is behind them which is really - - which really stems from the 2003 zoning, rezoning of Park Slope which attempted in quite dramatic fashion to cap the heights of buildings in the residential portions of our neighborhood in Park Slope.

There was a balance struck in that rezoning, particularly as it pertained to the hospital. The hospital was carved out to a large measure but not to the full extent of its property ownership in the immediate surroundings. And, a line was drawn down the middle of this block and we think it's - - having studied the map, we think it's unique in respect to the rezoning that it was this particular block, you could call it ground zero but there was a line drawn down the middle on an east-west basis between the north and south portions.

And, on the northern portion and particularly in the northeastern portion, significant zoning limits were imposed in terms of height and setback, you know, in the R7(b) and R6(b). And, so, we really bore that in mind as we were analyzing this project and, at the same time, we were mindful of the fact that the Department of City Planning and City Planning Commission had expressed intent to accord the hospital some degree of flexibility within its own campus for future development.

And, we think our recommendation of conditional approval strikes the balance between those two aspects.

We attempted to give them - - accord them some lateral flexibility. We recognize that they've certainly made the case with respect to the need for these larger floor plates so in terms of giving them some additional lateral bulk on the 6th Street side and in the rear yards, that's one thing. But, in terms of essentially letting them blow through the height limits in the R7(b) and R6(b) districts, that's where our Board drew the line and before the last presentation we had from them, we were told that the R7(b) section had essentially been brought down to complying height and setback.

I learned today for the first time that that's not completely the case but there's a portion and all I can say to that is our recommendation stands. We would like to see the R7-(b) be respected throughout that; that zoning lot. And, then, so really the outstanding issue is the R-6 portion of the mid-block on 5th Street.

And, you know, we give the hospital credit for adjusting its plans throughout our community review process. They haven't done a take it or leave it approach but where it stands now is not where the Community Board would like to see it.

In the R6-(b) portion, we recognize that there are challenges in bringing it all the way down to complying heights and that's why we didn't phrase our recommendation in that respect and I'm not a hospital architect but we think they can do more and particularly with respect to the programs that are slotted for the upper floors.

My reaction to that is they're nice to have. They're not necessary in the same way, certainly not to the same degree as the surgical facilities in terms of the case they made for need and for the size on the lower floors.

So, if those upper floor programs had to be shifted to another building, I recognize that the hospital would not be happy with that and maybe would be somewhat less efficient ambulatory care facility but it would not be the end of the world and it would mean a lot to the community to bring those heights on 5th Street down to complying levels.

I mean, this building, whether it's built as-of-right or pursuant to these variances, it's going to loom over our neighborhood one way or the other and we recognize that.

But, those height limits and setback limits were designed and the balance was struck to mitigate that effect and we think that they should be respected to a significantly greater degree than they have today.

So, with that said, I would otherwise rely on our letter to set forth the other conditions that we imposed, most of which the hospital is already committed to meet and I'm happy to answer any questions.

CHAIR SRINIVASAN: Are there any questions?

I have a question, Mr. Kummer, about the west - - the R7(b) district, they did make a presentation that for the most part, it does comply so there's really a very small portion

that doesn't comply and it's towards the R-6 so I know that you're very definitive. That you want it to be within the envelope and I can understand the reasons why. It was a very fine-grain rezoning that took place in 2003.

MR. KUMMER: It was and to build that portion of the building, they're tearing down five brownstones which are not landmarked.

CHAIR SRINIVASAN: Right, right.

MR. KUMMER: There's nothing we can really do to prevent that but they're replacing it with a structure that at least in terms of height and setback, we think should comply and, honestly, it was represented to us that in that section, it was going to be fully compliant.

CHAIR SRINIVASAN: Right. But, it's worthwhile taking a look at just to see what that departure is and it seems - -

MR. KUMMER: I'll take a look at it. Again, I learned about it for the first time today. I would be happy to.

CHAIR SRINIVASAN: And, in the R6 (b) - - well, the community just, if you could remind me, the Community Board's recommendation was not as definitive in terms that it should meet the envelope but you - -

MR. KUMMER: I'm sorry to interrupt.

CHAIR SRINIVASAN: You go ahead.

MR. KUMMER: At the time, honestly, our conversations were ongoing about that.

CHAIR SRINIVASAN: Okay.

MR. KUMMER: And, so there was - - the community, in our resolution, we expressed it more in conceptual than definitive terms but we did expect to see if there was going to be an effort to comply with that condition a significant drop in the height and we haven't seen that yet. We would like to see that.

CHAIR SRINIVASAN: Okay. Thank you. All right. Yes, Mr. Klein, just one minute, please. Yes, you're here to speak from the elected officials?

SPEAKER: Yes.

MR. KLEIN: I'm sorry. I'm sorry. Go ahead.

CHAIR SRINIVASAN: That's fine. Mr. Klein, you'll get an opportunity soon enough.

MS. HILL: Hi. I'm Lynn Hill. I'm Vice-President for Communication and External Affairs at New York Methodist Hospital. Thank you very much Commissioner and Commissioners for allowing me to speak.

I would like to read just some excerpts from - - statements that our elected officials have given me because they are not here today.

CHAIR SRINIVASAN: All right. You are not representing them?

MS. HILL: I am not representing them.

CHAIR SRINIVASAN: So, I think in that case, why don't we let Mr. Klein go forward and then you can also submit that into the record but - -

MS. HILL: Yes. I will submit it but I was just going to read some excerpts.

CHAIR SRINIVASAN: Mr. Klein. I understand you've asked for five minutes so we'll give you that.

MR. KLEIN: I'll speak quickly.

CHAIR SRINIVASAN: Okay. Thank you.

MR. KLEIN: Good afternoon, Madam Chair, Commissioners. My name is Stuart Klein. I represent the Preserve Park Slope Corporation which is an organization composed of Park Slope residents opposed to this application in its present form.

Before beginning my formal presentation, I had a comment on one or two of the statements made today.

There was a great deal of conversation - - a great deal of talk, rather actually somewhat (Unintelligible) in the nature about a complying building but, yet, in the course of the presentation, there was an admission that the complying building is, in fact, not complying.

So, then they went back to speak about the complying building and they're going to be going forward with the complying building which, in the prior sentence, they admit is not complying. So, I'm somewhat rather confused by all of that and I suggest to you that if there is, in fact, no complying building, it can't be used. Their ideas cannot be used as a baseline to determine all of the environmental issues and all of the parking and driving issues. They have to start all over again, essentially.

CHAIR SRINIVASAN: Right. My understanding is that you raised the issue about the rear yard and that beyond one hundred feet from corner you cannot have a rear yard.

MR. KLEIN: That's correct.

CHAIR SRINIVASAN: I think they're planning to readjust that.

MR. KLEIN: Well, they're planning to - -

CHAIR SRINIVASAN: Well, the issue about - - and we understand - - I agree that if that changes the complying development, then it needs to be reanalyzed. It may be a smaller development. It may be somewhat different in its configuration and we'll ask them to do that. I don't think it necessarily means you have to start from the beginning.

MR. KLEIN: Well, no, I disagree and I disagree with some caution because if you remember what I also said was many of the numbers were missing from the those plans so it was hard to determine if, in fact, there was any other non-complying issues so if we could possibly get those plans and take a look at it and see if, in fact, there are other levels of non-compliance, I would appreciate it.

But, it seems like it should have been caught. It should have been caught early on and I don't quite understand why it had to wait until my submission in order to discover that.

Several members of the community will speak today, many of them expert in this area and several have submitted letters. I believe we have had a total of about three hundred objectors, all submitting sworn affidavits or affidavits, rather, objecting to the project in its current iteration.

Please understand, we're not opposed to the expansion of Methodist Hospital. What we are opposed to or what the community is opposed to is this level of expansion.

And we seemed to have, in the course of your inquiry, you seem to have forgotten the requirements of the Cornell decision which the principal core of the Cornell decision is that there be needs, programmatic needs and while they have used the words needs again and again and again, they have not explored what those needs are. In fact, I don't think it was a verbal slip. Ms. Wagner said possible needs. Well, you either have needs or possible needs. It can't be both but you also have a basis for those needs.

And, there has been no statement whatsoever in the five or six hundred pages they have given you as to why they need this particular space; why they need these institutes and why, more importantly, they need them in this particular location.

It's palpably deficient. The record is palpably deficient with regards to the programmatic needs that actually exist to the institute.

Now, I'm disturbed by something else and that is in the course of this application, New York Methodist Hospital will have to apply for a Certificate of Need from the Department of Health.

In order to submit that application, you have to do surveys. You have to do studies. You have to do a great deal of work covering demographics; environmental issues, parking issues; everything else.

I cannot believe that New York Methodist planned this mega-structure, this 400,000 square foot addition to a historic neighborhood without any studies being performed. And, they have not shared those studies with the Community Board.

They have not shared those studies with the community and they have certainly not shared that study with you.

I respectfully submit that in the Columbia University case, 113-06-BZ, this very same law firm submitted a detailed programming study conducted by outside consultants to establish their need.

In 163-12-BZ, NYU, the same applicant's attorney, submitted a detailed study showing its need.

Other similar variances throughout Manhattan have shown, have given you detailed studies showing the need. All we have here is the expressed statement we need these things without any basis for why those needs exist.

With regard to the topography - -

CHAIR SRINIVASAN: All right. Mr. Klein, your time is up.

MR. KLEIN: Well, with all due respect, Madam Chair - -

CHAIR SRINIVASAN: I'll give you one more minute.

MR. KLEIN: Well, I will try but I will probably need more than that.

With regard to the slope. If you remember the Sloan application, 183-11-BZ, they quantified the amount of money it was going to cost, the cost of the topographical infirmities at that site.

The Board has consistently required that. In fact, in the Lafayette case, I believe it was, the Court of Appeals said you have to reduce that to hard numbers. It was not reduced to hard numbers here.

Another thing they failed to mention to you is that fifteen century old buildings are going to have to be destroyed to accommodate this monstrosity. And, I don't quite understand how that can be countenanced by the Board.

Francis Marone, (Phonetic) a noted architectural historian, in a letter dated February 6th which was submitted to the Board said I see no recognition on behalf of New York Methodist Hospital whatsoever on the part of the hospital planners that this expansion is to take place in a rare and magnificent setting.

Other people will speak today with regard to how much of an imposition is this going to be?

I don't how you can have a hundred thousand new people and four hundred thousand new square feet of space come into this neighborhood and not materially and negatively impact it.

And, finally, the one thing that I'm truly disturbed was not discussed and that was alternate variances. There is no minimum variance submission here and that's a major failing in this application.

We are prepared - - we have a list of professionals, very highly regarded professionals in the area who are willing to sit down with these people or do it independently and come up with a separate and distinct plan minimizing the size of this building and, yet, which will have the ability to accommodate each and every one of these needs assuming they, in fact, do exist. Thank you.

CHAIR SRINIVASAN: Thank you, Mr. Klein. Are there people here to speak on this item? Each person will be given three minutes. Yes. You will be given three minutes and the buzzer will go off.

MR. VICKERS: Madam Chair, Commissioner, I'm an attending Research Methodologist at Memorial Sloan Kettering Cancer where I work in the Division of Health Outcomes, a field of study that exams how the organization of health systems leads to differential effects on patients.

MR. COSTANZA: Please state your name.

MS. MATIAS: State your name for the record.

DR. VICKERS: Andrew Vickers; Dr. Andrew Vickers, yes. I'm also a professor of Public Health at Weil Cornell Medical College at Cornell University; the academic institution to which New York Methodist Hospital is affiliated.

I have numerous concerns about Methodist's plans and as a Brooklyn resident, I find it unconscionable that we expand medical facilities in the wealthiest neighborhoods while closing those in the very poorest areas of our borough.

Second, I have grave concerns about Methodist's strategy and its relationships to neighboring community. Their approach has been give us what we want or we will build a complying building that is far worse for us and far worse for you.

I can say that in my twenty years in health research, I have never previously experienced a hospital threatening its local community with mutually assured destruction.

However, I will focus my remarks on the substantive issue of whether Methodist's variance meets the standard for being the minimum required.

The key claim in the application is that Methodist has a programmatic need for adequate and appropriate space for ambulatory care facilities located on its main campus.

I was interested that they made numerous references to my institution, Memorial Sloan Kettering as to why the building has to be designed as it is.

I can say as faculty for fourteen years, I recognized very little of what they said.

Methodist has not shown that an expansion plan is adequate and appropriate.

There has been no clear set of arguments justifying the size of the expansion or explaining why a smaller expansion would be inadequate. Indeed, when the hospital presented its case to the Community Board all we were told was a list of anecdotes about family members of hospital staff being treated.

Second, Methodist claims that the new facilities need to be located on its main campus.

There is no specific medical rationale given as to why all of the new facilities cannot be geographically separated from the existing site. One's such rationale might be, for instance, if the procedures to be in the utility rooms had non (Unintelligible) of patients that would require urgent care.

In our city, it is very much the rule rather than the exception that hospitals have geographically separated units.

At Memorial Sloan Kettering, for example, the main campus is at York and 68th Street. The main site for out-patient chemotherapy is at 53rd Street and Lexington Avenue and the breast center is at 64th Street and 2nd Avenue.

At New York University, the medical center's main campus is at 1st Avenue between 30th and 34th Street and prostate cancer is four long blocks away on Lexington Avenue.

The campus ranges from 38th Street to 17th Street.

I've been involved in the development of new facilities at Memorial Sloan Kettering and we carefully consider a host of medical factors in choosing where to site the building.

For instance, our new surgical center is six blocks away from the main campus and this was deemed appropriate in terms of the - - can I have another thirty seconds

CHAIR SRINIVASAN: I'm sorry, I'm sorry. Your time is up.

DR. VICKERS: Can I make a concluding sentence?

CHAIR SRINIVASAN: A concluding sentence; one concluding sentence.

DR. VICKERS: Much of the 400,000 square feet requested by Methodist is for doctor's offices. It (Unintelligible) belief that Methodist cannot site those physician's offices away from campus if Memorial Sloan Kettering can locate a surgical facility away from main campus.

CHAIR SRINIVASAN: Thank you, thank you.

DR. VICKERS: So, the variance clearly and evidently does not meet the criteria being the minimum necessary.

CHAIR SRINIVASAN: Okay. Next speaker. I would ask all speakers to just respect when the bell goes off and - -

SPEAKER: I'll try not to speak more than Methodist did.

(UNIDENTIFIED SPEAKER) (Inaudible)

DR. CIPOREN: My name is Dr. Marvin Ciporen (Phonetic) and I have lived in Park Slope for forty-one years and like of my neighbors,

we all want the strong, healthy hospital. We understand its needs to expand. However, it's the wrong plan. And, as Ms. Wagner actually made the case for us as did Chairman Kummer, over the last number of months, the plan keeps changing and evolving but only because pressure has been put on them to add some specificity to a plan.

When they first came to the Community Board meeting, they were asked about what their plan is and for numbers to justify the expansion. They never gave any data and what, in fact, one of the representatives explicitly pointed out is that for them the building was the plan. That's (Unintelligible) backwards. There is no plan. It doesn't fit into the community and what I wanted to also point out is the things they neglected to mention.

While it's true that medical needs change, they might also mean that less space is needed rather than more.

Each of you have smart phones that have more computing power than we had when we sent people to the moon.

So, there's no reason to necessarily expect that you're going to need more space.

The United Hospital Fund Study had written an article explaining that the drive for maximizing fee for services drives unnecessary and unneeded development and that's exactly what this plan is about; that what New York Methodist is doing is trying to build something that is too large at the wrong place and that will cost more.

What they haven't told you, they talked about reaching out to other parts of Brooklyn.

What they've neglected to mention is they've done a horrible job in terms of serving the most vulnerable people in Brooklyn while in the last decade, they increased

the number of Medicaid patients they serve by sixty-seven percent just in our Community Board, which as Andrew pointed out, is a wealthy one.

The number of people on Medicaid increased by 115 percent and the number of people on Medicaid in Brooklyn increased by 276 percent. So, they're not looking to serve the poor. They're looking to serve their own bottom line and that's why they're looking to build a building that's non-contextual. They're trying to put a building in with a phony traffic study that no one who lives in the community recognized that didn't use the accepted methodology that neglected to account for the thousands of children that walk by the building in the construction zone. They neglected to talk about the increased truck traffic not only in construction but I'm going on - -

CHAIR SRINIVASAN: I'm sorry your time is up.

DR. CIPOREN: I'm going to wind up in a second. They neglected to talk about the fact that cars circle multiple times when they come by. In a democratic capitalistic society - -

CHAIR SRINIVASAN: I'm sorry. Your time is up.

DR. CIPOREN: This is my last sentence. In a democratic capitalistic society, we have rules and regulations and agencies like the BSA to make people think about the common good, not just the good of an institution. They can build over the garage that can make it better and cheaper.

CHAIR SRINIVASAN: Excuse me, sir, the next speaker, please.

MR. KLEIN: (Inaudible)

CHAIR SRINIVASAN: No, not right now. I'm sorry, Mr. Klein, you'll get a chance. Yes. The next speaker.

MR. ABRAMSON: Madam Chair, Commissioners, I'm a long-time Park Slope resident and a licensed architect who has spent forty years devoting a professional practice to old and historic buildings including nine as Chairperson of the City of Newark, New Jersey's Historic Preservation Commission.

MR. COSTANZA: I'm sorry, sir. State your name, please.

MR. ABRAMSON: I'm sorry. David Abramson.

MR. COSTANZA: Thank you, sir.

MR. ABRAMSON: Thank you. I'm sorry. Based on my review of the materials submitted by Methodist Hospital, I urge the variance be denied. I provided a detailed letter to you which I'll summarize briefly and, if time permits, hope to summarize a few things from other experts who submitted letters also but were unable to attend.

A consistent observation of all of us is that the proposed architectural design is inconsistent with the character of the historic neighborhood; poorly conceived, wrong for Park Slope and the variances should be denied.

The design of the proposed building alters the essential character of the neighborhood which is inconsistent with the criteria for granting a variance and with the commitment made by Methodist Hospital, the memoranda agreement dated September 15th, 2009 between Methodist Hospital and the Park Slope Civic Council and Community Board to endeavor to make every effort to preserve and add to the sense of place as defined by the Landmark's Commission; a sense of place, among other things; in this

neighborhood and the project area is characterized by virtually uninterrupted building fronts; set back areas; distances from the property lines including single-family row houses, apartment buildings, churches and even the hospital's own historic 8th Avenue building is set back.

The proposed building is built to the property lines on both 8th Avenue and 6th Street which destroys one of the key neighborhood historic district characteristics.

The proposed building lacks the myriad of details that enrich the neighborhood's buildings.

The essential sense of place in the neighborhood is defined by sky viewed over modestly scaled buildings. It's feature is interrupted only in one location within the project area at the hospital's own Wesley House.

The additional massive building height sought through the variance which proposes areas significantly taller than Wesley House and which have been continuously described in all the community meetings as eight stories, 154 feet tall, would significantly alter the character of sky over building. It would cluster two behemoths adjacent to each other.

The hospital's arguments against the building; the building complying design appear to be the result of a self-created hardship.

The information submitted by the hospital's own engineer indicates that the design was - - the garage was designed to support five additional floors as the Commissioners have pointed out.

The hospital made a clear design choice. They cannot claim now that structural reasons preclude the complying design.