

PROTECT THE VILLAGE HISTORIC DISTRICT

(A Project of Open Space Institute)

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PVHD'S COMMENTS ON ST. VINCENT'S JULY 15 AND JULY 23 RESPONSES TO QUESTIONS FROM THE LANDMARKS PRESERVATION COMMISSION

Protect the Village Historic District respectfully submits the following comments on the Responses of St. Vincent's Catholic Medical Center dated July 15, 2008, to the initial Questions posed by the Landmarks Preservation Commission and to those dated July 24, 2008, directed to the LPC's Supplemental Questions.

PVHD Comments of Responses of St. Vincent's dated July 15, 2008

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

For the first time in this proceeding, St. Vincent's has injected the location of its **Cancer Center** on West 15th Street as *the* compelling factor is why it cannot look beyond the Village or a small area above it for an alternative site for the new hospital. This is very odd. If the Cancer Center location is such a serious concern, why did St. Vincent's wait until now to raise it? The answer is, apparently, that it is not all that important, and it is certainly not decisive.

This is clear from the history of the Cancer Center, which is located at 325 West 15th Street – not in the Village and well over 250 yards from the O'Toole Building or the East Campus. The Hospital opened the Center in 1999, without any problem then or for the next nine years. However, for reasons St. Vincent's has not explained, sometime in 1997, the regional office Center for Medicare Services notified the Hospital that the Cancer Center did not qualify as an “on-site provider-based department” because it was over the 250 yards from the main campus. While the implications of that disqualification are not clear (given that it was not a problem for nine years), St. Vincent's appealed the ruling to the Health and Human Services Appeal Board and the Board reversed the decision this past February. In doing so, the Board did not say that the Cancer Center had to be no more than 327 yards from the main campus, as St. Vincent's purported was the case in its answers to the LPC's questions. To the contrary, it said that distance was only one factor to be considered in whether a particular facility qualified as “on site” department. It is perfectly clear from this decision that the Cancer Center could be 400 feet or 500 feet or even more from the main campus and would still be qualified.

If it were otherwise, of course, St. Vincent's would presumably had had to disqualify the O'Toole site from consideration for a new tower, since until February 2008, it was beyond the permissible 250 yard boundary. Of course, the Hospital never mentioned this to the LPC or anyone else.

Again, we note that the implications of the initial “disqualification” are far from clear. Assuming there would be some kind of money penalty, we do not know how much this would be or whether it would add up to any substantial sum. Nor do we know what kind of impact, if any, this might have on feasibility – an issue St. Vincent’s has refused to make a subject of its hardship application. Unless and until the Commission (and the public) better understand the consequences of the new hospital tower being located a substantial distance away from the Cancer Center, there is no basis for accepting the Hospital’s limited its search for alternatives to the 327 yard radius that Massey-Knakal used in its so-called study.

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

Here, again, St. Vincent’s relies on the purported Federal distance criteria to explain its limited search for alternatives. For the reasons noted above, this reliance is unjustified.

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?

St. Vincent’s asserts unequivocally that given the recommendation of the Berger Commission to close Cabrini and the NYS Department of Health’s swift adoption of that recommendation,

“[I]t is beyond doubt that any proposal which suggests a new acute care medical/surgical hospital on the Cabrini site will not receive NYSDOH approval.”

Despite this, St. Vincent’s has moved 85 psychiatric inpatient beds to Cabrini, continues its ongoing operation of inpatient hospice beds there and more recently, due to a fire at the Coleman Building, has transferred a number of other inpatients to Cabrini on an interim basis. At the very least, this should cause the LPC to pause and not accept St. Vincent’s unequivocal assertion at face value.

The fact is that the Berger Commission report focused primarily on hospital overbuilding and the duplication of unnecessary facilities. Many other issues – not least of all, impacts on historic districts and historic preservation – were simply not a part of its deliberations. The Commission did say St. Vincent’s needed to upgrade its facilities, but it did not prescribe how. Nor did the Commission address building a new hospital on the O’Toole site or pass judgment on whether Cabrini might be used on an interim basis as St. Vincent’s renovated its existing campus. The possibility that this might save money by making fuller use of a hospital complex that now stands largely empty but must be kept open to support St. Vincent’s psychiatric inpatient services might have been of interest to the Commission, one of whose central goals was, after all, to moderate the increasing costs of health care. But we do not understand that to have been a possibility that was brought to its attention. Nor, so far as we are aware, has possible interim use of Cabrini been discussed with the NYS Department of Health (other than St. Vincent’s dismissing it out of hand).

The reality is that if St. Vincent’s “hardship” application is denied and it decides that its best course is to renovate the East Campus buildings, it will utilize Cabrini as an interim facility to the degree that it assists in the renovation process, just as it has elected to use

Cabrini for its hospice and psychiatric services. Indeed, with that last commitment already being made, one can confidently expect that St. Vincent's will make increased use of Cabrini in any case. Otherwise, the carrying costs would simply be too great.

At the July 15 public hearing, Mr. Amoroso threw in two further arguments against using Cabrini. This first was the Berger Commission finding that the East Side was overly served by existing hospitals and that is why they recommended closing Cabrini. The second was that the other East Side hospital would be up in arms over any effort by St. Vincent's to shift its operations to Cabrini. As to the first assertion, this is presumably true, but that has not stopped St. Vincent's from placing its psychiatric and hospice patients at Cabrini. Moreover, PVHD is not suggesting that St. Vincent's establish a permanent medical/surgical presence at Cabrini, but rather that it be used on an interim basis only. As for the opposition of other East Side hospitals – if it were true – the fact that the use of Cabrini would be on an interim basis only would have to moderate their concern. Even more importantly, the interim use of Cabrini would be to service St. Vincent's historic catchment area and thus would not be in competition with the other East Side hospitals. Indeed, they might well see more patients rather than less, since some patients that would otherwise use St. Vincent's in the Village would probably end up at NYU or Bellevue or Beekman Downtown.

We are not hospital experts, and we have no hospital experts to consult with – none have been willing to be involved in refuting St. Vincent's claims lest their businesses suffer. But on their face, many of St. Vincent's claims are so self-serving, and in a large number of instances, so defy common sense, that it is incumbent on the Commission to find and retain experts who can evaluate the situation on an independent basis. This will be hard to do for the same reasons PVHD has been unable to hire anyone to work for it, and if it is not possible, then the Commission would well serve the public to bring the State Health Department into its process and allow it to answer the key questions, rather than relying on St. Vincent's second-hand assertions.

4. Has St. Vincent's explored merging with another hospital?

In two lengthy paragraphs that beat around the bush, St. Vincent's answer is “no.” The Hospital states that during its bankruptcy process, no other systems were willing to entertain “significant” discussions regarding a merger. However, we understand that at least one other hospital was interested in taking over the East Campus facilities, which might have led to a merger if St. Vincent's had not rejected the approach. It is also unclear how the Hospital defines “significant.”

St. Vincent's recurs in its answer to the Berger Commission, asserting that the Commission “determined current needs and future demands required that St. Vincent's Hospital remain **as currently organized** and undertake significant capital investments so that [it could carry out] 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.” While we are not wholly familiar with the Berger Commission Report, it defies common sense that the Commission would insist that an institution remain “as currently organized” if other options, including merger, were financially or operationally more advantageous. The fact is, we suggest, that St. Vincent's has not

explored merging with another hospital because it wants to maintain its own Catholic identity, not because the Berger Commission was against it.

5. What additional land would be required to build a new building on 6th Ave and 15th St, and [what is] the feasibility of acquiring such land? . . . Can land across the street from the 15th St. site be purchased, if not the land directly adjoining the site?

The bottom line here is that in order to provide floor area equivalent to what it is proposing to build on the O'Toole site, St Vincent's would have add approximately 10,000 square feet adjacent to its existing Staff House site. This would not only allow it to duplicate the hospital tower at O'Toole, but would also provide the space needed for materials handling and oxygen storage, which now takes place on the Triangle. (If materials handling took place at a nearby site – possibly across the street – the additional square footage required would be even less).

In order to secure the additional 10,000 square feet, St. Vincent's would have to acquire properties that extended an additional 52 feet westward – a very short distance on a block that measures some 800 feet. It would involve four parcels at most, and very likely, only three. The Hospital expresses concern about the uncertainties of an assemblage, but this would be a very modest assemblage indeed. Moreover, if it was necessary, the City or the State could exercise their powers of eminent domain, which is done often enough to resolve holdout problems for large commercial developments (e.g., Atlantic Yards, the Bank of America Building at One Bryant Park, etc.). For a project that most elected officials have described as essential, the use of eminent domain – if it were even needed -- would be no stretch in this case. And the benefits would be substantial, since the new tower would be erected outside the Historic District and would not constitute a dangerous precedent. In addition, the presence of the Foundling Hospital across Sixth Avenue, as well as a few undeveloped parcels in close proximity to the Staff House, would offer further options.¹

PVHD is not advocating that the 15th Street site be used, but are rather pointing out how St. Vincent's has obfuscated the feasibility of this alternative. We believe that there are many responsible alternative sites, including others further west that would have virtually no impact on existing residential areas, as well as the rehabilitation of the existing East Campus. We do not have the expertise, nor should it be our obligation, to establish the feasibility of particular alternatives. That is a burden the Commission should either require St. Vincent's to bear or should take upon itself.

¹ Among the other points St. Vincent's makes in its answer to Question 5 is that it would not be possible, within the existing 30,000 square foot lot size of the Staff House, to have the Emergency Department on one floor. We do not contest that an Emergency Department on more than one floor should be avoided (though we wonder why certain ancillary functions, such as filing and accounting, cannot be separated). But who, beyond St. Vincent's itself, has defined how large the new Emergency Department needs to be? The answer, so far as we are aware, is no one – and that raises important questions. It would be interesting to know, for example, how large St. Vincent's current Emergency Department is – and equally interesting, how large such Departments are in other New York City hospitals. It is very convenient that the Emergency Department St. Vincent's has defined fits into one 37,000 square foot floor on the O'Toole site. We assume that if the dimensions had been 2,000 square feet less, St. Vincent's would have made that work. Where is the dividing line, in short, and how fixed is it?

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 more elsewhere.

While St. Vincent's answer appears to be "no, there is no such requirement," it also suggests it is unlikely the State Department of Health would support relocation other than on the West Side. Whether or not this is so, PVHD has never taken the position that the Hospital should be exiled from the West Side. We believe that Cabrini can and should be used on an interim basis; and we believe that the use of Cabrini for St. Vincent's psychiatric patients demonstrates that there are no firm and fast rules against providing services on the East, as well as the West, Side. But we are confident that are feasible sites on the West Side that can support St. Vincent's continuing to operating in the catchment area it serves.

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

PVHD suggests that as long as St. Vincent's remained on the West Side within the service area it has described (the Battery to 59th Street), its mission would not be changed.

8. For how long has St. Vincent's been a Level 1 trauma center?

PVHD assumes this answer is correct.

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

We assume the financial information is correct. Given the use to which the O'Toole Building was put upon, we find it hard to believe that the only reference in the Hospital's records to the purposes for which it was acquired and renovated was "to make it usable for the hospital." It would seem to us a poor exercise of the trustees' fiduciary duties if the Board never understood or approved the use for the outpatient activities that have occupied it since the renovation was completed. Indeed, in a February 5, 1973 article, The New York Times reported that St. Vincent's was negotiating to buy the O'Toole Building (then the headquarters of the National Maritime Union), rather than building a completely new structure on the Triangle which was "to include ambulatory services, outpatient facilities and a mental health clinic." Since O'Toole was acquired and the other structure never built, we think it is evident that the purpose of the acquisition was to provide space for the services and facilities just described – which happen to be the services and facilities that still operate today.

10. How did St. Vincent's stage construction of the current emergency room?

PVHD assumes this answer is correct.

11. What other hospitals in NYC have undergone major upgrades of their emergency and operating facilities?

This answer by St. Vincent's makes it clear that New York City hospitals can and do upgrade and expand their emergency and surgical hospital facilities through renovation on a

fairly frequent basis. St. Vincent's claims that it would be "cost prohibitive" to follow this approach on the East Campus. However, the Hospital has provided no in-depth evidence that this is the case. Equally important, St. Vincent's is not claiming financial hardship and thus a decision based on the cost of such a renovation would be improper.

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 11th and 12th streets, build the new hospital and then sell Coleman, Link, O'Toole and the triangle site.

After setting up and knocking down two straw men that have nothing to do with the inquiry, St. Vincent's finally addresses the question in subsection (c). Acknowledging that the concept described in the question "may seem appealing" and that "a new clinical platform in the midblock . . . can be designed efficiently", the Hospital nonetheless asserts that there are insuperable problems, including the claim that such an alternative "would cost more than \$1.5 billion, thereby rendering this alternative unlikely to obtain NYSDOH approval in light of the current proposal." To say that these claims are unsupported by evidence would be a considerable understatement. Where is the asserted \$1.5 billion cost documented in any detail, and what independent evaluation by any qualified outside source has been made? The only item in the record that could possibly bear on these questions is the Existing Facilities Report, which is entirely conclusory and does not even address the configuration identified in the inquiry. Moreover, hazarding a guess as to what NYSDOH might or might not do is just that – a guess. If this claim is to be given any credence, the Commission should invite the State Department of Health to testify at a hearing. Finally, the cost claim is not relevant to St. Vincent's hardship application since it is based solely on physical hardship and excludes any consideration of financial issues.

13. If there were a scheme which either closes West 12th Street or builds over it, how much lower could the new hospital building be?
14. For the scheme currently proposed, what if there is not a lenticular-shaped tower but a lower and blockier building?

PVHD would not favor such configurations and thus has no response to these answers.

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 initial response is that it has never said it will upgrade the existing facilities if the new hospital is not approved, and this response has been repeated in a memo dated July 14 from Christopher Panczner, St. Vincent's General Counsel, who asserts that PVHD had misread and quoted out of context the statement that the Hospital made to its bankruptcy creditors at page 7 of its June 3 submission in the hardship phase of this proceeding. In fact, the further quotation that Mr. Panczner adds to provide the context actually reinforces the point we made. The addition is as follows:

“The projections included with the Disclosure Statement do not include the expected cost and expense likely to be incurred in connection with the process of obtaining various regulatory approvals, including various architectural and design costs, *or if that is unsuccessful in making the required deferred maintenance and capital improvements* [i.e., renovating the East Campus], nor do the projections include the corresponding improvements in financial performance that would thereafter be expected. SVCMC anticipates that the cost and expense of the regulatory process and associated costs for design will be borne by the developer chosen for the Manhattan Campus, and that *if extensive deferred maintenance and capital improvements become required, these costs will be paid from operations, philanthropy and the future sale of assets.*” (Italics added).

We will let the Commission judge for itself the implications of these and the other representations made by St. Vincent's in the bankruptcy case.

The remainder of the answer simply restates the general position that St. Vincent's has taken in this hardship phase – namely, that nothing other than a completely new facility will allow the Hospital to fulfill its mission. Aside from reiterating our disagreement with that claim, we simply point out that St. Vincent's has the burden of proving this contention. In our view, the many general conclusory statements that the Hospital has made or sponsored do not begin to meet that burden. The hard evidence that might buoy up these generalized claims is completely lacking in the record.

16. Has the State Department [of Health] 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 existing facilities?

The answer to the specific question is “no”, but St. Vincent's response so obfuscates the reply that it is virtually impossible to decipher the bottom line. Here, again, the Hospital invokes the Berger Commission report (which does not say that a completely new facility is required) and then relies on an asserted “working assumption relative to new facilities” that is nowhere documented in the record. Again, if the Commission is to give any credence to this sort of claim, it needs to secure the testimony of the State Department of Health in a setting that allows all interested parties to ask questions.

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?

St. Vincent's answer to this question is that the O'Toole tower will not be obsolete. This ingenuous response is supplemented in Mr. Amoroso's letter of July 23 in which he goes to considerable length to explain how new industry standards will assure the all future needs are met in the single tower the Hospital is proposing and, further, that in any case, the direction of State health policy is such that demands on hospitals will diminish in the future, despite an expected increase of more than one million new City inhabitants in the next 20 years.

We can not read the future. But one thing is clear. Everyone knows that America's health system – and the City's – is broken. It is far too costly, it does not reach many needy people, it is inefficient, it is haphazard, it is often dysfunctional. Perhaps Mr. Amoroso is correct that the increased emphasis on outpatient services will result in lesser demands on hospitals despite the growth in population. Perhaps he is right that medical research, medical school and nursing facilities – none of which the new St. Vincent's will support – will not be essential to the functioning or the financing of major hospitals. Perhaps he is correct that despite the unbroken history of hospital construction, technological advances and theories of patient care will not lead to obsolescence in another 20 years, or another 30 years, or maybe even in another 40 years. Perhaps. But as far as we are aware, Mr. Amoroso cannot read the future either, especially where, as here, he is projecting a scenario that runs largely counter to experience up to now. At one point or another – sooner, we suspect, than later – the new tower would be obsolete, and what then? St. Vincent's has no answer other than to deny that history tends to repeat itself. Santayana's famous remark need not be repeated. We think it is enough to say that as the health care system is reworked, as it must be, in the years ahead, it would, we believe, be a mistake to rely on the Hospital's claim that the new tower will buck the tide of history.

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 has chosen not to respond to this question directly. But from what it does say, the answers are clearly these: there are no new technologies that the Hospital has not be able to utilize in its existing facilities, and floor heights and column spacing have not prevented it from acquiring any state-of-the-art technologies. This is not to say that there are not difficulties occasioned by the existing physical configurations, and it is also undoubtedly true that these have reduced net available space. But as the answer states, "wherever possible, St. Vincent's has created a workaround where building conditions permit." No situations are cited where it has not been possible to implement new technology, so presumably there have been few, if any, such situations. To the contrary, as revealed in St. Vincent's answer to Question 19, there have been four instances of major new technology or equipment installation in the last three years alone.

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

Four instances are cited, naturally with emphasis on negative impacts. But the point is well made by the examples. The existing facilities can be and have been modified to meet emerging and changing needs.

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

This appears to an instance where things are getting bigger, not smaller, as St. Vincent's claims the need for additional space will be. We have no expertise in the field, but

it is hard to believe that as miniaturization advances, major medical equipment and imaging systems will not also be reduced in size.

21. When did St. Vincent's first solicit bids for this proposed project and when did it Rudin to be the developer?

PVHD assumes that this answer is correct.

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

This answer does not say that necessary improvements to the existing facilities cannot be accomplished. It rather points out the problems that would have to be addressed. We have no doubt that such problems exist, but there is no evidence that they cannot be overcome. Indeed, the instances that St. Vincent's cites in its answers to Questions 19 and 23 are clear evidence that solutions exist for even the most knotty problems. There are certainly added costs involved, but the record is devoid of anything other than conclusory statements of what these would be. Moreover, St. Vincent's is not claiming financial hardship.

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?

This answer cites two additional instance of how problems caused by shortcomings of existing facilities have been overcome. Please note that despite the difficulties, St. Vincent's successfully replaced one of its Cath Lab suites in 2007 and also found a way to accommodate a new backup generator. Moreover, while the Hospital claims that "future equipment upgrades are constrained by landlock," it does not say they are foreclosed.

PVHD Comments on St. Vincent's July 24 Responses to Supplemental Questions from the LPC

1. What is O'Toole now used for?

PVHD assumes that the direct answer to this Question is accurate. However, we wonder whether St. Vincent's would be guilty of malpractice if the O'Toole visitor requiring acute care treatment were to die while waiting for ambulance transfer when she could have been carried or rolled across 7th Avenue in a wheel chair or on a gurney in sufficient time to save her life.

2. Where would these services end up if O'Toole were demolished?

St. Vincent's response assumes that services currently provided on the East Campus, including "behavioral and acute care outpatient services and administrative services" that will

not be housed in the new hospital tower “will be relocated into new space nearby the hospital and the cancer center.” This is an easy answer, but finding that space will clearly be much more difficult in the real world. Moreover, additional space will also be needed for the large number of doctors displaced from the O’Toole Building. The answer also raises other questions. What, for example, will be the impact on the historic district if the space has to be newly created? And what costs will be involved in developing, maintaining and/or renting that space. The Hospital argues that renovating the East Campus would be much more costly than building the new O’Toole tower, but this answer demonstrates that there are additional costs St. Vincent’s will occur over many years by selling off the East Campus.

3. How did St. Vincent’s decide what not to include in the tower?

This answer is extremely general and virtually impossible to comment on. The core question is how much space does St. Vincent’s absolutely need for its acute care hospital and trauma center, and where are the calculations backing up that need? Additional questions include: how do these needs compare with other hospitals providing similar services; how many other hospitals have separated their inpatient and outpatient facilities to the extent that St. Vincent’s is proposing; and what experience have those other hospitals had in delivering services to the communities they serve.

4. What alternative offers did St. V. receive in the bankruptcy proceeding?

PVHD is concerned that the answer to this question is constrained by the technical limits that St. Vincent’s has placed on it. Thus, the Hospital responds that “there were no discussions with other hospitals or healthcare systems that matured to offers to merge with or purchase SVCMC assets.” For PVHD, at least, the question is not whether any discussion “matured to offers to merge or purchase SVCMC assets.” Rather, the relevant inquiry is whether there were any approaches made to St. Vincent’s by other hospitals that raised the possibility of merger or the purchase of assets. This is so because that information goes to the question of possible alternatives, including reuse of the East Campus by another hospital or health system. PVHD in fact understood that there had been at least one such inquiry. The fact that St. Vincent’s may have chosen not to entertain any approach by another hospital should not limit this Commission’s investigation of reasonable alternatives. Also, see our Comments on St. Vincent’s Answer to Question 4 of the Original Questions submitted by the LPC.

4. What is the minimum floor plate needed for an up-to-date hospital & what is on it?

Once again, St. Vincent’s provides numbers with no back up. Where did the 36,000 square foot and 45,000 square foot numbers come from? Our understanding is that the main factor defining the space requirements is housing the emergency department on a single floor? But who, beyond St. Vincent’s itself, has defined how large the new Emergency Department needs to be? As we have pointed out in Footnote 1 on page 4 of these comments, as far as we are aware, the answer is no one. In our view, it is incumbent on the Commission to look into these claims. Among other information it needs to secure is the size of St. Vincent’s current Emergency Department. Equally important, what are the sizes of Emergency Departments at

other Level 1 trauma center hospitals in the five boroughs? Armed with such information, the Commission will be in a much better position to consider what alternatives are possible.

5. What studies has St. V. made of alternative sites that it does not own or lease and who has conducted these studies?

St. Vincent's again cites the federal Medicare regulations as defining the reasonable boundaries for alternative site considerations. We have provided our thoughts on this response in our Comments on St. Vincent's Answer to Question 1 of the Original Questions submitted by the LPC.

6. What use is St. V making of Cabrini now?

Our thoughts on St. Vincent's use and potential use of Cabrini are set out in our Comments on St. Vincent's Answer to Question 3 of the Original Questions submitted by the LPC.

7. If St. Vincent's were to decide to reuse the East Campus for the hospital and with Cabrini available, wouldn't it be able to get started modernizing sooner than would be possible if it builds its tower on O'Toole?

The first part of this answer is difficult for us to understand, particularly the part that claims "there would be too few patients to support acute care at Cabrini during a phased renovation of the 12th Street Campus." Our understanding is that due to a fire in Coleman, St. Vincent's recently transferred a number of its inpatients to Cabrini and was able to provide adequate services to them even though the main acute care facilities remained on the West Side. After all, the two sites are only a mile apart. Otherwise, see our Comments on St. Vincent's Answer to Question 3 of the Original Question submitted by the LPC.

We do understand the second part of the answer, which states that "Cabrini Hospital's Clinical Space Profile" in only 300,000 square feet. However, the building appears to contain more space than that, suggesting that the "Clinical Space" is not all the remaining space. In any case, our suggestion is that Cabrini would be used as an interim facility during a phased reconstruction of the East Campus. While we are not experts on hospital construction, we do not understand why the space provided at any one time would have to be the total that will be built at O'Toole. To the contrary, the availability of 210,000 square feet (and perhaps it is more than that) would seem to offer a very real opportunity to relocate certain St. Vincent's services on an interim basis.

We also reemphasize the fact that the empty 210,000 square feet will constitute a heavy burden on whoever is maintaining the Cabrini facility. At the present time, it appears that this burden will fall largely on St. Vincent's – another cost that, as far as we are aware, had not been factored into the financial equation.

8. If selling the East Campus is to raise money for a new tower on O'Toole, aren't you then basically arguing financial hardship for which you have not submitted financial information?

The initial answer – “no” – is belied by the remainder of the response. This is clear from the sentence that follows the “no”:

“If the Rudin proposal for a residential development on the Main Campus did not exist, *i.e.*, the Rudins made a generous financial contribution to the hospital and the Main Campus was simply sold “as is” to a future bidder or bidders, St. Vincent's would still be seeking the same application for the demolition of O'Toole . . . “

To begin with, why, under those circumstances, would the Rudins make a generous contribution to St. Vincent's, which would have to be in the order of \$100 million at least? But more importantly, under the scenario assumed in the answer, St. Vincent's would still be selling off its Main Campus in order to generate the money it claims is needed to build a modernized structure. All the reasons St. Vincent's gives as to why only the O'Toole site will serve its future needs cannot disguise the reality that the Hospital needs to sell its Main Campus to generate the funding needed to build the tower. That has been its claim from the beginning – and it is a claim of financial hardship. Its claim is not that it cannot modernize the East Campus – its claim is that it cannot afford to modernize given the costs that it asserts would be involved. While PVHD believes those costs are significantly overstated and also need to be offset by other expenses St. Vincent's will incur because it sells off the East Campus, we submit that the facts make it clear that the Hospital is relying on financial hardship – not just physical – in this proceeding.

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