VILLAGE OF RIDGEWOOD
PLANNING BOARD
WEDNESDAY, OCTOBER 5, 2009
COMMENCING AT 7:42 P.M.

.....

IN THE MATTER OF: :
VALLEY HOSPITAL : TRANSCRIPT OF
PRESENTATION ON H-ZONE : PROCEEDINGS

.....

B E F O R E:

VILLAGE OF RIDGEWOOD PLANNING BOARD
THERE BEING PRESENT:

DAVID NICHOLSON, CHAIRMAN

DAVID PFUND, MAYOR

ANNE ZUSY, COUNCILWOMAN

JIM BOMBACE, FIRE CHIEF

MORGAN HURLEY, MEMBER

ANNE WARD, MEMBER

TOM RICHE, ALTERNATE MEMBER

CHARLES NALBANTIAN, ALTERNATE MEMBER

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RAYMOND SKORUPA, Medical Planning and Research International

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I N D E X

S P E A K E R S:

BLAIS BRANCHEAU 7
Questions by the Board: 10

RAYMOND SKORUPA 14
Questions by the Board: 80

E X H I B I T S

| NUMBER | DESCRIPTION | EVID. |
|---|---|---|

(NO EXHIBITS MARKED)

CHAIRMAN NICHOLSON: Ladies and gentlemen, we'll get started.

I'd like to call this special meeting of the Ridgewood Planning Board to order.

In accordance with the provisions of Section 10-4-8D of the Open Public Meetings Act, the date, location and time of the commencement of this meeting is reflected in a meeting notice, a copy of which schedule has been filed with the Village Manager and the Village Clerk and a copy of which schedule was mailed to The Ridgewood News and The Record newspapers of general circulation throughout the Village of Ridgewood. And a copy of which schedule was prominently posted on the bulletin board in the entry lobby of the Village Municipal Offices at 131 North Maple Avenue and on the Village website.

All of the foregoing notice procedures having been accomplished in accordance with the provisions of the Act.

Please rise for our flag salute.

(Whereupon, everyone stands for a recitation of the Pledge of Allegiance.)

CHAIRMAN NICHOLSON: Good evening, ladies and gentlemen, for the record and for the members of the public, I'd like to start with just a

brief summary of where we are in the process of evaluating possible changes to the Master Plan of the Village of Ridgewood as it relates to the H-Zone and Valley Hospital.

The last time we met in a special meeting for this purpose we were engaged in a process of receiving public questions and public comments concerning the testimony and the evidence that had been placed before the Board relative to the matter. We have paused that official process of receiving comment and questions from the public, to receive a report from a consultant engaged by the Board. And we are going to hear from our consultant tonight in a preliminary presentation of his report.

This is a work session, in that the conversation is between the Board and the Board's consultant. Tonight we will not be accepting any questions from the public, nor from the Hospital or representatives of the Concerned Residents of Ridgewood.

In the future, when the Board is satisfied with the report of our consultant, that report will be read into the record. And we will resume our public comment and questioning process.

Before we start with Ray Skorupa, he's

the principal of Medical Planning and Research International, our consultant, we are going to address one issue, one question, that had been asked of the Board of the Village Planner Blais Brancheau concerning square footage. And as it relates directly to Mr. Skorupa's report and his work, I think it's appropriate that we deal with that now.

And when Blais has had an opportunity to present his new spreadsheet, we'll start with Mr. Skorupa.

Barbara, would you take the roll call please?

MS. CARLTON: Mayor Pfund?

(NO RESPONSE.)

MS. CARLTON: Councilwoman Zusy?

COUNCILWOMAN ZUSY: Here.

MS. CARLTON: Mr. Bombace?

MR. BOMBACE: Here.

MS. CARLTON: Chairman Nicholson?

CHAIRMAN NICHOLSON: Here.

MS. CARLTON: Mr. Hurley?

MS. HURLEY: Here.

MS. CARLTON: Ms. Ward?

MS. WARD: Here.

MS. CARLTON: Mr. Nalbantian?

MR. NALBANTIAN: Here.

MS. CARLTON: Mr. Riche?

MR. RICHE: Here.

CHAIRMAN NICHOLSON: All right. Blais, I turn it over to you.

MR. BRANCHEAU: Thank you, Mr. Chairman, Board Members.

I have given the Board tonight a spreadsheet that sets out both summary and detailed calculations of existing and proposed floor area, both above grade and below grade.

This comes about as a result of our meeting in July, I believe it was, where there was some questions about the precise calculations of floor area. And there was some discrepancies in the figures that I had testified to and provided you with before.

Since that time, and the Board has hired Mr. Skorupa, to provide a more detailed analysis of the hospital facility. Mr. Skorupa has calculated based upon actual floor plans the floor areas of the Hospital. Whereas, up until that point, I had been relying upon tables that had been given to me by the Hospital, in which some cases interpolations and interpretations were being made of

the data based upon the tables. Whereas, what was presented to you tonight is based upon actual floor plans and building plans. So it's not a complete apples and apples comparison to other areas where the calculations are somewhat different than what I presented to you before are that I split the development into two phases. My second phase, actually, was comprised of two sub-phases. Whereas Mr. Skorupa's calculations that I've used for purposes of this identified them as three phases. It's really the same thing. It's just whether it's Phase I, Phase II or Phase III or whether it's Phase I, Phase IIA and Phase IIB.

Finally I excluded certain areas from my calculations, whereas -- such as rooftop equipment. And Mr. Skorupa's figures include them. They're identified in the more detailed calculation in the middle of the spreadsheet in the bottom row.

So you can cull those out if you want to really do a literal comparison between what I gave you, but I'd like to present what those figures show. Again, based upon Mr. Skorupa's calculations, looking at real plans provided to him by the Hospital.

Overall, for the total facility as it exists today, there is roughly 560,000 square feet of

buildings and roughly 230,000 square feet of parking structures, for a total of about 790,000 square feet.

The proposal at the completion of the final third phase would result in 605 -- would result, I'm sorry, in 1. -- a little -- between 1.1 and 1.2 million square feet of floor area in buildings and 480,000 square feet in parking structures.

That is an increase in floor area of over 605,000 square feet for regular buildings and an increase in floor area for parking structures of 200 -- over 250,000.

That represents, for just the buildings, 108 percent increase over existing conditions. And a 110 percent increase for parking structures. With an average increase for both combined 109 percent. So it's more than doubling the total volume of the buildings on the site.

I've also provided a summary of the above grade volume of the buildings, both existing and proposed. And there are no above grade parking decks on this site today, so that's represented as a zero. And the above grade floor area of the buildings is about 405,000 square feet.

At the completion of the full build-out

under the Renewal Plan the total floor area above grade for the buildings would be over 780,000 square feet. And the total floor area by parking structures, does not include the exposed upper deck of the parking structure but only the portions of the decks that would have a roof over them would be 223,000 square feet. For a total above grade floor area of slightly over 1 million square feet, which is about 149 percent increase.

So this is more than doubling, this is two-and-a-half times larger than what is presently visible above the ground today at the hospital facilities.

(Whereupon, Mayor Pfund is now in attendance at 7:50 p.m.)

MR. BRANCHEAU: Again, there's more detailed calculations if you wish to do the analysis below, but I don't want to take the Board's time or the meeting time up to go through those in detail unless there's questions.

CHAIRMAN NICHOLSON: Blais, I have a question, and then I'm going to ask the other Board Members if they do.

The proposed parking decks do, in fact, have parking on the upper slab; is that correct? The

roof?

MR. BRANCHEAU: On the roof, yes.

CHAIRMAN NICHOLSON: But you elected not to count that square footage, did I understand you correctly?

MR. BRANCHEAU: That's correct. The reason for that being that it's not really volume any more than surface parking is volumes because it's not -- it doesn't have a roof or walls that are enclosing it. So I didn't feel that it contributed to the visual mass of the structure. Whether you had parking on the roof of the deck or whether you had a garden on top of the deck, it wouldn't make a material difference as to the volume of the deck, as far as the visual. While I didn't feel -- I think it would be deceptive to count that and I didn't for this calculation.

CHAIRMAN NICHOLSON: Okay. I mean I understand your explanation. I'm not sure I -- I agree, but did you treat the existing parking structure square footage on the left-hand side of the page in exactly the same way?

MR. BRANCHEAU: Yes.

CHAIRMAN NICHOLSON: So we're making a apples to apples comparison?

MR. BRANCHEAU: Well, there is no -- there is only below grade parking structures. I didn't count any of the surface parking in the existing or in the proposed development. I only counted structured parking in that parking that is -- has a roof over it.

CHAIRMAN NICHOLSON: So the 228,975,000 square feet of the parking structure in the existing scheme is the lower level of the North parking.

MR. BRANCHEAU: And the lower level of the Linwood parking.

CHAIRMAN NICHOLSON: Oh, okay. Thank you.

COUNCILWOMAN ZUSY: Question.

CHAIRMAN NICHOLSON: Anne?

COUNCILWOMAN ZUSY: Blais, back on July 15th when I was asking all those questions about how much of the buildings and parking structures were there now as opposed to what would be there after, at the end of the renovation if it were to go as planned.

The semel question for me was exactly how much more, and I say it again, space in your face there would be at the end of this project were it to go forward compared to what we see now?

And I just want to double check that you -- that what I assume to be correct is, in fact, so, it would be 93 percent more building that would be physically obvious, as I understand what you say. And -- and including the park structures, there would be -- under this project, there would be a total of 149 percent more physical hospital space than is visible to the human eye; is that correct?

MR. BRANCHEAU: That's correct.

COUNCILWOMAN ZUSY: That would be 149 percent.

MR. BRANCHEAU: That's correct. That's above grade floors only.

COUNCILWOMAN ZUSY: Yes.

MR. BRANCHEAU: That doesn't count any basement or sub-basement floors.

COUNCILWOMAN ZUSY: I think that's crucial because this is one of the linchpins of this whole project. Thank you.

MR. BRANCHEAU: You're welcome.

CHAIRMAN NICHOLSON: Any other Board Members have questions for Blais concerning the square footage spreadsheet?

(NO RESPONSE.)

CHAIRMAN NICHOLSON: No?

Please let the record reflect that Mayor Pfund has joined us.

Thank you, Blais.

I would ask that you add footnotes to explain how you treated the parking levels both the existing and the proposed.

And the next we meet in the public session we will move this spreadsheet into the record.

Okay. That brings us to Mr. Skorupa, welcome.

Mr. Skorupa was engaged by the Board in August and has been working diligently on the task assigned Mr. Skorupa has prepared a preliminary report that the Board Members have received.

But tonight we're going to let Mr. Skorupa present his work orally and with audio visual aids.

So, Ray, I'd like to turn the mike over to you. I would ask initially, though, that you introduce yourself, describe your qualifications and describe, in your own words, the scope the Board laid in front of you.

MR. SKORUPA: Okay. Thank you.

It's a pleasure to be here. This has

been a very interesting and challenging assignment.

I've been doing medical planning for all of my professional career, which is about 35 years. I've trained as an architect and have worked in the U.S. I've worked in North American. I've worked in South America, in Asia and in Europe for the past 35 years, and have really dealt with medical planning.

So projects that -- or companies that we worked for, hospitals that we've worked for in the region, for example, Columbia Presbyterian; Columbia Presbyterian -- New York Hospital at Cornell, Mount Sinai Hospital, just to name a few.

Is that enough, you think, in terms of establishing credentials?

CHAIRMAN NICHOLSON: If you could mention anything in New Jersey?

MR. SKORUPA: OH, Robert Wood Johnson in New Jersey was a recent assignment, the Perth Amboy medical system, St. Francis Hospital in Trenton have been recent assignments.

CHAIRMAN NICHOLSON: Thank you. That's good.

MR. SKORUPA: Good.

I'm -- what I'm going to do, tonight

we're going to have really a hands on session, and I've split it up into five components. We're going look at the existing facility. We're going to look at the proposed Master Plan and Phase I. And then I'm going to make some comments about the Master Plan and the Phase I at the end of that. And then the fourth part of the presentation we'll use some small scale models that we've made of: The existing condition; the proposed condition; and then three, what we're calling, conceptual ideas about ways that one could move forward looking at some of the ideas that we put forth in the commentary that we've made about the current scheme. And then we'll cap off with looking at the recommendations that we've made preliminarily to the Planning Board and go through those in some detail.

So these are the five parts of the work session that we talked about tonight. Answer let me just say a little bit about what we viewed as the objectives of the study that we were to undertake.

One is that we thought that we would be able tho craft a framework to development that could both address the legitimate concerns of both the Valley Hospital and the community, and in particular the community that's directly adjacent to the Valley

Hospital.

The second thing that we want to bring to the study was to bring in an environmental perspective, because one of the things that we think is very important is to look at the current operating situation for large scale buildings; the impact that the environment has upon them; green buildings; the consumption of energy, things of that sort which are really driven by the environmental perspective.

And then the third thing we hope to bring to this is to give a 21st century perspective to medical planning.

And we see this as an opportunity to test some of those in terms of things that we think can make both the Hospital perform better as a place for patients to come, for staff to work, and also for the community at large in terms its relationship to this very important facility.

I might add a fourth thing too which is really not spoken here, but we realized the serious nature of what we're embarking upon because the impact of what is proposed, both on the community and in particular the nearby community, is very -- is a very serious issue.

And at the same time the Valley

Hospital is engaged in a project which really will have great impact upon its future, in terms of what it can do, what it can offer.

So we recognize the seriousness of what we're looking at. And we also recognize the impact that what we say may have on both of the stakeholders, that is the Valley Hospital and the community. And we say those with deliberation, with real thought about the potential impact of those.

So this is the existing site about 15 acres, three buildings, the Phillips Building, the Bergen Building and the Cheel Building.

As Blais has talked about there are two underground parking structures, the North parking structure has one level underground with parking on top. The south parking structure also called the Linwood structure has two levels underground with parking on top of that.

The current hospital has about 560,000 square feet of space. And as Blais says, these are areas that we determined from the actual plans that were given to us by Valley. We did computer takeoffs of the existing plans and these are the numbers that we've generated.

Now these differ a little bit from the

numbers that the architects gave to us in terms of their takeoffs. But we're close. I mean I think if you give two groups of people a set of plans to do takeoffs, they're going to vary a little bit, but I think in terms of the approximate numbers, we're really saying the same thing.

I don't think it's a worthwhile argument for us to quibble about whether it's 550 or 560. These are the numbers that we have confidence in and we've got plans that we can show how these were done. And if someone wants to look at them and to challenge those we would be glad for that to happen.

The same thing is true in terms of the parking structures. We looked at the existing plans of the two parking structures about 225,000 square feet of space below ground, not counting the roofs, not counting the parking on top of that.

The Hospital currently has about 1700 parking spaces. A significant portion of those are underground. We have documentation on the exact numbers. And there's significant parking on grade. I would characterize the Hospital as three buildings surrounded by a sea of parking.

And I think one of the things that we

will look at, and certainly one of the things that the architectural team looked at, is removing on-surface parking and putting it into parking structures.

The proposed Master Plan envisioned three phases. And we understand and support what the Master Plan envisions in terms of attempting to replace the three existing building. I mean the Phillips Building is the oldest of the buildings. Bergen is the next. And the Cheel Building is the newest one. Phase I replaces the Phillips Building with the new North Building. It's a larger building. Replaces all of the beds that are currently in the Phillips Building, replaces the operating theatres, the cardiac cath and other functions.

The second phase envisioned at some point in the future, not part of the Phase I project which is currently proposed as the next construction process -- project, would envision placing -- replacing the Bergen Building with the West Building.

And then there's a Phase III in which a proposed South Building could be constructed in the footprint of the Bergen Building.

And in our summary of space, and Blais referred back to that, Phase I and II would -- and --

would give the Hospital about a million square feet of space, 900,000 square feet of space. And then the new South Building would actually put it beyond that.

The exact numbers would vary somewhat for Phases II and III because there are only conceptual plans for those. No detailed plans as currently exist for Phase I.

In terms of parking, the North parking would be removed in Phase I, with an expansion of the south parking area which is two levels under grade with one level of parking structure above grade. Parking would be in that structure. And then the roof of that structure would also be proposed as a parking area.

And then when the Phillips Building is removed, a new -- another -- a second parking structure would be constructed of two levels below grade matching up the elevations of the south parking, the Linwood parking structure; three levels above grade with a fourth level of parking on top of that building. So that's the proposed Master Plan.

The proposed Phase I which, as we understand it, is the project that's currently scheduled to be built as the next expansion for the Hospital will be the Renewal of the Hospital. And it

would -- at the end of Phase I we would have a Hospital with three buildings: Bergen, Cheel and North Building. Phillips would have been removed. We would have two parking structures called the Linwood parking structure closest to Linwood Avenue, and then the Phillips parking structure just north of that, interconnected into that, with about 900,000 square feet of hospital space, about 480,000 of parking structures, not including the roofs, and about 1875 parking spaces, the lion's share of which would be in enclosed parking. I believe the parking on grade proposed for Phase I is about -- is less than 200 parking spaces. If I remember the number it's 177.

I'm going to switch now to the models and I invite the Planning Board to come up and gather around. I want to go through -- no, I'm sorry.

Let me just make some comments about Phase I before we go to the model. These are some of the things that we think that we were concerned about in terms of looking at both the Master Plan and Phase I. And we will address these in greater detail both in terms of our work session, in looking at the different solutions that are proposed, and also in terms of the recommendations that we would make to

the Master Plan revisions.

The first thing is we were concerned about the center of gravity is moving further to the north. It's sort of elongates the travel distances from parking especially to the -- to the center gravity for the Hospital.

More so, we were concerned that the development was shifting towards the Van Dien edge of the property, moving it very close to the Van Dien side of the property, the west side of the property.

The north wing actually complies with the current zoning laws. It's -- the current zoning laws permit you to be -- permit in this zone to be 40 feet to the edge of the property. The north wing is not quite at 40 feet. I think it's at 46 or 47 feet. And we think that's too close to the mass of the building to that -- to that edge of the property.

What even concerns us more and we'll see this a little bit later on is that when the Phase II part is built, which is the west wing, which is built along Van Dien, it's a fairly massive building as it relates to the edge of property. And we think that is even more of a concern in terms of the mass being so close to the edge of the property.

Another concern that we have, and I

think this has been voiced or at least some of the evidence that we were gathering for this is that there -- there's a huge amount of building mass dedicated to structured parking above grade. And that concerns us because one of the things that we want to suggest or recommend in our recommendations to the Planning Board is that above grade parking in this structured parking be minimized. And we'll talk a little bit more about that in terms of the way to do that, to make it structured parking, to put it below grade, and to minimize the amount of on grade parking and above grade structured parking.

Another thing that concerned us about the Master Plan was the excessive travel distances from parking to the center of gravity for the Hospital. And we'll show a plan later on which gives you some indication of the length of travel.

Currently, the zoning laws, and we think this is not good, permit -- require that 50 percent of the parking be within 500 feet of travel -- within a 500 feet travel distance. And a hundred percent, I believe, within 1,000 feet.

Is that correct, Blais? Have I -- yeah.

And we think for a modern hospital, for

an aging population, for an infirmed population. This is simply not the -- this is simply something that an institution, a hospital, should not do.

And looking at some of the internal operations of the hospital. And, again, there are significant areas of both the existing hospital and the proposed hospital which are without daylight.

I mean obviously the patient rooms have to have daylight because that's a code requirement.

But there are significant areas of the Hospital which have no outside window space. And part of the problem for that has been the fact that for a hospital of this size to be limited to four stories above grade, we think has caused some very serious internal shortcomings, that we're hoping that we can correct by suggesting some interrelationship between setbacks from the edge of property and height of building and switching of some of the mechanical areas, which currently are above grade, to below grade so that we can put the spaces that need to be next to daylight next to daylight.

And then the last thing that we commented about in terms of the Master Plan or Phase I, when we begin to look at the interior layouts of the proposed Phase I Master Plan, we think it's going

to be impossible to replace the Cheel Building at some point in the future because some parts of the Hospital that need to be there in order for it to operate are there. They're in a proper location. And we could not determine how one would relocate these and keep the Hospital operating, you know, in an efficient manner.

So that's sort of an overview in terms of what's there, what's proposed.

Some of the comments that we have, I mean these are the highlights in terms of sort of our reaction to both the Master Plan and the Phase I plan.

So I'd like to invite the Planning Board to come up and gather around. We've got five models that we're going to show, one existing, one of the proposed Master Plan, and then three alternatives that suggest a way that we could deal with some of the problems that we've identified as problems for us.

CHAIRMAN NICHOLSON: Ray, before we do that. I have just a couple of questions. And I want to ask of the other Board Members if they have any, because you've presented a lot of information and a lot of ideas in a very brief point of time.

And we've been talking about them for a long time. And I think they bear some questions.

One of the things that the Hospital has asserted during the our two-and-a-half years of considering this, was that the square footage proposed, at least in Phase I, was appropriate for a modern hospital with the mission of Valley Hospital.

Can you comment directly on that?

MR. SKORUPA: Okay. The -- we looked at what was proposed. And we've also looked and tried to measure this against other institutions of a similar nature, mainly in North American, but also internationally.

We think for a 450 bed hospital with significant amount of outpatient services currently located in remote off-site locations, for example: The Cancer Center, a lot of the doctors' offices, the outpatient services, some of the support things. We think an allocation of 2200 square feet per bed for a 454 bed hospital is an appropriate one for today's standards. And that puts us up, you know, a little less -- about a million square feet for the facility.

So, yes, we think that what's proposed in the north wing, the North Building, is appropriate for a 21st century all private quality healthcare

service.

CHAIRMAN NICHOLSON: Thank you, Ray.

MR. SKORUPA: Another -- just another issue that's come up in the earlier things had to do with is it a hundred percent private or it is some other, because that also has an impact in terms of the amount of square footage.

Today's standard, mandated standard is that new hospitals have to private, a hundred percent private. And so what's being proposed in this Hospital is consistent with the national standard.

In January of 2010 new standards are going to be published for healthcare institutions in the United States. And the private requirement is still part of that.

So we don't see this changing for the foreseeable future in terms of all private. And we think all private rooms has a big impact on the 2200 square feet of space that's required for a hospital.

Another factor, just to add a third thing to this, the fact it's a low hospital, low in the sense it's a four story hospital, we think has some penalty in terms of additional space because it stretches the Hospital out. You know if you could

take the same 454 beds and not be limited by some height restriction, we think that you could probably do it with less than 2200 square feet.

So those are the factors we think, in terms, of the overall square footages.

CHAIRMAN NICHOLSON: You anticipated almost all of my follow up questions.

I have one other and then I'll ask other Board Members if they have any before we move on to the models.

Very early on the Hospital had described a planning process that they had engaged in where they had examined the possibility of moving the entire operation to a much larger campus in another town, to some location unnamed, and the possibility of further divesting or rather spreading out of the Hospital's functions to remote locations and had come to the conclusion -- and forgive me Hospital folks if I summarize this too roughly -- that as the campus exists today in Ridgewood, it has all the functions or has functions required for the operation of the Hospital and none of those functions would appropriately be put in a remote location.

In your opinion is that also a fair statement?

MR. SKORUPA: I would agree with most of that, yes.

When I looked at what was currently on the campus and what could be decanted, and I'll quickly go through the list of what I think are the things that have to be there. And we speak -- we address this in our recommendation because we state fairly clearly that we think the Hospital -- that the Valley Hospital, on this site, ought to be limited to 454 beds. And limited to those services which are appropriate for a 454 bed hospital, which would be, obviously the beds, the major diagnostic services supporting those beds, the emergency room, which is really not an -- an inpatient function, but an outpatient function, but a critical component to the Hospital.

And then all the administrative and logistical and educational things which relate to the 454 bed inpatient facility.

The Hospital has embarked upon a strategic plan, we think, of decanting those things that can be decanted. And we would support that and say continue doing that, but limit those things that are to remain on the campus.

There's one area, though, which I think

it will become the source of contention, which is there are some appropriate diagnostic and treatment functions, for example, cardiac cath or electrophysiology or certain types of surgery which are really inpatient/outpatient, you know. And we think that from a -- from today's current clinical point of view, that a limited amount of those functions, based on current good clinical practice, should remain at the Hospital, even though they're outpatient services.

So have I answered the question or have I confused you?

CHAIRMAN NICHOLSON: No, you have.

Thank you.

MR. SKORUPA: Okay.

CHAIRMAN NICHOLSON: Are there any other Board Members who have questions for Ray at this time?

Anne, you wan to what grab a mike.

COUNCILWOMAN ZUSY: I know you're going to talk more about this in specifics later on, but I would like you to, in general, touch on some of the questions that you raised when you were putting together the purpose of the study on page 3 of the report, where you talk about elements of the Valley

Hospital proposal.

You added three -- am I allowed to do this?

"Which conflict with the character of the neighborhood and whether there are any alternate ways to accommodate both the Valley Hospital's needs and the community's concerns and whether or not there are any missed opportunities in the proposed plan."

Just trying to take another creative look outside the box and see where the possibilities might exist.

Could you just comment on that a little bit?

MR. SKORUPA: Yes. Okay.

We were given really a two part assignment by the Planning Board, one was to give medical planning advice vis-a-vis the revisions to the Master Plan, to give guidance to the Board in that regard; and, secondly, was to look at the details of both the Master Plan and the Phase I and to make comments about those.

So we -- we have woven those two things together in terms of a response.

And in terms of the specific things

that you've raised, we saw some opportunities that we thought had not been addressed in either the Master Plan or in the Phase I plan.

And I think there are probably three general categories which we grouped them into.

We think that one of the most important things for the community, especially the community close at hand, is the setback. And so we've proposed a fairly -- a big increase in the amount of setback to 130 feet. And we'll talk more about that.

We think the issue of height is less of an issue given the fact if, you know, if the building is 40 feet from the property edge, that's one thing. If it's 130 feet back, the height issue becomes something that we think there is some -- hopefully some framework for negotiation and some tradeoffs in that regard.

The third element was the massing of the building. We were looking for opportunities to reduce it -- to use your word "building in your face". We wanted to try to give the Hospital adequate space, maybe even improve the quality of the space, but do it in a way that mitigates, at least from the community's perspective, some of those things. And that would be the massing of the

building. Especially those things that do not have to be aboveground, for example parking, we think is a very good candidate for that. The other would be mechanical spaces. We've had a long discussion about what's the height of the mechanical space. Is it 20 feet, 17 feet, 24 feet?

And what we would like to see is as much of the mechanical space be moved below grade, noisy equipment, for example, is no longer sitting on the roof, but could be down below. There is an incremental cost for that because we have to bring fresh air into those spaces and things of that sort. But there are institutions who do this.

For example, a lot of the spaces that are the heavy users for those, air conditioning, are spaces that are low in the building, for example the O.R.s. I mean these are the huge -- with some fresh air requirements the -- the air changes. And these put those things close to where they're generated, not up on the roof and then bringing them down through the building.

So I think -- have I answered your question, Anne, in terms of sort of sketching out some of the things that we looked at?

COUNCILWOMAN ZUSY: Yes.

MR. SKORUPA: Okay.

CHIEF BOMBACE: I'd like to speak about the number of beds. And I'm just curious looking at not just that Ridgewood facility, but the regional area, and the hospitals that are in the regional area, is the number 454 beds for Valley an appropriate number?

In other words, should there be more or less depending upon the level of -- of how many hospitals in the area and the beds that they have, and the occupancy rates of all of these hospitals?

MR. SKORUPA: Well, you know, we looked at the statistical data for northern New Jersey. And you know the population growth projected by the U.S Department is not -- is not great, you know, so population is not going to grow a lot.

The other factor which has an impact on the number of inpatient beds is the aging of the population. So that is happening, but I think it's happening at a slightly lower rate in New Jersey because the New York metropolitan region is an expensive place to live, a lot of people on fixed incomes opt to move to another place. And so I think that has done something to mitigate the pressure on inpatients.

There are a number of hospitals that are closing, you know. And this has happened throughout the metropolitan region. I mean, for example, if you look at hospitals in New York City, a number of those have closed over the last year. The Berger report which was released, I believe, about three years ago, identified a dozen or so hospitals that were closed. New Jersey for the past decade, I guess, has been wanting to close hospitals.

So I think -- I think we're -- I think the 454 bed, as I see it, represents a high water mark. And I would be surprised if it were to get bigger.

In our report we mention the fact that we think an appropriate function for Valley Hospital, and a permission that ought to be given to the Hospital from a zoning point of view, is to change from an inpatient facility, what we call short term -- short term stay, you know, you come into the Hospital you're there for less than 24 hours. And it's really the same requirement, the same cycle of ambiance, I think, is what's going to develop over the next decade or so, where, you know, minimally invasive surgeries, things of that sort, will make the stay in hospital less and, therefore, the -- we

see a migration of 454 beds becoming maybe less, but that these would be converted to short term stay beds, which, in effect, are the same thing, except patients don't stay there for two or three days.

The turn over, the impact on that, for example, we looked very carefully at what is the difference between the inpatient impact on intensity of use and traffic versus outpatient. Outpatient is much higher.

For example, you have a 20-minute visit with the physician, you know, the turn over for parking, people coming and going, is several times higher than what it would be for either an inpatient or short term stay.

So to answer your question, we don't see it getting bigger. We think it may even get smaller over time. Again, these are predictions and who knows if one's going to be correct or not, but we see that as a high water mark.

And given the amount of space that's needed to do a proper job. If things change, if they have to modify that within that framework of space, then we think that's something that should be permitted to the Hospital.

CHIEF BOMBACE: Thank you.

CHAIRMAN NICHOLSON: Any other questions? Anne?

COUNCILWOMAN ZUSY: You mentioned -- you mentioned this briefly in a previous answer, but I'd like to have you elaborate on it, another one of the linchpins in this whole issue of the Hospital renovation has been whether or not everything that Valley says it needs to have on-site, in fact, needs to be on-site. Could you just elaborate a little bit on that. You're feeling that --

MR. SKORUPA: Yes, there was -- there was one thing that we saw that currently exists, for example, there's -- one floor is dedicated pretty much to pathology. And that is certainly a function that could be moved off campus. In fact, Valley could -- we don't -- we don't know this, but it could very well be that in their plans for -- for example, for renovating, upgrading the emergency room at some point in the future, maybe the pathology goes away to an off-site location. And the emergency room would move into that location.

So that was really the only major department that we saw. I mean there are, you know, support things, minor departments -- for example, the Breast Center, which is currently located on the

campus is scheduled to be moved off as part of the movement towards an off-site location.

I mean I think there's a lot of advantages for the Hospital to move certain functions off campus because I think it's more attractive, more convenient, less expensive.

And so we recognize that and would support that as a basic premise for mitigating the impact of a 450 bed hospital on the residential community.

COUNCILWOMAN ZUSY: And one last question, in your recommendations when you're talking on page 15 about:

"Capping outpatient D&T at 2009 volumes and also capping the emergency department capacity at 2009 volumes".

And I wanted to ask you why you're saying 2009? Would it not be better to cap it at the rates, the last few, that Pascack Valley was open?

MR. SKORUPA: Well, you know, the amount of space that -- there are two things I'd like to say about that. One is it's very difficult, I think, to determine what's an appropriate mechanism for limiting the growth of a clinical service. And we debated several ways to do that in terms of, you

know, how do you go about capping or limiting the amount of clinical activity and in turn traffic and things that goes on at the instruction.

And some of them are easier. For example, beds you can -- you know that's an easy one. Number of parking spaces is another one.

But it goes back to the question about outpatient services. There are a number of things within the outpatient service that we think makes it more difficult to -- to -- and maybe more difficult for the Planning Board, through zoning, to have an impact on.

So we -- that was a mechanism that -- that we choose in order to say, look, we think there ought to be a limit on some activities.

Another way to state that would be to limit the amount of space that one allocates for a particular function as another mechanism -- and may be that's even more appropriate for a Planning Board rather than for the number of procedures, et cetera, that take place.

I mean I think we're getting into -- in some of these smaller, you know, less global issues, I think there is a question of how does one -- how does a Planning Board make a statement about limiting

those activities? What's the appropriate format --

COUNCILWOMAN ZUSY: Right.

MR. SKORUPA: -- for that.

And that was -- you know, that's one way of us saying that to actually put a limit on the volume of things, but then how is the --

COUNCILWOMAN ZUSY: But I'm just suggesting a capacity for this may be inflated given the fact that that hospital has closed, no?

MR. SKORUPA: I have no reason to believe that -- you know, that these numbers are inflated based on what's happening in other places --

COUNCILWOMAN ZUSY: Okay.

MR. SKORUPA: Right. I mean the emergency rooms are experiencing a huge amount of growth and in -- in tough times, they grow even more because people begin to use them as a -- you know, as a primary care facility so...

COUNCILWOMAN ZUSY: Thank you.

CHAIRMAN NICHOLSON: Any other questions?

MR. SKORUPA: My technique is to wear people out, do you know that?

CHAIRMAN NICHOLSON: Ray, I think we can move on to the models.

MR. SKORUPA: Okay.

So let me invite the Board to come up and look at these. We've got the two models which are the existing site plan on the right, maybe get on this side it's better. There you go. Close that down.

So on the right-hand side you'll see these are about one foot equals 60 and they're relatively correct in terms of heights of buildings.

So when you look at the existing site plan you see to -- to the left is Linwood (indicating) to the right is the Robert -- the Ben Franklin high school. Yeah. Good point. Right.

Linwood is here. Van Dien is here. Benjamin Franklin is here. Phillips, Bergen, Cheel is here (indicating).

Underground parking, one level here, on the north end, two levels of parking here (indicating).

And then surrounded by what I call a sea of parking on grade, including the roofs of the parking structures.

Main entry is up here. The emergency entry is back here with ambulance and -- ambulance drop-off is on this end and walk-in entrance is here

(indicating).

Service entry -- service zone is down here, including the power plant, the current power plant is here (indicating). That's scheduled to be replaced, which I think is a good idea, moving to the new building, the North Building.

This is really the service end of the Hospital (indicating). And when I drove around, you know, I've been back several times, just to go back and get a sense of, you know, what the place feels like and, you know, my first impression that this is a very important street in terms of how you approach the Hospital (indicating). And this is obviously the secondary one (indicating). The main entry is off of that. You know there's a huge green feeling as in Ridgewood in general, is big setbacks from the streets, you know, that's a very important part, we think, of the character of the community.

And so that became a springboard for us when we began to look at what things do we want to keep and to strengthen in fact.

And then this is what's proposed (indicating). What would happen first would be a new parking structure, one level, with parking on the roof would be built on top of the existing Linwood

parking structure, two levels below grade. And then this would become parking because in order to do this you'd have to get rid of all the parking in the north end (indicating).

And as I understand it, this coupled with off-site parking during the course of construction, would keep the number of parking spaces roughly at its current level to accommodate the need. I believe the parking study shows that there was 1900, something like that, in terms of need. Am I correct, Blais, in terms of --

MR. BRANCHEAU: Yes, maybe a little more.

MR. SKORUPA: Right.

Then -- then once -- once that happens then we can excavate and build the new North Wing. The North Wing goes down two levels below grade. It goes down to minus 74. The grade is about 105, 106, so it's about 30 feet below grade. The lowest level becomes mainly mechanical and support things, for example, central sterile, engineering, things of that sort. Sort of a framework because we have to replace everything that's currently existing down on this end of campus (indicating) which is really the service end of the campus.

Then on the basement level is a replacement for several functions, the operating theatres are moved there, cardiac cath, specialty operating. So that we end up with about 24, 25, 26 operating procedure rooms consolidating a number of services into a single location.

And we think that's a very good planning -- planning move because it then consolidates recovery and prep and things like that. And a number of institutions are doing this. And we think that that's a very good move.

When we look at the plans, I'll show you, we support that concept, but what -- what we -- what we're troubled by is this is below grade (indicating) and there's virtually no window space, again, because there's no other choice for it in terms of the stacking of the building, the height of the building.

And then on level one which is at grade in the back end would be the main service entry, you know, the compactors, the loading docks for trucks and things like that are put up in this corner (indicating). Access would be from this end (indicating). And the functions which are currently sort of to the front door are moved to the back door.

One of the things that we will talk about later is requiring these services to be covered because, especially for the residents along Steilen Avenue -- is that Steilen Avenue? Being up against, you know, the service end with the noise, the odor, garbage deliveries, trucks being picked up, compactors being changed. So we think it's very appropriate to put that under cover so that in terms of noise is captured, and so it's less of an impact on the neighbors.

We're proposing that the rooftop become a roof garden, so that that's protected and, you know, we get two things from it. One is the residents get protection from to noise and odor and things from the service entry; and that their vista, especially from the upstairs parts of the houses, the two, three story houses along there, is then to a garden. So we'll talk about that a little bit more.

Then on the upper three levels are three nursing units -- six nursing units, two per floor, replacing all of the nursing units that were in this building (indicating). And they're placed in five rooms, you know, consistent with current standards. Some of them are a little bit larger than minimum. There are some more VIP or more luxurious

ones. And that's appropriate in terms of the market -- you know, the market the Hospital's aiming for in northern New Jersey.

And then the top is mechanical.

Included with this is a re -- sort of the front door, there's what I call the north atrium. And we'll talk more about that. I want to show some plans inside of that because we think, from an architectural point of view, this becomes a very critical thing when we begin to look at Phase II of this.

MAYOR PFUND: Ray, are you looking for this over here?

MR. SKORUPA: No, I've got some little pieces I want to add to this.

COUNCILWOMAN ZUSY: Building blocks.

MR. SKORUPA: Yes.

So this atrium, the atrium that's proposed, the north atrium we're calling it, goes in front of the Cheel building, is quite -- is quite generous and it's four stories. And when you look at the interior plan, we'll show them later on, there's a couple of passageways, interior corridors, and this open space, you know, are fairly grand, and we think appropriate in the sense that most institutions -- if

you -- if you come to the Hospital today there's really no front door. You're looking for a place to go in.

And so we certainly support the concept of having a front door. You know it's a beacon to the street.

We'll talk a little bit more about it later on because we think architecturally it exacerbates a problem in terms of -- of what happens in Phase II. This building -- so -- so at the end of this, when this -- when the North Wing is completed, the North Wing and the atrium for the North Wing, I -- I don't fully understand the -- hoe the renovation -- because we're attaching it directly onto the Cheel Building, and there's an interaction that goes on between the building that's there, the front door. And 'm sure the architects have studied this in terms of, you know, building something on to the face of an existing building and making it work. It's -- it's sort of painful, but I'm sure they've put a lot of effort into making it work.

Then what is proposed under Phase II, let me just -- and then Cheel building is -- number of floors that are renovated there, for example, the basement level of Cheel building which is currently

the operating theatre, recovery, et cetera, that becomes the prep and recovery room for all the O.R.s in that location. And that's another one, you know, it's an occupied space, you've got to renovate it. It's going to be a painful one. But I'm sure the architects have worked out a phasing plan where one can do this, so that we end up with that level being the operating theatres, the prep and recovery at the basement level.

And then there are other renovations that are happening up above. For example, obstetric service is a big service here. And so new obstetric beds go here (indicating), the existing labor and delivery rooms and beds in the Cheel building are upgraded. And that's appropriate too. I mean when we looked at the numbers and the amount of space that's dedicated to that, I don't think we could challenge it very much in terms of, you know, what's proposed there, because OB service is very competitive, you know, they're chosen for two reasons, either the physician or the space or some combination of those.

So there's a lot of competition that goes on in terms of having a quality space and a birthing center, and things like that. So in general

we didn't have a problem with what was proposed there.

And then very little is proposed to the Bergen Building. You know it's pretty much left as it is.

And then this structure -- so coming back then, the thing that really struck us about this was the amount of volume we're seeing here (indicating) you know it's a huge increase in terms of volume aboveground.

We have less of a problem with the volume here (indicating).

But then what concerns us was the Phase II of the project, which we mentioned earlier. This is th proposed building for Phase II. And it's not -- I'm sorry that's the wrong one.

What is proposed for Phase II of the building is that this building (indicating), which is to replace the Bergen Building, this building here and this building (indicating) would be torn down.

Now this is what troubles us the most, is when Phase II is completed and there is 46, 47-foot frontage along a very important street. And it's a massive building because you know this is a hundred and so feet. This is 200 or so feet

(indicating). So we've got more than 300 feet of building very close to the property edge. That's what really concerned us. And that's what made us also go back and look at this, because we felt part of what was happening was that this architectural element was also impacting on the amount of footprint that was available, in effect was pushing the building closer to Van Dien. So that was the concern.

So to sum up, the things that we were concerned about in this building were the setback, certainly Phase I, much more so in Phase II. And the amount of volume that was put on the site being above grade as opposed to being below grade.

So then that led us to look at some options in terms of studies, if I can have those here. Get this out of the way.

CHAIRMAN NICHOLSON: You want all three?

MR. SKORUPA: Yes.

So this was the first study that we looked at. And what we did was we said, let's move the building back. Let's take the footprint that was proposed for the North Wing and simply slide it back, you know keep this element in place (indicating) as

it was, and create a zone along the front.

And we chose the 130 feet for two reasons. One is we want to propose that underground parking is permitted here (indicating) actually any hospital function could be permitted underground, within -- you know, up to the property's edge. But we wanted to choose 130 foot setback so that we could put efficient structured parking, because that way you can get very good efficiency in terms of up and down ramps. It would also permit us to do this and not put hospital functions on top of it, because that was one of the things that we wanted to avoid, was putting hospital function on top of parking structure, because you can have longer spans and things like that.

For example, at Robert Wood Johnson, they have a huge parking structure below grade and above it they have two -- three large buildings sitting on top of that. There's the ambulatory care building. There is an education building, which is for the College of Medicine and Dentistry for New Jersey. And there's a big open space built on top of a parking structure. And the lion's share of it is below grade because there's a big differential between one street and the next. So there's a

history of that, you know.

And in our work, for example, in other countries, for example, we just finished a project in Singapore, a 550 bed new hospital built in a very similar residential area, although in Singapore buildings are much taller, the density is much higher. All of the parking was below grade, underneath the hospital.

Now, what -- the question I pose to this body and to the body, I just -- we're a wealthy country, you know, we have the best healthcare system in the world. We spent more per capita than any other country, why can't we do something that puts -- that takes away the -- the mass of the -- you know, the 15, 1600 cars, put them below grade, put them in a location that reduces the mass, mitigates the effect, and it moves it closer.

I mean one of the things that we -- that we pointed out was the travel distance from here to where the center of -- you know, this is going to be the front door here (indicating). It's over 500 feet, you know.

If we put parking here (indicating) and we could do the same thing back in here (indicating) then you have parking, you can go directly into the

Hospital. It's very short. It could be underground. It could be covered.

We also talked about putting the service back in here (indicating). We think parking could be placed back in here (indicating).

In this case, we would say one level of parking above grade because we want to create a roof garden along the back here (indicating) so that you can mitigate the impact of having a major hospital on the backside of the property.

Now, Phase II we propose would go here (indicating). As we began to look at this and determine, was that good? We saw two problems with this. One is it lengthens the Hospital, you know, makes the travel distance internally greater, and it presents a problem when we decide to take away Bergen because we've got a major building because this building (indicating) is -- would replace the Bergen Building.

Then you've got to do this in phases, or you've got to, you know, take down part of it, or create some temporary way to get to the main hospital (indicating). And so we thought this was not really an appropriate solution.

So we looked at option two. And in

this we were trying to do two things, one is that we were concerned about the form of the building. These -- it should be the same height.

In this one we addressed two things, one, we were concerned about the height -- the form of the building in terms of massing space and not having daylight. And so we said, well, look, can we pull the building back, bring it closer to the north property? We said there because of its being close to the Ben Franklin School that we would say a 30-foot, 35-foot setback there, wide enough for service access possibly, fire access in that space. But push it up closer, but pull it back here (indicating) and then configure the building so you can get a nursing unit here, a nursing unit here (indicating) and create at some sort of internal court so that we can get more daylight into the spaces. So that was what we were saying here.

The second thing we did we said let's put an architectural feature here, but let's not make it so massive and grand, make it maybe 30 feet wide or something of that sort, as opposed to 60 or 70 feet wide, limit the amount of activity here because in Phase II when this building comes along, then it helps us here in terms of keeping our

appearances back from the street. And this also will disappear we put a front door onto the institution, and now we're covering it up. So we were sort of saying, well, does it make sense to do that because when you build this eventually this building is going to go away (indicating) and maybe the front door is on this end, maybe emergency room is down here, it sort of changes the character of the building.

We're also showing more parking back in here, for example, maybe an employee parking goes back in here (indicating). Public parking here, employee parking here, service entry here (indicating). It's covered with a roof. This is all greenery with a rooftop garden (indicating). This is all greenery with at grade and the trees and it's softening the -- it's connection to Van Dien.

The existing parking can stay, with no parking on it and the rooftop has to be converted to greenery space so that we reduce the mass of the building, we think, by moving the parking underground.

This should be about the same area as what was proposed in the -- in the Phase I.

MAYOR PFUND: Where is the parking in that? How much on grade?

MR. SKORUPA: There are two -- there's parking here (indicating) which would be --

MAYOR PFUND: That's underground, you're saying?

MR. SKORUPA: All underground, everything is underground.

And this would be maybe -- this would have three levels of parking, we think we can go down to level 72 -- 72, 82, 92 and then a roof at 102. And then several feet of soil above that, so that we can add proper planting and trees and things like that (indicating). And then a garden back here (indicating) on the roof, probably 84, 92, 102 and then the rooftop with no parking on the roof (indicating).

We were also suggesting a service entry from here (indicating), eliminate the service back in here (indicating). We've got emergency room here (indicating). We've got parking for staff. could be parking. We don't have to make a strong distinction between the two (indicating) it can be shared.

And then make this the service entry (indicating) so that we can get proper clearances for trucks. You can have a 13, 14-foot, 15-foot

clearance for trucks. We can do that by dropping down the service entry to a lower level (indicating) and then making the service level here, covered.

COUNCILWOMAN ZUSY: Are these options one or two in your report at page 22, 23.

MR. SKORUPA: It's similar to those, we changed them just a little bit, yes.

COUNCILWOMAN ZUSY: The reason is I'm looking at the height of the option one, it's a height of four stories and then option two that height is six stories?

MR. SKORUPA: Yes, we changed those a little bit because of, you know, sort of actually got a fourth option that we don't have a model for.

So this would be option number three (indicating). And this -- and we talked about relaxing the height standard. And this one proposes a six story hospital as opposed to a four plus one mechanical. So it's a little bit higher. But it takes the mechanical and outs the mechanical below grade.

And the benefit for the Hospital in this regard is that we then can take, for example, the operating theatre, which is on the basement level, that can be moved up.

We can move other hospital functions, rather than have them below grade, move those up. So we would move two levels of hospital function up above grade and move one level of very deep mechanical below grade.

And as we mentioned earlier the heavy user from mechanical are lower in the building, so you would feed up to those. And you would put that there.

This one also shows a similar arrangement, what we propose here (indicating). That you could put a Phase II in front of the building as the next phase. And it shows parking and service area in the back.

So those are the three options that we looked at. So, yeah, right, yes, that would be Phase III. Phase III with no mechanical.

CHAIRMAN NICHOLSON: Ray, in all these options the number of parking spaces would be the same?

MR. SKORUPA: We tried to keep -- yes, what we tried to do was to keep this -- you know make this an apple to apple comparison, so that if we put more parking, if we reconfigured parking, we tried to keep everything as best we could equivalent so the

amount of space envisioned here (indicating) was roughly the same as what we envisioned in Phase I. The amount of parking that we envisioned was equal in terms of Phase I.

MAYOR PFUND: Now, that building to the south, is that going away too?

MR. SKORUPA: In Phase II this would go away (indicating), right. We would end up with a -- with three buildings -- at the end of Phase II, we would have a three -- in each of these a -- at the end of Phase II, would be three buildings, and then there was a provision for a fourth building.

What we said is that the fourth building, we think, would put it beyond what we think would be the million square feet that we allocated as saying that's what's necessary for a hospital.

But, certainly, as a Master Plan exercise, one could have a proposed location for a future building.

COUNCILWOMAN ZUSY: So how much more of an increase in physical hospital would you see with this option three?

MR. SKORUPA: We see this as being the same as --

COUNCILWOMAN ZUSY: As what it is

today?

MR. SKORUPA: Well, that's what we're -- what we're saying -- I mean all of these are equal in terms of the amount of space that we're allocating for the Hospital.

COUNCILWOMAN ZUSY: Yes.

MR. SKORUPA: This indicates that there's more habited space above grade, but more mechanical below grade. And that's the tradeoff for this. Yes, right.

COUNCILWOMAN ZUSY: Yes, I understand. But I mean for the same question I was asking Blais in July, how much more hospital would we see physically under option three.

MR. SKORUPA: The answer is the same for all of these.

COUNCILWOMAN ZUSY: And how much more is that?

MR. SKORUPA: We're going from 500 --

COUNCILWOMAN ZUSY: Compared to what you gave us today.

MR. SKORUPA: Well, as we said earlier, currently there's 550,000 square feet. We're proposing a million square feet as the limit. And we've tried to stick to that in all of these in terms

of a million square feet.

COUNCILWOMAN ZUSY: About how much of that would be above ground? What is the percentage above grade?

MR. SKORUPA: I can't tell you offhand, but I -- we can to do the calculation for that.

I mean essentially we tried to move -- currently there's about -- the target that we were shooting for, and I think we mentioned in our report, is we wanted to go to 40 percent above grade and 60 percent below grade. And that would be the total across the board for that, you know.

Currently it's -- I don't want to say the numbers, but...

COUNCILWOMAN ZUSY: When you have them I would love to get them.

MR. SKORUPA: Yes. Right. I mean we did the study looking at what's there. We compared that to what was proposed under the Master Plan, and then made a target in terms of what we would propose under the revisions to the Master Plan.

MR. BRANCHEAU: The 40/60 includes parking structure.

MR. SKORUPA: I'm sorry?

MR. BRANCHEAU: That is that 40/60

split includes the structured parking.

MR. SKORUPA: The 40/60 was hospital space I believe.

Let me not answer that because I'm now confused about the numbers. So we've got -- we did the study. And we did it. We broke it into hospital and parking, and then did the total for the two.

MR. RICHE: Let me ask you, if you may have -- you may not be able to address this, but in terms of the percentage of coverage existing, Valley's proposed plan, and then jump to the alternative number three plan in terms of the lot coverage.

MR. SKORUPA: We haven't done that calculation, but we can.

MR. RICHE: Off the top of your head, is that less coverage than what Valley's proposed plan is in terms of lot coverage? It should be because you're -- that's more space underground.

MR. SKORUPA: Yes. Yes. The big things were taking parking and putting it -- right, that's the big differential.

I would think the footprints of the buildings themselves are roughly same. But it's configured differently.

So, yes, the answer would be it's less than what was proposed and it mainly is accomplished by taking parking and putting parking underground.

MAYOR PFUND: So, Blais, one of the goals is condensing it all. That's something that you said was an objective that you set out to do. It looks more condensed in alternate three as opposed to one. And it also obviously pushes everything north because, I guess, there are things south. It almost seems like it's -- you know, with the -- it's a little bit higher and more dense there and closer to the school as opposed to more spread out throughout the property. Was that the goal were you trying to achieve?

MR. SKORUPA: Well, we wanted to create an efficient hospital, you know, that was one of the things that we wanted to do.

And, second --

MS. WARD: I'm sorry?

MR. SKORUPA: We wanted to create and efficient hospital. And that was why, for example, that we mentioned this because we think it's too linear.

So that was an objective. And the second objective is we wanted to improve the internal

operation of the hospital by bringing more spaces up above grade as opposed to putting them below grade.

I don't think it's actually -- I think all of them are similar in terms of their intensity, it may be that the way the --

MAYOR PFUND: That was just my visual -- particularly when you have one building which will ultimately be removed, it going to be -- seems like everything is just pushed in the north section there.

MS. HURLEY: Right.

MAYOR PFUND: But, again, I'm trying to find out if that's your intent. It may not be. I am not saying there's anything's wrong with it.

CHAIRMAN NICHOLSON: Ray, could you put up the Hospital's plan.

MR. SKORUPA: Yeah. Let me take away the --

MR. RICHE: Get the three of them there.

MR. SKORUPA: Yeah, there's another alternate, which was five stories, but we didn't -- we didn't do a scheme for that. You know instead of going up six stories -- we think that's the optimal and that's why we're recommending it because you want to put more space, more hospital above grade.

Another option would be to do five stories. And the height of -- this is a little bit taller than the four stories plus mechanical (indicating).

The five story habited space, mechanical below, is actually a little bit lower because we're substituting, you know, 14-foot high floor for 17, 18, 20-foot dimension. The mechanical --

MAYOR PFUND: You're recommendation is three?

MR. SKORUPA: Well, no, it's not. It's option four.

MAYOR PFUND: Okay.

MR. SKORUPA: Let me show that and then we can come back.

CHAIRMAN NICHOLSON: A couple more questions before we do that.

MR. SKORUPA: Yes. Okay.

CHAIRMAN NICHOLSON: Again, going back to the very beginning and some of the presentations by the Hospital's architect, floor to floor heights that were proposed to you concur that they're appropriate?

MR. SKORUPA: In general, yes, I think

what was proposed was 14 feet for the habited space of the hospital. And then, I think, 22 feet for the mechanicals.

We don't have any problem with the 14. As a matter of fact we would actually recommend, if one could, a greater clearance because it has an impact of term of possible buildings and things of that sort.

However, this building is tying in to the existing building, so there's a range, and we think the 14 works actually quite well. It's sort of a compromise between matching floor heights, matching ramps and putting in a modern building because, you know, the -- for example, the O.R. floors are some of the other floors I mean there's much more requirement for fresh air that means duct work, that means, you know much more above the ceiling, sprinkler systems, things of that sort.

So the pressure is on, you know, to maximize that.

So, yes, we would agree with that.

MAYOR PFUND: As a follow up what height would you recommend for the fourth floor?

MR. SKORUPA: Well --

MS. CARLTON: Excuse me, could you

share the microphone or take this one? Could you pass it around?

MAYOR PFUND: I'll shout.

Just to follow up on that question that you said it would almost be a higher height than the 14 if it didn't have to conform with the existing. What would that height be, if this was a new stand alone building?

MR. SKORUPA: Things we're doing in other -- let me just preface that with one -- one trend that we're seeing, and I think this is -- this is a valid on, what people are doing are building what they're calling "universal rooms" so that if a patient goes into a bedroom, the patient is not moved, for example, from -- to the critical care unit and back to that room. The trend is to create rooms that can treat any patient.

And I think what's going to happen will be that the infrastructure required for that -- I mean there are very few institutions that have been able to put this in place fully, but I think that's the trend that we're seeing happening.

And so the -- what the impact of that would be, more ventilation, because if you build an intensive care unit, for example, there's no

recirculation there, things of that sort.

You know we're in an era where we think bacterial and other infections are going to grow. I mean every year we're now faced with this world pandemic of something or other.

So I think there's going to be much more concern about spreading of bacterial pathogens within the hospital. And I think that's going to have an impact on height of buildings.

I would -- if we were building it free standing, I would recommend 15 feet floor height and higher ones on the floors that are dedicated to the operating rooms, and things of that sort, 16, 17 feet for those.

MAYOR PFUND: Thank you.

CHAIRMAN NICHOLSON: And the mechanical and equipment goes -- even if you put the mechanical equipment in the cellar, and I presume we're talking about chillers.

MR. SKORUPA: Chillers and air handlers.

CHAIRMAN NICHOLSON: And air handlers.

MR. SKORUPA: Yes. And pumps.

CHAIRMAN NICHOLSON: Isn't there still an outdoor component at least.

MR. SKORUPA: Well, the cooling -- in our report we -- the thing that we would not put in it would be the actual cooling towers.

The chillers could certainly go, but -- but there's going to be a cooling tower component. And we sort of side stepped that issue saying it would not be excluded from being on the rooftop location.

And, typically, I think in -- you know, it's a big campus too, and there are probably a number of locations that one could look at because the plume has to be looked at in terms of what impact it has on the buildings around it and things of that sort, so that was one exception.

But air handlers, for example, we recommend them going below. You've got to bring fresh air into those. You've got exhaust and the requirements for above grade intakes and exhaust, those are the type of things, things like that, that are not uncommon techniques.

CHAIRMAN NICHOLSON: One last question before you bring out the other one, you mentioned the north service ramp.

MR. SKORUPA: Yes.

CHAIRMAN NICHOLSON: Could you amplify

on that a little bit?

MR. SKORUPA: Well, one -- you know it goes to -- it goes to -- you know, we talked about it being a green buffer zone at grade here (indicating), with the potential of putting parking below that. We said back here would become a rooftop (indicating). I mean eventually we'd like to see the rooftop extended along here (indicating) so that you have the rooftop covering not only the service entry, but whatever parking we put back here.

But we would also like to see the emergency room drop-off and entry way to that under cover, again for the same reason. I mean it's a 7/24 operation. There's a lot of activity that goes around depending on what the -- how someone comes, whether it's ambulance or by police car, thing of that sort.

So we'd like for that to be covered also, mainly to protect the residents who live along that side. And it is set to be ventilated. So I mean we can have things like that that get covered, but it's protected so that you shield the noise, the lights and thing of that sort from here (indicating). So that's the proposal on the backside there.

The -- I haven't answered the question

how the service, we were saying, don't bring -- don't bring service through here because we want to make this as low as possible (indicating).

But on this end (indicating), which would be the service dock, you're going to have the 14, 15 foot clearance to structure, and so we were saying bring the service and fire access on this end (indicating). You know it's on the street close to the -- the school. They happen to agree somewhat. We're hoping that it's not too big of an impact in terms of the amount of traffic, but they're going to have traffic here.

Something like garbage delivery is probably something that -- I mean the Hospital has some control over that in terms of when it's coming too.

I know they -- I believe they have some off-site facilities for storage and may be some of that could come into play here, in terms of scheduling those, but that would be the idea of putting it here (indicating), eliminating from going the whole back distance here (indicating) and -- and the concept of having some sort of green roof along the back end (indicating).

CHAIRMAN NICHOLSON: Any other

questions?

MR. SKORUPA: I'm going to go to option four, which there is no model for it.

This is option four. And we've been struggling with conceptualizing -- let me just go back and say one thing about all the three options and the fourth option that we put on the table. We don't propose these are solutions. I mean, you know we've been studying this for just a few weeks. And it's not possible for someone in a matter of just a few weeks to give a solution to it. You know we don't think these are -- we're not proposing these as something one would go out and build tomorrow.

But what we are proposing them as conceptual options that indicate things which we think could be taken advantage of, things that could be done, and that if these were agreed to, then the architectural team for the Hospital would be encouraged to go back and to do their own version of what would satisfy the new Master Plan requirements in terms of setbacks, the height limitations and things of that sort.

We did these mainly to convince the Planning Board that there are other ways to look at this, and that the other ways may, in fact, have some

advantages, not only for the community, but also for the Valley Hospital. We know that this is not going to be well received by the Valley Hospital, in the sense that a lot of effort and money has already been expended on this. And these are fairly radical ideas in terms of what's been done to date.

Now, also, we're not criticizing the architects for what they did. I mean the plan that was developed was done within the framework of a zoning ordinance. And they created a scheme which fits the ordinance.

What we're proposing is that the Master Plan requirements change, and hence the ordinances change, and that the architects, the engineers for Valley, would in turn present a scheme which would comply with those requirements. And we think there's a whole range of those. I mean we think we've only touched some of them in terms of possibilities.

So, in any case, that's an intro. The fourth thing that we looked at, had to do with reversing the main atrium. You know this is the new Phillips Building (indicating). And we're suggesting to look at turning the atrium for the new Hospital east to west direction as opposed to north/south.

One of the things that we were

concerned about is the clearances between the Cheel Building and what was proposed in the North Wing, because it's very tight. And this says make this a big atrium (indicating), patient windows can open onto those. This can be an enclosed garden. And there are a number of examples in the U.S. in which patient rooms face onto enclosed atrium. For example Mount Sinai Hospital in New York has a very large atrium, and patient rooms face onto those. That's one that's close by, in terms of, you know, a precedent for doing that.

That would mean then that you could build this Phase I, accomplishing everything that either -- that has been proposed and that this then would remain the main entry (indicating), it would connect the back end of the Hospital because staff and so forth would come in this way (indicating). Patients and family could come in this way (indicating). And it really connects the two sides of the campus. And it takes away this very serious requirement, which is setback from Van Dien.

Then Phase II would occur here (indicating) -- Phase III, I'm sorry, would occur here.

We think this would be pretty much the

limit of what is currently required in terms of the million square feet because that would accomplish the amount of space that's required for a modern 454 bed hospital. And this represents some growth. And that -- we would say that about all three options that we presented, that those represent some growth beyond what's currently envisioned. Anyway that's option four.

MR. RICHE: How many stories?

MR. SKORUPA: Option four could either be four plus mechanicals, five or six. I think it would fit into any of those. It would cause more internal rearrangements if one were to do that, and in my view, improve the internal arrangements by permitting us a bit more habited spaces above ground, if we went to the five story or six story.

CHAIRMAN NICHOLSON: Thank you, Ray.

Is that the end of the presentation?

MR. SKORUPA: I've got one more slide and that's it.

CHAIRMAN NICHOLSON: Well, why don't you go ahead and do that and then we'll have some questions for you.

MR. SKORUPA: So what we tried to do on this slide is to indicate those major recommendations

for revision to the Master Plan.

The first thing that we would recommend is that all parking would be a structured parking and that it's predominantly underground. And we can give you some ranges in terms of what we think the split would be. But it would be the lion's share of parking would be underground, other than what we talked about on the Steilen side, which is one level of parking, structured parking, with the roof garden on top.

And we think the advantages of this is that it substantially reduces the mass of the building, it puts parking where it needs to be. It shortens the travel distances into the Hospital. And also it can be done at any time.

One could go -- we looked at the underground utilities that currently exist around the edges of the property. And it's our opinion that you could build any of this parking, both along Van Dien or Steilen tomorrow. It does not require any substantial relocation of the hospital functions.

The second thing that we recommend is that a green buffer, 130 feet deep, along the west face, along Van Dien and along Linwood. And this becomes the major buffer. It extends the primary

characteristic of the neighborhood, which is a substantial green zone. Parking would be permitted underneath the green buffer zone along both Van Dien and Linwood, but we would expect that the structural requirements would permit substantial trees and things on top of it by keeping the top of the roof several feet below grade.

And then on the Steilen side of the campus, we are also recommending 130 foot setback, and that this have a green roof garden covering -- and it can be phased. In the first phase it would cover service. And we think parking could be built and it would also cover parking in the north end.

The fourth thing we recommend is limit the total hospital area to a million square feet. And by that, we mean total area, including mechanical, power plant, circulation, exterior walls, things of that sort.

And we think that is an adequate amount of space for a 454 bed hospital, having some inpatient/outpatient diagnostic services, having an E.D. and would be a 21 century hospital with all private beds.

The next thing we recommend is limit parking to 2,000 parking spaces or 700,000 square

feet of structured parking. And going back again, this does not -- we're not -- in this case, we're not permitting parking on roofs, either the roofs are covered with a green area or they're covered with roof garden.

Limit short term parking to 200 spaces because these are really not meant for people coming to do something within the hospital, they're at the entrance to drop people off, go retrieve somebody. Somebody is dropped off at the emergency room. And that would give a total of 220 spaces.

By the way, also the 2,000 includes would -- it addresses the valet parking. We're saying there will be 2,000 spaces including whatever would be valet parking because that's another issue we tried to address was limiting the amount of valet parking, so that we don't take 2,000 square feet and turn it into 2500 square feet or 2600 square feet -- or parking spaces.

And then the final one is we recommend increasing the height limitation. And we'd prefer the six story, but five story is certainly better than the current one. And under that configuration, mechanical would not be -- the major mechanical enclosed spaces would not be permitted on the roof.

Cooling tower is an exception. Obviously there has to be exhaust fans and things like that. We were talking about enclosures for the major mechanical equipment space.

So, that's it. That's our -- looking at what's there, what's proposed, some possibilities and highlights of what we're recommending to the Planning Board.

We plan to supplement this with about a nine part report, essentially giving more detail to the things that we've talked about tonight.

CHAIRMAN NICHOLSON: Thank you, Ray.

Questions? Anne?

COUNCILWOMAN ZUSY: Just one question I have, if he can elaborate.

Ray, there's another area in this report which is what I'll call again another linchpin which plays right to the heart of this matter and has been a subject bandied about for months here. And I'd like to ask you to comment on it. I could read again, Gail, right?

MS. PRICE: Yes.

COUNCILWOMAN ZUSY: "Definition of permitted functions for the hospital. A key ingredient in the revisions to the Master Plan

for the Hospital zone would be establishment of an upper limit for the size and clinical activities of the Valley Hospital. We believe that there is a tipping point, if unconstrained, where the Valley Hospital would require a physical size and attendant activities that would produce unacceptable collateral damage to the immediate neighborhood. We do not believe that this condition exists today. We also are convinced that the proposed upgrade by the Valley Hospital would not reach the tipping point if a series of mitigating effort were put in place through the revised Master Plan for the Hospital Zone".

Could you elaborate on that?

MR. SKORUPA: Yeah, well, we thought very carefully about an institution of this size in this neighborhood. And thought very carefully about what would make it acceptable, a good neighbor, in this community. And we think the things that have the most impact on it would be the mass of the building, the amount of parking, because those two are things -- those two elements have direct consequences to the neighborhood around it.

And one way to limit the -- to mitigate because as you notice we use the word "mitigate" very carefully.

I think we implied, but didn't say, that what was proposed did not mitigate these. And, therefore, we were proposing things that we think mitigate those.

So, we think it's important that there be adequate space for the Hospital to function properly. We think there needs to be adequate parking for that. But we also -- and we spelled out in some detail, the mitigating elements that we think are needed in order to make them a good neighbor in the residential community.

MAYOR PFUND: Just a quick question with regards to the rooftop.

If it could not be put underground, and I understand your opinion that it could, is the height that they indicated an appropriate height if it's solely on the rooftop, if it's 22 feet?

MR. SKORUPA: Well, the problem is they're putting -- in this facility you have huge air handlers that need to go up into those spaces. And the air handlers are fairly massive and they have huge duct connections that go into them.

It's been our experience that about 20 feet clear is what generally works best for the given sizes, so you know, 22, plus -- 20 feet clear plus another couple of feet for structure, so I don't think it's an unreasonable requirement for that.

MAYOR PFUND: Thank you.

MR. SKORUPA: Could it be done in less? You know, as a penalty, you know, in terms of ducting and things of that sort.

I mean one can squeeze these down and get special equipment and things of that sort.

CHAIRMAN NICHOLSON: Thank you, Ray.

As you said, the Hospital, when they revised their plan, I think cognizant of the history of the land development plan approval for their buildings in the past. Ruled out probably almost immediately buildings over four stories high.

You came in with a fresh eye, not having been involved in those past discussions and see the benefit of buildings taller than four stories. And it would seem to me in looking at some of your schemes versus the Hospital scheme that -- that that is a significant -- that is the second most significant. The first being, of course, the parking. But the second most significant change in

perspective.

MR. SKORUPA: Right.

CHAIRMAN NICHOLSON: I presume that you would only support higher buildings with 130 foot setback?

MR. SKORUPA: Well, you know, we proposed four plus mechanical at 130 feet, so our preference would be to go to -- mainly for benefit to the Hospital I mean what we try to do is look for ways that we can offer things that would be attractive to the Valley Hospital in terms why should we change and go to this? You know I mean it seemed like to us that if one can indicate things which are of a benefit to the Hospital, maybe there's some advantage for them to do that, maybe there's some reason for them to replan. So that was part of the thinking in terms of looking at options to offer an attraction for every party saying if we do this, this is the benefit for you.

We tried to do it both for the community and for the hospital.

MAYOR PFUND: In your alternate one, you moved the North Building east, if I have that correct.

I believe there may have been some

testimony regarding the fact that it wasn't ideal for the Hospital to move it any further east because of the internal layout having to do with the location of the elevators and the shafts and the utilization within the building of that as a buffer between units. I may be off a little bit on that.

But do you have any comment as to that? Did you give any consideration to the internal buffers and whether or not by simply sliding it east that, in fact, it causes more problems than it may seem on the surface?

MR. SKORUPA: Yes, we did. There were -- to my recollection, there were a couple of issues related to the position of the North Wing. One had to do with the issue that you raised in terms of its connection to the nursing units and the core. And The second one had to do with the service dock and mechanical equipment space on the west end, on the Steilen end of that.

So we looked at it and this is the proposed plan. This is level four. And they're typical for levels two, three and four.

In red is what's proposed. This is the north atrium (indicating). This is the Cheel Building. And there are elements that are existing

that would probably be removed. And this is the major core. And these are the two circulation elements. And this appears to be open space. And this appears to be a four story space (indicating), you know, coming in at level one, going up to level four.

And then this is the connection to nursing unit one (indicating), which is here. And nursing unit two. These are not quite symmetrical. You know this unit actually starts somewhere in here (indicating), and this one starts somewhere over here (indicating). So they're not two equal ones. This is not exactly in the middle. So the architects, on their own, have shifted this off of an exact symmetrical plan.

We looked at a plan -- let me bring it up.

MAYOR PFUND: It's probably off a little bit at our request or our suggestion, but...

MR. SKORUPA: I apologize for searching here.

MAYOR PFUND: It looks like you did a lot of work.

MR. SKORUPA: We did.

I can't find it. I think it's -- I'll

submit it as a -- we did a plan in which we looked at this very issue. And we reconfigured the building so that we could give two nursing units per floor, as some sort of central access point. And we reconfigured the building so it was no longer a rectilinear shape, but was sort of a rhombus shape and put adequate space on the left-hand side, adequate space of the right-hand, to accommodate a 32 bed nursing unit using the room plans that the architects for Valley had. We just took those and pasted them in.

So we're convinced that a different shape can be done. And that you can get an equal to or better nursing unit. But it's not fixed to that particular shape.

MAYOR PFUND: Thank you.

CHAIRMAN NICHOLSON: Anybody else?

MR. RICHE: No.

CHIEF BOMBACE: No.

CHAIRMAN NICHOLSON: Ray, you had already indicated some of the things that you plan to add to the report.

I think to summarize some of the things that we've asked you specifically to add include an analysis of the aboveground versus below ground

square footage for the alternatives that you presented.

Is there anything else?

COUNCILWOMAN ZUSY: Coverage.

MS. PRICE: Coverage.

CHAIRMAN NICHOLSON: And lot coverage.

MR. SKORUPA: Okay. We've done the analysis above and below. And we'll do the lot coverage. And we'll do that with Blais because he's -- we'll use his interpretation of the current zoning so that we get it in the right format.

So, yes, we'll do both of those things.

CHAIRMAN NICHOLSON: Is there anything else Members of the Board, staff, Blais, Gail?

MS. PRICE: I just want everyone to -- I'm not sure where we're -- I'm assuming that we're going to go to another work session because Ray's not done with his formal report. So if we carry forward to another work session, there are a couple of options. When we conclude that, depending on where the Board goes at that point.

If the Board makes any changes to the Master Plan language that is currently pending and that we started the hearing on, if those changes are substantial changes, we're going to have to renotice

for a continuation of the hearing, and -- not start anew, but technically it's considered a new hearing, but the old testimony would be carried forward. But we'd have to renotice, so when scheduling, if the Board makes any changes, we need to factor that into the timeframe in between the work session and the next hearing.

MAYOR PFUND: I'm curious. You know, I'll look for you, but not for an answer right now, as to how we would proceed if in fact -- I mean what's interesting is with his alternative he's not trying to dictate the architecture of this plan, in essence, to show the options, which seemingly there are five from the original to the four alternatives. And is it something that we then want -- would like to encompass latitude within the Master Plan, so that all of these can be studied by the architects in the future for development or do we try to chose an alternate that we like or an original that we like? Or something else?

I'm not sure what we're going to be charged to do or looking to do, Again, not approving, that's for a site plan down the road. But, I guess, we're going to need some advice in terms of how we're proceeding.

MS. PRICE: Right now we have, in the language that Blais prepared, there are bulk regulations that are discussed.

So to the extent that those bulk regulations may not be relevant any more or may need to be modified, that's what the Board needs to consider after hearing the entire report from Ray, whether any of that needs to be modified, setbacks, height, buffers.

MAYOR PFUND: Or it could be expanded upon.

For example if we say -- and I'm not saying this is what I want, but as an example, alternative from what's proposed, 130 foot setback with an increase in height, I'm making it very simple, so we could, if we wanted to as a Board, give and alternate, our own alternate, so that there are choices in the future as to what to do. I mean is that --

MS. PRICE: I mean depending on what it was, because then let's just say the Board went ahead with a Master Plan Amendment, then the next step would be preparation and forwarding of an ordinance. And then Council would have to act on that ordinance. So it would need to be some form of specificity in

that ordinance for adoption so --

MAYOR PFUND: Right, but our -- our proposed Master Plan has some specificity in it that, in essence, if we'll be adopting some of the things at the hearing, we're going to have to either change it or give alternatives within our own Master Plan.

Is that what you see happening?

MS. PRICE: I think that, you know, all along the way that we've had input from the Hospital and at some point we're going to need that input again, in terms of where we're going, I believe, because depending on what the Board wants to do vis-a-vis the report feasibility of those items certainly is an issue.

MAYOR PFUND: So are we going to hear from the Hospital in response --

MS. PRICE: Well, that's an option for the Board. Certainly --

MAYOR PFUND: -- to that?

CHAIRMAN NICHOLSON: -- that's an option the Board has.

MAYOR PFUND: So that maybe we'll hear, yeah, we didn't think of that or we thought of that and it's no good to us because of this or, great, we love something that's something else. I mean I --

MS. PRICE: That's an option that the Board certainly has. And at this point Ray's report is a draft presentation for the Board. And I think at the next meeting it's hopeful that that will be completed and the Board will work through any questions.

But at that point the goal would be to release it in final format, and then have input back in terms of, you know, the acceptability of those items, the feasibility of those items. And then we have a session on that.

MAYOR PFUND: Is there a concern at this point of releasing this draft so that everyone who has an interest can start analyzing --

MS. PRICE: Well, it's --

MAYOR PFUND: -- it. I only ask that for timing purposes.

MS. PRICE: Yes.

MAYOR PFUND: That we're not three months down the road.

MR. BRANCHEAU: Dave, I have one concern. And I know we don't really have the time to do that prior to this meeting, but some of Ray's suggestions could have a potential impact on distribution of traffic entering and exiting the

site.

And I would like to see, before this is released, some analysis of -- by the Board's traffic consultant, on implications, if any, of the various proposals from a traffic impact standpoint because I don't think we'd want to be moving forward with that as a proposal if we were to find out, let's say, that it had a dramatic shift in traffic leading to an unacceptable situation.

So it need not be as detailed as what we've already gone through on traffic, but I can only suggest that given the level of effort that went into all the traffic studies, based upon distribution of parking, based upon driveway locations and so on and so forth, and the Board gave considerable weight to ensuring a relief valve, if you will, for people leaving the parking -- the parking decks to ensure that we wouldn't have too much queuing of parking at one driveway versus the other.

I think we need at least a preliminary conceptual look at this from a traffic standpoint to ensure that what the Board ultimately chooses to go forward with has considered the traffic impacts of Ray's alternatives.

MAYOR PFUND: Why -- and, again, you

can tell me to be quiet and I will, but if we give it out as a draft, with people understanding that we're going to look at the traffic impacts so -- I mean I don't want to spend a lot of your resources on it.

MR. BRANCHEAU: Well, I understand that. Yeah, and as a draft that's -- you know, I don't have an issue with that. I'm just saying that before the Board votes or takes any decisions to move forward with any amendments.

MAYOR PFUND: Well, I agree there's going to be a lot of further discussion as to what we've heard. I just don't want to delay things because it's really not fair if all of a sudden, you know, we don't get a final report for whatever, a month, and then people are going to want to respond to that. And is that going to take another two months?

MS. PRICE: I think our --

COUNCILWOMAN ZUSY: I think we should go ahead.

MS. PRICE: I think our next meeting is -- that we blocked out is in two weeks, on the 19th was the date that we had scheduled. And I think Barbara confirmed the availability of this location for that meeting.

So, I mean from a legal perspective -- it's up to the Board, but from a legal perspective we have not released any of our draft reports under, you know, the interagency work product, until the Board has signed off on those reports. So I posture that for the Board's consideration.

MAYOR PFUND: Your advice to the Board is to wait --

MS. PRICE: Two weeks.

MAYOR PFUND: -- in light of those requirements.

CHAIRMAN NICHOLSON: There is no --

MS. PRICE: I mean I -- I also think that there's been a presentation tonight, the information has been heard, there's representatives from the Hospital here and there's representatives from CRR. I don't think that anything is not --

MAYOR PFUND: That's why I'm wondering --

MS. PRICE: -- that's not known tonight.

MAYOR PFUND: -- what the harm is releasing the draft, if it's been presented to us, but I'll...

MS. PRICE: It would be my preference

not to release the actual document at this point, you know we're going to be back here in two weeks. And I think I'd rather release the full report.

COUNCILWOMAN ZUSY: Gail?

CHAIRMAN NICHOLSON: But, Gail, there's -- any concern -- and, Blais, I'll ask you the same, any concern of calling Joe Staigar and saying -- and giving him a copy of the draft before and asking Joe to give us a presentation in two weeks on what he feels might be the possible impacts to his report to Ray's suggestions. So at least we're --

MS. PRICE: Yes, we can do that absolutely.

CHAIRMAN NICHOLSON: -- we're moving ahead.

In fact, I also would ask Blais to consider, for a possible presentation on the 19th, your thoughts on how our Master Plan amendment draft might be changed along the lines that the Mayor has alluded to. How might we incorporate Ray's report into our ordinance?

MR. BRANCHEAU: I can do that. I can do it based upon each alternative or I can do it based upon all the alternatives in total, if that's the Board's pleasure.

CHAIRMAN NICHOLSON: Well, I think the sense of the Board is we'd like you to do that.

So on the 19th, we could not only hear from Ray with respect to his final report, and it's completion, but also work our way through the next steps with Joe and yourself and keep the ball rolling.

COUNCILWOMAN ZUSY: Mr. Chairman, I have a question.

CHAIRMAN NICHOLSON: Anne?

COUNCILWOMAN ZUSY: I was talking with Ray before our meeting this evening about the fact that he mentions in this report that we have -- we essentially have today, that he's not dealing with issues of construction because that was not particularly germane to the Master Plan per se, that we were talking about the possibility of considering the possibility of maybe having -- what did you call it a construction management consultant? Having someone like that might at some point along the way be something we might want to bring in to advise us on that, just as he's been advising us on the Hospital issue. Throw it out.

And also bring, Ray, when are you going to give us the rest of the report? You stated this

section is the first of a nine part final report? Is that coming in the coming weeks? Or how long do you think it will be?

MR. SKORUPA: I would think I could do it before the 19th.

COUNCILWOMAN ZUSY: Oh, right.

CHAIRMAN NICHOLSON: All right. So that's how we will proceed if no one objects.

Our next -- Gail's going to object.

MS. PRICE: No. I'm not objecting.

But the other possibility, just listening to the Board is, all the way along, I just want to put it on the record, number one, even though this is work session, that in order to get Ray started there was a meeting with the Hospital to go through certain documents and information that Ray was going to need. And Ray also met with Mr. Gould on behalf of CRR.

So there's nothing that would preclude an additional meeting between now and the 19th because that would also be an item. We've got feasibility, because we've had meetings all along in this process.

So if the Board wanted that to happen that could certainly be handled between now and the

19th. So that we just didn't lose the time frame.

CHAIRMAN NICHOLSON: That makes a lot of sense. I think the Board Members all agree.

MAYOR PFUND: Yes.

MR. HURLEY: Yes.

MR. RICHE: Yes.

CHAIRMAN NICHOLSON: Okay. So we will reconvene here on the 19th. We will hear, again, from Ray.

Blais, and you, as well. And, Blais, and, Gail, I'd ask that you reach out to Joe Staigar tomorrow morning, see if he can be with us on the 19th with some kind of reaction to Ray's work.

And to the members of the public and to the Hospital and the Concerned Residents of Ridgewood, looking to move on from the 19th to resume the public process.

And I would imagine starting that -- restarting that process with an opportunity for both the Hospital and the Concerned Residents of Ridgewood to comment on Ray's report.

And then following that process moving back to the public.

MR. COLLINS: We do not anticipate then that there would be public participation on the night

of the 19th of October?

MS. PRICE: No.

CHAIRMAN NICHOLSON: No it would be at the next session.

MR. COLLINS: Because we wouldn't have anything upon which to comment on.

CHAIRMAN NICHOLSON: That's correct.

Is everybody in agreement?

MS. HURLEY: Yes.

MAYOR PFUND: Yes.

CHAIRMAN NICHOLSON: Then, ladies an gentlemen, thank you.

Motion to adjourn?

MAYOR PFUND: So moved.

CHIEF BOMBACE: Second.

CHAIRMAN NICHOLSON: All in favor?

(Whereupon, all present Planning Board Members respond in the affirmative.)

CHAIRMAN NICHOLSON: Thank you ladies and gentlemen for coming out this evening. See you on the 19th.

(Whereupon, this matter will be continuing at a future date. Time noted 9:42 p.m.)

C E R T I F I C A T E

I, LAURA A. CARUCCI, C.C.R., R.P.R., a Notary Public of the State of New Jersey, Notary ID. #15855, Certified Court Reporter of the State of New Jersey, and a Registered Professional Reporter, hereby certify that the foregoing is a verbatim record of the testimony provided under oath before any court, referee, board, commission or other body created by statute of the State of New Jersey.

I am not related to the parties involved in this action; I have no financial interest, nor am I related to an agent of or employed by anyone with a financial interest in the outcome of this action.

This transcript complies with regulation 13:43-5.9 of the New Jersey Administrative Code.

_____
LAURA A. CARUCCI, C.C.R., R.P.R.
License #XI02050, and Notary Public of New Jersey #15855, Notary Expiration Date March 1, 2009

Dated: _____

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