GOVERNMENT
OF
THE DISTRICT OF COLUMBIA

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ZONING COMMISSION

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PUBLIC HEARING

IN THE MATTER OF: The Application of Arter and Hadden, on behalf of MedStar Health, Inc., for a map amendment from R-5-A to SP-1 and SP-2 for portions of Lot 2 in Square 3129.	Case No. 00-02

Thursday,
December 7, 2000

Hearing Room 220 South
441 4th Street, N.W.
Washington, D.C.

The Public Hearing of Case No. 00-02 by the District of Columbia Zoning Commission convened at 7:00 p.m. in the Office of Zoning Hearing Room at 441 4th Street, Northwest, Washington, D.C., Anthony J. Hood, Chairperson, presiding.

ZONING COMMISSION MEMBERS PRESENT:

ANTHONY J. HOOD	Chairperson
CAROL J. MITTEN	Vice Chairperson
HERBERT FRANKLIN	Commissioner
KWASI HOLMAN	Commissioner
JOHN G. PARSONS	Commissioner

OFFICE OF ZONING STAFF PRESENT:

Alberto Bastida,	Secretary, ZC
Gerald Forsburg,	Office of Zoning

OTHER AGENCY STAFF PRESENT:

Andrew Altman,Director,	Office of Planning
Steven Cochran,	Office of Planning
Ellen McCarthy,	Office of Planning

D.C. OFFICE OF CORPORATION COUNSEL:

Alan Bergstein,	Esq.
Marie Sansone,	Esq.

I N D E X

P-R-O-C-E-E-D-I-N-G-S

(7:07 p.m.)

CHAIRPERSON HOOD: Good evening, ladies and gentlemen. This hearing will please come to order.

This is a public hearing of the Zoning Commission of the District of Columbia for Thursday, December 7, 2000. My name is Anthony J. Hood, Chairperson of the Zoning Commission of the District of Columbia. Joining me this evening are Commissioners Herbert M. Franklin, Kwasi P. Holman, Carol J. Mitten, who serves as Vice Chair, and joining us shortly will be John G. Parsons.

I hereby declare this hearing open. Notice of today's hearing was published in the D.C. Register on October 27, 2000, and in The Washington Times on October 23, 2000. This hearing will be conducted in accordance with the provisions of 11 DCMR 3020.

The subject of this evening's hearing is Zoning Commission Case Number 00-02MA. The applicant and owner of the property, MedStar Health, Incorporated, represented by the law firm of Arter and Hadden, is requesting the Zoning Commission to approve an amendment to the zoning map from R-5-A to SP-1 and SP-2 for portions of Lot 2 in Square 3129.

According to the applicant, the proposed rezoning would allow the correction of existing deficiencies regarding space, parking, and internal and external circulation for The

Washington Hospital Center.

The order of procedure will be as follows: preliminary matters, applicant's case, report of the Office of Planning, report of other agencies, report of the Advisory Neighborhood Commission 2C --

VICE CHAIRPERSON MITTEN: 5C.

CHAIRPERSON HOOD: -- 5C, and I -- 5C, I'm sorry -- parties and persons in support, parties and persons in opposition. The Commission will adhere to this schedule as strictly as possible. Those presenting testimony should be brief and non-repetitive. If you have a prepared statement, please give copies to staff and orally present only the highlights. Please provide copies of your statement before summarizing.

All persons appearing before the Commission are to fill out two witness cards. These cards are located at each end of the table in front of us. Upon coming forward to speak to the Commission, please give both cards to the Reporter sitting to my right. If these guidelines are followed, an adequate record can be developed in a reasonable length of time.

The decision of the Commission in this case must be based exclusively on the public record. To avoid any appearance to the contrary, the Commission requests that persons present not engage members of the Commission in conversation during any recess or at any time. The staff will be available to discuss procedural questions.

Please turn off all beepers and cell phones at this time, so not to disrupt the proceedings.

Would all individuals planning to testify please rise to take the oath.

(Whereupon, an oath was administered to those individuals planning to testify.)

CHAIRPERSON HOOD: I'm going to ask, is there anyone present in opposition to this particular case? Again, is there anyone present in opposition to this particular case?

Mr. Moore, I'm going to ask -- first, I want to ask you, how much time do you think you need?

MR. MOORE: One hour.

CHAIRPERSON HOOD: One hour? I will also say, while you need an hour, I understand, but we have read your submittals. While we want full detail, again, be cognizant that we have read your submittals.

With that, Mr. Bastida, do we have any preliminary matters?

SECRETARY BASTIDA: Mr. Chairman, the staff has no preliminary matters. Thank you.

CHAIRPERSON HOOD: Okay. With that, colleagues, if everything is in order, we're now ready for the applicant's case.

MR. MOORE: Good evening, Chairperson. Am I on?

CHAIRPERSON HOOD: You're fine.

MR. MOORE: Okay. Good evening, Chairperson Hood

and members of the Commission. I'm Jerry A. Moore, III, of the law firm of Arter and Hadden, LLP, appearing this evening as counsel to MedStar Health, who is the owner and operator of the Washington Hospital Center and the National Rehabilitation Hospital.

This is a classic map amendment case, wherein MedStar seeks rezoning of all of its property on Square 3129 that is zoned R-5-A to the Special Purpose 1 and Special Purpose 2 zone districts. The parameters of this request are detailed in your packets and will be discussed again this evening.

The site, located on Lot 2 in Square 3129, contains approximately 1,500,000 square feet, or about 33-1/2 acres of land area. This rezoning is necessary and in the interest of the District of Columbia for three reasons.

First, the existing R-5-A zone district accords MedStar, the District of Columbia's predominant nonprofit health care provider, no more FAR space to improve and expand its services to the public.

Second, the 1998 amendments to the comprehensive plan, together with the past and future uses on the site, compel and substantiate a zoning consistency case.

Third, this rezoning will allow MedStar -- again, the District of Columbia's most frequently patronized and most highly regarded health care provider -- with building space it desperately needs to improve its medical services, off-street

parking, and internal and vehicular circulation.

We have done our homework. When it became clear that this rezoning was necessary, MedStar meticulously investigated the zoning alternatives that were available. Thereafter, it soon became clear that no category of residential zoning was appropriate because there is no chance that the site will ever be used for residential purposes.

The residential zoning will not allow a physician's office building, a critical element to MedStar's business, and the comprehensive plan does not support the continuation of residential zoning.

We also considered the pros and cons of utilizing the planned unit development process but quickly realized that this is a basic map amendment case rather than one that needs the extraordinary relief that the PUD process provides.

This is not a planned unit development case because, one, all development that MedStar has planned fits squarely within an existing zoning category; two, MedStar's plans do not require more height and density than the requested zoning category provides; and, three, MedStar's plans do not require development incentives; four, MedStar requests no relief from the existing matter of right standards; and, five, because of the volatile nature of its business, MedStar requires flexibility in the timing, location, and design of its structures.

And the Zoning Commission has already determined

that the special purpose zoning that MedStar requests is an appropriate zoning category for this square.

We also looked at the zoning of other hospitals in the District of Columbia. We discovered that Howard, George Washington, and Georgetown Universities are all located in districts that accord them significant amounts of building and use capacity. This is so because they are all subject to the campus provisions of Section 211 of the zoning regulations, which means that the FAR is governed by the university as a whole and not by the site itself.

Children's Hospital, National Medical Center, which is also located on Square 3129, is already zoned SP-2. There are four hospitals that are located in the R-5-A district -- Providence, Hadley Memorial, Greater Southeast, and Sibley. Of these, Sibley -- I believe those of you who have sat on the BZA from time to time -- is constantly -- not constantly, repeatedly in the BZA for area variances, so that they can expand within their lot envelope. They currently have an area variance case in the BZA, which goes to hearing in January of next year.

We would note here that MedStar provides a far greater breadth of services and has a far higher user count than any of these previously mentioned hospitals. Columbia Hospital for Women is located in an R-5-D zone district, which accords it approximately the same FAR as that being requested here by MedStar. D.C. General, Veterans, St. Elizabeths, and Walter Reed

Hospitals are virtually free to do what they want, because they are located on federal property that is unzoned.

We looked at the zoning in the area of the Washington Hospital Center and quickly determined that Square 3129 is zoned residential today because it was initially zoned that way in 1958 when the square was a vacant tract. A portion of the square was rezoned SP-2 in 1970 to accommodate the construction of the new Children's Hospital.

A portion was rezoned SP-1 in 1995 to accommodate MedStar's new physician's office building and parking pavilion 2. The site is unique in the District of Columbia because all of the property located to the north, to the east, and to the south of MedStar's site is unzoned because it's federal property.

There is, however, an R-4 zone district that begins approximately 500 feet to the north and to the west of the site. In 25 years of practicing real estate law, this is the only case that I can remember where the list of property owners located within 200 feet of a subject property numbers only two. The closest property owner other than the federal government is nearly 1,000 feet away.

We also researched the certificates of occupancy that have been issued to MedStar property since 1958. The site has been used predominantly as a hospital with a variety of ancillary uses that are provided as additional services to the users of this nonprofit institution.

In the end, we concluded that special purpose zoning is appropriate for this site because, one, the Zoning Commission has already determined that SP is an appropriate zone for the square; two, residential zoning is neither compatible with the past or future uses of the site, nor consistent with the comprehensive plan; and, three, because SP zoning is only the next highest zoning category after R-5.

CR zoning does not permit a hospital use as a matter of right. Therefore, it is not a good zone for MedStar. SP zoning, on the other hand, is consistent with the policy purposes of the Zoning Act in that it provides convenient health care services that will accommodate the day-to-day needs of local residents and workers, encourage stability in the area, and enhance the area's desirability for growth and development.

And the site is located on an arterial, which has easy access to multiple mass transit routes, is compact in area, and will provide substantial amounts of employment.

We are hopeful that your decision today will also be made easier by the detailed land use and planning discussions that have already been submitted. The written case will be supplemented and highlighted by the testimony and the exhibits that you will hear and see this evening.

Much of the technical evidence will be offered by persons who the Commission has recognized as experts in their fields in previous Zoning Commission and Board of Zoning

Adjustment cases. We have endeavored to organize our presenters in a logical and an efficient manner.

First, John L. Greene, MedStar's Executive Vice President for Corporate Services, will speak to who MedStar/Washington Hospital Center is. Unfortunately, Mr. Greene underwent unscheduled surgery on Monday of this week and for that reason is unable to be here this evening.

I cannot tell you how much he regrets his absence this evening. He has been at the center of this rezoning project since it was initiated nearly three years ago. In his place, Christine Swearingen, Vice President for Strategic Planning, will provide the testimony that Mr. Greene would have given.

Next, Dr. Lawrence Lessin, the Medical Director for the Washington Cancer Institute at the Washington Hospital Center, will describe how Washington Hospital Center works.

He will be followed by Clarence Brewton, Vice President, Regulatory Compliance and Community Development, who will describe MedStar's efforts to obtain and incorporate the views of its neighbors.

I think you all know Albert Dobbins, our city's former Planning Director and member of the board of the National Capital Planning Commission. Mr. Dobbins will speak to the planning considerations that support this application.

Mr. Dobbins will be followed by Gerald Oudens, the principal in the architectural firm of Oudens and Knoup, who will

describe MedStar's research and plans for the site.

I think the Commission is also familiar with Osborne George of O.R. George and Associates, which has undertaken a traffic and transportation analysis of the area in the context of this proposed rezoning. Mr. George has been accepted as an expert witness by this Commission on numerous occasions.

We trust that you will find our evidence to be substantial, efficiently presented, and persuasive. And with that, I'll first call on Ms. Swearingen to testify, unless there are questions from the Commission.

CHAIRPERSON HOOD: I think what we'll do, Mr. Moore, is to hear the case, and then we will ask our questions on the back end.

MR. MOORE: All right. If you would be so kind, as we -- we do have a Powerpoint presentation. Is there a way to turn that light off that is just under that -- over the screen, to make it more visible to the Board -- to the Commission? There. All right.

Ms. Swearingen?

MS. SWEARINGEN: Good evening, gentlemen and lady. My name is Christine Swearingen. I'm Vice President of Strategic Planning for MedStar Health, and I will very briefly describe to you our company and Washington Hospital Center.

MedStar Health is the largest health care system in the Baltimore-Washington region. It includes seven acute care

hospitals, over 3,000 licensed beds, over 22,000 employees, and over 4,000 affiliated physicians.

This overhead gives you an idea of the volumes that -- of services we provide. Just as an example, on any given day, over 1,700 people are being cared for in one of our hospitals. We also provide outpatient visits. We are a major provider of emergency services across the region. We operate the largest home health provider in the region and a nationally recognized heart program.

We are also a financially sound organization with close to $2 billion in assets and over $1.5 billion annually in revenues. In the District of Columbia, MedStar Health operates the Washington Hospital Center, the National Rehabilitation Hospital, Georgetown University Hospital, the Visiting Nurse Association, and MedStar Manor at Lamond Riggs, a long-term care facility.

We are here tonight because we need to do some significant things to address the needs of the Washington Hospital Center, to enable it to continue to provide the high-quality heart services, trauma care, emergency care, and other specialized services for which it has become well-known.

The Washington Hospital Center was established in 1958 at its current location through the merger of three community hospitals in the District -- Garfield Memorial Hospital; Episcopal Eye, Ear, and Throat Hospital; Central Dispensary and Emergency

Hospital. It has, since 1958, evolved from a community hospital to the District's largest health care facility.

The Hospital Center is the single largest provider of hospital outpatient, inpatient, and emergency services for the residents of the District of Columbia, and especially for residents who live east of Rock Creek Park.

We serve one in five District residents who are hospitalized. Over 60,000 residents seek care in our emergency room this year; over 4,000 babies will be delivered. We will provide over 200,000 outpatient procedures, over 2,700 open heart surgeries, one of the largest in the country, and over 100 kidney transplants, to name just a few of the services we provide.

The map which you are about to see indicates the primary service area for the Washington Hospital Center. The red cross in the middle of that indicates the location of the Hospital Center. The zip codes with the darkest blue shades are those from which the majority of the Hospital Center's patients are drawn.

We draw over -- about 50 percent of the patients from the District of Columbia itself, but, most important, large numbers of patients are drawn from the eastern part of the city, southeast and northeast D.C., and over into Anacostia.

This chart shows the numbers of District residents who were hospitalized in fiscal year '99 and shows in what hospitals they were served. As you can see here, the Washington Hospital Center is the single largest provider of inpatient care

for District residents, providing almost twice as many -- care to almost twice as many residents as the next largest hospital, D.C. General.

Many of you are aware of the fact that over the last 20 years services provided by hospitals have been on the decrease because of cutbacks in Medicare funding and because of managed care companies. What we are seeing, both locally and nationally, now is a reversal of that trend. As the babyboomers age, and as the population, the older population remains alive longer, we are starting to see a turnabout in the utilization trends.

What is demonstrated on this chart is the experience of District hospitals between calendar years '97 and '99. During that timeframe, there was actually an increase in inpatient admissions of over one percent with five hospitals showing increases, the largest increase at the Washington Hospital Center, which increased in admissions by almost 3,000 in that one -- in that three-year period.

Looking more historically between 1990 and the year 2000, admissions at the Hospital Center increased by almost 40 percent. That's a huge increase, especially in an institution which already was serving the largest number of patients in the District.

We are here tonight because the master plan is crucial to the Washington Hospital Center's future. It is

necessary to do a number of extremely important things. We need it to alleviate crowded and cramped facilities. We need to renovate substandard facilities to meet modern standards.

We need to replace obsolete facilities. We need to improve the access to facilities and services on campus. We must improve traffic flow and parking convenience and availability. We need to improve the aesthetic and healing environment for patients and visitors to the campus. We need to accommodate newer medical technology. We must make ambulatory services more accessible.

We need to consolidate our cardiac services, and we need to provide adequate space for the long-term needs of the institution's Centers of Excellence research and educational programs.

This is the problem facing us. The area limitations of the existing residential zone accord the Washington Hospital Center with no more building latitude to meet the needs of our patients and physicians. We are built to the capacity of the existing residential zoning envelope. It is extremely unlikely that this site will ever be used for residential purposes. As you will hear, we have done our homework.

We have a team of experienced professionals. We have done a survey of hospital needs. We have surveyed our community and listened to their needs and opinions. We have held multiple meetings with the D.C. Office of Planning and the D.C. Department of Public Works. We have met with council members of

the District of Columbia and with ANCs. We have met with community groups, and we have consulted with nearby institutions.

We are here tonight because we need your help to keep the Washington Hospital Center the hospital of choice.

Thank you.

MR. MOORE: All right. Questions of Ms. Swearingen?

CHAIRPERSON HOOD: I think what we'll do -- Mr. Moore, again, I think we'll wait --

MR. MOORE: All right.

CHAIRPERSON HOOD: -- until you finish the whole presentation. So if everybody can just kind of stay with us, please.

MR. MOORE: Okay.

DR. LESSIN: Good evening, Chairman Hood and members of the Commission. I'm Dr. Lawrence Lessin, a practicing medical oncologist and the Medical Director for the Washington Cancer Institute at Washington Hospital Center.

I'm a Washingtonian. I was born in Washington, D.C., at Garfield Hospital, one of the forerunners of the Hospital Center; educated in D.C. public schools, went off to college and medical school and came back to Washington where I've worked in universities and for the last seven years at Washington Hospital Center.

I actually worked in the old building of the

Washington Hospital Center in 1958 when I was a medical student, the year it opened.

In my testimony tonight, I'd like to describe who we are, the changing clinical needs of our patients, and how patients' needs are driving our attempts to expand and modernize the Washington Hospital Center.

First, let me give you a quick overview of the Washington Hospital Center from a medical standpoint and the services that we provide to the community. We are the largest provider of hospital services to D.C. residents, serving one out of every five hospitalized D.C. residents.

For the community immediately surrounding the Washington Hospital Center, and most of east of the Park, D.C., we are the front line caregiver. Most of this care is provided through our ambulatory clinics, which see over 100,000 outpatient visits, our Emergency Department with 54,000 visits last year, and we assist those who are unable to pay for their care by providing free or subsidized care totalling over $33 million annually.

Not only do we provide care to the sick and injured, we also provide a range of health promotion and wellness programs to the community to help people stay healthy.

As much as we are a major provider of primary health services, the Hospital Center is also the leader in specialized care and a regional referral center which outlying physicians and patients rely upon for their specialized services.

We're also a teaching and research hospital that trains over 200 medical, surgical, and obstetrical residents, as well as residents and fellows from most of the medical specialties, and we also train allied health students in nursing and the medical technical fields.

Our teaching and research programs bring to our patients leading-edge technology and innovation that helps us maintain a high level of quality of care.

We have specialized Centers of Excellence. Those centers, as you can see, include Washington Heart, the Washington Cancer Institute, the Washington National Eye Center, the Burn Center, the Transplant Center, and the MedStar Trauma Center for critical care services.

We are consistently listed in the HCIA's top 100 hospitals in the United States. Our heart center performed over 2,900 open heart surgeries last year alone and is amongst the largest such programs in the nation. In 1999, our cancer institute saw the largest number of cancer patients in the Washington Metropolitan area, and also received the Mercury Award recognizing it as one of the best regional cancer programs.

We have the area's only adult burn center where the most severely burned patients are treated, and our organ transplant center's experienced doctors and nurses enjoy a success rate well above the national average. Our trauma center, MedStar, is consistently named one of the nation's best Level 1 shock

trauma units and provides that level of care to the D.C. community with excellent transport and helicopter medical services.

As the few next slides will illustrate, many of our key clinical programs are growing and growing at rates where we will soon be out of room, and, in fact, in many of them we're out of room already.

The core of our facility, the main building, is over 40 years old. As I mentioned, I worked in it in 1958, and it's outdated. It was built as a state-of-the-art building in those years, but it is outdated for today's practice of medicine, let alone the projected needs for the practice of medicine in the years to come.

The next few slides will illustrate our problem of growth. In many ways, we are victims of our own success, and the level of care we provide the community, rendering us with crowded and congested facilities. We lack adequate space not only for some of our patient care activities but for teaching and research programs, and we are unable to, in some cases, provide basic amenities for our patients.

Right now, our growth in patient volume is outpacing available space for key clinical programs. This is a very real problem. The curve that you see here is just an example. This is the outpatient services number of visits per year annually provided by the Washington Cancer Institute alone, which is roughly about one-half or one-third of the total

outpatient visits provided. This is truly a problem for us.

Here we have growth in outpatient visits, which just illustrates the fact that as our outpatient population continues to grow, and the general population continues to age, we need to be able to meet their needs in terms of treatment, space, and resources. Again, here, you can see the trend in in-patient surgeries, keeping pace with other growth trends.

If we go on to the next slide, you can see the number of emergency room visits. The Hospital Center is the most active Emergency Room Department in the Washington area, and this is an old facility, which, as you can see in this photograph, is crowded, it's a busy, bustling place, if you have ever been there.

It's efficiently run because of the world-class Informatics and computer system that they have installed, nationally recognized for its excellence, but we're out of space and it slows down the management of these patients.

The next slide shows a typical shot in their intensive care unit, and here you can see a number of the high tech apparatus that are required to treat a single patient. Very often these rooms are more crowded than this, and you can't get by because of the presence of all of the machinery and all of the personnel that are needed to care for these folks.

Note the electric fan to improve air handling, to keep the patient comfortable as well as the other folks there.

So we are here to ask the Zoning Commission to allow us to expand and upgrade our facility, so that we can continue to provide the quality of care and the humane aspects of care that the community has come to expect and demand from us.

The doctors and nurses and other health care professionals who work in hospitals are really great at improvising. They can usually find a way to overcome just about any resource limitation, but hospital care has changed so much and so dramatically over the past 40 years that we simply don't have enough space even to improvise.

This is a picture of what we call the trailer park. You can see Children's Hospital on the left, with its nice glass facade there. The Washington Hospital Center red brick building is on the right, and many trailers in between where our Research Department and many administrative departments are located. These obviously are trailer temporary-type facilities in which we have been living in many cases for more than a decade.

With your help, hopefully we can continue to keep the hospital -- the Washington Hospital Center as the hospital of choice for the District of Columbia and its citizens.

Thank you.

MR. MOORE: Thank you very much.

Mr. Brewton?

MR. BREWTON: Good evening, Mr. Chairman, members of the Commission. My name is Clarence Brewton, Vice President

for Regulatory Compliance and Community Development for MedStar, and my testimony will focus on activities that we pursued in the community to inform them about this project and to explain our needs and to garner their support for the project.

And the first step in that process was to identify the major stakeholders who will be involved in this project, including the neighbors, neighboring residents who are mostly patients, the institutional neighbors, Advisory Neighborhood Commissions, and other organizations.

And the way we involve them, we wanted to involve them in the upfront planning process and not bring them in at the end of the process. And we did that by, first of all, surveying the community. We sent out 21,000 -- we surveyed 21,000 households to ask -- first of all, informing them about this project, and to ask their input, and to give us comments as we move forward with the planning process.

We used our community advisory group to help -- as a sounding board to help advisors on the various options that were being looked at, and to help us in terms of presenting our case to the community overall.

And that's when we developed the preferred alternative. We invited members of our community, chief constituents, in to look at that plan, to give us a final overview of what they felt we needed to do.

But what did the community tell us? Well, I think

number one on the list in terms of the community was issues of parking, the availability and access to parking. We also got many comments about how difficult it was to find your way around the Hospital Center, and those who have been there know the problems.

Seniors and the physically challenged in particular had major problems and told us so. And there was concern about personal safety while on campus.

Our neighbors to the south, the Bloomingdale community, had concerns about traffic on First Street and how that would impact them as we move forward with this plan.

How do we consider their concerns as we move forward with the planning process? First of all, we incorporated the community issues as goals of our planning initiative, and we evaluated all of the alternatives against their particular issues that they raise and used that as criteria for selecting the preferred option.

In the case of the Bloomingdale community, we did extensive collaboration with them in terms of traffic issues. During the course of the study, our traffic consultant worked with them on some immediate traffic mitigation strategies, and also, as you will see as we move forward with the presentation, there were other -- you will see some actions that we have taken to try to deal with this issue in the long term.

Once the plan was developed, then we had to go out and communicate with the community, and we developed extensive

materials. Our Community Relations Department, headed by Anne Chisholm and Jonette Wilson, helped us to develop various materials to take and show the community what we are trying to do, including video presentation, we published information in our community newsletter, and we had a model developed so that the people could actually see what we were trying to do and how it would impact their community.

And here's a sample of the collaterals that were developed by the Community Relations Department.

Then, we set out to meet with the community. We attended over 15 community meetings with various groups that you see on the Board, including our Advisory Neighborhood Commission which is 4D, which is our Commission, and 5C, the neighboring Commission. We worked closely with the Bloomingdale community, the Lamond Riggs community, the Michigan Park, and as you see the other organizations, and had numerous presentations and sometimes one and two follow-ups.

We briefed our institutional neighbors, particularly Children's Hospital, Veterans Affairs Hospital, the Soldiers and Airmen Home. We met and had one-on-one consultations, and we met with the whole group to describe our project and how it may impact, and had dialogue back and forth with the institutional neighbors.

We met with elected officials to explain what we were trying to do, met with the Mayor, members of the Council, the

Control Board members, and -- Control Board staff, rather, and Advisory Neighborhood Commissioners. And, obviously, we met with the various oversight committees, including the Office of Planning, Department of Public Works, the Zoning Commission staff, people at the Department of Health, to communicate our plans and objectives.

What has been the community's, you know, response? I think very positive and supportive of what we have done. And that's demonstrated through the letters of support that were submitted to the record and some that will be submitted to the record, as well as support from our institutional neighbors who have written on our behalf.

And I'm very fortunate and very gracious -- grateful tonight that a lot of members of the community have come out to testify on our behalf in person tonight to demonstrate their support of this project.

And last point -- I think we have involved the stakeholders in the upfront planning phase, and I think that has been a function of our success in getting their support. We have communicated the plan extensively to the community, and we believe we have earned their support and confidence in the plan that we bring forth tonight.

That concludes my testimony.

MR. MOORE: Thank you, Mr. Brewton.

Mr. Dobbins?

Before Mr. Dobbins comes up, Mr. Hood, I believe the members of the Commission are familiar with the background of Mr. --

CHAIRPERSON HOOD: Mr. Moore, I'm going to ask if you can turn your mike on.

MR. MOORE: Sorry.

CHAIRPERSON HOOD: To make sure we get all of this on the record.

MR. MOORE: I believe the members of the Commission are familiar with Mr. Dobbins and his background, and I would -- I have his resume here, if necessary. I would ask the Commission to recognize him as an expert in field planning placement.

CHAIRPERSON HOOD: Colleagues, we have -- could you just pass us his resume? We have a request -- I think most of us are familiar --

(Laughter.)

-- with Mr. Dobbins. We have a question, who is he, but --

(Laughter.)

COMMISSIONER PARSONS: We won't hold his past against him.

(Laughter.)

MR. DOBBINS: Thank you. Thank you very much.

CHAIRPERSON HOOD: Okay. Colleagues, no problem? Okay. We'll accept him as an expert.

MR. MOORE: Thank you.

MR. DOBBINS: Good evening, Chairman Hood and distinguished members of the D.C. Zoning Commission and staff. For the record, again, my name is Al Dobbins. I'm a professional city planner, and I've been asked by MedStar Health to peruse the proposed rezoning and to determine how that rezoning is related to the planning and policies -- the plans and policies of the District of Columbia.

My testimony will be brief. It will be in two parts. You've already received a verbal tour of the area from Mr. Moore in his opening statements. What I'd like to do is give you a visual tour of the area, both the site that is the subject of the rezoning and the surrounding area. And I want to highlight some of the features of the landscape that are related to the proposed rezoning.

First of all, what you see before you is an aerial photograph of all of Square 3129, which is a square that includes the Washington Hospital Center complex, which is a portion of the Washington Hospital Center to the left of First Street which bisects the entire square.

The complex occupies approximately 39 acres of land, and it's bounded on the north by Irving Street, on the south by Michigan Avenue, on the east by First Street, and on the west by this interchange that forms the union of Irving Street, Michigan Avenue, and --

MR. MOORE: Park Place.

MR. DOBBINS: -- and Park Place. That's correct. Thank you, Jerry.

(Laughter.)

If I could go back just one moment to the overhead, please, to the last slide. I want to call attention to the fact that the site in question has continuous frontage on Irving Street, and it has discontinuous frontage along Michigan, with Children's National Hospital constituting a part of the square but not part of the complex itself.

There are also four major hospital institutions on the square in total. There is the -- of course, the Washington Hospital Center, there is the Children's National Medical Center as I've already mentioned, there is the Veterans Affairs Medical Center over here in the eastern portion of the square, and there are also several other buildings on the square that are a part of the complex, including the East Building, which is not real obvious, but this is one of the oldest buildings on the complex, and several physicians office buildings and parking garages on the square.

To the west of the square, in this area here, you see a residential community that's approximately 400 feet across from this interchange. That connects Irving Street, Park Place, and Columbia Avenue with Michigan Avenue. This is a residential community consisting of townhouses and apartments that are typical

of what you find in urban Washington neighborhoods.

To the north -- and you get a better shot in other slides -- and to the south of the square, are two federal facilities with a significant amount of open space.

This is a view from the complex to the north. Again, there's a considerable amount of open space that immediately abuts Irving Street. And off in the distance, if you can make it out, is the U.S. Soldiers and Airmen's Home.

And then, again, to the south, once again, a significant amount of open space that's just beyond Michigan Avenue. And we can recognize the Capitol off in the distance. What you see in the foreground here is the old -- are the ruins of the D.C. sand filtration facility that was -- that's a part of McMillan Reservoir, which is located over in this portion of the site, or the square.

Now let me just briefly talk about some of the comprehensive plan designations in the area that would suggest to me, and hopefully to you, that the proposed rezoning is appropriate and consistent with the D.C. comprehensive plan for the nation's capital.

Here is the site, the Washington Hospital Center complex site. It is indicated as institutional land use, and it certainly is institutional in the sense that it is a significant medical center. The land that's to the north and to the east of the hospital site is federal land as shown by the light blue

color.

There's open space designation for the McMillan Reservoir area which is also federal-owned. There is, again, the moderate density residential land use designation in the area immediately to the west, and also a small sliver of open space also immediately to the west. That essentially serves, to a large extent, as a buffer between the more intense institutional uses that you find on the campus and the lower-scale, less-dense uses in the residential community to the west.

Over here in the southeast portion of the area you see a mixed use designation, and I understand that there is considerable conversation about what the future will be for the old sand filtration facilities in this area here. But it has a mixed use designation now, a combination of park land, retail, and residential.

Again, I think it's significant to note that the entire complex is surrounded by a major roadway system that separate its land use from the land use of its adjoining properties.

This gives you a quick look at what the existing zoning is in the adjacent areas, again to orient you. Here is the Washington Hospital complex center site. There is no zoning in the federal properties to the north and to the east. There is an R-4 residential zone designation to the west, and, again, this is federal land that is unzoned, McMillan, and this is the D.C.

property, which according to the plan should be zoned because D.C. land is supposed to be zoned, and I'm sure it will be zoned when the development proposals that are being considered now are actually moved forward.

This, again, gives us what the current zoning is on the Washington Hospital Center complex site itself. SP-1, which was part of a PUD and map amendment case in 1995; and SP-2, which was part of a PUD and map amendment case in 1989; and then R-5-A, which constitutes the major portion of the site.

And this is the proposed rezoning. The proposed rezoning is to -- would maintain, of course, the SP-2 for Children's Hospital, which is not really a part of this case. It would maintain the SP-1 PUD, the zoning for the physicians office building and parking garage that's located here along First Street.

But what it would do is it would rezone the R-5-A, existing R-5-A zoning from R-5-A to SP-2 in the core of the site and SP-1 around the periphery of the site. And I think this is an important point that should not be lost.

The SP-2 zoning, which would be the more intense SP designation, the more dense SP designation, is located in the center of the complex. The SP-1 zoning that's being requested is located along the periphery, both to the north and to the west and to the southeast, which we believe would provide for an appropriate and acceptable transition from the high intensity of

use in the center of the complex to the less dense and less intense uses that you find around the periphery of the site.

Now, that pretty much orients you to what's existing and what's proposed. Now I'd like to give you very briefly my analysis of the planning and policy issues associated with this rezoning, and the findings and conclusions that went along with my analysis.

First of all, and most importantly, it is my judgment that the proposed rezoning is not inconsistent with the District elements of the comprehensive plan. And I say that after looking at all 14 elements of the comprehensive plan, and noting specifically that there are specific objectives and goals in the general provision element of the plan, the economic development element of the plan, the human services element of the plan, the Ward 4 element of the plan.

And I believe you have that information in the package that was submitted to you prior to this hearing, but I would like to speak very specifically to the land use element of the plan, which we all know to be the most significant element of the plan as it relates to zoning in the District of Columbia.

This is an institutional land use, which is consistent with the land use designation that we saw in the comprehensive plan land use map. It is my belief that the proposed rezoning is supported by the updated master plan and is an efficient use of land resources given the history of the use of

that site, the fact that it has been zoned residential but has always had a hospital use associated with it.

The proposed rezoning from a land use perspective does promote a private institution that contributes significantly to the economic and cultural vitality of the District of Columbia, and the proposed rezoning implements a District land use policy that encourages the development of hospitals and related health care services.

In this particular location, this location is identified specially in the comprehensive plan as a location suitable for a hospital and health care use, and also a location that should be granted higher density rezoning with appropriate measures to mitigate potential adverse impacts. Again, the land use element of the plan clearly supports this effort, this proposed rezoning.

I've also looked at the National Capital Planning Commission's extending the legacy plan, and I know that there was -- a major objective of extending the legacy plan is to unify the city and the monumental core with the Capitol at the center, and there was a great deal of attention focused on the North Capitol Street corridor as a gateway to the monumental core of the District of Columbia.

And there are specific recommendations within the plan that encourages the improvement of key properties in the North Capitol gateway area, and this is a very key property in

that area. It is a property that is encountered along Michigan Avenue as you turn into the District of Columbia, and is certainly a gateway use a gateway feature to the core of the District of Columbia.

I've looked at the surrounding uses and the surrounding zoning. I've given you some indication of what the uses and zonings are in the area. I would note that the proposed SP-2 and SP-1 zoning -- rezoning builds upon the SP-2 and SP-1 zoning that already exists at the complex, and both of those zone designations were found to be compatible with the mixed and institutional and residential uses that are in the area by this Zoning Commission in previous cases.

I would restate the fact that the SP-1 located around the periphery of the site with the SP-2 at the core of the site provides for a proper transition of density from the core of the site to the surrounding community.

I also looked at the past and present uses of the site. It has been said many times that Square 3129 in total, and the complex in particular, have been in institutional health care use since 1958; that the SP-1 and SP-2 zones do permit a hospital use as a matter of right, which would make those zones appropriate for this particular location; and that they also allow for the development of a physicians office structure with the approval of the Board of Zoning Adjustment, which is not a permitted use in an R-5 zone.

So for these reasons and the final reason that SP-1 and SP-2 are, in fact, the highest zoning categories that are available to the Hospital Center and to the Zoning Commission, it would seem to me that the proposed rezoning is consistent with the plan, that it meets all of the tests associated with impact on its neighbors, and it is consistent with the uses and the zoning that's in the area.

Thank you very much.

MR. MOORE: Thank you, Mr. Dobbins.

Mr. Oudens?

Mr. Oudens, one moment of indulgence. He's going to sit over here.

CHAIRPERSON HOOD: Let me say, while you're getting ready, Mr. Moore, I want to acknowledge our colleague on the Board of Zoning Adjustment, Mrs. Ann Renshaw. Good evening.

MR. MOORE: Mr. Chairman, members of the Board, this is Gerald Oudens, a principal in the architectural firm of Oudens and Knoup. I would ask him just to take a couple of moments to give you the highlights of his career, and I will pass his resume out to the Commission with the request that he be admitted as an expert in the field of architecture and planning.

MR. OUDENS: Yes.

CHAIRPERSON HOOD: Could you turn your microphone on, please?

MR. OUDENS: Okay. Yes, I've been a practicing

architect for 42 years, and during all of that time I've specialized in the design of health care facilities; initially, during my tour of duty for the Department of the Air Force, in which I annually structured the military medical construction program; for 10 years as associate for hospital design with Metcalf and Associates; and for 30 years as a principal in my own practice.

I've been involved in some 30 master plans for hospitals and related institutions, including the National Institutes of Health. I've been responsible for perhaps some 400 hospital projects over that period of time. I'm active professionally, a fellow in the AIA, a fellow of the American College of Health Care Architects, a past president of the National Academy of Architects for Health.

Is that sufficient?

MR. MOORE: Is that sufficient?

(Laughter.)

CHAIRPERSON HOOD: We actually didn't need to read the resume.

(Laughter.)

Colleagues, we've heard the resume of Mr. Oudens. Any objections to him being an expert witness?

COMMISSIONER HOLMAN: No.

CHAIRPERSON HOOD: No objections? Hearing none, we will accept you as an expert witness.

MR. OUDENS: Thank you, and good evening, Chairperson Hood, members of the Commission, and staff.

I'd like to start by reviewing the development history on the Washington Hospital Center site -- I think that will be helpful -- and then review the master planning process, the findings and conclusions from that process, including the importance of the proposed map amendment to the hospital's ability to continue to plan and develop those urgent facilities needed for its future.

Back in 1958, prior to development, this is a 46.3-acre site. There should be a -- oh, there is a little zoning designation on here, the entire site at that time zoned R-5-A. Initial construction on the site in 1958 is a 700,000 square foot main hospital building and a 140,000 square feet or so nursing school and dormitory.

The next construction, the Hyman Building, donated by the Hyman Company, was built in 1962, provides about 18,000 square feet of research space currently occupied by MedStar Research. Professional Office Building South was completed in 1970. An ICU tile was also completed in 1970.

In 1970, the Center leased 7.3 acres of property to the Children's National Medical Center, which was rezoned SP-2 to permit that construction. In 1983, parking pavilion number 1 was completed, followed shortly by the National Rehabilitation Hospital. In 1986, two major constructions, this north addition

above the original main building and an MRI addition here attached to the nursing school, which by this time had become office space, the nursing school having been closed.

In 1992, the Washington Cancer Institute was completed, and in 1997, the most recent construction is here, Professional Office Building North -- oops, well, I won't go back to that -- no, that's okay -- and parking pavilion 2 on land that was rezoned SP-1, and those projects were built as part of a PUD.

Now, over the 42 years of its existence, the Hospital Center has expanded rapidly to increasing community demands. And like other hospitals, it has been and continues to be a work in process. We're well past the days when hospitals were in-patient affairs, program design built, and relatively static for a number of years.

It's particularly important that hospitals be able to continue to adapt and adjust to a rapidly evolving health care system. Hospital design has to try to anticipate changes in service patterns brought about by the third party payers, changes in reimbursement, by increasingly demanding regulations and design standards, by evolving technology, and the list is virtually limitless.

There are things happening in technology that have profoundly changed the design of hospital facilities in ways that are simply not wholly predictable.

So here we are, the Hospital Center, with 2.8

million square feet of construction, has exhausted its FAR in this property, and desperately needs to continue to respond to pent-up demand. And, in fact, it's that pent-up demand that prompted the master plan and this map amendment.

The master plan process started with the assessment of the condition of site and buildings. Obviously, we worked to prepare estimates of required space. And once we had a better understanding of what the hospital resources are, and what their needs potentially are, we came back and reconfirmed project objectives. And I'll go into each of these in a little bit more detail.

From those objectives, we prepared design guidelines and then planning alternatives based on those guidelines. We try to identify the basic viable planning alternatives, ranging from various levels of renovation and new construction to a totally new replacement hospital building.

We evaluated those alternatives against the objectives, and we came up with what we think is a proper strategy for the development of the Center, and that strategy becomes the basis for the master plan.

Now, back again, existing conditions. Essentially, you see during its development that the Hospital Center is a group of relatively new clinical facilities surrounding an aging -- in fact, obsolescent, if not obsolete, central plant.

Internally -- well, let me say that the condition

of those buildings, as you'd understand after 42 years, ranges from very poor to excellent. Internally, the additions to this main building have been made without benefit of a comprehensive long-term plan, their rapid responses to needs, community needs as they arose.

And what happened is that the main addition really becomes the core that holds all of this perimeter -- clinical facility together, while at the same time housing major clinical components, medical-surgical beds, and supporting services.

These little red lines you see in the plan here are eight foot wide corridors. These were originally planned in the initial building as departmental corridors, relatively limited circulation. They have now become main thoroughfares through the building. As you see here, this is the main east-west corridor through the building. This is a view down that long corridor which is usually, in fact, more clogged with traffic than this slide would suggest.

In the newer portions of the building, in the north addition, these large red area concourses have been developed which are more in the scale of traffic through the building. The problems with this development are that it's extremely confusing, difficult for people to find their way through the building.

Additionally, as space has become limited, departments have opted to take whatever space becomes available to meet their needs; and, therefore, there has been a great deal of

fragmentation in functional areas within the building. That fragmentation makes operation inefficient within the building. It also makes it very difficult for people to find services.

And we keep -- we recurringly hear, as you heard in Mr. Brewton's testimony, the community survey -- one of the main items commented upon were the difficulties of accessing services in the Hospital Center.

Another problem -- this is a vacant intensive care room, as compared to the one you saw occupied a few moments ago. Many spaces in -- that room is over here in the intensive care tower. The intensive care rooms range from 110 to 120 square feet.

Current standards for intensive care rooms are 150, and the next release of minimum guidelines for hospital construction, which really undergird licensure laws for hospitals, will raise that amount to 180 square feet. We're almost 100 percent less space per room than the minimum guidelines suggest we need.

Similarly, this is a view of the Emergency Department. The Emergency Department designed, in 1986, for 25,000 visits, 23,000 square feet, is now accommodating approaching 65,000 visits a year. The way they've done it is staff are literally working shoulder to shoulder in the nurses station. Patient treatment bays have been tripled up. For example, two nine-foot wide curtain bays have become three six-

foot wide curtain bays -- six feet is an arm span -- to accommodate staff, equipment requirements for emergency care. This is simply unacceptable.

On the perimeter of the site, we have similar concerns. This is Hospital Center Drive, which loops in through the site from First Street and back out to First Street. All of the new construction on the site has been built along Hospital Center Drive. Therefore, all of these buildings -- NRH, parking pavilion, north addition, Cancer Institute, the POBs -- they all face inward in the site on that drive.

The other thing that that access requires is that all traffic to the site use First Street. That means that all of the traffic to the -- virtually all of the traffic to the Hospital Center, 55 percent of it here at the intersection of Irving and First Streets, another 35 percent here at Michigan and First, a total of 90 percent of traffic coming to the site comes through those two intersections.

The remaining 10 percent is over here in the southwest corner. There's a service entrance to the site to the service areas and to some employee parking down in that southwest corner.

Parking provisions on site -- 40 percent of the parking is up here in the northwest corner in parking pavilion number 2 -- number 1, another 33 percent in parking pavilion number 2, and some underground parking under the office buildings.

The balance of the parking is in surface lots wherever land is available on all other unoccupied areas of the site.

The difficulties with parking is all facilities are used for all users. Visitors, employees share parking spaces. So an employee parking in the parking pavilion 1, for example, who works out in dietary -- this portion of the hospital -- is moving through the building to that location.

Similarly, visitors who can't find parking in parking pavilion 1 park in number 2. They have to try to find their way through the building to the person they're visiting. Normally, thoughtful planning tries to locate parking for -- near obvious points of entry to the building.

Landscape -- nice pockets of landscape have been developed. They are project-related. At the corner of First and Irving, for example, very nice garden to the east of NRH and nice buffer plantings along the north side at Irving Street. And as you enter the site on Hospital Center Drive, a new garden at the professional office buildings, nice plantings at the entrances to these facilities.

Beyond that, the west and southeast portions of the site are largely undeveloped and present not a terribly favorable image to the neighborhood.

I failed to mention earlier, talking about traffic to the site, the Emergency Department is way over here in the west side of the building. Access to Emergency is via First Street,

and then Hospital Center Drive past stop signs, speed bumps, and so forth, over to that west side of the building.

Now, as we assessed existing conditions, we worked with staff to develop space projections for the buildings. We had -- we met with Hospital Center governance, administration, medical staff, department people, perhaps 150 to 200 meetings. We reviewed the capacity task force report, which tracked historic caseload and projected caseload for the next five years.

And from the interviews, caseload data, and so forth, we constructed a space program, and I'd like to give you some of the significant parts of that program. The acute care -- these bars, existing area is yellow, existing required is blue, projected required is gray.

The acute care units, for example, have about 60 percent of what they need to meet regulations and provide quality health care. Their planned in the original portions of the building, nursing units offer about 270 square feet per bed, nursing unit wide, against the requirement for about 550 square feet.

I think the story can be repeated for cardiology care. We've talked about the Intensive Care Unit and emergency services.

The bottom line is right now the Hospital Center needs about a 50 percent requirement in existing space just to meet current standards and operating -- efficient operating

requirements. And beyond this period, based on projected caseload, we see yet another 50 percent increase in space to accommodate that work.

In real numbers, the current gross floor area in the Hospital Center, that is the floor area chargeable against FAR -- is close to two million square feet. We currently require 2.9 million square feet, and we anticipate the potential for 3.9 million square feet over a 15-year period.

These are a little difficult to read. I don't know why. But the development plan objectives, of course, included correcting functional and space deficiencies, modernizing in-patient facilities, and -- but, more importantly, providing a basis for renewal and growth.

One of the things that became very apparent as we worked with the Hospital Center is while the obvious needs are the pressures for current space, a real need is to determine how the Hospital Center addresses the next 50 years. And there are some things that simply have to be done. Plans have to be made to replace the main hospital building, and then within -- and the plan has to be developed in a way that permits the Hospital Center to incrementally provide for priority needs.

In other words, the big replacement hospital -- it doesn't work for a number of reasons. The Hospital Center could be building space that ultimately is not the direction it should take based on an evolving health care environment. And, of

course, as mentioned earlier, we've got to increase user convenience and the healing aspects of the building.

In looking at the existing site, it becomes obvious that about 140,000 square feet, or six percent of total building area, is incorporated in the East Building and the Hyman Building. Those two buildings commandeer about 24 percent of the available acreage -- R-5-A acreage on the site.

And it's obvious that the development -- construction development potential for the Center is here to the east and to the southeast.

We reasoned, therefore, that a plan that proposed a major new addition to the east, replacing obsolete clinical facilities in the main building, and consolidating in this location the fundamental medical-surgical nursing units, ambulatory care services, in conjunction with the POBs to the north, would offer improvements in these services, but also the opportunity for a new -- where is it? Oh, there it is -- for a new entrance to the Center here.

The plan proposes to develop a new entrance plaza from First Street to -- obvious from First Street, to landscape, to develop Medical Center Boulevard along First Street, possibly with a traffic oval here identifying the main entrance to the Hospital Center. And then, at that main entrance, to consolidate all of those services that are most sought after by visitors and patients.

As we move around the site, we would keep, obviously, the new -- we would keep and expand the Cancer Institute, convert the north addition, assign that to cardiology services, build a new Intensive Care Unit and Emergency Department on the west -- over to the west end of the site, and, in conjunction with that, parking both for Emergency Department folks and for employees at lower levels.

To develop a new entrance from Irving Street to the Emergency site so that ambulances can move directly to Emergency without circumnavigating the site to get back there. To command build the lab and administration addition.

And then, with the completion of that work, move back into the main building and to rebuild areas vacated by clinical functions for facilities that support all of this clinical activity around the perimeter. Those would include service departments, expanded research space, physicians offices, offices related to the adjacent clinical facility -- for example, cardiology offices here adjacent to the new cardiology wing -- radiation -- I mean, oncology offices, and a three-story expansion on the Cancer Institute.

Parking -- we would obviously continue to use parking pavilions 1 and 2, but this would become employee parking with a -- and the proposal is to develop a direct entrance from Irving Street west and Irving Street east into this parking pavilion number 1, and to assign it essentially as employee

parking.

Parking pavilion number 2 remains to serve the two physicians office buildings under the main entrance plaza. And in surface lots here along First Street we would develop parking for visitors, and then over on the west -- southwest corner of the site additional employee parking.

This surface parking -- well, the surface parking here on the southeast corner of the site would be a reserve for future development facilities that are likely to be required but cannot specifically be named or quantified at this point, those facilities properly related to the hospital building and sharing main entrance off of the entrance plaza.

Now, the proposed zoning is based on this distribution of facilities. The high density development to the hospital at the core of the site, we've proposed that this be SP-2. We need the 3.5 FAR that SP-2 offers, and we need the 90-foot height.

I would also say that I had mentioned earlier that various alternatives had been considered. This zoning is structured such that various alternatives might be pursued. I mean, this master plan is not a construction plan. It's a strategy, a framework for development. We will -- it proposes to build for priority needs within the next five years -- the Intensive Care Unit, the Emergency Department, the lab expansion, and Cancer Institute expansion.

But when we get beyond that initial stage of development, the nature and scale of the development becomes increasingly speculative. It's important that the Hospital Center be able to retain the options of developing in a variety of ways over here on the east side of the site. And as Mr. Dobbins reported, this SP-2 area we're proposing to surround with SP-1 with its lower density.

The SP-1 PUD area of the existing professional office buildings and parking pavilion number 2 remains unchanged.

In numbers, you know, current zoning R-5-A, we've got nearly one and a half million square feet. With this development potential, the existing PUD, offers 417,000 square feet. What this proposed zoning would do is take the R-5 area and divide it between SP-1 and SP-2, with its increased development potential, and, therefore, a total development site -- the potential for the -- total gross area potential for the site of 4.9 million square feet as opposed to 1.7 million now.

That's the potential that this rezoning would offer. Existing gross floor area, were it 1,957,000, that's our calculation. We recognize that it exceeds the area permitted under current FAR, and I think that that has happened unwittingly over the years as buildings have been added. There are various ways to take FAR off, and I won't spend a lot of time in that detail.

The estimated gross floor area requirements that

you saw in the plan that we presented is about 3.9 million square feet.

Now, the plan -- you recall this earlier drawing with its way finding problems. The proposed project starts with a concourse here. What we'd like to do is to take the scale of these new concourses at the professional office building and the north addition and extend that through the building, so that we facilitate access to the various parts of the building and try to make this feel like a single building rather than a complex that's been put together over time.

The site proposal includes, as I mentioned, direct access to parking pavilion number 1, improved access and development of employee parking down here in the southwest corner of the site. The attempt here is to get all traffic off of First Street, with the exception of visitors and physicians, and to move employee traffic out to the perimeter of the site with entrances in the northwest and southwest corners of the site.

The net result is a reduction of about 20 percent to 35 percent of that traffic coming in at First, another 15 percent at Michigan Avenue. We've reduced traffic at these intersections from 90 percent of the total to about 50 percent of the total. The remaining traffic -- 20 percent here in the southwest corner and 30 percent directly to parking pavilion number 1.

Again, landscaping -- our concept is to take -- to

build on the nice work that's happening up here in the northeast portion of the site, and to extend buffer plantings around the entire perimeter of the site, improve surface parking areas with internal parking as well as -- internal planting as well as perimeter buffer planting, create the new main entrance plaza and First Street boulevard, and then augment plantings within the site as already established at existing main entrances.

A concept of what that plaza might look like is this -- improved First Street with entry plaza to the building. At the building entrance, a concourse not only appropriate in scale to the size of this institution but also a user-friendly one that as one enters the building six stories immediately perceptible -- understanding where the elevators are for visitors where ambulatory services are, admissions, the other things that people look for immediately entering a hospital.

And then, through the building, this is a section through the existing east-west building, main building, where corridors are in the middle of this building, eight feet wide. You saw the photograph at this level. We would propose here to move the corridor into the adjacent space, make it a 20-foot wide boulevard overlooking perhaps an interior dining atrium. Nice, but important from the standpoint of way finding. People encounter and then reencounter spaces of this nature, and it helps them understand where they are in the building.

Now, this is the site as it appears right now. By

2005, we would anticipate construction of the Intensive Care and Emergency Department, lab and administration expansion, and the associated access from Irving Street and Emergency Department parking, and expansion of the Cancer Institute.

As I mentioned earlier, beyond this point, the precise nature of the development becomes a little more speculative, but by 2010 perhaps some development to the east along with the main entrance plaza, the development of the First Street boulevard, and improvement of surface parking down here in the southeast corner. And then long term, let's say 2015 or beyond, construction of additional services down here in the southeast corner of the site.

And, with that, I'll conclude my presentation.

MR. MOORE: Thank you for your indulgence. We just have a short presentation by Mr. Osborne George on the transportation issues.

I believe, Mr. Chairperson, members of the Commission, that Osborne George has been admitted numerous times as an expert on transportation and parking issues before the Zoning Commission and before the Board of Zoning Adjustment. I have his resume here for you. In submitting it, I would ask the Commission to --

CHAIRPERSON HOOD: Let me just say I'm hearing from my colleagues that there are no problems. We will accept him as an expert witness.

MR. MOORE: Thank you.

Mr. George?

CHAIRPERSON HOOD: Let me just ask -- let me get a sense of a timeframe. Five minutes?

MR. MOORE: Five minutes.

CHAIRPERSON HOOD: Okay.

MR. GEORGE: Good evening, Chairman Hood, members of the Commission. I'm Osborne George, and I'm very pleased to be here this afternoon representing Washington Hospital Center.

Mr. Chairman, I didn't see the movie, but I understand the voice in the cornfield said, "If you build it, they will come." And if you rezone the way Al Dobbins says you could, and build it the way Gerry Oudens says you should, then they will come. And we're talking about visitors and employees and patients, and so on.

And so as we scoped out our study, we saw as our mission the role of putting together what we call some pieces of the puzzle. And what we've tried to illustrate there is that we were trying to answer, what mode would they use? When would they come? From what origins? What level of transit usage? What mitigation options are available to the Hospital Center? And, lastly, but perhaps most importantly, what potential benefits could accrue to the area as a whole?

Next slide, please.

And so we developed our study process and scope in

compliance with city guidelines and procedures. We've spent the past two and a half years going through planning and analysis. We believe we've adhered to current professional standards and practice, and, very importantly, we've taken a very conservative approach in our estimates as far as trip generation and to ensure that adequate factors of safety are provided as far as our long-term projections.

Next slide, please.

We believe we've addressed the community concerns. You've heard talk about Bloomingdale, the community to the south. They are perhaps the community that has been most impacted. We had a very close working relationship with that community throughout the process as you've heard.

We've considered the potential development needs of other sites in the area. You've heard mention of the U.S. Soldiers and Airmen's Home, of the McMillan Reservoir site, and so on.

We believe we've also been compatible with other studies, ongoing projects, that are being planned by the District of Columbia. And I'll tell you briefly about them. And, lastly, we believe we've capitalized on the potential for transportation demand management.

In other words, how can we do -- what can a major institution such as the Washington Hospital Center do to reduce travel demand not only as far as its immediate access needs but in

terms of reducing travel on the roadways of the region as a whole?

Next slide, please.

We've concluded that the applicant's proposal is feasible from the transportation perspective. We believe that with the plans that the hospital has and with the mitigation measures that it would result in minimal community impacts, if any. Funding issues have been addressed, and we believe they have been duly resolved. And we believe that the proposal in the long term would lead to the accrual of significant public benefits in terms of transportation.

Next slide, please.

We'll run through very briefly, Mr. Chair. We studied a wide study area, a total of approximately 14 intersections and all of the key arterials and portal points to the campus.

Next slide, please.

We were able to determine the directions of approach to the hospital, and we determined that these provide us -- provided us with opportunities to better utilize the transportation system.

Next slide, please.

As far as the existing situation, we did determine that there are currently some constraints. Gerry Oudens was correct; 90 percent of the traffic currently utilizes the two entryways off First Street. The intersection in the southwest

corner is unsignalized, and so you do have capacity and operational problems at that location. So we were able to analyze and quantify the existing situation.

Next slide, please.

Okay. Again, just briefly because Mr. Oudens touched on it, we've determined that a big -- a major problem with regard to the existing access constraints is the distribution of parking on the site. Approximately 70 percent of the parking is located within these two structures. Another I believe 25 percent is located along First Street.

So, as you can see, with two parking structures here, an underground parking garage, and two major lots here, all of your parking is directly accessible from First Street. That was a major challenge; at the same time, it presented a major opportunity as far as our planning and as far as our mitigation process.

Next slide, please.

One of the things that we had available to us and which we utilized was that we had a good base of data. The hospital has existed on the site for a long time, and so we were able to contain the site to determine trip generation rates, to determine parking usage, levels of parking usage, which we used in forecasting the future parking and traffic generation needs.

Next slide, please.

We did quantified levels of service for the area.

These have been addressed with the Department of Public Works, the Office of Policy and Planning, the existing situation, the projected situation with no improvements, and, finally the future situation long term with recommended mitigation actions.

Next one, please.

What we determined, that these locations, the two portal points into the campus, into the complex from Irving Street to the north and Michigan Avenue to the south, and from the west entrance, which we've termed Hospital Center Drive South, as well as the intersection of Michigan Avenue and North Capitol Street are very important. We call them critical to the needs of the community.

Because of the location of Bloomingdale to the south and the potential of adverse impacts, we also looked at one key intersection within this area in order to be sure that we duly addressed impacts on the community.

Next one, please.

Again, we analyzed as far as the future. I won't go into this in any detail -- but to come up with the mitigation measures for the various intersections. We have here the existing lane configurations for each one, and then went through and determined through analysis and simulation what would be the best lane configuration for those locations in the future.

Next slide, please.

Two major opportunities presented themselves, Mr.

Chairman. I'd refer to this street, which is North Capitol Street, and the interchange which is to the east of the site. The city is currently undergoing a major project to upgrade North Capitol Street, structural upgrading of North Capitol Street.

We were able to show them that there are currently operational constraints at this off ramp and at this intersection, which spill over so to speak and potentially -- and, in fact, they now do impact the operations along the corridor. And so we were able to reach an understanding with the city, the Design Division, to incorporate this project into the city's North Capitol Street corridor project.

Next one, please.

A major opportunity presented itself from the west side. Mr. Dobbins talked about the vacant land to the west of the hospital. We researched the record. All of this land, which is vacant, is owned by the federal government. It was deeded to the city I think in the early 1900s for the purpose of highway construction purposes. It is now vacant --

CHAIRPERSON HOOD: Mr. George, may I just interrupt you for a second?

Are you getting that on the record?

Okay. Fine. I just wanted to make sure you were speaking clearly into the mike.

MR. GEORGE: Yes, sir. Thank you. All right.

We were able to come up with roadway modification

on the west side that would allow for a portal point into the campus from the west. And, again, the Emergency entrance is located at this point. Mr. Oudens talked about the criticality of providing direct access because of ambulance needs. This roadway is -- I think is -- I'll use the term littered with speed humps, and an alternative access here would benefit more than the traffic access needs of the campus.

So, again, we worked out a configuration here which was discussed and gone over very carefully with the Department of Public Works, and we think that this is feasible. As you will hear perhaps from Mr. Moore, the Washington Hospital Center has undertaken some commitments as far as implementing this improvement.

Next slide, please.

The improvements provided that we propose are summarized on this exhibit -- at Irving Street, the main entrance, and linking to the interchange to the east -- a direct right turn in, right turn out entrance to the parking pavilion 1 site at this location, a direct entrance into the campus from this point, and improvements at the two intersections to the south at First Street and Michigan Avenue and at the Michigan Avenue, Hospital Center Drive South, which is to the west of the Children's National Medical Center.

Next one, please.

Okay. We've developed cost estimates for these

improvements, so we understand what the undertaking would be for the hospital and the cost-sharing arrangement that have been discussed.

Next slide, please.

What have we found? Mr. Chair, there are challenges. We discussed access constraints presently, on-site parking distribution, limited access points, community impacts -- yes, there are some. Bloomingdale community we discussed, some thru traffic issues.

I'd just like to quote this here, "Improvements are needed presently." The answer to that, if it were worded as a question, is yes.

We talked about the Irving Street deficiencies. To quote a Department of Public Works official, and I believe I am quoting verbatim, "Certain improvements are needed even if the Center does not build another square foot of space." And so there are needs which need to be addressed regardless of what happens.

Those are the challenges. What are the opportunities? We think we've enjoyed a favorable working relationship with the city agencies, numerous meetings and work sessions. The Department of Public Works has had significant and direct input to our study process. We think we've had a favorable working relationship with the community, and I've discussed that. We've had a good base of data.

Next slide, please.

There are favorable trip distribution opportunities that are available to the hospital, and we've tried to take advantage of that. Of the 5,700 employees at the hospital today, over 60 percent are medical staff. A lot of them come in and leave during the off-peak periods. The medical staff typically have hours of 7:00 to 3:00, shifts 7:00 to 3:00, 3:00 to 11:00, and 11:00 to 7:00. That means a significant number of the staff enter and leave during the off-peak periods.

This was verified from our traffic surveys. We think this is an opportunity. It reduces, it diffuses the impact.

The hospital has access to public transportation. There are two Metro rail stations, Catholic University, Brookland station to the east, the newly opened Georgia Avenue Petworth station to the west. The hospital currently has a number of shuttle buses linking the campus with the Catholic University station. The service is planned to be expanded to the west to cover the Georgia Avenue Petworth station.

There is a transfer terminal, transit transfer terminal to -- I should state onsite. This would be expanded and enhanced according to the plan that Gerry Oudens has discussed.

Next slide, please.

What have been the outcomes? We have concluded that rezoning and development of the WHC site can be undertaken as proposed. Transportation facilities we believe will be adequate. There will be minimal community impacts. There are significant

public benefits which we believe will accrue.

Is there another one?

And this, Mr. Chair, is the essence of my presentation. Thank you.

MR. MOORE: Mr. Chairman, I offer each of the presenters here that have presented today for questions from the Board.

We can turn the lights on, if you'd like.

CHAIRPERSON HOOD: Okay.

MR. MOORE: Thank you for being so patient to listen to us.

CHAIRPERSON HOOD: Sure. Thank you for your presentation.

Colleagues, we -- let me see, maybe if some of the presenters can come to the table. I'm not sure exactly how many you had, but at least four can come to the table.

Commissioners, I'm sure we have a number of questions. Who would like to start off? Mr. Holman? Thank you.

COMMISSIONER HOLMAN: All right. Let's see, could someone help me recall the overall increase in density on the site? I seem to recollect something in the range of three million. Is that correct?

MR. OUDENS: Yes. This is Gerald Oudens. The required density at the moment is 2.9 million square feet of applicable zoning area. The projected density under the master

plan is 3.9 million square feet. The density that would be permitted by the rezoning, the map amendment, would be 4.9 million square feet.

COMMISSIONER HOLMAN: Okay. I'm just trying to -- because I'm trying to visualize the campus and the -- I guess the taller buildings would predominate in the center of the campus, and it would decrease somewhat on the perimeter. I'm just trying to -- this is -- is this going to be -- I don't want to use the word "massive," but it's going to be a rather large complex.

And I understand somewhat the transportation impacts, but I guess what I'm trying to understand is to what degree the improvements are related to regulatory requirements, shall we say, and to what extent they're related to competitive challenges, if you can -- if they can be distinguished.

MR. OUDENS: Well, I could try to estimate that. At the moment, the 900,000 square feet or so shortfall in existing space, that's largely regulatory facilities that are simply inadequate in terms of size of individual spaces, or in terms of the compression of activity into less space than that activity really need accommodate.

Beyond that, the projected future needs are caseload driven, and those caseloads are reasonably anticipated. You saw testimony that showed the rate at which caseloads are increasing at the Hospital Center, and that space is directly related to caseload increases.

We also have in the mix an estimated 500,000 square feet of allowance for things that we know will happen. We just don't know what specifically or when -- wellness centers, increasing community medicine initiatives, women's centers, initiatives in many areas -- brain attack, the list -- we have a list of some 30 or 40 potential future programs that if they occur we need to have a way of addressing them.

COMMISSIONER HOLMAN: And I guess along those lines you looked, I'm sure, at various alternative zoning schemes to address these needs. And I guess I'd be putting words in your mouth if I said that this was -- you felt this was the most appropriate. Perhaps if that is, in fact, the case you could tell me why others might not work along those lines.

MR. OUDENS: Well, yes, we do believe this is the most appropriate, not only in terms of the plan as we've laid it out but in terms of the plan as it actually may emerge over a long period of time. The SP zone is the next higher zoning level that gives us both the density we require, the height we require in certain portions of the campus, and the use that we require.

As was commented during testimony, hospitals permitted by right, office buildings permitted by exception, and SP, and we need both of those occupancies, really, throughout the site. Yes, I do think this is the most appropriate zone.

COMMISSIONER HOLMAN: There is -- I notice that you refer to the area that the Center occupies as a campus, and I

guess what it brought to mind, at least to me, was the idea of campus plans and the way the Commission regulates universities and revisits that plan from time to time.

One of the -- I think the differences between that regulatory scheme and the one that's being proposed is that this is basically a one-shot opportunity to basically zone the area into the -- well into the future. And I'm just -- if you could comment on that, you know, I'd appreciate it.

MR. OUDENS: Yes, Mr. Holman. I tried to use the word "complex" rather than "campus." The Hospital Center I think defies a campus plan, because I think that the future is largely unpredictable.

I think that the first five years of the plan were very comfortable with the specific program for Intensive Care, Emergency Department, and other facilities. And we can see that happening, and we know that will be happening, and we'd be very happy to more closely define those projects.

But what happens on the east side of the site is really a product of so many things in the health environment. Our best guess, if we maintain license capacity, that drives the east addition. If we maintain surgical caseloads, the numbers of surgeries that are included in the program drive the size of that addition right now. But those things are so changeable, fragile, malleable, that it would be very, very difficult to put a precise definition on the plan beyond the, I would say, five-year time

period.

COMMISSIONER HOLMAN: Okay. That's all for now, Mr. Chair.

COMMISSIONER FRANKLIN: Mr. Chairman?

CHAIRPERSON HOOD: Commissioner Franklin?

COMMISSIONER FRANKLIN: Mr. Moore, I haven't discussed this with my colleagues, but I'm sure everybody up here wants to be helpful to an institution that is so important to the future of not only the city but the region. And the data you've given us is just extraordinary in terms of what you -- the pressures that you've been under --

MR. MOORE: Thank you.

COMMISSIONER FRANKLIN: -- in the Washington Hospital Center. And I think the master plan is extraordinarily thorough and comprehensive and very credible. It's credible in part because it's quite an indictment of what's there now. I mean, to not put too fine a point on it, the place is a mess. It's a mess from an architectural and site planning standpoint, from a circulation standpoint, from signage and way finding, from parking, and all of the things that you've mentioned.

And so the question I ask myself is if we change the zoning, as you've requested, what assurance do we have that it's not going to continue to be a mess? So I have a couple of questions that are addressed in that vein. Has MedStar actually formally -- the governing body adopted the master plan?

That's for Mr. Moore, actually.

MR. MOORE: Mr. Franklin, this master plan has, as Mr. Oudens has said, been the result of two years of study and surveys and meetings. And, as you know, the medical community is very, very intelligent, and a lot of different views have come into this. And as a result of those surveys and multiple meetings, the plan has gone to the Governing Board of the hospital, and the answer to your question is yes.

COMMISSIONER FRANKLIN: The Governing Board has formally adopted this master plan?

MR. MOORE: The Governing Board has approved the master plan as the plan of the hospital for the future.

COMMISSIONER FRANKLIN: Okay. And I gather it hasn't chosen amongst the alternatives that were set forth in the plan at this point.

MR. OUDENS: It has. It certainly has reviewed and commented on the alternatives, and understands the pluses and minuses. In fact, the suggestion of let's destroy this mess and build a whole new building came from governance at the Center.

The difficulty with that is an enormous expenditure for a single plant to meet initial needs essentially without the proof long term that that enormous expenditure is justified as the health requirements may evolve.

Yes, the Board has seen all alternatives. And they look upon this as the best strategy for addressing both its

current needs and its long-term needs.

COMMISSIONER FRANKLIN: Well, carrying on from I think the line that Mr. Holman began, your written materials and your presentation -- Mr. Moore's presentation tonight did address why you thought planned unit development process was inappropriate.

And I gather that flexibility and unpredictability of the future, etcetera, are all weighing on that subject. But when you look at the SP zone, you have to go before the Board of Zoning Adjustment, would you not, for a physicians office structure, for a parking lot or a parking garage, for a hotel or inn if you should decide downstream that it's important to have that kind of accommodation?

And there are also all kinds of setback requirements that strike me as being totally irrelevant to a complex of this nature. So it seems to me that the SP dog comes with a lot of fleas, in terms of the flexibility point. And I'm struggling to try to in my mind craft something that would do two things -- one, give you the kind of flexibility that I think you reasonably require; and on the other hand give the public and this Commission some sense that this master plan is for real and not just a consultant's report that, you know, is embraced one day and then radically ignored or altered the next.

So why wouldn't this lend itself to a -- perhaps a fairly general PUD in terms of what might be called site

conditions? So that you wouldn't have to worry downstream about the Commission reviewing architectural designs, and the like, so long as the basic concepts of the plan were being adhered to. What would be the problem with that?

MR. MOORE: Well, Mr. Franklin, we looked at PUD very hard, and that's one of the first questions I, as a zoning lawyer, would raise when they ask you your opinion. But it quickly becomes clear that the hospital has a master plan, but it does not yet know exactly where the building is going to be, how big the buildings are going to be, nor does it have the latitude to turn -- to let -- to go back to the -- time latitude to go back to the Zoning Commission to seek amendments.

I'll give you an example.

COMMISSIONER FRANKLIN: Well, if I could interrupt you. Does it have the latitude to go before the Board of Zoning Adjustment for special exceptions for parking facilities?

MR. MOORE: If that were to come to pass. What we're looking to here is to get the main hospital structure, the use that would be counted as a hospital. And to the extent that there needs to be ancillary facilities with a physicians office building, yes, we know that the zoning regulations call for that to be a special exception.

But there are no other intermediate zoning categories that really fit our needs. The jump is from residential to SP. That sounds good. There's already SP there on

the square in two places with Children's Hospital and the physicians office building.

CR doesn't permit a hospital use as a matter of right. It's not a waterfront, and commercial is --

COMMISSIONER FRANKLIN: Yes, I understand all of that.

MR. MOORE: -- not appropriate.

COMMISSIONER FRANKLIN: But what I'm suggesting is that if this were a specially crafted PUD, in return for being relieved, if you will, of the need to go before the BZA for the special exception uses that are required under that form of zoning, in return for being relieved of that, you could assure that the basic concepts of this plan, which strikes me, you know, as an excellent plan, would be adhered to.

MR. MOORE: Well, that's certainly something that -- as I indicated earlier, Mr. Greene is not here, and he -- he calls the shots. That's certainly something that we could look at if it is the Commission's wish that we do so.

What scares us about the PUD is its finality. You've got to come up with an exact design, an exact placement for every single building.

COMMISSIONER FRANKLIN: Well, I'm suggesting that --

MR. MOORE: And if --

COMMISSIONER FRANKLIN: -- as I read the

regulations, that may not be absolutely required, if we interpret the regulations. It says a first stage would be -- you actually are -- I think have come up with the equivalent of a first stage PUD in terms of the plan.

MR. MOORE: Yes.

COMMISSIONER FRANKLIN: And then it says the second stage is a detailed site plan review to determine compliance with the intent and purposes of the process and the first-stage approval in this title.

Well, I think we could write a PUD -- I'm speaking for myself, I don't know if anyone up here agrees, but it seems to me we could craft a PUD approval that would, in essence, reflect what has been explained to us as the plan without requiring that subsequently we take a look at the architecture and the kind of things that we look at in detail.

But at the same time it gives some sense of the preservation of the public interest in the fact that this plan really means something, and we're not just giving you a blank check, because from a -- if we don't do it that way, what you are asking for, let's face it, is a blank check.

MR. MOORE: Well --

COMMISSIONER FRANKLIN: I mean, it's very nice to have a consultant there who is an excellent consultant, obviously, but governing bodies change their minds. Some affluent person may come down the pike maybe and say, "I'll give you $100 million to

put a building here if you name it for me." And the pressures become very intense.

MR. MOORE: Well, obviously, that's something that needs the direction from higher ups than the zoning lawyer. I should say that we have withstood the suggestions that this is a PUD over the last three years that we've been dealing with this, only on -- with the judgment that the hospital needs the flexibility to be able to create buildings -- its building -- meet its building requirements without having to keep coming back.

One, we can't tell you what it is today. We can't tell you in 2000 what the building requirements are going to be in 2005 or in 2010. We know generally, but we don't know specifically.

Secondly, it takes too much time to come back to the Commission to really get the PUD amended as we need be.

You've sat -- you, Mr. Franklin, sat on the George Washington Hospital case. That was just a simple case where you moved the hospital across the street and made it a lot smaller. That case took us a year and a half to get through the BZA.

COMMISSIONER FRANKLIN: And that was before the BZA.

MR. MOORE: Right.

COMMISSIONER FRANKLIN: And you're telling me that you're quite content to go before the BZA on parking lots and parking garages and physicians office buildings.

MR. MOORE: Well, it's a tradeoff, Mr. Franklin. Your point is well taken, and I understand it completely. It's a tradeoff. It's a tradeoff as to --

COMMISSIONER FRANKLIN: Well, that's what I'm looking for is a tradeoff. I think that we should be able to offer you what I would call a site plan PUD and save you from going before the BZA, if in turn you will agree that basically if there's going to be any significant departure from this overall master plan that you'd come back to the Commission. That's all I'm suggesting, but I just need to leave it to my colleagues to --

MR. MOORE: I understand.

COMMISSIONER FRANKLIN: -- cogitate over it.

MR. MOORE: I understand. I understand you completely, and I thank you for your very kind comments, and I understand what you're saying.

VICE CHAIRPERSON MITTEN: Maybe I'll pick up where Mr. Franklin left off, then. I share Mr. Franklin's concern about the notion of giving you all a blank check. And while we've heard a lot about the master plan, what you're asking for in terms of density well exceeds even what you can foresee 15 years from now.

And what we have to do as a Commission is make sure that at the maximum, which is, you know, close to five million square feet, that all of the protections that should be in place are there.

So maybe I'll just begin by asking, in presenting

this request for a map amendment to the various folks, first of all, was it made clear what the maximum buildout will be in terms of what it could be, or has the focus really been on the plan that the Hospital Center has?

MR. MOORE: Mr. Brewton, can you take that question? She wants to know -- the question is, when we made our presentation to the community groups, was it made clear to the community groups what the maximum buildout would be in the SP-1/SP-2 zoning envelope? Or did we just concentrate on telling them about uses?

Is that a fair --

VICE CHAIRPERSON MITTEN: Well, did you just concentrate on presenting what the plan -- the master plan is, which is not nearly as dense as what the rezoning could permit?

MR. BREWTON: Well, we concentrated on our proposed plan, but there were a number of people in the community who asked that question, what is the potential, the maximum potential?

There were a lot of very sophisticated community people who asked that question, and we had to address that in the presentations.

VICE CHAIRPERSON MITTEN: And then, what did you say?

MR. BREWTON: We indicated that that's -- that that -- given the zoning options that we had in terms of the next level of zoning, that we were going to the next level of available

zoning, and there was nothing in between those two points. But our intent was not to build out to that max, based on this plan that had been presented to the -- by our consultants.

VICE CHAIRPERSON MITTEN: Okay.

MR. MOORE: Ms. Mitten, if there was a zone category that was available to us where we could, as a matter of right, without having to go through the general administrative BZA or the BZA process, where we could get a 4.9 million square feet, where we could have a hospital as a matter of right, where we could have the parking that Mr. Franklin is talking about, that's the zone that we'd have asked for, because in my mind this is a classic map amendment case.

Why? Because it's -- we're not asking for any increased density. We're just asking to fit within a matter of right zoning category. And the closest one that is available to us is not -- not CR, it's not commercial, it's not residential. The only one left -- not waterfront. The only one left is SP.

VICE CHAIRPERSON MITTEN: Well, I guess I would differ with you on one point, which is the way that it differs from a classic map amendment case is that the transportation issues have become the most important thing. And there have been proffers made, and the proffers seem to be critical to the acceptance of the map amendment, and yet we're not able to condition the map amendment on these proffers.

MR. MOORE: Well, actually, I believe the zoning

regulations permit the Commission, under 3022, to have the applicant to submit any memoranda of understanding as part of the record. And we are prepared to do that.

As you know, we've worked out certain understandings with the Department of Public Works and with the help of the Office of Planning, and we are prepared to submit to the record, as the zoning regulations require, that memorandum of understanding for the record. And I presume that the Zoning Commission will make its decision based on what's in the record.

VICE CHAIRPERSON MITTEN: And is the plan in terms of transportation management that's been proposed to -- does it address the maximum buildout for the site, or does it address what's been proposed in the maser plan?

MR. MOORE: We have -- well, first of all, I'll let Mr. George address that, and then I'll chime in.

MR. GEORGE: Commissioner Mitten, Osborne George for the record. As I indicated, as far as the projections, we were as conservative as we think we could be. Over the past year, we've done an extensive research on one project for the General Services Administration, through which, as part of a consulting team, we developed a transportation management plan handbook for the federal government agencies within the region.

Now, the estimate has been developed through extensive research that you can have trip reductions through effective transportation management plans of between 30 and 40

percent. We were extremely conservative in assuming only 15 percent.

So we think that given the other trip-making characteristics which we've cited, the 60 percent plus medical staff on the site, and the non-peak hour trip generation, we think that with an effective transportation management plan, which MedStar is committed to, we think that there could easily be a significant additional number of trips undertaken.

VICE CHAIRPERSON MITTEN: You know, I think I used the wrong term, and I sent you down the wrong path.

MR. GEORGE: Okay.

VICE CHAIRPERSON MITTEN: I meant the proffers, the -- you know, those -- I don't know how you -- what -- how you would characterize them, the mitigation efforts --

MR. GEORGE: Okay.

VICE CHAIRPERSON MITTEN: -- or the infrastructure improvements, and so on.

MR. GEORGE: Yes.

VICE CHAIRPERSON MITTEN: Are those based on the master plan buildout or the maximum density that would be permitted by the rezoning?

MR. GEORGE: They are based on the master plan buildout. They have given due consideration to the potential -- maximum potential of the site. Let me just repeat that to make sure it's clear.

VICE CHAIRPERSON MITTEN: Okay.

MR. GEORGE: They are based on the densities proposed in the master plan, but our study has given due consideration to the additional million or so square feet.

I think we can expand on that easily. The improvements which we've developed, and which are incorporated in the proffers or the memoranda of understanding that Mr. Moore describes, assumed buildout of the Soldiers Homes property and of the McMillan Reservoir.

Now, let me just touch on the Soldiers Home property. There is no plan for that site as of now. The only thing we have is three development scenarios for that site. We assumed the scenario that would yield the greatest number of trips. So we have allowed in there for development of Soldiers Home, and even then we show that we are adequate.

So the densities assumed for that site are so great that we think that reasonably, as you can see, if there's a reduction in the densities from Soldiers Home, some modest increase in the densities from Washington Hospital Center, we think that the system could certainly accommodate the additional traffic.

VICE CHAIRPERSON MITTEN: I have just another question that -- and this is something that I just think I'd like to have submitted for the record because I was a little disturbed by it. Mr. Oudens kind of made light of the fact that the actual

density exceeds the permitted density on the site.

And I don't expect you to explain it now, but at least from what I saw on the chart that was up in the Powerpoint presentation, it looked like it's about 20 percent. And so I'd like just for the record some explanation of how such a thing could happen.

MR. OUDENS: It certainly was not my intention, Ms. Mitten, to make light of that. But the permitted density on the site is about 1,750,000 square feet. Our measurements taken during the course of preparing the master plan suggests that there are actually about 1,950,000 square feet, about 200,000 square feet in excess of the 1.7 million. What would that be?

VICE CHAIRPERSON MITTEN: That's probably closer to 15 percent.

MR. OUDENS: Yes. Now, there are various ways in which that happens, and I won't go into a great deal of detail. But as buildings are built and added to, and one uses a convention for trying to determine cellar space, which is in a ratio to exterior wall, there are ways in which additional space can be added, which is characterized as cellar space.

But when you actually run through the computation, it gets shifted over as applicable zoning area. And I think unwittingly, assuming in the first point that our takeoffs are accurate, and I think we could do it 12 times and perhaps get 12 slightly varying answers, but I think that this has happened

unwittingly over a long period of time.

And I know how it happens, because in our own practice if we worked on a project for many years we'll develop a statement of zoning area, and then tend to apply that zoning area from project to project without looking at the nuance of what the additional project itself might do to the calculation of the area. And I think that's what happened here.

But the fact is that it does appear to us that the built area does exceed the permitted FAR that pertains on the site.

VICE CHAIRPERSON MITTEN: Okay. I think I might have said that was the last question, but I did have one other question, which is in the prehearing submission an Exhibit F, which is the only one that I found that -- in the prehearing submission that depicts what the proposed rezoning is, it includes the existing SP-1 PUD site within the SP-1 area.

And I did not see a parallel exhibit in the Powerpoint presentation, so I think we just need some kind of clarification on what precisely you're asking for if -- if it's not what's represented in the --

MR. OUDENS: Absolutely. Exhibit F is incorrect and should be supplanted. Exhibit F should show the SP-1 PUD area as -- this was an early zoning study that suggests that changing the PUD -- you see that black area in the PUD area is a proposed office building.

And one of the alternatives considered during the development of the plan was to add professional offices in that location, and, therefore, seek an adjustment or a change in the PUD. Ultimately, the application does not change the PUD, and this exhibit is incorrect.

VICE CHAIRPERSON MITTEN: Okay. Thank you.

CHAIRPERSON HOOD: Commissioner Parsons?

COMMISSIONER PARSONS: Well, I've been sitting here reflecting on our discussions in 1995 when we had a PUD for the professional office building, or POB as you call it, or whatever you call it, P-O-B, and its parking pavilion.

And I know we spent a great deal of time, or at least I did, because this is my interest, in how inhumane a campus this is -- a place that rejects humanity on its exterior. Those are my words, not yours.

We spent a lot of time on way finding. We spent a lot of time on landscaping, the all-important garden at the parking pavilion. And I was one that -- one of the Commissioners who insisted that we have a master plan before we went any further here. And I guess I naively thought that we would come back with a master plan that showed some response to the importance of how people feel about a place.

My reaction to this is frightening. That is, it continues its factory-like institution. It is enormous. It must be the biggest hospital complex in the world at five million

square feet. I mean, it's a million and a half square feet bigger than the Pentagon.

So I don't know how to deal with this, because it -- it -- I expected buildings to be removed, some of those temporary buildings to be removed rather than replaced. And my reaction is totally negative.

But with saying all of that, let me go on with some questions. SP allows you build to 90 feet, and I'm looking at some cross sections here that are at 7 point -- excuse me, you probably know it better than I, but they're right in here. It's 7.1C. There are two sections on that page.

And I'm trying to ascertain what height the buildings that you propose will be, and I'm interested in ensuring that we do not obstruct the views from the Soldiers Home to the north as it looks towards the city to the south.

Most of your buildings appear to be about six stories, but what is the real answer here?

MR. OUDENS: The building height at the core of the campus, in the SP-2 area, is seven stories. And that easily could be a 90-foot building. The Children's Hospital to the south of this building exceeds 90 feet. We've been up on the Soldiers and Airmen's Home property and looked across our campus and know that building to 90 feet at the core of the site does not block views from the Soldiers and Airmen's Home to the Capitol and the areas that you saw in Mr. Dobbins' slide.

COMMISSIONER PARSONS: That would include the 18-foot penthouse on top of the 90-foot building?

MR. OUDENS: Well, the -- yes, in fact, it would. But the -- presuming that there is an 18-foot penthouse on top of the 90-foot building, I guess that's what --

COMMISSIONER PARSONS: Oh, there will be.

MR. OUDENS: -- what's permitted. Right.

COMMISSIONER PARSONS: So --

MR. OUDENS: But even that construction does not clear the helicopter paths on the Children's Hospital. I'm quite comfortable.

You know, the Soldiers and Airmen's Home, there's quite a dramatic rise in that campus --

COMMISSIONER PARSONS: Yes.

MR. OUDENS: -- when you get to the occupied parts of the site. And the views across our campus would not be affected by the proposed -- the potential development at the core of the site.

COMMISSIONER PARSONS: So it appears in this section, at least BB, that your buildings would not come near the height of the hospital, the Children's Hospital to the south. I mean, they are much lower.

MR. OUDENS: Well, Section AA, if you look above the -- no, I'm sorry, it's Section BB, the main entrance plaza, east addition. They are lower, but maybe 10, 15, 20 feet. I

mean, they're in that order of magnitude.

COMMISSIONER PARSONS: Do you think those are 90 feet as shown in the section?

MR. OUDENS: You know, I'm not absolutely sure.

COMMISSIONER PARSONS: Okay.

MR. OUDENS: But I would point out that the view from the Soldiers and Airmen's Home site is a downhill view on the diagonal and --

COMMISSIONER PARSONS: Do you know what the elevation is there? I see that your elevation is --

MR. OUDENS: I don't happen to know.

COMMISSIONER PARSONS: -- 182 at the ground plane on your topographic map.

MR. OUDENS: Uh-huh.

COMMISSIONER PARSONS: Let me ask you about First Street. I don't know who can answer this question, but it appears as though you're creating a new entrance, not only to your own property but the VA Hospital. What is that about?

MR. OUDENS: First, let me explain, if it's not clear in the master plan, that First Street is actually private property owned jointly by the Hospital Center and the Veterans Affairs Medical Center. We proposed a traffic oval with some kind of element that could be seen from Irving and Michigan to denote and make easier access to the main entrance of the Hospital Center.

We met with the Veterans Affairs Medical Center Directors and floated that idea past them. They were not -- they were not terribly impressed. I think that they felt that that oval, which first extends into their land, that was not the main issue. The main issue had to do with where it brings traffic into their site.

We suggested that this would be an enormous improvement over the entry toward First Street -- I mean, toward Irving Street that uses a significant part of their campus, and we felt that an entrance in this location would really facilitate a planned ambulatory care building there in terms of space available for that building and its associated parking.

I don't think we've had a definitive no, but we've certainly not had a yes either. And I'd say that our plan is not dependent on that traffic oval, and it is perhaps presumptuous to leave the oval on our drawings.

COMMISSIONER PARSONS: All right. Then, let's talk about the building which is labeled "Future Expansion, Wellness Center, Southeast Complex," or new programs and initiatives, which is the biggest building on the campus. But you're really not definitive as to what that's going to be.

MR. OUDENS: Right.

COMMISSIONER PARSONS: Even in your model, you show it as a surface parking lot. Getting back to Mr. Franklin's point, we have a process of a PUD that deals in two steps, and

many of us have forgotten that because virtually every PUD that comes to us is a first- and second-step PUD; that is, I'm here once, and I want to get out of here. So we do two-step PUDs.

Well, the concept of a one-step PUD was to do a master plan, and then as additional buildings came online you'd come back for a second stage for that building. And, gosh, I can't recall other than -- well, it doesn't make any difference, but I think there's been one case in 20 or so years where we've done that.

And I think we should explore that as an option here to -- to talk about a master plan concept in a PUD, which is what the PUD was intended to do 30 years ago when it was established, and then add elements to it at a later time, because I -- the only way I can think to do it otherwise is to not zone those portions of the property that you're not ready to deal with.

And that is this multi-named future expansion site that is not before us in any fashion, other than you're going to build two levels of parking in it, as I understand it. Is that right? That's the only real commitment here is there will be ground level and basement for parking. Is that correct?

MR. OUDENS: Actually, in the very southeast corner of the site, it's surface parking, until that part of the site is developed.

COMMISSIONER PARSONS: Today.

MR. OUDENS: Yes, it is surface parking today, remains surface parking until -- under this plan. Until that part of the site is developed, it's surface parking. And as the site is developed, subsurface parking under the main plaza is extended to the south.

COMMISSIONER PARSONS: Well, these plans seem to show two levels -- basement and ground floor, 7.2A, 7.2B. Not that that's a commitment, but it's an indication of what you felt you would do. And I would think with that kind of a massive addition you'd need at least two floors of parking.

Is that correct, Mr. George? Or you were dealing with getting to the place rather than parking in it in most of your testimony.

MR. GEORGE: The actual -- I'm sorry.

MR. OUDENS: Actually, I would like to comment on that, if I may, Commissioner Parsons --

COMMISSIONER PARSONS: Sure.

MR. OUDENS: -- in terms of what the drawings show. Actually, we have two levels of parking under that building, plus parking -- when the building is built. The plan includes two levels of parking, one at a basement level, one at a ground floor, which is still one floor below grade.

And in this -- you know, the current designation of floors is first floor is ground floor at the Hospital Center. So, in effect, we have parking at grade, which is the first floor

level, and parking at two levels below, the ground floor and the basement floor.

COMMISSIONER PARSONS: Well, let's look at Figure 7.1D. That says P, 1,540, which I assume is the number of spaces. That's the proposed vehicular access and parking.

MR. OUDENS: That's correct.

COMMISSIONER PARSONS: Does that mean 750 on the floor, or does that mean 1,540 on the floor?

MR. OUDENS: No, it means 770 on the floor.

COMMISSIONER PARSONS: All right. So the total parking on the complex, when you're completed, is how many?

MR. OUDENS: 6,250 spaces.

COMMISSIONER PARSONS: Okay. With commitments for all of the shuttle systems and all of the things that you've included to reduce the parking demand.

I notice you have two helicopter facilities at the moment, or helipads I'll call them for lack of a better term, and you end up with one at the end of the line -- at the end of the day. Is that true?

MR. OUDENS: No. What we have now actually is a helicopter pad and a helicopter parking area. There is really one landing and takeoff area and a parking/service area. The plan is not sufficiently definitive on helicopter facilities.

In fact, what the Hospital Center would like to do is to create a hangar/maintenance area. How that is to be

developed is not sufficiently developed at this plan level. But there is one pad now, and there would be one pad in the future.

COMMISSIONER PARSONS: Well, why don't we look at Figure 2.2 and Figure 7.1A, because I'm confused.

MR. OUDENS: Yes. 2.2 -- my memory is that that's showing two helicopter areas. One is a landing pad and the other is a helicopter park. The smaller square near the hospital at the -- at MedStar is the landing pad. There is then a surface drive, a bridge across a service drive that -- where helicopters can be moved to that pad over to an adjacent parking pad, but not a landing pad. It's an area where two or three helicopters can be parked.

COMMISSIONER PARSONS: So the hospital doesn't have its own helicopters, does it?

MR. OUDENS: I believe it does, yes.

COMMISSIONER PARSONS: It has its own helicopters?

MR. OUDENS: Yes.

COMMISSIONER PARSONS: So a hangar is needed, but it hasn't been developed. Is that it? It probably --

MR. OUDENS: That's correct. Helicopters needing serving now are, as I understand it, flown off-site for service and back. It has no maintenance facility now. The program includes, but doesn't define in the design, a 4,000 square foot helicopter maintenance facility. How that's specifically to be

addressed we can't -- we don't know at this point.

COMMISSIONER PARSONS: So we might lose a little more green space with that, huh? Don't comment on that, but I -- I presume it's got to be in the same vicinity. You can't drive over to the maintenance facility.

MR. OUDENS: Yes, it would be in the vicinity of the pad. Yes.

COMMISSIONER PARSONS: All right. That's all the questions I have.

CHAIRPERSON HOOD: Okay. I just have a few questions. In Exhibit F in your submission, Exhibit F, I looked at that and I also looked at the existing site plan. And I'm kind of touching on where Mr. Parsons was. My concern is for your new construction opportunities that you have listed here, it seems like it's taking away the existing parking that you have now for your existing requirements.

For your projected requirements, how do you plan to remedy that problem? Because I see the problem with parking getting worse as opposed to getting better, and also then going into the community.

Now, I'm assuming -- and you know what happens when you assume -- that there is going to be parking within those buildings. So if you can just clarify that for me.

MR. OUDENS: Yes, I will, Chairperson Hood. Exhibit F, you know, these large black areas on that exhibit were

meant to represent the massing that would be permitted under the proposed -- under that proposed zoning.

For example, that long black block along the Irving Street side of the site, I think that's probably what you're referring to in terms of eliminating parking.

CHAIRPERSON HOOD: Exactly.

MR. OUDENS: In order to achieve the density permitted within the SP-1 zone in that area, we would have to build a five-story building, 1,250 feet long. That's what that represents. There's no intention to eliminate the parking structure or eliminate National Rehabilitation Hospital.

But we understand that the Commission's concern would be with the -- what is permitted by right within the proposed zoning. And this was one of a series of studies that looked at various zoning alternatives and what the resultant massing might be under that alternative.

CHAIRPERSON HOOD: So parking remains --

MR. OUDENS: Yes.

CHAIRPERSON HOOD: Mr. George, I need you to kind of walk me through, in your transportation analysis --

MR. GEORGE: Yes, sir.

CHAIRPERSON HOOD: -- on page 10.

MR. GEORGE: Could you tell me the --

CHAIRPERSON HOOD: C9, page 10.

MR. GEORGE: Okay. Can you tell me which document?

The date? I think we had a couple of submissions. Is that September 20?

CHAIRPERSON HOOD: This is your May 11, 2000. Oh, I'm sorry.

MR. MOORE: That's the addendum. He's got the addendum, Osborne. That. What you have in your hand.

MR. GEORGE: Yes, okay.

CHAIRPERSON HOOD: September 20, 2000. It's got two dates on it.

MR. GEORGE: Okay.

CHAIRPERSON HOOD: Okay.

MR. GEORGE: The page on it again, please?

CHAIRPERSON HOOD: It's C9, page 10.

MR. GEORGE: Okay. C9.

CHAIRPERSON HOOD: Right.

MR. GEORGE: Yes, sir.

CHAIRPERSON HOOD: Right. I think we're on -- where we're coming down Irving Street, those three arrows, what do they represent? Are they lanes?

MR. GEORGE: Yes, sir, lanes of traffic.

CHAIRPERSON HOOD: Okay. So we have three lanes on Irving Street, am I correct?

MR. GEORGE: That is correct.

CHAIRPERSON HOOD: Okay. Those three lanes existing -- you're representing that three lanes are now turning

-- and walk me through this -- are now turning into the facility, the Hospital Center.

MR. GEORGE: Existing -- no, they are -- Irving Street is --

CHAIRPERSON HOOD: Okay. Curving. Okay. Okay. Okay.

MR. GEORGE: Yes, right. So they are turning -- the three lanes turn and continue along Irving Street.

CHAIRPERSON HOOD: Okay. So that's just showing the curve to the left.

MR. GEORGE: That is correct.

CHAIRPERSON HOOD: Now, show me on the proposed, what are we proposing here? You have two now that are still curving, and one going straight?

MR. GEORGE: Yes, sir.

CHAIRPERSON HOOD: That's what you have proposed?

MR. GEORGE: That is correct.

CHAIRPERSON HOOD: What do you have now? You have one curving and two going straight now.

MR. GEORGE: No. It's actually a T intersection, and from Irving Street eastbound all lanes must turn left to continue along Irving Street toward North Capitol Street.

CHAIRPERSON HOOD: Going towards Kenyon. That's --

MR. GEORGE: Yes, exactly, going towards Kenyon on the schematic. But keeping in mind, Chairman Hood, that Kenyon --

this is a one-way pair. Irving Street at that point goes eastbound; Kenyon Street goes westbound.

CHAIRPERSON HOOD: And that's what confused me, because I go to church that way every Sunday, and I must be -- I don't know what I'm doing because this --

(Laughter.)

I must be going a different way or something.

Anyway, okay, I don't want to belabor that.

MR. GEORGE: Yes.

CHAIRPERSON HOOD: I don't want to belabor that.

MR. GEORGE: I think -- I'm sorry we didn't have -- we were not able to access the aerials. I think it would be very useful -- the aerial photographs which we used.

CHAIRPERSON HOOD: Okay.

MR. GEORGE: But it's -- yes.

CHAIRPERSON HOOD: I'll work that out.

I wanted to ask Ms. Swearingen, you mentioned in your testimony that zip codes -- you had the zip codes of the patients who basically use the facility, but you didn't give us the zip codes. I would like to have them.

MS. SWEARINGEN: Can we get them to you?

CHAIRPERSON HOOD: Yes, at a later time. That'll be fine.

MS. SWEARINGEN: Sure. We'd be happy to do that.

CHAIRPERSON HOOD: Mr. Brewton, you mentioned in

your consultations with the surrounding neighborhood and the community that you finalized or you came to some kind of consensus with the key constituents. Who are the key constituents?

MR. BREWTON: Well, we have what we call the D.C. alliance, and this is a group of community organizations that we've worked with over the years. And as the plan came together, we invited that group into the hospital to look at our plans before we really launched our communication to the broader community. There are about 13 organizations represented in that group.

CHAIRPERSON HOOD: Okay. ANCs, civic associations --

MR. BREWTON: ANCs, civic associations --

CHAIRPERSON HOOD: All right. Okay.

MR. BREWTON: -- etcetera.

CHAIRPERSON HOOD: That clarifies it for me. Okay. That's all I have.

Colleagues, any other questions? Also, if we could get a paper copy of the Powerpoint presentation, if that could be provided

SECRETARY BASTIDA: Mr. Chairman, the staff has a technical question.

CHAIRPERSON HOOD: Okay. Mr. Bastida?

SECRETARY BASTIDA: The staff reviewed the existing zoning for the site and concluded that the entire site is R-5-A.

There is not SP-1. The SP-1 is related, in our opinion -- and I would be glad that you clarified that for me -- to the existing PUDs, which if that PUD were to disappear, it would revert back to the R-5-A.

You cannot use the SPs to do anything else. And I think that it's important that you -- you might want to put that in writing rather than trying to clarify it right now.

MR. MOORE: All right. I'll address that in writing. My understanding is that the -- in 1970, the Children's Hospital in 1970, 1985 -- in 1985 and 1988, the Children's Hospital applied for a PUD and change of zoning. I know that the Washington Hospital Center applied for a PUD in 1994, with a change of zoning to the SP zone district, but I'll address it --

SECRETARY BASTIDA: No, these -- a related map amendment that is only valid for that PUD under those conditions, and that zoning cannot be used for anything else but only for that PUD.

MR. MOORE: I think that's the case in all PUDs, isn't it?

SECRETARY BASTIDA: Well, that is correct. So clarifying that -- thank you.

VICE CHAIRPERSON MITTEN: Can I just piggyback on that, just so we're perfectly clear? In making the modification to Exhibit F of the prehearing submission, and as I look at the -- you had three zoning strategies that you had included in the

master plan, in each one of those you exclude the SP-2, the PUD SP-2 where the Children's National Medical Center is. But in all of the calculations you include the SP-1 PUD site.

And I think for clarity and for accuracy, just don't even include the SP-1 PUD in the chart, in the bottom, and then we won't get confused.

MR. MOORE: Point well taken, Ms. Mitten.

VICE CHAIRPERSON MITTEN: Okay. Great. Thanks.

COMMISSIONER FRANKLIN: Mr. Chairman, I have just a minor question.

This has to do with landscaping, streetscapes, etcetera. The master plan material leaves me with the impression that somehow or other you want to create on First Street something that is a pedestrian-friendly environment through landscaping and other amenities. How many pedestrians use First Street?

MR. OUDENS: None.

COMMISSIONER FRANKLIN: And how many are likely to use First Street?

MR. OUDENS: I think that the potential for the development of the USSA -- the Soldiers and Airmen's Home property, and, you know, we had discussions with our core development and the Soldiers and Airmen's administrative group, in consideration of development of the sand filter site property.

There has been a great deal of speculation in that area about an overall development plan, and it seemed to us that

First Street was an opportunity to relate properties to the north and south of the Hospital Center in a very friendly way, and make it part of that community.

We totally agree that the Hospital Center turns its back to the community. I think that was unwitting, based on the early street plan and the way that buildings were added, and so forth, and the plan tries to redress that, not only with the new main entrance but with that boulevard and the image of the Center -- that the Center presents to the community.

COMMISSIONER FRANKLIN: Well, I'm not a landscape architect, so I shouldn't be talking about this subject. But it seems to me that it's apparent that this thoroughfare is really not in any sense of the word going to become pedestrian-friendly, simply by virtue of the fact of where it is, the volume of traffic, the fact that people are not going to be walking along it who really have better things to do.

I guess the question, then, is, you know, how should it be treated in a way that, you know, creates a very gracious and welcoming environment for people arriving in vehicles? And I don't know whether that's distinctively different from what you would do for pedestrians, but somebody ought to look at that from a -- both a hardscape and a softscape standpoint.

MR. OUDENS: I agree.

CHAIRPERSON HOOD: I just have one last question. In the ANC letter from ANC-5C -- no, I'm sorry, this was from 4D,

one of the unanswered questions was, "Would there be any free parking?" I believe that was asked by the community. And then it stated the question went unanswered, so I was wondering, is it going to go unanswered again tonight or --

MR. MOORE: I think the answer to that, Mr. Hood, is I doubt it.

CHAIRPERSON HOOD: Okay. Okay. All right.

Any other questions, colleagues? There are no other questions.

I will ask if there is a representative from the ANC who wants to cross examine the applicant. Okay. If not, we'll move now to the Office of Planning's report. And remember, we have your report, and due to the hour I would ask -- my colleagues and I have read it, so if we can get the quickest version that you have to offer.

MS. McCARTHY: Good evening, Mr. Hood, and I would be happy to make this very brief.

The site, as you have observed, is a very large site, 1.7 million square feet approximately of which about one and a half million is before you today for rezoning. The others, as you've just indicated, were rezoned by map amendment, and, therefore, related to the PUD.

And the Office of Planning -- well, let me skip down to really the basics. The Office of Planning, as you know, recommended approval of this rezoning with a condition, and the

condition was that before the zoning action became final there be a signed letter between the MedStar and the Department of Public Works, making arrangement for money to be either in escrow or some final arrangement for the transfer of funds to pay for the construction of a number of improvements that are listed in the document that -- the documents that we're passing out to you now.

The top letter was a letter that we received from Mr. Laden of the Department of Public Works that -- my understanding was he was sending to MedStar for their signing on the bottom line to agree in principle to the discussions there.

In addition to that, the Department of Public Works had the memorandum, which is dated December 5th -- it says, "Subject: Zoning Commission Case 00-2, Proposed Map Amendment, Washington Hospital Center," which provides a little more detail about those improvements, which my understanding was the Department of Public Works intended to attach as an exhibit to that letter.

And then, in addition, Mr. Laden had sent to us a list of TDM measures, traffic demand management measures, that they expected -- that were based on those which had been proposed by Mr. George in his report and which the Department of Public Works was asking for MedStar to commit in writing to the implementation of those measures, too.

Let me just briefly address the issue that the Commission had raised about matter of right versus planned unit

development on this site, because as you know the Office of Planning had originally asked for a PUD on this site for many of the same reasons that the Commission has articulated this evening.

But MedStar and Mr. Moore felt strongly that that was not necessary, argued that, in fact, this was a zoning consistency case in response to the comp plan amendments which the Council had adopted in 1998.

And as a PUD, we felt there would be two -- the two major advantages which a PUD conveyed on this site would be design control and the ability to force commitment to a transportation measure and identify what measures were being implemented as each building went forward to be implemented.

With regard to the design criteria, though, we felt in terms of any adverse impact on those that would be affected by design on the site, the fact that the nearest neighbors were 400 feet away, the fact that it was so buffered by federal property and fairly major arterials, and the fact that the SP-1, the lower zoning with the 65 feet was surrounding the site, and that the higher zoning was only in the interior, made us less concerned about having direct control over the design of the site.

With regard to the transportation improvements, though, we communicated to MedStar that we felt strongly that since there was no legal means to control whether or not the plan was fully adhered to, or whether the site would be completely built out at the full amount of square footage that was capable --

that it could be built out to under the rezoning, that, therefore, we had to assume and Mr. George had to assume that there would be full buildout of the square footage, which by our calculations was about five million square feet.

And that that -- that, therefore, any infrastructure improvements that were committed to should be based on that full buildout and not simply on the amount of square footage that has been indicated by -- was indicated by the plan.

That's what we have asked for, and that was our understanding of what was being submitted. But there is -- what makes all of these numbers a little bit confusing, and I think Mr. Oudens was referring to that somewhat, is there is square footage which is chargeable to FAR, but this plan also has a fairly large amount of square footage which is underground; and, therefore, the exact calculation of that is difficult.

But the amount of square footage that exists now that is now chargeable is substantially more than what the zoning on the site would indicate is the square footage on the site. But as we indicated in our discussions with Mr. George, the reason that we really wanted him to be conservative, as he indicated he was, was because the zoning on the site only controls that which is chargeable to FAR.

If the hospital was going to be constructing a large amount of square footage that was going to generate demand, but that demand was going to be underground or not chargeable to

square footage -- to FAR, we felt that all of that needed to be accommodated within the projections -- the transportation projections that were made.

And that was also the message that we conveyed to the Department of Public Works. We had asked the Department of Public Works to be here tonight because we thought they were far more capable than we were at answering really specific questions about the relationship between the infrastructure improvements, the level of service at those intersections, and the demand projected in Mr. George's studies. And, unfortunately, they were not able to attend.

But that is -- that is what we conveyed to the Department of Public Works before they reached this agreement with MedStar about what needed to be financed in order for DPW to feel comfortable with the amount of square footage that was going to be permitted under this rezoning.

So that's -- which we would expect would be reflected in the final memorandum of understanding, and, therefore, that was why we recommended that before the zoning -- if you approved this before that order would become final, that you would be able to review a signed memorandum of understanding which clearly identified the traffic improvements that were going to be paid for and the schedule under which that was going to be done.

I know that we all in our conversation, in the most

recent telephone conversation which Mr. Laden alluded to, dealt with the fact that although MedStar was originally saying we're -- and Mr. Greene was very direct in committing to being willing to put money into escrow, he wanted that to bear resemblance to the timetable for the development of subsequent buildings, so that the money wasn't in the escrow now, sitting around waiting for several years for those improvements to be built.

Department of Public Works raised the issue that they are planning to proceed anyway in 2001 with the design of intersection improvements at North Capitol and Irving that -- that they had planned to do anyway. They will need to modify those because of what Washington Hospital Center is planning.

And so MedStar committed orally in that telephone conversation that they would advance some of that funding so that even if they didn't have a building specifically being built at that point in time, recognizing that you need to do the intersection improvement when the intersection improvement is being constructed otherwise. And so they did commit to do that in advance.

But in any rate, the details of the timing and what is going to be financed and when we expect to be submitted to you in a signed memorandum of understanding before the Commission would make a final decision on this. And I believe that's timing that was acceptable to Mr. Moore as well.

CHAIRPERSON HOOD: Okay. Thank you, Ms. McCarthy

and Office of Planning.

Colleagues, I would ask that we have a general consensus to accept the Office of Planning report, a late submittal. Any problems? So accepted.

Any questions for the Office of Planning?

COMMISSIONER FRANKLIN: Yes, Mr. Chairman.

The memorandum of understanding, or whatever, is it the Office of Planning's view that the Commission ought to rezone the property as requested in reliance on a memorandum of understanding that is entered into between MedStar and the District DPW? And should that occur, and subsequently for whatever reason the memorandum of understanding unwinds, that we would then on our own change the zoning back? How do you -- what assurance would we have in making -- in rezoning the property that the agreements that we're relying on will be sustained and implemented?

MS. McCARTHY: That is an issue that I put to Mr. Bergstein from the Office of Corporation Counsel, and -- because originally we were arguing that the decision in a very limited number of cases which had been before the Commission before as map changes, but which included in them covenants, that bound the applicant to adhering to certain conditions, we asked that there be a third party covenant with a community group or some third party entity which had the standing to sue if that -- the actions which are called for in the covenant were not executed.

MedStar was not happy with that idea, but Mr. Bergstein indicated that he felt there were problems with the enforceability of that arrangement as well, and that a letter agreement whereby Washington Hospital Center or MedStar bound heirs and assigns to implementing and paying for those transportation improvements was something that was legally binding.

And while not perfect, and while not nearly as controllable as a planned unit development, because you couldn't condition each building on the execution of individual agreements for that building, he did feel that the letter agreement was enforceable. And rather than risk practicing law without a license, since Mr. Bergstein isn't here, Mr. Moore maybe can address that to you in his rebuttal testimony and deal with what he and Mr. Bergstein felt was the enforceability of that agreement.

COMMISSIONER FRANKLIN: So what I'm hearing you say is that you are recommending an out and out rezoning and reliance on some agreement as preferable to a -- what I would call an unconventional PUD.

MS. McCARTHY: I don't think we ever said it was preferable, but I think we said given what the applicant's desires were, and what appeared to be the importance of providing additional density on the site, we were willing to recommend approval if a document that was felt by the corporation counsel

and the Commission to be enforceable was in place that bound MedStar and its heirs and assigns to providing the necessary transportation infrastructure and improvements.

And I think the fact that the major improvement that needs to be made is the intersection improvements at Irving and North Capitol, and the fact that MedStar -- that the timetable for that is fairly close at hand, like under design as of the next year, and the fact that MedStar was willing to commit to that in that timetable that Public Works had, helped mitigate our concern about the fact that this was -- this was not something where the major kind of transportation improvements were going to be 10 years down the road when we were all gone and it was less likely that anybody was going to be around that knew that.

But we do recognize the problem with the fact that once this becomes matter of right, somebody goes in with a building permit, there's nothing automatically within the District's permit approval process that will withhold the approval of a building permit pending fulfilling that contract.

It's something that would have to be remembered and committed to and enforced by the Commission or the Office of Planning or somebody knowledgeable about the fact that, gee, weren't those transportation improvements supposed to be implemented, you know, in the course of that work being done. And that -- you know, we admit that's not an ideal situation.

COMMISSIONER FRANKLIN: Thank you.

CHAIRPERSON HOOD: Thank you.

Commissioner Mitten?

VICE CHAIRPERSON MITTEN: Mr. Chairman, there is a memo from Ken Laden to Andrew Altman that's attached to this I presume draft letter to Mr. Greene from Mr. Laden. And one of the things that he asked for -- and I don't know if this has somehow fallen out of the discussion -- is that -- and this is on page 2 of the memorandum -- is that recommended improvements 1 through 4 should be constructed before any of the new buildings proposed in this zoning map amendment are occupied by MedStar.

MS. McCARTHY: Right. I'm sorry. I did -- I switched around 1 through 4 and 5 through 6. You're right. Those improvements get done first. The design -- MedStar pays for the design, and the District government was planning on the implementation costs of 5 and 6.

VICE CHAIRPERSON MITTEN: Okay. So is this letter, this draft letter to Mr. Greene, is that meant to be the full substance of what they are committing to, because that letter alone does not address the timing issue?

And I know Mr. Laden isn't here to answer for himself, but can you answer it?

MR. COCHRAN: I believe that Mr. -- Steve Cochran, Office of Planning. I believe that Mr. Greene -- Mr. Laden's letter refers directly to this first memo, and that in -- were Mr. Greene to sign the letter, he would also be agreeing to the

attached memorandum.

It just so happens that the memorandum to Mr. Altman, dated December 4th, and signed by Mr. Laden, is also the same attachment that he would have attached to the letter to Mr. Greene. So he's agreeing to everything in there, once he signs and --

VICE CHAIRPERSON MITTEN: Okay. Well, that's not perfectly clear from what is in front of me. So --

MR. COCHRAN: Okay.

VICE CHAIRPERSON MITTEN: -- I was just wanting to be perfectly clear to what -- that that is part of the commitment.

MS. McCARTHY: Right. On page 2 of that attached memo, Mr. Laden had stated the recommended improvements 1 through 4 should be constructed before any of the new buildings proposed in this zoning map amendment are occupied by MedStar. Cs of O should be denied until recommended improvements 1 through 4 are constructed.

COMMISSIONER FRANKLIN: How can that happen? If the buildings are in accordance with the existing new zoning, how can a C of O be denied?

MS. McCARTHY: That's where I'm getting into the practicing law without a license part, because that was our concern as well, and that's where the lawyers that were involved felt the letter agreement was an enforceable agreement. And maybe corp counsel can shed some more light on how it envisioned that to

be enforceable, and maybe Mr. Moore can.

CHAIRPERSON HOOD: Let me just ask, Mr. Bastida, can we phrase those questions to our corporation counsel, so we can have some guidance on that before we make our final decision, if that would be in line with what you would ask for, Commissioner Franklin?

SECRETARY BASTIDA: Yes. The answer to the question is yes, Mr. Chairman. The staff have another question which is contract zoning, and that -- I would put it to the corporation counsel also. The Commission has no authority to request anything from the applicant.

The only thing that the Commission can do is receive something from the applicant and then incorporate it.

CHAIRPERSON HOOD: Okay.

SECRETARY BASTIDA: Because otherwise it's tantamount to contract zoning.

CHAIRPERSON HOOD: Okay. Again, if we can all -- take all of that to corporation counsel, and we can have some correspondence from them before we make our final decision.

Any other questions, Commissioner Mitten?

VICE CHAIRPERSON MITTEN: I had one more.

In the section of the comprehensive plan that's quoted on page 3 of the Office of Planning report, and this runs to the issue of, you know, this being a consistency case, comprehensive plan consistency case, the quote begins as, "The

land use objectives are to encourage with high density rezoning as necessary, and with appropriate measures to mitigate potential adverse impact on surrounding areas, the development of hospitals and related health care services in the area bounded by Michigan Avenue," etcetera.

In terms of this being a quite long-range plan in that -- for what they can foresee their possible needs, that's a 15-year timeframe. For what would be provided by the rezoning is well beyond that. And what their immediate needs are is less than what they have this abstract future need.

Have you considered in any way that we could take a more incremental approach, given that there's a reluctance to -- on the part of the applicant at least to do a PUD, that we could take a more incremental approach and still be meeting the objectives of the comprehensive plan but not really exceeding the direction that the comprehensive plan sends us in?

MS. McCARTHY: One of the -- that gets back as well to a question that was also being discussed earlier, is there anything in between SP-1 and 2 and R-5-A? And it was true for the amount of square footage that was being contemplated by the hospital in the plan was able to be accommodated where the site could be rezoned R-5-D instead of SP-1 and SP-2.

It deals -- the hospital would still be a matter of right in that instance, but you would still have the issue Commissioner Franklin raised with regard to the BZA on any

commercial development or parking garages, office building, hotel, anything like that. But at least in terms of Mr. Moore's concern that the square footage immediately planned could be accommodated -- that could be accommodated within that zoning envelope.

VICE CHAIRPERSON MITTEN: Well, I guess I'm thinking you don't even have to go to R-5-D. I mean, in terms of what their immediate needs are, which were, if I understand correctly how the master plan laid it out on -- this is Chapter 1, page 7, which talks about the needs and breaks them into basically two categories, which is the current need to correct deficiencies, and then a future need, which is somewhat more abstract, although they've quantified it for various service sectors.

The existing need is about a million square feet, and the future need is about 1.7 million square feet. So I guess what I was driving at is in terms of doing something that allows them to meet their existing need, which I believe can be more or less accommodated with R-5-B, and then allow the area to mature, because there's a lot more going on there than just McMillan, sand filtration site, and the available area in the Soldiers Home.

And that's also outlined in greater detail in the master plan, which brings in, you know, increased enrollment in area universities nearby, that there has been a park proposed for the McMillan -- existing McMillan Reservoir, and then we have a conference center that's been approved by the Zoning Commission that's going to be built, and we have a new John Paul, II,

cultural center that just opened.

So there's a lot going on there that we're really not going to be able to capture the effect of it if we just go whole hog right now.

MS. McCARTHY: That's right. We had -- we were very conscious of that -- all of that surrounding development, and that -- in addition to the list that you gave, there was also all that's happening in the New York Avenue corridor, which is substantial. And that was one of the reasons that we had asked Mr. George as well to consider not only the full impact of buildout of the Washington Hospital Center site, but also an increase in demand in general for what was going on in that neighborhood.

But certainly -- there certainly is nothing that would preclude the Commission from saying this is -- you know, what's been advertised is the greatest amount, and the Commission could -- to the way that I remember all of the Commission's regulations, it would certainly be able to say, no, we're only comfortable with R-5-B or R-5-C at this point in time, and come back to us for a greater amount later when you've exceeded that amount.

VICE CHAIRPERSON MITTEN: But what's the position of the Office of Planning on that? I mean, you said that in the beginning you were encouraging a PUD from the applicant, and there was a lot of resistance to that. And so, you know, you've just

accommodated their request as best you can, and extracted the most significant mitigation, which is significant which is, you know, somewhat problematic for some reasons.

So given that this would allow a more studied approach over time, what's your view on an approach like that?

MS. McCARTHY: We certainly would not want to see development on one particular -- any one particular site there preclude the ability for other sites to develop because all of the infrastructure, for example, was taken up by one particular project.

So a -- and we're very conscious of the fact that there are -- there's a lot going on there. There's enormous development potential in that -- in the broader, greater -- in the broader McMillan area, was one of the reasons that we had -- that we asked the Hospital Center to come and make a presentation as part of the work we were doing on McMillan along with the conference center and the Soldiers and Airmen's Home, and everybody that was doing developments on that site.

I guess being the Office of Planning we would always prefer to be anticipating what could be happening in the future, and to be somewhat conservative and try to have some control over that.

So I don't know if you want to comment on that any -- in any other direction, but I guess something that would accommodate MedStar's needs and yet provide the Commission with a

sense of comfort about their ability to control the impacts of that development is something that I don't think the Office of Planning would be opposed to.

CHAIRPERSON HOOD: Okay. Colleagues, any other questions? Okay. With that, applicant, do you want to -- do you have any questions of Office of Planning?

MR. MOORE: No, we don't.

CHAIRPERSON HOOD: Okay. The ANC, I don't believe the ANC was represented.

Do you have any cross examination for the Office of Planning? Okay.

Okay. With that, the report of other agencies. We received some Department of Public Works. I think we've expounded enough on that from Mr. Laden. Did we get anything else from any other agencies? I don't believe we did.

SECRETARY BASTIDA: No, Mr. Chairman. Staff doesn't have reports for any other D.C. agencies.

CHAIRPERSON HOOD: Let me just ask, which ANC Commission area is this in? I know it's in 5C. Is it in another area also?

MR. MOORE: Mr. Hood, we're in 4D.

CHAIRPERSON HOOD: It was 4D.

MR. MOORE: Yes.

CHAIRPERSON HOOD: Okay. I guess two ANCs were noticed.

Let me ask if there is any report of Advisory Neighborhood Commission 4D.

SECRETARY BASTIDA: No, Mr. Chairman. The staff has not received a report from 4D.

CHAIRPERSON HOOD: Other than the letters saying unanimous support, that's --

SECRETARY BASTIDA: Right. You have a report from 5C.

CHAIRPERSON HOOD: From 5C as well. Okay.

SECRETARY BASTIDA: That we received on December 6th.

CHAIRPERSON HOOD: Okay. Let me do this. Since I asked this question earlier, let me go parties and persons in opposition, first? Okay. Parties and persons in support?

Okay. If you want to come and testify. Put the clock on.

Also, may I ask, have you filled out --

SECRETARY BASTIDA: Witness cards, please.

CHAIRPERSON HOOD: If you can come to the table. We need each person that's going to testify to fill out two witness cards. Is there anyone else who wishes to testify? Okay. So we have four people who need to testify.

Let me start to my right, and I will ask that you would introduce yourself and give your address. Also, if you can turn -- thank you.

MS. HOLMES: Thank you very much. Good evening, Mr. Chair and other members of the committee. My name is Hattie Holmes, and I am Advisory Neighborhood Commissioner for 4D, and I would like to thank you for allowing me to come to represent my Commission.

Washington Hospital Center has worked with this Commission for several years on community projects. This evening I want to address the role of the institution -- the institution has played in improving community health. Many of my constituents have chronic diseases, such as hypertension and diabetes. Preventive health care plays a major role in controlling and preventing these diseases.

Washington Hospital Center has initiated a number of health and wellness programs in Ward 4. These programs include screenings, workshops, and most recently an adult aerobics class which is very, very popular. I applaud the institution for initiating these programs and understanding the role of preventive practices in improving community health status.

Additionally, many of my constituents have received high quality medical care from the Hospital Center's caring and dedicated staff. We, the community, want our community hospital to continue to deliver these services and ask that you approve the application for a map amendment.

Approval of this map amendment contributes to improving health status and ensures a strong, financially viable

hospital for the residents of Ward 4 and the District of Columbia.

Thank you.

CHAIRPERSON HOOD: Thank you, Ms. Holmes.

Ms. Jones? If you can hand it to staff. Thank you.

MS. JONES: Good evening, Chair, Mr. Hood. Hi. My name is Cleopatra Jones. I am President of the Bloomingdale Civic Association. I reside at 117 Seaton Place, Northwest, Washington, D.C. 20001.

And this testimony is in support of Case Number 00-2, MedStar Health rezoning application. Thanks for the opportunity to testify on behalf of Washington Hospital Center application.

I reside in the Bloomingdale community, and access to quality medical care is critical, especially in a community with increasingly high rates of cancer, heart disease, and hypertension. In order to continue to provide quality services, Washington Hospital Center must modernize its facilities and expand services.

The Bloomingdale Civic Association received briefings on the proposed development plan for the hospital, supported the proposed -- the civic association proposed -- supported the proposed plan for campus redevelopment for the following reasons. It will improve traffic patterns and increase parking. A consistent problem when patients or visitors come to

the campus is the availability of parking. The proposed plan improves the location and availability of parking.

As an advocate for seniors, it is important that the medical facility provides them easy access. The proposed plan will improve access for seniors and the physically challenged.

Better signs and directions. Visitors and patients have difficulty finding services at the hospital. Signs are often confusing. The plan improves signs and will make it easier for patients and visitors to locate and access services.

Washington Hospital Center is a vital resource in the community and a major provider of services to the District residents. We must maintain and improve the important community resource. To improve the health status of District residents, I urge you to approve Washington Hospital Center's application for a map amendment.

Thank you for this opportunity to testify.

CHAIRPERSON HOOD: Thank you.

Next? Good evening.

MS. BARNES: I'm Celia Dianne Barnes, and I'm a resident of the Bloomingdale community. Thank you for this opportunity to express my views on the application before you for the map amendment for Washington Hospital Center.

As a long-time resident of the District of Columbia, I am aware of the poor health status of citizens in our city. Accessible, high quality medical care is critical in a

community with high rates of cancer, heart disease, hypertension, and a declining but still high immortality rate.

I am here this evening to urge you to approve Washington Hospital Center's application for a map amendment. The Washington community needs a strong hospital with the latest equipment and facilities. Washington Hospital Center has played a major role in the lives of the District residents. The Hospital Center, our community hospital, must continue to deliver high quality service to the citizens.

In order to maintain competitive and provide high quality medical care, the Washington Hospital Center must improve its facilities and keep pace with the new technology advances in health care. In my opinion, this map amendment will allow the Hospital Center to remain a world-class health care facility.

Thank you.

CHAIRPERSON HOOD: Thank you.

Commissioner Phillips?

MR. PHILLIPS: Yes, sir. Good evening, Mr. Chairman, and to the Commissioning Board. I link this testimony for myself as the Vice Chairman and as the commissioning body that we came to agreement to on the testimony today.

For more than 40 years, Washington Hospital Center has provided medical care to the Washington community. The institution has contributed significantly to improving the health status of residents in the community. In order to continue to

meet community needs, the hospital must expand services, and it must purchase new equipment and improve and replace buildings.

As Vice Chairperson of ANC-5C, I am writing a letter of support for Washington Hospital Center application for a map amendment. The map amendment will ensure continuous services for the community in a state-of-the-art hospital.

My support for the map amendment is based on two reasons. First and foremost, the hospital provides quality health care services. I personally have a -- have been a consumer of these services and praise the institution as a first-rate hospital with a caring and dedicated staff.

I also offer my support because of the hospital's involvement in the community, especially the youth mentoring programs. One such program that they partnership is the Edgewood Youth Development Center, which you may view at www.danspix.eydc -- as a condition of my -- excuse me -- as a condition and expand my community outreach programs for the youth and adults, such as training and employment and summer jobs.

As a member of the community, Washington Hospital Center, a not-for-profit institution, has an obligation to address community needs and be at the forefront for the good neighbor policy.

This is from our commissioning body here that we came together with just at our meeting Tuesday, December 5th. "I write on the occasion to inform you that the officers and the

members of Advisory Neighborhood Commission 5C, ANC, met on December 5, 2000, to consider, among other issues, the application Washington Hospital Center to make certain map amendments to their 20-year master plan.

"In this regard, it is important to note that timely and proper notice was given to the public concerning the meeting at which this issue was discussed with Ms. Anne Chisholm, Director of Community Relations, from the Washington Hospital Center.

"In addition, it is initial to indicate to you that a quorum of our membership was present at that time that the matter was voted upon by the body. In brief, ANC-5C would like to expand its unanimous support for the application request to make the proposed map amendment to their 20-year master plan.

"Indeed, at the time of this writing, it is our estimate that the information of the proposed amendment will have advised impact on the surrounding residential community.

"Over the past year or so, the Washington Hospital Center has been working closely and cooperatively with the Bloomingdale Civic Association, and residents of single-member District 5C-04 to address certain problems of traffic congestion that have been historically associated with heavily traveled corridors which lead to and from the hospital.

"Importantly, several of the traffic claiming measures recommended by these groups have already been implemented

by our local government's Bureau of Traffic Services."

And on behalf of the hospital, Ms. Chisholm's response was cooperative with the ANC and Bloomingdale Civic Association to squarely address and resolve any negative traffic, parking, or other adverse impact that may result from the proposed development of the Washington -- of the hospital site at some point in the future.

A concern about the affordable public parking for visitors and patients of the hospital was expressed by a number of members of our group. In this connection, a recommendation was made that the hospital provide a certain number of free parking spaces for the patrons and/or that a system of substantially discount parking fees be developed and implemented by those patrons of the hospital who request or are in need of them.

We are -- we thank you in advance for seriously considering the position of ANC-5C with respect to the application of Washington Hospital Center to make certain map amendments to its 20-year master plan. Indeed, we expect that you will give our commitments on the matter the great weight to which they are entitled.

Thank you very much.

CHAIRPERSON HOOD: Thank you.

Colleagues, any questions of this panel? Okay. No questions. I want to thank you all for your patience, and thank you for your testimony.

If there is no one else wanting to testify in support, I'm going to ask, Mr. Moore, if you can come back to the front and do your closing remarks, your brief closing remarks.

MR. MOORE: Okay. A preacher's son is always brief, Mr. Hood.

(Laughter.)

Mr. Chairperson and members of the Board, this has been a long hearing process, but that's not surprising given the level of effort and commitment that MedStar has put into this application. For the -- I guess we can -- can we dim the lights again, Steve, please? We try to be --

CHAIRPERSON HOOD: It's getting late. We don't want anybody to go to sleep.

(Laughter.)

MR. MOORE: For the past 30 months, MedStar has been surveying its professional and non-professional staff, regularly consulting with its institutional and residential neighbors, meeting on numerous occasions with the D.C. Office of Planning and the D.C. Department of Public Works, held meetings with area members of the D.C. Council and with the senior staff of the D.C. Financial Control Authority, and with the Mayor of the District of Columbia.

It then went with the citizens again, all in an effort to devise a plan, choose a zone, and support the application that is before you this evening. We thank you for

your time and close attention to our presentation.

All of these meetings, conferences, remeetings, adjustments, improvements, refinements, negotiations, have consumed nearly 32 months of our lives. Our endeavor has convinced us that we are absolutely right -- doing the right thing zoning-wise, citizen-wise, medical-wise, and business-wise. However, convincing yourself doesn't necessarily win an argument.

Thus, we are hopeful that the evidence that you have heard and seen this evening, together with that which is already in the record, has earned your vote to approve this application.

We've established that the existing residential zoning is, one, inappropriate for the past, present, and future uses of the property. Residential zoning just doesn't work for us. Two, residential zoning is unable to provide MedStar with the space it needs to serve its patients. And, three, residential zoning is inconsistent with the comprehensive plan.

I should say here that in the 32 months we've been working on this we -- we, first, went to the Council of the District of Columbia, and we talked with the Council, and the Council ultimately, at our request, passed amendments to the -- in 1998 to change the language in the comprehensive plan so that we could come to this Commission with a map amendment case that would be supported in the comprehensive plan for an SP zone district.

Now, SP, I've said before and I'll say again --

isn't the perfect district, but it is the only district -- the only district that we can look at that will suit our needs. R won't work for us, and this is -- and it won't work comprehensive planning-wise. It won't work planning-wise. With respect to the comprehensive plan, it won't work planning-wise. Simply, it is not a zone for us.

W is out. It's not a waterfront. CR does not permit a hospital as a matter of right. We don't want to even get into putting it on a commercial zone, you know, where we would have everything a matter of right, but someone would accuse us of wanting to build office buildings.

SP is the proper zone. We have done our homework to ensure that.

We have concluded that the requested special purpose zoning is suitable and not inconsistent with either the comprehensive plan or the legacy plan, has already been found by the Commission to be an appropriate district for this square.

It's the next highest zoning category after residential and will allow the density and uses that this distinguished D.C. health care provider and employer needs to continue its record of excellence.

There is expert testimony on record that this rezoning is consistent with the Zoning Act and the comprehensive plan, will not adversely affect the use and enjoyment of neighboring property, and can be easily accomplished without harm

to the city's transportation system.

We are pleased, fortunate, and gratified that each of the neighboring Advisory Neighborhood Commissions -- 4D and 5C -- community groups, and institutional property owners, have been persuaded of the merits of this application and have expressed their support for its approval in the record.

Ladies and gentlemen of the Zoning Commission, we have done our homework on this application. There is substantial and uncontroverted evidence in the record, the documents, the substantial work that MedStar has done to assure itself and others that this rezoning and the development plan that may follow will be well managed.

For its part, MedStar has presented expert testimony and written evidence in the record demonstrating why it needs this rezoning and why this rezoning is important and appropriate. There is no question on this record that the proposed rezoning is critically important to the survival of this distinguished health care facility.

Just recently, the Washington Hospital Center was named among the 100 best hospitals in the country. It is crucial to the interest of our city that the Washington Hospital Center continue to be a first-class facility and the facility of choice for the residents of our city and the people of this region.

The new and better service components to the residents of this city are in the record and undisputed. And

speaking of public benefits, any D.C. resident has to be excited about the new buildings, convention center, restaurant, retail stores, technical communication services, office buildings, and new housing opportunities that this year and next has brought and are bringing to our city.

These are not just idle musings by the applicant's zoning attorney. These are facts that anyone can see and feel just by looking around.

We are a city on the move. The development plans of MedStar are a part of the rebirth and renewal of the city of Washington, and we urge the Zoning Commission to recognize this reality as a matter of zoning policy. These are the facts. These are the reasons. And these are the public policies on which MedStar submits that it has met its burden of proof and that it is entitled to the zoning/rezoning that has been requested.

We thank you for your time and close attention to our detailed and lengthy presentation.

May I just add that with respect to the issue that was raised by Mr. Franklin, as I indicated, I don't have the authority to say yes or no to any form of a PUD. I can say to you that I will go back to those people who do have the authority to make decisions in this area, and the record will remain open.

I would ask the record to remain open, Mr. Hood, for the purposes of receiving at least two documents -- one, the document that we are negotiating with the Department of

Transportation with respect to MedStar contributing to the road improvements; and, second, a position from MedStar with respect to the idea that Mr. Franklin advanced as to whether there is a mechanism within the confines of the PUD process that will allow the Commission to approve this application in a way that is -- that MedStar can fulfill its development needs.

Thank you for your time and attention. We can turn the lights on.

CHAIRPERSON HOOD: Okay. We thank you, Mr. Moore.

Commissioner Franklin?

COMMISSIONER FRANKLIN: Yes. I just had one other request, and I appreciate your offer to explore that, because it certainly will make life easier for me.

And I think you have to look at it in the sense of what I'd call a -- not a standard PUD. What are the circumstances that you would find acceptable under a PUD-like order of the Zoning Commission? And if, by the way, the conclusion is that under no circumstances would that be acceptable, it would be helpful to know that as well.

MR. MOORE: Okay.

COMMISSIONER FRANKLIN: But also, I would like to have you supply evidence of the adoption by the governing body of MedStar of the master plan.

And I would hope, Mr. Chairman, that the Office of Planning, with the assistance of the Office of Zoning, would look

into creatively how the PUD process could meet the needs of MedStar as well as the public interest.

CHAIRPERSON HOOD: Okay. I'm sure that both staffs have heard your request, Commissioner Franklin.

Also, added to that list, we asked for a paper copy of the Powerpoint presentation.

MR. MOORE: Yes. And the zip code --

CHAIRPERSON HOOD: And the zip codes. Thank you.

Also, I believe we asked for some comments back from corp counsel, and that's all I have on my list.

SECRETARY BASTIDA: Also, the --

CHAIRPERSON HOOD: You need to turn your microphone on, Mr. Bastida.

SECRETARY BASTIDA: Yes. I'm sorry. The applicant is supposed -- is going to address the issue of the existing zoning, the overall zoning for the site.

CHAIRPERSON HOOD: Okay.

SECRETARY BASTIDA: If we were to certify the site now, what is existing zoning will have to be certified R-5-A. That's the opinion of the Office of Zoning. And the applicant would like to address that issue.

CHAIRPERSON HOOD: Okay. Mr. Altman, did you have something?

MR. ALTMAN: No.

CHAIRPERSON HOOD: Oh, I'm sorry.

(Laughter.)

Okay. The record will be open until --

SECRETARY BASTIDA: Excuse me, Mr. Chairman. Ms. Mitten said something about clarification of the computation, and the applicant provided something verbally. Would she like something else in writing?

VICE CHAIRPERSON MITTEN: I think that's probably about as much as there is to say, so that's -- that was fine.

CHAIRPERSON HOOD: Okay. Thank you.

PARTICIPANT: I agree with that, Ms. Mitten.

(Laughter.)

CHAIRPERSON HOOD: Okay. Let me get some dates, Mr. Bastida.

And, Mr. Moore, I want to see if that accommodates you for when we're going to close the record.

MR. MOORE: Thank you.

SECRETARY BASTIDA: Well, it depends upon the applicant, when he feels that he can obtain all of that information. I was thinking that it might take some time, and it is because of the holidays, so I was going to suggest December 29th to submit that for the record.

CHAIRPERSON HOOD: Would you need more time, Mr. Moore?

MR. MOORE: May we have more time, Mr. Hood, for the following reasons? Number one, this issue of PUD versus map

amendment case -- Mr. Greene just had surgery, and I just need -- I don't know what his availability is going to be in the next couple of weeks, at least for the end of the year.

CHAIRPERSON HOOD: Would you like February 1st?

MR. MOORE: Yes. And, secondly, we've got to work -- negotiate an arrangement with the D.C. Department of Public Works, and we just need a little more time than is usually the case for a map amendment case.

SECRETARY BASTIDA: What amount of time, Mr. Moore, would you like to --

MR. MOORE: February 1st will do nicely.

SECRETARY BASTIDA: Okay. Then we'll do it to February 2nd. That is a Friday. And we will give you until February 16th for providing findings of fact and conclusions of law.

MR. MOORE: Thank you.

CHAIRPERSON HOOD: Okay. Ladies and gentlemen, the other Commissioners and I would like to thank you for your testimony, assistance, and patience. The record in this case will be kept open until February 2nd for submissions of any additional information.

Any special information or reports specifically requested by this Commission must be filed no later than the close of business, at 4:45 p.m., on February 2nd, in Suite 210 of this building, 441 4th Street, Northwest.

The Commission will make a decision in this case at one of its regular monthly meetings following closing of the record. These meetings are held at 1:30 p.m. on the second Monday of each month with some exceptions, and are open to the public.

If any individual is interested in following this case further, I suggest that you contact staff to determine whether this case is on the agenda of a particular meeting.

You should also be aware that should the Commission propose affirmative action, the proposed action must be referred to the National Capital Planning Commission, NCPC, for federal impact review. The Zoning Commission will take final action at a public meeting following receipt of the NCPC's comments, after which a written order will be published.

Thank you, and I now declare this hearing closed.

(Whereupon, 10:33 p.m., the proceedings in the foregoing matter were adjourned.)