File No. 120549 Board Item No. 48

COMMITTEE/BOARD OF SUPERVISORS

AGENDA PACKET CONTENTS LIST

Board of Supervisors Meeting Date 7/17/12

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☐	☐	Form 126 – Ethics Commission
☐	☐	Award Letter
☐	☐	Application
☒	☐	Public Correspondence

OTHER (Use back side if additional space is needed)

*	☐	☐	Planning Dept Appeal Response (Exhibits A and B)
*	☐	☐	Letter from Michael Lightly on behalf of CA Nurses Assoc. (Exhibits 1-14)
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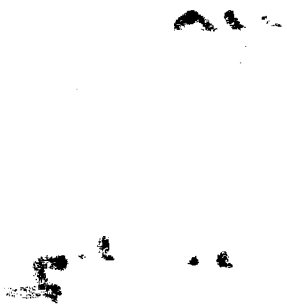
Completed by: Victor Young Date June 7, 2012

Completed by: _____ Date _____

An asterisked item represents the cover sheet to a document that exceeds 25 pages.
The complete document can be found in the file.



AGREEMENT TO CONTINUE TO JULY 17: Appeal of Planning Commission Certification of the Final Environmental Impact Report - California Pacific Medical Center Long Range Development Plan Project

Judson True to: Joy Lamug 06/07/2012 01:41 PM

Cc: Angela Calvillo, AnMarie Rodgers, Audrey Pearson, Bill Wycko, BOS-Legislative Aides, BOS-Supervisors, Cheryl Adams, Devyani Jain, Elaine Warren, gloria, Joy Navarrete, Kate Stacy, Linda

All:

Please be aware that I have received written confirmation from both the appellants and the project sponsor to continue this appeal to July 17, 2012 at 4pm.

Our office has requested that there be a notation of this agreement on the Board agenda for June 12.

Please let me know if you have any questions.

Best,
Judson

Judson True
Office of Supervisor David Chiu
City Hall, Room 264
San Francisco, CA 94102
415.554.7451 desk
415.554.7454 fax

Joy Lamug — Dear Ms. Smith: The Office of the Clerk of the B... 05/18/2012 05:14:55 PM

From: Joy Lamug/BOS/SFGOV
To: gloria@gsmithlaw.com
Cc: Cheryl Adams/CTYATT@CTYATT, Kate Stacy/CTYATT@CTYATT, Marlena Byrne/CTYATT@CTYATT, Scott Sanchez/CTYPLN/SFGOV@SFGOV, Bill Wycko/CTYPLN/SFGOV@SFGOV, AnMarie Rodgers/CTYPLN/SFGOV@SFGOV, Tina Tam/CTYPLN/SFGOV@SFGOV, Linda Avery/CTYPLN/SFGOV@SFGOV, Angela Calvillo/BOS/SFGOV@SFGOV, Rick Caldeira/BOS/SFGOV@SFGOV, Victor Young/BOS/SFGOV@SFGOV, Joy Navarrete/CTYPLN/SFGOV@SFGOV, Devyani Jain/CTYPLN/SFGOV@SFGOV, Elaine Warren/CTYATT@CTYATT, Audrey Pearson/CTYATT@CTYATT, BOS-Supervisors/BOS/SFGOV, BOS-Legislative Aides/BOS/SFGOV, nelsonGK@sutterhealth.org
Date: 05/18/2012 05:14 PM
Subject: Appeal of Planning Commission Certification of the Final Environmental Impact Report - California Pacific Medical Center Long Range Development Plan Project

Dear Ms. Smith:

The Office of the Clerk of the Board is in receipt of your appeal filed on May 16, 2012, on behalf of the California Nurses Association/National Nurses United, Council of Community Housing Organizations, Cathedral Hill Neighbors Association, Bernal Heights Neighborhood Center, Jobs with Justice San Francisco, and San Franciscans for Healthcare, Housing, Jobs, and Justice from the decision of the Planning Commission's April 26, 2012, Certification of a Final Environmental Impact Report

identified as Planning Case No. 2005.0555E, through its Motion No. 18588, for the proposed California Pacific Medical Center Long Range Development Plan Project.

A hearing date has been scheduled on **Tuesday, June 12, 2012, at 4:00 p.m.,** at the Board of Supervisors meeting to be held in City Hall, Legislative Chamber, Room 250, 1 Dr. Carlton B. Goodlett Place, San Francisco, CA 94102.

Please provide 18 copies to the Clerk's Office by:

8 days prior to the hearing:	any documentation which you may want available to the Board members prior to the hearing;
11 days prior to the hearing:	names of interested parties to be notified of the hearing in label format.

[attachment "CPMC FEIR Appeal.pdf" deleted by Judson True/BOS/SFGOV]

If you have any questions, please feel free to contact Legislative Deputy Director, Rick Caldeira, at (415) 554-7711 or Legislative Clerk, Joy Lamug, at (415) 554-7712.

Thanks,
Joy

Joy Lamug
Board of Supervisors
Legislative Division
City Hall, Room 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102
Tel: 415.554.7712
Fax: 415.554.7714
Email: joy.lamug@sfgov.org

Fw: CPMC full board hearing date
Rick Caldeira to: Victor Young 06/07/2012 01:13 PM

For file.
---- Forwarded by Rick Caldeira/BOS/SFGOV on 06/07/2012 01:14 PM ----

From: Judson True/BOS/SFGOV
To: Rick Caldeira/BOS/SFGOV@SFGOV,
Cc: Angela Calvillo/BOS/SFGOV@SFGOV
Date: 06/07/2012 11:49 AM
Subject: Fw: CPMC full board hearing date

FYI below.

I also received a verbal agreement to a July 17 continuance from the appellants, but I am waiting for their written agreement. I will forward it ASAP.

Thank you very much,
Judson

Judson True
Office of Supervisor David Chiu
City Hall, Room 264
San Francisco, CA 94102
415.554.7451 desk
415.554.7454 fax

---- Forwarded by Judson True/BOS/SFGOV on 06/07/2012 11:50 AM ----

From: "Farrar, Mark" <FarrarM@sutterhealth.org>
To: <Judson.True@sfgov.org>
Cc: <ken.rich@sfgov.org>
Date: 06/06/2012 04:26 PM
Subject: RE: CPMC full board hearing date

Judson

The 17th is acceptable.

Mark

From: Judson.True@sfgov.org [mailto:Judson.True@sfgov.org]
Sent: Monday, June 04, 2012 5:55 PM
To: Farrar, Mark
Cc: ken.rich@sfgov.org
Subject: RE: CPMC full board hearing date

Hello Mark -

Thank you very much for your email below. We appreciate CPMC's willingness to continue the Board's consideration of the EIR appeal of your project.

However, regarding the specific date of the continuance, July 17 would match up better with the proposed schedule of Land Use hearings on this important and complex project.

For context, the appellants requested July 24.

Thank you for your consideration and I look forward to your response.

Judson

Judson True
Office of Supervisor David Chiu
City Hall, Room 264
San Francisco, CA 94102
415.554.7451 desk
415.554.7454 fax

From: "Farrar, Mark" <FarrarM@sutterhealth.org>
To: <ken.rich@sfgov.org>, <Judson.True@sfgov.org>
Date: 06/04/2012 10:17 AM
Subject: RE: CPMC full board hearing date

Ken and Judson

California Pacific Medical Center (CPMC) , as applicant/project sponsor and real party in interest, confirms its agreement to a continuance of the hearing of the appeal filed on May 16, 2012, from the April 26, 2012 decision of the Planning Commission, by Motion No. 18588, certifying the Final EIR for the proposed CPMC Long Range Development Plan (Planning Department Case No. 2005.055E) from June 12. It is our request that this hearing be re-scheduled for July 10th instead of the 17th as noted below.

Mark

From: kenneth.j.rich@gmail.com [mailto:kenneth.j.rich@gmail.com] **On Behalf Of** Ken Rich
Sent: Friday, June 01, 2012 6:13 AM
To: Farrar, Mark
Subject: Fwd: CPMC full board hearing date

Mark -

See below - looks like we are good for 7/17. Can you send Judson the email he requests confirming that CPMC agrees to continue to 7/17?

Ken Rich
Project Director
Office of Economic and Workforce Development
City Hall, Room 448
(415) 554-5194
ken.rich@sfgov.org

---------- Forwarded message ----------
From: <Judson.True@sfgov.org>
Date: Thu, May 31, 2012 at 5:09 PM
Subject: Re: CPMC full board hearing date
To: ken.rich@sfgov.org
Cc: Jason Elliott <jason.elliott@sfgov.org>, kenneth.j.rich@gmail.com, Nickolas.Pagoulatos@sfgov.org

Hi Ken -

July 17 sounds good.

Can you please ask CPMC to email me confirming their agreement with the continuance? Good to have for the file (we ask the same of the appellants).

Thanks,
Judson

Judson True
Office of Supervisor David Chiu
City Hall, Room 264
San Francisco, CA 94102
415.554.7451desk
415.554.7454fax

=

Fw: Continuance of CPMC FEIR Board hearing date
Rick Caldeira to: Victor Young 06/07/2012 01:37 PM

For file.
----- Forwarded by Rick Caldeira/BOS/SFGOV on 06/07/2012 01:38 PM -----

From: Judson True/BOS/SFGOV
To: Rick Caldeira/BOS/SFGOV@SFGOV, Angela Calvillo/BOS/SFGOV@SFGOV,
Date: 06/07/2012 01:33 PM
Subject: Fw: Continuance of CPMC FEIR Board hearing date

Agreement from appellants.

Judson True
Office of Supervisor David Chiu
City Hall, Room 264
San Francisco, CA 94102
415.554.7451 desk
415.554.7454 fax

----- Forwarded by Judson True/BOS/SFGOV on 06/07/2012 01:36 PM -----

From: Gloria D Smith <gloria@gsmithlaw.com>
To: "Judson.True@sfgov.org" <Judson.True@sfgov.org>
Cc: Michael Lighty <mlighty@calnurses.org>, Pilar Schiavo <pschiavo@calnurses.org>, pam allen <pallen@calnurses.org>, Joanne Jung <JJung@CalNurses.Org>
Date: 06/07/2012 01:29 PM
Subject: Fw: Continuance of CPMC FEIR Board hearing date

Judson,
Forgive me, I forgot to include key coalition members in my earlier email regarding the continuance.

The Law Offices of Gloria D. Smith

Please consider the environment before printing this e-mail.

----- Forwarded Message -----
From: Gloria D Smith <gloria@gsmithlaw.com>
To: "Judson.True@sfgov.org" <Judson.True@sfgov.org>
Sent: Thursday, June 7, 2012 12:58 PM
Subject: Continuance of CPMC FEIR Board hearing date

Judson,
I write to confirm that the coalition sponsoring the appeal of the CPMC FEIR fully supports continuing the hearing to July 17, 2012. Thank you.

The Law Offices of Gloria D. Smith

 Please consider the environment before printing this e-mail.

File 120549

BS-11 6pgs

RECEIVED
BOARD OF SUPERVISORS
SAN FRANCISCO
2012 JUN -7 AM 9:52
AK

June 5, 2012

To: Board of Supervisors

City and County of San Francisco

From: OWL-SF

The Older Women's League of San Francisco focuses on issues unique to women as they age. We advocate for improved access to high-quality and affordable healthcare for the women of SF. We also advocate for quality of life issues, including a safe, livable, city for women throughout the city and from every socioeconomic bracket. We educate ourselves and our peers about issues affecting older women, and we VOTE!

We oppose the CPMC Developmental Plan to build a mega-hospital on Van Ness and to downsize St. Luke's Hospital. OWL recommends that the plans for the rebuild be delayed until 2013 when the Healthcare Master Plan goes into effect and guides official decisions regarding health care needs and consistency for the entire City. If the plan must go forward, we recommend that CPMC be responsive to community needs and build 2 full service hospitals rather than one large hospital,

Please see that Sutter Health rebuilds CPMC "the right way." We demand the following:

1) CPMC must provide charitable care (including shortfalls in Medi-Cal and Healthy San Francisco) equal to the average level of care provided by similar SF hospitals for a minimum of 20 years.
2) CPMC must charge fair prices and provide some price protection to insurers so that residents insured by different policies (including those covering current and retired City employees and their families) have access to CPMC services.
3) CPMC must build and operate St. Luke's as an acute care hospital of at least 180 beds with a full complement of services for a minimum of 20 years, without the right to close down or substantially reduce services unless consent of the City and input from community stakeholders is obtained.
4) St. Luke's must have robust Centers of Excellence, including Senior Health and Community Health, adding substantial value to existing services.
5) CPMC must restore and maintain adequate skilled nursing facility beds spread among 3 campuses. The 110 beds currently agreed upon are inadequate.
6) CPMC must provide psychiatric services at St. Luke's and the Cathedral Hill Hospital, including acute, sub-acute and outpatient services.
7) The City must have input in Community Healthcare Programs in order to address changing circumstances, community needs and evolving medical practices.

8) SF has adopted a policy of maintaining a relationship between jobs and housing. In the current plan, housing is mostly addressed through a Down Payment Loan Plan, which provides no net gain in housing for the City. There should be new affordable housing to provide a net increase in housing for the increased workforce.
9) The current plan commits CPMC to giving only 40 local residents jobs per year for 5 years. CPMC must commit to more local hires and contribute to workforce development required to achieve local hiring goals.
10) Nurses should be guaranteed a fair and neutral vote on whether or not the union will be carried over into the new hospital
11) Transportation issues are not adequately addressed considering the size of the 555 bed hospital proposed for Cathedral Hill. Seniors are particularly dependent on public transportation. Solutions must be found regarding safety issues, impacts on seniors, people with disabilities, and people with mobility issues.

Thank you for considering our opinions and our needs in the upcoming vote.

Melanie Grossman

Melanie Grossman, Ph.D., L.C.S.W.

Chair, Political Advocacy Committee

Older Women's League, San Francisco

BOARD of SUPERVISORS

City Hall
1 Dr. Carlton B. Goodlett Place, Room 244
San Francisco 94102-4689
Tel. No. 554-5184
Fax No. 554-5163
TDD/TTY No. 554-5227

NOTICE OF PUBLIC HEARING

BOARD OF SUPERVISORS OF THE CITY AND COUNTY OF SAN FRANCISCO

NOTICE IS HEREBY GIVEN THAT the Board of Supervisors of the City and County of San Francisco will hold a public hearing to consider the following proposal and said public hearing will be held as follows, at which time all interested parties may attend and be heard:

Date: **Tuesday, June 12, 2012**

Time: **4:00 p.m.**

Location: **Legislative Chamber, Room 250 located at City Hall, 1 Dr. Carlton B. Goodlett Place, San Francisco, CA 94102**

Subject: **File No. 120549. Hearing of persons interested in or objecting to the Planning Commission's decision, dated April 26, 2012, Certification of a Final Environmental Impact Report identified as Planning Case No. 2005.0555E, through its Motion No. 18588, for the proposed California Pacific Medical Center Long Range Development Plan Project. (Appellant: Law Offices of Gloria D. Smith on behalf of the California Nurses Association/National Nurses United, Council of Community Housing Organizations, Cathedral Hill Neighbors Association, Bernal Heights Neighborhood Center, Jobs with Justice San Francisco, and San Franciscans for Healthcare, Housing, Jobs and Justice.)** (Filed May 16, 2012)

Pursuant to Government Code Section 65009, notice is hereby given, if you challenge, in court, the matter described above, you may be limited to raising only those issues you or someone else raised at the public hearing described in this notice, or in written correspondence delivered to the Board of Supervisors at, or prior to, the public hearing.

In accordance with Section 67.7-1 of the San Francisco Administrative Code, persons who are unable to attend the hearing on these matters may submit written comments to the City prior to the time the hearing begins. These comments will be made a part of the official public records in these matters, and shall be brought to the attention of the Board of Supervisors. Written comments should be addressed to Angela Calvillo, Clerk of the Board, Room 244, City Hall, 1 Dr. Carlton B. Goodlett Place, San Francisco, CA 94102. Information relating to this matter is available in the Office of the Clerk of the Board and agenda information will be available for public review on Thursday, June 7, 2012.

Angela Calvillo
Clerk of the Board

MAILED/POSTED: June 1, 2012 1865

The Law Offices of Gloria D. Smith
48 Rosemont Place
San Francisco, CA 94103
(415) 308-9124
gloria@gsmithlaw.com

June 4, 2012

Joy Lamug
Board of Supervisors
Legislative Division
City Hall, Room 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102

RE: Documentation in support of Appeal of San Francisco Planning Commission's Certification of the California Pacific Medical Center (CPMC) Long Range Development Plan FEIR (Planning Commission No. 2005.0555E)

Dear Ms. Lamug:

On behalf of the coalition opposing the above-referenced project, this letter, and accompanying documents, responds to your office's request that we provide 18 copies of documents the Board must consider in its review of the CPMC LRDP FEIR. Given the size and complexity of the project and its administrative record, we are still working through the factual issues supporting our appeal. For that reason, we may supplement this filing. Please do not hesitate to contact me if you any questions. Thank you.

Dated: June 4, 2012

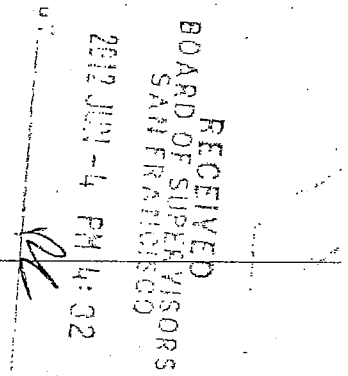
LAW OFFICES OF GLORIA D. SMITH

By:

Gloria D. Smith
For California Nurses Association/National Nurses United, Council of Community Housing Organizations, Cathedral Hill Neighbors Association, Bernal Heights Neighborhood Center, Jobs with Justice San Francisco, And San Franciscans for Healthcare, Housing, Jobs, and Justice

The Law Offices of Gloria D. Smith
48 Rosemont Place
San Francisco, CA 94103
(415) 308-9124
gloria@gsmithlaw.com

April 25, 2012



Via electronic mail

San Francisco Planning Commission
San Francisco Planning Department
1650 Mission Street, Suite 400
San Francisco, CA 94103

Elizabeth.Watty@sfgov.org

Re: Comments on Final Environmental Impact Report for the CPMC Long Range Development Project

Dear President Fong and the Planning Commission:

These comments are submitted on behalf of the California Nurses Association/National Nurses United ("CNA") on the Final Environmental Impact Report ("Final EIR") for the CPMC Long Range Development Plan ("Project"). CNA is one of California's oldest nonprofit social welfare institutions. Founded in 1903, today CNA represents over 86,000 members in California. CNA has represented its members on nursing public health issues before municipal, county, and state bodies for over 100 years. CNA members provide professional care for patients in medical facilities in San Francisco, the Bay Area, and throughout the state. CNA's comments are made in its representative capacity of CNA members and their families who currently reside in San Francisco County, on behalf of its members and their families throughout California, and on behalf of health care consumers generally who are directly affected in their health and general welfare by the availability of, access to, quality health care services.

CNA has been actively involved in every aspect of CPMC's long range planning efforts and CEQA review for the Project, including the submission of extensive comments on the Draft EIR. Unfortunately, the Final EIR fails to remedy and adequately respond to the many defects CNA identified in the Draft EIR. The Final EIR continues to omit and understate impacts to traffic and air quality, fails to adopt all feasible mitigation for these and other impacts, and fails to ensure that mitigation that is identified is enforceable and effective.

Even with many impacts improperly minimized or ignored altogether, the Final EIR still recognizes that the Project would result in an inordinate number of significant impacts, including 30 impacts to traffic alone. Moreover, this Project overturns the land use designations and mitigations of the existing Special Use District, designed to limit greenhouse gas emissions through promotion of housing and restrictions on vehicles. Under the new District created for the

Project, there will be substantially more commuter car trips and car-based regional visitors on the most congested traffic corridor in the city. The extraordinary number of impacts resulting from the Project and dramatic variance from the existing vision for the Van Ness area begs the question of whether proposed construction of the Cathedral Hill Campus at such a massive scale is appropriate for this already severely congested and impacted area.

The Project's many significant and unavoidable impacts and disruption to the existing community plan underscores the importance of a rigorous alternatives analysis. Yet, rather than provide a meaningful analysis of Project alternatives, the EIR sets forth an impermissibly narrow set of Project objectives, fails to analyze a reasonable range of alternatives, and fabricates a series of obstacles to preclude an informed consideration of alternatives. As recommended by CNA in our comments on the Draft EIR, an alternative that reduces the size of the Cathedral Hill Hospital and centralizes some services at other CPMC campuses, including the St. Luke's campus, is feasible and would significantly reduce impacts as compared to the proposed Project. Given that this alternative is feasible, environmentally superior, and meets legitimate project objectives, CEQA compels its adoption over the project as proposed.

The EIR for the Project continues to fall below CEQA's standards of adequacy and may not be lawfully approved. These comments have been prepared with the assistance of three technical experts: Mr. Tom Brohard, P.E., Dr. Petra Pless, and Mr. Matt Hagemann, P.E. This letter highlights their principle concerns, which are set forth more fully in their respective reports on the Final EIR attached herein.

I. THE FINAL EIR FAILS TO ADEQUATELY ANALYZE AND MITIGATE PROJECT IMPACTS

An EIR is "the heart of CEQA." *Laurel Heights Improvement Assn. v. Regents of University of California,* 47 Cal. 3d 376, 392 (1988) (*"Laurel Heights I"*). "The purpose of an environmental impact report is to provide public agencies and the public in general with detailed information about the effect that a proposed project is likely to have on the environment; to list ways in which the significant effects of such a project might be minimized; and to indicate alternatives to such a project." Pub. Res. Code § 21061. The EIR "is an environmental 'alarm bell' whose purpose it is to alert the public and its responsible officials to environmental changes before they have reached ecological points of no return. The EIR is also intended 'to demonstrate to an apprehensive citizenry that the agency has, in fact, analyzed and considered the ecological implications of its action.' Because the EIR must be certified or rejected by public officials, it is a document of accountability." *Laurel Heights I*, 47 Cal. 3d at 392 (citations omitted). As set forth below, the Final EIR fails to meet CEQA's standards of adequacy. Impacts continue to be omitted and understated. Moreover, for impacts that are identified, the Final EIR fails to adopt all feasible mitigation and ensure that what mitigation that is proposed is defined and enforceable.

A. The EIR's Traffic Analysis Continues to Understate the Severity of Project Impacts, Avoid Acknowledging Significant Emergency Service Delays, and Fails to Ensure Mitigation is Adopted and Enforceable

As more fully set forth in the attached report by traffic expert Tom Brohard (Attachment A), the Final EIR continues to understate the Project's significant traffic impacts through deeply flawed assumptions, avoids acknowledging impacts to emergency response times, and fails to require an enforceable Transportation Demand Management Plan.

~~1. The Final EIR Uses an Incorrect Baseline for Muni Service~~

Under CEQA, the baseline from which environmental impacts are assessed is typically conditions as they existed at the time the Notice of Preparation is issued. CEQA Guideline § 15125; *Save Our Peninsula Committee v. Monterey County Board of Supervisors,* 87 Cal. App. 4th 99, 122 (2001). The relevant Notice of Preparation for this Project was issued in 2009. Nonetheless, the EIR relies on MUNI passenger data from 2006 to evaluate Project transit impacts. Because MUNI ridership on the relevant transit lines increased by over 10% from 2006 to 2009, the EIR's use of 2006 data serves to understate Project transit impacts by assuming more transit capacity then actually exists. To remedy this defect and provide an accurate depiction of the Project's transit impacts, the EIR's transit analysis must be revised to use 2009 transit data.

2. The EIR Downplays the Severity of Project Impacts by Altering Traffic Inputs to Conclude that *More* Traffic Would Result in *Less* Congestion

The Final EIR continues to improperly tinker with traffic modeling inputs to reach the conclusion that an increase in traffic volume would result in less congestion. For example, the EIR paradoxically concludes that despite an increase in traffic volume at Eighth and Market, intersection performance will improve from LOS F to LOS E without any physical improvements. (Table 4.5-17 on Page 4.5-94 .) In other words, more traffic creates less congestion. The Final EIR was able to reach this conclusion by changing the peak hour factor for 2015 and 2030. (Response TR-8 on Page C&R 3.7-10.) There is no legitimate justification for this change. As explained by traffic expert Tom Brohard:

> The peak hour factor and other user input variables should remain consistent in the different scenarios to properly compare changes in delay. While peak hour factors in the future must be estimated, the resulting calculations of delay must be tempered by engineering judgment for reasonableness. Increasing the peak hour factor for future years increases the theoretical capacity. By changing inputs in the CPMC EIR, future delays are reported to be better than they will be and the intersection performance improves from LOS F to LOS E at Eighth/Market. Without constructing physical improvements, adding traffic to failing intersections just cannot reduce delay or improve intersection LOS performance.

(Attachment A at 3.) The Final EIR commits a similar error in its analysis of traffic impacts at the intersection of Franklin and Sutter. By improperly changing inputs, the Final EIR misleads decision makers and the public on the true severity of project impacts in direct contravention of CEQA. CEQA Guidelines § 15151 (EIR must reflect "a good faith effort at full disclosure.")

3. The Final EIR Fails to Adequately Analyze Impacts to Emergency Vehicle Response

CEQA specifically calls for an analysis of project impacts to emergency response times. Guidelines, Appendix G, Sec. X. Nonetheless, the Final EIR continues to dismiss the impacts of delays to emergency vehicle access to the Project resulting from the severe congestion in the vicinity of the Project area – congestion the Project itself will further exacerbate. The Final EIR claims that emergency vehicle access is not a concern because the multi-lane roadways used for emergency access allow higher speeds for emergency vehicles since their width would purportedly allow vehicles to move out of their path. However, as more fully set forth in the attached analysis by Tom Brohard, emergency vehicles will not be able to effectively maneuver in the LOS F gridlock conditions that occur at critical intersections. This will add time to the emergency trips before treatment can begin at the Cathedral Hill site and potentially place health and human safety at risk. (Attachment A at 4-5.) The Final EIR fails to mitigate, much less acknowledge this impact. In doing so the EIR violates CEQA's fundamental purpose: to "inform the public and its responsible officials of the environmental consequences of their decisions before teat are made." *Laurel Heights Improvement Ass'n v. Regents of the University of California*, 6 Cal.4th 1112, 1123 (1993) ("*Laurel Heights II*").

4. An Expanded Transportation Demand Management Program Must be Required as Part of Project Approval

CEQA requires that mitigation be fully enforceable. CEQA Guideline § 15126.4(a)(3). In addition, a public agency may not approve a project "if there are feasible alternatives or mitigation measures available which would substantially lessen the significant environmental effects of such projects...." Pub. Res. Code § 21002. The Final EIR's expanded Transportation Demand Management (TDM) Program fails to meet both of these criteria. First, the Final EIR provides only that an expanded TDM Program "might" be required as a condition of approval. (C&R TR-37.) Because of the project's traffic impacts are significant; all feasible mitigation, including the TDM Program, must be adopted to reduce this impact. Second, it appears that the existing TDM program has not been faithfully implemented. The Final EIR acknowledges that several TDM provisions in the existing program will be "reinstated". (Appendix F at 10-11.) This suggests that TDM measures were either never implemented or abandoned. Given this history, the Final EIR must ensure the expanded TDM is enforceable and measures are not discarded after project approval. Accordingly, the Final EIR must be revised to require adoption of the TDM Program and include monitoring of TDM measures and penalties for non-compliance. *See* CEQA Guidelines § 15097.

B. The Final EIR Fails to Ensure Adequate Disclosure and Mitigation of Impacts Resulting from Exposure to Contaminated Soil and Groundwater

The Final EIR fails to remedy serious shortcomings in mitigation purportedly designed to protect construction workers and neighborhood residents from exposure to contaminated soil and groundwater during Project construction. In comments on the Draft EIR, soil and groundwater expert Matt Hagemann pointed out that the Project's proposal to self-certify conditions were safe for workers and neighbors was insufficient, especially in light of the numerous documented instances of soil and groundwater contamination posing health risks during construction and excavation. In response, the Final EIR dismissed concerns for the need for regulatory oversight on the grounds that the Project's site assessments and contingency plans would be submitted to the San Francisco Department of Public Health ("SFDPH") for review. (C&R 3.18-10.) However, merely submitting assessments and plans to SFDPH is insufficient to ensure regulatory review and effective mitigation. As Mr. Hagemann states in his response to the Final EIR, given the many demands on SFDPH, the department typically does not have the resources to review assessments and proposed mitigation plans absent compensation. (Attachment B.) Thus, because it was not specifically funded to do so, SFDPH did not comment on earlier site assessments done submitted by CPMC. Conditions documented by the Project proponent without an objective third-party regulatory review are unreliable for decision making and constitute inadequate disclosure and mitigation. To remedy this defect, the EIR must be revised to fund SFDPH to conduct the necessary review and monitoring of the Project's environmental site assessments and environmental contingency plans.

C. The Final EIR Fails to Adequately Analyze and Mitigate the Project's Air Quality Impacts

As set forth more fully in the attached report by air quality expert Dr. Petra Pless, the Final EIR fails to adequately respond and address concerns raised by Dr. Pless in her comments on the Draft EIR concerning the EIR's analysis and mitigation of the Project's air quality impacts.

In her comments on the Draft EIR, Dr. Pless raised concerns over the Draft EIR's failure to identify significant near-term Project impacts from NOx emissions. In response, the Final EIR incorrectly claimed that the EIR acknowledged the significance this impact. In fact, the EIR only analyzed impacts at full-buildout in 2030 and not from near-term activities in the 2015 timeframe. Not only does the Final EIR continue to omit an analysis of this impact in direct contravention of CEQA's disclosure requirements, but its misleading and inaccurate response to Dr. Petra's concerns fails to constitute the good faith, reasoned analysis required by CEQA. CEQA Guidelines § 15088(c).

The Final EIR's failure to recognize near-term impacts from NOx emissions results in a corresponding failure to mitigate this impact. While the Final EIR points to its TDM program, the TDM program does not address NOx emissions from stationary sources. As stationary

sources on the proposed Cathedral Hill Campus contribute 23% of total NOx emissions in 2015, the Final EIR's failure to both acknowledge and evaluate mitigation for these sources is a significant and fatal oversight.

In addition, the Final EIR continues to appear content to declare the Project's many air quality impacts "significant and unavoidable" without adopting all feasible mitigation to reduce these impacts. As set forth in the attached report by Dr. Pless, the Final EIR's proposed mitigation of construction emissions is improperly vague, fails to address NOx pollution, ignores the potential pollution-control advances that will likely occur over the Project's nine-year construction lifetime, and, in the case of the use of on-road haul trucks, underestimates impacts by assuming the effects of mitigation that has not been required. With regard to operational emissions, the Final EIR fails to discuss mitigation for area source and other stationary sources of operational emissions including the 19 natural gas-fired hot water, steam, and heating boilers that would be installed at the Cathedral Hill Hospital, St. Luke's Replacement Hospital and Davies Campus and fails to respond to recommendations to look to off-site mitigation as a means to further reduce air quality impacts.

D. The Final EIR Fails to Adopt all Feasible Mitigation to Reduce the Project's Greenhouse Gas Impacts

1. San Francisco's Greenhouse Gas Reduction Strategy Cannot be Relied Upon to Avoid Adoption of Greenhouse Gas Mitigation Because the Strategy Does Not Meet CEQA's Tiering Requirements

The Final EIR's assertion that the Project's greenhouse gas impacts are mitigated because San Francisco purportedly has a "qualified greenhouse gas reduction plan" fails because San Francisco's plan does not meet CEQA minimum requirements. CEQA Guidelines § 15183.5 provides that a project may rely on a plan to reduce greenhouse gas emissions to support a finding that the project's greenhouse gas impacts are not significant if that plan does all of the following:

(A) Quantify greenhouse gas emissions, both existing and projected over a specified time period, resulting from activities within a defined geographic area;

(B) Establish a level, based on substantial evidence, below which the contribution to greenhouse gas emissions from activities covered by the plan would not be cumulatively considerable;

(C) Identify and analyze the greenhouse gas emissions resulting from specific actions or categories of actions anticipated within the geographic area;

(D) Specify measures or a group of measures, including performance standards, that substantial evidence demonstrates, if implemented on a project-by-project basis, would collectively achieve the specified emissions level;

(E) Establish a mechanism to monitor the plan's progress toward achieving the level and to require amendment if the plan is not achieving specified levels;

(F) Be adopted in a public process following environmental review.

While the San Francisco plan does quantify emissions, establish a reduction target and set forth a number of emission reduction measures, the emission reduction benefits of these measures are not quantified and it is unclear how these measures will collectively function to achieve the stated emission reduction goals. In addition, the plan does not requirement amendment if continued monitoring indicates that emissions reduction goals are not on track to be reached. Finally, it does not appear that the plan underwent environmental review. Because the San Francisco's Greenhouse Gas Reduction Strategy does not meet the standards of Guideline § 15183.5, it may not legitimately be used to assert the Project's greenhouse gas impacts are less than significant and that additional mitigation need not be adopted.[1] (See FEIR, C&R at 3.10-25 (stating that no additional mitigation is required due to Project's purported consistency with San Francisco GHG Reduction Strategy).)

2. The Final EIR Fails to Adopt All Feasible Mitigation for GHGs

Because the Project may not rely on the Greenhouse Gas Reduction Strategies, it must adopt all feasible mitigation to reduce Project emissions to BAAQMD's 1,100 ton numeric threshold. Unfortunately, the Final EIR fails to do so. Instead, the Final EIR dismisses many feasible measures to reduce Project impacts. For example, the CEQA Guidelines specifically recognize off-site mitigation as reduce GHG impacts yet the Final EIR refuses to consider funding community energy efficient retrofits or contributing to the City's own Local Carbon Offset Fund. Indeed, according to San Francisco's own GHG Strategies document, San Francisco has established its own carbon fund to facilitate off-site mitigation of GHGs within the City.[2] The Project could readily contribute to this fund mitigate its GHG impacts. The Final EIR could also commit the Project to participating in CleanPowerSF when it becomes available and to choosing an energy supply option that provides a 100% renewable energy supply. CleanPowerSF is the City's custom-tailored community choice aggregation program, which allows cities and counties to pool their citizens' purchasing power to buy electricity. CleanPowerSF will enhance local control, create competition, and provide San Franciscans with an alternative choice of cleaner energy beyond what is provided by Pacific Gas & Electric ("PG&E").[3]

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[1] The FEIR's assertion that BAAQMD approved of the Greenhouse Gas Reduction Strategies as a means to determine the significance of GHG impacts is unavailing because BAAQMD does not have the authority to override CEQA's legal requirements.

[2] San Francisco Planning Department, *Strategies to Address Greenhouse Gas Emissions*, at V-7 http://www.sf-planning.org/ftp/files/MEA/GHG-Reduction_Rpt.pdf.

[3] CleanPowerSF; http://cleanpowersf.org/.

E. The Final EIR Fails to Provide Sufficient Evidentiary Support and Respond to Comments on Commuting Assumptions that Are the Basis for the EIR's Traffic, Air Quality and GHG Impact Analysis

The Final EIR continues to lack sufficient evidence to support a key assumption underlying transportation, air quality and greenhouse gas impacts. The EIR assumes that 50%+ of employees will commute from within San Francisco based on decade-old employee surveys of limited sample size.[4] It was also assumed the remaining employees would reside in the Bay Area and not beyond. If more employees reside outside of San Francisco than assumed in the EIR, the EIR would underestimate the already significant impacts on transportation, air quality and greenhouse gas pollution and improperly avoid the adoption of additional mitigation needed to further reduce these impacts. Accordingly, to accurate asses Project impacts, it is critical that the EIR provide a thorough and up-to-date analysis of the Project's jobs/housing relationship. Reliance on a decade old survey is insufficient to ensure the accuracy of this assumption. At a minimum, given the changes in the affordable housing and jobs market over the past decade, the EIR must be revised to provide more up-to-date and more complete survey data.

In addition, because the City relies on planning documents (e.g. the 2004 Housing Element) and programs and policies to address project and cumulative housing impact, rather than project based analyses, neither the Draft EIR nor the Final EIR provide evidence to support the conclusion housing will be adequate to accommodate employees generated by projects in San Francisco. The City of San Francisco does not analyze the impacts of individual projects on housing demand and affordability. Rather, the City takes a citywide, comprehensive approach, relying on the 2004 Housing Element and policies and programs to meeting the demand for housing. This approach allows project after project (e.g. CPMC LRDP, Twitter, Salesforce, etc.) to be approved and built generating thousands of new employees without analysis of the cumulative impacts on housing supply and jobs-housing fit.

F. The EIR Fails to Adequately Mitigate the Project's Housing Impacts and Comply with Long-Standing Policies on Housing Mitigation

For well over thirty years San Francisco has had a policy that development which adds, through its workforce, net new households to San Francisco should seek to mitigate the impact of that addition on the constrained San Francisco housing market. That policy is articulated in detail both in the General Plan Housing Element, Section 413 of the Planning Code, the Jobs-Housing Linkage Program and in the various area plans, including Article 8 of the Van Ness Area Plan.

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[4] Surveys that indicate employee residency in San Francisco and the Bay Area in Appendix B to the January 29, 2010 Adavant Consulting report "CPMC LRDP Travel Demand Estimation for the San Francisco Campuses", footnoted in Table 31 on Page 67 of the Cathedral Hill Traffic Study, include: 2001 – Pacific and California Campuses; 2002/2003 – Pacific, California, and Davis Campuses.

The policy, while addressing the total housing impacts caused by development induced net new San Francisco located workforce, specifically highlights the affordable housing impacts in San Francisco's prohibitively expensive housing market. Indeed, the policy has recently been restated in reference to proposed changes in areas plans by the Board of Supervisors Resolution No. 461-10 of September, 2010 ("Resolution supporting existing area plan housing requirements" File No. 100755) which states that no area plan with a housing requirement should be amended to allow development in that area "unless that new development project shall substantially fulfill the underlying housing production goal as a condition of granting that exception."

The proposed Project, the Van Ness Area Plan amendments intended to provide the Project with an exception to existing regulations, and the proposed Development Agreement all fail to meet the test of this long-established policy and fail specifically to meet the 2010 policy to "substantially fulfill the underlying housing production goal as a condition of granting that exception." To comply with this policy, *the Development Agreement ("DA") must be amended to require an 80/20% split between new permanently affordable housing production and down payment assistance.*

The primary housing impact of the project will be the demand its new workforce creates for new housing in San Francisco. That demand can only be met by the project sponsors providing assistance for the development of new housing units to be built in San Francisco. Down payment assistance programs are limited to existing housing and provide no net new housing opportunities. Meeting 80% of that new housing demand would "substantially fulfill" the housing obligation generated by the project.

In addition, the proposed DA housing program creates a new Down Payment Loan Program (DALP) that is separate from the existing DALP administered by the Mayor's Office of Housing. It would be funded at a level twice that of the MOH program and could have a negative impact on that program by giving "market preference" to CPMC employees. *The DA must be amended to require the down payment assistance program be the current MOH program at the current MOH level of $100,000 per household and that the program NOT be limited to CPMC employees.* A separate and differently sized DALP is simply bad policy, one that could hard the existing MOH program. Moreover, limiting it to CPMC employees, selected by CPMC is simply a proposal that is far to open to manipulation by this private entity.

Finally, the housing portion of the existing DA simply ignores the key relationship between jobs created in the project, what portion of those new employees will live in San Francisco and the demand that new San Francisco resident workforce will place on San Francisco housing supply. There should be a dynamic relationship between the housing requirement placed on project sponsors and the number of existing San Francisco residents permanently employed at the project. Accordingly, *a payment of $73M would "substantially fulfill the underlying housing production goal" required in the Board of Supervisor Resolution*

461-10 for the development approval sought by Sutter/CPMC at the Van Ness site. Any decrease in the $73M, but no less than $58M, would be acceptable to the extent that CPMC provides that ratio of the permanent jobs created as local hire jobs. At the very heart of the Van Ness Area Plan is the prescient notion that there should be a relationship between the joint location of both housing and jobs in a transit rich environment like Van Ness Avenue. It was the first step in creating and area plan based upon the notion of "transit oriented development." Since that time, such "smart growth" concepts have become the basis for both more advanced area plans such as the Market/Octavia Plan and the Eastern Neighborhoods plan.

"Smart growth" concepts are intended to reduce the private car based commuting workforce by creating housing opportunities linked by transit to employment. Each existing resident, already housed, that could be employed in a new development would greatly advance this policy. Housing requirements for major new developments should reflect that relationship. More housing mitigation should be required if the proportion of the new workforce are non-resident than if they are existing residents. Reductions in housing mitigation should be offered if more existing residents are hired. Because these policies have direct implications on Project air quality, traffic, and greenhouse gas impact, they must be considered in a revised EIR.

II. THE FINAL EIR'S ALTERNATIVES ANALYSIS IS INADEQUATE

The analysis of alternatives lies at the "core of an EIR." *Citizens of Goleta Valley v. County of Santa Barbara*, 52 Cal. 3d 553, 564 (1990). "Without meaningful analysis of alternatives in the EIR, neither the courts nor the public can fulfill their proper roles in the CEQA process . . . . [Courts will not] countenance a result that would require blind trust by the public, especially in light of CEQA's fundamental goal that the public be fully informed as to the environmental consequences of action by its public officials." *Laurel Heights I*, 47 Cal. 3d at 404. Here, the Final EIR fails to remedy the Draft's defective alternatives analysis. Project objectives are impermissibly narrow so as to favor only the Project as proposed, the EIR does not examine a reasonable range of alternatives, and suggestions for legitimate and feasible alternatives raised by the public are rejected on spurious grounds.

A. The Final EIR's Project Objectives are Impermissibly Narrow

Under CEQA, "a lead agency may not give a project's purpose an artificially narrow definition." *In Re Bay Delta Coordinated Environmental Impact Report Coordinated Proceedings*, 43 Cal. 4th 1143, 1166 (2008). The Final EIR continues to violate this requirement by setting forth a Project objective of "consolidating specialized services and Women's and Children's services into one centralized acute-care hospital." (DEIR at 6-6.) This objective favors maximum build-out of one facility for no legitimate purpose. Indeed, the Final EIR fails to articulate an underlying rationale for why *all* specialized services must be consolidated in a single facility versus distributing some of these specialized services at other facilities. Moreover, given the traffic conditions at the Cathedral Hill location, the reduced accessibility of that site

further militates against centralizing all services in a single location. As set forth in CNA's comments on the Draft EIR, centralizing some combination of services at the St. Luke's Hospital is both far preferable in terms of health care and would significantly reduce the Project's environmental impacts. Yet, by improperly setting an objective of consolidating all specialized services in a single facility, the Final EIR precludes an objective consideration of project alternatives.

B. The Final EIR Fails to Consider a Meaningful Range of Alternatives

Under CEQA, an EIR must consider and analyze a wide range of alternatives to the project. "Without meaningful analysis of alternatives in the EIR, neither courts nor the public can fulfill their proper roles in the CEQA process." *Laurel Heights I*, 47 Cal.3d 376, 404 (1988). Accordingly, "[a] major function of an EIR 'is to ensure that all reasonable alternatives to proposed projects are thoroughly assessed by the responsible official." *Save Round Valley Alliance v. County of Inyo*, 157 Cal.App.4th 1437, 1456 (2007) (citations omitted). The Final EIR fails to present "a reasonable range of potentially feasible alternatives" required by CEQA. CEQA Guidelines § 15126.6(a).

A reasonable alternative is one that would feasibly attain most of the project's basic objectives while avoiding or substantially lessening the project's significant impacts. *See* Pub. Res. Code § 21100(b)(4); CEQA Guidelines § 15126.6(a). In direct contravention of this requirement, the EIR sets up straw alternatives that would not meet project objectives, thereby favoring the Project as proposed. When CNA proposed a modified alternative that would both better meet Project objectives while reducing impacts, the Final EIR responded that this alternative need not be considered because the EIR already considered a reasonable range of alternatives. (C&R 3.22-13.) Because the alternative proposed by CNA is more feasible than those originally set forth in the EIR and more consistent with overall Project objectives, and the range of alternatives proposed in the Draft EIR did not meet CEQA's requirements, the Final EIR violated CEQA by claiming the modified alternative proposed by CNA need not be analyzed.

Indeed, the City's response to the numerous comments it received requesting a modified Alternative 3A that "it is not clear or anticipated that "Alternative 3A Plus," with a similar amount of development at the Cathedral Hill and St. Luke's Campuses as Alternative A but a different mix of services, would result in any further substantial reductions in the LRDP impacts" entirely misses the mark. (Response ALT-1, C&R 3.22-12.) Alternative 3A Plus need not result in "any further substantial reductions in the LRDP impacts" compared to Alternative 3A; it only needs to result in fewer environmental impacts than the proposed LRDP to be a feasible alternative.

C. The Final EIR's Rejection of Alternatives Does Not Withstand Scrutiny

1. Alternative 3A Would Substantially Meet Project Objectives

The Draft EIR identified Alternative 3A, *i.e.*, a smaller Cathedral Hill hospital and a larger St. Luke's hospital around a relocated Women's and Children's Center, as the environmentally superior alternative. Specifically, the Draft EIR found that Alternative 3A would reduce significant and unavoidable transportation and circulation impacts compared to the proposed LRDP. (Draft EIR at 6-403.) However, the Draft EIR insists that Alternative 3A would not meet project objectives to the same extent as the proposed LRDP because:

- Alternative 3A would not be consistent with the project objective of rebuilding and revitalizing the St. Luke's Campus as a community hospital (with appropriately sized medical office building support).

- Alternative 3A would not be consistent with the project objective of ensuring that the new centralized acute-care hospital is appropriately located because the St. Luke's Campus is not centrally located.

- Alternative 3A would not fully realize the overarching objective of optimizing the use of CPMC's resources to provide an integrated health care system and high-quality health care.

- Alternative 3A would not meet the project objectives related to minimizing redundancies and optimizing patient safety and clinical outcomes through strategically grouped, multidisciplinary services, and limited patient transfers.

(Draft EIR at 6-6.) City's responses to comments additionally provide that Alternative 3A would disrupt the continuum of care at St. Luke's Campus, because of the need to phase construction of a larger hospital at the St. Luke's Campus. (Response ALT-1, C&R 3.22-14.)

The City's argument that Alternative 3A would not be consistent with the project objective of rebuilding and revitalizing the St. Luke's Campus as a community hospital (with appropriately sized medical office building support) is without merit. According to the Draft EIR, the St. Luke's Replacement Hospital proposed under Alternative 3A "would be identical to that proposed under LRDP" and could therefore provide the exact same services as those proposed under the LRDP. The project objectives describe the proposed services at St. Luke's Campus as medical/surgical care, critical care, emergency/urgent care, and gynecologic and low-intervention obstetric care. Development under Alternative 3A would provide additional services at the Women's and Children's Center and a larger MOB which would neither eliminate nor make infeasible any of these proposed services. Thus, under Alternative 3A, the St. Luke's Campus would be rebuilt and revitalized as a community hospital that is an integral part of CPMC's larger health care system and would provide services such as medical/surgical care, critical care, emergency/urgent care, and gynecologic and low-intervention obstetric care. As a

larger facility, it could thus eliminate redundancies, and reduce patient transfers. This could be achieved by centralizing at the St. Luke's Campus some combination of services that are currently duplicated at the St. Luke's and Cathedral Hill campuses (*e.g.,* cardiology, oncology, orthopedics, gastroenterology, respiratory, and urology); the Women's and Children's Center [c]ould remain at the Cathedral Hill Campus. As the City admits, Alternative 3A Plus would result in essentially very similar environmental impacts as Alternative 3A. (Response ALT-1, C&R 3.22-14.) In other words, it would reduce the significant and unavoidable transportation and circulation impacts at the Cathedral Hill Campus compared to the proposed LRDP.

The Draft EIR argument that St. Luke's is not sufficiently centrally located to justify a bigger hospital, again relegates the smaller St. Luke's to marginal status and neglects the service needs of under-served south of market San Francisco residents. By comparison, given the traffic conditions at the Cathedral Hill location, the reduced accessibility there mitigates against "centrality." Rather than the Draft EIR's impermissibly narrow focus on one set of services - WCC - to evaluate the project objectives of resource optimization, patient safety and clinical outcomes, the revised EIR should fully analyze Alternative 3A Plus proposed by CNA.

2. Alternative 3A Plus Would Not Disrupt the Continuum of Care

The Final EIR asserts that expanding St. Luke's would disrupt the continuum of care due to the timing of required hospital retrofits at the California and Pacific Campuses. (C&R 3.22-17.) This dismissive response omits the fact that there are literally hundreds of cases where an extension of hospital retrofit deadlines have been requested and granted. (Attachment D, Office of Statewide Health Planning and Development, Summary of Requests for Extensions to Seismic Safety Deadlines, dated 1/28/2009.) In fact, CPMC submitted a timely request prior to the March 31, 2012, for another retrofit extension under newly enacted regulations. Given the frequency with which retrofit extensions are dispensed, this or a similar extension could thus address the purported continuum of care concerns cited in the Final EIR. Accordingly, purported continuum of care concerns are not a legitimate basis upon which to reject the environmentally superior Alternative 3A Plus.

3. Larger Hospitals Do Not Equate with Improved Care

In response to comments requesting that the size of the proposed new 555-bed Cathedral Hill hospital be reduced, the City claims that "larger hospitals result in improved medical success rates" based on "a recent London School of Economics study of almost 1,200 hospitals in America, Britain, Canada, France, Germany, Italy, and Sweden." To support this conclusion, the City cites to an article that appeared in the weekly newspaper *The Economist*:

> How to Save Lives: Five Simple Rules for Running a First-Class Hospital, The Economist, 2010 (Oct. 21). The London School of Economics study concluded that hospitals with the best management practices also ranked best on a standardized measure of medical success: death rates among emergency patients experiencing heart attacks. The researchers "found that bigger is better when it came to good management. Hospitals employing 1,500 or more staff are better run than

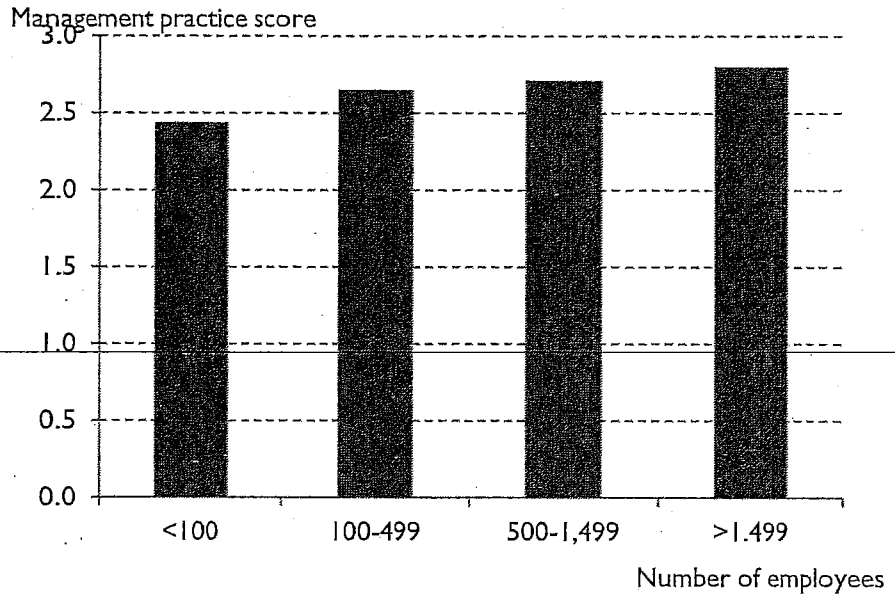
those employing more than 500, which, in turn, outperform those with more than 100 staff." The proposed Cathedral Hill Hospital would be considered a large hospital, consistent with this criterion. The researchers also found that the higher medical success score of hospitals with the best management practices "works across countries and cultures, and has unambiguous results."[5]

There are a number of problems with the City's response. First, the response essentially admits that CPMC would pursue the greatest medical success at the Cathedral Hill Hospital at the expense of the St. Luke's Replacement Hospital because it would be considerably smaller and have fewer than 1,500 employees. While the EIR does not provide the number of staff that would be employed the St. Luke's Replacement Hospital, it projects 1,190 full time equivalent employees by 2015 for the entire campus which includes employees at the associated medical office building. (Draft EIR, Table 4.3-10, p. 4.3-16.) Thus, according to the City's reasoning, the St. Luke's Replacement Hospital would likely not perform as well as a larger hospital with more than 1,500 staff.

Second, the City implies that the larger the hospital, the better the medical success score. This is incorrect. The cited London School of Economics study provides no information regarding the comparative performance of larger hospitals beyond 1,500 employees. In fact, review of the study results indicate that beyond 1,500 employees the improvement in management practice score, the measure employed by the study to judge the performance of hospitals of different sizes, would likely plateau, as shown in the figure below.[6]

[5] Major Response HC-2, C&R 3.23-12.

[6] Stephen Dorgan and Dennis Layton, McKinsey & Company, Nicholas Bloom, Stanford University, Rebecca Homkes, Raffaella Sadun, and John van Reenen, London School of Economics, Management in Healthcare: Why Good Practice Really Matters, 2010; http://worldmanagementsurvey.org/wp-content/images/2010/10/Management_in_Healthcare_Report_2010.pdf.



Number of hospital employees vs. management score

(Data from: Stephen Dorgan and Dennis Layton, McKinsey & Company, Nicholas Bloom, Stanford University, Rebecca Homkes, Raffaella Sadun, and John van Reenen, London School of Economics, Management in Healthcare: Why Good Practice Really Matters, 2010)

Furthermore, review of the London School of Economics study shows that *The Economist*, which is a newspaper and not a peer-reviewed study, overly simplified and hyped the results of the London School of Economics study. The statement cited by the City that "hospitals with the best management practices also ranked best on a standardized measure of medical success: death rates among emergency patients experiencing heart attacks" is not supported by the study.

The management practice score developed by the study to judge the performance of hospitals of different size consists of three measures: a health-related measure, the reduction in risk-adjusted 30-day acute myocardial infarction mortality rates; a financial success measure, the increase in earnings before interest, tax, depreciation, and amortization ("EBITDA") per bed; and a customer satisfaction measure, the percentage of people that would recommend the hospital. The study calculated that in the U.S., a one point increase in management practice score is associated with a 7% reduction in risk-adjusted 30-day acute myocardial infarction mortality rates; a 14% increase in EBIDTA per bed; and a 0.8% increase in the percentage of people that would recommend the hospital.[7] The study states that each of these percentages reports the

[7] The study states that all regressions include controls for hospital size and age, proportions of managers with a clinical degree, ownership, proportion of doctors in employment, network dummy, region, third party management, and interview controls. Regressions include only survey respondents where information was available. The sample size in the U.S. was N=216.

coefficient of a different regression and all coefficients are significant at the 5% level, except the acute myocardial infarction regression, which is significant at the 10% level.[8] Thus, the least significant measure contributing to the overall management practice scores for different hospital sizes is health related. As a rule of thumb, statistical analyses typically assume a threshold level of significance of 5% for reliably identifying a statistically significant relationship. In this case, the sole health-related measure that contributes to the management practice score does not meet this threshold. In other words, the reduction in death rates among emergency patients experiencing heart attacks is not reliably different for smaller compared to larger hospitals.

Further, as shown in the figure above, the study found that the differences in management practice scores were more pronounced between hospitals with less than and more than 100 direct employees.[9] Specifically, the study found a management practice score of 2.44 for hospitals with fewer than 100 direct employees and 2.65 for hospitals with 100 to 499 employees, a difference of 0.21 points. The difference in management scores between larger hospitals with 100 to 499 employees, 500 to 1,499 employees, and 1,500 or more employees are not as pronounced at 0.06 and 0.09. Thus, the economies-of-scale effect is much more noticeable when comparing a very small to a medium sized hospital but becomes less pronounced when comparing medium sized to large hospitals.

Finally, the study concludes that in the private sector, a reason for the correlation is that well managed hospitals are able to grow more as they become more successful. Thus management determines size, rather than size determining management. Thus, the City's conclusion that a larger Cathedral Hill Hospital would provide better health outcomes is not supported. In contrast, based on the study, a larger St. Luke's Replacement Hospital with more than 1,500 employees would likely perform better than the currently proposed 80-bed hospital and be more profitable for CPMC and result in higher customer satisfaction.

III. CONCLUSION

For the reasons set forth above, the Final EIR falls short of CEQA's standards of adequacy. The Final EIR must be revised and recirculated to address the EIR's continued deficiencies addressed herein and in the attached expert reports.

LAW OFFICES OF GLORIA SMITH

Matthew Vespa

By: _____

Matthew Vespa

[8] *Ibid.*
[9] *Ibid.*

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Attachment A: Report from Tom Brohard and Associates to Gloria Smith Re: Final Environmental Impact Report for the California Pacific Medical Center Long Range Development Plan – Transportation Issues, Dated April 17, 2012.

Attachment B: Report from Matt Hagemann, SWAPE to Gloria Smith Re: Comments and Responses on Draft Environmental Impact Report, California Pacific Medical Center (CPMC) Long Range Development Plan, Dated April 20, 2012

Attachment C: Report from Dr. Petra Pless to Gloria Smith Re: Review of Final Environmental Impact Report, California Pacific Medical Center (CPMC) Long Range Development Plan, Dated April 22, 2012

Attachment D: Attachment D, Office of Statewide Health Planning and Development, Summary of Requests for Extensions to Seismic Safety Deadlines, Dated Jan. 28, 2009

ATTACHMENT A

Tom Brohard and Associates

April 17, 2012

Ms. Gloria Smith
The Law Offices of Gloria D. Smith
48 Rosemont Place
San Francisco, CA 94103

SUBJECT: Final Environmental Impact Report for the California Pacific Medical Center Long Range Development Plan – Transportation Issues

Dear Ms. Smith:

At your request, I have reviewed the March 2012 Final Environmental Impact Report (Final EIR) prepared for the San Francisco Planning Department for the California Pacific Medical Center (CPMC) Long Range Development Plan (Project). My review focused on responses to my prior comments of October 18, 2010 (Letter 92) and March 8, 2011 (Letter 121) regarding transportation issues submitted with your letters on behalf of the California Nurses Association.

Even with certain impacts minimized or ignored, the EIR still concludes that of the 100 traffic impacts associated with the Cathedral Hill Campus, 30 impacts are significant, unavoidable, and cannot be mitigated. Placing a hospital of this magnitude in this area will not only further exacerbate already highly congested traffic conditions, but raises serious concerns over delays in emergency response times as a result of congested roadways. To reduce these impacts and better serve the community, CPMC should spread the proposed development to several other campuses including to the St. Luke's Campus rather than concentrating services at the Cathedral Hill Campus. From a transportation perspective, an alternative distributing patients and services equally across the City should be evaluated in a revised EIR.

While corrections were made in the EIR in response to some of my comments, significant concerns remain. The Final EIR does not properly disclose, analyze or mitigate traffic and transit impacts through alternatives and/or traffic improvements. These errors serve to understate the severity of Project impacts. The errors identified in this letter require that each of these issues be reanalyzed and reevaluated through additional study in a revised and recirculated EIR.

1) The Final EIR Uses an Incorrect Baseline for Muni Service - In my comments on the Draft EIR, I concluded that the EIR's transit analysis incorrectly relies on old data that has not been validated to account for increased passenger boardings or adjusted to reflect reductions in Muni service on the transit lines serving the five CPMC campuses (Comment 92-12 TR).

   In response, C&R Table 3.7-10 on C&R Page 3.7-38 of the Final EIR provided generalized data showing annual weekday passenger boardings for

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Muni on CPMC lines increased from 455,495 in 2006 to 504,019 in 2009 before dropping to 485,589 in 2010.

While Muni boardings on the CPMC lines rose by nearly 11 percent between 2006 and 2009 from the data provided in C&R Table 3.7-10, Page C&R 3.7-38 states validation and/or adjustments were not made to the 2006 data in the transit analysis to account for these increases. On the other hand in the traffic potion of the analysis in the June 2010 Cathedral Hill Campus Transportation Impact Study, peak hour traffic counts at critical intersections conducted in 2006 were validated by making new peak hour counts in 2009. Page 17 states "A comparison of the 2006 and 2009 traffic count data found that peak hour volumes at seven of the 26 intersections studied generally decreased or were approximately the same. These fluctuations were within an acceptable margin for daily and season variations in traffic patterns, and based on this, the 2006 data was confirmed to be valid for evaluating existing conditions for this analysis." Validation and/or adjustments should have also been made in the transit analysis.

Using lower Muni passenger boardings from 2006 incorrectly provides additional passenger capacity that did not actually exist in 2009 with higher passenger boardings. To establish an appropriate baseline to analyze transit impacts, the higher Muni boardings in 2009 must be used as a baseline to properly identify transit impacts of the Project. The failure to establish a proper baseline in 2009 serves to downplay the significant transit impacts caused by the Project by taking advantage of transit capacity that did not exist. Without proper baseline data, the transit analysis is flawed.

2) Traffic Analysis Is Improperly Tweaked to Generate Reduced Delay with Higher Traffic Volumes - The Final EIR continues to paradoxically forecast future reductions in delay with increased traffic volumes. Adding traffic to failing intersections or those operating at capacity does not reduce delay or improve intersection performance unless physical improvements are made. These EIR results are the function of improper user input adjustments at critical intersections including Eighth/Market and Franklin/Sutter as follows:

   a) Inconsistencies at Eighth/Market (Comment 92-23 TR) – Table 4.5-17 on Page 4.5-94 of the Draft EIR reports delay of greater than 80 seconds and Level of Service (LOS) F for the existing AM peak hour baseline conditions at Eighth/Market. With higher volumes and no improvements in 2015, delay is reduced to 78.8 seconds and intersection performance improves to LOS E without Project traffic. With still higher volumes and no improvements in 2030, delay is reduced to 76.4 seconds and intersection performance remains at LOS E without Project traffic. These results defy logic since more traffic results in more delay. If the EIR is really correct,

then adding even more traffic would continue to reduce delay and would further enhance intersection performance.

The Final EIR justified this outcome on the grounds that the peak hour factor, one of many user inputs to the traffic calculations of LOS, was changed. The peak hour factor relates the peak 15 minute period within the peak hour to the overall peak hour, with higher values approaching 1.00 indicating steadier, more uniform flow under congested conditions. Response TR-8 on Page C&R 3.7-10 states an increase in the peak hour factor to 0.98 for 2015 and 2030 was used to account for more even distribution of traffic in the peak hour and the possible "metering" effect of closely spaced signalized intersections. Changing the peak hour factor caused the average baseline delay in future scenarios to be reduced at Eighth/Market.

The June 2010 Cathedral Hill Campus Transportation Impact Study provides traffic volumes for Eighth/Market for existing conditions in Figure 7B on Page 21, for 2015 without Project traffic in Figure 16B on Page 84, and for 2030 without Project traffic in Figure 23B on Page 151. From my review of these Figures, I found that the AM peak hour baseline traffic volumes at Eighth/Market are forecast to increase from 2,479 to 2,542 in 2015 (2.5 percent) to 2,619 in 2030 (5.6 percent). More baseline traffic should result in more delay, not less, yet the EIR calculations show just the opposite. By changing user input variables such as the peak hour factor, the EIR incorrectly lowered the baseline average intersection delay. Less baseline delay then reduces the overall delay when Project traffic is added, takes advantage of traffic capacity that does not exist, and can mask significant traffic impacts.

The peak hour factor and other user input variables should remain consistent in the different scenarios to properly compare changes in delay. While peak hour factors in the future must be estimated, the resulting calculations of delay must be tempered by engineering judgment for reasonableness. Increasing the peak hour factor for future years increases the theoretical capacity. By changing inputs in the CPMC EIR, future delays are reported to be better than they will be and the intersection performance improves from LOS F to LOS E at Eighth/Market. Without constructing physical improvements, adding traffic to failing intersections just cannot reduce delay or improve intersection LOS performance.

b) Inconsistencies at Franklin/Sutter (Comment 92-24 TR) – Table 4.5-18 on Page 4.5-98 of the Draft EIR reports delay of 65.5 seconds and LOS E for the existing PM peak hour baseline conditions at Franklin/Sutter. With higher volumes and no improvements in 2015, delay is reduced to 57.0 seconds at LOS E without Project traffic. When Project traffic is added in

2015, delay is reduced to 56.4 seconds at LOS E. With still higher volumes and no improvements in 2030, delay is reduced to 66.1 seconds and performance remains at LOS E without Project traffic. When Project traffic is added in 2030, delay is reduced to 65.5 seconds at LOS E. These results defy logic since more traffic results in more delay. If the EIR is really correct, then adding even more traffic would continue to reduce delay and would further enhance intersection performance.

The Final EIR justified this outcome on the grounds that the peak hour factor, one of the user inputs to the traffic calculations of LOS, was changed. The peak hour factor relates the peak 15 minute period within the peak hour to the overall peak hour, with higher values approaching 1.00 indicating steadier, more uniform flow under congested conditions. Response TR-8 on Page C&R 3.7-10 states an increase to 0.98 for 2015 and 2030 was assumed to account for more even distribution of traffic in the peak hour and the possible "metering" effect of closely spaced signalized intersections. Changing the peak hour factor caused the average baseline delay in future scenarios to be reduced at Franklin/Sutter.

The June 2010 Cathedral Hill Campus Transportation Impact Study provides traffic volumes for Franklin/Sutter for existing conditions in Figure 7A on Page 20, for 2015 without Project traffic in Figure 16A on Page 83, and for 2030 without Project traffic in Figure 23A on Page 150. From my review of these Figures, I found that the PM peak hour baseline traffic volumes at Franklin/Sutter are forecast to increase from 3,394 to 3,533 in 2015 (4.1 percent) to 3,851 in 2030 (13.5 percent). More baseline traffic should result in more delay, not less, yet the EIR calculations show just the opposite. By changing user input variables such as the peak hour factor, the EIR incorrectly lowered the baseline average intersection delay. Less baseline delay then reduces the overall delay when Project traffic is added, takes advantage of traffic capacity that does not exist, and can mask significant traffic impacts.

The peak hour factor and other user input variables should remain consistent in the different scenarios to properly compare changes in delay. While peak hour factors in the future must be estimated, the resulting calculations of delay must be tempered by engineering judgment for reasonableness. Increasing the peak hour factor for future years increases the theoretical capacity. By changing inputs in the CPMC EIR, future delays are reported to be better than they will be at Franklin/Sutter. Without constructing physical improvements to increase intersection capacity, adding traffic to intersections operating at capacity just cannot reduce delay.

3) Enhanced Transportation Demand Management Plan Must Be Required – In my comments on the Draft EIR, I indicated that CEQA requires lead agencies to impose all feasible alternatives and/or mitigation measures before concluding that traffic impacts are "significant and unavoidable." All feasible mitigation measures must also include enhancements to the current CPMC TDM plan (Comment 92-25 TR).

   In response, the Final EIR indicated the TDM Program is a part of the LRDP rather than a mitigation or improvement measure. Response TR-37 indicates an expanded and enhanced TDM Program "might" be required by City decision-makers as a condition of approval. Pages 10 and 11 of Appendix F in the Final EIR provide the various components of the current CPMC TDM Plan as well as enhancements to the TDM Program planned in the near-term (0 to 2 years), mid-term (2 to 5 years), and long-term (5+ years).

   Response TR-45 on Page C&R 3.7-69 states "Since trip generation used in the transportation analyses was based on CPMC travel surveys, the traffic analysis already assumes some reduced level of private vehicle use by employees, patients, and visitors because of the continued implementation of existing TDM measures. Based on the surveys and the SF Guidelines, it was assumed that 20 to 40 percent of employees and 30 percent of patients would use public transit for their trips to CPMC campuses."

   Page 4.7-74 of the Draft EIR states "It should be noted that the travel demand estimates reflect the effects of CPMC's existing Transportation Demand Management (TDM) Program." From Page 11, monitoring of the effectiveness of the TDM Plan is not a part of the existing TDM Program but will begin in the next two years. Without monitoring the current TDM Program, the effectiveness of the existing CPMC TDM Program cannot be determined with any degree of certainty. Further, it appears that the TDM Program has changed as several of the TDM measures listed on Pages 10 and 11 are proposed to be "reinstated" in the future.

   All feasible mitigation measures must be imposed to reduce significant traffic impacts. While the transportation analyses do not take any additional trip reduction credits for the TDM Program enhancements, CPMC must be still required to implement all TDM enhancements to improve the CPMC TDM Plan to reduce their vehicle trips. Regular reporting of the TDM monitoring together with periodic enforcement and penalties for non-compliance must be required before the City can consider adopting a "Statement of Overriding Considerations" to offset traffic and transit impacts considered to be "significant and unavoidable".

4) Emergency Vehicle Access Must Be Reanalyzed – In my comments on the Draft EIR, I indicated that several critical intersections in the vicinity of the

Cathedral Hill Campus currently operate at LOS E or LOS F and additional critical intersections are forecast to degrade to LOS E or LOS F in 2015 and in 2030 with the addition of Project traffic. Under capacity conditions at LOS E and under gridlock conditions at LOS F, vehicles will be queued back significant distances in all traffic lanes on the approaches to congested signalized intersections. Stopped vehicles will not be able to simply "maneuver out of the path of the emergency vehicle" as the adjacent lanes on the approaches to the gridlocked traffic signals will already be occupied by other vehicles. This is a significant impact for a hospital project and must be fully evaluated and mitigated (Comments 92-8 TR and 121-3 TR).

Response TR-100 on Page C&R 3.7-171 of the Final EIR states the multi-lane roadways used for emergency access allow higher speeds for emergency vehicles because roadway width allows other vehicles to move out of their paths. Pages C&R 3.7-171 and 172 also indicates the California Vehicle Code requires vehicles to yield to emergency vehicles and remain stopped until the emergency vehicle passes, and that emergency vehicles could also travel in lanes opposite the flow of traffic to bypass congestion.

Under congested and gridlocked traffic conditions forecast in peak hours with the addition of CPMC trips, stopped vehicles in all traffic lanes will not be able to simply maneuver out of the way of emergency vehicles. This condition will force emergency vehicles to travel in the wrong direction on City streets, exposing the wrong-way emergency vehicle to other vehicles traveling in the proper direction. Severely congested intersections will also create additional delay for emergency vehicles, adding time to the trip before treatment can begin. These are significant impacts that have not been properly studied or mitigated, and cannot simply be dismissed as "less than significant" on Page 4.5-146 of the Draft EIR.

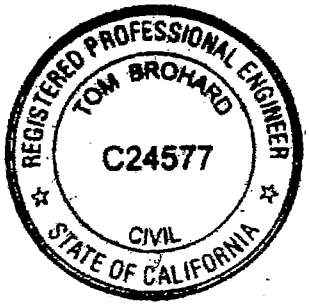
If you should have any questions regarding these findings, please contact me at your convenience.

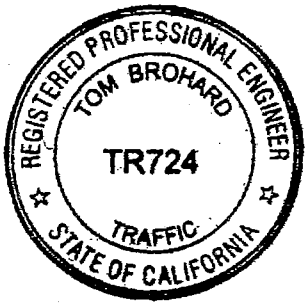
Respectfully submitted,

Tom Brohard and Associates

Tom Brohard

Tom Brohard, PE
Principal





ATTACHMENT B

SWAPE Technical Consultation, Data Analysis and Litigation Support for the Environment

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April 18, 2012

Gloria D. Smith
The Law Offices of Gloria D. Smith
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Subject: **Comments and Responses on Draft Environmental Impact Report, California Pacific Medical Center (CPMC) Long Range Development Plan**

Dear Ms. Smith:

In an October 18, 2010 letter, I provided comments on the Draft Environmental Impact Report for the California Pacific Medical Center ("DEIR"). I stated that numerous instances of soil and groundwater contamination have been documented that may pose risks to construction workers and to neighboring residents during excavation and transportation of contaminated soil. I also stressed in my comments that no documented regulatory review of contaminated soil or groundwater had been conducted. As such, I concluded the project applicant simply self-certified in the DEIR that conditions are safe for construction and workers and neighboring residents will not be put at risk.

The Response to Comments ("Response") provides a repetitive answer to comments in my October 2010 letter. In short, the Response generally states, in addressing the need I expressed to further evaluate areas of contamination before construction (p. C&R 3.18-7):

- Requirements for the submittal of campus-specific environmental contingency plans (ECPs), which serve as both site mitigation plans (SMPs) and unknown contingency plans for the campuses, to SFDPH [San Francisco Department of Public Health] for review and approval. The ECPs identify procedures for the submittal of a site closure/certification report to SFDPH for closure of underground storage tanks (USTs) at the Cathedral Hill,

Pacific, Davies, and St. Luke's Campuses. Such measures and requirements are intended to reduce potential impacts to a less-than-significant level.

- The ECPs would ensure the safe and effective removal/closure of potentially hazardous subsurface soil and groundwater conditions in accordance with local, state, and federal requirements.

- The ECPs for these CPMC campuses also require that a health and safety plan that outlines the specific procedures required to safeguard the health and safety of workers while onsite be prepared by a certified industrial hygienist for implementation by the LRDP site contractor during all phases of demolition and construction at the CPMC campuses. This would address potential threats to the health and safety of both site construction workers and the public during LRDP-related construction activities.

In addressing the need I stated for regulatory oversight of area of contamination, the Response states:

- The Phase I environmental site assessments (ESAs) prepared for the five CPMC campuses covered under the proposed CPMC LRDP recommended the preparation of environmental contingency plans (ECPs) to fully mitigate the known and unknown hazards associated with existing on-campus and proposed LRDP development-related conditions. The ECPs specifically addressed the management of potential health impacts associated with the disturbance of chemically impacted soil from the CPMC campuses. The ECPs also recommended that a health and safety plan be prepared by a certified industrial hygienist for implementation during demolition and construction at the existing and proposed CPMC campuses by the site contractor. The health and safety plan would address potential threats to the health and safety of both on-campus construction workers and the public during LRDP-related construction activities. Furthermore, SFDPH review, approval, and oversight of LRDP-related construction development activities for all CPMC campuses would also occur following the project sponsor's submittal of the SMPs and unknown contingency plans to the SFDPH for each existing and proposed CPMC campus, as required by Mitigation Measures M-HZ-N1a and M-HZ-N1b in the CPMC LRDP Draft EIR, pages 4.16-46 and 4.16-48, respectively. Under the LRDP, ECPs would be prepared for each existing and proposed CPMC campus and they would serve as both the SMPs and unknown contingency plans for CPMC campuses. (p. C&R 3.18-9)

- It should be noted that SFPDH reviewed the ESAs for the four existing and one proposed CPMC campuses in 2008 and 2009 and reviewed the CPMC LRDP Draft EIR in 2010, and the ECPs will be submitted for review and approval by SFDPH, prior to the

commencement of any LRDP-related construction activities or site work at the five CPMC campuses. During their review of the ESAs and CPMC LRDP Draft EIR, SFDPH did not recommend a voluntary cleanup agreement for the four existing or one proposed CPMC campuses. As described in Mitigation Measures M-HZ-N1a and M-HZ-L1a in the Draft EIR, pages 4.16-46 and 4.16-52, respectively, the project sponsor would be required to submit the previously prepared ECPs (which serve as both SMPs and unknown contingency plans) to SFDPH for near-term and long-term projects at various CPMC campuses under the proposed LRDP. SFDPH approval of ECPs would be required before issuance of site, building, or other permits by City agencies for LRDP-related construction and development activities involving subsurface disturbance. Any additional recommendations from the SFDPH would be incorporated into the ECPs as a condition of the issuance of site, building, or other permits by City agencies. (p. C&R 3.18-10)

No records of the SFDPH review were included in the DEIR. The DEIR further states:

> The ESAs prepared for the CPMC campuses were submitted to the SFDPH (Stephanie Cushing, Senior Environmental Health Inspector) in 2008 and 2009, and a copy of the Draft EIR was forwarded to the SFDPH for review during the public review period of the Draft EIR. No comments were received from SFDPH on the Draft EIR. (p. C&R 3.18-25)

It is my understanding that without a voluntary cleanup agreement, SFDPH review time is limited because of demands on staff for other projects where hourly rates are reimbursed. Therefore, the lack of SFDPH review is understandable and highlights the need for a voluntary cleanup agreement which requires reimbursement of SFDPH staff time.

As stated, without regulatory review, the applicant is self-certifying that conditions and mitigation measures are safe for construction workers and neighboring residents. In my opinion, conditions documented by the developer without an objective third-party regulatory review are unreliable for decision making and constitute inadequate disclosure in the DEIR. A formal review of soil and groundwater conditions needs to be conducted and certified by a regulatory agency for inclusion in a revised DEIR.

Sincerely,

M Hagemann

Matt Hagemann, P.G., C.Hg.

ATTACHMENT C

Pless Environmental, Inc.
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(415) 492-2131 voice
(815) 572-8600 fax

BY EMAIL

April 22, 2012

Gloria Smith
The Law Offices of Gloria D. Smith
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San Francisco, CA 94103

Re: Review of Final Environmental Impact Report for California Pacific Medical Center Long Range Development Plan, San Francisco, CA

Dear Ms. Smith,

Per your request, I have reviewed the responses provided by the City of San Francisco ("City") to comments received on the Draft Environmental Impact Report ("Draft EIR") for the California Pacific Medical Center ("CMPC") Long Range Development Plan ("LRDP" or "Project").[1]

The comments below address issues I raised in my October 18, 2010 comment letter on the Draft EIR for the LRDP[2] that were not or not adequately addressed in the City's responses. To simplify review, my comments follow the cross reference numbering matrix for comments and responses ("C&R") established by the City.

I. The EIR Fails to Identify Significant Impacts on Air Quality Resulting from Project Operational NOx Emissions in 2015

I previously commented that the Draft EIR failed to identify significant impacts on air quality resulting from the Project's operational emissions of nitrogen

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[1] City of San Francisco, California Pacific Medical Center (CPMC) Long Range Development Plan, Comments and Responses, SCH No. 2006062157, March 29, 2012 (hereinafter "Final EIR").

[2] Pless Environmental, Inc., Re: Review of Final Environmental Impact Report for California Pacific Medical Center Long Range Development Plan, San Francisco, CA, October 18, 2010 (Comment Letter No. 91).

oxides ("NOx") in the interim years before full buildout of the Project. My comments provided a summary table for net daily emission changes attributable to operations under the CPMC LRDP in 2015 compared to existing conditions based on information provided in the administrative record. This table demonstrates that NOx emissions in 2015 would exceed the daily significance threshold established by the Bay Area Air Quality Management District ("BAAQMD") in its 2010 CEQA Guidelines. (Comment No. 91-35 to 91-37.) In response, the City claims that "[t]he Draft EIR, as part of Impact AQ-3 beginning on page 4.7-38, acknowledges significant and unavoidable impacts with respect to near-term (2015) operational emissions associated with the proposed LRDP, although it does not provide the specific numeric values of emissions that would occur in 2015." (Response AQ-12, C&R 3.9-36.) This is incorrect.

The Draft EIR, as part of Impact AQ-3 beginning on page 4.7-38, discusses impacts associated with net changes in daily and annual operational emissions from near-term projects in 2030 based on Tables 4.7-6 and 4.7-7 compared to the 1999 CEQA Guidelines published by the BAAQMD. The description for Impact AQ-3 also states explicitly that these impacts occur at full buildout, *i.e.*, in 2030. My comments relate to net changes in daily operational emissions from near-term projects in 2015 compared to the BAAQMD's 2010 CEQA Guidelines. Thus, the City's response fails resolve my comments.

Further, the Draft EIR, as part of Impact AQ-3 beginning on page 4.7-38, only identifies significant impacts on air quality resulting from net changes in operational emissions of coarse particulate matter ("PM10"); it does not identify significant impacts due to operational emissions of NOx.

While the City's response appears to acknowledge that impacts on air quality due to operational emissions in 2015 will be significant, it fails to require adequate mitigation. In response to my prior comments to this effect, the City claims that "... all feasible mitigation was evaluated for near-term and long-term projects and has been incorporated into the proposed LRDP as part of the proposed expanded TDM [transportation demand management] program, described in the Draft EIR (pages 5-14 to 5-15) and further explained in this C&R document (see Response AQ-11, page C&R 3.9-27). CPMC already implements and would implement further improvements to its TDM program, which would serve to reduce Vehicle Miles Traveled (VMT) and thereby air quality emissions from vehicular sources by reducing the number of vehicle trips. No reliable methodology exists for quantifying the reduction in vehicle trips and corresponding reduction in air quality emissions that would result from implementation of the proposed enhancements to CPMC's TDM program. See Response AQ-11 (page C&R 3.9-27). The key elements of CPMC's existing TDM program are described on pages 4.5-74 to 4.5-75 in the Draft EIR. No other feasible measures have been identified that would serve to potentially reduce criteria pollutants

associated with the significant and unavoidable impact with respect to near-term (2015) operational criteria air pollutants." (Response AQ-12, C&R 3.9-36.).

The City's response is not adequate because its analysis evaluates and requires mitigation measures only for PM10 emissions, not for NOx emissions. While the measures in the TDM program would equally address PM10 and NOx emissions from vehicle exhaust, NOx emissions from other sources, *i.e.*, area sources and stationary sources are not addressed by the TDM program and are not adequately mitigated. Particularly stationary sources contribute substantially to the daily total NOx emissions. For example, at the Cathedral Hill Campus stationary sources contribute 23%[3] of the total NOx emissions in 2015. (*See* Table 2 in Comment No. 91-37.)

As discussed in Comment II below, NOx emissions from stationary sources are not adequately mitigated. Thus, this impact remains significant and not adequately mitigated.

The City notes "that quantified emission levels in 2015 were included as part of the administrative record supporting the analysis of the Draft EIR, and thus they are not considered new impacts needing to be discussed as part of the Draft EIR." (Response AQ-12, C&R 3.9-36.) This conclusion is erroneous. The presence in the administrative record of emission calculations showing significant impacts does not constitute adequate disclosure unless these impacts are discussed in the text of the Draft EIR. As discussed above, the City has failed to discuss the significant impacts on air quality due to operational NOx emissions in 2015. Thus, this impact must be evaluated and adequately mitigated.

II. The Final EIR Fails to Require All Feasible Mitigation for Significant Impacts on Air Quality Resulting from Project Operational Emissions

I previously commented that the Draft EIR fails to require all feasible mitigation to substantially lessen or avoid the significant and unavoidable impacts associated with the Project's operational air pollutant emissions as required by CEQA. (Comments No. 91-38 and 91-39.)

The BAAQMD, the public agency whose mission it is to improve air quality and public health in the San Francisco Bay area, expressed similar concerns with respect to particulate matter emissions:

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[3] (13.60/59.78) = 0.228.

> "District staff is concerned about the significant and unavoidable air quality impacts identified in the DEIR that are associated with Project construction and operation emissions. The San Francisco Bay Area region is currently in nonattainment for state and federal ozone standards and fine particulate matter (PM2.5) standards, and for state PM10 standards. *The emissions associated with this Project need to be mitigated to the maximum extent feasible to ensure the Project does not adversely affect the region's ability to attain heath-based* [sic] *ambient air quality standards."*

[Comment Nos. 109-2 and 112-2; *emphasis* added.]

In response, the City discusses potential mitigation measures that would reduce the LRDP's significant emissions of particulate matter from two source categories, a) mobile source emissions and b) stationary sources:

a. **Mobile source emissions:** The City states that in the urban environment of the proposed LRDP, coarse particulate matter ("PM10") emissions associated with vehicular traffic would be reduced "as much as feasible" by implementing the traffic reduction components of CPMC's existing transportation demand management ("TDM") program. The City states that for purposes of the Draft EIR, estimates of the LRDP traffic conservatively assumed implementation of only the existing TDM measures but that proposed enhancements to the TDM would further reduce estimated project traffic and associated emissions. (C&R 3.9-50 and 3.9-52.)

   The City states that further mitigation of particulate matter emissions, particularly of fine particulate matter ("PM2.5"), would be dependent on the technological advancement of vehicular and light truck engines and fuels which are regulated by the state and/or federal government. The City finds that such improvements to the vehicle fleet and fuels would not be feasible to implement by CPMC as part of or as mitigation to the operational emissions of the proposed LRDP. (C&R 3.9-50 to -52.)

   With respect to other measures that could reduce roadway particulate matter, the City finds that increased street sweeping is not practicable given the fiscal constraints that currently exist. (C&R 3.9-50 and 3.9-52.)

b. **Stationary source emissions**: With respect to particulate matter emissions from stationary sources, the City states that the LRDP would comply with BAAQMD and California Air Resources Board ("ARB") regulatory requirements in effect at the time equipment is procured for each stationary source.

> At the proposed Cathedral Hill Hospital, Cathedral Hill Medical Office Building ("MOB"), and St. Luke's Replacement Hospital, the project sponsor proposes to install Tier 2-compliant emergency diesel generators that additionally would be equipped with Level 3 verified diesel emission controls ("VDECs"), specifically diesel particulate filters ("DPFs"). The emergency diesel generators at the Davies Neurosciences Institute and St. Luke's MOB/Expansion Building would install Tier 3-compliant generators for engines below 750 horsepower that additionally would be equipped with Level 3 VDECs. (C&R 3.9-50 to 3.9-51.)

The City finds that "despite the implementation of all feasible mitigating strategies included as part of the CPMC TDM program and through compliance with the applicable regulatory requirements for stationary sources anticipated to be in effect at the time of equipment procurement, a significant and unavoidable impact would occur from operational PM10 emissions, as measured by the BAAQMD regional significance thresholds." (Response AQ-20, C&R 3.9-52.) The City's response with respect to feasible mitigation is inadequate and its finding that impacts on air quality remain significant after implementation of the proposed measures is not acceptable.

First, the City's discussion of potential mitigation measures addresses only one pollutant, particulate matter. As discussed in Comment I above, the LRDP would also result in significant impacts on air quality due to operational emissions of NOx in the interim years until full buildout (2015). While the City acknowledges these significant impacts, it fails to discuss the effectiveness of the above proposed measures to reduce NOx emissions to the extent feasible. Any reduction in traffic resulting from enhanced TDM measures would result in a concurrent reduction of NOx emissions; however, the proposed Level 3 DPFs for emergency diesel generators would not reduce NOx emissions, which, as explained in Comment I, are significant in 2015.

Second, the City's response only addresses emissions from vehicular traffic and emergency generators; it fails to discuss mitigation for area source and other stationary sources of operational emissions including the 19 natural gas-fired hot water, steam, and heating boilers that would be installed at the Cathedral Hill Hospital (8), St. Luke's Replacement Hospital (9) and Davies Campus (2).[4]

Third, according to the EIR, it will take nine years to construct the various CPMC components. (Draft EIR, Table 2-1.) The emergency generators and boilers would not be

[4] Draft EIR, administrative record files received by City Folder: "Ch 4.7 AQ Admin Record DEIR", File "28 08010089.AQ.CPMC.2010.pdf".

purchased and installed until late during the construction phase. Thus, any mitigation measure aimed at reducing emissions from stationary sources should be worded so it requires that the equipment meet the most stringent emission level requirements at the time it is purchased, not the most stringent controls available at the time the EIR is certified. The most stringent emission levels for each pollutant at the time the equipment is purchased should be determined in collaboration with the BAAQMD and should include a best available control technology ("BACT") evaluation for each purchased piece of equipment regardless of its maximum rated horsepower or heat input.

Finally, in the urban environment surrounding the CPMC's components there are numerous other, not project-related emission sources that contribute to local and regional impacts on air quality and contribute to greenhouse gas emissions. Emissions from these sources could be reduced through programs or funding sponsored by the Project proponent. I previously suggested that the City evaluate the following community energy efficiency building retrofits and funding of carbon offset programs as two examples that could serve as an inspiration for additional feasible mitigation to reduce air pollutant and greenhouse gas emissions:

- **Community Energy Efficiency Building Retrofits:** Mitigation could include funding programs that provide for energy efficiency retrofits of existing buildings and housings in the City, with a particular focus on rental and low-income housing. As one example, the Chula Vista Energy Upgrade Project included $210,000 worth of mitigation funds "for energy efficiency and related improvements to local homes and business, ... intended to directly benefit the residents potentially most affected by the proposed project." These upgrades could include installation of a heat-reflecting "cool roof" and heat-reducing window awnings, high-efficiency air conditioning systems with programmable thermostats, and energy-saving fluorescent lighting fixtures that feature daylight and occupancy sensors.

- **Funding of Carbon Offset Programs:** Mitigation could include providing funds to the BAAQMD, Audubon Society, California Wildlife ReLeaf, or other organizations to fund carbon reduction or sequestration projects. For example, the 2007 ConocoPhillips settlement included an agreement to mitigate and offset greenhouse gas emissions by providing (1) $7 million to the BAAQMD to create a fund for carbon offsets, (2) $200,000 to the Audubon Society for restoration of wetlands in the San Pablo Bay for purposes of carbon sequestration, and (3) $2.8 million to California Wildlife ReLeaf for reforestation projects, estimated to sequester 1.5 million metric tons of CO_2 over the lifetime of the forest.

The City provided no response addressing these proposed measures nor did it evaluate any additional mitigation measures. Additional measures that could be evaluated include, for example:

- Fund a street sweeping program.

- Fund a program to replace City-owned vehicles (buses, heavy-duty trucks) or stationary equipment (*e.g.*, generators, boilers, diesel-powered pumps) with new or electrified equipment or retrofit existing vehicles or stationary equipment with emission control devices.

- Contract services, *e.g.*, commercial laundry services, food suppliers, etc., only with local companies, *i.e.*, that conduct their operations within a 100-mile radius to reduce vehicle miles traveled.

- Contract services, *e.g.*, commercial laundry services, food suppliers, etc., only with "green" certified companies whose operations are likely associated with lower emissions than their non-certified competitors. For example, the Textile Rental Services Association of America ("TRSA") certifies commercial laundries as "Green Clean" if they follow best management practices including as boiler heat recovery or direct-fired hot water heater, wastewater heat recovery, alternative energy, solar or geothermal, energy audit fleet vehicles, alternative fuels, fleet vehicle route optimization, preventative boiler or water heater maintenance program, etc.[5]

All these measures are feasible and would reduce local and regional emissions and therefore should be evaluated and required to reduce the Project's significant operational emissions of air pollutants. These measures would also reduce greenhouse gas emissions.

III. The Final EIR Fails to Require All Feasible Mitigation for Significant Impacts due to Greenhouse Gas Emissions from Near-term and Long-term Operational Emissions

The City's assertion that the Project's greenhouse gas ("GHG") impacts are mitigated to the extent feasible because the LRDP would comply with the City's "Qualified GHG Reduction Strategy" is not acceptable because the City's plan does not

[5] TRSA, Clean Green, Certification Requirements; http://www.trsa.org/page/certification-requirements.

meet CEQA minimum requirements. CEQA Guidelines Section 15183.5 provides that a project may rely on a plan to reduce greenhouse gas emissions to assert the project's greenhouse gas impacts are not significant if that plan does all of the following:

(a) Quantify greenhouse gas emissions, both existing and projected over a specified time period, resulting from activities within a defined geographic area;

(b) Establish a level, based on substantial evidence, below which the contribution to greenhouse gas emissions from activities covered by the plan would not be cumulatively considerable;

(c) Identify and analyze the greenhouse gas emissions resulting from specific actions or categories of actions anticipated within the geographic area;

(d) Specify measures or a group of measures, including performance standards, that substantial evidence demonstrates, if implemented on a project-by-project basis, would collectively achieve the specified emissions level;

(e) Establish a mechanism to monitor the plan's progress toward achieving the level and to require amendment if the plan is not achieving specified levels;

(f) Be adopted in a public process following environmental review.

According to San Francisco's greenhouse gas strategies document, San Francisco has established its own carbon fund to facilitate off-site mitigation of GHGs within the City.[6] While the plan does quantify greenhouse gas emissions, establish a reduction target and set forth a number of emission reduction measures, the emission reduction benefits of these measures are not quantified and it is unclear how these measures will collectively function to achieve the stated emission reduction goals. In addition, the plan does not require amendment if continued monitoring indicates that emissions reduction goals are not on track to be reached. Finally, it does not appear that the plan underwent environmental review. Thus, the City's greenhouse gas reduction strategy does not meet the standards of CEQA Guidelines Section 15183.5 and may not be used to assert that the Project's greenhouse gas emissions have been mitigated to the extent feasible.

[6] San Francisco Planning Department, Strategies to Address Greenhouse Gas Emissions, p. V-7; http://www.sf-planning.org/ftp/files/MEA/GHG-Reduction_Rpt.pdf.

In addition to the above discussed mitigation measures in Comment II, the following additional mitigation measures are available and should be evaluated and required to the extent feasible:

- Contribute funding to the San Francisco Carbon Fund. For example, the San Francisco International Airport provides carbon kiosks, the "Climate Passport," that allow individuals to calculate the carbon footprint of any given flight and purchase offsets that support local carbon projects. According to the City's greenhouse gas strategies document, the cost per ton for carbon offsets purchased through the Climate Passport calculator is $13.50. For every ton purchased, $12.00 goes to purchasing carbon offsets from the Garcia River Forest Project and covering costs associated with locating, researching, and verifying high quality projects as well as the other general operating costs typically incurred by any organization. The remaining $1.50 goes to the San Francisco Carbon Fund to support local San Francisco carbon reduction projects.[7] There is no reason why offsets that are deemed feasible for individuals to offset their carbon footprint could not be applied to the LRDP.

- Commit to participating in CleanPowerSF when it becomes available and to choosing an energy supply option that provides a 100% renewable energy supply. CleanPowerSF is the City's custom-tailored community choice aggregation program, which allows cities and counties to pool their citizens' purchasing power to buy electricity. CleanPowerSF will enhance local control, create competition, and provide San Franciscans with an alternative choice of cleaner energy than what Pacific Gas & Electric ("PG&E"), the main current service provider.[8]

IV. The EIR Fails to Require All Feasible Mitigation for Significant Impacts on Air Quality from Construction Emissions

I previously commented on the Draft EIR's failure to require all feasible mitigation to reduce toxic air contaminant emissions from diesel-powered construction equipment. (Comment Nos. 91-53 through 91-56.) The BAAQMD similarly recommended implementation of the following set of mitigation measures specific to the proposed LRDP to reduce the significant health risks associated with the diesel particulate matter ("DPM") emissions from Project construction:

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[7] *Ibid.*

[8] CleanPowerSF; http://cleanpowersf.org/.

- Tier 4 or equivalent equipment for all uses where such equipment is available;

- Replacement of diesel generator power by power from the electricity grid or by solar power generation (When neither of these options was available, BAAQMD requested the cleanest diesel generators and control technology available); and

- Restriction for on-road haul trucks utilized during construction to model year 2007 engines, equipped with diesel particulate filters (DPFs) or newer engines.

In response, the City amended Mitigation Measure M-AQ-N2 to include the following requirements:

- Where sufficient electricity is available from the PG&E power grid, electric power shall be supplied by a temporary power connection to the grid, provided by PG&E. Where sufficient electricity to meet short-term electrical power needs for specialized equipment is not available from the PG&E power grid, non-diesel or diesel generators with Tier 4 engines (or equivalent) shall be used.

- During any construction phase for near-term projects, at least half of each of the following equipment types shall be equipped with Level 3-verified diesel emission controls (VDECs): backhoes, concrete boom pumps, concrete trailer pumps, concrete placing booms, dozers, excavators, shoring drill rigs, soil mix drill rigs, and soldier pile rigs. If only one unit of the above equipment types is required, that unit shall have Level 3 VDECs retrofits.

- For long-term projects, which are presumed to begin when Tier 4 equipment would be widely available, all diesel equipment of all types shall meet Tier 4 standards.

(Response AQ-9, C&R 3.9-17.)

The City provided an "amended construction analysis that identifies the resultant criteria pollutant emissions inventory as a result of implementation of the revised mitigation plan for the CPMC LRDP. Therefore, ... the proposed LRDP would incorporate all feasible mitigation to reduce potential impacts related to the LRDP's construction emissions, including DPM." The City concludes that "even with the implementation of all feasible mitigation, this impact would remain significant and

unavoidable." (C&R 3.9-19.) The City's conclusion is not acceptable because, contrary to the City's assertion, the revised mitigation measures do not constitute "all feasible" mitigation.

First, the construction period for the various CPMC components stretches over nine years. Thus, mitigation aimed at reducing emissions from construction equipment should be worded so it requires the most stringent control at the time the equipment is used, not the most stringent control available at the time the EIR is certified.

Second, the mitigation measure aimed at reducing emissions from mobile equipment by requiring that at least half of some types of equipment is equipped with Level 3 VDECs is not specific to which pollutant must be addressed. The City only discusses the use of diesel particulate filters ("DPFs") but fails entirely to address the significant NOx emissions during construction which would exceed the BAAQMD's 2010 significance threshold of 54 lb/day multiple times (near-term project NOx construction emissions: 324 lb/day; long-term project NOx construction emissions: 102 lb/day).

Third, the mitigation measure that aims to mitigate construction emissions from long-term projects is vague and subject to interpretation. The City should require that Tier 4 equipment be used as soon as it becomes available.

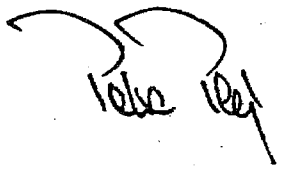
Fourth, the City fails to require the BAAQMD's recommendation for requiring on-road haul trucks utilized during construction to model year 2007 engines, equipped with diesel particulate filters (DPFs) or newer engines. The City states that "[d]iesel emissions from on-road hauling trucks would be equivalent to the emissions performance of model year 2007 vehicles or later." (Response AQ-8, C&R 3.9-19.) This is incorrect. The underlying analysis assumes that on-road hauling trucks diesel emissions would be equivalent to the emissions performance of model year 2007 or later. (Appendix C, Memorandum Re: Revisions to CPMC Construction Emissions and Health Risk Analysis, March 7, 2011, p. 5 and Footnote 4 to Tables 1b and 1d.) Thus the revised estimates of mitigated emissions assume cleaner engines but the City fails to include a corresponding mitigation measure. Thus, health risks are greater than presented in the revised health risk analysis and not adequately mitigated.

V. Conclusion

The EIR for the LRDP continues to be deficient because it fails to identify significant impacts on air quality and fails to require adequate mitigation for significant air pollutant and greenhouse gas emissions.

Please feel free to call me at (415) 492-2131 or e-mail at petra@ppless.com if you have any questions about the comments in this letter.

Regards,



Petra Pless, D.Env.

ATTACHMENT D

Office of Statewide Health Planning and Development
Facilities Development Division

Revision Date: 1/2[illegible]09

Summary of Requests for Extensions to Seismic Safety Deadlines

As Submitted to California's Office of Statewide Health Planning and Development by California's General Acute Care Hospitals in accordance with the Alquist Hospital Facility Seismic Safety Act

If you have a question, please call the toll free Seismic Safety Extension Information line at **(866) 667-3794.**

Facility ID	Facility Name	City	Status	Comment Period		Type of Extension Requested
				Begin Date	End Date	
11757	Kaiser Foundation Hospital - Bellflower	Bellflower	Approved[2]	*********	*********	Diminished Capacity
10670	Kaiser Foundation Hospital - Fontana	Fontana	Approved[2]	*********	*********	Diminished Capacity
11758	Kaiser Foundation Hospital - Harbor City	Harbor City	Approved[2]	*********	*********	Diminished Capacity
11296	Kaiser Foundation Hospital - Oakland	Oakland	Approved[2]	9/28/2006	11/12/2006	Diminished Capacity
11295	Kaiser Foundation Hospital - Hayward	Hayward	Approved	2/20/2002	4/6/2002	Diminished Capacity
10797	Kaiser Foundation Hospital - Redwood City	Redwood City	Approved	2/20/2002	4/6/2002	Diminished Capacity
12008	Providence St. Joseph Medical Center	Burbank	Approved	3/7/2002	4/21/2002	1801
10180	General Hospital, The	Eureka	Approved	4/11/2002	5/26/2002	Diminished Capacity
13078	Kaiser Foundation Hospital - Anaheim	Anaheim	Approved	4/11/2002	5/26/2002	Diminished Capacity
10604	Kaiser Foundation Hospital - North Sacramento	Sacramento	Approved	4/11/2002	5/26/2002	Diminished Capacity
12804	Mission Hospital Regional Medical Center	Mission Viejo	Approved	4/11/2002	5/26/2002	Diminished Capacity
12645	North Coast Health Care Centers - Fulton	Santa Rosa	Approved	4/11/2002	5/26/2002	Diminished Capacity
11054	North Coast Health Care Centers - Sotoyome	Santa Rosa	Approved	4/11/2002	5/26/2002	Diminished Capacity
14568	Petaluma Valley Hospital	Petaluma	Approved	4/11/2002	5/26/2002	Diminished Capacity
10362	Queen Of The Valley Hospital - Napa	Napa	Approved	4/11/2002	5/26/2002	Diminished Capacity
10183	Redwood Memorial Hospital	Fortuna	Approved	4/11/2002	5/26/2002	Diminished Capacity
11059	Santa Rosa Memorial Hospital	Santa Rosa	Approved	4/11/2002	5/26/2002	Diminished Capacity
10184	St. Joseph Hospital - Eureka	Eureka	Approved	4/11/2002	5/26/2002	Diminished Capacity
10457	St. Joseph Hospital - Orange	Orange	Approved	4/11/2002	5/26/2002	Diminished Capacity
10458	St. Jude Medical Center	Fullerton	Approved	4/11/2002	5/26/2002	Diminished Capacity
10695	St. Mary Regional Medical Center	Apple Valley	Approved	4/25/2002	6/9/2002	2006
11002	Mercy Medical Center	Redding	Approved	4/25/2002	6/9/2002	2006
13812	Mercy Medical Center Mt. Shasta	Mt. Shasta	Approved	2/24/2006	4/10/2006	2006
11121	St. Elizabeth Community Hospital	Red Bluff	Approved	7/16/2002	8/30/2002	Diminished Capacity
12872	Alvarado Hospital Medical Center	San Diego	Approved	7/16/2002	8/30/2002	Diminished Capacity
11510	Centinela Hospital Medical Center	Inglewood	Approved	7/16/2002	8/30/2002	Diminished Capacity
11645	Daniel Freeman Memorial Hospital	Inglewood	Approved	7/16/2002	8/30/2002	Diminished Capacity
10537	Desert Hospital	Palm Springs	Approved	7/16/2002	8/30/2002	Diminished Capacity
13085	Encino-Tarzana Regional Medical Center	Tarzana	Approved	7/16/2002	8/30/2002	Diminished Capacity

Revision Date: 1/28/2009

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Facility ID	Facility Name	City	Status	Comment Period		Type of Extension Requested
				Begin Date	End Date	
12834	Fountain Valley Regional Hospital & Medical Center -	Fountain Valley	Approved	7/16/2002	8/30/2002	Diminished Capacity
11658	Garfield Medical Center	Monterey Park	Approved	7/16/2002	8/30/2002	Diminished Capacity
11863	Midway Hospital Medical Center	Los Angeles	Approved	7/16/2002	8/30/2002	Diminished Capacity
11722	Queen of Angels/Hollywood Presbyterian Medical Center	Los Angeles	Approved	7/16/2002	8/30/2002	Diminished Capacity
18007	Western Medical Center - Santa Ana	Santa Ana	Approved	7/16/2002	8/30/2002	Diminished Capacity
11386	Alhambra Hospital	Alhambra	Approved	7/23/2002	9/6/2002	Diminished Capacity
10127	Fresno Community Hospital & Medical Center	Fresno	Approved	9/17/2002	4/13/2007	2006
10207	Bakersfield Memorial Hospital-34th Street	Bakersfield	Approved	10/3/2002	11/17/2002	Diminished Capacity
11480	California Hospital Medical Center - Los Angeles	Los Angeles	Approved	10/3/2002	11/17/2002	Diminished Capacity
10697	Community Hospital of San Bernardino	San Bernardino	Approved	10/3/2002	11/17/2002	Diminished Capacity
10972	Dominican Santa Cruz Hospital/Soquel	Santa Cruz	Approved	10/3/2002	11/17/2002	Diminished Capacity
11844	Glendale Memorial Hospital & Health Center	Glendale	Approved	10/3/2002	11/17/2002	Diminished Capacity
10838	Marian Medical Center	Santa Maria	Approved	10/3/2002	11/17/2002	Diminished Capacity
10606	Mercy General Hospital	Sacramento	Approved	10/3/2002	11/17/2002	Diminished Capacity
13012	Methodist Hospital Of Sacramento	Sacramento	Approved	10/3/2002	11/17/2002	Diminished Capacity
12137	Northridge Hospital Medical Center	Van Nuys	Approved	10/3/2002	11/17/2002	Diminished Capacity
11548	San Gabriel Valley Medical Center	San Gabriel	Approved	10/3/2002	11/17/2002	Diminished Capacity
10811	Sequoia Hospital	Redwood City	Approved	10/3/2002	11/17/2002	Diminished Capacity
10694	St. Bernardine Medical Center	San Bernardino	Approved	10/3/2002	11/17/2002	Diminished Capacity
10840	St. Francis Medical Center Of Santa Barbara	Santa Barbara	Approved	10/3/2002	11/17/2002	Diminished Capacity
12457	St. Francis Memorial Hospital	San Francisco	Approved	10/3/2002	11/17/2002	Diminished Capacity
10750	St. Joseph's Medical Center Of Stockton	Stockton	Approved	10/3/2002	11/17/2002	Diminished Capacity
12012	St. Mary Medical Center	Long Beach	Approved	10/3/2002	11/17/2002	Diminished Capacity
12460	St. Mary's Medical Center San Francisco	San Francisco	Approved	10/3/2002	11/17/2002	Diminished Capacity
11198	Woodland Memorial Hospital	Woodland	Approved	10/3/2002	11/17/2002	Diminished Capacity
11848	Brotman Medical Center	Los Angeles	Approved	10/17/2002	12/1/2002	Diminished Capacity
12831	Lakewood Regional Medical Center	Lakewood	Approved	10/17/2002	12/1/2002	Diminished Capacity
10316	Mercy Medical Center Merced - Dominican Campus	Merced	Approved	10/17/2002	12/1/2002	Diminished Capacity
10315	Mercy Medical Center Merced - Community Campus	Merced	Approved	10/17/2002	12/1/2002	Diminished Capacity

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Facility ID	Facility Name	City	Status	Comment Period		Type of Extension
				Begin Date	End Date	Requested
10607	Mercy San Juan Hospital	Carmichael	Approved	10/17/2002	12/1/2002	Diminished Capacity
10375	Sierra Nevada Memorial Hospital	Grass Valley	Approved	10/17/2002	12/1/2002	Diminished Capacity
12201	Whittier Hospital Medical Center	Whittier	Approved	10/17/2002	12/1/2002	Diminished Capacity
10006	Biggs-Gridley Memorial Hospital	Gridley	Approved	10/28/2002	12/12/2002	Diminished Capacity
10210	Kern Valley Hospital	Lake Isabella	Approved	10/28/2002	12/12/2002	Diminished Capacity
10200	Northern Inyo Hospital	Bishop	Approved	10/28/2002	12/12/2002	Diminished Capacity
11000	Mayers Memorial Hospital	Fall River Mills	Approved	10/30/2002	12/14/2002	Diminished Capacity
11846	Long Beach Memorial Medical Center	Long Beach	Approved [3]	11/4/2002	12/19/2002	Diminished Capacity
19009	Miller Children's Hospital	Long Beach	Approved [3]	11/4/2002	12/19/2002	Diminished Capacity
12755	Saddleback Memorial Medical Center	Laguna Hills	Approved	11/4/2002	12/19/2002	Diminished Capacity
10513	Seneca Hospital	Chester	Approved	12/3/2002	1/17/2003	Diminished Capacity
14181	Scripps Green Hospital	La Jolla	Approved	12/17/2002	1/31/2003	Diminished Capacity
12268	Scripps Memorial Hospital	Chula Vista	Approved	12/17/2002	1/31/2003	Diminished Capacity
12363	Scripps Memorial Hospital	La Jolla	Approved	12/17/2002	1/31/2003	Diminished Capacity
12309	Scripps Memorial Hospital Encinitas	Chula Vista	Approved	12/17/2002	1/31/2003	Diminished Capacity
12339	Scripps Mercy Hospital	San Diego	Approved	12/17/2002	1/31/2003	Diminished Capacity
11064	Sonoma Valley Hospital	Sonoma	Approved	12/17/2002	1/31/2003	Diminished Capacity
11706	Robert F. Kennedy Medical Center	Hawthorne	Approved	12/18/2002	2/1/2003	Diminished Capacity
10801	Seton Medical Center	Daly City	Approved	12/18/2002	2/1/2003	Diminished Capacity
10202	Southern Inyo Hospital	Lone Pine	Approved	12/18/2002	2/1/2003	Diminished Capacity
12014	St. Vincent Medical Center	Los Angeles	Approved	12/18/2002	2/1/2003	Diminished Capacity
13078	Kaiser Foundation - Anaheim	Anaheim	Denied	12/19/2002	2/2/2003	1801
11295	Kaiser Foundation - Hayward	Hayward	Denied	12/19/2002	2/2/2003	1801
10797	Kaiser Foundation - Redwood City	Redwood City	Denied	12/19/2002	2/2/2003	1801
11159	Community Memorial Hospital - San Buenaventura	Ventura	Approved	12/23/2002	2/6/2003	Diminished Capacity
10604	Kaiser Foundation Hospital - Sacramento	Sacramento	Denied	12/23/2002	2/6/2003	1801
10685	Kindred Hospital - Ontario	Ontario	Denied	12/23/2002	2/6/2003	1801
11414	Kindred Hospital - Los Angeles	Los Angeles	Pending	12/23/2002	2/6/2003	1801
10856	Regional Medical Center	San Jose	Approved	12/26/2002	2/9/2003	Diminished Capacity

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Facility ID	Facility Name	City	Status	Comment Period Begin Date	Comment Period End Date	Type of Extension Requested
10322	Modoc Medical Center	Alturas	Approved	12/26/2002	2/9/2003	Diminished Capacity
11787	Little Company of Mary Hospital	Torrance	Approved	12/27/2002	2/10/2003	1801
12443	UCSF/Mount Zion	San Francisco	Approved	1/3/2003	2/17/2003	1801
11621	Encino-Tarzana Regional Medical Center	Encino	Approved	1/8/2003	2/22/2003	Diminished Capacity
10440	Los Alamitos Medical Center	Los Alamitos	Approved	1/8/2003	2/22/2003	Diminished Capacity
12787	Suburban Medical Center	Paramount	Approved	1/8/2003	2/22/2003	Diminished Capacity
11887	Motion Picture & Television Hospital	Woodland Hills	Approved	1/25/2007	3/11/2007	Diminished Capacity
12348	Paradise Valley Hospital	National City	Approved	1/22/2003	3/8/2003	Diminished Capacity
11748	Citrus Valley Medical Center - IC Campus	Covina	Approved	1/29/2003	3/15/2003	Diminished Capacity
11971	Citrus Valley Medical Center - QV Campus	West Covina	Approved	1/29/2003	3/15/2003	Diminished Capacity
13093	Foothill Presbyterian Hospital - Johnston Memorial	Glendora	Approved	1/29/2003	3/15/2003	Diminished Capacity
11001	Redding Medical Center	Redding	Approved	1/29/2003	3/15/2003	Diminished Capacity
11966	Pomona Valley Hospital Medical Center	Pomona	Approved	1/31/2003	3/17/2003	Diminished Capacity
11085	Doctor's Medical Center	Modesto	Approved	2/11/2003	3/28/2003	Diminished Capacity
10778	Sierra Vista Regional Medical Center	San Luis Obispo	Approved	2/11/2003	3/28/2003	Diminished Capacity
10541	Hemet Valley Medical Center	Hemet	Approved	2/24/2003	4/10/2003	Diminished Capacity
10707	Victor Valley Community Hospital	Victorville	Denied	3/17/2003	5/1/2003	Diminished Capacity
10969	Dominican Santa Cruz Hospital/Frederick	Santa Cruz	Approved	3/27/2003	5/11/2003	Diminished Capacity
10556	Riverside Community Hospital	Riverside	Approved	3/27/2003	5/11/2003	Diminished Capacity
12295	Sharp Coronado Hospital and Healthcare Center	Coronado	Approved	4/2/2003	5/17/2003	Diminished Capacity
16116	Clovis Community Hospital	Clovis	Approved	4/16/2003	5/31/2003	2006
12050	Shriners Hospital for Crippled Children	Los Angeles	Approved	4/23/2003	6/7/2003	Diminished Capacity
11646	Pacific Alliance Medical Center Inc.	Los Angeles	Approved	5/7/2003	6/21/2003	Diminished Capacity
12372	Tri-City Medical Center	Oceanside	Approved	5/7/2003	6/21/2003	Diminished Capacity
10604	Kaiser Foundation Hospital - Sacramento	Sacramento	Pending	5/12/2003	6/26/2003	2006
11668	Glendale Adventist Medical Center	Glendale	Approved	5/13/2003	6/27/2003	Diminished Capacity
10468	South Coast Medical Center	Laguna Beach	Denied	6/5/2003	7/20/2003	1801
10214	Mercy Hospital	Bakersfield	Approved	6/25/2003	8/9/2003	Diminished Capacity
11164	Los Robles Regional Medical Center	Thousand Oaks	Approved	6/26/2003	8/10/2003	Diminished Capacity

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Facility ID	Facility Name	City	Status	Comment Period		Type of Extension
				Begin Date	End Date	Requested
10932	San Jose Medical Center	San Jose	Approved	6/26/2003	8/10/2003	Diminished Capacity
11858	Methodist Hospital Of Southern California	Arcadia	Approved	6/30/2003	8/14/2003	Diminished Capacity
12662	Eisenhower Medical Center	Rancho Mirage	Approved	7/1/2003	8/15/2003	Diminished Capacity
11688	Granada Hills Community Hospital	Granada Hills	Approved	7/9/2003	8/23/2003	Diminished Capacity
11927	Pacific Hospital of Long Beach	Long Beach	Approved	7/9/2003	8/23/2003	Diminished Capacity
10009	Enloe Medical Center - Cohasset	Chico	Denied	7/23/2003	9/6/2003	2006
12088	Coast Plaza Doctors Hospital	Norwalk	Approved	9/10/2003	10/25/2003	Diminished Capacity
11114	Fremont Medical Center	Yuba City	Approved	9/23/2003	11/7/2003	Diminished Capacity
11205	Rideout Memorial Hospital	Marysville	Approved	9/23/2003	11/7/2003	Diminished Capacity
12551	Verdugo Hills Hospital	Glendale	Approved	9/25/2003	11/9/2003	Diminished Capacity
10843	Santa Barbara Cottage Hospital	Santa Barbara	Approved	10/6/2003	11/20/2003	Diminished Capacity
11968	Presbyterian Intercommunity Hospital	Whittier	Approved	10/8/2003	11/22/2003	Diminished Capacity
11242	Childrens Hospital and Research Center at Oakland	Oakland	Approved	10/16/2003	11/30/2003	Diminished Capacity
11792	Community Hospital of Long Beach	Long Beach	Approved	10/29/2003	12/13/2003	Diminished Capacity
12140	Valley Presbyterian Hospital	Van Nuys	Approved	11/4/2003	12/19/2003	Diminished Capacity
10400	Chapman Medical Center	Orange	Approved	11/5/2003	12/20/2003	Diminished Capacity
13059	Coastal Communities Hospital	Santa Ana	Approved	11/5/2003	12/20/2003	Diminished Capacity
10874	Community Hospital of Los Gatos	Los Gatos	Approved	11/5/2003	12/20/2003	Diminished Capacity
12744	Daniel Freeman Marina Hospital	Marina del Rey	Approved	11/5/2003	12/20/2003	Diminished Capacity
10745	Doctors Hospital of Manteca	Manteca	Approved	11/5/2003	12/20/2003	Diminished Capacity
10038	Doctor's Medical Center - San Pablo Campus	San Pablo	Approved	11/5/2003	12/20/2003	Diminished Capacity
10450	Garden Grove Hospital and Medical Center	Garden Grove	Approved	11/5/2003	12/20/2003	Diminished Capacity
10545	John F. Kennedy Memorial Hospital	Indio	Approved	11/5/2003	12/20/2003	Diminished Capacity
12878	Monterey Park Hospital	Monterey Park	Approved	11/5/2003	12/20/2003	Diminished Capacity
13077	Placentia Linda Hospital	Placentia	Approved	11/5/2003	12/20/2003	Diminished Capacity
13061	Western Medical Center Hospital	Anaheim	Approved	11/5/2003	12/20/2003	Diminished Capacity
10287	John C. Fremont Healthcare District	Mariposa	Approved	11/5/2003	12/20/2003	2006
11162	Ventura Couty Medical Center	Ventura	Approved	11/26/2003	1/10/2004	Diminished Capacity
12985	Elastar Community Hospital	Los Angeles	Approved	12/4/2003	1/18/2004	Diminished Capacity

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Facility ID	Facility Name	City	Status	Comment Period		Type of Extension Requested
				Begin Date	End Date	
11140	Sierra View District Hospital	Porterville	Approved	12/22/2003	2/5/2004	Diminished Capacity
11910	Los Angeles Community Hospital of Norwalk	Norwalk	Approved	12/23/2003	2/6/2004	Diminished Capacity
11545	Los Angles Community Hospital	Los Angeles	Approved	12/23/2003	2/6/2004	Diminished Capacity
10287	John C. Fremont Healthcare District	Mariposa	Approved	12/23/2003	2/6/2004	Diminished Capacity
11718	Hollywood Community Hospital of Hollywood	Hollywood	Approved	12/23/2003	2/6/2004	Diminished Capacity
10257	Madera Community Hospital	Madera	Approved	12/24/2003	2/7/2004	Diminished Capacity
11731	Good Samaritan Hospital	Los Angeles	Approved	12/29/2003	2/12/2004	Diminished Capacity
11169	Ojai Valley Community Hospital	Ojai	Approved	1/8/2004	2/22/2004	Diminished Capacity
13018	Kaiser Foundation Hospital	Fresno	Approved	1/27/2004	3/12/2004	2006
15570	Kaiser Foundation Hospital - South Sacramento	Sacramento	Approved	1/27/2004	3/12/2004	2006
10691	Redlands Community Hospital	Redlands	Approved	2/5/2004	3/21/2004	Diminished Capacity
10743	Lodi Memorial Hospital	Lodi	Approved	2/9/2004	3/25/2004	Diminished Capacity
10741	Lodi Memorial Hospital - West	Lodi	Approved	2/9/2004	3/25/2004	Diminished Capacity
12249	Torrance Memorial Medical Center	Torrance	Approved	2/9/2004	3/25/2004	Diminished Capacity
11417	Barlow Respiratory Hospital Facility	Los Angeles	Approved	3/3/2004	4/17/2004	Diminished Capacity
12322	Grossmont Hospital	La Mesa	Approved	3/4/2004	4/18/2004	Diminished Capacity
13336	Sharp Chula Vista Medical Center	Chula Vista	Approved	3/4/2004	4/18/2004	Diminished Capacity
12364	Sharp Memorial Hospital	San Diego	Approved	3/4/2004	4/18/2004	Diminished Capacity
11549	Community Hospital of Huntington Park	Huntington Park	Approved	3/17/2004	5/1/2004	Diminished Capacity
13224	Greater El Monte Community Hospital	South El Monte	Approved	3/17/2004	5/1/2004	Diminished Capacity
11869	Mission Hospital of Huntington Park	Huntington Park	Approved	3/17/2004	5/1/2004	Diminished Capacity
13084	San Dimas Community Hospital	San Dimas	Approved	3/17/2004	5/1/2004	Diminished Capacity
13999	Twin Cities Community Hospital	Templeton	Approved	3/17/2004	5/1/2004	Diminished Capacity
11906	Northridge Hospital Medical Center (Roscoe)	Northridge	Approved	3/29/2004	5/13/2004	Diminished Capacity
13019	La Palma Intercommunity Hospital	La Palma	Approved	6/1/2004	7/16/2004	Diminished Capacity
12008	Providence St. Joseph Medical Center	Burbank	Approved	6/1/2004	7/16/2004	Diminished Capacity
17700	Sutter Roseville Medical Facility	Roseville	Approved	6/1/2004	7/16/2004	2006
10628	Sutter Memorial Hospital	Sacramento	Approved	6/9/2004	7/24/2004	Diminished Capacity
11672	East Valley Hospital	Glendora	Approved	6/17/2004	8/1/2004	Diminished Capacity

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Facility ID	Facility Name	City	Status	Comment Period		Type of Extension Requested
				Begin Date	End Date	
12874	Century City Hospital	Los Angeles	Approved	6/21/2004	8/5/2004	Diminished Capacity
10162	Sierra Kings District Hospital	Reedley	Approved	6/25/2004	8/9/2004	Diminished Capacity
11210	Alameda Hospital	Alameda	Approved	6/29/2004	8/13/2004	Diminished Capacity
12285	Children's Hospital	San Diego	Approved	7/7/2004	8/21/2004	Diminished Capacity
11268	Alameda County Medical Center, Fairmont Campus	San Leandro	Approved	7/19/2004	9/2/2004	Diminished Capacity
11288	Alameda County Medical Center, Highland Campus	Oakland	Approved	7/19/2004	9/2/2004	Diminished Capacity
10130	University Medical Center, Fresno	Fresno	Approved	8/24/2004	10/8/2004	Diminished Capacity
10475	West Anaheim Medical Center	Anaheim	Approved	8/30/2004	10/14/2004	Diminished Capacity
11922	Orthopaedic Hospital	Los Angeles	Approved	10/1/2004	11/15/2004	Diminished Capacity
14190	Pomerado Hospital	Poway	Approved	10/4/2004	11/18/2004	Diminished Capacity
12347	Palomar Medical Center	Escondido	Approved	10/4/2004	11/18/2004	Diminished Capacity
10431	Huntington Beach Hospital	Huntington Beach	Approved	10/7/2004	11/21/2004	Diminished Capacity
10831	Goleta Valley Cottage Hospital	Santa Barbara	Approved	11/1/2004	12/16/2004	Diminished Capacity
16319	Irvine Regional Hospital & Medical Center	Irvine	Approved	11/3/2004	12/18/2004	Diminished Capacity
16483	University Hospital	Los Angeles	Approved	11/3/2004	12/18/2004	Diminished Capacity
16228	San Ramon Regional Medical Center	San Ramon	Approved	11/3/2004	12/18/2004	Diminished Capacity
11726	Providence Holy Cross Medical Center	Mission Hills	Approved	11/10/2004	12/25/2004	Diminished Capacity
10220	Ridgecrest Regional Hospital	Ridgecrest	Approved	11/15/2004	12/30/2004	Diminished Capacity
10468	South Coast Medical Center	Laguna Beach	Approved	10/27/2004	1/19/2005	Diminished Capacity
10804	Peninsula Medical Center, Burlingame Facility	Burlingame	Approved	12/8/2004	1/22/2005	Diminished Capacity
12432	Laguna Honda Hospital	San Francisco	Approved	12/23/2004	2/6/2005	Diminished Capacity
10729	Dameron Hospital	Stockton	Approved	1/27/2005	3/13/2005	Diminished Capacity
11774	Lancaster Community Hospital	Lancaster	Approved	2/22/2005	4/8/2005	Diminished Capacity
10446	University of California - Irvine Medical Center	Orange	Approved	2/24/2005	4/10/2005	Diminished Capacity
11002	Mercy Medical Center	Redding	Approved	4/1/2005	5/16/2005	Diminished Capacity
14304	Mammoth Hospital	Mammoth Lakes	Approved	4/19/2005	6/3/2005	Diminished Capacity
12006	St. John's Hospital and Health Center	Santa Monica	Approved	4/20/2005	6/4/2005	Diminished Capacity
12964	French Hospital Medical Center	San Luis Obispo	Approved	4/21/2005	6/5/2005	Diminished Capacity
10766	Arroyo Grande Community Hospital	Arroyo Grande	Approved	4/21/2005	6/5/2005	Diminished Capacity

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Facility ID	Facility Name	City	Status	Comment Period		Type of Extension
				Begin Date	End Date	Requested
10261	Kentfield Rehabilitation Hospital	Kentfield	Approved	4/29/2005	6/13/2005	Diminished Capacity
11034	Sutter Medical Center of Santa Rosa	Santa Rosa	Approved	5/5/2005	6/19/2005	Diminished Capacity
11072	Sutter Warrack Hospital	Santa Rosa	Approved	5/5/2005	6/19/2005	Diminished Capacity
11344	St. Rose Hospital Hayward Facility	Hayward	Approved	5/19/2005	7/3/2005	Diminished Capacity
12235	Downey Regional Medical Center	Downey	Approved	7/25/2005	9/8/2005	Diminished Capacity
12047	Sherman Oaks Hospital	Sherman Oaks	Approved	8/9/2005	9/23/2005	Diminished Capacity
11260	Eden Medical Center	Castro Valley	Approved	8/16/2005	9/30/2005	Diminished Capacity
11256	San Leandro Hospital	San Leandro	Approved	8/17/2005	10/1/2005	Diminished Capacity
10529	Corona Regional Medical Center	Corona	Approved	8/22/2005	10/6/2005	Diminished Capacity
10192	Pioneers Memorial Healthcare District	Brawley	Approved	8/23/2005	10/7/2005	Diminished Capacity
11177	Simi Valley Hospital Care Services	Simi Valley	Approved	9/13/2005	10/28/2005	Diminished Capacity
13072	Chino Valley Medical Center	Chino	Denied	9/27/2005	11/11/2005	Diminished Capacity
10032	Colusa Regional Medical Center	Colusa	Approved	10/3/2005	11/17/2005	Diminished Capacity
13035	Bear Valley Community Hospital	Big Bear Lake	Approved	10/17/2005	12/1/2005	Diminished Capacity
10175	Glen Medical Center	Willows Facility	Approved	3/13/2006	4/27/2006	Diminished Capacity
12180	Doctor's Hospital of West Covina	West Covina	Approved	3/13/2006	4/27/2006	Diminished Capacity
10428	Hoag Memorial Hospital Presbyterian	Newport Beach	Approved	3/13/2006	4/27/2006	Diminished Capacity
10514	Eastern Plumas Healthcare	Portola	Approved	3/13/2006	4/27/2006	Diminished Capacity
12328	Kindred Hospital San Diego	San Diego	Approved	3/9/2006	4/23/2006	Diminished Capacity
10476	Kindred Hospital Westminister	Westminister	Approved	3/9/2006	4/23/2006	Diminished Capacity
11321	Kindred Hospital - San Francisco Bay Area	San Leandro	Approved	3/15/2006	4/29/2006	Diminished Capacity
11414	Kindred Hospital - Los Angeles	Los Angeles	Approved	3/15/2006	4/29/2006	Diminished Capacity
11768	Kindred Hospital - La Mirada	La Mirada	Approved	3/15/2006	4/29/2006	Diminished Capacity
12359	UCSD Hillcrest Medical Center	San Diego	Approved	5/12/2006	6/26/2006	Diminished Capacity
10836	Lompoc District Hospital	Lompoc	Approved	5/12/2006	6/26/2006	Diminished Capacity
12823	North Sonoma County Hospital District	Healdsburg	Approved	5/12/2006	6/26/2006	Diminished Capacity
11598	East Los Angeles Doctor's Hospital	Los Angeles	Approved	5/12/2006	6/26/2006	Diminished Capacity
10919	O'Conner Hospital	San Jose	Approved	4/3/2006	5/18/2006	Diminished Capacity
11843	Memorial Hospital of Gardena	Gardena	Approved	5/12/2006	6/26/2006	Diminished Capacity

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Facility ID	Facility Name	City	Status	Comment Period		Type of Extension Requested
				Begin Date	End Date	
11776	Kindred Hospital San Gabriel Valley	West Covina	Approved	5/12/2006	6/26/2006	Diminished Capacity
11111	Memorial Medical Center	Modesto	Approved	4/6/2006	5/21/2006	Diminished Capacity
10048	Mt. Diablo Medical Center	Concord	Approved	4/7/2006	5/22/2006	Diminished Capacity
10081	John Muir Medical Center	Walnut Creek	Approved	4/7/2006	5/22/2006	Diminished Capacity
11410	Avalon Municipal Hospital	Avalon	Approved	4/18/2006	6/2/2006	Diminished Capacity
12416	California Pacific Medical Center - Davies Campus	San Francisco	Approved	4/18/2006	6/2/2006	Diminished Capacity
10109	Barton Memorial Hospital	South Lake Tahoe	Approved	4/18/2006	6/2/2006	Diminished Capacity
13225	City of Angels Medical Center - Downtown Campus	Los Angeles	Approved	4/18/2006	6/2/2006	Diminished Capacity
11172	St. John's Regional Medical Center	Oxnard	Approved	4/18/2006	6/2/2006	Diminished Capacity
11525	Children's Hospital of Los Angeles	Los Angeles	Approved	4/18/2006	6/2/2006	Diminished Capacity
12042	Pacifica Hospital of the Valley	Sun Valley	Approved	4/18/2006	6/2/2006	Diminished Capacity
10685	Kindred Hospital Ontario	Ontario	Approved	4/18/2006	6/2/2006	Diminished Capacity
10943	Stanford University Medical Center	Stanford	Approved	2/21/2006	4/7/2006	Diminished Capacity
10935	Santa Clara Valley Medical Center	San Jose	Approved	4/18/2006	6/2/2006	Diminished Capacity
13181	St. John's Pleasant Valley Hospital	Camarillo	Approved	4/18/2006	6/2/2006	Diminished Capacity
12482	California Pacific Medical Center - Pacific Campus	San Francisco	Approved	4/18/2006	6/2/2006	Diminished Capacity
12404	California Pacific Medical Center - West Campus	San Francisco	Approved	4/18/2006	6/2/2006	Diminished Capacity
10338	George L. Mee Memorial Hospital	King City	Approved	4/18/2006	6/2/2006	Diminished Capacity
11847	Mission Community Hospital - Panorama Campus	Panorama City	Approved	4/18/2006	6/2/2006	Diminished Capacity
10190	El Centro Regional Medical Center	El Centro	Approved	4/18/2006	6/2/2006	Diminished Capacity
10382	Anaheim Memorial Medical Center	Anaheim	Approved	6/15/2006	7/30/2006	Diminished Capacity
13068	Kindred Hospital	Brea	Approved	4/21/2006	6/5/2006	Diminished Capacity
10407	Kindred Hospital	Santa Ana	Approved	4/26/2006	6/10/2006	Diminished Capacity
11175	Santa Paula Hospital	Ventura	Approved	4/26/2006	6/10/2006	Diminished Capacity
13087	Mad River Community Hospital	Arcata	Approved	10/11/2006	11/25/2006	Diminished Capacity
10321	Surprise Valley Healthcare District	Cedarville	Approved	4/17/2006	6/1/2006	Diminished Capacity
10214	Mercy Bakersfield, Southwest Campus	Bakersfield	Approved	4/24/2006	6/8/2006	Diminished Capacity
16477	Lucile Packard Children's Hospital	Palo Alto	Approved	5/5/2006	6/19/2006	Diminished Capacity
10273	Marin General Hospital	Greenbrae	Approved	5/8/2006	6/22/2006	Diminished Capacity

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10295	Frank R. Howard Memorial Hospital	Willits	Approved	5/17/2006	7/1/2006	Diminished Capacity
10112	Marshall Medical Center	Placerville	Approved	5/17/2006	12/27/2006	Diminished Capacity
11214	Alta Bates Summit Medical Center - Alta Bates	Berkeley	Approved	5/17/2006	7/1/2006	Diminished Capacity
11322	Alta Bates Summit Medical Center - Summit North	Oakland	Approved	5/17/2006	7/1/2006	Diminished Capacity
11399	Antelope Valley Hospital	Lancaster	Approved	5/11/2006	6/25/2006	Diminished Capacity
11125	Trinity Hospital	Weaverville	Approved	5/15/2006	6/29/2006	Diminished Capacity
10512	Plumas District Hospital	Quincy	Approved	5/22/2006	7/6/2006	Diminished Capacity
10013	Enloe Medical Center - Esplanade Campus	Chico	Approved	5/26/2006	7/10/2006	Diminished Capacity
10009	Enloe Medical Center - Cohasset Campus	Chico	Approved	5/26/2006	7/10/2006	Diminished Capacity
12525	Sutter Solano Medical Center	Vallejo	Approved	6/8/2006	7/23/2006	Diminished Capacity
10348	Salinas Vally Memorial Hospital	Salinas	Approved	6/12/2006	7/27/2006	Diminished Capacity
10810	San Mateo Medical Center	San Mateo	Approved	6/20/2006	8/4/2006	Diminished Capacity
13066	Saddleback Memorial Medical Center	San Clemente	Approved	6/29/2006	8/13/2006	Diminished Capacity
17725	Sutter Davis Hospital	Davis	Approved	7/10/2006	8/24/2006	Diminished Capacity
10052	Sutter Delta Medical Center	Antioch	Approved	7/10/2006	8/24/2006	Diminished Capacity
12443	UCSF Medical Center at Mount Zion	San Francisco	Approved	7/10/2006	8/24/2006	Diminished Capacity
12182	West Hills Hospital & Medical Center	West Hills	Approved	7/13/2006	8/27/2006	Diminished Capacity
10553	Palo Verde Hospital	Blythe	Approved	7/18/2006	9/1/2006	Diminished Capacity
10014	Feather River Hospital	Paradise	Approved	7/18/2006	9/1/2006	Diminished Capacity
10696	San Antonio Community Hospital	Upland	Approved	7/19/2006	9/2/2006	Diminished Capacity
12841	Tri-City Regional Medical Center	Hawaiian Gardens	Approved	7/20/2006	9/3/2006	Diminished Capacity
10330	Community Hospital of the Monterey Peninsula	Monterey	Approved	7/21/2006	9/4/2006	Diminished Capacity
13901	Sutter Maternity and Surgery Center	Santa Cruz	Denied	7/25/2006	9/8/2006	Diminished Capacity
11760	Kaiser Los Angeles	Los Angeles	Approved	1/25/2007	3/11/2007	Diminished Capacity
12875	Kaiser West Los Angeles	Los Angeles	Approved	7/26/2006	9/9/2006	Diminished Capacity
13111	Kaiser San Diego	San Diego	Approved	7/26/2006	9/9/2006	Diminished Capacity
17207	Kaiser Baldwin Park	Baldwin Park	Approved	7/26/2006	9/9/2006	Diminished Capacity
15666	Kaiser Woodland Hils	Woodland Hills	Approved	7/26/2006	9/9/2006	Diminished Capacity
10753	San Joaquin General Hospital	French Camp	Approved	7/31/2006	9/14/2006	Diminished Capacity

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11098	Kindred Hospital	Modesto	Approved	8/15/2006	9/29/2006	Diminished Capacity
12992	Doctor's Hospital Medical Center of Montclair	Montclair	Approved	7/31/2006	9/14/2006	Diminished Capacity
10631	Kindred Hospital Sacramento	Folsom	Approved	8/8/2006	9/22/2006	Diminished Capacity
10309	Memorial Hospital	Los Banos	Approved	8/9/2006	9/23/2006	Diminished Capacity
10757	Sutter Tracy Community Hospital	Tracy	Approved	8/11/2006	9/25/2006	Diminished Capacity
11007	Eastern Plumas Healthcare	Loyalton	Approved	8/14/2006	9/28/2006	Diminished Capacity
11733	Huntington Memorial Hospital	Pasadena	Approved	8/17/2006	10/1/2006	Diminished Capacity
10494	Sutter Auburn Faith Hospital	Auburn	Approved	8/28/2006	10/12/2006	Diminished Capacity
12112	Temple Community Hospital	Los Angeles	Approved	8/31/2006	10/15/2006	Diminished Capacity
13072	Chino Valley Medical Center	Chino	Approved	8/31/2006	10/15/2006	Diminished Capacity
11527	City of Hope National Medical Center	Duarte	Approved	9/7/2006	10/22/2006	Diminished Capacity
14345	Sutter Lakeside Hospital	Lakeport	Approved	9/7/2006	10/22/2006	Diminished Capacity
11759	Kaiser Foundation Hospital	Panorama City	Approved	9/25/2006	11/9/2006	Diminished Capacity
16164	Kaiser Foundation Hospital	Riverside	Approved	9/25/2006	11/9/2006	Diminished Capacity
12952	Kaiser Foundation Hospital Santa Teresa	San Jose	Approved	9/28/2006	11/12/2006	Diminished Capacity
10072	Kaiser Foundation Hospital	Walnut Creek	Approved	9/28/2006	11/12/2006	Diminished Capacity
12459	St. Luke's Hospital	San Francisco	Approved	9/29/2006	11/13/2006	Diminished Capacity
13142	Kaiser Foundation Hospital	Vallejo	Approved	9/28/2006	11/12/2006	Diminished Capacity
13086	Kaiser Foundation Hospital	S. San Francisco	Approved	9/28/2006	11/12/2006	Diminished Capacity
15570	Kaiser Foundation Hospital	South Sacramento	Approved	3/23/2007	5/7/2007	Diminished Capacity
16242	Kaiser Foundation Hospital	Santa Rosa	Approved	9/28/2006	11/12/2006	Diminished Capacity
10268	Kaiser Foundation Hospital	San Rafael	Approved	9/28/2006	11/12/2006	Diminished Capacity
12430	Kaiser Foundation Hospital San Francisco Geary	San Francisco	Approved	9/28/2006	11/12/2006	Diminished Capacity
10155	St Agnes Medical Center	Fresno	Approved	10/11/2006	11/25/2006	Diminished Capacity
11366	Washington Hospital Healthcare System	Fremont	Approved	10/13/2006	11/27/2006	Diminished Capacity
17749	Kaiser Hospital - Richmond Campus	Richmond	Approved	9/28/2006	11/12/2006	Diminished Capacity
16324	Kaiser Foundation Hospital	Manteca	Approved	2/23/2007	4/9/2007	Diminished Capacity
12765	Delano Regional Medical Center	Delano	Approved	10/12/2006	12/19/2006	Diminished Capacity
11285	Alta Bates Summit Medical Center-Herrick Campus	Berkeley	Approved	10/12/2006	11/26/2006	Diminished Capacity

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11306	Laurel Grove Hospital	Castro Valley	Approved	10/12/2006	11/26/2006	Diminished Capacity
11338	Alta Bates Summit Medical Center - Summit Campus	Oakland	Approved	10/12/2006	11/26/2006	Diminished Capacity
12463	San Francisco General Hospital	San Francisco	Approved	10/12/2006	11/26/2006	Diminished Capacity
10786	Mills Health Center	San Mateo	Approved	10/12/2006	11/26/2006	Diminished Capacity
10554	Parkview Community Hospital Medical center	Riverside	Approved	10/13/2006	11/27/2006	Diminished Capacity
12023	Little Company of Mary - San Pedro Hospital	San Pedro	Approved	10/13/2006	11/27/2006	Diminished Capacity
12375	Promise Hospital of San Diego/University Community Medi	San Diego	Approved	10/23/2006	12/7/2006	Diminished Capacity
12882	Los Angeles Metropolitan Medical Center	Los Angeles	Approved	10/26/2006	12/10/2006	Diminished Capacity
12476	UCSF Medical Center	San Francisco	Approved	11/1/2006	12/16/2006	Diminished Capacity
11428	Bellflower Medical Center	Bellflower	Approved	11/6/2006	12/21/2006	Diminished Capacity
10381	Anaheim General Hospital	Anaheim	Approved	11/9/2006	12/19/2006	Diminished Capacity
12573	Tustin Hospital & Medical Center	Tustin	Approved	11/9/2006	12/24/2006	Diminished Capacity
10391	Anaheim General Hospital Buena Park	Buena Park	Approved	11/9/2006	12/24/2006	Diminished Capacity
10648	Barstow Community Hospital	Barstow	Approved	11/13/2006	12/28/2006	Diminished Capacity
10247	Redbud Community Hospital	Clear Lake	Approved	11/13/2006	12/28/2006	Diminished Capacity
10226	Tehachapi Valley Healthcare District	Tehachapi	Approved	11/21/2006	12/19/2006	Diminished Capacity
16703	Continental Rehabilitation Hospital of San Diego	San Diego	Approved	11/27/2006	12/27/2006	Diminished Capacity
10219	Good Samaritan Hospital	Bakersfield	Approved	11/29/2006	12/27/2006	Diminished Capacity
10619	University of California, Davis Medical Center	Davis	Approved	11/29/2006	1/13/2007	Diminished Capacity
16679	Patient's Hospital of Redding	Redding	Approved	10/26/2006	12/19/2006	Diminished Capacity
10301	Mendocino Coast District Hospital	Fort Bragg	Approved	11/29/2006	12/27/2006	Diminished Capacity
10112	Marshall Medical Center	Placerville	Approved	11/30/2006	12/27/2006	Diminished Capacity
10377	Tahoe Forest Hospital,	Truckee	Approved	12/5/2006	12/27/2006	Diminished Capacity
10162	Sierra Kings District Hospital	Reedley	Denied	12/5/2006	12/7/2006	SB 1801
11976	LAC/Rancho Los Amigos National Rehab Center	Downey	Approved	12/6/2006	1/3/2007	Diminished Capacity
10122	Coalinga Regional Medical Center	Coalinga	Approved	12/7/2006	1/3/2007	Diminished Capacity
10029	Mark Twain St. Joseph's Hospital	San Andreas	Approved	12/8/2006	1/22/2007	SB 2006
14370	Children's Hospital of Orange County	Orange	Approved	12/8/2006	1/3/2007	Diminished Capacity
12198	White Memorial Medical Center	Los Angeles	Approved	12/8/2006	12/27/2006	Diminished Capacity

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10559	San Gorgonio Memorial Hospital	Banning	Approved	12/11/2006	1/3/2007	Diminished Capacity
11441	Beverly Hospital	Montebello	Approved	12/7/2006	12/27/2006	Diminished Capacity
11363	Valley Memorial Hospital	Livermore	Approved	12/12/2006	12/27/2006	Diminished Capacity
16245	HealthSouth Bakersfield Rehabilitation Hospital	Bakersfield	Approved	2/23/2007	4/9/2007	Diminished Capacity
10160	Selma Community Hospital	Selma	Approved	1/25/2007	3/11/2007	Diminished Capacity
10242	Central Valley General Hospital	Hanford	Approved	12/14/2006	1/28/2007	Diminished Capacity
10237	Hanford Community Medical Center	Hanford	Approved	1/25/2007	3/11/2007	Diminished Capacity
16681	Southwest Healthcare System	Murietta	Approved	1/25/2007	3/11/2007	Diminished Capacity
10707	Victor Valley Community Hospital	Victorville	Approved	1/25/2007	3/11/2007	Diminished Capacity
11809	Harbor - UCLA Medical Center	Torrance	Approved	1/25/2007	3/11/2007	Diminished Capacity
15801	Olive View - UCLA Medical Center	Sylmar	Approved	12/15/2006	1/29/2007	Diminished Capacity
12259	Martin Luther King Jr / Drew Medical Center	Los Angeles	Approved	12/15/2006	1/29/2007	Diminished Capacity
13110	Oak Valley District Hospital	Oakdale	Approved	1/25/2007	3/11/2007	Diminished Capacity
16632	Valleycare Medical Center	Pleasanton	Approved	12/18/2006	2/1/2007	Diminished Capacity
12601	Kaweah Delta District Hospital	Visalia	Approved	1/25/2007	3/11/2007	Diminished Capacity
15749	Inland Valley Regional Medical Center	Wildomar	Approved	1/25/2007	3/11/2007	Diminished Capacity
15630	Orange Coast Memorial Medical Center	Fountain Valley	Approved	12/20/2006	2/3/2007	Diminished Capacity
12004	St Francis Medical Center	Lynwood	Approved	12/20/2006	2/3/2007	Diminished Capacity
10366	St Helena Hospital	St. Helena	Approved	1/25/2007	3/11/2007	Diminished Capacity
14560	Ukiah Valley Medical Center / Hospital Drive	Ukiah	Approved	2/23/2007	4/9/2007	Diminished Capacity
10208	Kern Medical Center	Bakersfield	Approved	1/25/2007	3/11/2007	Diminished Capacity
10235	Corcoran District Hospital	Corcoran	Approved	1/25/2007	3/11/2007	Diminished Capacity
12033	UCLA Medical Center	Santa Monica	Approved	2/23/2007	4/9/2007	Diminished Capacity
12127	UCLA Medical Center	Los Angeles	Approved	2/23/2007	4/9/2007	Diminished Capacity
11152	Sonora Regional Medical Center - Forest Campus	Sonora	Approved	1/25/2007	3/11/2007	Diminished Capacity
11154	Tuolumne General Hospital	Sonora	Approved	1/25/2007	3/11/2007	Diminished Capacity
11151	Sonora Regional Medical Center - Fairview Campus	Sonora	Approved	12/21/2006	1/25/2007	Diminished Capacity
10890	Good Smaritan Hospital	San Jose	Approved	12/27/2006	2/10/2007	Diminished Capacity
16244	Los Robles Regional Medical Center-East Campus	West Lake Village	Approved	1/25/2007	3/11/2007	Diminished Capacity

Summary of Requests for Extensions to Seismic Safety Deadlines

As Submitted to California's Office of Statewide Health Planning and Development by California's General Acute Care Hospitals in accordance with the Alquist Hospital Facility Seismic Safety Act

If you have a question, please call the toll free Seismic Safety Extension Information line at **(866) 667-3794.**

Facility ID	Facility Name	City	Status	Comment Period		Type of Extension Requested
				Begin Date	End Date	
11785	Promise Hospital of East Los Angeles	Los Angeles	Approved	1/25/2007	3/11/2007	Diminished Capacity
10405	College Hospital	Costa Mesa	Approved	2/2/2007	3/19/2007	Diminished Capacity
14100	Hi-Desert Medical Center	Joshua Tree	Approved	2/2/2007	3/19/2007	Diminished Capacity
11547	Community Hospital of Gardena	Gardena	Approved	5/25/2007	6/20/2007	Diminished Capacity
11704	Vista Specialty Hospital of San Gabriel Valley	Baldwin Park	Approved	2/15/2007	4/1/2007	Diminished Capacity
13030	Valley Plaza Doctors Hospital	Perris	Approved	5/25/2007	6/16/2007	Diminished Capacity
14102	Rancho Specialty Hospital	Rancho Cucamonga	Approved	1/25/2007	3/11/2007	Diminished Capacity
11887	Motion Picture and Television Hospital	Woodland Hills	Approved	1/25/2007	3/11/2007	Diminished Capacity
10231	Mercy Westside Hospital	Taft	Approved	2/23/2007	4/9/2007	Diminished Capacity
10848	Santa Ynez Valley Cottage Hospital	Solvang	Approved	1/25/2007	3/11/2007	Diminished Capacity
10019	Oroville Hospital	Oroville	Approved	2/1/2007	3/18/2007	Diminished Capacity
11145	Tulare District Hospital	Tulare	Approved	2/1/2007	3/18/2007	Diminished Capacity
10186	Jerold Phelps Community Hospital	Garberville	Approved	1/25/2007	3/11/2007	Diminished Capacity
10625	Sutter General Hospital	Sacramento	Approved	12/27/2006	12/28/2006	Diminished Capacity
11874	Monrovia Community Hospital	Monrovia	Approved	6/5/2007	6/14/2007	Diminished Capacity
12763	Desert Valley Hospital	Victorville	Approved	2/2/2007	3/19/2007	Diminished Capacity
16877	Sun Health Robert H. Ballard Reabilitation Hospital	San Bernardino	Approved	2/2/2007	3/19/2007	Diminished Capacity
10137	Kingsburg Medical Center	Kingsburg	Approved	2/2/2007	3/19/2007	Diminished Capacity
10883	El Camino Hospital	Mountain View	Approved	2/1/2007	3/18/2007	Diminished Capacity
12881	San Joaquin Community Hospital	Bakersfield	Approved	2/2/2007	3/19/2007	Diminished Capacity
11787	Little Company of Mary Hospital	Torrance	Approved	2/2/2007	3/19/2007	Diminished Capacity
11052	Palm Drive Hospital	Sebastopol	Approved	2/2/2007	3/19/2007	Diminished Capacity
16325	Moreno Valley Community Hospital	Moreno Valley	Approved	2/1/2007	3/18/2007	Diminished Capacity
16148	Menifee Valley Medical Center	Sun City	Approved	2/2/2007	3/19/2007	Diminished Capacity
17282	Arrowhead Regional Medical Center	Colton	Approved	2/1/2007	3/18/2007	Diminished Capacity
12313	Fallbrook Hospital District	Fallbrook	Approved	2/2/2007	3/19/2007	Diminished Capacity
12024	Miracle Mile Medical Center	Los Angeles	Approved	12/29/2007	2/23/2007	Diminished Capacity
10684	Colorado River Medical Center	Needles	Approved	1/3/2007	5/24/2007	Diminished Capacity
13333	Henry Mayo Newhall Memorial Hospital	Valencia	Approved	2/2/2007	3/19/2007	Diminished Capacity

Summary of Requests for Extensions to Seismic Safety Deadlines

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If you have a question, please call the toll free Seismic Safety Extension Information line at (866) 667-3794.

Facility ID	Facility Name	City	Status	Comment Period		Type of Extension Requested[4]
				Begin Date	End Date	
10681	Mountains Community Hospital	Lake Arrowhead	Approved	2/15/2007	4/1/2007	Diminished Capacity
14214	Kaiser Foundation Hospital	Roseville	Approved	2/15/2007	4/1/2007	Diminished Capacity
10127	Community Regional Medical Center	Fresno	Approved	2/15/2007	4/1/2007	Diminished Capacity
13073	Loma Linda University Medical Ctr - E. Campus Hospital	Loma Linda	Approved	2/15/2007	4/1/2007	Diminished Capacity
10677	Loma Linda University Medical Ctr	Loma Linda	Approved	2/15/2007	4/1/2007	Diminished Capacity
16713	Children's Recovery Center of Northern California	Campbell	Approved	2/15/2007	4/1/2007	Diminished Capacity
11090	Emanuel Medical Center	Turlock	Approved	3/7/2007	4/21/2007	Diminished Capacity
10640	Hazel Hawkins Memorial Hospital	Hollister	Approved	4/9/2007	5/10/2007	Diminished Capacity
11810	LAC & USC Medical Center	Los Angeles	Approved	7/20/2007	9/3/2007	Diminished Capacity
10049	Contra Costa Regional Medical Center	Martinez	Pending	12/28/2007	2/11/2008	Diminished Capacity
16245	HealthSouth Bakersfield Rehabilitation Hospital	Bakersfield	Approved	1/28/2009	3/14/2009	Diminished Capacity

[1] If you wish to comment on any extension request, please send your comment by the end date of the comment period to:

Attention: Seismic Safety Extension Program
Office of Statewide Health Planning and Development
Facilites Development Division
1600 Ninth Street, Room 420
Sacramento, CA 95814

Any comment period ending on a Saturday, Sunday or State holiday will default to the next State working day.

[2] Acted upon prior to adoption of Public Notice and Comment Policy effective March 1, 2002.

[3] Original request posted November 4, 2002; modified request posted January 13, 2003.

[4] Definition of Extension Request Types:

Diminished Capacity -

Summary of Requests for Extensions to Seismic Safety Deadlines

As Submitted to California's Office of Statewide Health Planning and Development by California's General Acute Care Hospitals in accordance with the Alquist Hospital Facility Seismic Safety Act

If you have a question, please call the toll free Seismic Safety Extension Information line at **(866) 667-3794.**

Facility ID	Facility Name	City	Status	Comment Period		Type of Extension Requested
				Begin Date	End Date	
	The Office may grant hospitals an extension to the January 1, 2008 seismic compliance deadline, for both structural and SPC 2 & NPC 3, non-structural requirements (SPC 2 and/or NPC3 compliance) if it is evident that compliance will result in an interruption of healthcare services provided by general acute care hospitals within the area. The hospital owners shall request extensions in one-year increments up to a maximum of five years beyond the mandated date of compliance (1/01/08). See proposed draft of Section 1.5.2.1 of Article 1, Chapter 6, Part 1, Title 24, of the California Code of Regulations or current regulations also known as the California Building Standards Code. Pending					

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Summary of Requests for Extensions to Seismic Safety Deadlines

As Submitted to California's Office of Statewide Health Planning and Development by California's General Acute Care Hospitals in accordance with the Alquist Hospital Facility Seismic Safety Act

If you have a question, please call the toll free Seismic Safety Extension Information line at **(866) 667-3794.**

Facility ID	Facility Name	City	Status	Comment Period		Type of Extension Requested
				Begin Date	End Date	

1801-

The Office may grant hospitals an extension delay to the January 1, 2008 seismic compliance deadline for both structural and non-structural requirements (SPC 2 and/or NPC 3 compliance), if the hospital agrees that on or before January 1, 2013, designated services shall be provided by moving into an existing conforming building, relocated to a new building or retrofit existing building to designated seismic performance categories. See proposed draft of Sections 1.5.2.3 through 1.5.2.5 of Article 1, Chapter 6, Part 1, Title 24 of the California Code of Regulations or current regulations also known as the California Building Standards Code.

2006 -

The Office may grant hospitals an extension delay to the January 1, 2008 seismic compliance deadline for non-structural requirements, (NPC-3 Compliance) if the hospital is located in Seismic Zone 3 areas as indicated in the 1995 edition of the California Building Standards Code and have met the NPC 2 requirements and associated deadlines. See proposed draft of Section 1.5.2.2 of Article 1, Chapter 6, Part 1, Title 24 of the California Code of Regulations or the current regulations also known as the California Building Standards Code.

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UNIVERSITY OF CALIFORNIA
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April 26, 2012

San Francisco Planning Commission
1650 Mission Street, Suite 400
San Francisco, CA 94103

Re: Comments on Final Environmental Impact Report for the California Pacific Medical Center Long Range Development Plan (Case No. 2005.0555E)

Dear President Fong and Members of the Planning Commission:

These comments on the Final Environmental Impact Report ("FEIR") for the California Pacific Medical Center ("CPMC") Long Range Development Plan ("LRDP") are submitted on behalf of San Franciscans for Healthcare, Housing, Jobs, and Justice ("SFHHJJ") and its member organizations. SFHHJJ is a broad coalition of neighborhood and labor groups that has focused on the environmental impacts and social and fiscal consequences of the proposed project. Its member organizations include the Good Neighbor Coalition, the Council of Community Housing Organizations, the Bernal Heights Neighborhood Center, the Cathedral Hill Neighbors Association, the National Union of Healthcare Workers, the Chinese Progressive Association, and the South of Market Community Action Network.

After reviewing the Comments and Responses on the Draft Environmental Impact Report for the CPMC LRDP (hereinafter, "C&R"), we address in this letter our strong objections to: 1) the manner in which project alternatives were proposed and analyzed; and 2) the cursory treatment and dismissal of applicable San Francisco housing policies. We also endorse the comments and consultants' reports separately submitted on behalf of the California Nurses Association/National Nurses United.

In its current form, the CPMC Environmental Impact Report (EIR) cannot be certified by the City of San Francisco. It fails to meet the overriding purposes of an EIR, which are "to provide public agencies and the public in general with detailed information about the effect that a proposed project is likely to have on the environment; to list ways in which the significant effects of such a project might be minimized; and to indicate alternatives to such a project." Pub. Res. Code sec. 21061. The Draft Environmental Impact Report ("DEIR") must be revised

for compliance with the California Environmental Quality Act ("CEQA"). These revisions will then require the DEIR's recirculation for further comment.

1. THE ALTERNATIVES ANALYSIS REMAINS FATALLY INADEQUATE DUE TO THE PROJECT SPONSOR'S IMPERMISSIBLY NARROW PROJECT OBJECTIVES.

The alternatives analysis of the DEIR remains legally inadequate for three principal reasons. First, as the lead agency, it is the City's project objectives that matter, not the project sponsor's. Second, CEQA requires identification and analysis of "basic" project objectives, and the project objectives stressing consolidation of the hospital on a single site is not a "basic" project objective. Third, contrary to the claims of the DEIR and the C&R, there is nothing so unique or specific about this project to justify otherwise impermissibly narrow project objectives.

Inappropriate project objectives undermine the DEIR's alternatives analysis. Because each alternative's feasibility is assessed by its ability to meet the project objectives, when those objectives are impermissibly narrow, the lead agency is effectively letting the project sponsor inappropriately curtail an adequate alternatives analysis. Essentially, the tail is wagging the dog. As currently written, the DEIR's alternatives analysis is inadequate, and the Planning Commission cannot certify the EIR.[1]

A. It is the lead agency's objectives that matter, not the project sponsor's.

Section 15126.6(a) of the State CEQA Guidelines requires analysis of "a range of alternatives..., which would feasibly attain most of the basic objectives of the project...." However, contrary to statements in the C&R, it is the **lead agency's objectives** at issue, not the project sponsor's. As stated by the Court of Appeal in a case cited by the C&R, "The process of selecting the alternatives to be included in the EIR begins with the establishment of project objectives **by the lead agency**." (emphasis added).[2] The C&R glaringly misstates this proposition as follows: "CEQA requires that the EIR include an evaluation of the environmental consequences of the alternative...and a comparison of the degree of attainment of the **stated project sponsor's objectives**" (emphasis added).[3] The effect of this mischaracterization is to give the incorrect impression that legally the project sponsor's objectives no matter how framed trump any other consideration when comparing the merits of the proposed project and project alternatives.

Nothing in CEQA requires the City to adopt by rote a project applicant's objectives, especially if those objectives are inconsistent with CEQA's mandates. In fact, as the lead agency, the City has an obligation to accept only those objectives that comply with CEQA. If

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[1] CEQA Guidelines § 15090(a) ("Prior to approving a project the lead agency shall certify that... the final EIR has been completed in compliance with CEQA.").

[2] *Jones v. Regents of University of California*, 183 Cal.App.4th 818, 825 (2010), citing to *In re Bay-Delta etc.*, 43 Cal.4th 1143, 1163 (2008).

[3] C&R 3.22-13.

the project sponsor provides a project description or project objectives that do not comply with CEQA, the lead agency must either revise them or request that the project sponsor do the same. Otherwise, under CEQA Guidelines section 15090(a), the lead agency may not certify the EIR.

Here, the City as lead agency has taken without question CPMC's project objectives even though they are impermissibly narrow. The City then uses those objectives to disqualify alternatives and/or paint alternatives as infeasible. The C&R properly notes that the feasibility determination is "made by the lead agency's decision-makers as part of the project review process" rather than in the EIR.[4] But this review cannot take place if, as in this instance, the DEIR eliminates and fails to analyze alternatives on the grounds that they are infeasible in light of project objectives. In reviewing alternatives, the CPMC DEIR rejected on this ground a number of reasonable alternatives including an alternative that complies with current City code.[5] Because the DEIR gives such excessive credence to the project sponsor's framing of objectives, it effectively pre-empts the ability of lead agency decision-makers to review alternatives that well may be feasible when evaluated in light of the lead agency's basic objectives, not the project sponsor's self-serving statement of objectives.

B. The more than two pages of project objectives include several that are overly detailed and purposefully narrowing, not "basic" as required by CEQA.

The DEIR identifies no less than eighteen project objectives, many of which are so detailed that they narrow the project alternatives at the outset of the analysis. The danger of overly narrow project objectives is clear. Take for example a property owner looking to expand a three-story mixed use residential and commercial building on his property. If the project objectives are to build a 10-story, concrete office building, with no setbacks and no residential component, and then eliminates every project alternative for not meeting those criteria, this defeats the purpose of CEQA's alternatives analysis mandate.

Here, the CPMC DEIR has done the exact same thing. The DEIR identifies one project objective as "[e]fficiently consolidate CPMC's campuses by consolidating specialized services... into one centralized acute-care hospital."[6] Another is "[o]ptimize patient safety and clinical outcomes by (1) strategically grouping service lines and specialized services) [and] (2) providing multidisciplinary concentration of care for multisystem diseases..."[7] Yet another is "[e]nsure that this program-wide medical care consolidation and distribution minimizes redundancies."[8]

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[4] C&R at 3.22-13.

[5] DEIR at 6-20 (rejection of a three-campus alternative), DEIR at 6-22 (rejection of a three-campus alternative with integrated acute care facility), DEIR at 6-23 (rejection of a four-campus alternative), DEIR at 6-25 (rejection of retro-fitted four-campus alternative; DEIR at 6-28-30 (rejection of a "code-complying" alternative).

[6] DEIR at 6-6.

[7] *Id.*

[8] *Id.*

These detailed project objectives are not "basic" objectives, as required by CEQA.[9] "Basic" means "of, relating to, or forming the base or essence" and "constituting or serving as the basis or starting point."[10] Furthermore, the CEQA Guidelines expressly prohibit embellishing project objectives with more detail than is necessary.[11] Instead of stating an objective as consolidating services at Cathedral Hill, the EIR should identify as an objective the policy reason or reasons behind the need for consolidation. Only then should each alternative be assessed on its ability to meet "basic" policy objectives.

CPMC's position as articulated in the DEIR and C&R is that consolidation is necessary to ensure efficiencies. However, there is in these documents no factual basis and no policy analysis justifying such efficiencies, for example, in terms of the quality or accessibility of healthcare. A preliminary review of the scientific and medical literature indicates that there is no consensus on whether consolidation of hospital services at a single "mega-hospital" provides notable benefits for patients or communities.[12] Such research, however, does indicate that hospital consolidation in the 1990s raised the price of healthcare for patients by five percent and may have raised prices even more in some markets.[13] With respect to actual benefits of consolidation and its efficiencies, most studies indicate that such consolidation does produce cost savings for hospitals.[14]

The C&R cites *Jones v. Regents of University of California*[15] as standing for the proposition that consolidated or "clustered" development is a valid project objective. As done elsewhere when citing a case, the C&R misinterprets this case's applicability. In *Jones*, the project sponsor was the Lawrence Berkeley National Laboratory, a federal government research campus and a major international center for physics and energy research, much of which is undertaken by and with the United States Department of Energy. The Laboratory was looking to expand its main research campus. Its basic project objective was not to consolidate development. The stated objectives were to "improve access and connections to enhance scientific and academic collaboration and interaction," "promote the free exchange of ideas," and provide opportunities to "spontaneously form research partnerships" (internal quotations omitted),[16] all of which ring true as basic underlying objectives of a major national scientific laboratory.

By contrast, the DEIR and C&R uncritically accept CPMC's desired end result--a

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[9] CEQA Guidelines §15126.6 ("An EIR shall describe a range of reasonable alternatives to the project, or to the location of the project, which would feasibly attain most of the **basic objectives** of the project...") (emphasis added).

[10] Merriam Webster Online, *available* at [http://www.merriam-webster.com/dictionary/basic].

[11] CEQA Guidelines § 15124 ("The description of the project shall contain the following information but should not supply extensive detail beyond that needed for evaluation and review of the environmental impact.")

[12] William B. Vogt and Robert Town, *How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?*, Robert Wood Johnson Foundation, The Synthesis Project, Issue No. 9 (February 2006), at 8 & 11.

[13] *Id.* at 5.

[14] *Id.* at 9.

[15] 183 Cal.App.4th 818 (2010).

[16] *Id.* at 826 & 829.

consolidated mega-hospital--without identifying its underlying objectives. This desired end result is a feature or method of providing medical services, not a beneficial outcome, such as having seismically safe hospitals, providing quality healthcare, or serving particular underserved populations. It is disingenuous to use the *Jones* case, with its statement of broad underlying objectives, to legally justify CPMC's impermissibly narrow objectives as legitimate grounds for rejecting otherwise feasible alternatives.

C. This project is neither so "unique" nor "specific" as to justify the use of such narrow project objectives.

The C&R also argues that when projects are "subject to a very specific project scope and development requirements," impermissibly narrow objectives are justified.[17] The C&R points to nothing in CEQA to justify this. Instead, it again misapplies a legal precedent. This time it relies on *Save San Francisco Bay Association v. San Francisco Bay Conservation and Development Commission*,[18] where the development objective was to construct an underwater aquarium. The court held that such an objective justified excluding alternatives without waterfront access.

Here, there are no such unique constraints. The only "unique constraints" that the C&R identifies are project needs concerning "space allocation for hospital/medical institutions."[19] Such general location concerns in no way justify referring to this project as a project of "very specific project scope."[20] An aquarium has a unique claim that it needs to be located by the water. A hospital needs a location of sufficient size, but such a concern is not unique to its business. If it were so, any sizeable project could similarly categorize itself as so unique and thereby circumvent otherwise impermissible interpretations of CEQA. Such an interpretation would completely invalidate CEQA's general prohibition against such specific, narrowing, and detailed objectives.

D. The DEIR's reliance on CPMC's impermissibly narrow project objectives renders the DEIR's alternatives analysis inadequate and non-certifiable.

CPMC's argument is that it needs to consolidate virtually all specialty services at its Cathedral Hill campus, and that as part of this consolidation it must move services and staff from St. Luke's to Cathedral Hill. As discussed above, the benefit for patients and the public of consolidating all specialty services at a single site remains unclear. The DEIR and C&R make assertions about the need to consolidate services in a single mega-hospital but provide no concrete policy justification, which makes reliance on the narrowness of the related listed objectives that much more objectionable. It is one thing to consolidate at a particular location specific specialty services and quite another to claim a need to consolidate all specialty services at a single location.

[17] C&R at 3.2-11.
[18] 10 Cal.App.4th 908 (1992).
[19] C&R at 3.2-11.
[20] *Id.*

Alternative 3A, which locates women and children's services at St. Luke's instead of Cathedral Hill, is the environmentally superior alternative. Alternative 3A Plus, which was not evaluated, would involve instead proposals for other specialty services to be situated at St. Luke's. Sound policy arguments can be made for expanding the new hospital to be built on the St. Luke's Campus and downsizing the proposed hospital for the new Cathedral Hill Campus. While there are potential cost savings for CPMC in centralizing in one location all inpatient specialty services, there is no conclusive evidentiary support that such consolidation is a preferable method for providing accessible and quality hospital services for consumers and taxpayers. Nor is such a concentration of services otherwise in the public interest, especially in the event of a catastrophic disaster, such as an earthquake. Moreover, the long-term financial viability of the St. Luke's Campus requires having anchor specialty services that will attract both doctors and a broad demographic cross-section of patients. Yet the evaluation of such alternatives in the DEIR was either cut short or not undertaken because of its unexamined acceptance of CPMC's impermissibly narrow project objectives.

As a result, the EIR's Alternatives Analysis does not comply with CEQA, and the City as the lead agency is not in a position to review in an informative and intelligent manner the comparative impacts of a reasonable range of alternatives. "Without meaningful analysis of alternatives in the EIR, neither courts nor the public can fulfill their proper roles in the CEQA process."[21] It is black letter law under CEQA that a major function of an EIR "is to ensure that all reasonable alternatives to proposed projects are thoroughly assessed by the responsible official."[22]

The Planning Commission should direct staff to redefine the project objectives in such a way as to not predetermine viable project alternatives as infeasible. Once the project objectives are appropriately defined, the EIR must then reevaluate the project alternatives, and perhaps examine additional project alternatives, such as Alternative 3A Plus. Alternatives previously found "infeasible" when measured against inappropriately narrow objectives deserve a legally sufficient analysis. Until these legal insufficiencies are addressed, the City cannot certify the EIR.

2. THE EIR FLATLY IGNORES ANALYZING THE CONSIDERABLE ENVIRONMENTAL IMPACTS RELATED TO THE PROJECT'S UNDERMINING OF SAN FRANCISCO HOUSING POLICIES.

Even though multiple comments, including those from former Planning Commissioner Olague and continuing Commissioner Miguel,[23] point out that the EIR is inadequate due to its failure to identify conflicts between the project and the Van Ness Avenue Area Plan (VNAAP)

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[21] *Laurel Heights Improvement Ass'n. v. Regents of University of California.*, 47 Cal.3d 376, 404 (1988).
[22] *Save Round Valley Alliance v. County of Inyo*, 157 Cal.App.4th 1437, 1456 (2007) (citations omitted).
[23] C&R at 3.3-9.4.

and the Van Ness Special Use District (VNSUD), the DEIR and C&R continue to dismiss these concerns outright and without analysis. Ignoring the housing-related environmental impacts of CPMC's LRDP is inconsistent with CEQA. Until these environmental impacts are analyzed, the City cannot certify the DEIR.

A. Housing elements and planning policies and regulations concentrating housing development are clearly "adopted to protect the environment," and impacts to these plans must be analyzed in the DEIR.

The C&R claims that "CEQA does not require an analysis of all plans and policies, but rather asks whether a proposed project would conflict with any plan or policies adopted to protect the environment."[24] However, in considering project alternatives, CEQA expressly identifies "general plan consistency, other plans or regulatory limitations" as factors to be taken into account when addressing feasibility.[25]

Furthermore, housing elements *are* plans enacted for protection of the environment. Regional planning efforts undertaken for the past several years by the Association of Bay Area Governments, local and state climate change initiatives, and transportation planning all depend on the geographic allocation of housing units. The VNAAP and VNSUD, the policies and regulations of which concentrate housing development along a central San Francisco thoroughfare, reflect significant environmental protection interests that include: 1) concentrating housing development downtown, where residents can rely on walking, biking and public transportation; 2) concentrating development away from greenfields; and 3) concentrating development near jobs and city services.

Building a commuter-oriented mega-hospital complex in what has been planned as the heart of a residential district makes future residential development on the project parcels impossible, and, even more significantly, reduces the likelihood of future housing development in the immediate vicinity of the project. This undermines the VNAAP and VNSUD and will result in significant environmental impacts, which have been completely ignored by the DEIR. It is also relevant to underscore that these policies have recently been re-affirmed by the San Francisco Board of Supervisors in a resolution passed by the Board with the CPMC project very much in mind. This resolution states that no area plan with a housing requirement should be amended to allow development in that area "unless that new development project shall substantially fulfill the underlying housing production goal as a condition of granting that exception."[26]

B. The project is not exempt from the housing policies of VNAAP and VNSUD because a 1987 EIR failed to identify one of the project parcels as a potential housing site.

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[24] C&R at 3.3-96.

[25] CEQA Guidelines § 15126.6(f)(1).

[26] S. F. Board of Supervisors Resolution No. 461-10, Resolution Supporting Existing Area Plan Housing Requirements, File No. 100755 (September 2010).

The C&R argues that because the Environmental Impact Report for the VNAP and VNSUD, a document dating back to 1987, did not identify the proposed hospital site as a potential housing site, the DEIR is not required to analyze the impacts of the project on amendments to the VNAAP and VNSUD.[27] An EIR from 1987 is not a binding planning policy document. In fact, it would be absurd to even assume that any EIR from 25 years ago even remotely reflects conditions on the ground in 2012.

Moreover, the C&R argument is wrong legally and factually. Its legal premise is that because the Cathedral Hill hospital site was in the Western Addition A-2 redevelopment project area in 1987, it is not subject to the housing policies of the VNAAP and the statutory provisions of the VNSUD. The Western Addition A-2 redevelopment project area has expired. It no longer exists. Upon the expiration of a redevelopment project area, the governing land use controls and procedures revert to those provisions ordinarily applicable to a project site. In this case, the effect is that all General Plan, special area plan, and Planning Code provisions now apply to the entire Cathedral Hill project site. Factually, the site of the Cathedral Hill medical office building located on the east side of Van Ness Avenue was never in the Western Addition A-2 redevelopment project area. This project is bound by the policies and planning regulations of the VNAAP and the VNSUD. To assert otherwise is ludicrous.

C. Because the EIR has not sufficiently analyzed the environmental impacts of the proposed changes in San Francisco housing policy, the EIR cannot be certified.

The EIR is legally deficient in its complete failure to identify and address the environmental impacts resulting from significant changes to housing policy that are involved in allowing the development of a medical center as a new VNAAP policy and in creating a medical use sub-district as part of the VNSUD.

As it exists now, the VNAAP describes a vision for the Van Ness Corridor that overwhelmingly prioritizes the creation of new housing to establish a commercially vibrant and pedestrian friendly neighborhood. The preferred building type set forth in the VNAAP is a building with a ground floor commercial podium and three stories of housing.[28] At the very heart of the VNAAP is the notion, far advanced for its time, that there should be a relationship between the joint location of both housing and jobs in a transit rich environment like Van Ness Avenue.

The VNAAP objectives and policies are implemented through the VNSUD, which specifically requires that in newly constructed structures there be a 3 to 1 or greater ratio of residential uses to non-residential uses.[29] There are provisions for modifying this requirement

[27] C&R at 3.3-99.

[28] VNAAP Objective 1 and Policy 1.1 sets forth as an overriding priority the "continued development of new housing including affordable units, and the encouragement of high density housing above a commercial podium," which is what is meant by mixed-use in this context. *Available* at [http://www.sf-planning.org/ftp/General_Plan_Van_NessAve.htm].

[29] S.F. Planning Code sec. 243(c)(8)(A).

for a medical use but only if three findings are made: (1) a "substantial increment of new housing on Van Ness Avenue will not be significantly compromised"; (2) the project "provides space for an institutional, hotel, medical, cultural or social service use meeting an important public need which cannot reasonably be met elsewhere in the area"; and (3) "Housing cannot reasonably be included in the project."[30] There are also provisions for reducing market rate housing requirements by making financial contributions in support of affordable housing.[31]

The exemption to the policies and housing requirements included in the VNAAP and VNSUD requires a showing that its approval will not negatively impact the housing objectives of the plans. The EIR needs to analyze the environmental consequences of granting this exemption for the Van Ness Avenue corridor and its future physical development as a concentrated center for housing. The DEIR makes no such showing and fails to conduct any analysis of the environmental impacts of eviscerating a major housing policy and planning document and implementing regulatory controls.

The DEIR and C&R rejoinder also sidestep the need for a jobs/housing linkage analysis of the income level and other relevant demographic factors of new CPMC employees to determine the additional demand for affordable housing in San Francisco. This is particularly a concern because of the likely impacts for residential development in the Tenderloin neighborhood, which abuts the Cathedral Hill Campus site.

The existing VNAAP is a model for "smart growth" concepts that have become the basis for more advanced San Francisco area plans such as the Market/Octavia Plan and the Eastern Neighborhoods plan. To understand the full environmental consequences of the VNAAP and VNSUD changes requested by CPMC, there need to be additional land use, air quality, greenhouse gas, transportation, and transit analyses and modeling to determine the impacts of placing a huge new commuter-oriented land use, such as a 555-bed hospital, on a major thoroughfare identified in multiple planning and policy documents as a prioritized housing area.

One example of the continuing short shrift given standard environmental concerns affecting the area immediately adjacent to the proposed Cathedral Hill Campus project is the FEIR's treatment of Tenderloin traffic impacts. Having ignored in the DEIR the traffic, transit, and pedestrian safety impacts of the Project within the Tenderloin, the FEIR includes a supplemental Tenderloin traffic study. It assumes, however, without any explanation that notwithstanding more than half of the new 28,000 trips to the Project site will be by automobile, there will be only 4 additional vehicles at the 7th and Market intersection in the AM peak[32] and 1 additional vehicle in the PM peak.[33] This intersection is a major point in the flow of traffic coming from Interstate 80 crossing Market and then proceeding north on Leavenworth before turning west on streets in the Tenderloin to reach a destination at Van Ness and Geary. These assumptions defy common knowledge about San Francisco traffic patterns.

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[30] S.F. Planning Code sec. 243(c)(8)(B)(iv).
[31] S.F. Planning Code sec. 243(c)(8)(B)(i)&(ii).
[32] C&R Appendix E, Cathedral Hill Supplemental Sensitivity Analyses, at E-17.
[33] *Id.* at E-24.

The proposed VNAAP and VNSUD amendments substantially reverse and undermine important San Francisco housing-centric objectives and policies. Without further factual analyses that truly assess the environmental impacts of these changes, the City as the lead agency is not in a position to make reasoned determinations about the project and its alternatives and to evaluate whether there are overriding considerations sufficient to offset the numerous significant and unavoidable environmental impacts stemming from the project.

3. EVEN IF THE DEIR IS CERTIFIED IN ITS CURRENT, LEGALLY INADEQUATE CONDITION, THE CITY SHOULD NOTE THE EGREGIOUS INCONSISTENCIES BETWEEN THE PROJECT AND THE CITY'S ADOPTED PLANNING POLICIES AND NOT APPROVE THE PROJECT IN ITS CURRENT FORM.

While we understand that the EIR is a procedural and disclosure document, and that CEQA analysis only requires the City to examine the project's impacts on the physical environment, the Planning Commission is within its authority to make a determination of the project's consistency with sound planning policy, health care delivery policy, and other best practices related to the social and economic welfare of the City of San Francisco. The impacts of this project for San Francisco residents and taxpayers are enormous. The delays in the project coming before the Planning Commission are largely due to the project sponsor's intractability. The complexities of the issues, important ones of which are still not resolved, strongly counsel against any rush to judgment to certify an inadequate EIR and approve a still seriously flawed project.

Conclusion

For the foregoing reasons, the FEIR does not meet the standards of adequacy required by CEQA. This EIR must be revised and re-circulated to address its continuing deficiencies as addressed here and in other comment letters and testimony.

Respectfully submitted,

UC Hastings Civil Justice Clinic
for San Franciscans for Healthcare, Housing, Jobs, and Justice

by Mark N. Aaronson

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October 19, 2010

Environmental Review Officer
San Francisco Planning Department
1650 Mission Street, Suite 400
San Francisco, CA 94103

Re: Preliminary Comments on the Draft Environmental Impact Report for the CPMC Long Range Development Plan

Dear Review Officer:

On behalf of the California Nurses Association/National Nurses United ("CNA"), this letter provides **preliminary** comments on the draft environmental impact report ("DEIR") for the CPMC Long Range Development Plan ("Project"). These comments are preliminary because the applicant, California Pacific Medical Center, and the City's Planning Department have failed to provide CNA with foundational data and information the City relied upon to draft its analyses and to support its conclusions in the DEIR. Requests for DEIR background data and studies were either greatly delayed by unnecessary back and forth or were denied altogether. As a result, CNA was unable to ascertain exactly what it is the City is proposing to do; it was in many instances impossible to verify many of the DEIR's technical analyses, assumptions and conclusions. If and when we obtain the withheld data, we will supplement these comments accordingly.

I. INTRODUCTION

CNA has been actively involved in every aspect of CPMC's long range planning efforts. Most recently, CNA spoke at the Planning Department's June 9, 2009, scoping meeting and submitted written comments on June 26, 2010. CNA's scoping comments pointed out the need for the City to properly address, among other things, project alternatives, cumulative impacts, traffic congestion and the need for the City to not present the public with an overly complicated EIR given its wish to combine both project-specific and programmatic issues into one CEQA document. Unfortunately, as explained below, the City's DEIR did not reflect the myriad of substantive comments from numerous members of the public submitted after the Notice of Preparation for the DEIR. Nor did the DEIR comply with the requirements of the California Environmental Quality Act ("CEQA").[1] Accordingly, the City may not approve the Project or grant any permits for it until it revises the EIR in a manner that makes it understandable to the reader and addresses all of the Project's environmental impacts. The City must recirculate a revised EIR for public review and comment.

[1] Public Resources Code §§ 21000 *et seq.*

CNA is one of California's oldest nonprofit social welfare institutions. Founded in 1903, today CNA represents over 80,000 members throughout the country. CNA has represented its members on nursing and public health issues before municipal, county, and state bodies for over 100 years. CNA members provide professional care for patients in medical facilities in San Francisco and throughout the Bay Area. CNA's comments are made in its representative capacity of CNA members and their families who currently reside in San Francisco County, on behalf of its members and their families throughout California, and on behalf of health care consumers generally who are directly affected in their health and general welfare by the availability of, access to, and quality and safety of health care services.

In addition, like the public at large, CNA members are concerned about sane and sustainable land use and development in San Francisco. CNA members live in the communities that suffer the impacts of environmentally detrimental and poorly planned projects. Ill-conceived development, in turn, may jeopardize human health and safety. This is particularly true here because numerous CNA members work in or live near Project facilities and will be negatively impacted by, among other things, increased traffic, poor air quality, undisclosed and unmitigated ground water and soil contamination, and impacts on affordable housing. Finally, CNA members are harmed by the fact that the City failed to comprehensively address the Project's effects on various communities' access to safe and affordable medical care. CNA therefore has a strong interest in enforcing environmental laws such as CEQA to protect its members.

We have prepared these comments with the assistance of four technical experts: Dr. Petra Pless, Ms. Terrell Watt, Mr. Tom Brohard, P.E. and Mr. Matt Hagemann, P.E. The comments of each of these experts along with their *curriculum vitae* are attached herein. Please note that this letter merely discusses only a small portion of each expert's comments; therefore, each expert's letter should be addressed and responded to separately.

II. PROJECT DESCRIPTION

The DEIR is both a project-specific and 20-year, long range development plan that encompasses CPMC's multi-phased plan to meet state seismic safety requirements. In addition to changes at its four existing medical facilities, the DEIR proposes a new hospital complex, the Cathedral Hill Campus. The four existing CPMC medical campuses are the Pacific Campus in the Pacific Heights area, the California Campus in the Presidio Heights area, the Davies Campus in the Duboce Triangle area, and the St. Luke's Campus in the Mission District.

A. Cathedral Hill Campus

At this site, the existing Cathedral Hill Hotel and 1255 Post Street Buildings would be demolished and CPMC would design, construct, and operate the proposed Cathedral Hill Campus. This campus would include a newly constructed 15-story, 555-bed hospital at the northwest corner of the intersection of Van Ness Avenue and Geary Boulevard and a medical office building ("MOB") at the northeast corner of the intersection of Van Ness Avenue and Geary Street, across Van Ness Avenue from the proposed Cathedral Hill Hospital site. A pedestrian tunnel beneath Van Ness Avenue would connect the hospital and MOB. An existing MOB at the intersection of Sutter and Franklin Streets, currently partially used as an MOB, would be fully converted for use as an MOB.

B. Pacific Campus

At this campus, CPMC would convert an existing hospital into a new ambulatory care center, including a new building, additional underground parking, renovation of other existing buildings and demolition of four existing buildings. The existing acute-care services and Women's and Children's Center would be relocated to the proposed Cathedral Hill Hospital.

C. Davies Campus

New development would include the construction of a new Neuroscience Institute building, a new MOB, and related parking improvements.

D. St. Luke's Campus

Development would include demolition of the existing St. Luke's Hospital tower, Redwood Administration Building, and magnetic resonance imaging trailer; construction of the new 80-bed, acute-care St. Luke's Replacement Hospital; and construction of the proposed MOB/Expansion Building and associated underground parking.

E. California Campus

The existing acute-care services and Women's and Children's Center would be relocated to the proposed Cathedral Hill Hospital. CPMC would sell the California Campus by 2020, after relocating that campus's inpatient services (*i.e.*, care of all patients staying longer than 24 hours) to the proposed Cathedral Hill Hospital and its other services to the Pacific Campus. Some existing on-site medical activities would continue at the California Campus in a relatively small amount of space that CPMC would lease back from the new property owner indefinitely.

The DEIR/LRDP would be implemented in two phases: the *near-term* phase (Cathedral Hill Campus and St. Luke's Campus projects and Neuroscience Institute at Davies Campus) and the *long-term* phase, *i.e.*, projects that would commence significantly after 2015 or are contingent upon the completion of near-term projects (including projects the Pacific Campus and California Campus and Castro Street/14th Street MOB at Davies Campus).

III. THE DEIR DID NOT COMPLY WITH CEQA

A. The DEIR Is So Poorly Organized and Poorly Written It Precludes Informed Decision Making

CEQA requires agencies to inform the public and responsible officials of the environmental consequences of their decisions ***before*** they are made, thereby protecting the environment and informed self-government.[2] A well-prepared and fully documented EIR is the "heart" of this requirement.[3] The following are examples of how DEIR failed to satisfy these purposes:

- The DEIR is so poorly written and so poorly organized that it is largely comprehensible to even the most seasoned CEQA practitioners.
- The DEIR created confusing and unconventional terms to describe the significance of a particular environmental impact. In nearly 15 years of reviewing CEQA documents, our office has never seen, for instance, an EIR describe an environmental impact as "potentially significant and unavoidable." This term in oxymoronic. Environmental impacts can only be deemed significant and unavoidable at the end of the process ***after*** the lead agency has imposed all feasible alternatives and/or measures to mitigate significant impacts.
- The City did not need to invent nine different ways to distinguish between significant and insignificant impacts. These terms served no other purpose than to confuse readers.
- The DEIR employed far too many acronyms for any reviewer to keep track of. There is no reason why the preparers could not take the time to spell out infrequently used terms.
- The DEIR's structural and organizational flaws render the document nearly incomprehensible. For example, the DEIR's Transportation and Circulation chapter is organized by topic such as roadway network, intersection operations, transit operations, bicycle facilities, parking, impact evaluations, and mitigation measures. Discussions of each campus are presented one after the other under the individual topic rather than continuously as a complete discussion of each campus. Such organization makes it extremely difficult and unnecessarily complex to follow the analysis of the individual projects proposed for each of the five campuses. This technique demonstrates nothing more than lazy drafting.
- The EIR omitted credible analysis and substantial evidence for its conclusions regarding the significance of Project impacts. Instead, conclusions are based on bare and unverifiable assertions.
- The DEIR omitted a mitigation monitoring and reporting plan ("MMRP"). Instead, mitigations measures lack specificity, performance objectives, enforceability and timelines for implementation.

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[2] CEQA Guidelines § 15002(a)(1);*Berkeley Keep Jets Over the Bay Com. v. Board of Port Comrs.* (2001) 91 Cal.App.4th 1344, 1354.

[3] *No Oil, Inc. v. City of Los Angeles* (1974) 13 Cal.3d 68, 84.

Given the intense public interest surrounding this project from all quarters of the City, as evidenced by the large turnouts at both the scoping and Planning Commission hearings, it is unconscionable for the City to issue a CEQA document that no one can understand.

Indeed, while the Project is large, and will affect numerous San Francisco communities, it is not a particularly complicated project *per se*. Had the City taken the time to prepare a decently organized CEQA document, it would not have precluded an untold number of interested residents from even understanding what it is CPMC is proposing to do. Shamefully, the City's substandard work has done just that. However, if, on the other hand, the City did view the Project as so complicated that it was unable to issue an EIR that anyone could comprehend, then the Project itself is too large and complicated to be considered under a single CEQA document and the Project requires several smaller actions. Either way, the City's EIR has made a mockery of informed decision making and must be withdrawn and properly revised.

Substantively, as best as we can discern given the DEIR's impenetrable nature, the document did not comply with CEQA because it:

- Failed to accurately describe the Project and its environmental setting;
- Failed to disclose all potentially significant environmental impacts;
- Employed misleading and illegal baselines;
- Deferred mitigation;
- Failed to identify effective and enforceable mitigation for each significant impact; and,
- Recommended that the City override some 100 significant Project impacts absent any attempt to mitigate these impacts.

Based on the above deficiencies, the City failed, as a matter of law, to inform the public and decision makers about the Project's significant impacts on air quality, traffic and transit, land use, the loss of access to affordable health care, and soil and ground water contamination at the Project's various sites.

In addition, the DEIR identified a number of significant and unavoidable environmental impacts associated with the construction and operation of the Project. The City may adopt a statement of overriding considerations only ***after*** it has imposed all feasible mitigation and analyzed all feasible alternatives to reduce the Project's impact to less than significant levels.[4] CEQA prohibits the City from approving the Project with significant environmental impacts when feasible mitigation measures or alternatives can substantially lessen or avoid its impacts.[5]

Finally, if a mitigation measure or alternative would itself cause one or more significant effects in addition to those that would be caused by the Project as proposed, the effects of the mitigation measure must be analyzed.[6]

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[4] CEQA Guidelines §§ 15126.4, 15091.

[5] CEQA § 21002.

[6] CEQA Guidelines, at § 15126.4(a)(1)(D).

A. THE EIR FAILS TO INCLUDE ALL THE RELEVANT DATA IN A SINGLE REPORT

An EIR must be "a compilation of all relevant data into a single formal report which would facilitate both public input and the decision making process."[7] The City failed to provide the public with the DEIR's appendices and supporting documentation despite this data being an integral and inseparable component of the EIR itself. In our experience, DEIR appendices are physically attached to the DEIR and include traffic counts, air quality data and other supporting studies and information on which the preparers relied in their analyses and conclusions. Here, the City separated the supporting documentation from the DEIR and would only provide this information in compact disc ("CD") format after a member of the public pre-paid $10.00 per CD. Creating extra red tape and charging the public for information it is freely entitled to violates CEQA.

B. THE EIR DID NOT ADEQUATELY DESCRIBE THE PROJECT

An accurate, stable and finite project description is the *sine qua non* of an informative and legally adequate EIR.[8] Without it, CEQA's objective of fostering public disclosure and informed environmental decision-making is stymied. Only through an accurate view of the Project may affected outsiders and public decision-makers balance the proposal's benefit against its environmental cost, consider mitigation measures, assess the advantage of terminating the proposal and weigh other alternatives in the balance. "An accurate, stable, and finite Project Description is the sine qua non of an informative and legally sufficient EIR."[9] The adequacy of an EIR's project description is closely linked to the adequacy of the EIR's analysis of the project's environmental effects. "If the description is inadequate because it failed to discuss the complete project, the environmental analysis will probably reflect the same mistake."[10]

More specifically, an EIR must include a description of the physical environmental conditions in the vicinity of the Project.[11] Conversely, an EIR violates CEQA if the description of the Project's environmental setting, including the surrounding area, is inaccurate, incomplete or misleading.[12] The DEIR omitted an overall description of the Project's environmental setting within San Francisco and the relevant Bay Area communities. The DEIR was required to describe the Project in regional terms for all of the relevant resource areas such as land use, air quality, traffic and transit, access to safe and affordable health care and public services, to name a few. Instead, the DEIR narrowly discussed the environmental setting, regulatory framework, cumulative conditions, significance criteria, and impact evaluations for each impact evaluation. This approach denied the reader of an understanding of the entire Project's overall impacts on the City and surrounding communities outside San Francisco.

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[7] (*Russian Hill Improvement Association v. Board of Permit Appeals* (1975) 44 Cal.App.3d 158, 168.)

[8] *County of Inyo v. City of Los Angeles* (1977) 71 Cal.App.3d 185, 192.

[9] *Id.*

[10] Kostka and Zischke, "Practice Under the California Environmental Quality Act."

[11] CEQA Guidelines § 15125

[12] *Bakersfield Citizens for Local Control v. City of Bakersfield* (2004) 124 Cal.App.4th 1184.

Then, within the DEIR's narrow impact evaluations, it first provided a summary of the level of significance for each campus including mitigation, if required, and then discussed impacts associated with construction and operation of the Project components and their mitigation measures separately for *Near-Term Projects* at the Cathedral Hill, Davies, and St. Luke's Campuses and *Long-Term Projects* at the Pacific and Davies Campuses.[13] In some sections project-specific individual and cumulative impacts were discussed in separate sections (*e.g.*, land use), in other instances they are discussed in the same paragraph (*e.g.*, air quality). In short, the DEIR contains an impermissibly narrow description of the Project's environmental setting depriving readers of the Project's regional impacts.

1. The DEIR Omitted a Description of Changes in Access to Health Care in San Francisco and the Bay Area

Most troublesome is the DEIR's complete silence on a description of CMPC's current regionalization process that permeates all aspects of access to healthcare in San Francisco and the Bay Area at large. CPMC is affiliated with Sutter Health. Sutter is going through a process of "regionalization," in which its twenty-six affiliate hospitals are collapsed into five regional structures. As a result, the corporate entity of CPMC has ceased to exist, while all CPMC operations, finance, and governance have dissolved into Sutter West Bay, which encompasses all of San Francisco.

Sutter's regionalization entails large-scale closures of services and increased transfer of patients between cities in the Bay Area. CNA has now been involved in CEQA review regarding Sutter's construction plans in Castro Valley, Oakland, Santa Rosa, San Mateo County, and San Francisco. In each instance, Sutter presents the respective plan in a vacuum, isolated from the simultaneous rebuilds the next town over. [14]

Sutter has drastically reduced the number of licensed hospital beds both at CMPC campuses and regionally. Specifically, if all of Sutter's plans in the Bay Area were approved, would entail eliminating 881 licensed hospital beds in the Bay Area between the CPMC campuses, Alta Bates Summit Medical Center in Berkeley and Oakland (Herrick Campus and Summit Campus), San Leandro Medical Campus (complete closure proposed), Eden Medical Center in Castro Valley, Sutter Medical Center of Santa Rosa, and Mills-Peninsula Health Services ("Mills Peninsula") in Burlingame and San Mateo.

The planned consolidation of by Sutter across the Bay Area assumes increased transfer of patients between cities. For example, earlier this spring a stroke patient in Novato was transferred to CPMC in San Francisco rather than to the nearest stroke center in Greenbrae in Marin County. Traffic burdens (and associated air quality and greenhouse gas emissions) caused by additional patient transports to and from San Francisco as a result of regionalization are not addressed in the DEIR. This information must be included a revised EIR that fully and accurately depicts the regional setting for health care.

[13] Draft EIR at pages 4-1 – 4-3.

[14] *See* attached Letter from Michael Lighty, CNA Director of Public Policy, (Oct. 19, 2010.)

2. Additional Omissions from the DEIR's Project Description

Below are examples of omitted environmental setting information from a land use perspective that must be included in a revised EIR are:

- A detailed description of the distribution of existing health care services in San Francisco and the surrounding Bay Area communities including the overall availability of general and specialized services, facilities locations and size, emergency room admissions and ambulance trips, personnel, charity care and trauma, among other factors.

- A complete description of both the local and regional health care service setting must provide information on any gaps or leakage of San Francisco's health care needs, accessibility of services, and other basic background information to provide "baseline conditions" for analyzing Project impacts.[15]
- Projected health care services needs based on changing demographics and geographical distribution (*e.g.*, aging population, and projected growth in the City's southeastern quadrant).
- Information on the housing in the areas surrounding all five campuses.
- Information concerning cumulative projects including potential cumulative development of other health care services projects in the City and adjacent Bay Area communities.
- Information on existing jobs-housing balance and jobs-housing fit in San Francisco and adjacent Bay Area communities.

C. The DEIR Failed To Fully Analyze Alternatives

The DEIR failed to adequately describe a full and reasonable range of Project alternatives. CEQA requires that an EIR "describe a range of reasonable alternatives to the project ... which would feasibly attain most of the basic objectives of the project but would avoid or substantially lessen any of the significant effects of the project, and evaluate the comparative merits of the alternatives.[16] Here, the DEIR failed to consider feasible alternatives to the 555-bed hospital complex at the Cathedral Hill site. While the DEIR was not required to analyze an inordinate number of alternatives, it was required to consider a reasonable number with enough specificity so that the public and decision makers could fully evaluate Project options.

The Project's centerpiece is the proposed 555-bed Cathedral Hill campus from which all other Project components derive. The presumed inevitability of the Cathedral Hill campus permeates the entire EIR and resulted in a cursory and deficient alternatives analysis, especially with respect to larger, viable St. Luke's campus.

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[15] Without this information, very basic impact analyses cannot be performed (*e.g.*, how far will patients travel for care? What are the transportation and air quality impacts of those travel patterns?).

[16] CEQA Guidelines § 15126.6(a); *Citizens of Goleta Valley v. Board of Supervisors* (1990) 52 Cal.3d 553; *Laurel Heights Improvement Association v. Regents of the University of California* (1988) 47 Cal.3d 376.

The DEIR's alternatives section enumerates CPMC's "core medical" objects for the project,[17] among those are:

- Consolidating CPMC's campuses by consolidating specialized services and Women's and Children's services into one centralized acute-care hospital;
- Distributing inpatient capacity among campuses which includes "an optimal number" of smaller, community based hospitals, ambulatory care facilities, and medical offices;
- Ensuring that consolidation minimizes redundancies in terms of staffing, equipment, support spaces, central processing and other facilities to avoid inefficiency and unnecessary costs;
- Rebuilding St. Luke's into a community hospital that provides medical/surgical care, critical care, emergency care and gynecologic and low-intervention obstetric care;
- Maintaining CPMC's prominent role in San Francisco and the greater Bay Area in terms of research and medical education; and,
- Enhancing CPMC's role as a provider of medical and administrative jobs.

In a nutshell, the DEIR's preferred alternative seeks to largely consolidate CPMC services into one 555-bed mega-hospital and MOB, on one tiny parcel, in one of the most diverse and gridlock-plagued sections of the City, Geary Street at Van Ness/Highway 101. The DEIR failed to justify the geographic inequity the preferred alternative would create in the City. At Project completion, patients in the City's southeast quadrant will still have to travel to other sections of the City for most specialized care; whereas, residents and local small businesses close to Cathedral Hill will be burdened by a medical facility too large for the site to adequately support in terms of land use, traffic and transit.

In terms of reducing traffic congestion and to better serve the community, CPMC should spread the proposed development to several other campuses including to the St. Luke's Campus rather than concentrating services at the Cathedral Hill Campus. Access to and from St. Luke's Campus is closer to Highway 101 for vehicles and to major transit facilities such as the 24th Street BART Station for transit patrons. Moreover, the St. Luke's Campus is the most accessible CPMC facility for those Sutter patients traveling from San Mateo and Santa Clara counties. From a transportation perspective, a Project alternative that distributes patients and services equally across the City should be evaluated in a revised EIR.

The DEIR concluded that alternative 3A would be the environmentally superior alternative. This alternative entails a larger St Luke's Hospital and smaller Cathedral Hill Hospital. However, the DEIR designed a bigger St Luke's Hospital around a relocated women's and children's program. As Mr. Lighty explained in his attached letter, this creates an alternative that is not supportable because it would shift most women's and children's services to the southern half of the City (CPMC and U.C.S.F. Mission Bay). CNA supports the environmentally superior alternative of a larger St Luke's, but with a different complement of services. Instead of shifting all of women's and children's services to St. Luke's, CPMC can easily centralize other services already planned at St Luke's Hospital. CPMC currently plans to offer some level of

[17] DEIR at page 6-6, 7.

cardiology, oncology, orthopedics, gastroenterology, respiratory, and urology at St. Luke's Hospital and to duplicate every single one of these services at Cathedral Hill Hospital with a higher standard of care for insured patients. Instead, CPMC could centralize some combination of these services for all CPMC patients at St. Luke's Hospital.[18]

In contrast to the proposed project, a smaller Cathedral Hill Hospital and a larger St. Luke's Hospital would be by far preferable in terms of health care and would also considerably reduce some of these environmental impacts. We support the environmentally superior alternative of a larger St. Luke's Hospital with a clinical anchor and a smaller Cathedral Hill Hospital.

D. The DEIR Failed to Disclose and/or Analyze All Potentially Significant Impacts

An EIR must disclose all of a project's potentially significant environmental impacts, because CEQA requires public agencies to avoid or reduce environmental damage by requiring alternatives and/or mitigation measures, and disclosing these requirements prior to project approval.[19] Here, the DEIR failed to disclose and/or analyze numerous potentially significant impacts. Instead, the DEIR contains only cursory analyses of impacts associated with soil and groundwater contamination, traffic and transit, land use, air quality, and access to affordable and safe healthcare. With these omissions, the City violated one of CEQA's most critical components because only after the City investigates and discloses these impacts can it move to the next step of showing it has imposed all feasible alternatives and/or measures to mitigate the Project's significant impacts. In short, unless these impacts are properly analyzed, they will not be fully addressed through either mitigation or alternatives, all in violation of CEQA.

1. The DEIR Failed To Adequately Analyze Potential Contaminants in Soil and Groundwater

According CNA's hazardous waste expert, Matt Hageman, a former EPA senior scientist, CPMC has known for at least two years that all five Project sites present some level of contamination that has not been adequately investigated and disclosed. Indeed, the DEIR and its supporting documents indicate numerous instances of potential soil and groundwater contamination, along with evidence of additional widespread contamination that must be fully investigated in a revised EIR.[20] These are potentially serious problems given each of the Project sites occur in densely populated areas in very close proximity to neighboring residents, passersby, workers at nearby businesses and construction workers at the sites themselves. A revised EIR must include special precautions to ensure that construction workers are not put at risk when they touch and breathe contaminants through dust and vapors. Likewise a revised EIR must include protection for neighboring residents and those living along transportation corridors at risk from harmful dust and vapors generated during excavation and transport of contaminated soil in and through their neighborhoods.

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[18] Camden Group Utilization Project Report at page 22.

[19] CEQA section 21100(b)(1); CEQA Guidelines § 15002(a)(2) and (3); *see also Citizens of Goleta Valley v. Board of Supervisors* (1990) 52 Cal.3d 553, 564; *Laurel Heights Improvement Ass'n v. Regents of the University of California* (1988) 47 Cal.3d 376, 400).

[20] Matt Hagemann Letter (Oct. 18, 2010) at page 17.

Not only did the DEIR fail to fully inform the public of these hazards, CPMC has not contacted the San Francisco Department of Public Health, the agency that oversees subsurface soil and water contamination of the type presented here. The SFDPH should have been contacted so that its independent assessment of any necessary remediation or mitigation could be included in the DEIR for public review. Mr. Hagemann's attached letter details the specific contaminant risk for each DEIR site, and shows the need for SFDPH oversight.

2. The DEIR Failed to Disclose Severe Impacts on Traffic and Transit

The DEIR minimized the Project's actual impacts on traffic congestion because unlike most California jurisdictions, the City's criteria used to identify significant impacts for development projects do not address incremental increases in delay at intersections once gridlock conditions occur at Level of Service (LOS) F. This means that a development project could add any number of trips to an already failing intersection without being considered as contributing to cumulative traffic increases for the most congested roadways. This lax criterion in turn allows a developer to minimize a project's actual impacts and allows it to avoid mitigating its worst impacts on traffic congestion.

Here, many of the intersections identified in the DEIR already operate at LOS F in peak hours under existing conditions, and the number of failing intersections will significantly increase in Years 2015, 2020, and 2030.[21] The Project's contributions to additional vehicle trips to these failing intersections will increase delay well beyond existing conditions. This issue is particularly serious for a hospital project. For example, the DEIR did not analyze how the increased traffic around the Cathedral Hill Campus will affect access for ambulances, labor and delivery vehicles and others urgently trying to reach the hospital. During gridlock traffic conditions which are much of the time around Van Ness Avenue, emergency patients may face life threatening delays while waiting in traffic. The DEIR failed to consider these and other critical circumstances in the traffic analysis.

Concerning Project-specific impacts, the DEIR did not adequately analyze increases in both transit use and vehicle miles traveled resulting from the Project. CPMC is the second largest employer in San Francisco.[22] The total number of employees at all of the CPMC campuses will increase by 4,170 employees system-wide. This new employment, while certainly a benefit to the City, will create population growth and household growth.[23] People traveling into the City and across the City for these new job opportunities will increase traffic and further burden public transit. Because the DEIR did not factor in these new commuters, a revised EIR must analyze this impact.

Concerning public transit, the DEIR made erroneous assumptions that transit service would increase once the Project was operational. However, given severe budgetary constraints which directly affect/reduce service levels for the San Francisco Municipal Transportation Agency (Muni), and given projected increases in ridership, the DEIR grossly underestimated impacts the Project would have on Muni. According to the DEIR, the City is in the process of implementing "recommendations designed to make Muni service more reliable, quicker and

[21] DEIR Tables 4.5-17, 4.5-18, 4.5-35, 4.5-37, 4.5-38, and 4.5-39.

[22] DEIR at page 5-16.

[23] *Id.* at page 4.3-31.

more frequent." [24] From this, the DEIR assumed that increased Muni service would accommodate increased Project-related ridership thereby mitigating any potential transit impacts. But, as shown below, these assumptions are wrong; thus, the DEIR failed to calculate and disclose the Project's actual impacts on public transit.

CNA's traffic expert, engineer Tom Brohard, determined that transit service enhancements have, in fact, been suspended given the ongoing fiscal emergency. Indeed Muni service is frequently cut and then occasionally partially restored, with only incremental losses at best but never system-wide increases. Accordingly, in Mr. Brohard's opinion, the DEIR erred in its finding that it was reasonably foreseeable that Muni would increase services in the areas serving the five CPMC campuses.[25] Where the DEIR assumed that service enhancements would be made, the transit analysis of near term and long term transit conditions was flawed. This flawed analysis in turn resulted in a significant under estimation of impacts.

Mr. Brohard also found numerous errors in the DEIR's ridership data for all five campuses. These errors were both within various tables as well as in comparison to the DEIR's forecast number of Project transit riders in the description of transit impacts. These errors are described in detail in Mr. Brohard's attached comment letter.

3. The DEIR Failed to Disclose Significant Impacts on Land Use

The Project would have numerous potentially significant impacts on San Francisco land use, including its local planning and policies, on its population, housing and employment. None of these were adequately disclosed in the DEIR. Below is a brief example of the significant impacts CNA's land use expert Terrell Watt uncovered:

- Impacts related to population, housing and jobs including an increased demand for housing affordable to the full CPMC workforce generated by the proposed Project (*e.g.*, construction plus induced and indirect employees);
- Impacts associated with the Project's inconsistencies on local plans and policies such as amendments to the General Plan, zoning code and other departures from adopted plans, policies and regulations;
- Growth-inducing impacts as a result of unmet demand for housing and particularly housing affordable to the Project workforce as well as growth inducing impacts associated with exempting this Project from applicable policies, plans and regulations. In addition, the DEIR failed to analyze the growth inducing impacts related to indirect and induced growth in employment to serve the Project and foreseeable uses at the California Campus sites once sold;
- Cumulative impacts, including those related to housing demand, public services, employment and air quality within San Francisco and the greater Bay Area.
- Impacts associated with the shifts and changes in health care city-wide that would in turn change patient patterns (travel distances, types of trips, etc.), increased impacts on air quality emissions, public services and possibly other health care services (*e.g.*,

[24] DEIR at page 4.5-61.

[25] Transit services were dramatically reduced in December 2009 and May 2010, twice in the last 10 months, and partially restored in September 2010.

competition and or the abandonment of the California Street Campus could result in loss of other existing services).

As mentioned, the Project would require General Plan amendments, variances from the existing Codes, FAR amendments, parking reductions and other significant departures from adopted plans, policies and regulations. The numerous sweeping departures from adopted plans and policies call into question whether the Project benefits and merits justify all of necessary land use changes required for Project approval. Among the inconsistencies are proposals to deviate from:

- Height and bulk limits: for example, an amendment is required to the Height and Bulk District map to reclassify the block for the Cathedral Hill hospital from the 130-V Height and Bulk District to a 265-V Height and Bulk District, allowing a maximum height of 265 feet.
- Height limit for Cathedral Hill campus: Conditional Use authorization is required for the Cathedral Hill Hospital and Cathedral Hill MOB in an RC-4 zoning district to allow buildings taller than 40 feet within the Van Ness Special Use District.
- Off-street loading space dimension: the proposed Cathedral Hill campus would also require Conditional Use authorization to exceed the allowable parking..

Also, because the DEIR omitted critical documents for review (*e.g.* text for proposed policy amendments), it is impossible to fully evaluate the Project's consistency/inconsistency with the City's plans and policies. Moreover, the DEIR based its findings of Project consistency on the presumption that the Project would obtain all of the myriad major entitlements, amendments and exceptions from existing plans, policies and regulations such as changes to:

- The San Francisco General Plan and all applicable elements, including the Housing Element
- Regional Plans and policies (*e.g.*, Bay Area Air Quality Management plans and regulations)
- Van Ness Avenue Area Plan ("VNAP")
- Market & Octavia Neighborhood Plan
- Mission Area Plan
- Japantown Better Neighborhood Plan
- Mission District Streetscape Plan
- Measure M

The DEIR's Project consistency "analysis" provided only conclusory statements of consistency that are in most cases unsupported by evidence in the record. A revised EIR must include a table with the text of applicable policies and provisions and a specific description of why the Project is or is not consistent with each applicable policy or provision. As it stands, the DEIR failed to disclose significant impacts on land use.

4. The DEIR Failed to Disclose Significant Impacts on Housing

The Project will result in significant unmitigated impacts on affordable housing; specifically impacts on affordable housing that will be needed to meet the Project's workforce. The DEIR concluded that the Project would not have negative effects on housing because it relied on numerous erroneous assumptions.[26] Conversely, the DEIR ignored important factors indicating that housing demand would be much greater than disclosed, such as the Project's full new household demand, including the construction workforce and including indirect and induced jobs (the multiplier effect); jobs-housing fit; and cumulative jobs-housing fit. Finally, the DEIR omitted key considerations which wrongly skewed the conclusion that the Project's impacts on housing impacts would not be significant. Among those were:

- The DEIR failed to describe all elements of the Project that would generate housing demand, such as construction workforce, Project-induced and indirect employees. A proper analysis of full housing demand would result in a significant shortfall of housing, particularly housing affordable to segments of the new direct, Project-induced, indirect and long-term construction workforce.

- The DEIR failed to account for the additional indirect employment (based on a reasonable multiplier[27]) generated by Project construction. As a result, net new demand for housing will likely be even greater.
- The DEIR failed to investigate where workers will likely live. Instead, the DEIR simply relied on the assumption from the CPMC IMP that 49% of employees reside in San Francisco, 22% in the South Bay/Peninsula, less than 19% in the East Bay, and 8% in the North Bay to extrapolate the locations where future employees will reside. Census and other information are available to more accurately project the likely places workers will live.
- The DEIR failed to deduct from planned and projected housing, housing that would be developed on these sites under current planning and zoning, absent the proposed Project.
- The DEIR omitted new housing required under current City regulations, which CPMC is now seeking an exemption from constructing.[28]
- The DEIR failed to analyze the "housing fit" – that is the cost of housing compared with the Project workforce's ability to pay for that housing. Various segments of the net new workforce, as well as indirect and induced jobs, are likely to fall into lower income categories.

Had the DEIR taken the above factors into consideration it would have more accurately reflected the Project's contribution to the significant demand on housing affordable to the CPMC

[26] Terrell Watt Letter (October 18, 2010) at page 11.

[27] The total jobs generated by a project can be determined using "multipliers" that indicate the number ratio of direct jobs to indirect and induced jobs. Used to measure the number of times each dollar of direct spending cycles through an economy thereby producing indirect and induced spending, multipliers also describe indirect and induced employment produced by a project's economic impacts.

[28] DEIR at page 4.3-33.

workforce. The DEIR must be revised to take into account the above factors as fully described in Ms. Terrell's comment letter.

5. The DEIR Failed to Disclose and Adequately Mitigate Significant Impacts on Air Quality

In its air quality section, the DEIR failed to identify and mitigate significant impacts on air quality because it failed to provide an analysis after buildout of all near-term projects in 2015. Instead, the DEIR only provided emission estimates and conclusions as to their significance for the year 2030, long after all LRDP-related projects will be build out. Consequently, the DEIR fails to require mitigation for those significant impacts it failed to identify.

6. The DEIR Failed To Disclose Impacts on Health Care Access

Under the LRDP, CMPC is proposing to remove from service approximately 743 licensed beds at the existing St. Luke's Hospital (149 beds), California Campus (299 beds), and Pacific Campus (295 beds). The newly constructed Cathedral Hill Hospital would only provide 555 beds, exclusively in private single-occupancy rooms,[29] *i.e.*, 188 fewer beds than currently provided by the existing CPMC campuses many of which are in double-occupancy rooms.[30] This removal of beds would result in reduced access to health care and a major shift of the current hospital patient population to other hospitals in the region, particularly for patients at the St. Luke's Campus. The DEIR failed to address any of the associated impacts on traffic, transportation, parking, air quality, and public services.

St. Luke's Hospital provides accessible acute care and inpatient services to the local community consisting of ethnically diverse, predominantly low-income patients from neighborhoods regardless of the patients' economical class or hospital reimbursement status. The most recent available data for the St. Luke's Hospital indicate that in 74.5% of the inpatient population was covered by Medicare, Medi-Cal, Workers' Compensation, or other government health programs (38.1% were covered by Medi-Cal, California's public health insurance program which provides needed health care services for low-income individuals including families with children, seniors, persons with disabilities, foster care, pregnant women, and low income people with specific diseases such as tuberculosis, breast cancer or HIV/AIDS[31]), and only 21.3% were covered by private insurance.[32] In contrast, the most recent available data for the Pacific Campus indicate that only 34.3% of the inpatient population was covered by government programs (7.5% by Medi-Cal) and that 63.5% of patients were covered by private insurance.[33]

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[29] Draft EIR at page 1-21.

[30] Draft EIR at page 2-8.

[31] Medi-Cal is financed equally by the State and federal government.

[32] California Office of Statewide Health Planning and Development, Hospital Discharge Summary Reports, St. Luke's Hospital, Report Period: January 1, 2009 – June 30, 2009 and Report Period: July 1, 2009 – December 31, 2009; http://www.oshpd.ca.gov/MIRCal/Default.aspx.

[33] California Office of Statewide Health Planning and Development, Hospital Discharge Summary Reports, California Pacific Medical Center - Pacific Campus, Report Period: July 1, 2009 – December 31, 2010 and Report Period: January 1, 2010 – June 30, 2010; http://www.oshpd.ca.gov/MIRCal/Default.aspx.

The proposed Cathedral Hill Hospital (555 beds) would barely accommodate the 594 acute-care services and Women's and Children's Center that would be relocated from the California Campus (299 beds) and the Pacific Campus (295 beds) to the proposed Cathedral Hill. It can be anticipated that few patients currently relying on the 229 beds at the existing St. Luke's Hospital would be accommodated at the new Cathedral Hill Hospital for a number of reasons:

- Not all services that are currently available at St. Luke's Hospital would be available at the Cathedral Hill Hospital, including SNF beds.
- Physicians are free to decide whether they will accept Medi-Cal patients, which constitute a large portion of St. Luke's Hospital patient population. Given the choice between higher-paying private or government insurance, they often deny Medi-Cal patients.
- Beneficiaries of government programs are often not eligible for private single-occupancy room services[34] if multiple-occupancy rooms are available.

As a result, most patients with insurance coverage limitations and relying on the acute care and SNF beds at the existing St. Luke's Hospital would not have access to the services offered by the new Cathedral Hill Hospital and would have to resort to accessing other hospitals in the City, or when those hospitals are overwhelmed as is often the case, in the greater region. Many of the patients currently frequenting St. Luke's Hospital do not have access to personal transportation and would be limited to time-consuming public transportation from the City to elsewhere. This may severely affect their health care.

The shift of the current patient population with insurance coverage limitations from the community-accessible St. Luke's Hospital to other hospitals in the City and region would have a number of adverse effects and consequences. For one, it would increase the regional vehicle miles traveled as patients and visitors would be forced to travel to hospitals that are located further from their homes and out of the City. Emergency service vehicles, forced to transport patients to hospitals located further away, would be tied up longer for transports to emergency departments at other hospitals which, in turn, would put additional pressure on the dispatch capacity at the City and County's Police Department and the Fire Department and increase the average response time and associated adverse consequences on the timely delivery of emergency cases to acute care units.

The increased vehicle miles traveled associated with the longer trips of patient, visitor, and emergency vehicles to and from other hospitals would also increase the regional air pollutant and greenhouse gas emissions and associated adverse impacts on public health. Most importantly, however, the shift of patient populations from the existing St. Luke's Hospital to other hospitals, including government and county-funded community hospitals (*e.g.*, San Francisco General Hospital and Laguna Honda Hospital and Rehabilitation Center) and the loss of an additional 109 acute care beds would put a severe strain on the already severely overtaxed

[34] *See,* for example, the following provisions of the Medicare Claims Processing Manual: Chapter 2: Admission and Registration Requirements, Section 10.6 – Hospitals May Require Payment for Noncovered Services, Revision 1472 dated March 6, 2008, and Chapter 3: Inpatient Hospital Billing, Section 40.2.2 – Charges to Beneficiaries for Part A Services, (I) Private Room Care, Revisions 1609 and 1612 dated October 3, 2008. These rules provide that private room (1-bed patient care room) care is not a Medicare covered service. Thus, private rooms may be denied by a Medicare provider to a beneficiary "who requests it but is unable to prepay or offer the assurance of payment..." (*see* Chapter 2, Section 10.6.)

acute care capacity in the City and County. For example, because the San Francisco General Hospital is the only Level I Trauma Center in a service area of over one million people, the hospital maintains a very high patient volume and is usually on a constant "Total Divert" status, which means that incoming emergency patients (with the exception of trauma, psychiatric, pediatrics, and obstetrics and gynecology) are diverted to other nearby hospitals. In addition, the loss of local access to acute care would result in disproportionate adverse socio-economic impacts on low-income residents who are already faced with a lack of and access to other medical care, child care, transportation, etc. Adding this extra burden of not having local access to community-based acute care would constitute environmental injustice.

The EIR is inadequate because it does not analyze the burden on City services for the services CPMC has already eliminated or would not provide in the future. CPMC has already closed 55% of its psychiatric services (at the Davies Campus) over the course of the past five years and 70% over the past decade, despite a growing need for those same services. From 2000 through 2007, inpatient psychiatric census went up 20% at CPMC, before the closure at Davies Campus.[35] Instead, their psychiatric patients are shifted to other providers. Citywide there is a crisis of inpatient adult psychiatric services. Citywide inpatient psychiatric bed capacity has dropped by 23% since 2000, according to licensing data published by the Office of Statewide Health Planning and Development ("OSHPD"). CPMC is responsible for 63 of the 79 psychiatric beds that have been closed in the City since 2000. This primarily places additional burden on San Francisco General Hospital ("SF General"), but also on St. Francis Memorial Hospital ("St Francis") which is operated by Catholic Health Care West ("CHW"). The City has no data about the need for psychiatric services, let alone psychiatric emergencies, 5150s[36], substance abuse, drug detoxification, etc. and the Draft EIR fails to provide any information how the LRDP would impact the need and supply for these services.

In addition, there are unknown and unexamined additional losses of services at Davies Medical Center. Davies has historically served as a community hospital for the Castro District, and has been home to AIDS and HIV services. The LDRP reduces licensed bed capacity at the Davies Campus substantially and proposes to shift its clinical focus away from community-serving functions to neuroscience services. The DEIR, IMP, and LDRP lack any explanation of what services would be lost at the Davies Campus in order to make way for the new expanded neurosciences program, and specifically any commitments to maintain AIDS/HIV programs. It would be a significant loss of services if AIDS/HIV patients had to travel to new providers because of an erosion of CPMC's commitment as a result of its clinical realignment.

In sum, the DEIR omitted any investigation and disclosure of the direct physical changes and reasonably foreseeable indirect physical changes described above. In addition, it failed to analyze the potentially significant adverse individual and cumulative impacts associated with the physical change of closing the existing hospital facilities and the resulting transfer of a large

[35] *See* attached Letter from Michael Lighty.

[36] Section 5150 is a section of the California Welfare and Institutions Code (specifically, the Lanterman-Petris-Short Act) which allows a qualified officer or clinician to involuntarily confine a person deemed to have a mental disorder that makes them a danger to him or her self, and/or others and/or gravely disabled. A qualified officer, which includes any California peace officer, as well as any specifically designated county clinician, can request the confinement after signing a written declaration. When used as a term, 5150 (pronounced "fifty-one-fifty") can informally refer to the person being confined or to the declaration itself.

portion of the existing patient population to other hospitals. All of this must be included in a revised EIR.

E. The DEIR Must Describe Effective Mitigation Measures for Each Significant Environmental Impact

An EIR must propose and describe mitigation measures sufficient to minimize the identified significant adverse environmental impacts.[37] Also, mitigation measures must be designed to minimize, reduce or avoid an identified environmental impact or to rectify or compensate for that impact.[38] Where several mitigation measures are available to mitigate an impact, each should be discussed and the basis for selecting a particular measure should be explained. [39] The City may not rely on mitigation measures of uncertain efficacy or feasibility.[40] "Feasible" means capable of being accomplished in a successful manner within a reasonable period of time, taking into account economic, environmental, legal, social and technological factors.[41] Mitigation measures must be fully enforceable through permit conditions, agreements or other legally binding instruments. [42] A lead agency may not make the required CEQA findings unless the administrative record clearly shows that all uncertainties regarding the mitigation of significant environmental impacts have been resolved.

Here, the DEIR lacks effective mitigation for impacts associated with site contamination, affordable housing, traffic congestion and public transit, and toxic air emissions. Additional mitigation measures must be included and a full EIR recirculated for public review.

1. The DEIR Lacks Effective Measures to Mitigate Soil and Groundwater Contamination

As shown above, Mr. Hagemann's review of the DEIR and associated documents evidenced widespread risks associated with soil and groundwater contamination affecting all five Project sites. Nevertheless, the DEIR proposed just one mitigation measure for this potentially significant impact. Worse, the fatally vague and unenforceable measure would defer any mitigation to just before commencement of excavation/construction work. Specifically, the DEIR proposed "management protocols based on the site-specific environmental contingency plans once work begins.[43] Not only is this measure completely void of meaningful specificity, it unlawfully defers mitigation to just prior to the time of actual excavation.

CEQA requires the City to fully assess and disclose the extent of the contamination before Project approval, and then propose feasible alternatives and/or measures to mitigate these impacts. In addition, in Mr. Hagemann's opinion, the applicant must immediately engage the City of San Francisco's Public Health Department through a voluntary cleanup application, and

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[37] CEQA sections 21002.1(a), 21100(b)(3).

[38] CEQA Guidelines section 15370.

[39] *Id.* at section 15126.4(a)(1)(B).

[40] *Kings County Farm Bureau v. City of Hanford* (1990) 221 Cal.App.3d 692, 727 (finding groundwater purchase agreement inadequate mitigation measure because no record evidence existed that replacement water was available).

[41] CEQA Guidelines section 15364.

[42] *Id.* at section 15126.4(a)(2).

[43] See M-HZ-N1a, DEIR at page 4.16-43.

disclose that process in a revised EIR. By entering into a voluntary cleanup agreement, the applicant can be assured that assessment and cleanup of the contamination will be sufficient for a regulatory determination that no further action is warranted. This step will also ensure that the clean-up efforts are dealt with well before site excavation, thereby protecting construction workers and nearby residents. Finally, all action required by the SFDPH must be included in a revised EIR along with the results of investigations to address soil and groundwater contaminants. The SFDPH requirements must be included as mitigation measures to ensure the measures are enforceable and actually occur.

2. The DEIR Lacks Effective Measures to Mitigate the Project's Impacts on Affordable Housing

As shown above, the DEIR's impact analysis for Project-related impacts on housing was incomplete and seriously flawed. A revised DEIR that included the impacts described by CNA expert Terrell Watts, would require measures to mitigate significant housing affordability, supply, including jobs-housing balance issues. Generally speaking, a revised EIR must show that CPMC will replace units demolished as a result of construction of the Cathedral Hill campus. In addition, a revised EIR must show that CPMC will provide housing required under the Van Ness Avenue Area Plan and other policies calling for housing on a square footage basis based on commercial development, along with impact fees and other means of generating financing for housing that is affordable for the Project's workforce. Other measures that must be analyzed in a revised EIR include:

- A commitment to build housing for the workforce at one or more of the Project sites. Total units should be based on a nexus study or other detailed study of actual Project-related housing demand and jobs-housing fit analyses.
- A revolving loan fund at no interest toward the building of new affordable units in the Project areas and/or rehabilitation of existing units by community non-profits.
- An additional revolving loan fund at no interest to rehabilitate local area housing with specific attention to leveraging other funding to increase the energy efficiency of these units (thereby saving residents on energy bills and reducing greenhouse gas and air quality emissions).
- Creation of a "Coalition Advisory Committee" (and specialized technical sub-committees on housing, energy efficiency and other issues). Among the considerations of the Committee should be to support local community land trust that would help to provide affordable housing in the Project areas and a rental assistance program for low-income staff and workforce.

3. The DEIR Lack Effective Measures to Mitigate the Project's Impacts on Traffic Congestion and Public Transit

The DEIR identified over 150 traffic impacts associated with the LRDP. For the near term, years 2015 and 2020, the DEIR identified 98 traffic impacts, with 58 of those associated with the Cathedral Hill Campus alone. For the long term, year 2030, the DEIR identified 53 cumulative traffic and transit impacts, with 42 of these associated with the Cathedral Hill Campus alone. The intense development proposed for the Cathedral Hill Campus creates nearly two-thirds of all of the Project's overall impacts to the roadway and transit system. Of the

100 traffic impacts associated with the Cathedral Hill Campus, the DEIR indicated that 30 impacts are significant, unavoidable, and cannot be mitigated. Worse, in Mr. Brohard's expert opinion, the DEIR's estimate of unmitigable impacts is likely low.

For 2015, the DEIR identified the intersections of Van Ness/Market and Polk/Geary as significantly impacted by traffic generated by the Cathedral Hill Campus.[44] For both, the DEIR found that mitigation in terms of increasing vehicular capacity at the intersections was not feasible. Therefore, the DEIR omitted any mitigation measures to reduce Project impacts to less-than-significant levels aside from hoping that CPMC would expand its current transportation demand management program ("TDM") to discourage use of private automobiles. Although this may reduce the number of trips through the intersection, the extent of this program or reduction to impacts is not known, is vague and wholly unenforceable.

CEQA requires that the City impose all feasible alternatives and/or mitigation measures before concluding that traffic impacts are "significant and unavoidable" as it did here. The DEIR must document the geometry of both intersections that the City finds to have significant and unavoidable traffic impacts, then identify the specific traffic measures or alternatives evaluated, and discuss why each of these options cannot feasibly be implemented. Without adding this analysis to a revised EIR for public review, the City may not dismiss the potential mitigation measures as infeasible.

All feasible mitigation measures must also include enhancements to the current CPMC TDM plan. The DEIR acknowledged that "CPMC has indicated that it is planning on expanding its current TDM program..." but offers no specifics or evaluation of potential vehicle trip reductions that could be achieved. Enhancements to the existing CPMC TDM Plan include the following:

- Designating a TDM Coordinator
- Promoting the TDM Program
- Increasing financial incentives to transit use and disincentives to single occupancy vehicle ("SOV") use
- Providing amenities to transit and bicycle users
- Expanding shuttle bus program

The Project's traffic mitigation strategy requires much, much more. Still, at a minimum, the DEIR must evaluate the potential effectiveness of these TDM measures and many others. CPMC must be required to implement necessary additional TDM measures to mitigate traffic impacts considered to be "significant and unavoidable."

4. The DEIR Lacks Effective Measures to Mitigate the Project's Health Impacts Related to Toxic Emissions from Diesel-Powered Construction Equipment

The Project would be built out over a period of 20 years employing a variety of diesel-powered construction equipment such as air compressors, backhoes, cranes, delivery trucks,

[44] DEIR at 4.5-98.

dozers, drill rigs, excavators, generators, fork-lifts, tractors, loaders, rollers, scrapers, water trucks, paving equipment, pile drivers, rollers, etc. In addition, the Project would be constructed concurrently with many other construction projects in the City and the region. During this time, heavy-duty diesel-powered construction equipment would emit considerable amounts of diesel particulate matter, which would travel into nearby residential areas, increase ambient concentrations of this carcinogen, and result in adverse health impacts.

Diesel exhaust emitted from this equipment is a complex mixture of gaseous and solid materials. The visible emissions in diesel exhaust are known as diesel particulate matter ("DPM"), which includes carbon particles or "soot." Diesel exhaust also contains a variety of harmful gases and over 40 other known cancer-causing substances and is estimated to contribute to more than 75% of the added cancer risk from air toxics in the United States. Diesel exhaust has been linked to a range of serious health problems including an increase in respiratory disease, lung damage, cancer, and premature death. Fine diesel particles are deposited deep in the lungs and can result in increased respiratory symptoms and disease; decreased lung function, particularly in children and individuals with asthma; alterations in lung tissue and respiratory tract defense mechanisms; and premature death.[45]

The DEIR acknowledged that diesel particulate matter is a toxic air contaminant and carcinogen. It further acknowledged that lifetime cancer risks for child exposure at all five Project campuses attributable to construction equipment diesel exhaust would greatly exceed the significance threshold of ten in one million adopted by the Bay Area Air Quality Management District ("BAAQMD").[46] To mitigate this significant health risk, the DEIR proposed to implement essentially one mitigation measure to reduce diesel-caused particulate matter:[47]

- Implement Accelerated Emission Control Device Installation on Construction Equipment: To minimize the potential impacts on residents living near the CPMC campuses from the construction activities in that area, CPMC shall make reasonable efforts to ensure that all construction equipment used at these campuses would use equipment that meets the EPA Tier 4 engine standards for particulate matter and NOx control (or equivalent) throughout the entire duration of Construction activities, to the extent that equipment meeting the EPA Tier 4 engine standards is available to the contractor at the time construction activities requiring the use of such equipment occur.[48]

This measure is wholly inadequate because even the DEIR acknowledged that the above measure was unlikely to reduce carcinogenic risks, because it is unknown whether such

[45] California Air Resources Board, Health Effects of Diesel Exhaust; http://www.arb.ca.gov/research/diesel/diesel-health.htm, accessed July 22, 2010; California Air Resources Board, Initial Statement of Reasons for Rulemaking, Proposed Identification of Diesel Exhaust as a Toxic Air Contaminant, Staff Report, June 1998.

[46] The excess lifetime cancer risk due to diesel exhaust emissions during construction of the Cathedral Hill Campus is estimated at 111 in one million. Draft EIR, Table 4.7-14, at page 4.7-67 (the table fails to include "per million"), and Memorandum from Sharon Libicki, Elizabeth Miesner, Michael Keinath, and Jennie Louie, ENVIRON, to Vahram Massehian, Sutter Health, Re: CPMC Construction Health Risk Analysis, July 2, 2010; provided as administrative record PDF file "33 08010089.AQ.ENVIRON.2010."

[47] *See* DEIR pp. 4.7-36 – 4.7-37, M-AQ-N10a, M-AQ-10b, M-AQ-10c, and M-AQ-L10, which are identical to mitigation measure M-AQ-N2 and M-AQ-N9.

[48] Draft EIR at pages 4.7-36 – 4.7-37.

equipment would even be available by Project construction. Worse, the measure is vague and unenforceable because it only requires CPMC to "make reasonable efforts" to mitigate toxic emissions.

A revised EIR must include recently adopted BAAQMD measures that are much more stringent than the above measure for reducing construction equipment exhaust. These include:

- Project plans demonstrating that the off-road equipment (more than 50 horsepower) to be used in the construction project (*i.e.*, owned, leased, and subcontractor vehicles) would achieve a project wide fleet-average 20 percent NOx reduction and 45 percent PM reduction compared to the most recent California Air Resources Board fleet average. Acceptable options for reducing emissions include the use of late model engines, low-emission diesel products, alternative fuels, engine retrofit technology, after-treatment products, add-on devices such as particulate filters, and/or other options as such become available.
- Requiring that all construction equipment, diesel trucks, and generators be equipped with Best Available Control Technology for emission reductions of NOx and PM.
- Requiring all contractors use equipment that meets CARB's most recent certification standard for off-road heavy duty diesel engines.[49]

These mitigation measures are feasible and must be required to reduce the Project's significant health risks associated with diesel particulate matter emissions from construction equipment exhaust.

F. The DEIR Failed to Propose Feasible Mitigation Measures Before Concluding That Numerous Project Impacts Were Unavoidable, Relying Instead Upon A Statement of Overriding Considerations

The DEIR listed 62 significant and unavoidable impacts on traffic congestion; 29 significant and unavoidable impact on air quality and greenhouse gases.[50] These appalling numbers are worsened by the fact that the DEIR omitted any meaningful analysis of mitigation measures studied but rejected on grounds they were infeasible. The public is entitled to know whether the City made any effort to mitigate numerous significant impacts on traffic congestion, air quality and climate.

Under CEQA, a lead agency may not conclude that an impact is significant and unavoidable without requiring the implementation of all feasible mitigation measures to reduce the impact to less than significant levels. [51] If an agency is unable to provide a specific mitigation measure, CEQA requires the articulation of performance criteria at the time of project approval.[52] CEQA Guidelines make clear that a lead agency must make a "fully informed and publicly disclosed" decision that "specifically identified expected benefits from the project

[49] Bay Area Air Quality Management District, California Environmental Quality Act, Air Quality Guidelines, June 2010, Table 8-3, page 8-5.

[50] DEIR at pages 5.1 – 5.7.

[51] CEQA Guidelines sections 15126.4, 15091.

[52] *Sacramento Old City Association v. City Council of Sacramento* (1991) 229 Cal.App.3d 1011, 1028-1029.

outweigh the policy of reducing or avoiding significant environmental impacts of the project."[53] Here the City did no such thing, it simply gave up on taking any steps to curb the nearly 100 significant impacts on traffic, air quality, noise and climate change.

For example, the DEIR concluded that emissions of criteria pollutants associated with operation of the Project's near-term and short-term project components would exceed the daily thresholds of significance for PM10 and would therefore be significant.[54] The DEIR omitted a discussion of the feasibility of *any* mitigation measures whatsoever; instead, it merely stated that "[n]o feasible mitigation is available to reduce this impact to less than significant."[55] However, the DEIR lacked any foundation for this claim, because it failed to identify or evaluate any potential mitigation measures and provide analysis to support its conclusion that no feasible mitigation measures were available. The DEIR then determined that operational criteria pollutant emissions associated with implementation of the Project's near-term and long-term components would result in *significant and unavoidable* impacts on air quality by contributing to or resulting in a violation of air quality standards. This finding and the utter lack of a discussion of the feasibility of any mitigation measures is not acceptable under CEQA.

Similarly critical intersections in the vicinity of the Cathedral Hill Campus currently operate at LOS E or LOS F under existing conditions in one or both peak traffic hours. The DEIR also indicated additional critical intersections in the vicinity of the Cathedral Hill Campus would degrade to LOS E or LOS F in 2015 and in 2030 with the addition of Project traffic. For capacity conditions at LOS E and under gridlock conditions at LOS F, vehicles will be queued back significant distances in all traffic lanes on the approaches to congested signalized intersections. Stopped vehicles will not be able to simply "maneuver out of the path of the emergency vehicle" as the adjacent lanes on the approaches to the gridlocked traffic signals will already be occupied by other vehicles. This is a significant impact for a hospital project and one that must be fully evaluated and mitigated.

Given that the proposed Project is a ***hospital***, with numerous dispatched and private emergency vehicles requiring access each day, the City cannot simply find that these impacts are unavoidable. Instead, in a revised EIR, the City must fully explain and support the DEIR's broad statement that "...the proposed Cathedral Hill Campus project emergency vehicle access impact would be less than significant." A revised EIR must show that the City has analyzed both LOS E and gridlock conditions at LOS F all around the vicinity of the Cathedral Hill Campus and has mitigated these impacts to significantly reduce or eliminate health and safety risks resulting from delays to emergency and labor and delivery vehicles.

G. Cumulative Impacts Are Significant and Unmitigated

An EIR must investigate and disclose all potentially significant "cumulative impacts."[56] Cumulative impacts can result from individually minor but collectively significant projects taking place over a period of time."[57] A legally adequate "cumulative impacts analysis" views a

[53] CEQA Guidelines section 15043(b).

[54] *See* Draft EIR, Table S-2, at pages S-65 and 4.7-41.

[55] Draft EIR at page 4.7-41.

[56] CEQA Guidelines section 15130(a);

[57] *Communities for a Better Environment v. Cal. Resources Agency* (2002) 103 Cal.App.4th 98, 117.

particular project over time and in conjunction with other related past, present, and reasonably foreseeable probable future projects whose impacts might compound or interrelate with those of the project at hand. "Cumulative impacts can result from individually minor but collectively significant projects taking place over a period of time."[58]

As shown above, Sutter intends to eliminate 881 licensed hospital beds in the Bay Area. This planned consolidation across the Bay Area assumes increased transfer of patients between cities. For example, earlier this year a stroke patient in Novato was transferred to CPMC in San Francisco rather than to the nearest stroke center in Greenbrae in Marin County. Traffic burdens, and associated air quality and greenhouse gas emissions, caused by additional patient transports to and from San Francisco as a result of regionalization are not addressed in the DEIR. Impacts resulting from regional transfers present potentially significant unmitigated impacts that must be investigated and disclosed in a revised EIR.

More specifically, Mr. Lighty's letter shows that Sutter eliminated a total of 231 licensed beds at the CPMC campuses: 124 acute care beds, 22 psychiatric care beds, and 101 skilled nursing beds; only the number of rehabilitation beds increased by 16. Now, even though the LRDP would include construction of a brand-new 555-bed hospital at the Cathedral Hill Campus, Sutter proposes to further eliminate another 188 licensed beds: 109 acute care beds and 79 skilled nursing beds.[59] Thus, between the year 2006 and the proposed LRDP at total of 419 licensed beds are removed from service including 233 acute care beds, 22 psychiatric care beds, and 180 skilled nursing beds. And, on November 1, 2010, CPMC will sell its dialysis programs at the Pacific and Davies Campuses.[60]

In addition to the drastic reduction of acute care, psychiatric care and skilled nursing facility ("SNF") beds under the LRDP as shown in **Error! Reference source not found.** Lighty's letter, several other hospitals in the region are or have been reducing their services. The Sutter-affiliate Mills Peninsula recently closed their acute rehabilitation unit in Burlingame, San Mateo County,[61] advising patients to come to acute rehabilitation units at CMPC campuses in the City, specifically the Davies Campus. Sutter also plans on closing the SNF and dialysis unit at the Mills-Peninsula campus[62] and the SNF at the Santa Rosa Hospital. Now, CPMC plans to close the only sub-acute unit in San Francisco, forcing patients and their families to leave San Francisco for care. Combined with the recent closure of the SNF and sub-acute care at the Seton Medical Center in Daly City[63] and reductions at the Laguna Honda Hospital and Rehabilitation Center, the elimination of SNF beds and acute care beds under the LRDP further compounds the existing regional shortage.

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[58] CEQA Guidelines § 15355(b).

[59] Letter from Michael Lighty (Oct. 19, 2010) at page 4.

[60] San Francisco Business Times, CPMC Will Sell Dialysis Unit to DaVita, September 3, 2010; http://www.bizjournals.com/sanfrancisco/stories/2010/09/06/story12.html.

[61] San Mateo Daily Journal, Nurses Oppose Acute Rehab Move, September 24, 2009; http://www.smdailyjournal.com/article_preview.php?type=lnews&id=117024; and San Jose Mercury News, Nurses, Mills-Peninsula Square Off Over Rehab Care in San Mateo County, September 23, 2009.

[62] San Francisco Business Times, Mills-Peninsula Taking Scalpel to Money-Losers, October 15, 2010; http://www.bizjournals.com/sanfrancisco/stories/2010/10/18/story3.html?b=1287374400%255E4103181 *or* http://snipurl.com/1bdg6v [www_bizjournals_com].

[63] Silicon Valley Mercury News, Seton Medical Center to Close Skilled-Nursing Unit, October 7, 2010; http://www.mercurynews.com/ci_16283420?source=most_emailed.

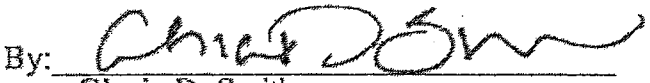
In San Francisco, the proposed closure of the SNF at the St. Luke's Hospital in addition to the recent reductions in SNF beds at the California Campus in 2009/2010 represents an 83% reduction in CPMC's SNF bed capacity. SNF is the state licensing category for nursing homes, but historically a number of hospitals have opened licensed SNFs for patients who were too sick to be transferred to free-standing nursing homes. The only additional SNF services planned in San Francisco are 22 extra SNF beds part of the proposed rebuild of the Chinese Hospital. Patients will be put at risk if the patient population currently treated by the 178 historically offered by CPMC is simply placed in lower-level care SNFs. Worse still, if the need for SNFs is not met, these patients will need to be shipped out of San Francisco. SNF patients tend to have stays from three days to several weeks, which will result in multiple additional trips by their family members out of the City to visit them.

The CPMC LRDP is part of Sutter's business plan for the Bay Area and must be analyzed in the context of the cumulative effects of those plans. This includes: transfer of stroke patients from the Novato Community Hospital in Marin County to CPMC; transfer of sub-acute patients and psychiatric patients out of San Francisco; transfer of SNF patients out of San Francisco; transfer of pediatric and acute rehabilitation patients into San Francisco from San Mateo County; and potential closure of the San Leandro Hospital. The DEIR fails entirely to analyze those cumulative impacts.

III. CONCLUSION

The City's DEIR failed to satisfy CEQA's fundamental mandate of informing the public and decision makers of the potentially significant environmental impacts of a proposed project, and imposing all feasible alternatives and measures to mitigate those impacts to less than significant. This is especially true here given the myriad of undisclosed and unmitigated impacts, City-wide and regionally, this hopelessly confusing DEIR presented. The DEIR must be revised to address the deficiencies described herein and in the attached documents and re-circulated for public review.

LAW OFFICES OF GLORIA D. SMITH

By: 
Gloria D. Smith

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Tom Brohard and Associates

March 8, 2011

Ms. Gloria Smith
The Law Offices of Gloria D. Smith
48 Rosemont Place
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SUBJECT: California Pacific Medical Center – Transportation/Circulation Impact Comparison between Alternative 3A and the LRDP Project

Dear Ms. Smith:

At your request, I am providing additional comments on the Transportation and Circulation Section of the Draft Environmental Impact Report (Draft EIR) for the California Pacific Medical Center (CPMC) Long Range Development Plan (LRDP Project) which was published by the San Francisco Planning Department in July 2010. My prior comments, submitted on October 18, 2010, focused on an analysis of Section 4.5 of the Draft EIR which deals with transportation and circulation impacts associated with buildout under the proposed LRDP Project. These additional comments analyze transportation and circulation impacts of the LRDP Project for the Cathedral Hill and the St. Luke's Campuses compared to those that would be associated with Alternative 3A.

These comments do not necessarily endorse all aspects of Alternative 3A. Instead, approval of Cathedral Hill and St. Luke's hospitals roughly the size of those described in Alternative 3A would significantly reduce the overall Project-related traffic impacts described in my October 18, 2010 letter.

As described in Section 6 of the Draft EIR, the size of the proposed Cathedral Hill Hospital and associated parking would be reduced under Alternative 3 compared to full buildout under the LRDP because the Women's and Children's Center would be relocated to the St. Luke's Campus. Under Alternative 3A, the Cathedral Hill Campus would provide a total of 400 beds and the St. Lukes Campus would provide 240 beds including the 160 beds for the relocated Women's and Children's Center. Significantly, this alternative reduces traffic congestion City-wide because two more equally sized hospitals would distribute services among two campuses instead of concentrating much of CPMC's resources at one site.

Page 6-403 of the Draft EIR concludes that "Alternative 3A would be the environmentally superior alternative other than the No Project Alternative." I concur with the Draft EIR's conclusion that "Alternative 3A would reduce some of the significant and unavoidable impacts on transportation and circulation identified under the proposed LRDP" and that buildout under Alternative 3A would not result in any additional transportation and circulation impacts near the St. Lukes Campus. As such, Alternative 3A is the preferred alternative for transportation and circulation.

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Ms. Gloria Smith
CPMC Transportation/Circulation Comparison of Alternative 3A and LRDP
March 8, 2011

Transportation and Circulation Impact Comparison between Alternative 3A and the LRDP Project

According to Section 6 of the Draft EIR, Alternative 3A would cause no additional significant impacts regarding transportation and circulation. Instead, it listed the following **benefits** for Alternative 3A compared to buildout under the LRDP:

Traffic Impacts

- Reduces development at the Cathedral Hill Campus in Years 2015 and 2030, thereby eliminating the significant unavoidable traffic impacts at Van Ness Avenue at Market Street.
- Avoids construction of the Two-Way Post Street Variant and the Medical Office Building (MOB) Access Variant, thereby eliminating significant unavoidable impacts at Van Ness Avenue at Market Street, Polk Street at Geary Street, and Franklin Street at Bush Street.
- Reduces vehicle delays at other intersections near Cathedral Hill Campus.

Transit Impacts

- Adds 314 fewer AM and 258 fewer PM peak hour transit trips, about half of the net-new transit trips forecast for the LRDP Project.
- Decreases demand for the CPMC shuttle service with reduced development.
- Reduces impacts to Muni transit services with reduced development.

Pedestrian Impacts

- Eliminates the significant and unavoidable pedestrian conflict impact under the LRDP Project MOB Access Variant at the proposed Cathedral Hill MOB driveway on Geary Street.
- Adds 369 fewer AM and 303 fewer PM peak hour pedestrian trips, about half of the net-new pedestrian trips forecast for the LRDP Project.

Construction Impacts

- Shortens the construction duration because of the reduced size of the Cathedral Hill Hospital under Alternative 3A.

Parking Impacts

- Eliminates peak-period queues and spillbacks from traffic entering parking garages that would block traffic lanes on adjacent streets at the entrances to the three parking garages at the Cathedral Hill Campus.

Clearly, a number of the significant transportation and circulation impacts that would occur under the LRDP can be avoided with implementation of Alternative 3A without incurring penalties elsewhere. Six significant and unavoidable traffic impacts at three

intersections in the vicinity of the Cathedral Hill Campus would be eliminated. Also, the significant and unavoidable pedestrian conflict impact at the Cathedral Hill MOB driveway on Geary Street would be avoided under Alternative 3A because the MOB Access Variant would not be required. At the same time, the corresponding increase of 160 beds at the St. Luke's Campus would not result in any additional significant unavoidable traffic impacts. In other words, Alternative 3A, which would relocate the Women's and Children's Center from Cathedral Hill Campus to St. Luke's Campus, is by far the environmentally superior alternative with respect to traffic and circulation.

Many of the intersections in the vicinity of the proposed Cathedral Hill Campus are already failing during peak traffic hours as there is more vehicle demand than capacity available. These intersections currently operate at Level of Service (LOS) "F", the lowest performance measurement of efficiency. Under LOS "F" conditions, flow is forced and each vehicle moves in lockstep with the vehicle in front of it, with frequent slowing and stopping required. The number of these failing intersections will significantly increase in future years. Adding LRDP trips to these failing intersections will increase vehicle delay and gridlock beyond what is already being experienced, with no relief in sight.

Transportation gridlock is particularly critical for a hospital project. Access for ambulances and for labor and delivery vehicles to the proposed Cathedral Hill Campus will be adversely impacted by the severe congestion. Intersections and roadways near the Cathedral Hill Campus, located in a high-density neighborhood at the intersection of two major traffic corridors, already experience heavy use, congestion and lengthy delays. Adding hospital patients and employees concentrated at one very large hospital campus, rather than spreading medical services across several campuses, would present unnecessary health risks for patients stuck in traffic on Van Ness Avenue trying to reach the emergency room or labor and delivery. Excessive delays for patients requiring immediate care could be a daily event during rush hour, and potentially worse in the event of an accident, routine construction, or other disruption. Such circumstances pose unacceptable and avoidable health and safety risks and should have been examined in the Draft EIR.

My prior analysis recommended spreading the proposed development to several other campuses including to the St. Luke's Campus rather than concentrating services at the Cathedral Hill Campus. Access to and from St. Luke's is closer to Highway 101 for vehicles and to major transit facilities such as the 24th Street BART Station for transit patrons. Moreover, the St. Luke's Campus is the most accessible CPMC facility for those Sutter patients traveling from San Mateo and Santa Clara counties.

In my opinion, the City could eliminate all significant, Project-related traffic impacts near the Cathedral Hill Campus. With proper planning, the Cathedral Hill Campus could generate the same number of PM peak hour vehicle trips as that of the former hotel and office uses, thus avoiding the LRDP Project's projection of generating three times more PM peak hour vehicle trips than these former uses. For this to occur, the City would approve a new Cathedral Hill hospital one third the size of that proposed in the LRDP. In

addition, my analysis indicates reducing development at the Cathedral Hill Campus by two thirds would also eliminate the significant transit impacts that will occur with the LRDP Project. A size reduction on this order would eliminate many of the traffic-related safety concerns expressed here and by others commenting on the Draft EIR.

From a transportation perspective, CPMC should spread the proposed LRDP development away from the Cathedral Hill Campus to several other CPMC facilities including the St. Luke's Campus. In my opinion, this would better serve the entire City and could be accomplished in a manner that would minimize any significant transportation impacts near other campuses. A Project alternative that distributes patients and services more equally across the City should be evaluated in a revised EIR.

Should you have any questions regarding these findings, please contact me at your convenience.

Respectfully submitted,

Tom Brohard and Associates

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March 8, 2011

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Dear Ms. Smith:

RE: Additional Comments on the Land Use Aspects of the proposed CPMC LRDP

This letter provides additional comments on the land use aspects of the California Pacific Medical Center (CPMC) Long Range Development Plan (LRDP) published by the San Francisco Planning Department in July 2010. My prior comments, submitted on October 18, 2010, focused on land use impacts associated with the entire CPMC DEIR. These additional comments analyze the LRDP's land use impacts for the Cathedral Hill and the St. Luke's Campuses compared to those that would be associated with Alternative 3A. As shown below, the DEIR's Alternative 3A is not only the environmentally superior alternative; it is the only alternative that can conform to the City's existing planning framework. Specifically, the overarching planning principles under the City's Proposition M in combination with the San Francisco General Plan support a shift of beds to St. Luke's and making it a clinical anchor, while reducing the size of the Cathedral Hill campus. Table 1 at the end of this letter summarizes the impact and policy reasons supporting such an alternative.

I. The San Francisco General Plan Supports a Larger St. Luke's Hospital and A Correspondingly Smaller Cathedral Hill Campus

As explained in my comments of October 18, 2010, the proposed Cathedral Hill campus is indisputably inconsistent with San Francisco's General Plan and the applicable Van Ness Avenue Area Plan (VNAP). These plans, along with the other elements of the General Plan, provide a clear and strong vision for the Van Ness Corridor both in terms of uses and scale. Specifically, the plans call for a mix of residential and supportive commercial uses that are appropriately scaled for the Corridor. That vision has been and continues to be successfully implemented as evidenced by the existing and emerging mix of residential and supportive commercial uses. The proposed Cathedral Hill campus would be a huge departure in both use and scale from the vision set forth in these plans.

The DEIR proposed a major General Plan Amendment to address inconsistencies between the proposed Cathedral Hill campus and the VNAP. The proposed amendment would carve out a new

Subarea 4. The "Van Ness Subarea 4 Medical Use Subdistrict" would encompass both the Cathedral Hill hospital and associated Medical Office Building ("MOB"). Such a carve-out for a new sub-area would create an incompatible "island" in the middle of the Van Ness Corridor, and would both overwhelm and destroy the fabric of the diverse and thriving Polk Street and Tenderloin neighborhoods. These adjacent neighborhoods have longstanding and vibrant mixed uses, diverse residents, and distinct small businesses. A carve out for the massive Cathedral Hill would put tremendous pressure on these neighborhoods to convert existing smaller, more pedestrian friendly services, affordable housing and small scale employment opportunities to uses that cater to the new hospital and MOB. In contrast, the neighborhood surrounding St. Luke's hospital has evolved with the hospital, thus a facility along the lines of Alternative 3A that would be reconstructed and located on the existing footprint, would present far fewer land use impacts.

The City may decide to amend the General Plan; however, any land use inconsistencies proposed by the LRDP must be resolved according to the following Proposition M guiding principles:

- That existing neighborhood-serving retail uses be preserved and enhanced and future opportunities for resident employment in and ownership of such businesses be enhanced;
- That existing housing and neighborhood character be conserved and protected in order to preserve the cultural and economic diversity of our neighborhoods;
- That the City's supply of affordable housing be preserved and enhanced;
- That commuter traffic not impede Muni transit services or overburden our streets or neighborhood parking.

The proposed Cathedral Hill Campus' uses, sheer scale and resulting elimination of both existing and required housing would be irreconcilably inconsistent with Proposition M's current policies. In addition, the 2009 General Plan Housing element includes a number of policies for the Van Ness corridor that give preeminence to mixed use and housing. For example:

- Implementation 1.6: The Planning Department will continue to implement the Van Ness Avenue Plan which requires residential units over commercial uses.

- Implementation 2.1: The City will continue to implement the Proposition M policy that requires that existing housing and neighborhood character be conserved and protected in order to preserve the cultural and economic diversity of neighborhoods.

- Policy 2.5: Preserve the existing stock of residential hotels. Residential or single-room occupancy hotels (SRO's) represent a unique and often irreplaceable resource for thousands of lower income elderly, disabled, and single-person households. Most of these hotels are close to downtown and have been subject to strong economic pressures that led to conversion or demolition...The retention of remaining units of housing permanent residents should be supported.

Contrary to these and other policies articulated for the Corridor in the Housing Element and other applicable plans, the proposed Cathedral Hill campus would remove existing housing and SRO rooms, and eliminate the potential for future housing on the campus sites as envisioned by the plans.

Finally, the proposed Cathedral Hill campus is clearly inconsistent with the already in place VNAP, because the VNAP encourages high-density mixed use development over a large scale hospital and MOB. Likewise, VNAP contains strong provisions for the preservation of existing housing resources and mixed uses. According to the DEIR, major amendments would be needed to bring the project into conformance with the City's General Plan VNAP, Planning Code – VNSUD, zoning. These amendments would create internal inconsistencies within the General Plan and create vertical inconsistencies with the code.

In comparison, St. Luke's is an existing medical facility which would be replaced by a new campus within the existing footprint. As such it is a superior location for additional beds and a clinical anchor. Amendments are necessary only to accommodate the proposed scale of the facilities and street configuration.

II. A Smaller Cathedral Hill Campus is Essential for Neighborhood Compatibility

The proposed Cathedral Hill Campus would be located is an area that is bustling with activity and composed mainly of a mix of residential and commercial uses. The area is a focal point for high-density mixed use development because of its central location within the jurisdiction of the Van Ness Avenue Area Plan (VNAP) and the associated Van Ness Special Use District (VNSUD) (Planning Code Section 243). For this reason, the General and Area plans and supporting codes (VNSUD) have strong, interwoven and internally consistent policy guidance for mixed use including residential, neighborhood commercial services and retention of affordable housing and businesses. Because of the strong and focused policies, the Corridor has evolved into a model for vibrant, walkable mixed use development.

Amendments to these plans and codes to allow an oversized, 555-bed medical center will destabilize the fabric of this area and adjacent areas such as the Tenderloin. Existing policies have already directed the retention of existing businesses, jobs, and residential and single-room occupancy hotels (SRO's), which represent unique and often irreplaceable resources that are subject to strong economic pressures that often lead to conversion or demolition.

III. Feasible Solution for Traffic and Housing Issues and Impacts

The City has a viable means of avoiding the above described land use impacts as well as reconciling some of the major policy inconsistencies. By simply shifting beds and services from Cathedral Hill to the St. Luke's campus, the City could create two equitably sized campuses that would greatly eliminate traffic and land use conflicts.

Under the DEIR's preferred alternative, the Van Ness Corridor will be subject to significant and avoidable traffic and housing related impacts. Many intersections along the Corridor in the vicinity of the proposed Project already operate at LOS F in peak hours and under existing conditions and the number will significantly increase in future years. Moreover, regional trips and associated air quality impacts will result from shifting the current population from the community accessible St. Luke's to the Cathedral Hill campus. Contrary to City policy, the Cathedral Hill campus will result in direct impacts to housing by requiring the demolition of five dwelling units and 20 residential hotels on MOB site. In addition, the Cathedral Hill MOB will result in the loss of "future" housing units which are currently required under existing plans and zoning requirements. The loss of housing presents both environmental impacts and policy inconsistencies. Downsizing the Cathedral Hill campus and shifting beds and services to the St.

Luke's campus will result in less severe transportation impacts to the Van Ness Corridor and, depending on the configuration of the downsized campus, could also result in fewer housing impacts. The St. Luke's campus already has close access to and from Highway 101 for vehicles, and to easy access to BART, making it the most accessible campus for regional patients. A smaller Cathedral Hill campus and larger St. Luke's is a feasible solution for both housing and traffic impacts associated with the proposed Cathedral Hill campus.

IV. Conclusion

The DEIR's Alternative 3A is not only the environmentally superior alternative; it is the only alternative that can conform to the City's existing planning framework. The Cathedral Hill campus requires a major departure from the planning vision for the Van Ness Corridor; a departure that will impact existing and future uses and result in irreconcilable inconsistencies in planning policies and codes. The overarching planning principles under the City's Proposition M in combination with the San Francisco General Plan support a shift of beds to St. Luke's and making it a clinical anchor, while reducing the size of the Cathedral Hill campus.

Sincerely,

Terry Watt

Terry Watt, AICP

Table 1
Summary of Issues/Impacts and Solutions

Issue/Impact	Cathedral Hill ("CH")	Solution	St. Luke's	Solution
Proposition M The following Priority Policies are hereby established [by Proposition M, Nov. 4, 1986]. They shall be included in the preamble to the General Plan and shall be the basis upon which inconsistencies in the General Plan area resolved: 1. Preservation and enhancement of neighborhood retail uses and future opportunities for resident employment in and ownership of such businesses; 2. Protection of the	CH campus is inconsistent with at least four principles of Proposition M. By eliminating existing housing and putting pressure on the neighborhood and adjacent neighborhoods (e.g. Lower Polk and Tenderloin in particular), for conversion. The project as proposed is inconsistent with these provisions.	Downsize CH Campus.	Consistent with and supportive of Proposition M principles.	Increasing beds and adding a clinical anchor at St. Luke's will increase the probability for project success and both preserve jobs and create opportunities for resident employment.

existing neighborhood character. 3. Preservation and enhancement of affordable housing; 4. Discouragement of commuter traffic.				
Land Use Compatibility	Project as proposed is incompatible with existing land uses in the immediate and adjacent neighborhoods.	Downsize CH project by a minimum of 400 beds and include mitigation measures protective of existing neighborhood businesses and housing.	The campus would be developed within the existing footprint.	Increasing beds by up to 240 (Alt. 3A) would be consistent with existing use and can be designed to be compatible with the neighborhood.
Planning Consistency	Inconsistent with overarching policy framework of the General Plan which provides strong policy and implementation provisions to encourage housing and mixed uses. Specifically the Housing Element, Area Plan and Special Use District which call for mixed use and appropriate scale for the Van Ness Corridor. Specifically, the sites for the hospital and MOB are located in a RC-4 residential-commercial, High Density zoning district, which encourages a mixture of high-density dwellings with supporting commercial uses.	Downsize the CH project and include housing (either in-lieu or by protecting housing on MOB site)	The project requires general plan amendments for height and street vacation, but is consistent with the existing land use. The campus is not within the Mission Area Plan. Like CH campus, the site is zoned for RH-2, but the project is a replacement of the existing medical campus on the existing footprint.	

	Inconsistent with code requirements related to height,			
Housing	Would have a direct impact by requiring the demolition of five dwelling units and 20 residential hotels on MOB site. In addition, would result in the loss of housing units that are required under current plans and zoning for a development on the campus sites.	Downsize the CH project to eliminate loss of some housing and include housing in the project (either built or in-lieu fees).	Would not impact housing.	None needed.
Traffic	Significant traffic impacts will occur as a result of the project. Many intersections already operate at LOS F in peak hours and under existing conditions and the number will significantly increase in future years. Moreover, regional trips and associated AQ impacts will result from shifting the current population from the community accessible St. Luke's to CH campus.	Downsize CH campus and shift the proposed development to other campuses where transportation impacts would not be as severe.	Regional trips will increase as a result of the shift of current patients from St. Luke's to other hospitals in the City and region.	Increase St. Luke's campus which has access to and from 101 for vehicles and to BART. Moreover, it is the most accessible for regional patients.

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October 18, 2010

Gloria D. Smith
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Subject: Comments on the California Pacific Medical Center Long Range Development Plan

Dear Ms. Smith:

I have reviewed the July 21, 2010 California Pacific Medical Center (CPMC) Long Range Development Plan Draft Environmental Impact Report (DEIR) for issues associated with hazardous substances and hazardous waste. I have identified a number of areas where the DEIR fails to adequately disclose potential contaminants in soil and groundwater and fails to address known contamination through remediation and mitigation measures. Instead, the DEIR defers further assessment and remediation, i.e. removal of contaminated soils, until construction has begun, despite knowing of the presence of contaminants for at least two years. The DEIR also fails to document any communication with regulatory agencies in an attempt to address the known and suspected contaminants prior to construction. Failure to engage regulators may delay construction if contamination is found upon excavation that would require regulatory oversight of cleanup because of potential harm to construction workers and neighboring residents. Because the construction is to be undertaken in a densely populated area, the risk to neighboring residents is a potentially significant issue that needs to be addressed in a revised EIR.

The CPMC Long Range Development Plan provides for a 20 year development strategy to meet State seismic safety requirements for hospitals and to develop a master plan for its four existing medical campuses:

- Pacific Campus at Sacramento and Buchanan Streets;

- California Campus at Maple and California Streets;
- Davies Campus at Castro and 14th Streets; and
- St. Luke's Campus at Cesar Chavez and Valencia Streets.

A new medical campus (Cathedral Hill) is proposed at Van Ness Avenue and Geary Boulevard for completion by 2015. To construct the new campus, CPMC would demolish the existing Cathedral Hill Hotel and 1255 Post Street Office Building and construct the proposed new Cathedral Hill Hospital, a 15-story, 555-bed hospital at the northwest intersection of Van Ness Avenue and Geary Boulevard. In addition, a nine-story medical office building would be constructed at the northeast intersection of Van Ness Avenue and Geary Street. Implementation of the Long Range Development Plan at Pacific Campus would result in the decommissioning of an existing nine-story hospital building and its renovation and conversion to a ambulatory care center (ACC), construction of a new nine-story ACC building addition and new structured parking, and renovation of other existing buildings at this campus.

New development at Davies Campus would include the construction of a new four-story Neuroscience Institute building at the corner of Noe Street and Duboce Avenue, currently occupied by a 206-space surface parking lot. A new three-story Castro/14th Street MOB (and related parking improvements) would also be developed at Davies Campus after demolition of the existing on-site 290-space structured parking garage, currently located at the corner of 14th and Castro Streets.

Development at St. Luke's Campus would include construction of a new five-story, 80-bed, acute-care replacement hospital at the site of the existing 3615 Cesar Chavez Street Surface Parking Lot, and demolition of the existing 1970's St. Luke's Hospital tower and construction of a five-story MOB/Expansion Building (and related parking improvements) on this former hospital site.

In my experience in the review of over three-dozen DEIRs for hazardous waste issues over the past seven years, I have never seen such poor disclosure of potential contamination issues. Because of the poor disclosure and because further investigation of the contamination is deferred, construction workers may be at risk during excavation of soil. The failure of the applicant to disclose these issues is made even more significant by the massive scale of this development in a densely populated urban environment which may put neighboring residents at risk during construction. The public, who has the potential to be directly affected by cleanup activities when dusts and vapors may be generated, has the right to review a DEIR that adequately discloses contamination issues that have been vetted with regulatory agencies and that have been addressed by remediation and mitigation prior to excavation.

Hazardous Substances Issues

To assess potential environmental contamination issues, the applicant commissioned the preparation of a number of Phase I and Phase II Environmental Site Assessments (ESAs) as summarized in the DEIR in Section 4.16, Hazards and Hazardous Materials.

The purpose of the ESAs was to:

> identify recognized environmental conditions (RECs) at the Site to assist CPMC in supplying information to the City and County of San Francisco for their use in preparing sections of an Environmental Impact Report (EIR) for the Long Range Plan. **A REC is the presence or likely presence of any hazardous substances or petroleum products on a property under conditions that indicate an existing release, a past release, or a material threat of a release of any hazardous substances or petroleum products into structures on the property or into the ground, groundwater, or surface water of the property.**[1]

This definition is consistent with the American Society for Testing and Materials' (ASTM) definition of a REC, an organization that develops and publishes voluntary consensus technical standards.[2] The DEIR also states (DEIR, p. 4.16-2):

> The ESAs also identify other known and potential environmental conditions that do not meet the definition of a REC.

As discussed below, the findings of "potential environmental conditions" or "potential recognized environmental conditions"(the actual term used in the Phase I ESAs)is inconsistent with ASTM guidance and is unnecessarily confusing There is no middle ground or hedging: the presence or the potential presence of hazardous substances or a material threat of a hazardous substance release into the environment constitutes a recognized environmental condition according to the ASTM definition. There is no ASTM definition for a "potential recognized environmental condition," the finding made numerous times in the Phase Is reports and repeated in the DEIR. (see for example, p. 4.16-10 of the DEIR where "two hydraulic elevators and demolished residential structures represent potential RECs.")

The ASTM does define the term "potential environmental concern" for but the tem only applies to property transactions made with limited environmental due diligence, using a process that is

[1]See for example, August 20, 2009 Phase I Environmental Site Assessment Saint Luke's Campus Tower Area, p. 1
[2]http://www.astm.org/Standards/E1527.htm

not a rigorous as conducting a Phase I ESA.[3] Thus that term is not appropriate here. The ASTM definition for potential environmental concern is as follows:

> the possible presence of any hazardous substances or petroleum products on a property under conditions that indicate the possibility of an existing release, a past release, or a threat of a release into structures on the property. or into the ground, ground water, or surface water of the property.[4]

The finding of a "potential environmental concern" may be an impetus for additional inquiry. ASTM states, "Upon completing the *transaction screen questionnaire*, if the *user* concludes that further inquiry or action is needed (for example, consult with an environmental consultant, contractor, governmental authority, or perform additional governmental and/or historical records review)," the user should proceed with such inquiry.[5] Such an inquiry would be the conduct of a Phase I and a Phase II ESA, as appropriate.

Therefore for this project, a finding of a "potential recognized environmental condition" is double speak and is inconsistent with ASTM definitions. Per standard practice, as set forth in ASTM guidance, where RECs are documented in a Phase I, further full investigation is warranted to assess the potential for subsurface contamination, and the need for mitigation and/or remediation. The additional investigations involve the collection of soil and groundwater samples in what are called Phase II ESAs. Here where the applicant found "potential recognized environmental conditions" during the CPMC Phase Is, it did not require further Phase II investigations through soil or groundwater sampling. Therefore, the findings of potential RECs constitute inadequate disclosure and are unresolved environmental issues that warrant further investigations.

To resolve the findings of the potential RECs, the San Francisco Department of Public Health (SFDPH), the local agency which oversees subsurface soil and water contamination of this type, should be engaged to review the Phase I and the Phase II reports. There is no indication that, to date, the SFDPH has reviewed the findings of any of the Phase Is. The SFDPH must independently assess whether further action is necessary to protect public health during excavation, grading, and transportation of contaminated soil and groundwater.

The Phase I and Phase II reports were completed over a seven-year period beginning in 2003. Therefore the applicant has had ample time to submit the reports to SFDPH for review, under a voluntary cleanup agreement. Instead, the applicant included the reports in the DEIR without regulatory review and, as a result, I consider the status of the conditions described, including

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[4] http://www.astm.org/BOOKSTORE/COMPS/136.htm
[5] http://www.edrnet.com/reports/whitepapers/e1528whitepaper.pdf

soil and groundwater contamination, to be without resolution and therefore inadequately disclosed. Moreover, the DEIR did not adequately describe the Project's environmental conditions accurately or adequately. A revised DEIR must eliminate confusing terms such as "potentially recognized" so that reviewers can assess the Project's true impacts.

Contaminants documented and suspected in soil in the Project area include petroleum hydrocarbons, lead, and dry cleaning solvents, such as trichloroethylene (TCE). Health effects of lead include[6]:

> Long-term exposure of adults can result in decreased performance in some tests that measure functions of the nervous system. It may also cause weakness in fingers, wrists, or ankles. Lead exposure also causes small increases in blood pressure, particularly in middle-aged and older people and can cause anemia. Exposure to high lead levels can severely damage the brain and kidneys in adults or children and ultimately cause death. In pregnant women, high levels of exposure to lead may cause miscarriage. High level exposure in men can damage the organs responsible for sperm production.

Health effects for petroleum hydrocarbons include[7]:

> Some of the TPH compounds can affect your central nervous system. One compound can cause headaches and dizziness at high levels in the air. Another compound can cause a nerve disorder called "peripheral neuropathy," consisting of numbness in the feet and legs. Other TPH compounds can cause effects on the blood, immune system, lungs, skin, and eyes. Animal studies have shown effects on the lungs, central nervous system, liver, and kidney from exposure to TPH compounds. Some TPH compounds have also been shown to affect reproduction and the developing fetus in animals.

Health effects of TCE include[8]:

> Breathing small amounts may cause headaches, lung irritation, dizziness, poor coordination, and difficulty concentrating. Breathing large amounts of trichloroethylene may cause impaired heart function, unconsciousness, and death. Breathing it for long periods may cause nerve, kidney, and liver damage. Drinking large amounts of trichloroethylene may cause nausea, liver damage, unconsciousness, impaired heart function, or death. Drinking small amounts of trichloroethylene for long periods may cause liver and kidney damage, impaired immune system function, and impaired fetal development in pregnant women, although the extent of some of these effects is not yet clear. Skin contact with trichloroethylene for short periods may cause skin

[6] http://www.atsdr.cdc.gov/toxfaqs/tf.asp?id=93&tid=22
[7] http://www.atsdr.cdc.gov/toxfaqs/tf.asp?id=423&tid=75
[8] http://www.atsdr.cdc.gov/toxfaqs/tf.asp?id=172&tid=30

rashes. The International Agency for Research on Cancer (IARC) has determined that trichloroethylene is "probably carcinogenic to humans."

Exposure to the known and suspected contaminants in the Project area may result in significant health impacts to construction workers who may come into dermal contact with soils or who may breathe dusts. Exposure to known and suspected contaminants may also occur when those who live close to the site, or those who live along transportation routes, breathe contaminated dust.

Pacific Campus

The applicant prepared a total of 10 Phase I ESAs for individual buildings at the eight parcels of the Pacific Campus. A summary of the Phase I findings is presented below where, in my opinion, there is the potential for environmental contamination that was not adequately addressed in the Phase I investigations.

2323 Sacramento

A January 17, 2008 Phase I[9] found two hydraulic piston-driven elevators to be located in buildings at the Site. The Phase I stated (p. 3):

> The presence of these hydraulic elevators represents a potential that petroleum hydrocarbons may have been released to the soil. However, because they do not indicate a release or imminent threat of release, they do not qualify as a recognized environmental condition.

This statement is in consistent with the ASTM definition of a REC which states that a "material threat of a release of any hazardous substances or petroleum products into structures on the property or into the ground, groundwater, or surface water of the property" constitutes a REC.[10]The Phase I also found the potential for a REC to be associated with artificial fill which may be present under the Site and which may contain residual chemicals (p. 3).

The Phase I only provides for a plan to address contamination upon development in stating (p. 3):

> Prior to redevelopment, we recommend that an Environmental Contingency Plan be prepared to describe procedures to be followed in the event environmental issues are

[9]California Pacific Medical Center, 2008 (January 17). *Phase I Environmental Site Assessment (Updated and Revised), Pacific Hospital,2333 Buchanan Street, California.* San Francisco, CA. Prepared by Treadwell & Rollo, Inc., San Francisco, CA.

[10]See for example, August 20, 2009 Phase I Environmental Site Assessment Saint Luke's Campus Tower Area, p. 1

encountered during excavation activities (i.e., discolored soil, lead based materials, or potential hazardous material releases in soil or groundwater).

In my opinion, the finding in the Phase I -- that the hydraulic elevators represent a potential for petroleum hydrocarbons to have been released to the soil -- is a REC. The finding of a "potential recognized environmental condition" in the Phase I is inconsistent with recognized definitions such as that of ASTM.

According to ASTM guidance, a finding of a REC typically results in the conduct of a Phase II investigation, to include the collection of soil samples, to further investigate the Phase I findings.[11]

Recommendation: A Phase II subsurface investigation must be conducted to investigate the potential for soil and groundwater contamination associated with the two "potential recognized environmental concerns," the two hydraulic elevators at the site and possible artificial fill. In our experience, we are aware of other sites where the project EIRs analyzed impacts associated with hydraulic elevators and required a sampling investigation along with a regulatory letter of closure.[12]That is the proper protocol for this type of environmental hazard.

2405 Clay Street

A Phase I for the Site was completed on August 10, 2006.[13] The Phase I found three "potential recognized environmental conditions" (Phase I, p. 3):

- the former presence of a laundry facility;
- the former presence of the carpentry and machine shop (including a paint spray booth); and
- potential artificial fill.

According to the Phase I, two former businesses may have released chemicals to the soil or groundwater as follows (Phase I, p. 2):

> • A laundry was operated in the eastern part of the Site from prior to 1913 until sometime after 1929. It was not determined during this ESA whether dry cleaning was performed at this facility, or whether dry-cleaning solvents may have been released to

[11] http://en.wikipedia.org/wiki/Phase_I_Environmental_Site_Assessment

[12] http://www.wlac.edu/DEIR/Chapter%203%20Environmental%20Setting,Impacts%20and%20Mitigation.pdf

[13] California Pacific Medical Center. 2006 (August 10). *Phase I Environmental Site Assessment, Clay-Webster Parking Garage, 2405 Clay Street, San Francisco, California*. San Francisco, CA. Prepared by Treadwell & Rollo, Inc., San Francisco, CA.

the soil or groundwater at the Site. Therefore, this former Site use constitutes a potential recognized environmental condition.

• A carpentry and machine shop, with a paint spray booth, were operated on the Site from prior to 1950 until after 1970. It was not determined during this ESA whether lubricants, paints, solvents, or heavy metals were released to the soil or groundwater at the Site. Therefore, this former use constitutes a potential recognized environmental condition

In response to the so-called "potential recognized environmental conditions," the Phase I proposed that an environmental contingency plan be prepared to describe procedures to evaluate and address environmental issues encountered during excavation activities (i.e., discolored soil, lead based materials, or potential hazardous material releases in soil or groundwater).

Recommendation: As stated above, for consistency and clarity, the term "potential recognized environmental condition" must first be eliminated from a revised EIR; then, the revised EIR must include a Phase II ESA describing any identified soil and groundwater sampling at both the laundry site and the carpentry and machine shop.

3773 Sacramento Street

The applicant conducted a February 8, 2008 Phase I for the Site which includes a two-story parking garage.[14] From 1953 to 1966, "Art Craft Cleaners" occupied the site (Phase I, p. 3). No information about the cleaners was provided in the Phase I. However, an existing groundwater well was sampled and concentrations of volatile organic compounds (VOCs) were detected as follows: tetrachloroethene (PCE) at 1.3 micrograms per liter (µg/L), trichloroethene (TCE) at 0.7 µg/L, and cis-1,2-dichloroethene (cis-1,2-DCE) at 0.6 µg/L. These concentrations are below drinking water standards and, although the detected VOCs are typically associated with dry cleaning operations, the Phase I states that the former cleaners was not a source of the contamination (p. 4):

> The previous dry-cleaning operations at the former "Art Craft Cleaners" that was at the Site between 1953 and 1966 is a less likely source as it is cross-gradient from the well, with respect to groundwater flow.

[14]California Pacific Medical Center. 2008 (February 8). *Phase I Environmental Site Assessment and Well Sampling (revised and updated), Parking Garage, 3773 Sacramento Street, San Francisco, California*. San Francisco, CA. Prepared by Treadwell & Rollo, Inc., San Francisco, CA.

The Phase I attributes the contamination to a potential off-site, upgradient source (Phase I, p.4). The potential impact from the "Art Craft Cleaners" was not assessed by the groundwater sampling in the Phase I because the well was judged to be cross gradient.

Recommendation: A Phase II must be conducted to determine potential soil and groundwater contamination from the "Art Craft Cleaners." A Phase II is also necessary to address the potential off-site source of contamination. Without sampling, construction workers may be at risk from inhalation of VOC vapors and dermal contact with VOC-contaminated soil during excavation. A revised EIR must describe any contaminants found during the Phase II and must include measures to remediate/mitigate the contaminants.

2351 Clay Street

A January 17, 2008 Phase I ESA was completed for the Site which is known as the Stanford Building, a seven-story medical clinic and office building. The Phase I found greater than two hundred chemicals to be listed as stored in the basement, "Boiler Room" and the second floor. The Carpentry and Paint Shops in the basement of the Stanford Building contain chemicals such as various paints, thinners, methyl ethyl ketone, muriatic acids, degreasing solvents, epoxy floor coatings, and cleaners (Phase I, p. 2). No observations of floor drains or liquid waste management practices, current and historic, were provided in the Phase I.

The Phase I found no recognized environmental conditions to be associate with the Site.

Recommendation: The applicant must conduct a Phase II investigation in the basement of the Site, which includes a sampling investigation in areas where liquid wastes may have drained from the former carpentry and paint shops. Any mitigation or remediation that would be necessary to protect worker safety or the safety of residents during transportation of hazardous materials must be included in a revised DEIR.

2200 Webster Street

The applicant completed a Phase I for this site on January 17, 2008. This site consists of a five-story medical research laboratory and office building.[15] The Phase I classified two hydraulic elevators as "potential recognized environmental conditions." These decommissioned elevators may have released petroleum products to soil or groundwater during operation. Additionally, artificial fill may be present beneath the Site from previous demolition of residential buildings at the Site (Phase I, p. 3).

[15]California Pacific Medical Center. 2008 (January 17). *Phase I Environmental Site Assessment (Updated and Revised), Gerbode Building,2200 Webster Street, California*. San Francisco, CA. Prepared by Treadwell & Rollo, Inc., San Francisco, CA.

Recommendation: As discussed above, we consider "potential recognized environmental conditions" to be recognized environmental conditions that must be the subject of a Phase II sampling investigation. Results of a Phase II investigation must be disclosed in a revised EIR along with measures to remediate and mitigate these environmental hazards prior to construction and subject to the approval of the SFDPH.

2333 Buchanan Street

A Phase I was completed for the Site, a hospital and a parking lot, on January 17, 2008.[16] The Phase I documented a 10,000 gallon diesel underground tank, along with an underground water tank, to be located on the east side of the hospital. The Phase I states (p. 4):

> The San Francisco Department of Public Health (SFDPH) reported a pressure test violation for the diesel tank on 18 February 2003. Both tanks were removed in 2003 during construction of an access shaft for installing a linear accelerator at the hospital. The removal was approved by the SFDPH, but follow-up documentation was not obtained. Because the replacement of the tank was approved and because soil around and under the tank was removed to construct the access shaft, it is unlikely that petroleum products were released, or if released would remain, at significant concentrations in soil at the Site. Therefore, this fuel tank does not represent a recognized environmental condition.

In my opinion, unless documentation can be obtained, the former fuel tank represents a recognized environmental condition.

Recommendation: The applicant must document whether the underground diesel tank was properly resolved and closed, including a finding that the SFDPH approved these actions. If the documentation is not available, a Phase II investigation should be conducted. All of this must be described in a revised EIR.

California Campus

3698 California Street and 3773 Sacramento Street

A February 8, 2008 Phase I[17] revealed one REC: an open environmental case with the SFDPH regarding documented releases of petroleum hydrocarbons to soil in the truck dock area caused by an underground fuel storage tank. (Phase I/II, p. 4) To address the REC, the

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[16] California Pacific Medical Center, 2008 (January 17). *Phase I Environmental Site Assessment (Updated and Revised), Pacific Hospital,2333 Buchanan Street, California.* San Francisco, CA. Prepared by Treadwell & Rollo, Inc., San Francisco, CA.

[17] California Pacific Medical Center, 2008 (January 17). *Phase I Environmental Site Assessment (Updated and Revised), Pacific Hospital,2333 Buchanan Street, California.* San Francisco, CA. Prepared by Treadwell & Rollo, Inc., San Francisco, CA.

Applicant commissioned a Phase II investigation that involved sampling three existing groundwater wells. The applicant sampled a groundwater boring in June 2006 to evaluate potential groundwater contamination from an upgradient source and sampled again in July 2006.[18] Analysis of the groundwater samples did not detect compounds that would likely be associated with potential onsite and offsite sources. On the basis of the findings, the consultant recommended that the applicant submit a report for case closure with the SFDPH. There is no documentation in the DEIR or supporting materials that such a report was prepared or submitted. The SWRCB "Geotracker" web site, accessed in October, 2010, indicates the site is still open, and that the site will be closed only upon the abandonment of three existing monitoring wells.[19] The DEIR omitted the consultant's Phase I recommendation for case closure. The DEIR does not discuss the open status of the site. This must be resolved.

Recommendation: A revised EIR must include documentation that a proper resolution and closure occurred.

3700 California Street

A February 19, 2008 Phase I[20] found one REC in connection with the Site: a finding of dark oily liquid and staining adjacent to a floor drain "indicating the material threat of release of hazardous materials or petroleum products" (Phase I, p. 5). The Phase I also documented the presence of two abandoned USTs , including a 1,000-gallon and a 4,000-gallon tank (Phase I, p. 4) According to the Phase I, a SFDPH letter approved the in-place closure of one abandoned UST; however, during the Phase I file review , the applicant could not determine which tank was abandoned. Other materials reviewed during the Phase I indicted the conversion of a 4,000-gallon storage tank to water storage but the Phase I did not conclude if this plan was completed. The Phase I states that soil samples collected at the 4,000-gallon UST in 1990 did not detect petroleum hydrocarbons as diesel fuel and the Phase I concluded "it is unlikely that past use of the tank has impacted soil at the Site (Phase I, p. 4). No documentation that the USTs were closed was found in the files during the Phase I review.

The Phase I found one recognized environmental condition in connection with the Site: the dark oily liquid and staining observed near the floor drain in Room G200. A REC was not found in association with the former USTs for which the Phase I found no records of closure.

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[18] *Ibid.*

[19] http://geotracker.swrcb.ca.gov/profile_report.asp?global_id=T0607500094

[20] California Pacific Medical Center. 2008 (February 19). *Phase I/Phase II Environmental Site Assessment (Updated and Revised), Children'sHospital, 3700 California Street, San Francisco, California.* San Francisco, CA. Prepared by Treadwell & Rollo, Inc., San Francisco, CA.

The applicant conducted a Phase II to address the oily staining which involved the collection of one soil sample beneath the floor drain.[21] The analysis of the sample found detectable concentrations of petroleum hydrocarbons, a PCB compound and metals. The Phase II found "detected soil concentrations were found to not represent a significant risk to human health and would not likely be considered a hazardous waste if the Site were redeveloped and soil disposal were needed" (Phase, II, p. 8).

Recommendation:

Because the documentation in the Phase I did not include a record of UST closure, the applicant must conduct an additional Phase II investigation to confirm the presence of the 1,000- and the 4,000-gallon USTs at the site. In addition, the applicant must sample the USTs for the presence of potential contaminants and submit to SFDPH the results of the analysis for regulatory closure of the site prior to development. All of the new information must be disclosed in a revised EIR including measures to mitigate and remediate these potentially harmful conditions.

Davies Campus

Two Phase Is were completed for the Davies Campus: one for the "northeast corner" and another for the "southern parking area."

Northeast Corner

On April 28, 2008, the applicant completed a Phase I for the northeastern corner of the Ralph K. Davies Medical Center Campus.[22]

The Phase I states (p. 3):

> One 7,500-gallon underground tank is closed in place at the Site, which formerly contained diesel fuel for boilers and emergency generators at the hospital west of the Site. This tank was permitted by the SFFD for abandonment in 1998, and the tank was reportedly cleaned and filled with concrete. No documentation of abandonment activities or conditions were found in the records searched.

The Phase I did not document specifically who reported that the tank was cleaned and filled with concrete.

The Phase I also states the following USTs to be present at the Site (p. 3):

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[21] *Ibid.*

[22] California Pacific Medical Center. 2008 (April 28). *Phase I Environmental Site Assessment, Noe Street Medical Office Building, SanFrancisco, California.* Project San Francisco, CA. Prepared by Treadwell & Rollo, Inc., San Francisco, CA.

> Two 2,000-gallon tanks for diesel fuel (actually one 2,000-gallon removed tank and one active 2,500-gallon underground tank south of the Site). The removal of the 2,000-gallon tank and replacement with the 2,500-gallon tank were permitted by the SFFD in 1998. No violations associated with these tanks were found in the documents examined. However, no documentation of removal activities or conditions associated with the 2,000-gallon tank were found in the records.

The Phase I found a REC to be associated with the 7,500-gallon UST but not with the other USTs at the site. Despite the identification of a REC, no Phase II was conducted.

Recommendation:

In my opinion, because a REC was identified, and because no closure records have been found for the 7,500-galllon and the 2,000-gallon USTs, the applicant must conduct a Phase II subsurface investigation must to investigate the potential for the presence of soil contamination to be associated with these tanks. The investigation must be disclosed, along with any necessary mitigation in a revised EIR to ensure that construction workers are not at risk during earthmoving activities.

Southern Parking Area

The Phase I states[23] (p. 3):

> from circa 1913 to the 1960s, a greenhouse was located near the northern boundary of the west part of the Site, which may indicate the use or release of pesticides on the site.

The Phase I also found (p. 3):

> A 2,500-gallon diesel underground storage tank (UST) for supplying the emergency generator at the southern hospital is located in the upper parking lot of the eastern part of the Site (Photograph 6). This UST is operated under a permit from the San Francisco Fire Department. CPMC personnel indicated that this 2,500 gallon UST replaced a former 2,000 gallon UST in 1988. Closure documents for the previous UST were not available.

The Phase I did not find a REC to be associated with the former greenhouse. It is important to note that pre-1970s greenhouses are frequently associated with soil contaminated with organochlorine pesticides such DDT and DDE. Given the pre-1970s greenhouse and because

[23]California Pacific Medical Center. 2008 (February 13). *Phase I Environmental Site Assessment, South Davies Campus Parking Areas, San Francisco, California.* Project San Francisco, CA. Prepared by Treadwell & Rollo, Inc., San Francisco, CA.

closure documents are not available for the 2,500-gallon UST, the applicant must prepare a Phase II analysis to include soil sampling in these areas.

Recommendation:

The applicant must prepare a Phase II analysis for a revised EIR and include any measures necessary to mitigate or remediate the risk of human exposure during earthmoving activities. A Phase II must also be completed to sample for petroleum hydrocarbons in the vicinity of the 2,500-gallon UST. Coordination of the Phase II activities with the SFDPH must be documented in a revised DEIR.

Saint Luke Campus

A Phase I was completed for the tower area of the Saint Luke Campus on August 20, 2009 and found:[24]

> an inactive diesel underground storage tank at the site that was reportedly abandoned in place in 2000 by cleaning and filling with cement. This tank was "closed" in place by with the approval of the SFDPH; no documents indicating releases of fuel from this tank were found (Phase I, p. 3).

Note: The Phase I includes no information about the contents of the UST or the capacity of the UST. The quotation marks were in the Phase I itself.

The Phase I concluded:

> Several other known and potential environmental conditions, which do not meet the definition of Recognized Environmental Condition, but may impact Site redevelopment were identified at the Site. These include:
>
> - The presence of artificial fill, which may contain elevated levels of metals, organic chemicals, and/or asbestos;
> - The presence of underground tanks in an area to be excavated;
> - The possible presence of an acid neutralization sump; and
> - The potential presence of deposits of ash from a former hospital incinerator.

There is no documentation for the UST closure. Most important, there is no discussion in the Phase I of why the above features do not meet the definition of a REC, or whether the features

[24]California Pacific Medical Center. 2009 (August 20). *Phase I Environmental Site Assessment, St. Luke's Campus Tower Area, 3555 CesarChavez Avenue, San Francisco, California.* San Francisco, CA. Prepared by Treadwell &Rollo, Inc., San Francisco, CA.

are potentially significant impacts under CEQA. These conditions may in fact meet the definition of a REC and thereby warrant the preparation of a Phase II to include sampling.

One REC was identified in the Phase I: Oily staining was observed at a utility vault indicating a release of hazardous materials or petroleum products. However, the he Phase I did not conclude that a Phase II investigation was needed, despite the finding of a REC. Instead, it recommended only that prior to Project construction an environmental contingency should plan be prepared "describing procedures to be followed to address known and unknown environmental conditions at the Site (Phase I, p. 5).

Recommendation: The applicant must conduct a Phase II subsurface investigation to investigate the potential for the presence of soil contamination associated with the USTs, and to address the soil staining. The investigation must be included a revised EIR and contain mitigation or remediation measures to ensure that nearby residents or construction workers are not at risk during earthmoving activities.

Cathedral Hill Campus

The applicant prepared nine Phase I/Phase II reports to assess the potential for environmental conditions associated with the old Cathedral Hill Hotel (1101 Van Ness Avenue), the 1255 Post Street Office Building and two parcels at 1375 Sutter Street, all proposed for development under the DEIR.

1101 Van Ness Avenue and 1255 Post Street (Proposed Cathedral Hill Hospital)

Although no RECs were found in a 2003 Phase I,[25] the applicant's consultant recommended additional sampling to address the potential for earthquake fill to contain elevated levels of lead in the northeastern part of the site, and recommended sampling of the expected area of earthquake fill in the site's southeast area (Phase I, p. 15). Based on the soil sample analysis, the 2003 Phase II ESA[26] determined that no significant release of hazardous materials would trigger regulatory requirements for long-term monitoring or remediation has occurred at the site (DEIR, p. 4-16.4).

In summarizing Phase II for the site, the DEIR states:

> Based on the soil sample analysis, the Phase II ESA determined that no significant release of hazardous materials that would trigger regulatory requirements for long-term

[25] California Pacific Medical Center. 2003. *Phase I Environmental Site Assessment, Cathedral Hill Hotel and Office Building: 1101 Van NessAvenue and 1255 Post Street, San Francisco, California.* San Francisco, CA. Prepared by Treadwell & Rollo, Inc., San Francisco, CA.

[26] California Pacific Medical Center. 2003 (October 13). *Phase II Environmental Site Assessment, Cathedral Hill Hotel, 1101 Van Ness Avenue, San Francisco, California.* San Francisco, CA. Prepared by Treadwell & Rollo, Inc., San Francisco, CA.

monitoring or remediation has occurred at the site. Therefore, with the exception of the limited area of earthquake fill containing elevated concentrations of lead in the northeastern part of the site and the expected area of earthquake fill in the southeast part of the site, no RECs or other potential environmental conditions were found during the ESAs of the proposed Cathedral Hill Hospital.

Recommendation: The Phase II ESA determination that no regulatory intervention is needed must be confirmed by submitting the Phase II ESA to the SFDPH under a voluntary cleanup agreement for review. The regulatory determination must be included in a revised DEIR along with any measures to mitigate or remediate conditions that would pose a hazard to construction personnel or to residents adjacent to the construction or along transportation routes.

1020, 1028/1030, and 1062 Geary Street and 1100 Van Ness Avenue

A Phase II Environmental Site Assessment was completed on February 12, 2010 for an area bounded by Van Ness Avenue to the west, Cedar Street to the north, a commercial/residential mixed-use building to the east, and Geary Street to the south.[27] The Phase II was completed to follow-up on findings made in Phase I ESAs that had been previously completed for the six buildings at 1020 through 1062 Geary Street and the building at 1100 Van Ness Avenue.

The applicant found earthquake fill containing high lead concentrations is present under much of the Site. During redevelopment, this material will be excavated and disposed as non-RCRA hazardous waste. This material likely underlies the buildings with no basement at 1020, 1028/1030, and 1062 Geary Street to a depth of four to six feet. Fill material underlying 1062 Geary Street shows elevated concentrations of petroleum hydrocarbons, likely as a result of activities at the former auto repair shop. This material will also be excavated during construction of the planned medical office building. Groundwater in an adjacent well in Cedar Street contained concentrations of petroleum and cyanide exceeding their health-based regulatory screening levels.

The DEIR erroneously deferred sampling of contaminants until excavation is undertaken. Under this proposal, the site's true environmental conditions would not be adequately disclosed. For example, the DEIR makes no attempt to quantify the amount of contaminated soil that would underlie the entire two-block site, or the impact the excavation, mobilization and transport of

[27] *California Pacific Medical Center. 2010. Phase II Environmental Site Assessment, Planned Medical Office Building California Pacific Medical Center Cathedral Hill Campus San Francisco, California. San Francisco, CA. Prepared by Treadwell & Rollo, Inc., San Francisco, CA.*

the soil would have on the neighboring residential and commercial properties and their inhabitants.

Recommendation: The applicant must revise the EIR to include any measures to mitigate or remediate the contaminated soil to protect the health of the construction workers and the neighboring residents or the public along transportation routes. It must also document communication with the SFDPH to ensure that all necessary regulatory actions are taken, including any necessary cleanup of groundwater and soil. Finally, a revised EIR must document an application for voluntary cleanup with the SFDPH to ensure that cleanup of the known contaminants in conducted prior to construction. If cleanup and regulatory closure is deferred until construction, the applicant may encounter conditions that will require delays while regulators determine if the contaminants have been adequately addressed.

Summary and Recommendations

The DEIR and the supporting Phase I and Phase II reports document numerous instances of soil and groundwater contamination. These documents also evidence the potential for additional widespread contaminants where the applicant must conduct proper further investigation as required by CEQA. The conditions have been known, in most instances for at least two years, yet the applicant has made no attempt to engage the SFDPH. Instead, the DEIR proposes to further delineate areas of contamination only once project construct begins. These omissions result in inadequate documentation in DEIR of the extent and severity of the contamination at numerous sites throughout the Project area. Failure to adequately disclose the contamination puts the public at risk. Construction workers may be put at risk when they touch and breathe contaminants (through dust and vapors). Neighboring residents and those living along transportation corridors may be at risk from harmful dust and vapors generated during excavation and transport of contaminated soil in and through their neighborhoods.

To address known and potential soil and groundwater contamination at the proposed campuses, the DEIR proposes Mitigation Measure M-HZ-N1a (p. 4.16-43) which would require the preparation and approval of soil management plans that include "management protocols based on the site-specific environmental contingency plans." This measure also requires air quality monitoring during tank removal activities and sampling of surrounding soils to ensure that leaks have not occurred subject at that time, finally, to SFDPH approval. This is not sufficient.

The preparation of plans to address known and suspected contamination only at the time of excavation is wholly inadequate. A revised EIR is required to immediately assess the extent and severity of all Project-related contamination. The revised EIR must include alternatives and measures to mitigate or remediate all potentially significant contamination impacts. In addition, the applicant must immediately engage the City of San Francisco's Public Health

Department through a voluntary cleanup application. By entering into a voluntary cleanup agreement now, the applicant will be assured that assessment and cleanup of the contamination will be sufficient for a regulatory determination that no further action is warranted. However, all further action required by the SFDPH must be included in a revised DEIR along with the results of investigations that may be required to address known or suspected soil and groundwater contaminants. The steps that are necessary to meet SFDPH requirements must be included in a revised EIR as mitigation measures to assure the public that contaminants will be adequately addressed.

So far, the applicant appears to either hope to avoid or delay formal regulatory oversight. By doing so, the applicant not only risks delaying project construction until serious contamination issues are resolved, but also puts the public at risk because many of contamination risks have not been disclosed and thus not mitigated. The DEIR must be revised to include documentation of communication with the SFDPH and the results of any investigations that are required by the agency to protect public health. Any measures that are required by SFDPH must be stated in a revised EIR and addressed through remediation or mitigation prior to excavation.

Sincerely,

Matt Hagemann, P.G.

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October 18, 2010

Via mail and email

Gloria Smith
The Law Offices of Gloria D. Smith
48 Rosemont Place
San Francisco, CA 94103
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RE: Comments on the Draft Environmental Impact Report for the proposed California Pacific Medical Center Long Range Development Plan

Dear Ms. Smith:

The purpose of this letter is to provide you with comments on the Draft Environmental Impact Report (hereinafter DEIR) for the proposed California Pacific Medical Center Long Range Development Plan (hereinafter CPMC LRDP or proposed Project). My qualifications as a planning expert include a Bachelor's Degree in Environmental Studies from Stanford University, a Master's Degree in City and Regional Planning from the University of Southern California and over twenty years as a professional planning consultant and paralegal. My resume is attached to this letter, Attachment 1.

These comments focus on the following sections of the DEIR:

- Land Use
- Plans and Policies
- Population, Employment and Housing

In preparing these comments, I have reviewed the following documents:

- The proposed CPMC LRDP DEIR and appendices
- The Administrative Record to the DEIR, provided by the City of San Francisco
- Applicable Plans, Policies and Codes

As described in detail below, the DEIR fails to address the impacts of the whole Project, including all aspects of the Project capable of generating significant impacts. Specifically, key elements of the

proposed Project are apparently not complete or not yet available[1] rendering the project description incomplete and inadequate to support disclosure and analysis of Project-related impacts. Other information about the Project was disclosed in the DEIR, but was extremely difficult to locate.[2] This approach violates the information gathering purpose of CEQA.

As a result of missing and incomplete information concerning the proposed Project, as well as flawed assumptions and analyses, the DEIR fails to disclose and analyze potentially significant impacts from this expansive Project on the region, the City and local neighborhoods including, but not limited to: 1) significant unmet demand for housing, and in particular, housing affordable to the workforce; 2) jobs-housing imbalance and related impacts on transportation, air quality, growth inducement and public services; and 3) other impacts that would be generated by the proposed Project as well as the Project plus cumulative projects. In short, the release of this DEIR was premature because information critical to the disclosure and analysis of Project-related impacts has not yet been provided to the public for review. A revised DEIR must be prepared with full and adequate project description and environmental setting sections. Once this key information is available to fully analyze all of the Project's potentially significant impacts, then the City will be in a position to ensure that is has required all feasible measures and/or alternatives to mitigate the Project's identified impacts.

I. Introductory Comments

The proposed Project is of a scale that would reshape how health care is provided in San Francisco. Virtually eliminating services at the California Campus, reducing beds and the scope of services at St. Luke's and converting Davies into a specialty facility, among other Project proposals would generate a myriad of impacts not evaluated in the DEIR. Major flaws with this DEIR along these lines stem from two overarching deficiencies: First, the DEIR fails to describe the existing conditions with respect to health care services (e.g., the full health care system including people, facilities, services that provide health care to San Francisco's population). As such, the DEIR's analyses of Project impacts is incomplete. Second, the because the City lacks a Health Care Services Master Plan[3], the analysis of this and other

[1] Examples of project description information that is not included in the DEIR or the administrative record include but is not limited to: 1) the proposed detailed text of plan and policy amendments; and 2) the project's specific proposal for replacement housing.

[2] For example, information about the construction workforce was buried in the Transportation and Circulation section of the DEIR and not described in the project description. See DEIR Table 4.5-10. Another source of useful information concerning project details is the Alternatives chapter. See DEIR, Chapter 6. For example, it is in the Alternatives chapter that tables can be found describing key details such as: a) building square footage by specific use; b) proposed project square footage compared with existing uses; and c) staffing. See e.g. Tables 6-1, 6-10a and 6-11. These numbers, and the assumptions underlying them, are necessary to assess the Project's various environmental impacts, especially those that are estimated based on square footage (e.g. employment generation, parking, and transportation). As such, these and other "numbers" set forth in the various sections of the DEIR must be presented clearly in one place in a revised DEIR; the project description.

[3] Supervisor Campos's proposal for the completion of a Health Care Services Master Plan should come first, at least the overall framework, and major projects evaluated for consistency with that Plan. CPMC's proposal predetermines major outcomes that may or may not result in adequate services for San Francisco. A determination should be made whether the timeline for seismic upgrades allows completion of the Master Plan

health care projects is at best piecemeal and incomplete. Moreover, feasible alternatives to the proposed Project are not devised with the success of San Francisco's overall health care services system in mind.[4]

Project impacts must be analyzed in comparison with existing health care system services currently serving the San Francisco population (e.g., in San Francisco and in adjacent communities serving San Francisco's population) so that all potentially significant impacts can be analyzed including impacts stemming from the responses to such questions as listed below. This is the environmental baseline for the Project.[5] If proposed project's like the CPMC LRDP are not evaluated based on its impacts compared with the existing health care setting (existing environmental conditions) potentially significant impacts cannot be analyzed, including but not limited to:

1. How and where lower income people will receive health care, and the corresponding range of effects on transportation, air quality and public services?
2. What new gaps in health care services result from the proposed Project? Such gaps translate into physical environmental impacts, including, but not limited to additional and potentially longer trips by San Franciscan's to obtain service as well as people without adequate health care which can lead to physical environmental problems including demand for additional facilities (e.g., specialized shelters; diversion of public funding from other services; and the like). None of these impacts are addressed in the DEIR.
3. How will the proposed Project impact other existing health care providers locally and regionally? Will the Project capture the higher-end medical services; thereby potentially putting other facilities and services at risk for economic failure? Do some of the competing facilities currently provide a range of not necessarily profitable services to the lower income residents that will be

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"vision" first and review of major projects second. This is the first question the City's decision-makers should ask before any further consideration of the Project.

[4] The Project's stated overarching objectives only include optimizing the use of CMPM's resources to provide an integrated health-care system affording the highest quality of patient care to CPMC's patient population in the most cost-effective and operationally efficient manner. DEIR at page 6-5. The City's objective is not represented here – to support the health care services system community-wide that affords the highest quality of patient care to all of San Francisco's population. Whether the proposed Project helps or hinders that overall goal cannot be know without – at a minimum – comparison of the Project as proposed to the existing health care services system serving the SF population. Such an evaluation would expose any gaps in services in the current system and/or gaps that would be created by the proposed Project.

[5] Every CEQA document must start from a "baseline" assumption. The CEQA "baseline" is the set of environmental conditions against which to compare a project's anticipated impacts. Section 15125(a) of the CEQA Guidelines (14 C.C.R., § 15125(a)) states in pertinent part that a lead agency's environmental review under CEQA:

> "...must include a description of the physical environmental conditions in the vicinity of the project, as they exist at the time [environmental analysis] is commenced, from both a local and regional perspective. This environmental setting will normally constitute the baseline physical conditions by which a Lead Agency determines whether an impact is significant."

impacted? Might existing facilities be forced out of business, resulting in "blighted" neighborhoods? The DEIR does not address this potential set of impacts.

4. What are the unmet health care services needs and will these needs be impacted by the proposed Project? If needs remain unmet in the City, impacts to transportation, air quality, greenhouse gas emissions and other impacts increase.
5. How will emergency patients be accommodated if they need to be air-lifted in or out of the City?
6. How will the proposed Project impact services at St. Luke's? How will proposed changes and reduced services impact the southeastern portion of the City in addition to the City at large?
7. Given the proposed Project's actual indirect and likely significant induced job/services multiplier effect, the Project will impact existing neighborhoods and health care services. Therefore, must additional businesses or residences be converted to health care support services for the new Cathedral Hill Campus?

These and other questions must be analyzed and addressed in a revised DEIR containing a full description of the existing health care services.

In addition, the City's environmental review of health care project proposals like the CPMC LRDP is occurring piecemeal because the City lacks a Master Plan for health care services. The preparation of a Master Plan is critical to major health care project review, but more importantly to making decisions that will result in meeting existing and future public health care services needs. Without a Master Plan, the environmental review of the proposed Project cannot be complete.

II. Project Background

The DEIR's project description sections describe the existing Project sites in a fair amount of detail. However, understanding the Project as proposed requires reviewing numerous sections of the DEIR in order to get a sense of the whole Project, as the key elements are not adequately or clearly described in the project description section (e.g., construction activities, workforce, and health care services to be provided at each campus). Table 1 below, provides a comparison of the existing CPMC campuses to the proposed Project assembled from a review of the entire DEIR to inform the comments in this letter.

According to the DEIR, CPMC's long range strategy is to meet state seismic safety requirements for hospitals and create a 20-year framework and institutional master plan (IMP) for CPMC's four existing medical campuses and one proposed new medical campus in San Francisco, the Cathedral Hill Campus. The four existing CPMC medical campuses are the Pacific Campus in Pacific Heights, the California Campus in the Presidio Heights area, the Davies Campus in the Duboce Triangle area, and the St. Luke's Campus in the Mission District. DEIR at page 1-1. The Project's objectives do not address how the proposed Project results in benefitting the overall health care services system for the San Francisco community.

Summary of Key Project Elements

The proposed Project would add a major new medical campus in the Cathedral Hill area by 2014 and cease operations of the California Campus by 2020. Other key project elements include.

- Design, construction and operation of Cathedral Hill campus, including a 555-bed hospital and medical office buildings at two locations.
- Development of a new ambulatory care center, underground parking, and renovation of existing buildings at the Pacific campus.
- Development of a new neuroscience institute building and new medical office building (MOB) and parking improvements at Davies campus.
- Construction of a new 80-bed acute-care replacement hospital and an MOB/expansion building after the demolition of the existing tower at St. Luke's.
- Sale of the California campus (by 2020) after relocating impatient services (all patients staying longer than 24 hours) to the proposed Cathedral Hill Hospital and other services to the Pacific campus. A limited amount of leased office at the California campus would be used indefinitely for medical activities. DEIR at page 1-1 to 1-2.

Table 1 compares the existing CPMC campuses to the proposed CPMC campuses and briefly discusses the proposed changes.

Table 1
Comparison of Existing CPMC Campuses to Proposed CPMC Campuses

Existing CPMC	Proposed CPMC	Comments
Four-campuses: • Pacific • California • Davies • St. Luke's	Four-campuses: • Cathedral Hill • Pacific • Davies • St. Luke's	The changes to services at each of these facilities are not well described in the DEIR project description. In order for the DEIR to be an adequate information document, this and other detailed information about the Project, must be clearly described in the project description as this information is essential to the adequate analysis of transportation-related, air quality, greenhouse gas, housing and other impacts.
Four acute care hospitals	Three acute care hospitals • Cathedral Hill (555 bed acute care hospital) • Davies • St. Luke's	Again, these changes likely impact who accesses the hospitals and how these patients travel – beyond CPMC – for services. Additional details are needed to analyze those likely implications of the proposed Project. Such details must be described in a revised project description.

1,253 licensed beds/ 875 staffed beds	952 licensed beds/ 831 staffed beds	St. Luke's Campus: Reduction of licensed beds from 229 (150 acute and 79 skilled nursing) to 80 beds. Overall licensed beds would be reduced by 178 beds.
45 emergency room bays	65 emergency room bays	The DEIR's description of existing and projected emergency room trips/admissions related to CPMC, as well as existing and projected total San Francisco population-related emergency room trips/admissions is incomplete. The omission of this information renders impact analyses related to transportation, air quality and greenhouse gas emissions incomplete.
2 triage areas	3 triage areas	
No helicopter landing	No helicopter landing	No helicopter landing could have impacts on health care services, but also on air quality and greenhouse gas emissions due to reliance on other heliports outside of San Francisco.
2004: 648,530 outpatient visits		Detailed patient information needed to fully assess Project impacts is not included in the DEIR.
2004: 1/3 of all emergency room visits – approx. 70,220		See above. This information is needed to fully assess Project impacts and should be provided by facility and campus.
2006: Full-time equivalent personnel: Pacific: 2,641 California: 1,638 Davies: 925 St. Luke's: 597 Total: 5,801 (2008 data)	2030: Full-time equivalent personnel: Cathedral Hill: 5,380 Pacific: 2,060 California: 10 Davies: 1,750 St. Luke's: 1,530 Total: 10,730	The DEIR improperly omits information concerning future employment at the California campus sites. The sale of these sites is part of the Project and as such assumptions concerning future use and total employment should be included if not in the project description, in the cumulative and growth-inducing sections of the DEIR.

Housing units Cathedral Hill: 5 residential units and 20 residential hotel units.	Housing units = None	CPMC is still working with the Mayor's office to determine how to address replacement housing. CPMC is seeking exceptions and amendments to City regulations that would require housing be provided as a ratio to non-residential uses.

III. Potentially Significant Impacts Were Either Not Analyzed or Inadequately Analyzed in the DEIR

A fair argument clearly can be made based on the record that the proposed Project will have a number of potentially significant impacts that were either not disclosed in the DEIR at all or were inadequately analyzed. These include, but are not limited to:

- Impacts related to population, housing and jobs including an increased demand for housing affordable to the full workforce generated by the proposed Project (e.g., construction plus induced and indirect employees). The DEIR only analyzes a segment of net new employment generated by the Project, thereby underestimating the proposed Project's impact on housing. This impact in turn results in an underestimation of traffic, parking, air quality and greenhouse gas emissions impacts (see letters submitted under separate cover by Dr. Petra Pless, and Tom Brohard, P.E.). These impacts are commonly analyzed as jobs-housing balance and jobs-housing "fit" impacts.
- Impacts associated with Project-Plan inconsistencies including, but not limited to, precedent setting amendments to the general plan, zoning code and other departures from adopted plans, policies and regulations that could result in significant impacts not disclosed or analyzed in the DEIR.
- Growth-inducing Impacts as a result of unmet demand for housing and particularly housing affordable to the Project workforce as well as growth inducing impacts associated with exempting this Project from applicable policies, plans and regulations. In addition, the DEIR fails to analyze the growth inducing impacts related to indirect and induced growth in employment to serve the Project and foreseeable uses at the California campus sites once sold.
- Cumulative impacts, including those related to housing demand and potential development at the abandoned California campus.
- Potentially significant impacts associated with the shifts and changes in health care city-wide that would in turn change patient patterns (travel distances, types of trips, etc.), increased impacts on air quality emissions, public services and possibly other health care services (e.g., competition and or the abandonment of the California Street campus could result in loss of other existing services). These impacts are not addressed in the DEIR.

A revised DEIR must not only disclose these likely significant impacts, it must also include a reasonable range of alternatives capable of reducing or eliminating significant impacts.

A. The Project Description is Incomplete

The DEIR's Project Description sections omit information that is essential to an adequate analysis of Project-related and cumulative impacts. Key examples vital information omitted from the DEIR are a plan for replacement housing for units demolished to make way for Project construction and a clear and compete description of the change in health care services to be provided by each campus. According to the DEIR, CPMC is continuing to work with the Mayor's Office of Housing to identify the best mechanism to meet the City's need to place the units lost and is evaluating a range of options. DEIR at pages 4.3-33. While the actual replacement number as a percent of total units in the City may be low, as a cumulative total for the income level these lost units represent, replacement units is a significant issue and as such should be a key element of the Project Description.[6] In addition the location of these affordable units may render their loss even more significant as they are in a high-end neighborhood. Similarly, additional detail concerning the exact types of health care services and target patient profiles is essential to an accurate and thorough description of Project-related and cumulative impacts. Impacts such as whether CPMC will result in a loss of key services to San Francisco residents cannot be analyzed without additional information on both the proposed Project as well as existing health care services.

Other information missing from the DEIR's Project Description sections includes, but is not limited to the following:

- Profile of the "net" new CPMC workforce by income range and job type to inform analyses of jobs-housing balance, jobs-housing fit and actual demand for additional housing affordable to the workforce. Only general information concerning the net new workforce can be gleaned from the DEIR (e.g., such as provided in Table 4.5-10 which provides no information on the income range of physicals and staff). Income has been shown to play a significant role in where an employee lives and therefore commuting distance.
- A financing plan for the proposed Project and a discussion of whether such a financing plan would include sale of the California campus to finance the project. The financing plan would necessarily result in disclosure of related environmental impacts and alternatives.
- Specific retail service and other commercial uses. This detailed information is critical to accurate trip generation assumptions, parking demand and determining whether or not uses will actually result in reducing trips/air quality and greenhouse gas emissions or merely become attractors for additional vehicle trips.
- Projected emergency room admissions and ambulance trips for both near-term and long-term project phases. This information is essential to an analysis of the adequacy of health care services and conclusions concerning impacts such as cumulative impacts of transit and

[6] The omission of the details of the replacement units as part of the Project Description also represents an example of improperly omitted and/or deferred mitigation as the discussions with the Mayor's housing team is the DEIR's basis for not requiring additional mitigation. DEIR at page 4.3-33. Moreover, the DEIR fails to include any disclosure or analysis of the cumulative numbers of affordable housing being displaced by cumulative projects in the project area and City-wide.

traffic generated by patients having to travel greater distances for services. Details including total projected psychiatric admissions is essential for impact analyses as well.

- Actual disclosure of the wording (proposed text) of all required plan, policy and regulation amendments.
- Justification (proposed findings) for the requested variances.
- Justification (proposed findings) for all other exceptions/amendments including but not limited to parking, housing, Proposition M, etc.
- Events schedule and visitors (e.g., CPMC currently has a robust schedule of seminars, lectures, workshops and other events). This information was used at least in part based on surveys for the transportation section of the DEIR, but does not appear in the Project Description.
- The construction schedule in Appendix B provides a general overview of expected activities for near-term projects (the DEIR fails to provide adequate information on the buildout of long-term projects). Also, some sections of the DEIR provide additional details on construction activities by campus (e.g., Transportation and Noise). However, the DEIR omitted the details concerning the construction workforce, thus is it impossible to analyze impacts including housing demand, transportation, air quality and other impacts. This information would include, but is not limited to the type of worker by trade and tier status. The US Census provides information on the construction workforce including: area workforce characteristics by type of worker, worker residence locations, wages, and status – full or part-time. It is highly possible that given the cost of housing in the City that lower paid workers (Tier 1 or Blue Color Construction Workers) reside outside the area and thus have long commutes to and from their residences. Again, this information is readily available and critical to complete the DEIR's Project Description.[7]

Without this critical project description information, the DEIR cannot disclose or analyze the project-related and cumulative impacts. In addition, the actual General Plan amendment language is essential to a determination of whether the proposed Project will result in Plan inconsistencies. A revised DEIR must be prepared when the project description is complete.

B. The DEIR Omits Critical Project Setting Information

CEQA requires that an initial study contain "an identification of the environmental setting." Guidelines Section 15063(d)(2). Here, however, the DEIR's Environmental Setting section omits essential information.

Examples of omitted Environmental Setting information that must be included in a revised DEIR are:

[7] Just as the transportation section describes construction period traffic impacts based on detailed descriptions of the Worker Population by Construction Phase, so should the section concerning Population, Employment and Housing. See e.g. Table 4.5-29. This information should be the starting basis for a revised analysis of jobs-housing balance and jobs-housing fit impacts.

- A detailed description of San Francisco's existing (and surrounding Bay Area communities, if applicable) health care services including personnel, services, facilities, emergency room admissions and ambulance trips, etc. This complete description of the health care service setting should provide information on any gaps or leakage of San Francisco's health care needs to other communities, accessibility of services, and other basic background information to provide a "baseline conditions" basis for analyzing Project impacts. Without this information, very basic impact analyses cannot be performed (e.g., how far will patients travel for care? What are the transportation, air quality and greenhouse gas emissions impacts of those travel patterns?).
- Projected health care services needs for the projected San Francisco population based on changing demographics (e.g., aging population, etc.).
- Additional information concerning the housing stock in the area surrounding the campuses (How much of the substandard stock is not occupied/livable? Are there overcrowding conditions? What are the rents and for-sale prices? What are the current rental and owner profiles? What is the current jobs-housing fit in these neighborhoods? The City? Region?).
- Information concerning the available construction workforce in the area by trade.
- More detailed information concerning cumulative projects including potential cumulative development at the California campus (based on the General Plan and Zoning/other), and in particular, other health care services projects in the City and immediately adjacent communities (e.g., Southern Marin, Peninsula, inner East Bay).
- Information on existing jobs-housing balance and jobs-housing fit in San Francisco and the region. The DEIR only provides information on employed residents-jobs. This is not an adequate surrogate for either jobs-housing balance or jobs-housing fit. Impacts that flow from a lack of jobs-housing balance and fit include but are not limited to increase in- and out-commuting, impacts on air quality and greenhouse gas emissions. The distance of commutes and other information critical to a thorough impact analysis can only be determined based on adequate setting information.

A revised DEIR must be prepared that includes this information and based on this information, analyzes the full impacts of the proposed Project on housing, jobs-housing balance, jobs-housing fit and the related impact topics of transportation, impacts on air quality and greenhouse gas emissions, among others.

C. The Project Will Have Potentially Significant Impacts on Housing

Any environmental review must analyze the proposed project's potential impacts to population, housing and jobs. The DEIR includes discussions of potential housing impacts in number of chapters of the DEIR including Population, Housing and Employment; Land Use; Plans and Policies, Growth Inducement and Alternatives. In every discussion, the DEIR concludes that the Project would not result in any significant impacts to housing without mitigation. Specifically, the DEIR reached the sweeping conclusion that the project would not result in any significant impacts to population, employment and housing including demand for housing or housing displacement. The DEIR reaches this conclusion without an adequate

significant because those growth and housing projections make the Project contribution to housing demand appear small in number.

When *full* Project housing demand is compared to existing availability of housing affordable to the workforce, impacts are likely significant. If the analysis also includes the loss of actual housing units plus the loss of future housing that could occur on the Project campus sites under current plans and zoning and takes into consideration jobs-housing "fit," Project related impacts will be much more significant than presented in the DEIR. The DEIR's baseline calculation violates the plain language of CEQA.

For the housing sections, a revised DEIR must analyze the proposed Project's *full* impacts on the existing conditions. The revised analysis must also identify the likely significant short-fall of housing affordable to the Project's direct, indirect, and Project-induced workforce as a result of the proposed Project plus cumulative projects. More detailed setting information concerning the status of affordable housing in the Project neighborhoods, City and beyond must be a basis for this revised analysis.

Incomplete Project Description and Assumptions for Housing: In addition to reliance on the wrong environmental baseline to justify conclusions of less than significant impacts, the overarching conclusion that the Project would not have significant housing impacts is not supported by the facts:

1) The DEIR fails to describe all elements of the Project that generate housing demand including, but not limited to construction workforce, Project-induced and indirect employees. If all of these net new employees are included, the underestimation of the Project's housing demand is even greater than disclosed in the DEIR. A proper analysis of full housing demand would likely result in a significant shortfall of housing, particularly housing affordable to segments of the new direct, Project-induced, indirect and long-term construction workforce.
2) The DEIR fails to account for the additional indirect employment (based on a reasonable multiplier[9]) generated by the construction component of the Project. As a result, net new demand for housing will likely be even greater. Table 4.5-29 provides an indication of the workers by general phase/shift. Total construction should provide a basis for applying a multiplier to determine the housing need for this element of the Project in a revised analysis.
3) The DEIR fails to account for where workers will likely live and simply relies on the assumption from the CPMC IMP that 49% of employees reside in San Francisco, 22% in South Bay/Peninsula; 19% in East Bay; 8% in North Bay to extrapolate the locations where future employees will reside. DEIR at pages 4.3-12 to 13. Moreover, these assumptions, valid or not, do not include construction workers. Census and other information are available to more accurately project the likely places workers will live. These studies clearly show a correlation between worker

[9] The total jobs generated by a project can be determined using "multipliers" that indicate the number ratio of direct jobs to indirect and induced jobs. Used to measure the number of times each dollar of direct spending cycles through an economy thereby producing indirect and induced spending, multipliers also describe indirect and induced employment produced by a project's economic impacts.

wages and salaries the location of their residences.[10] A revised DEIR must do the work and not simply extrapolate from the prior Plan.

4) The DEIR fails to deduct from planned and projected housing, housing that would be developed on these sites under current planning and zoning. Moreover, the DEIR fails to regard the loss of this potential housing as an impact.
5) The DEIR does not include housing that would be required to be built under current City regulations, but that the Project is requesting to be excused from constructing. DEIR at page 4.3-33.
6) The DEIR fails altogether to analyze the "housing fit" – that is the cost of housing compared with the Project workforce's ability to pay for that housing. Various segments of the net new workforce, as well as indirect and induced jobs, are likely to fall into lower income categories.

As a result of these and other omissions, flawed and incomplete analysis and assumptions, the Project is likely to result in significant demand for housing affordable to the workforce over supply in the immediate neighborhoods surrounding the Project's various campuses, in the City and potentially around the Bay Area (Marin, East Bay, Peninsula).

After including a complete project description and environmental setting, a revised DEIR must disclose and analyze the full impacts of the proposed Project on housing such as housing demand over supply taking into consideration jobs-housing fit, unmet demand for housing affordable to the workforce and impacts on the housing supply (e.g., as a result of amending plans, zoning and code sections). It is likely that a revised CEQA analysis along the lines described above would show significant impacts on housing requiring full alternatives and mitigation to address housing impacts.

Feasible Mitigation Measures to Address Significant Housing Impacts Including Unmet Demand for Affordable Housing: The DEIR does not identify any mitigation measures because it finds that project-related and cumulative impacts associated with housing to be less than significant. DEIR at pages 4.3-21 to 4.3-42. As described above, these conclusions are based on incomplete and flawed analyses. A revised DEIR must include feasible mitigation measures to reduce and/or eliminate significant housing, housing affordability, housing supply, jobs-housing balance and jobs-housing fit impacts. Such measures generally include but are not limited to replacement housing on or off site for units demolished as well as for units required under the City's policies and regulations (e.g., Van Ness Avenue Area Plan (VNAP) regulations requiring development of residential square footage for each square foot of non-residential uses); impact fees and other means of generating financing for housing affordable to the workforce. The Project applicant should also consider entering into a Community Benefits Agreement with affected community residents and stakeholders and set forth enforceable benefits that could also be relied on to mitigate project housing impacts. Other measures that should be considered include:

[10] Academic and empirical research supports our inference from Census statistics that wages matter to residents' decisions where to work and live. See Attachment 2 and 3 hereto: "Wages, benefits, hours, commuting time, and license renewal for Iowa Registered Nurses;" and "The Effects of Housing Prices, Wages, and Commuting Time on Joint Residential and Job Location Choices."

- A commitment to build housing for the workforce on one or more of the Project campus sites. Total units should be based on a nexus or other detailed study of actual Project-related housing demand and jobs-housing fit.
- A revolving loan fund at no interest toward the building of new affordable units in the Project areas and/or rehabilitation of existing units by community non-profits working in collaboration with a "Coalition Advisory Committee" (see below). The size of the loan fund must be sizable enough to substantially address the full impacts of the Project particularly on affordable housing demand. As an example, a revolving loan fund of approximately $20 million over 5 years would allow for the creation or preservation of about 200 units of affordable housing, with the fund providing acquisition and/or construction loans for rehabilitation, new construction or preservation of existing subsidized properties at risk of converting to market.
- An additional revolving loan fund at no interest could be established to rehabilitate housing in the areas surrounding the campuses, with specific attention to leveraging other funding to increase the energy efficiency of these units (thereby saving residents on energy bills and reducing greenhouse gas and air quality emissions).
- Creation of a "Coalition Advisory Committee" (and specialized technical sub-committees on housing, energy efficiency and other issues). Among the considerations of the Committee should be to support local community land trust that would help to provide affordable housing in the Project areas and a rental assistance program for low-income staff and workforce.

A Community Benefits Agreement can also provide a useful vehicle to mitigate for parking, traffic, energy, air quality and other impacts associated with the Project.

D. The DEIR Underestimates Project-Related Employment and Fails to Adequately Disclose and Analyze Jobs-Housing Balance and Jobs-Housing Fit Impacts

The DEIR concludes that Project-level and cumulative impacts associated with employment would be less than significant. DEIR at pages 4.3-18 to 4.3-31. The DEIR further concludes that cumulative impacts with respect to employment would be less than significant without adequate data or analysis. DEIR at page 4.3-31. Obviously, the Project's contribution to new jobs in San Francisco is a good outcome. However, these new direct, indirect and temporary employees must be accounted for in the environmental analysis. The DEIR concludes as follows:

> The total number of personnel at CPMC campuses would grow to approximately 10,730 by 2030. This would be a net new growth of 4,170 full time equivalent (FTE) personnel CPMC system wide between 2006 and 2030. This personnel growth would create population growth and household growth of approximately 3,480 people or approximately 3% and 1,409 households or approximately 3% overall, that would be within ABAG's population projections for San Francisco. Also, the increase in housing demand could be accommodated by the city's vacant housing supply

(approximately 17,100 vacant units)[11] and available capacity to build approximately 34,100 new housing units. DEIR at page 4.3-31.

These conclusions are based in part on the projected employment generated by the Project being within ABAG's employment forecasts. DEIR at page 4.3-31. As described above, comparison of the Project against future population projections relies on an improper baseline. Id. A revised DEIR must evaluate the physical and other environmental impacts of net new employment generated by the Project against existing conditions (e.g., existing supply of housing at rents/prices affordable to new employees).

The DEIR appears to grossly underestimate employment generated by the Project. According to the DEIR, the Project will generate 10,730 full time equivalent (FTE) personnel at the four campuses. For analysis purposes, the DEIR relies on an overall project impact of only 4,170 net new jobs. This figure underestimates the full employment impact of the proposed Project because it does not include construction workers, or induced and indirect jobs. Nor does the projected number include any non-medical jobs at the California campus (under the foreseeable scenario that campus will be sold and redeveloped consistent with existing plans and policies).[12]

The DEIR underestimates new jobs generated by the Project and the impacts associated with this underestimation for reasons including, but not limited to, the following:

- Omission of total "net" new direct **and** indirect and Project-induced jobs. The DEIR does not appear to include jobs that would be generated by the Project based on a reasonable multiplier effect and failure to apply that multiplier to certain key categories of population generated by the Project (e.g., to construction workers, medical services, etc.).

- Jobs associated with the redevelopment/future use of the California campus sites after they are sold and reused/redeveloped.

- The actual imbalance of jobs and housing taking into consideration the salaries of new jobs with housing costs or "Jobs-Housing Fit."

The omission of ALL indirect and induced jobs in the DEIR's analysis of employment and population growth and jobs-housing balance has a ripple effect throughout the DEIR. Specifically, to the extent the DEIR underestimated total new jobs and population generated as a result of the Project directly and indirectly, other impacts including, but not limited to traffic, parking, greenhouse gas emissions, public services, air quality, among others are also underestimated.

Indirect and Project-Induced Jobs: The impact of the proposed Project on the local, regional and even State economies is greater than the total of direct spending and direct job creation. This economic ripple effect is typically measured by an "input-output" economic model such as IMPLAN. While these models have historically been used to describe the economic benefits of projects, they are increasingly being used in DEIR's to analyze the full job generation potential of projects and therefore the full

[11] Inadequate information is provided on the locations, type, condition and price/rent of these units to support any conclusion that they are adequate for the Project's workforce needs.

[12] Or potentially purchased by another medical group desirous of the same exemptions from City plans, policies and regulations CPMC is seeking.

environmental impact of projects. The multiplier effects for the proposed uses likely range from a minimum of .5 or ½ additional new job for every job created to over 1.4 under commonly applied models. Of course employment multiplier effects can vary depending upon the specific types of jobs being created. The redevelopment of the St. Luke's campus site may not result in as high a multiplier due to the fact a medical facility already exists and so do complimentary services in the area. However the multiplier for a new hospital at the Cathedral Hill site could mean that a higher multiplier effect is warranted because of the introduction of a brand new facility in an area that may lack complementary services. A revised DEIR must re-analyze the multiplier based on the specific types of jobs generated by the Project and produce a revised analysis of impacts to employment, population and housing, jobs-housing balance, jobs-housing fit, traffic, greenhouse gas emissions and air quality impacts among other impacts.

A typical multiplier based on what is known about the Project would suggest that the DEIR has grossly underestimated indirect and induced jobs by a significant number. A recent Oregon Study found that the average physician in Oregon supported 14 to 48 total jobs or 25 total jobs on average[13]. While some of those jobs are reflected in other employee categories for the Project (e.g., staffing on site), some are not and would be created off-site in support services and other jobs. A University of Kentucky Study of Rockcastle Hospital and Respiratory Care Center concluded that for every hospital job, an additional .48 jobs were created in the local economy.[14] Not only must a revised DEIR include an analysis of the impacts of all jobs – indirect, Project-induced, construction, but the multiplier should be applied to construction as well as facility jobs by job classification and salary. Moreover, depending upon the location of all net new jobs (including induced and indirect), revised impact analyses for traffic, air quality, urban decay, housing demand, jobs-housing fit, and greenhouse gas emissions impacts is required. These new jobs have the potential to significantly increase the impacts of the Project as well as to influence the mitigation measures necessary to reduce or eliminate Project-related and cumulative impacts.

Jobs-Housing Fit: As a result of the omissions and flawed assumptions underlying the DEIR's analysis of employment, the DEIR's analysis of employment growth and housing demand and supply is incomplete and inadequate. If the DEIR had completed an adequate analysis as described above, it would have shown significant impacts associated with the Project in terms of jobs-housing balance, demand for housing and related impacts.

Cumulative Impacts are Not Adequately Analyzed: The DEIR uses forecasted employment growth as a proxy for "related projects." DEIR at page 4.3-6. Based on this approach, the DEIR concludes that the Project's incremental employment effect is not "cumulatively considerable" within the meaning of CEQA and hence its cumulative employment impact is less than significant. DEIR at 4.3-31. To the contrary, there is information concerning likely future employment growth based on the cumulative list as well as planning and zoning. A revised analysis should be prepared that uses both methodologies to re-evaluate cumulative impacts to jobs and in particular jobs-housing fit.

Feasible Mitigation Measures to Reduce or Eliminate Potentially Significant Employment Related Impacts: The DEIR does not identify any mitigation measures to address employment impacts because

[13] Attachment 4. The Economic Contributions of Oregon's Physician Practices, May 2010.
[14] Attachment 5. CBRE Consulting, Inc. Direct, Indirect, and Induced Economic Impacts of UC San Diego; Attachment 6. Kentucky Study, www.cauky.edu/krhw

it finds that Project-related and cumulative-impacts associated with employment to be less than significant. DEIR at page 4.3-31. A revised DEIR must include feasible mitigation measures to reduce or eliminate employment related impacts to transportation, housing and air quality, such as measures that would draw new employees from the local workforce. In addition to housing related measures (see list above), mitigation measures should consider all of the following:

1. Creation of a Local Apprentice Employment Program that involves training and other strategies to maximize the number of local entry-level opportunities for area residents in both service and construction jobs that lead to middle-income careers.
2. Establishment of a Local First Source Policy to promote the hiring of local journey-level workers (in a community benefits agreement and the development agreement).
3. Creation of a small business assistance program and funding for small businesses in the project areas that exist and could provide secondary services (to reduce the impacts of a multiplier).
4. Establishment of a scalable Transportation Demand Management Fee linked to the average vehicle miles traveled of the construction workforce. The revised analysis of construction worker transportation impacts would provide a basis for this fee.

E. The DEIR Fails to Adequately Analyze the Project's Significant Inconsistencies with Adopted Plans and Policies

The Project as proposed requires general plan amendments, variances from the existing Codes, Floor Area Ratio (FAR) amendments, parking reductions and other significant departures from adopted plans, policies and regulations in order to be built. DEIR Chapter 3. The lengthy list of necessary and sweeping departures from adopted plans and policies call into question whether the Project benefits and merits justify the requested departures and amendments. Because the DEIR omitted critical documents for review (e.g. proposed policy amendment text), it is impossible to fully evaluate Project consistency with adopted plans and policies. Moreover, Project consistency is based on the Project receiving all of the myriad major entitlements, amendments and exceptions from existing plans, policies and regulations. This is not the correct method for measuring Project consistency.

Broadly speaking, in order to protect California's land resources and improve the quality of life in the state, each California City and county must adopt a comprehensive, long-term general plan governing development.

The myriad of applicable existing plans and policies from which to evaluate Project consistency includes, but is not limited to, the following:

- The San Francisco General Plan and all applicable elements, including the Housing Element
- Regional Plans and policies (e.g., Bay Area Air Quality Management plans and regulations)
- Van Ness Avenue Area Plan (VNAP)
- Market & Octavia Neighborhood Plan
- Mission Area Plan
- Japan town Better Neighborhood Plan

- Mission District Streetscape Plan
- Measure M

The Project consistency "analysis" contained in the DEIR provides conclusory statements of consistency that are in most cases unsupported by evidence in the record. For example, according to the DEIR, the Project is "generally consistent with the Recreation and Open Space Element. Implementing the LRDP would result in an increase in FTE employees and new San Francisco residents." The paragraph points to other sections of the DEIR for further information. DEIR at page 3-7. In the place of such conclusory statements, a revised DEIR must include a table with the full text of applicable policies and provisions and a specific description of why the Project is or is not consistent with each applicable policy or provision. While other sections of the DEIR contain statements regarding Project consistency or general consistency with applicable plans, policies and regulations, these statements are largely devoid of analysis and evidence to support the conclusions of Project-plan/policy consistency even with amendments and exceptions. The table below provides just a few of the key examples of plan provisions where Project consistency has not been adequately demonstrated.

Examples of Applicable Plan, Policy, or Regulation	Comment
Van Ness Avenue Area Plan (VNAP): The focus of this visionary plan is to revitalize the area by encouraging new retail and housing to facilitate the transformation of Van Ness Avenue into an attractive mixed use boulevard. The VNAP does not encourage medical centers and instead encourages high-density mixed use development. To accomplish this the VNAP has a number of key provisions including: • Establishes a require ratio for new development of 3 square feet of residential use for every 1 square foot of nonresidential uses. • Eliminates density for residential uses. • Allowable FAR of 7.0:1.	The proposed Project requires a major general plan amendment to achieve heights and bulks that are inconsistent with VNAP, to waive housing requirements and density requirements, among other amendments and exclusions necessary for the Project as proposed to be found consistent with the VNAP. In addition the proposed Project is inconsistent with the overall vision of the VNAP and would impact its objectives for a vital pedestrian environment, lower parking ratios and mix of uses. Requested amendments would also increase the current allowable floor area ratio (FAR) of 7.0:1 to an FAR of 9.0:1. Waiver of density limits in the VNAP was intended to encourage housing, not a major medical center. The DEIR concludes that with the proposed amendments, the project is "generally consistent" with the VNAP. This could not be a greater reach. Permitting the CPMC project to completely ignore the VNAP, including its residential requirements, opens the door for further erosion of the Plan and its vision. Neither the direct Project impacts, nor the precedent set by allowing the Project to ignore the VNAP is adequately analyzed in the DEIR.
Housing Element: Applicable provisions include	The proposed Project has numerous

proposed housing on the CPMC sites (e.g. Cathedral Hill), requirements for adequate housing for the workforce and requirements for replacement housing.	inconsistencies with the City's Housing Element that are not analyzed or disclosed in the DEIR including but not limited to: • Inconsistencies with sites (housing site inventory) designated for housing and that would help the City meet its regional housing needs assessment. • Inconsistencies with housing element policies requiring non-residential uses to do their fair share to provide workforce housing. • Inconsistencies with replacement housing requirements.
Proposition M – Accountable Planning Initiative which added Section 101.1(b) to the Planning Code to establish eight priority policies including preservation and enhancement of affordable housing and discouragement of commuter automobiles.	The findings for consistency between the Project and Measure M priority policies are not supported by the evidence in the DEIR. Additional information and mitigation is needed to make such findings of consistency particularly with the provisions noted.

Other Project inconsistencies with applicable plans, policies or regulations include, but are not limited to the following:

- Height and bulk limits for numerous campuses: For example, an amendment is required to the Height and Bulk District map to reclassify the block for the Cathedral Hill hospital from the 130-V Height and Bulk District to a 265-V Height and Bulk District, allowing a maximum height of 265 feet. DEIR at Table S-1.
- Height limit for Cathedral Hill campus: Conditional Use authorization is required for the Cathedral Hill Hospital and Cathedral Hill MOB in an RC-4 zoning district to allow buildings taller than 40 feet within the Van Ness Special Use District. DEIR at Table S-1.
- Off-street loading space dimension: The proposed Cathedral Hill campus would also require Conditional Use authorization to exceed the allowable parking. DEIR at Table S-1.

A revised DEIR must include a detailed table that provides the applicable text of all policies and regulations for all applicable plans, policies and regulations and provides the rationale for a finding of Project consistency with each. If consistency can only be found because of amendment or exception to a policy or regulation, feasible alternatives and mitigation should be described that would not require the amendment or exception. For example, consistency with the VNAP housing requirements could be achieved by providing those required units or other measures described above.

The DEIR contains evidence that the Project is inconsistent with a number of adopted policies. DEIR Table S-1; See also Project Description chapters for each campus site. Since the project description sections fail to describe the proposed text of the necessary general plan amendments and the proposed text of other required exceptions and amendments, the significance of these impacts cannot be analyzed. Unless and until the Project is shown to be consistent with all applicable plans and policies, either through appropriate amendments that do not render plans internally inconsistent or through changes to the project, it cannot be approved.

Moreover, feasible alternatives and mitigation to address policy and regulation inconsistencies must be identified. For example, a reduced scale project at the Cathedral Hill campus would be more consistent with policies and regulations (e.g., Floor Area Ratio (FAR)) for those sites.

F. The DEIR Fails to Adequately Analyze the Project's Growth Inducing Impacts

The DEIR concludes that the Project will not result in direct or indirect substantial growth inducement. The conclusion of the DEIR's "analysis" of growth inducement is that implementing the proposed CPMC would not induce substantial population of employment growth and the growth that is generated is within growth projections and projected housing capacity. DEIR at pages 5-16 to 5-17. This conclusion is reached notwithstanding the DEIR's admission that:

- CPMC is the second largest private employer in San Francisco;
- The analysis fails to consider all growth generated by the Project (e.g., the multiplier effect on direct construction and ongoing operations jobs including induced and indirect jobs); and
- The analysis fails to consider growth at the California Campus once sold; among other considerations.

As discussed in detail above, every CEQA document must start from a "baseline" assumption. A revised DEIR must include an analysis of the extent to which the Project could lead to growth in the area beyond the existing conditions. At a minimum, the analysis should include: a) identification of infill parcels in the Project areas that may be underutilized or vacant; and b) the potential for additional growth of secondary services to the Project (e.g., from housing to janitorial, plumbing, repairs/maintenance and other specialized support services not provided by the Project). Moreover, the analysis should evaluate the potential growth inducing effects of sweeping land use; zoning and code changes that could be replicated by other projects (e.g., Floor Area Ratio (FAR) and other variances). Such an analysis should also include an evaluation of the potential for the project to "gentrify" the neighborhood thereby displacing existing housing and non-residential uses.

G. Feasible Alternatives to the Project Exist that Mitigate Impacts

CEQA's purpose of avoiding or substantially reducing effects of a project through the adoption of feasible alternatives is defeated where an EIR fails to ensure that information about potentially feasible alternatives is subject to public and decision-maker review. The DEIR dismisses alternatives based on statements such as the CPMC decided that the alternative would not be cost effective. See e.g. DEIR at page 6-24:

"According to CPMC, retrofitting could not bring existing on-campus structures up to 'new construction' standards of safety without prohibitive costs."

Where a project proponent asserts that various alternatives are not financially feasible or cost effective, they must disclose the financial information and economic data and analysis underlying the assertion to allow the public and decision-makers to fully understand why certain alternatives could be rejected as infeasible.

The DEIR identifies Alternative 3A as the environmentally superior alternative other than the No Project alternatives. See DEIR at page 6-401. In describing the merits and limitations of Alternative 3A, the DEIR points to specific project elements, such as the loss of the pedestrian through connection at St. Luke's, that could be addressed with more detailed attention to the planning for that campus. Given that the alternatives analysis contains the same flaws as the DEIR's analysis of the Project as described in detail in the sections of this letter above, a revised DEIR must re-analyze Project alternatives. Such a re-analysis should focus on the environmentally superior alternatives and specifically, should modify those alternatives for re-analysis in a manner that would further reduce impacts while potentially improving performance related to project objectives. Reducing the development program at the Cathedral Hill campus while maintaining and/or expanding the health care services at the St. Luke's campus would be a likely candidate for revised analysis. Finally, a revised and recirculated DEIR must include sufficiently detailed financial and economic analysis to allow the public and decision-makers to understand why some alternatives warrant rejection, including the retrofit-only alternative.

CONCLUSION

For all the above reasons, the City must prepare and recirculate a revised DEIR based on a complete project description and environmental setting that addresses these omissions.

Very truly yours,

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Terry Watt
DocuSigned By: Terry Watt
Terrell Watt, AICP

Attachments:

1. Resume of Terrell Watt
2. Imerman, Mark M. and Orazem, Sikdar and Russell. Wages, benefits, hours, commuting time, and license renewal for Iowa Registered Nurses; September 15, 2006.
3. So, Kim and Orazem and Otto. The Effects of Housing Prices, Wages, and Commuting Time on Joint Residential and Job Location Choices; 2001.
4. Isgrigg, Jo, Ph.D., Beleciks, Moorhead, Dodson, Swendsen, Conkin, Beck. The Economic Contributions of Oregon's Physician Practices; May 7, 2010.

5. Description of Multipliers: CBRE Consulting, Inc Chapter VII. Direct, Indirect, and Induced Economic Impacts of UC San Diego
6. KY Rural Health Works. Economic Impact of Rockcastle Hospital and Respiratory Care Center, Inc. On Four Kentucky Counties: Fayette, Jefferson, Franklin & Madison; January 2005.

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October 19, 2010

Environmental Review Officer
San Francisco Planning Department
1650 Mission Street, Suite 400
San Francisco, CA 94103

Re: Preliminary Comments on the Draft Environmental Impact Report for the California Pacific Medical Center Long Range Development Plan

Dear Review Officer:

I have reviewed the Draft Environmental Impact Report ("Draft EIR") for the California Pacific Medical Center ("CMPC") Long Range Development Plan ("LRDP"). The Draft EIR was published by the City of San Francisco ("City") as the lead agency under the California Environmental Quality Act ("CEQA") for public review on July 21, 2010.[1] My comments below pertain to health care issues and environmental impacts that would result from implementation of the LRDP.

It is my opinion that the Draft Environmental Impact Report to implement California Pacific Medical Center's Long-Range Development Plan is critically flawed in deciding to ignore healthcare in its impact analyses, particularly in its cumulative impact analyses. All of the land use arguments are in their essence cost-benefit arguments about health care. Therefore, an analysis of the CEQA impacts of the LRDP, possible mitigation measures, and alternatives is incomplete and meaningless without an analysis of its health care implications.

My qualifications as a health expert include Director of Public Policy for the California Nurses Association/National Nurses United, former Oakland Planning Commissioner, and member of the San Francisco Blue Ribbon Panel for the St. Luke's Campus. My résumé is attached to this letter.

Background

CPMC consists of four hospitals in San Francisco, CA, and is affiliated with Sutter Health ("Sutter"). The LRDP is CPMC's multi-phased strategy to meet state seismic safety requirements for its hospitals and create a 20-year framework and institutional master plan for CPMC's four existing medical campuses and one proposed new medical campus, the Cathedral Hill Campus. The four existing

[1] City of San Francisco, California Pacific Medical Center (CPMC) Long Range Development Plan, Draft Environmental Impact Report, SCH No. 2006062157, July 21, 2010.

CPMC medical campuses are the Pacific Campus in the Pacific Heights area, the California Campus in the Presidio Heights area, the Davies Campus in the Duboce Triangle area, and the St. Luke's Campus in the Mission District.

I. Elimination of Services and Patient Transfers in the Bay Area Resulting from Sutter's Regionalization

Sutter is going through a process of "regionalization," in which its twenty-six affiliate hospitals are collapsed into five regional structures. As a result, the corporate entity of CPMC has ceased to exist, while all CPMC operations, finance, and governance have dissolved into Sutter West Bay. Sutter West Bay is the region covering Sutter operations from San Francisco north to Clear Lake.[2]

Historically, Sutter has tied together its affiliate networks with shared purchasing, compliance, contracting, treasurer, government relations, legal, pensions, employee benefits, etc. However, each affiliate also had relative autonomy in the pursuit of its own business plans. Sutter's major leverage over its affiliates was their participation in the Sutter Health Obligated Group. By affiliating with Sutter, previously independent hospitals agreed to keep only two weeks of operating cash on hand, while transferring all excess cash to Sutter Corporate. In practice, cash transfers through the Obligated Group have been inconsistent, and apparently political among the Sutter affiliates. (It is this inconsistency that is in part the basis of the current lawsuit by Marin General Hospital to recover the over $120 million Sutter transferred out of the Marin Healthcare District in the years leading up to the restoration of local governance.)[3]

As Sutter regionalizes its hospitals, it is engaged in a parallel regionalization of all its affiliated physician foundations. It appears that in the next five years, assuming the regionalization process is successful, Sutter intends to roll out a commercial insurance product to make it competitive with Kaiser Permanente ("Kaiser"). It can be assumed that Sutter has been imposing this insurance, named "Sutter Select," on its employees as a captive patient population to seed the launch of the product.

More important for CEQA review, Sutter's regionalization entails large-scale closures of services and increased transfer of patients between cities in the Bay Area. CNA has now been involved in CEQA review regarding Sutter's construction plans in Castro Valley, Oakland, Santa Rosa, San Mateo County, and San Francisco. In each instance, Sutter presents the respective plan in a vacuum, isolated from the simultaneous rebuilds the next town over.

Over the years, Sutter has drastically reduced the number of licensed hospital beds both at CMPC campuses and regionally. Specifically, if all of Sutter's plans in the Bay Area were approved, would entail eliminating 881 licensed hospital beds in the Bay Area between the CPMC campuses, Alta Bates Summit Medical Center in Berkeley and Oakland (Herrick

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[2] San Francisco Business Times, Cal Pacific Chief Takes on Regional Role, March 6, 2009; North Bay Business Journal, Sutter hospital CAO has history of managing quality, change, October 26, 2009.

[3] Sacramento Bee, Marin Hospital District Sues Sutter, August 27, 2010

Campus and Summit Campus), San Leandro Medical Campus (complete closure proposed), Eden Medical Center in Castro Valley, Sutter Medical Center of Santa Rosa, and Mills-Peninsula Health Services ("Mills Peninsula") in Burlingame and San Mateo.

The planned consolidation of by Sutter across the Bay Area assumes increased transfer of patients between cities. For example, earlier this spring a stroke patient in Novato was transferred to CPMC in San Francisco rather than to the nearest stroke center in Greenbrae in Marin County.[4] Traffic burdens (and associated air quality and greenhouse gas emissions) caused by additional patient transports to and from San Francisco as a result of regionalization are not addressed in the Draft EIR.

Table 1 below summarizes the past and planned future loss of licensed beds in the Bay Area.

Table 1: Reduction in number of licensed beds at Sutter-affiliated campuses in the Bay Area

Sutter Facility	2010 licensed beds	Rebuild plans	Recent past cuts	Future cuts outside rebuild plans	Total loss of licensed beds
Alta Bates Summit (Summit Campus, Oakland[a]	(345)	(309)	0	0	(36)
Alta Bates Summit (Herrick Campus, Berkeley)[b]	(180)	unknown	(18)	(77)	(95)
California Pacific Medical Center (San Francisco)[c]	(1,042)	(854)	(231)	0	(419)
Eden Medical Center (Castro Valley)[d]	(178)	(130)	(31)	0	(79)
San Leandro Hospital (San Leandro)[e]	(122)	0	0	(122)	(122)
Santa Rosa Medical Center (Santa Rosa)[f]	(135)	(70)	0	0	(65)
Mills Peninsula (San Mateo/Burlingame)[g]	(288)	(243)	(20)	0	(65)
				TOTAL	(881)

a Phase I of the rebuild at Summit Campus only

b 18 beds eliminated from adolescent psychiatric care in 2007; further cuts planned when Herrick Campus moves to Summit Campus include: closure of 40-unit pulmonary sub-acute care and reduction of adult/adolescent psychiatric care from 105 to 68 beds.

c Based on Draft EIR, Table 2-2, *see* Table below

d 31-bed acute rehabilitation unit closed in 2010

e Sutter intends to close the San Leandro Hospital; currently lawsuits are pending with hospital district, community, doctors, nurses, and other health care workers fighting to maintain San Leandro Hospital as a full-service acute care hospital

f Sutter recently obtained approval to rebuild Sutter Medical Center of Santa Rosa at a much smaller size; a lawsuit has been filed challenging the EIR

g 20-bed acute rehabilitation unit closed in 2010; cuts in addition to those listed in the table would result from closures of pediatrics and skilled nursing facility beds as announced by Mills-Peninsula in the past week

As Table 1 shows, almost half of the licensed beds eliminated by Sutter region-wide (881 beds) are removed at the CPMC campuses (419 beds) in San Francisco. Table 2 below shows a summary of licensed beds at the CPMC campuses for the time period from 2006 through 2010 and the future reductions proposed under the LRDP.

[4] Marin Independent Journal, Doctors Criticize Sutter Handling of Stroke Patient, May 18, 2010

Table 2: CPMC historic and proposed licensed hospital beds under LRDP by bed type[b]

Bed Type	2006	2007	2008	2009	2010	LRPD	A Δ (2010 - 2006)	B Δ (LRDP - 2010)
Cathedral Hill Campus								
Acute care	-	-	-	-	-	555	-	555
Rehabilitation	-	-	-	-	-	-	-	-
Psychiatric care	-	-	-	-	-	-	-	-
Skilled nursing	-	-	-	-	-	-	-	-
TOTAL	-	-	-	-	-	555	-	555
Pacific Campus								
Acute care	295	295	295	295	295	-	-	(295)
Rehabilitation	-	-	-	-	-	-	-	-
Psychiatric care	18	18	18	18	18	18	-	-
Skilled nursing	-	-	-	-	-	-	-	-
TOTAL	313	313	313	313	313	18	-	(295)
California Campus								
Acute care	319	299	299	299	299	-	(20)	(299)
Rehabilitation	-	-	-	-	-	-	-	-
Psychiatric care	-	-	-	-	-	-	-	-
Skilled nursing	101	101	101	101	-	-	(101)	-
TOTAL	420	400	400	400	299	-	(121)	(299)
Davies Campus								
Acute care	219	219	219	115	115	115	(104)	-
Rehabilitation	32	32	32	48	48	48	16	-
Psychiatric care	22	22	22	-	-	-	(22)	-
Skilled nursing	38	38	38	38	38	38	-	-
TOTAL	311	311	311	201	201	201	(110)	-
St. Luke's Campus								
Acute care	150	150	150	150	150	80	-	(70)
Rehabilitation	-	-	-	-	-	-	-	-
Psychiatric care	-	-	-	-	-	-	-	-
Skilled nursing	79	79	79	79	79	-	-	(79)
TOTAL	229	229	229	229	229	80	-	(149)
All Campuses								
Acute care	983	963	963	859[c]	859[c]	750	(124)	(109)
Rehabilitation	32	32	32	48	48	48	16	-
Psychiatric care	40	40	40	18	18	18	(22)	-
Skilled nursing	218	218	218	218	117	38	(101)	(79)
TOTAL	1,273	1,253	1,253	1,143[c]	1,042[c]	854	(231)	(188)

a Data from Draft EIR, Table 2-2, page 2-10

b Shaded cells indicate years in which the number of licensed beds were reduced compared to the prior year(s)

c The Draft EIR, Table 2-2, incorrectly adds up the number of existing acute care beds for all campuses and, consequently, the total number of beds for 2009 and 2010.

This summary table shows that from 2006 to 2010, Sutter eliminated a total of 231 licensed beds at the CPMC campuses: 124 acute care beds, 22 psychiatric care beds, and 101 skilled nursing beds; only the number of rehabilitation beds increased by 16 (*see* Column A). Now, even though the LRDP would include construction of a brand-new 555-bed hospital at the Cathedral Hill Campus, Sutter proposes to further eliminate another 188 licensed beds: 109 acute care beds and 79 skilled nursing beds (*see* Column B). Thus, between the year 2006 and the proposed LRDP at total of 419 licensed beds are removed from service including 233

acute care beds, 22 psychiatric care beds, and 180 skilled nursing beds. And, on November 1, 2010, CPMC will sell its dialysis program at the Pacific and Davies Campuses.[5]

II. Impacts on Health Care Access and Quality Resulting from Citywide and Regional Reduction of Licensed Beds

In addition to the drastic reduction of acute care, psychiatric care and skilled nursing facility ("SNF") beds under the LRDP as shown in Table 2, several other hospitals in the region are or have been reducing their services. The Sutter-affiliate Mills Peninsula recently closed their acute rehabilitation unit in Burlingame, San Mateo County,[6] advising patients to come to acute rehabilitation units at CMPC campuses in the City, specifically the Davies Campus. Sutter also plans on closing the SNF and dialysis unit at the Mills-Peninsula campus[7] and the SNF at the Santa Rosa Hospital. Now, CPMC plans to close the only sub-acute unit in San Francisco, forcing patients and their families to leave San Francisco for care. Combined with the recent closure of the SNF and sub-acute care at the Seton Medical Center in Daly City[8] and reductions at the Laguna Honda Hospital and Rehabilitation Center, the elimination of SNF beds and acute care beds under the LRDP further compounds the existing regional shortage.

In San Francisco, the proposed closure of the SNF at the St. Luke's Hospital in addition to the recent reductions in SNF beds at the California Campus in 2009/2010 represents an 83% reduction in CPMC's SNF bed capacity. SNF is the state licensing category for nursing homes, but historically a number of hospitals have opened licensed SNFs for patients who were too sick to be transferred to free-standing nursing homes. The only additional SNF services planned in San Francisco are 22 extra SNF beds part of the proposed rebuild of the Chinese Hospital. Patients will be put at risk if the patient population currently treated by the 178 historically offered by CPMC is simply placed in lower-level care SNFs. Worse still, if the need for SNFs is not met, these patients will need to be shipped out of San Francisco. SNF patients tend to have stays from three days to several weeks, which will result in multiple additional trips by their family members out of the City to visit them.

The CPMC LRDP is part of Sutter's business plan for the Bay Area and must be analyzed in the context of the cumulative effects of those plans. This includes: transfer of stroke patients from the Novato Community Hospital in Marin County to CPMC; transfer of sub-acute

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[5] San Francisco Business Times, CPMC Will Sell Dialysis Unit to DaVita, September 3, 2010; http://www.bizjournals.com/sanfrancisco/stories/2010/09/06/story12.html.

[6] San Mateo Daily Journal, Nurses Oppose Acute Rehab Move, September 24, 2009; http://www.smdailyjournal.com/article_preview.php?type=lnews&id=117024; and San Jose Mercury News, Nurses, Mills-Peninsula Square Off Over Rehab Care in San Mateo County, September 23, 2009.

[7] San Francisco Business Times, Mills-Peninsula Taking Scalpel to Money-Losers, October 15, 2010; http://www.bizjournals.com/sanfrancisco/stories/2010/10/18/story3.html?b=1287374400%255E4103181 *or* http://snipurl.com/1bdg6v [www_bizjournals_com].

[8] Silicon Valley Mercury News, Seton Medical Center to Close Skilled-Nursing Unit, October 7, 2010; http://www.mercurynews.com/ci_16283420?source=most_emailed.

patients and psychiatric patients out of San Francisco; transfer of SNF patients out of San Francisco; transfer of pediatric and acute rehabilitation patients into San Francisco from San Mateo County; and potential closure of the San Leandro Hospital. The Draft EIR fails entirely to analyze those cumulative impacts.

A report by the Lewin Group that analyzed changes to inpatient services proposed by the CPMC 2008 Institutional Master Plan ("2008 IMP") within the context of citywide health needs, including emergency department capacity, transitional care, urgent care services, and behavioral health services,[9] anticipates a citywide shortage of 30% above available skilled nursing bed capacity in the next ten years based on the City's aging baby boomer population.[10] The Lewin Group Report did not distinguish among different types of SNF beds. The complexity of care for patients in SNFs connected to an acute care is much higher. Patients in units licensed as SNFs that are connected to acute care hospitals need a higher level of care than patients in freestanding SNFs. Hospital-based SNFs, often called Post-Acute units, can provide peripherally inserted central catheters (PICC or PIC lines), multiple IV medications, complex wound care, daily labs, daily diagnostic services, easy transfer to more critical units, and on-site hospitalists. CPMC claims not to track re-admissions from SNFs back to acute care or from freestanding facilities back to acute care. However, there have been pilot programs in which patients died or were readmitted because they were prematurely discharged to lower acute care facilities.

CPMC has stated publicly that it will restore 62 SNF beds to the LRDP, however, these additional beds are not reflected anywhere in the Draft EIR. Making this change requires either new construction or modification to the proposed uses of the existing sites. The Draft EIR will be incomplete if it does not make clear where and when SNF beds will be provided. Patients will be at risk if those SNF beds are not on an acute care campus. CPMC has argued that it is cost-prohibitive to build SNFs into an acute care building, because SNFs are not required to meet the same standards of seismic compliance (although the Chinese Hospital is doing just that). CPMC could easily locate 62 SNF beds on two to three floors of a non-acute care building or medical office building adjoining an acute care hospital.

The Lewin Group Report found that the CPMC IMP "does not address a potential city-wide shortage of transitional and skilled nursing service capacity, nor does it aim to improve access to mental health services..."[11] Many of the licensed beds proposed to be reduced by the 2008 IMP have already been eliminated, as shown in Table 2. For example, the Davies Campus has eliminated 104 acute care beds and 22 psychiatric care beds in 2008/2009. (*See* Table 2.)

The Lewin Group Report also found that "full execution of the IMP will further stress the system's capacity to treat and care for patients requiring transitional care, chronic condition support and inpatient mental health services."[12] The report concluded that "[w]ithout an

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[9] The Lewin Group, California Pacific Medical Center Institutional Master Plan Review, June 26, 2009 (hereafter "Lewin Group Report"); www.rebuildcpmc.org/assets/FinalLewinReport.pdf *or* http://snipurl.com/1b9pxd [www_google_com].

[10] Lewin Group Report at page 22.

[11] Lewin Group Report at page 1.

[12] Lewin Group Report at page 33.

alteration in how care is delivered throughout the city, a significant shortage or change in migration patterns is projected to occur."[13] The Draft EIR fails to address these shortages and the physical and associated social and economic impacts attributable to the migration of patient populations in and out of San Francisco including the resulting longer travel distances and reduced access to health care.

III. Reduced Access to Health Care for St. Luke's Hospital Patients

In addition to the 231 licensed beds that were removed in the past years (2006-2010) at the CPMC campuses, under the LRDP, CMPC would remove from service another 743 licensed beds at the existing St. Luke's Hospital (149 beds), California Campus (299 beds), and Pacific Campus (295 beds). The newly constructed Cathedral Hill Hospital would only provide 555 beds, exclusively in private single-occupancy rooms,[14] *i.e.*, 188 fewer beds than currently provided by the existing CPMC campuses many of which are in double-occupancy rooms.[15] This removal of beds would result in reduced access to health care and a major shift of the current hospital patient population to other hospitals in the region, particularly for patients at the St. Luke's Campus. The Draft EIR fails entirely to address any of the associated impacts on traffic, transportation, parking, air quality, and public services.

At present, St. Luke's Hospital provides accessible acute care and inpatient services to the local community consisting of ethnically diverse, predominantly low-income patients from neighborhoods regardless of the patients' economical class or hospital reimbursement status. The most recent available data for the St. Luke's Hospital indicate that in 74.5% of the inpatient population was covered by Medicare, Medi-Cal, Workers' Compensation, or other government health programs (38.1% were covered by Medi-Cal, California's public health insurance program which provides needed health care services for low-income individuals including families with children, seniors, persons with disabilities, foster care, pregnant women, and low income people with specific diseases such as tuberculosis, breast cancer or HIV/AIDS[16]), and only 21.3% were covered by private insurance.[17] In contrast, the most recent available data for the Pacific Campus indicate that only 34.3% of the inpatient population was covered by government programs (7.5% by Medi-Cal) and that 63.5% of patients were covered by private insurance.[18]

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[13] Lewin Group Report at page 22.

[14] Draft EIR at page 1-21.

[15] Draft EIR at page 2-8.

[16] Medi-Cal is financed equally by the State and federal government.

[17] California Office of Statewide Health Planning and Development, Hospital Discharge Summary Reports, St. Luke's Hospital, Report Period: January 1, 2009 – June 30, 2009 and Report Period: July 1, 2009 – December 31, 2009; http://www.oshpd.ca.gov/MIRCal/Default.aspx.

[18] California Office of Statewide Health Planning and Development, Hospital Discharge Summary Reports, California Pacific Medical Center - Pacific Campus, Report Period: July 1, 2009 – December 31, 2010 and Report Period: January 1, 2010 – June 30, 2010; http://www.oshpd.ca.gov/MIRCal/Default.aspx.

The Cathedral Hill Hospital (555 beds) would barely accommodate the 594 acute-care services and Women's and Children's Center that would be relocated from the California Campus (299 beds) and the Pacific Campus (295 beds) to the proposed Cathedral Hill. It can be anticipated that few patients currently relying on the 229 beds at the existing St. Luke's Hospital would be accommodated at the new Cathedral Hill Hospital for a number of reasons:

- Not all services that are currently available at St. Luke's Hospital would be available at the Cathedral Hill Hospital, including SNF beds.
- Physicians are free to decide whether they will accept Medi-Cal patients, which constitute a large portion of St. Luke's Hospital patient population. Given the choice between higher-paying private or government insurance, they often deny Medi-Cal patients.
- Beneficiaries of government programs are often not eligible for private single-occupancy room services[19] if multiple-occupancy rooms are available.

As a result, most patients with insurance coverage limitations and relying on the acute care and SNF beds at the existing St. Luke's Hospital would not have access to the services offered by the new Cathedral Hill Hospital and would have to resort to accessing other hospitals in the City, or when those hospitals are overwhelmed as is often the case, in the greater region. Many of the patients currently frequenting St. Luke's Hospital do not have access to personal transportation and would be limited to time-consuming public transportation from the City to elsewhere. This may severely affect their health care.

The shift of the current patient population with insurance coverage limitations from the community-accessible St. Luke's Hospital to other hospitals in the City and region would have a number of adverse effects and consequences. For one, it would increase the regional vehicle miles traveled as patients and visitors would be forced to travel to hospitals that are located further from their homes and out of the City. Emergency service vehicles, forced to transport patients to hospitals located further away, would be tied up longer for transports to emergency departments at other hospitals which, in turn, would put additional pressure on the dispatch capacity at the City and County's Police Department and the Fire Department and increase the average response time and associated adverse consequences on the timely delivery of emergency cases to acute care units.

The increased vehicle miles traveled associated with the longer trips of patient, visitor, and emergency vehicles to and from other hospitals would also increase the regional air pollutant and greenhouse gas emissions and associated adverse impacts on public health. Most importantly, however, the shift of patient populations from the existing St. Luke's Hospital

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[19] *See*, for example, the following provisions of the Medicare Claims Processing Manual: Chapter 2: Admission and Registration Requirements, Section 10.6 – Hospitals May Require Payment for Noncovered Services, Revision 1472 dated March 6, 2008, and Chapter 3: Inpatient Hospital Billing, Section 40.2.2 – Charges to Beneficiaries for Part A Services, (I) Private Room Care, Revisions 1609 and 1612 dated October 3, 2008. These rules provide that private room (1-bed patient care room) care is not a Medicare covered service. Thus, private rooms may be denied by a Medicare provider to a beneficiary "who requests it but is unable to prepay or offer the assurance of payment..." (*see* Chapter 2, Section 10.6.)

to other hospitals, including government and county-funded community hospitals (*e.g.*, San Francisco General Hospital and Laguna Honda Hospital and Rehabilitation Center) and the loss of an additional 109 acute care beds would put a severe strain on the already severely overtaxed acute care capacity in the City and County. For example, because the San Francisco General Hospital is the only Level I Trauma Center in a service area of over one million people, the hospital maintains a very high patient volume and is usually on a constant "Total Divert" status, which means that incoming emergency patients (with the exception of trauma, psychiatric, pediatrics, and obstetrics and gynecology) are diverted to other nearby hospitals. In addition, the loss of local access to acute care would result in disproportionate adverse socio-economic impacts on low-income residents who are already faced with a lack of and access to other medical care, child care, transportation, etc. Adding this extra burden of not having local access to community-based acute care would constitute environmental injustice.

The Draft EIR is inadequate because it does not analyze the burden on City services for the services CPMC has already eliminated or would not provide in the future. CPMC has already closed 55% of its psychiatric services (at the Davies Campus) over the course of the past five years (*see* Table 2) and 70% over the past decade, despite a growing need for those same services. From 2000 through 2007, inpatient psychiatric census went up 20% at CPMC, before the closure at Davies Campus. Instead, their psychiatric patients are shifted to other providers. Citywide there is a crisis of inpatient adult psychiatric services. Citywide inpatient psychiatric bed capacity has dropped by 23% since 2000, according to licensing data published by the Office of Statewide Health Planning and Development ("OSHPD"). CPMC is responsible for 63 of the 79 psychiatric beds that have been closed in the City since 2000. This primarily places additional burden on San Francisco General Hospital ("SF General"), but also on St. Francis Memorial Hospital ("St. Francis") which is operated by Catholic Health Care West ("CHW"). The City has no data about the need for psychiatric services, let alone psychiatric emergencies, 5150s[20], substance abuse, drug detoxification, etc. and the Draft EIR fails to provide any information how the LRDP would impact the need and supply for these services.

In addition, there are unknown and unexamined additional losses of services at Davies Medical Center. Davies has historically served as a community hospital for the Castro District, and has been home to AIDS and HIV services. The LDRP reduces licensed bed capacity at the Davies Campus substantially and proposes to shift its clinical focus away from community-serving functions to neuroscience services. The Draft EIR, IMP, and LDRP lack any explanation of what services would be lost at the Davies Campus in order to make way for the new expanded neurosciences program, and specifically any commitments to maintain AIDS/HIV programs. It would be a significant loss of services if AIDS/HIV patients had to travel to new providers because of an erosion of CPMC's commitment as a result of its clinical realignment.

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[20] Section 5150 is a section of the California Welfare and Institutions Code (specifically, the Lanterman-Petris-Short Act) which allows a qualified officer or clinician to involuntarily confine a person deemed to have a mental disorder that makes them a danger to him or her self, and/or others and/or gravely disabled. A qualified officer, which includes any California peace officer, as well as any specifically designated county clinician, can request the confinement after signing a written declaration. When used as a term, 5150 (pronounced "fifty-one-fifty") can informally refer to the person being confined or to the declaration itself.

In sum, the Draft EIR fails entirely to discuss the direct physical changes and reasonably foreseeable indirect physical changes and to analyze the potentially significant adverse individual and cumulative impacts associated with the physical change of closing the existing hospital facilities and the resulting transfer of a large portion of the existing patient population to other hospitals.

IV. Potential Future Failure of St. Francis Memorial Hospital and St. Luke's Hospital

The Draft EIR is inadequate because it fails to analyze the potential future failure of St. Francis and St. Luke's Hospital and the associated impacts on health care services, which have cumulative environmental impacts on traffic and transit, parking, blight, and public services.

St. Francis

The Draft EIR fails to analyze the risk of blight and reduced access to health care in case CHW's Saint Francis should fail as a result of CPMC taking over their few lucrative patients. CHW has currently budgeted St. Francis at a loss of $2 million per year. This loss is sustainable because St. Francis' charity care, psychiatric care, and emergency room care are offset by a few services to insured patients. St. Francis has the City's premier burn unit, sports medicine, infusion, spine and joint surgeries. It does not make sense for Cathedral Hill to duplicate services provided five blocks away at St. Francis rather than ensuring that St. Francis will continue to be efficiently utilized and successful.

The DEIR is inadequate because it fails to analyze the potential risk of failure of St. Francis as a result of the duplication of services at the Cathedral Hill Campus and the related blight on the surrounding neighborhood and burden on city services which are left to pick up additional low-income patient loads from displaced patients.

St. Luke's Hospital

CPMC identifies eight of San Francisco's 24 zip codes as "primary St. Luke's service area."[21] Those eight zip codes combined generate 42% of the City's emergency room visits; 49% if patients with no zip codes are included, many of whom are homeless. Using CPMC's benchmarking year of 2007, those eight zip codes generate about 4,200 inpatient discharges from St. Luke's Hospital, but almost 8,000 inpatient discharges from other CPMC campuses.[22] This demonstrates that there is a need for services in the southeastern part of the City that is not currently met, a fact that would be further exacerbated by reducing St. Luke's Hospital to an unsustainable 80 beds. Clearly, this argues for shifting more services into the southeastern part of the City to respond to the proportionally higher emergency room volume which would also reduce traffic impacts caused by reducing the distance patients

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[21] Lewin Group Report.

[22] Based on data from California Office of Statewide Health Planning and Development, Hospital Discharge Summary Reports; http://www.oshpd.ca.gov/MIRCal/Default.aspx.

must currently (and under the LRDP) travel to get to the emergency room. Shifting services to St. Luke's Hospital would also reduce the burden on San Francisco General Hospital's already overwhelmed emergency department.

The plan for the St. Luke's Campus is not a plan for a viable hospital but a plan for maintaining segregation under which underinsured patients would go to St. Luke's Hospital while insured patients would go to Cathedral Hill Campus for better services. The emergency room at the St Luke's Hospital is the busiest CPMC emergency room and would be expanded under the plan. However, the plan for St. Luke's Hospital is basically a plan for as many beds as are needed to minimally support the emergency room and no more. None of the underlying problems due to which Sutter wanted to close the hospital in the past are solved. At present, the St. Luke's Hospital is planned with only 80 beds, which is likely too small to succeed.

If the hospital turns out to be unprofitable in the future, Sutter would likely close it, further exacerbating health care access to underinsured patients as well as the shortage of beds in San Francisco. As an 80-bed hospital, St. Luke's Hospital is also too small to be viable for sale or transfer to another hospital operator should Sutter decide to stop maintaining acute care services.

V. Traffic and Transportation Problems Due to Increased Traffic at Cathedral Hill Campus

The Draft EIR's traffic and transportation analyses all suffer from the same fundamental mistake, *i.e.*, failing to recognize that the projected future *levels of service* at intersections in the vicinity of the CPMC campuses is *not the only relevant criterion* that needs to be analyzed and would *not be the only consequence* of implementing the LRDP.

The Draft EIR does not adequately analyze how the increased traffic around the Cathedral Hill Campus will affect access for ambulances, patients being transferred to and from other Sutter hospitals, patients attempting to reach the emergency room, and labor and delivery vehicles. The traffic engineer Tom Brohard concludes in his comments on the Draft EIR:

> Many of the intersections studied in the Draft EIR already operate at LOS F[23] in peak hours under existing conditions, and the number of these failing intersections will significantly increase [in future years] ... Adding [LRDP] ... trips to these failing intersections will increase vehicle delay beyond what is already being experienced, with no relief in sight. This issue is particularly critical for a hospital project. For example, the Draft EIR does not analyze how the increased traffic around the Cathedral Hill Campus will affect access for ambulances and labor and delivery vehicles. During gridlock traffic conditions which are much of the time on Van Ness

[23] Level of Service ("LOS") F is the lowest measurement of efficiency for a road's performance. Flow is forced; every vehicle moves in lockstep with the vehicle in front of it, with frequent slowing required. Facilities operating at LOS F generally have more demand than capacity.

Avenue, emergency patients could face life threatening delays while waiting in traffic.[24]

In other words, due to the location of the Cathedral Hill Campus as it sits in a high-density neighborhood at the intersection of two major traffic corridors experiencing heavy use and congestion and the fact that most patients and employees would be concentrated at one campus rather than being spread out across several campuses, chances are that in a bad traffic jam on Van Ness Avenue babies will be born in traffic and patients will die trying to get to the emergency room. Such patient safety hazards will be a daily event during rush hour, and potentially worse in the event of an accident, construction, or other disruption as occurred last year one block away.[25] This cannot be the intention of a health care provider for providing optimal care for its patients.

To mitigate access problems at the Cathedral Hill Campus, Mr. Brohard recommends:

> To reduce these impacts and better serve the community, CPMC should spread the proposed development to several other campuses including to the St. Luke's Campus rather than concentrating services at the Cathedral Hill Campus. Access to and from St. Luke's Campus is closer to Highway 101 for vehicles and to major transit facilities such as the 24th Street BART Station for transit patrons. Moreover, the St. Luke's Campus is the most accessible CPMC facility for those Sutter patients traveling from San Mateo and Santa Clara counties. From a transportation perspective, a Project alternative that distributes patients and services equally across the City should be evaluated in a revised EIR.

Since more patients come to CPMC from San Mateo County than from Marin County, shifting services to St. Luke's Hospital would reduce this traffic impact. A bigger St. Luke's Hospital also makes more sense for CPMC's patient population and would reduce the above discussed health care access issues for patients currently frequenting St. Luke's Hospital.

VI. The Draft EIR Fails to Evaluate Potentially Significant Adverse Impacts on Public Services Associated with the CPMC LRDP

The California Environmental Quality Act ("CEQA") Guidelines, Appendix G, require that the environmental review of a project include the assessment of impacts to public services. Specifically, Appendix G requires the lead agency to identify:

> "Would the project result in substantial adverse impacts associated with the provision of new or physically altered governmental facilities, need for new or physically altered facilities..., *in order to maintain acceptable service ratios, response times, or other performance objectives for any of the public services:*

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[24] Letter from Tom Brohard and Associates to Law Offices of Gloria Smith, Re: Review of Draft Environmental Impact Report for the California Pacific Medical Center Long Range Development Plan – Transportation and Circulation Comments, October 18, 2010.

[25] San Francisco Chronicle, PG&E Says 1920s Power Line Sparked SF Fire, July 16, 2009; http://articles.sfgate.com/2009-07-16/bay-area/17217311_1_power-line-pg-e-underground-fire.

Fire Protection?
Police Protection?
Schools?
Parks?
Other public facilities?"

While the Draft EIR contains a discussion of response times of the City's Fire Department, Police Department and finds these adequate to handle the demand by the LRDP[26], it does not analyze the impacts on these services associated with the qualitative changes in the patient population described above and the associated impacts on response times due to transfer of patients to other hospitals in the region. The Draft EIR entirely fails to address the impacts on service ratios, response times, and other performance objectives to other public hospitals, including government and county-funded community hospitals, that would result from patient populations having to migrate within or out of the City.

The CEQA Guidelines, Section 15126.2, provide that:

> "An EIR shall identify and focus on the significant environmental effects of the proposed project. ... Direct and indirect significant effects of the project on the environment shall be clearly identified and described, giving due consideration to both the short-term and long-term effects. The discussion should include relevant specifics of the area, the resources involved, *physical changes*, alterations to ecological systems, and changes induced in population distribution, population concentration, the human use of the land (including commercial and residential development), *health and safety problems caused by the physical changes*, and other aspects of the resource base such as water, historical resources, scenic quality, *and public services. ...*"

Here, the Draft EIR fails to identify and describe the short-term and long-term effects with respect to *physical changes, health and safety problems caused by the physical changes, and public services* associated with implementation of the LRDP. As a result, the Draft EIR fails to assess the any associated significant impacts.

VII. The Draft EIR Fails to Evaluate Potentially Significant Adverse Social and Economic Impacts Associated with the CPMC LRDP

Elsewhere the CEQA Guidelines, Section 15382, define a significant effect on the environment to mean:

> "... a substantial, or potentially substantial, adverse change in any of the physical conditions within the area affected by the project, including land, air, water, minerals, flora, fauna, ambient noise, and objects of historic or aesthetic significance. An economic or social change by itself shall not be considered a significant effect on the environment. *A social or economic change related to a physical change may be considered in determining whether the physical change is significant.*

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[26] Draft EIR at Section 4.11 Public Services.

The above discussed reduction of licensed beds at three of the CPMC hospitals and the change in service resulting from the restricted access to service provided by the new Cathedral Hill Hospital
would result in direct environmental impacts (*e.g.*, increased vehicle miles traveled and associated increased air pollutant and greenhouse gas emissions) and would result in adverse economic and social effects. These effects must be analyzed under CEQA.

Title 14, Section 15064, Subsection (e) of the California Administrative Code provides the following guidance for evaluating the changes:

> "Economic and social changes resulting from a project shall not be treated as significant effects on the environment. Economic or social changes may be used, however, to determine that a physical change shall be regarded as a significant effect on the environment. Where a physical change is caused by economic or social effects of a project, the physical change may be regarded as a significant effect in the same manner as any other physical change resulting from the project. Alternatively, economic and social effects of a physical change may be used to determine that the physical change is a significant effect on the environment. *If the physical change causes adverse economic or social effects on people, those adverse effects may be used as a factor in determining whether the physical change is significant. For example, if a project would cause overcrowding of a public facility and the overcrowding causes an adverse effect on people, the overcrowding would be regarded as a significant effect."*

The Court in Bakersfield for Local Control v. City of Bakersfield (5th Dist. 2004), Cal. App. 4th 1184 [22 Cal Rptr. 3d 203], affirmed:

> "Subdivision (e) of Guidelines section 15064 provides that when the economic or social effects of a project cause a physical change, this change is to be regarded as a significant effect in the same manner as any other physical change resulting from the project. (...) *Conversely, where economic and social effects result from a physical change that was itself caused by a proposed project, then these economic and social effects may be used to determine that the physical change constitutes a significant effect on the environment."*

All patients depend on their local community hospitals for critical health care services, regardless of their ability to pay. Clearly, the elimination of service to a large portion of the patient population that currently frequents St. Luke's Hospital constitutes a significant effect on public health caused *directly* by the elimination of services at existing CPMC hospital and the replacement with far fewer beds at the Cathedral Hill Hospital that would only be accessible to patients without insurance coverage limitations. What's more, these changes in service would not only affect the patient population with insurance coverage limitations but also all other Californians due to the increased pressure on emergency department services when beds are not available.

What's more, impending Medi-Cal cuts will affect all hospitals and will even more severely impact "safety net" hospitals. The severity of the cuts could force some hospitals to close or reduce access to essential health care services. As a result, hospitals with already overcrowded emergency rooms will be further inundated with more patients, longer wait times, and financial stresses.

As Sutter aptly summarizes on one of its websites:

> "The loss of critical hospital services will not only be devastating for low income Californians but will also present an increasingly harmful public health scenario for all Californians.
>
> ...
>
> Most important, where will patients go when hospitals are forced to close their doors? More than 70 California hospitals have closed in the past 10 years. Statewide, nearly half of California's hospitals operate in the red and many are either near or already in bankruptcy proceedings. When hospital ERs are backlogged with Medi-Cal and other patients who can't find doctors to care for them, *it doesn't matter how good the insurance coverage is when patients have to drive several hours to receive emergency care.*"[27]

These impacts should have been analyzed by the Draft EIR but were not.

VIII. The Large Size of the Cathedral Hill Hospital Does Not Guarantee Better-Quality Patient Care

The LRDP proposes to build a 555-bed hospital at the Cathedral Hill Campus, at the same time reducing the St. Luke's Hospital from 229 acute care and skilled nursing beds to 80 licensed acute care beds, terminating services at the California Campus, and all but eliminating services at the Pacific Campus (295 acute care beds eliminated, 18 psychiatric care beds remaining). (*See* Table 2.)

The 555-bed Cathedral Hill Hospital would require a myriad of variances, major entitlements, amendments and exceptions from existing plans, policies and regulations. The Draft EIR's consistency determination for the LRDP is based on the presumption that CPMC would successfully obtain changes to the following:

- San Francisco General Plan and all applicable elements, including the Housing Element
- Regional plans and policies (*e.g.*, Bay Area Air Quality Management District plans and regulations)
- Van Ness Avenue Area Plan ("VNAP")
- Market & Octavia Neighborhood Plan
- Mission Area Plan
- Japan town Better Neighborhood Plan
- Mission District Streetscape Plan

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[27] Eden Medical Center, A Sutter-Affiliate, What's New At Eden, California's Fiscal Emergency Puts Hospitals and Patients in Jeopardy, May 22, 2008; http://www.edenmedcenter.org/whatsnew/whatsnew_new.html.

- Measure M

It is no secret why Sutter is intent on building such a large hospital despite all the variances, major entitlements, amendments and exceptions from existing plans, policies and regulations it needs: profit. Research on hospital size and profitability indicates that large hospitals are more profitable. According to a 2002 article in the Journal of Health Care Finance: "The relationship between hospital profitability and hospital bed size revealed that when bed size increases, hospital profitability increases, decreases, and then increases again."[28] The study found that the turning points for patient profit proportion are 238 and 560 beds, respectively for the total profit proportion; the turning points in bed size are 223 and 504, respectively. These results on the relationship between bed size and hospital profitability indicate that medium-size hospitals are in general the least profitable. The findings regarding the profitability of large hospitals in this study are supported by the Medicare Cost Reports for 2006 which show that the more beds a hospital has, the more likely it will be profitable. For hospitals with more than 550 beds, 90% had a positive net income; for smaller hospitals, the percentage with positive net income drops to 72%.

The Cathedral Hill Campus is too big for the site. The benchmarking report provided by the City's and County's Office of the Legislative Analyst ("OLA") showed that most hospitals of the size of Cathedral Hill in major urban areas occupy far larger sites.[29] In fact, for its Santa Rosa facility, Sutter tried to justify that 25 acres of land would be necessary to accommodate a 174-bed, 360,000-square foot hospital.[30] Here, Sutter would squeeze 555-bed, 655,100-square foot hospital and 307,400 square feet of MOB buildings onto 3.85 acres.[31] As discussed before, this would result in numerous impacts including impacts on health care, traffic and transportation, parking, air quality, greenhouse gas emissions, to name a few.

So far, CPMC has not provided any evidence that health care benefits from a large hospital would outweigh the significant land use and environmental impacts that would result from locating this hospital on a very small site on one of the City's major thoroughfares with already compromised traffic flow and reducing its services in other parts of the City. Neither has CPMC presented any evidence that the environmentally superior project alternative of a bigger St Luke's and smaller Cathedral Hill would diminish health care benefits from the entire project.

The only evidence CPMC has produced so far in support of concentrating services at the Cathedral Hill Campus is a selection from the U.S. News & World Report hospital rankings that show that some of the top-rated hospitals are also big.[32] The comparison is irrelevant

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[28] Kim YK, Glover SH, Stoskopf CH, Boyd SD, The Relationship between Bed Size and Profitability in South Carolina Hospitals, J Health Care Finance, Vol. 29(2):53-63, Winter 2002; abstract available at http://www.ncbi.nlm.nih.gov/pubmed/12462659.

[29] Alexa Delwiche and Frances Zlotnick, City and County of San Francisco, Office of the Legislative Analyst, Legislative Analyst Memorandum, April 3, 2009, Re: OLA No. 003-009).

[30] Sutter Health statement at May 27, 2010 County of Sonoma Board of Supervisors hearing.

[31] San Francisco Planning Department, Notice of Preparation of an Environmental Impact Report and Notice of Public Scoping Meeting, California Pacific Medical Center Long Range Development Plan, May 27, 2009 at pages 13 and 18.

[32] Presented at Planning Commission hearing, November 19, 2009.

because those bigger hospitals are not on a single city block. It might be a relevant comparison if CPMC had 20+ acres, but they do not. Moreover, the methodology of the U.S. News & World Report rankings does not conclude that bigger hospitals are better are better than smaller hospitals. In fact, it uses 200 beds as a threshold criterion for being on the list and only looks at admittedly "cherry-picked" specialties. The rankings are not designed to show overall hospital quality and outcomes, and rely on indicators of dubious healthcare value (like magnet status and physician opinion polling). The rankings are designed to guide consumers with rare conditions who can travel for low-volume, high-cost, high-risk specialists; they are useless for health care planning purposes.

In fact, scientific studies on the issue of hospital size versus health care benefits are inconclusive and most conclusions are dependent on specialization of services. There is evidence supporting specialization and arguing for consolidation of services to achieve higher case volume, up to a point and only for certain services. There is evidence that certain services achieve better outcomes from higher volume, but not that higher volume of specific services indicates overall larger hospital size. There is no evidence that patients benefit from co-location of clinically unrelated services, like birthing and cardiology. There is no evidence that hospital size is proportional to any indicator of patient care above certain thresholds. There is only limited evidence that what relationship exists between size and patient outcomes is a causal relationship rather than related to factors other than size. Moreover, some studies conclude that large hospitals have higher costs, longer patient stays, lower patient satisfaction in emergency room care, and higher rates of infection or sepsis.

What evidence exists on the relationship between size and quality argues less in favor of an oversized 555-bed Cathedral Hill Hospital but clearly against an undersized 86-bed hospital at St. Luke's Campus. Some of the health problems associated with very small hospitals would be solved if St. Luke's Hospital were increased to 200 beds. The fact is that the trend in California is not to build hospitals as large as 555 beds, except those connected to universities. Most hospitals are between 200-300 beds, and California is almost never building urban hospitals as small as 80 beds, as is proposed for the St. Luke's Campus.

IX. Conclusion

As explained above, the Draft EIR is inadequate because it fails to analyze the health care implications of the LRDP and associated impacts on air quality, greenhouse gas emissions, public health, and public services. Specifically, the Draft EIR fails to include an evaluation of the potentially significant impacts due to the change in patient population resulting from loss of access to acute care to patients with insurance coverage limitations associated with the elimination of acute care and SNF at the St. Luke's Hospital.

CPMC has asked the City for numerous variances and massive entitlements and concessions from a land use perspective. The LRDP as proposed has several significant and unavoidable environmental impacts. The Draft EIR concludes that the environmentally superior alternative is a bigger St. Luke's Hospital and smaller Cathedral Hill Hospital. CPMC's justification for not choosing this environmentally superior alternative is that healthcare benefits would vastly offset the environmental problems. Unfortunately for CPMC, the balance of evidence on healthcare is that healthcare would also be better served by the environmentally superior alternatives.

It is not acceptable that a health care provider with a dominant market share in San Francisco (33% in 2007) deliberately changes its services to reap greater profits while denying access to health care to a large part of its patient population that is not profitable. To put the non-profit status of Sutter into perspective: as of December 31, 2009, Sutter had a $2.63 billion investment portfolio and paid its CEO $2.8 million in 2008; the CEO's top 14 lieutenants each made between $830,000 and $1.8 million annually.[33] Sutter's operations at the CPMC campuses in San Francisco contributed $150-180 million in profit annually, representing the largest single source of Sutter's total profits of $700 million per year. Sutter must rebuild CPMC to comply with state seismic deadlines and will not risk loss of its most profitable affiliate. This means that there is no credible alternative of "no project." Sutter will rebuild, and can easily afford any additional costs of redesign, project alternatives, community benefits, development agreements, and any mitigation measures.

As the San Francisco Chronicle and Business Week reported in August, the Sacramento Bee reported in April, and Kaiser Health News and San Jose Mercury News reported in October of this year, Sutter's business model is designed as a monopoly model, in which it makes itself indispensable to insurers and then charges higher rates.[34] The LRDP as proposed will increase Sutter's regional monopoly, and increase costs of health care for everyone, including taxpayer-funded health plans for public employees. The Draft EIR is incomplete if it does not address the ways in which the LRDP will increase cost of care for everyone and consider appropriate mitigation measures in this area.

The Draft EIR concludes that the environmentally superior alternative is alternative 3A, which is a bigger St Luke's Hospital and smaller Cathedral Hill Hospital. However, the Draft EIR designs a bigger St Luke's Hospital around a relocated women's and children's program. This creates an alternative that is not supportable because it would shift most women's and children's services to the southern half of the City (CPMC, University of California at Mission Bay, SF General). CNA supports the environmentally superior alternative of a bigger St Luke's, but with a different complement of services. Instead of all of women's and children's services being moved, CPMC can easily centralize other services already planned at St Luke's Hospital. CPMC currently plans to offer some level of cardiology, oncology, orthopedics, gastroenterology, respiratory, and urology at St. Luke's Hospital and to duplicate every single one of these services at Cathedral Hill Hospital with a higher standard of care for insured patients. Instead, CPMC could centralize some combination of these services for all CPMC patients at St. Luke's Hospital.[35]

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[33] Health Care Renewal, How Oligopolists Rationalize Their Market Domination: the Examples of Sutter and the Carilion Clinic, August 20, 2010; http://hcrenewal.blogspot.com/2010/08/how-oligopolists-rationalize-their.html.

[34] Bloomberg News/BusinessWeek, Hospital Monopolies Ruin MRI Bill as Sutter Gets Price it Wants, August 20, 2010; Kaiser Health News, California Hospitals: Prices Rising Rapidly, but Quality Varies, October 17, 2010; Sacramento Bee, California's Higher Hospital Costs Add to Health Insurance Hikes, April 18, 2010.

[35] Camden Group Utilization Project Report at page 22.

In contrast to the proposed project, a smaller Cathedral Hill Hospital and a larger St. Luke's Hospital would be by far preferable in terms of health care and would also considerably reduce environmental impacts. We support the environmentally superior alternative of a larger St. Luke's Hospital with a clinical anchor and a smaller Cathedral Hill Hospital.

I recommend that the City require a revision of the Draft EIR that adequately discusses and mitigates these issues.

Sincerely,

Michael Lighty
Director of Public Policy
California Nurses Association/ National Nurses United

Michael Lighty

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Oakland, CA 94612
510-273-2242

Skills

- **Expert on healthcare policy**
- **Effective advocate for nurses and universal healthcare**
- **Experienced in planning, design review and development project review**

Education

Stanford University
1978 - 1983

- BA Humanities Honors (1/88)
- MA Modern Thought and Literature (1/88)
- Student Co-Director, Stanford Workshops on Political and Social Issues

Experience

California Nurses Association/National Nurses Organizing Committee CNA/NNOC

Director of Public Policy
November, 2008– present
Coordinate the national political and legislative work for 85,000 member union of Registered Nurses; issues include healthcare reform, patient rights, labor law reform, budget, tax and economic development policy.

Director of Administration
September, 1999 - November, 2008
Directed the accounting, membership, facilities and events staff for growing union; served as the Executive Director designee for the California Nurses Foundation; responsible for budget development and contract administration and vendor relations; continued to coordinate organization's political work, including managing state-wide initiative campaign (prop 89) and grassroots lobbying, and the landmark 2004-2005 campaign to preserve California's safe hospital staffing law and workers' rights.

Political Action Coordinator
November, 1995 - September, 1999
Coordinated state-wide political work including an initiative campaign (prop 216), which help launch the national HMO patients rights movement, and grassroots lobbying, rallies and events to win the first in the nation nurse-to-patient ratio law for safe hospital staffing.

Labor Representative
February, 1994 - November, 1995
Negotiated collective bargaining agreements, organized and represented nurses at Bay Area hospitals.

Member, Board of Port Commissioners, City of Oakland
April, 2010 -

Member, City of Oakland Planning Commission
November, 1999 - September, 2007
Chaired the Zoning Update Committee and served a term as Vice-Chair of the Commission. Active on Design Review Committee.

Board Affiliations

Shepherd Canyon Neighborhood Association, Design Review Chair
March, 2009 - present

Labor Project for Working Families, Board Member
February, 2008 - present

Martin Luther King Freedom Center, Board Member
December, 2007 - present

East Bay Lesbian, Gay, Bi-Sexual and Transgender Democratic Club, Board Member
2005 - present

Park Day School, Board Member
1999 - 2002
Chaired the Long-Range Planning Committee which oversaw fiscal and strategic planning

Tom Brohard and Associates

October 18, 2010

Ms. Gloria Smith
The Law Offices of Gloria D. Smith
48 Rosemont Place
San Francisco, CA 94103

SUBJECT: Review of Draft Environmental Impact Report for the California Pacific Medical Center Long Range Development Plan – Transportation and Circulation Comments

Dear Ms. Smith:

At your request, I have reviewed the July 21, 2010 Draft Environmental Impact Report (Draft EIR) prepared for the San Francisco Planning Department for the California Pacific Medical Center (CPMC) Long Range Development Plan (Project). My review focused on Section 4.5 of the Draft EIR, Transportation and Circulation. I have also reviewed various other documents including the June 2010 Traffic Impact Studies prepared by Fehr & Peers for each of the five campuses in the Project and the "California Pacific Medical Center Institutional Master Plan 2008 Transportation Study" prepared by CHS Consulting Group.

Education and Experience

Since receiving a Bachelor of Science in Engineering from Duke University in Durham, North Carolina in 1969, I have gained over 40 years of professional engineering experience. I am licensed as a Professional Civil Engineer both in California and Hawaii and as a Professional Traffic Engineer in California. I formed Tom Brohard and Associates in 2000 and now serve as the City Traffic Engineer for the City of Indio and as Consulting Transportation Engineer for the Cities of Big Bear Lake, Mission Viejo, and San Fernando. I have extensive experience in traffic engineering and transportation planning. During my career in both the public and private sectors, I have reviewed numerous environmental documents and traffic studies for various projects. Several recent assignments are highlighted in the enclosed resume.

Proposed Project

The CPMC Long Range Development Plan proposes significant changes to five medical campuses in San Francisco, with projects planned for completion in Years 2015, 2020, and in 2030. According to the Draft EIR, the Project generally includes:

- Cathedral Hill Campus would be developed with a new hospital, new medical office building (MOB), and conversion of an existing office building from a partial MOB to a full MOB as follows: a vacant hotel and office building would be demolished and replaced by a new 1,163,800 square foot hospital with

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555 beds; seven existing buildings would be demolished and a new MOB would be constructed; and interior modifications would convert the 1375 Sutter facility to a full MOB.

- Pacific Campus would be converted to outpatient care to serve the area north of Market Street. The existing acute care and emergency functions would be transferred to the Cathedral Hill Campus after completion of the hospital in 2015. The Ambulatory Care Center (ACC) would then be expanded and on-site parking would be added.

- California Campus would not be changed in the near term. After the new Cathedral Hill Hospital opens in 2015 and after the ACC expansion at the Pacific Campus in Year 2020, the California Campus would close.

- Davies Campus functions would continue, together with construction of a Neuroscience building in the near term and a second MOB in the longer term.

- St. Luke's Campus would include construction of a replacement hospital with 145,000 square feet and 80 beds, and a new MOB/Expansion Building.

Transportation Issues

Section 4.5 of the Draft EIR, Transportation and Circulation, is organized by topic such as roadway network, intersection operations, transit operations, bicycle facilities, parking, impact evaluations, and mitigation measures. Discussions of each campus are presented one after the other under the individual topic rather than continuously as a complete discussion of each campus. This organization of the Draft EIR makes it extremely difficult and unnecessarily complex to follow the analysis of the individual projects proposed for each of the five campuses.

The Draft EIR identifies over 150 traffic impacts associated with the CPMC Long Range Development Plan. For the near term in Years 2015 and 2020, the Draft EIR identifies 98 traffic impacts, with 58 of those associated with the Cathedral Hill Campus. For the long term in Year 2030, the Draft EIR identifies 53 cumulative traffic and transit impacts, with 42 of these associated with the Cathedral Hill Campus. From this summary of traffic and transit impacts alone, the intense development proposed for the Cathedral Hill Campus creates nearly two-thirds of all of the Project's overall impacts to the roadway and transit system. Of the 100 traffic impacts associated with the Cathedral Hill Campus, the Draft EIR indicates that 30 impacts are significant, unavoidable, and cannot be mitigated. My review indicates that the Draft EIR's estimate of unmitigable impacts is likely low.

To reduce these impacts and better serve the community, CPMC should spread the proposed development to several other campuses including to the St. Luke's

Campus rather than concentrating services at the Cathedral Hill Campus. Access to and from St. Luke's Campus is closer to Highway 101 for vehicles and to major transit facilities such as the 24th Street BART Station for transit patrons. Moreover, the St. Luke's Campus is the most accessible CPMC facility for those Sutter patients traveling from San Mateo and Santa Clara counties. From a transportation perspective, a Project alternative that distributes patients and services equally across the City should be evaluated in a revised EIR.

In addition to the impacts that have been identified in the Draft EIR, conditions will actually be worse based upon the criteria used by the City and County. Unlike most other agencies, the San Francisco criteria used to identify significant impacts for development projects do not address incremental increases in delay at intersections once gridlock conditions occur at Level of Service (LOS) F. In other words, a development project could add a number of trips to an already failing intersection without being considered as contributing considerably to cumulative traffic increases for the most congested movements, and without requiring any mitigation measures.

Many of the intersections studied in the Draft EIR already operate at LOS F in peak hours under existing conditions, and the number of these failing intersections will significantly increase in Years 2015, 2020, and 2030 according to Tables 4.5-17, 4.5-18, 4.5-35, 4.5-37, 4.5-38, and 4.5-39 of the Draft EIR. Adding Project trips to these failing intersections will increase vehicle delay beyond what is already being experienced, with no relief in sight. This issue is particularly critical for a hospital project. For example, the Draft EIR does not analyze how the increased traffic around the Cathedral Hill Campus will affect access for ambulances and labor and delivery vehicles. During gridlock traffic conditions which are much of the time on Van Ness Avenue, emergency patients could face life threatening delays while waiting in traffic.

Finally, the Draft EIR did not adequately analyze increases in both transit use and vehicle miles traveled resulting from the Project. According to Page 5-16 of the Draft EIR, CPMC is the second largest employer in San Francisco. The total number of employees at all of the CPMC campuses will grow to approximately 10,730 by 2030. This would be a net growth of 4,170 employees to the CPMC system between 2006 and 2030. This new employment would create population growth and household growth of approximately 3,480 people or approximately 3 percent according to Page 4.3-31 of the Draft EIR. People traveling into the City and across the City for these new job opportunities will increase traffic and further burden public transit. Thus, a revised EIR must analyze this impact.

More specifically, my review of the Draft EIR and the supporting traffic studies indicates a number of technical errors and inconsistencies in the Transportation and Circulation Analysis of the Project. Each of the issues identified below must

be addressed and reevaluated through additional study in a revised and recirculated EIR as follows:

1) Muni Service Assumptions Do Not Match Existing Baseline – In discussion regarding San Francisco Municipal Transportation Agency, Page 4.5-17 of the Draft EIR states "Figures 4.5-6 through 4.5-10 (beginning on Page 4.5-18) present Muni lines serving each campus, while Tables 4.5-1 through 4.5-5 (beginning on Page 4.5-23) present the frequency of service for the Muni bus, light rail, and cable car lines serving each study area. The information on frequency of service reflects Muni service before the December 5, 2009 service changes that resulted from SFMTA's ongoing fiscal emergency... On December 5, 2009, Muni service changes associated with the budget deficit were implemented. The fiscal emergency declared on April 21, 2009 continued through fiscal year 2010. As a result, SFMTA is facing a shortfall in its current fiscal year, which ended on June 30, 2010. To address the continuing fiscal emergency, SFMTA implemented reductions in service beyond those implemented on December 5, 2009. As noted above, the transit service and ridership data do not reflect the recent changes to Muni service resulting from SFMTA's ongoing fiscal emergency because ridership data for post-implementation conditions is not currently available for all lines."

   From my review of the SFMTA website, service changes included discontinued routes and route segments, extended and modified routes, and changes to service hours and frequencies. Service reductions were initially implemented on December 5, 2009 and additional reductions were made on May 8, 2010. While about 60 percent of the May 8, 2010 service reductions were subsequently restored on September 4, 2010, current Muni services are significantly reduced compared to 2006 and 2007 when the ridership data used in the Draft EIR was collected by Muni. With reduced service frequencies and the same level of transit ridership, some Muni lines are certainly experiencing higher occupancy than identified in the Draft EIR. This increase, combined with a large workforce at Project buildout, was not analyzed in the Draft EIR.

   In the evaluation of traffic impacts in the Draft EIR, peak hour traffic counts at critical intersections conducted in 2006 were validated by making new peak hour counts in 2009 and comparing the traffic volumes. However in the transit analyses in the Draft EIR, ridership and occupancy validation of the data collected in 2006 and 2007 prior to the service reductions has not occurred. Without updating and comparing ridership, service levels and transit capacity, current transit occupancy after the Muni service reductions has not been determined. Further, while the Draft EIR states that SFMTA does not have current ridership data for all lines, the Draft EIR should have included a validation process for the critical transit lines, particularly those approaching

capacity that serve the five campuses. Without proper baseline data, the transit analysis is flawed.

2) Assumptions Regarding Future Muni Service Increases Are Not "Reasonably Foreseeable" – Page 4.5-61 of the Draft EIR states "SFMTA and the City Controller's Office are in the process of implementing the TEP, a review of the City's public transit system with recommendations designed to make Muni service more reliable, quicker and more frequent. The TEP proposals were endorsed by the SFMTA Board of Directors in October 2008."

   From my review of the SFMTA website, plans to implement the TEP (Transit Effectiveness Project) and its numerous transit service enhancements have been suspended with the ongoing fiscal emergency. In my opinion, it is **not** reasonably foreseeable that Muni will increase transit services in the areas adjacent to the five CPMC campuses when transit services have been dramatically reduced in December 2009 and May 2010, twice in the last 10 months. As the Draft EIR has assumed that the TEP service enhancements will be made, the transit analysis of near term and long term transit conditions is flawed. This flawed analysis in turn resulted in a significant under estimation of impacts.

3) Numerous Errors in Muni Corridor Analyses for Near and Long Term – There are many errors in the ridership data, both within various tables as well as in comparison to the Draft EIR's forecast number of Project transit riders in the description of transit impacts. While the first two examples discussed in detail relate to the Cathedral Hill Campus, there are other similar errors for each campus that are also summarized below. The inconsistencies between the impact statements and the tables, together with internal errors in the tables, void the subsequent calculations of transit capacity utilization as well as all transit mitigation measures that have been based on these flawed analyses.

   a) Cathedral Hill Campus - AM Peak – Impact TR-27 on Page 4.5-118 of the Draft EIR indicates that the Cathedral Hill Campus will generate 586 new transit trips in the AM peak hour. In comparing the forecast ridership in Table 4.5-21 in 2015 under "No Project" and "Project" conditions in the AM peak hour, 479 new transit riders will be generated by the Cathedral Hill Campus (the difference between the sum of the ridership in all directions in 2015 with Project and without Project – 9,499 minus 9,020 equals 479). In comparing the forecast ridership in 2030 under "No Project" and "Project" conditions, 479 new transit riders will be generated by the Cathedral Hill Campus (the difference between the sum of the ridership in all directions in 2030 with Project and without Project – 10,183 minus 9,704 equals 479). The 586 new transit riders at the Cathedral Hill Campus in 2015 and 2030 as stated in Impact TR-27 must be used to evaluate transit impacts, not the 479 new transit riders in Table 4.5-21.

b) Cathedral Hill Campus– PM Peak – Impact TR-27 on Page 4.5-118 of the Draft EIR indicates that the Cathedral Hill Campus will generate 551 new transit trips in the PM peak hour. In comparing the forecast ridership in Table 4.5-21 in 2015 under "No Project" and "Project" conditions in the PM peak hour, 498 new transit riders will be generated by the Cathedral Hill Campus in the PM peak hour (the difference between the sum of the ridership in all directions in 2015 with Project and without Project – 9,667 minus 9,169 equals 498). In comparing the forecast ridership in 2030 under "No Project" and "Project" conditions, 289 new transit riders will be generated by the Cathedral Hill Campus in the PM peak hour (the difference between the sum of the ridership in all directions in 2030 with Project and without Project – 10,852 minus 10,563 equals 289). The number of new transit riders in the PM peak hour at the Cathedral Hill Campus in 2015 and in 2030 in Table 4.5-21 should be the same, not 209 less in 2030. The 551 new transit riders at the Cathedral Hill Campus in 2015 and 2030 as stated in Impact TR-27 must be used to evaluate transit impacts, not the 498 new transit riders in 2015 and the 289 new transit riders in 2030 in Table 4.5-21.

c) St. Luke's Campus – PM Peak - Impact TR-86 on Page 4.5-201 of the Draft EIR indicates that the St. Luke's Campus will generate 39 new transit trips in the PM peak hour. In comparing the forecast ridership in Table 4.5-21 in 2015 and in 2030 under "No Project" and "Project" conditions in the PM peak hour, 67 new transit riders will be generated by the St. Luke's Campus in the PM peak hour. The new transit riders forecast in the PM peak hour at the St. Luke's Campus in Impact TR-86 should be the same in Table 4.5-21 to properly evaluate transit impacts at the St. Luke's Campus in 2015 and in 2030.

d) California Campus – PM Peak – In the southbound direction, the baseline ridership in Table 4.5-21 is 1,421, the same number of riders for existing conditions and for ridership forecasts in both 2015 and 2030. The lack of southbound baseline ridership growth is not a reasonable assumption.

e) Pacific Campus – PM Peak - Impact TR-60 on Page 4.5-168 of the Draft EIR indicates that the Pacific Campus will generate 37 new transit trips in the PM peak hour. In comparing the forecast ridership in Table 4.5-36 in 2015 and in 2030 under "No Project" and "Project" conditions in the PM peak hour, 190 new transit riders will be generated by the Pacific Campus in the PM peak hour. The new transit riders forecast in the PM peak hour at the Pacific Campus in Impact TR-60 should be the same in Table 4.5-36 to properly evaluate transit impacts at Pacific in 2015 and in 2030.

f) Davies Campus – PM Peak – In the southbound direction, the baseline ridership in Table 4.5-21 is 1,421, the same number of riders for existing

conditions and for ridership forecasts in both 2015 and 2030. The lack of southbound baseline ridership growth is not a reasonable assumption. Even though the Davies Campus is several miles from the California Campus, existing ridership and forecasts for 2015 and 2030 in the southbound, eastbound, and westbound directions for the Davies Campus are identical to the existing and the forecast ridership for the California Campus, without and with Project riders added. This cannot be correct.

4) Traffic Inconsistencies with January 2008 CPMC Transportation Study – Appendix B to the 2008 CPMC Institutional Master Plan is the "California Pacific Medical Center Institutional Master Plan 2008 Transportation Study" prepared by CHS Consulting Group. Both the 2008 Transportation Study and the Draft EIR utilize the same traffic count data collected in 2006. With the same traffic count data in both evaluations and under the same intersection geometry, calculations of delay and Level of Service would yield identical results for each intersection, but they do not match each other.

In my review, I compared Table 2 on Page 12 of the Transportation Study to Table 4.5-17 on Page 4.5-94 in the AM Peak and to Table 4.5-18 on Page 4.5-95 in the PM Peak in the Draft EIR. In most of the comparisons set forth below, delay and Level of Service are significantly better in the Draft EIR than calculated in the 2008 Transportation Study using the same data. While the comparisons below only involve the Cathedral Hill Campus, I also found other significant differences in calculated delay and Level of Service for each campus when comparing the two documents. These inconsistencies must be eliminated to develop proper traffic analyses of baseline conditions as well as for forecast conditions in 2015 and in 2030, together with appropriate traffic mitigation measures for the Project. The City must perform an accurate analysis and include all feasible alternatives and measures to mitigate traffic congestion impacts.

Cathedral Hill – AM Peak – Significant Delay/LOS Differences

Intersection	2008 Study Delay/LOS	Draft EIR Delay/LOS
Gough/Geary	67.7/E	>80/F
Gough/Post	24.8/C	10.7/B
Gough/Sutter	25.2/C	9.5/A
Franklin/Geary	21.0/C	8.7/A
Franklin/Post	29.3/C	15.2/B
Franklin/Sutter	48.5/D	17.0/B
Van Ness/Geary	36.2/D	22.7/C
Van Ness/Bush	38.0/D	23.6/C
Polk/O'Farrell	30.4/C	18.6/B
Polk/Geary	22.0/B	47.9/D
Polk/Post	38.5/D	18.3/B
Polk/Sutter	69.4/E	27.5/C

Cathedral Hill – PM Peak – Significant Delay/LOS Differences

Intersection	2008 Study Delay/LOS	Draft EIR Delay/LOS
Gough/Geary	49.0/D	29.9/C
Gough/Post	23.5/C	8.8/A
Gough/Sutter	26.2/C	15.0/B
Franklin/O'Farrell	58.8/E	30.7/C
Franklin/Geary	47.2/D	22.1/C
Franklin/Sutter	39.1/D	65.5/E
Franklin/Bush	28.3/C	9.7/A
Van Ness/O'Farrell	40.6/D	26.3/C
Van Ness/Geary	42.8/D	26.3/C
Van Ness/Post	20.3/C	14.4/B
Van Ness/Sutter	22.2/C	16.9/B
Van Ness/Bush	46.6/D	26.6/C
Polk/O'Farrell	41.8/D	18.3/B
Polk/Post	20.6/C	15.9/B

5) Draft EIR Contains Numerous Inconsistencies in Traffic Analyses for Near and Long Term – As pointed out above, there are many inconsistencies in the evaluation of 2006 baseline traffic data for the Cathedral Hill Campus and the other campuses. In addition, there are also inconsistencies within the various tables in the Draft EIR that provide delay and associated Level of Service for 2006 baseline conditions, 2015 No Project and Project conditions, and 2030 Cumulative No Project and Project conditions. While the examples discussed below relate to the Cathedral Hill Campus, there are other similar inconsistencies for the campuses. The inconsistencies within Tables 4.5-17 on Page 4.5-94 and 4.5-18 on Page 4.5-95 of the Draft EIR for the Cathedral Hill Campus, as well as in tables for other campuses, must be reconciled to provide proper traffic analyses of the Project.

   a) Cathedral Hill Campus – AM Peak – For the intersection of Eighth/Market, Table 4.5-17 indicates delay of greater than 80 seconds and Level of Service (LOS) F for the existing baseline conditions in the AM peak in 2006. In 2015 with higher traffic volumes than 2006 and without any identified traffic improvements, delay is reduced to 78.8 seconds and performance improves to LOS E without Project traffic. In 2030 under cumulative conditions with higher traffic volumes than 2015 and without any identified traffic improvements, delay is reduced to 76.4 seconds and performance remains at LOS E without Project traffic. Without improvements, adding traffic to failing intersections or those operating at capacity does not reduce delay or improve intersection LOS performance.

   b) Cathedral Hill Campus – PM Peak – For the intersection of Franklin/Sutter, Table 4.5-18 indicates delay of 65.5 seconds and Level of Service (LOS) E for the existing baseline conditions in the PM peak in

2006. In 2015 with higher traffic volumes than 2006 and without any identified traffic improvements, delay is reduced to 57.0 seconds and performance remains at LOS E without Project traffic. Without improvements, adding traffic to intersections operating at capacity does not reduce delay.

6) Traffic Impacts and Mitigation Measures - Impact TR-1 and Impact TR-2 on Page 4.5-98 of the Draft EIR identify the intersections of Van Ness/Market and Polk/Geary as significantly impacted by traffic generated by the Cathedral Hill Campus in Year 2015. For each, the Draft EIR states "Providing additional traffic lanes or otherwise increasing vehicular capacity at this intersection is not feasible because it would require narrowing of sidewalks to substandard widths, and/or demolition of buildings adjacent to these streets. Signal timing adjustments may improve intersection operations, but would likely be infeasible due to traffic, transit or pedestrian signal timing requirements. Therefore, no feasible mitigation measures have been identified to reduce project impacts to less-than-significant levels. CPMC has indicated that it is planning on expanding its current transportation demand management program (TDM) to discourage use of private automobiles; although this may reduce the number of trips through this intersection, the extent of this program or reduction to impacts is not known. The traffic impact at the intersection would therefore remain significant and unavoidable."

CEQA requires lead agencies to impose all feasible alternatives and/or mitigation measures before concluding that traffic impacts are "significant and unavoidable." The Draft EIR and the supporting Traffic Study for the Cathedral Hill Campus must document the geometry of both intersections that the City finds to have significant and unavoidable traffic impacts, then identify the specific traffic measures or alternatives evaluated, and discuss why each of these options cannot feasibly be implemented. Without doing this, the Draft EIR may not dismiss the potential mitigation measures as infeasible.

All feasible mitigation measures must also include enhancements to the current CPMC TDM plan. The Draft EIR acknowledges that "CPMC has indicated that it is planning on expanding its current TDM program..." but offers no specifics or evaluation of potential vehicle trip reductions that could be achieved. Enhancements to the existing CPMC TDM Plan were included on Pages 117 through 119 of the 2008 Transportation Study prepared by CHS Consulting Group, and include the following:

- Designate a TDM Coordinator
- Promotion of the TDM Program
- Increase financial incentives to transit use and disincentives to SOV use
- Provide amenities to transit and bicycle users
- Expanded shuttle bus program

At a minimum, the Draft EIR must evaluate the potential effectiveness of these additional TDM measures and others that also may be appropriate. CPMC must be required to implement necessary additional TDM measures to mitigate traffic impacts considered to be "significant and unavoidable".

7) Emergency Vehicle Access Will Be Significantly Impacted – Impact TR-52 on Pages 4.5-145 and 4.5-146 of the Draft EIR lists various streets that would be used by emergency vehicles to transport patients to the Cathedral Hill Campus and states "These streets are multi-lane arterial roadways that allow the emergency vehicles to travel at higher speeds and permit other traffic to maneuver out of the path of the emergency vehicle. Because Franklin Street, Van Ness Avenue, Post Street, and Bush Street have multiple lanes, vehicles would be able to yield to emergency vehicles destined to the proposed Cathedral Hill Campus. Given the above, the proposed Cathedral Hill Campus project emergency vehicle access impact would be less than significant."

   Several critical intersections in the vicinity of the Cathedral Hill Campus currently operate at LOS E or LOS F under existing conditions in one or both peak traffic hours as reported in Tables 4.5-17 on Page 4.5-94 and 4.5-18 on Page 4.5-95 of the Draft EIR. These tables also show that additional critical intersections in the vicinity of the Cathedral Hill Campus will degrade to LOS E or LOS F in 2015 and in 2030 with the addition of Project traffic.

   Under capacity conditions at LOS E and under gridlock conditions at LOS F, vehicles will be queued back significant distances in all traffic lanes on the approaches to congested signalized intersections. Stopped vehicles will not be able to simply "maneuver out of the path of the emergency vehicle" as the adjacent lanes on the approaches to the gridlocked traffic signals will already be occupied by other vehicles. This is a significant impact for a hospital project and must be fully evaluated and mitigated. In this instance, the City cannot simply find that these impacts are unavoidable. Instead, in a revised EIR, the City must fully explain and support the Draft EIR's broad statement that "...the proposed Cathedral Hill Campus project emergency vehicle access impact would be less than significant." A revised EIR must show that the City has analyzed both LOS E and gridlock conditions at LOS F all around the vicinity of the Cathedral Hill Campus and has mitigated these impacts to significantly reduce or eliminate health and safety risks resulting from delays to emergency and labor and delivery vehicles.

8) Significant Construction Impacts Can Be Mitigated – Page 4.5-154 of the Draft EIR states "...for the 4-month period when there is overlap in excavation between the proposed Cathedral Hill Hospital and MOB, Level of Service would be LOS E or LOS F at up to nine of the study intersections. Thus, the project's construction impacts on intersection operations at these nine study

intersections would be significant." To reduce or eliminate the significant traffic impacts at nine intersections, the Draft EIR must analyze traffic impacts that would occur without any overlap in construction of the Hospital and MOB.

Construction of the proposed Cathedral Hill tunnel under Van Ness Avenue, a State Highway, requires Caltrans approval and a permit. Open cutting of Van Ness Avenue to construct the tunnel together with the lane closures outlined in Table 4.5-33 on Page 4.5-158 will result in significant congestion and traffic impacts during construction of the tunnel over 10 months. To mitigate these significant traffic impacts, the Draft EIR must confine the lane closures and construction activities to hours that meet the San Francisco's LOS D standard (no lane closures northbound before 10 PM and no lane closures southbound before midnight). The Draft EIR must also consider mitigating traffic impacts of the tunnel construction by boring underground to avoid lane closures rather than open cutting of Van Ness Avenue.

9) Parking Impacts Will Be Significant – Table 4.5-34 on Page 4.5-164 summarizes the parking supply and demand for each campus. As shown, the Cathedral Hill Campus is proposed to have a parking shortage where demand exceeds supply by 162 spaces. Other parking shortages will occur at the Davies Campus (203 spaces) and at the St. Luke's Campus (309 spaces). Without the 623 "off-campus" parking spaces, the Project shortage is 664 parking spaces, about 15 percent of the overall parking demand.

From Footnote 1 to Table 4.5-34, the 623 "off-campus" parking spaces include 400 spaces at the Japan Center Garage, 180 spaces at 855 Geary Street Garage, and 43 spaces in the garage at 2015 Steiner Street. The discussion in this portion of the Draft EIR does not disclose if the "off-campus" parking spaces at the three locations have been leased by CPMC and would therefore be available to make up a portion of the overall parking shortage. To consider these "off-campus" spaces as part of the parking supply, the Draft EIR must require that CPMC guarantee that the 623 spaces are available and that adequate shuttle service to and from their campuses will be provided.

In the parking discussion for the individual campuses, the Draft EIR notes that on-street parking nearby is not available during most hours. In conflict with this, the Draft EIR then suggests that motorists can locate parking on these streets. Available off-street parking at certain campuses will also be limited during construction, and the Draft EIR does not provide mitigation for these significant impacts.

The California Pacific Medical Center (CPMC) Long Range Development Plan (Project) in San Francisco creates significant traffic and transit impacts that have not been properly disclosed, analyzed or mitigated through alternatives and/or

traffic improvements. The errors identified in this letter require that each of these issues be reanalyzed and reevaluated through additional study in a revised and recirculated EIR. If you should have any questions regarding these findings, please contact me at your convenience.

Respectfully submitted,

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Enclosure

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May 16, 2012

Angela Cavillo
Clerk of the Board
San Francisco Board of Supervisors
City Hall, Room 244
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San Francisco, CA 94102

RE: Appeal of San Francisco Planning Commission's Certification of the California Pacific Medical Center (CPMC) Long Range Development Plan FEIR (Planning Commission No. 2005.0555E)

Dear Ms. Calvillo:

Pursuant to San Francisco Administrative Code Section 31.16, and on behalf of the California Nurses Association/National Nurses United, Council of Community Housing Organizations, Cathedral Hill Neighbors Association, Bernal Heights Neighborhood Center, Jobs with Justice San Francisco, and San Franciscans for Healthcare, Housing, Jobs, and Justice ("Coalition"), this letter sets out the issues for appeal of the San Francisco Planning Commission's certification of the California Pacific Medical Center Long Range Development Plan final environmental impact report ("FEIR" or "EIR").

I. Introduction

Code Section 31.16 requires appellants to submit a letter to the Clerk of the Board within twenty calendar days of the Planning Commission's FEIR certification describing the specific grounds of appeal. This letter meets that requirement. Nevertheless, given the complexity of CPMC's Long Range Development Plan ("LRDP"), the fact that it took the Planning Department some three years to process

the CPMC's application, the size and scope of the EIR and associated documents, and the myriad ways the EIR violated CEQA, the Coalition sets forth here a list and brief explanation of its grounds for appeal, and will subsequently augment this letter with additional facts and evidence supporting the issue list.

As the Board knows, the constituent members of the Coalition have actively, continuously and in good faith worked towards a Project that ensures that healthcare services will be equitably distributed throughout the City's populations, and for a Project that will not unnecessarily disrupt established neighborhoods, affordable housing, traffic and public transportation. Throughout the process, the Coalition has put forth substantial evidence showing that a smaller Cathedral Hill facility in favor of a more robust St. Luke's is the superior environmental alternative and, unlike the proposed Project, is fully consistent with San Francisco policy priorities regarding healthcare, affordable housing, and public transit.

II. The Coalition's Grounds for Appeal

The Planning Commission's April 26, 2012 certification of the CPMC LRDP FEIR violated CEQA in numerous ways. For example, the FEIR:

- Violated CEQA's most basic informational requirements by omitting adequate facts and evidence to support the EIR's conclusions;
- Failed to accurately describe the Project and its environmental setting;
- Employed misleading and illegal baselines, especially concerning traffic and public transportation impacts as they relate to the proposed Cathedral Hill facility;
- Deferred requiring measures to mitigate impacts on traffic and public transportation, and air quality;
- Omitted effective and enforceable mitigation for significant Project impacts, especially concerning the Cathedral Hill facility;

- Adopted a statement of overriding considerations for some 30 significant impacts without first imposing all feasible measures or alternatives to mitigate those impacts;

- Failed to adequately and accurately investigate and disclose numerous environmental impacts for the Cathedral Hill hospital and MOB, thereby sidestepping the CEQA requirement to mitigate such impacts; and,

- Did not analyze Project alternatives that were both environmentally superior and met the City of San Francisco's healthcare objectives to provide equitable distribution of healthcare services across the City for all residents rather than concentrating specialized services in one mega-hospital and MOB on a single parcel in one of San Francisco's most congested areas.

A. The FEIR Violated CEQA's Most Basic Informational Requirements by Omitting Adequate Facts and Evidence to Support the FEIR's Conclusions

"The purpose of an environmental impact report is to provide public agencies and the public in general with detailed information about the effect which a proposed project is likely to have on the environment; to list ways in which the significant effects of such a project might be minimized; and to indicate alternatives to such a project." (Pub. Res. Code § 21061.)

The FEIR failed to meet CEQA's standards of adequacy. Aside from the substantive flaws, the EIR was so poorly written and organized that it remains largely incomprehensible to even the most seasoned CEQA practitioners. For example, the EIR created confusing and unconventional terms to describe the significance of a particular environmental impact, rendering it nearly impossible for readers to ascertain which impacts where truly significant and requiring mitigation. In nearly 15 years of reviewing CEQA documents, our office has never seen, for instance, an EIR describe an environmental impact as "potentially significant and unavoidable." Environmental impacts can only be deemed significant and unavoidable at the end of the process after the lead agency has imposed all feasible

alternatives and/or measures to mitigate significant impacts. Similarly, the City invented nine different ways to distinguish between significant and insignificant impacts. Again, this is inconsistent with CEQA and leaves readers unable to understand the Project's true impacts. The EIR employed far too many acronyms, despite the glossary, for any reviewer to keep track of. There is no reason why the preparers could not take the time to spell out infrequently used terms.

The EIR's structural and organizational flaws render the document nearly incomprehensible. The EIR's Transportation and Circulation chapter is organized by topic such as roadway network, intersection operations, transit operations, bicycle facilities, parking, impact evaluations, and mitigation measures. Discussions of each campus are presented one after the other under the individual topic rather than continuously as a complete discussion of each campus. Such organization makes it extremely difficult and unnecessarily complex to follow the analysis of the individual projects proposed for each of the five campuses. Members of the public should not have to bear the burden of lax organization and drafting.

Substantively, the FEIR continued to omit and/or understate the Project's significant environmental impacts. Then, for impacts that were identified, the FEIR frequently minimized the severity of impacts and did not adopt all feasible measures and alternatives to mitigate those impacts. Finally, the FEIR omitted requirements to ensure that the included mitigation measures were specifically defined and fully enforceable.

1. The FEIR Did Not Disclose the Cathedral Hill Facility's True Impacts on Traffic and Transportation

First, the FEIR's traffic analysis for the Cathedral Hill facility remains fatally flawed because, among other things, it minimized the Project's significant traffic impacts by employing artificial assumptions. As traffic expert Tom Brohard

has repeatedly described throughout this process, the City utilized a flawed methodology to analyze traffic impacts at the Eighth/Market and Franklin/Sutter intersections. These intersections are both vital to San Francisco traffic flow in general, and critical to unimpeded emergency access to the Cathedral Hill facility in particular. The end result allowed the City to "mask significant traffic impacts" rather than actually construct physical improvements to mitigate traffic delays or adopt one of the proposed alternatives to avoid the problem altogether. (*See, e.g.,* Attachment A, letter from Tom Brohard to Gloria D. Smith (May 11, 2012).) Specifically, contrary to customary and acceptable practice, the City incorrectly increased the peak hour factor to create a result of less baseline delay. This questionable approach allowed the City to report a reduction in overall delay at the subject intersections once Project-caused traffic is added, taking advantage of traffic capacity that did not exist, skewing actual Project impacts.

Second, the FEIR did not disclose serious impacts to emergency response times, which CEQA specifically requires. (CEQA Guidelines, Appendix G, Sec. X.) The FEIR continued to dismiss the impacts of delays to emergency vehicle access to the Cathedral Hill facility. This omission defied logic. Not only is the area surrounding Cathedral Hill already severely congested, a 555-bed hospital and MOB will further exacerbate the current gridlock resulting in dire delays for emergency vehicles.

According to the FEIR, there would be no problem for emergency vehicle access because the multi-lane roadways used for emergency access allow higher speeds for emergency vehicles since their width would purportedly allow vehicles to move out of their path. However, as shown by traffic engineer Tom Brohard, emergency vehicles would not be able to effectively maneuver in the LOS F gridlock conditions that already occur at critical intersections. Once the Project is operational these conditions can only worsen, especially because the Cathedral site

is currently empty. Delay of emergency vehicles will add time to emergency trips before treatment can begin at the Cathedral Hill hospital and potentially place health and human safety at risk. The FEIR failed to mitigate, much less acknowledge this dangerous impact. In so doing the EIR violated CEQA's fundamental purpose: to "inform the public and its responsible officials of the environmental consequences of their decisions before they are made." (*Laurel Heights Improvement Ass'n v. Regents of the University of California* (1993) 6 Cal.4th 1112, 1123.)

Finally, as shown by Mr. Brohard and discussed in subsection C below, the FEIR failed to disclose the true impacts the Cathedral Hill facility will have on public transit.

2. The FEIR Did Not Disclose the Project's True Jobs/Housing Relationship and Resulting Impacts

The FEIR assumed that approximately 50% of employees will commute from within San Francisco based on decade-old employee surveys of limited sample size. It also assumed the remaining employees would reside in the Bay Area and not beyond. If more employees reside outside of San Francisco than the EIR assumed, the EIR underestimated the already significant impacts on transportation, air quality and greenhouse gas pollution; and improperly avoided requiring additional measures to mitigate these impacts. Accordingly, to accurately assess Project impacts, the EIR was required to provide a thorough and up-to-date analysis of the Project's jobs/housing relationship. Reliance on a decade old survey was insufficient to ensure the accuracy of the EIR's assumptions. At a minimum, given the changes in the affordable housing and jobs market over the past decade, the EIR should have provided more up-to-date and more complete survey data.

Similarly, because the City relied on planning documents (e.g. the 2004 Housing Element) and programs and policies to address project and cumulative housing impacts, rather than project based analyses, the FEIR omitted evidence to support the conclusion that housing will be adequate to accommodate employees generated by projects in San Francisco.

In general, the City of San Francisco does not analyze the impacts of individual projects on housing demand and affordability. Rather, the City takes a citywide, comprehensive approach, relying on the 2004 Housing Element and policies and programs to meeting the demand for housing. This approach allows project after project (e.g. CPMC LRDP, Twitter, Salesforce, etc.) that generate thousands of new employees to approved without analyzing the cumulative impacts on housing supply and jobs-housing fit. This practice is inconsistent with CEQA.

The Project's main impacts on housing will be to affect both the supply and demand its new workforce will create for new housing in San Francisco. On the supply side, CPMC seeks exceptions to General Plan and Planning Code mandatory housing obligations for the Van Ness Avenue corridor. The Van Ness Avenue Area Plan and the Van Ness Special Use District (VNSUD) contemplate and require intense development of residential housing along Van Ness Avenue. The EIR provided no factual analysis whatsoever of the effects on housing supply of the Project's inability to provide housing onsite or for the development of housing on nearby sites as required by the VNSUD and reaffirmed by a recent Board of Supervisors' resolution. (*See* Board of Supervisors Resolution No. 461-10, Resolution Supporting Existing Area Plan Housing Requirements, File No. 100755 (September 2010). On the demand side, the EIR did not present any information regarding the demographics of the proposed workforce for the new Cathedral Hill campus thereby denying public officials the kind of information needed to determine the linkages between this new workforce and the demand especially for nearby

affordable housing. Given San Francisco's high priority emphasis on the need for affordable housing, the EIR's failure to provide such factual analyses are glaring deficiencies.

To offset the Project's lack of housing, CPMC must provide assistance for the development of new housing units in San Francisco. Most problematic is the proposed housing program in the Development Agreement, which would create a new down payment loan program ("DALP") that is separate from the existing DALP administered by the Mayor's Office of Housing ("MOH"). It would be funded at a level twice that of the MOH program and could have a negative impact on that program by giving "market preference" to CPMC employees. At the very least, the Development Agreement must be amended to require the down payment assistance program be the current MOH program at the current MOH level of $100,000 per household and that the program NOT be limited to CPMC employees. A separate and differently sized DALP is simply bad policy because it would create additional competition for existing housing and adds nothing to San Francisco's housing supply. Moreover, limiting the program to CPMC employees, selected by CPMC, is simply a proposal that is far too open to manipulation by this private entity.

3. The FEIR Did Not Disclose the Project's True Impacts on Air Quality including Green House Gas Emissions

First, Dr. Petra Pless submitted expert analysis showing significant near-term Project impacts from harmful NOx emissions. (See Attachment B, email from Dr. Petra Pless to Gloria D. Smith (May 14, 2012).) However, the EIR only analyzed impacts at full-buildout in 2030 and omitted analysis of near-term activities in the 2015 timeframe. The FEIR's failure to recognize near-term impacts from NOx emissions results in a corresponding failure to mitigate this impact. While the FEIR pointed to its TDM program, the TDM program is unavailing because it did not address NOx emissions from stationary sources. The Cathedral

Hill facility's stationary sources would contribute 23% of total NOx emissions in 2015. The FEIR's failure to both acknowledge and evaluate mitigation for these sources was an unlawful omission.

Second, the FEIR cannot rely on the City's existing programs to mitigate Project greenhouse gas emissions. According to the FEIR, the Project's greenhouse gas impacts would be mitigated through San Francisco's purportedly qualified greenhouse gas reduction plan. However, San Francisco's plan does not meet CEQA's minimum requirements for such programs. (CEQA Guidelines § 15183.5) Under CEQA, the City may only rely on a plan to mitigate greenhouse gas emissions if that plan does all of the following:

(A) Quantifies greenhouse gas emissions, both existing and projected over a specified time period, resulting from activities within a defined geographic area;

(B) Establishes a level, based on substantial evidence, below which the contribution to greenhouse gas emissions from activities covered by the plan would not be cumulatively considerable;

(C) Identifies and analyzes the greenhouse gas emissions resulting from specific actions or categories of actions anticipated within the geographic area;

(D) Specifies measures or a group of measures, including performance standards, that substantial evidence demonstrates, if implemented on a project-by-project basis, would collectively achieve the specified emissions level;

(E) Establishes a mechanism to monitor the plan's progress toward achieving the level and to require amendment if the plan is not achieving specified levels;

(F) Is adopted in a public process following environmental review.

The San Francisco plan does quantify emissions, establish a reduction target and sets forth a number of emission reduction measures; but, the emission reduction benefits of these measures are not quantified and it is unclear how these measures will collectively function to achieve the stated emission reduction goals. In addition, the plan does not require amendment if continued monitoring indicates that emissions reduction goals are not achieved. Finally, it does not appear that the plan underwent environmental review. Because the San Francisco Greenhouse Gas Reduction Strategy does not meet the standards of Guideline § 15183.5, it may not be used to claim the Project's greenhouse gas impacts will be less than significant and that additional mitigation is not required.[1] (FEIR, C&R at 3.10-25 (stating that no additional mitigation is required due to Project's purported consistency with San Francisco GHG Reduction Strategy).)

Because the City may not rely on the Greenhouse Gas Reduction Strategies, it must adopt all feasible mitigation to reduce Project emissions to BAAQMD's 1,100 ton numeric threshold. In violation of CEQA, the Final EIR rejected measures Dr. Pless submitted to reduce GHG emissions to threshold levels.

B. The FEIR Did Not Accurately Describe the Project and its Environmental Setting

First, as a component of a project description, CEQA requires a lead agency to include a description of environmental conditions from both a local and regional perspective: "knowledge of the regional setting is critical to assessment of environmental impacts." (CEQA Guidelines, § 15125.) According to the EIR, the Project will draw patients, visitors, hospital and educational staff and students from outside of San Francisco. For example, the Project will allow CPMC to provide

[1] The FEIR's assertion that BAAQMD approved of the Greenhouse Gas Reduction Strategies as a means to determine the significance of GHG impacts is unavailing because BAAQMD does not have the authority to override CEQA's legal requirements.

specialized services that are currently only available in Northern California by a limited number of providers, and CPMC intends to serve as an education, training and research institution for the greater Bay Area. (EIR at 6-6.) Given that the Project will extend its reach throughout the greater Bay Area and beyond, the EIR was required to at least analyze the overall availability of general and specialized services in the Bay Area. A complete description of both the local and regional health care service setting would provide information on any gaps or leakage of San Francisco's health care needs, accessibility of services, and other basic background information to provide "baseline conditions" for analyzing Project impacts.

Likewise, disclosure of the regional setting would in turn require the City to investigate and disclose any potentially significant impacts on traffic and transportation, air quality and other resources as a consequence of San Francisco's "new world-class and state-of-the art" hospitals. Because CPMC intends to draw on the larger, regional community, attendant environmental impacts must be disclosed.

Second and related, analysis of the regional setting should have included disclosure of CMPC's current regionalization process, which affects all aspects of access to healthcare in San Francisco and the Bay Area at large. CPMC is affiliated with Sutter Health. Sutter is going through a process of "regionalization," in which its twenty-six affiliate hospitals are collapsed into five regional structures. As a result, the corporate entity of CPMC has ceased to exist, while all CPMC operations, finance, and governance have dissolved into Sutter West Bay, which encompasses all of San Francisco. Sutter's regionalization has caused large-scale closures of services and increased transfer of patients between cities in the Bay Area. Sutter has sponsored hospital construction projects in Castro Valley, Oakland, Santa Rosa, San Mateo County, and San Francisco. In each instance,

Sutter presented the respective plan in a vacuum, isolated from the simultaneous rebuilds, expansions or reductions in the next town over.

All told, Sutter has consistently reduced the number of licensed hospital beds both at CMPC campuses and regionally. Specifically, if all of Sutter's plans in the Bay Area were approved, this would entail eliminating 881 licensed hospital beds in the Bay Area between the CPMC campuses, Alta Bates Summit Medical Center in Berkeley and Oakland (Herrick Campus and Summit Campus), San Leandro Medical Campus (complete closure proposed), Eden Medical Center in Castro Valley, Sutter Medical Center of Santa Rosa, and Mills-Peninsula Health Services ("Mills Peninsula") in Burlingame and San Mateo. As explained below and as will be further detailed in documentation CNA is compiling for the Board's review, Sutter's plan to eliminate beds and consolidate services will be done strategically to serve Sutter's interests in maximizing profits by reducing beds at hospitals located in less affluent communities and at hospital units that provide less remunerative services while securing Sutter's bargaining power with the large, institutional fee payers (i.e., heath insurance companies, employee benefit funds, self-insured employers, etc.). Not only will this very deliberate scheme have devastating consequences for underinsured people in poor communities and affect all health care consumers by escalating costs for hospital services, it will have very real consequences on issues central to CEQA analysis.

CPMC's LRDP is part of Sutter's business plan for the Bay Area and must be analyzed in the context of the cumulative effects of those plans. This includes: transfer of sub-acute patients and psychiatric patients out of San Francisco; transfer of SNF patients out of San Francisco; transfer of pediatric and acute rehabilitation patients into San Francisco from San Mateo County; and potential closure of the San Leandro Hospital. The EIR did not analyze these cumulative impacts. Sutter's planned consolidation across the Bay Area will increase the

transfer of patients between cities. Traffic burdens (and associated air quality and greenhouse gas emissions) caused by additional patient transports to and from San Francisco as a result of regionalization were not addressed in the FEIR.

The drastic reduction of acute care, psychiatric care and skilled nursing facility ("SNF") beds under the LRDP was not adequately addressed in the FEIR. The Sutter-affiliate Mills Peninsula recently closed their acute rehabilitation unit in Burlingame, San Mateo County, advising patients to come to acute rehabilitation units at CMPC campuses in the City, specifically the Davies Campus. Sutter also plans to close the dialysis unit at the Mills-Peninsula campus and the SNF at the Santa Rosa Hospital. Now, CPMC plans to close the only sub-acute unit in San Francisco, forcing patients and their families to leave San Francisco for care. Combined with the recent closure of the SNF and sub-acute care at the Seton Medical Center in Daly City and reductions at the Laguna Honda Hospital and Rehabilitation Center, the elimination of SNF beds and acute care beds under the LRDP further compounds the existing regional shortage.

In San Francisco, the proposed closure of the SNF at the St. Luke's Hospital in addition to the recent reductions in SNF beds at the California Campus in 2009/2010 represents an 83% reduction in CPMC's SNF bed capacity. Patients will be put at risk if the patient population currently treated by the 178 beds historically offered by CPMC is simply placed in lower-level care SNFs. Or, if the need for SNFs is not met, these patients will be shipped out of San Francisco. SNF patients tend to have stays from three days to several weeks, which will result in multiple additional trips by their family members out of the City to visit them.

Despite expert opinion and public requests to remedy these omissions, the FEIR was silent on these important environmental and healthcare issues. Instead, it sidestepped such matters by inaccurately claiming that members of the public

must affirmatively provide evidence of potentially significant impacts before an agency has an obligation to fully describe a project and its environmental setting. However, neither decision makers nor the public can assess potentially significant impacts until the lead agency accurately describes the project and its environmental setting. The City's approach violated CEQA's informational requirements.

C. The FEIR Relied On An Unlawful Baselines to Minimize Impacts at the Cathedral Hill Facility

The FEIR minimized Cathedral Hill impacts on public transit by employing an incorrect baseline. Specifically, the FEIR relied on 2006 passenger data to evaluate the Cathedral Hill facility's impacts on Muni. The CEQA baseline from which agencies evaluate environmental impacts is typically conditions as they existed at the time the Notice of Preparation was issued—here, 2009. (CEQA Guideline § 15125.) MUNI ridership on the relevant transit lines increased by over 10% from 2006 to 2009. The FEIR's use of 2006 data skewed the Cathedral Hill facility's transit impacts by assuming more transit capacity then actually exists.

In addition, and as mentioned above, the FEIR minimized significant traffic impacts at the Cathedral Hill facility by employing artificial assumptions and inputs in the baseline analysis.

D. The FEIR Adopted a Statement of Overriding Considerations for More Than 30 Significant Impacts Without First Imposing all Feasible Measures or Alternatives to Mitigate Those Impacts

CEQA required the City to impose all feasible measures and/or alternatives to mitigate the Project's potentially significant impacts before it could lawfully override those impacts and certify the EIR. (CEQA Guidelines § 15093.) Here, the City went straight to the override and ignored numerous ways to minimize the LRDP's negative effects.

Traffic engineer Tom Brohard provided expert opinion that the significant traffic and transit impacts associated with the Cathedral Hill hospital and MOB could be minimized by reducing the size of the Cathedral Hill facility and equitably distributing healthcare services to St. Luke's and other CPMC campuses. He also showed that requiring physical roadway improvements and a meaningful transportation demand management ("TDM") program could lessen impacts. The City ignored Mr. Brohard's suggestions, especially concerning the CEQA requirement that the EIR must contain an enforceable TDM program to lessen vehicle trips to and from Cathedral Hill. (See Section E below)

Concerning air quality, the FEIR acknowledged that many air quality impacts would be "significant and unavoidable," but did not impose all feasible mitigation to reduce those impacts. Air quality expert Dr. Pless showed that the FEIR's proposed mitigation of construction emissions was improperly vague, did not address NOx pollution, ignored potential pollution-control advances that will likely occur over the Project's nine-year construction lifetime, and, in the case of the use of on-road haul trucks, underestimated impacts by assuming the effects of mitigation that was not required. Concerning operational emissions, the FEIR omitted mitigation for area sources and other stationary sources of operational emissions including the 19 natural gas-fired hot water, steam, and heating boilers that would be installed at the Cathedral Hill Hospital, St. Luke's Replacement Hospital and Davies Campus. Finally, the FEIR did not respond to recommendations to look to off-site mitigation as a means to further reduce air quality impacts.

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E. The FEIR Failed to Identify Effective and Enforceable Mitigation for Significant Project Impacts, Especially Concerning the Cathedral Hill Facility

CEQA requires that mitigation be fully enforceable, and a public agency cannot approve a project "if there are feasible alternatives or mitigation measures available which would substantially lessen the significant environmental effects of such projects...." (CEQA § 21002; CEQA Guideline § 15126.4(a)(3).) The FEIR's 'expanded' Transportation Demand Management (TDM) Program did not meet either of these criteria.

First, according to the FEIR, an expanded TDM Program "might" be required as a condition of approval. (C&R TR-37.) Because the Planning Commission has certified a statement of overriding considerations for traffic impacts at Cathedral Hill, CEQA requires the City to ensure **all** feasible mitigation has been imposed; any workable measures **must** be required and cannot be optional.

Second, it appears that the existing TDM program is in no way enforceable because it has not been consistently implemented in the past. According to the City, several TDM provisions in the program will need to be "reinstated" (Appendix F at 10-11.) In this way, the certified TDM program is not only amorphous, but some of its measures have either never been implemented or have been abandoned. In any case, the TDM program is not a component of a specific and enforceable mitigation plan. Given this history, the City was required to ensure that the expanded TDM plan includes all feasible measures and is not discarded after Project approval. To comply with CEQA, the EIR must require adoption of a full TDM Program and include monitoring of its measures with penalties for non-compliance. (*See* CEQA Guidelines § 15097.)

F. The FEIR Failed to Objectively Analyze Project Alternatives that Were Both Environmentally Superior and Met the City of San Francisco's Healthcare Objectives

As an initial matter, the FEIR did not include "a reasonable range of potentially feasible alternatives" as required by CEQA. (CEQA Guidelines § 15126.6(a)). A reasonable alternative is one that would feasibly attain most of the project's basic objectives while avoiding or substantially lessening the project's significant impacts. (*See* CEQA § 21100(b)(4); CEQA Guidelines § 15126.6(a).) In direct contravention of this requirement, the EIR set up straw alternatives that would not meet project objectives, thereby favoring the Project as proposed. When CNA proposed a modified Alternative 3A (also referred to as Alternative 3A Plus) that would both better meet Project objectives while reducing impacts, the City responded that this alternative need not be considered because the EIR already considered a reasonable range of alternatives. (FEIR C&R 3.22-13.) Because a Alternative 3A Plus is more feasible than those originally set forth in the EIR, more consistent with basic Project objectives, and the range of alternatives proposed in the DEIR did not meet CEQA's requirements, the FEIR violated CEQA by claiming the modified alternative proposed by CNA and others need not be analyzed.

The City responded to the numerous public comments requesting a modified Alternative 3A with, "it is not clear or anticipated that Alternative 3A Plus, with a similar amount of development at the Cathedral Hill and St. Luke's Campuses as Alternative A but a different mix of services, would result in any further substantial reductions in the LRDP impacts." (FEIR Response ALT-1, C&R 3.22-12.) This response entirely misses the mark and violates CEQA.

Second, the EIR's alternatives analysis relied on inappropriate Project objectives to ignore viable alternatives. Inappropriate project objectives undermine the EIR's alternatives analysis, because each alternative's feasibility is assessed by

its ability to meet the project objectives. Here, the FEIR's Project objectives were impermissibly narrowed, effectively letting CPMC limit the alternatives analysis.

CEQA requires analysis of "a range of alternatives..., which would feasibly attain most of the basic objectives of the project...." (CEQA Guidelines § 15126.6(a).) However, contrary to the FEIR, it is the lead agency's objectives at issue, not the project sponsor's. CEQA requires that "the process of selecting the alternatives to be included in the EIR begins with the establishment of project objectives by the lead agency."

Nothing in CEQA required the City to adopt by rote CPMC's objectives. In fact, the City had an obligation to accept only those objectives that actually met broader City goals and complied with CEQA. If CPMC provided a project description or project objectives that did not comply with CEQA, the City was required to revise them. Instead, the City relied on CPMC's objectives to disqualify alternatives and/or deem alternatives infeasible. In reviewing alternatives, the EIR rejected a number of reasonable alternatives including Alternative 3A Plus that complied with current City code. Because the EIR deferred to CPMC, it effectively preempted the City's ability to fairly review a reasonable range of alternatives.

Specifically, the EIR identified eighteen project objectives, many of which were so detailed that they impermissibly narrowed the Project alternatives at the outset of the analysis. For example, the EIR identified one project objective as "[e]fficiently consolidate CPMC's campuses by consolidating specialized services... into one centralized acute-care hospital." (DEIR at 6-6.) Another was "[o]ptimize patient safety and clinical outcomes by (1) strategically grouping service lines and specialized services) [and] (2) providing multidisciplinary concentration of care for multisystem diseases..." (*Id.*) Yet another is "[e]nsure that this program-wide medical care consolidation and distribution minimizes redundancies." (*Id.*) These

overly detailed Project objectives are not "basic" objectives, as required by CEQA. (CEQA Guidelines § 15126.6.)

Third, CPMC's claim that it must consolidate virtually all specialty services at its Cathedral Hill campus was also not supported by the record. Alternative 3A, which would locate women and children's services at St. Luke's instead of Cathedral Hill, is the environmentally superior alternative and would more equitably distribute healthcare services throughout the City. Alternative 3A Plus, which the City refused to evaluate, would involve other specialty services to be situated at St. Luke's in order to ensure this particular facility remains viable to provide long term medical services to residents in the City's southeast quadrant.

Fourth, the City's argument that Alternative 3A would not be consistent with the project objective of rebuilding and revitalizing the St. Luke's Campus as a community hospital (with appropriately sized medical office building support) is also not supported by the record. According to the EIR, the St. Luke's Replacement Hospital proposed under Alternative 3A "would be identical to that proposed under LRDP" and could therefore provide the exact same services as those proposed under the LRDP. The Project objectives described the proposed services at St. Luke's Campus as medical/surgical care, critical care, emergency/urgent care, and gynecologic and low-intervention obstetric care. Development under Alternative 3A would provide additional services at the Women's and Children's Center and a larger MOB which would neither eliminate nor make infeasible any of these proposed services. Thus, under Alternative 3A, the St. Luke's Campus would be rebuilt and revitalized as a community hospital that is an integral part of CPMC's larger health care system and would provide services such as medical/surgical care, critical care, emergency/urgent care, and gynecologic and low-intervention obstetric care. As a larger facility, it could thus eliminate redundancies, and reduce patient transfers, which in turn would reduce or eliminate environmental impacts to traffic, transit and air quality.

The EIR argument that St. Luke's is not sufficiently centrally located to justify a bigger hospital, relegated the smaller St. Luke's to marginal status and neglected the service needs of under-served south of market San Francisco residents. More directly, the FEIR ignored St. Luke's proximity to the 24th Street BART station and nearby Highway 101 ramp access. By comparison, given the traffic conditions at the Cathedral Hill location, reduced accessibility eliminates any advantages of "centrality." Rather than the EIR's impermissibly narrow focus on one set of services - WCC - to evaluate the project objectives of resource optimization, patient safety and clinical outcomes, CEQA required the City to fully analyze Alternative 3A Plus in terms of patient access to healthcare and environmental impacts.

Fifth, according to the FEIR, expanding St. Luke's would disrupt the continuum of care due to the timing of required hospital retrofits at the California and Pacific Campuses. (FEIR C&R 3.22-17.) This dismissive response omits the fact that there are literally hundreds of cases where an extension of hospital retrofit deadlines have been requested and granted. In fact, CPMC submitted a timely request prior to the March 31, 2012, for another retrofit extension under newly enacted regulations. Given the frequency with which retrofit extensions are dispensed, this or a similar extension could thus address the purported continuum of care concerns cited in the FEIR. Accordingly, purported continuum of care concerns are not a legitimate basis upon which to reject the environmentally superior Alternative 3A Plus.

Finally, according to the FEIR, "larger hospitals result in improved medical success rates." This response shows that CPMC would pursue the greatest medical success at the Cathedral Hill facility at the expense of the St. Luke's Replacement Hospital because it would be considerably smaller and have fewer than 1,500

employees. While the EIR did not provide the number of staff that would be employed the St. Luke's Replacement Hospital, it projects 1,190 full time equivalent employees by 2015 for the entire campus which includes employees at the associated medical office building. (DEIR, Table 4.3-10, p. 4.3-16.) Thus, according to the City's reasoning, the St. Luke's Replacement Hospital would likely not perform as well as a larger hospital with more than 1,500 staff. In addition, the City claimed that the larger the hospital, the better the medical success score. This is incorrect and is not substantiated in the record.

III. Conclusion

As shown above, the Planning Commission certified the CPMC FEIR even though it violated CEQA in numerous ways. Getting this right is critically important: the Project will affect all of San Francisco's citizens for generations to come. The Board of Supervisors has a legal and moral obligation to thoroughly scrutinize this Project to ensure that healthcare services are equitably distributed throughout the City's populations and that the Project does not unnecessarily disrupt established neighborhoods, affordable housing, traffic and public

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transportation. Reducing the size of the Cathedral Hill facility in favor of a more robust St. Luke's would achieve these and other environmental mandates.

Dated: May 16, 2012

LAW OFFICES OF GLORIA D. SMITH

By:

Gloria D. Smith,
For California Nurses Association/National Nurses United, Council of Community Housing Organizations, Cathedral Hill Neighbors Association, Bernal Heights Neighborhood Center, Jobs with Justice San Francisco, and San Franciscans for Healthcare, Housing, Jobs, and Justice

Attachments
cc: Bill Wycko,
Environmental Review Officer
Devyani Jain
Elizabeth Watty

ATTACHMENT
A

Tom Brohard and Associates

May 11, 2012

Ms. Gloria Smith
The Law Offices of Gloria D. Smith
48 Rosemont Place
San Francisco, CA 94103

SUBJECT: California Pacific Medical Center Long Range Development Plan Final EIR – Further Clarification and Explanation of "Tweaked" Traffic Analysis

Dear Ms. Smith:

At your request, I am providing additional clarification and explanation of my earlier comments on the Draft Environmental Impact Report (Draft EIR) and my recent rebuttal to the Response to Comments in the Final Environmental Impact Report (Final EIR) for the California Pacific Medical Center (CPMC) Long Range Development Plan (LRDP Project). My initial comments, submitted on October 18, 2010, focused on deficiencies in Section 4.5 of the Draft EIR which deals with transportation and circulation impacts associated with the proposed LRDP Project. My recent letter, submitted on April 17, 2012, focused on the inadequacies of several responses to my initial comments on the Draft EIR, particularly the changing of critical input parameters to the traffic analysis software. Tweaking of the critical input peak hour factor has created unreasonable results which do not make any sense at Eighth/Market and at Franklin/Sutter.

There are many input variables in the traffic analysis software used to calculate delay and Level of Service (LOS) and extreme care must be taken when adjusting these variables to make sure that the results are reasonable. The peak hour factor, one of these critical variables, relates traffic flow during the highest 15 minutes in the peak hour to traffic flow over the entire 60 minutes in the peak hour. Values approaching 1.00 represent steady, uniform traffic flow which occurs during congestion conditions whereas lower values such as 0.92 indicate more fluctuations in traffic flow over the entire peak hour. The resulting calculated average vehicle delay is extremely sensitive to even seemingly very minor changes in the peak hour factor.

In response to my initial comments questioning how delay could be reduced and how the Level of Service could improve when more baseline traffic was added in 2015 and 2030, the Final EIR admitted that the peak hour factor was changed. Response TR-8 on Page C&R 3.7-10 states "The peak hour factor used in the existing conditions was based on observed traffic counts. Because forecasted traffic volumes cannot be observed, analysis of future intersection operations must assume a peak hour factor. It was assumed that at intersections where the peak hour factor was below 0.95 under the existing conditions, adding background traffic to study intersections would increase the uniformity (i.e., spread out traffic volumes throughout the peak hour). To reflect this condition, a peak hour factor of 0.98 was assumed for 2015 Modified Baseline and 2030 Cumulative conditions. This is a standard approach used by the Planning Department because the

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number of closely spaced intersections where traffic growth at adjacent intersections can have the effect of 'metering' traffic during congested periods, such as peak hours. Under certain conditions, this can cause average delay at an intersection to improve in a future scenario, as it did at the intersections of Eighth/Market and Franklin/Sutter."

At Eighth/Market, baseline traffic volumes through the intersection in the AM peak hour without project traffic added increase from 2,479 in existing to 2,542 in 2015 and then to 2,619 in 2030. In the EIR analysis, intersection performance for the existing volumes is reported as LOS F with average vehicle delay over 80 seconds when using a peak hour factor of less than 0.95. With a seemingly very minor increase in the peak hour factor to 0.98, intersection performance improves to LOS E with average vehicle delay of 78.8 seconds with 63 more vehicles added to the 2015 baseline. Using the same peak hour factor of 0.98, average vehicle delay is reduced further to 76.4 seconds with 140 more vehicles over exiting added to the 2030 baseline. Common sense indicates adding 63 more baseline trips in 2015 and 140 more baseline trips in 2030 at Eighth/Market will not improve the Level of Service from "F" to "E" or reduce the average vehicle delay.

At Franklin/Sutter, baseline traffic volumes through the intersection in the PM peak hour without project traffic added increase from 3,394 in existing to 3,533 in 2015 and then to 3,851 in 2030. In the EIR analysis, intersection performance for the existing volumes is reported as LOS E with average vehicle delay of 65.5 seconds while using a peak hour factor of less than 0.95. With a seemingly very minor increase in the peak hour factor to 0.98, average vehicle delay is reduced to 57.0 seconds with 139 more vehicles added to the 2015 baseline. Using the same peak hour factor of 0.98, average vehicle delay is 66.1 seconds with 457 more vehicles over existing added to the 2030 baseline. Common sense indicates adding 139 more baseline trips in 2015 and 457 more vehicle trips in 2030 to Eighth/Market will not reduce the average delay that will be experienced.

Intersection performance can only be improved and reductions in average delay can only be achieved by constructing physical improvements such as more traffic lanes to increase intersection capacity. No physical improvements are planned or assumed at Eighth/Market or at Franklin/Sutter. By incorrectly increasing the peak hour factor by even a seemingly very minor amount, the calculations result in less baseline delay. In turn, this then reduces the overall delay when Project traffic is added, takes advantage of traffic capacity that does not exist, and can mask significant traffic impacts.

Adjusting the peak hour factor in the above described manner is not the normal practice in our traffic engineering and transportation planning profession. I have reviewed hundreds of traffic studies and environmental documents in my career and have not seen this unique methodology employed before. I have also discussed the EIR's approach with several well-respected colleagues and they unanimously agree that increasing the peak hour factor will result in an inconsistent and potentially flawed analysis. One colleague also reminded me that other agencies do not allow such manipulation of the peak hour factor (i.e., Caltrans requires the use of a constant peak hour factor of 0.92 for all scenarios).

Ms. Gloria Smith
CPMC LRDP – Further Clarification/Explanation of "Tweaked" Traffic Analysis
May 11, 2012

While peak hour factors for the analysis of future conditions must certainly be assumed, the bottom line results must be reasonable and credible. The adjustment of peak hour factors in the analysis of the CPMC LRDP has created unreasonable and non-credible results that defy all logic. Carrying this flawed approach to the extreme indicates that adding even more traffic would continue to improve intersection operations and reduce delay even further, ultimately resulting in free flowing traffic conditions. Clearly, that will not occur.

Should you have any questions regarding these comments, please contact me at your convenience.

Respectfully submitted,

Tom Brohard and Associates

Tom Brohard

Tom Brohard, PE
Principal

ATTACHMENT
B

Subject: Harmful effects of nitrogen oxides

From: Petra Pless (petra.pless@gmail.com)

To: gloria@gsmithlaw.com;

Date: Monday, May 14, 2012 11:22 AM

Ms. Smith,

In answer to your question regarding the potential health effects of nitrogen oxides ("NOx"):

NOx are a group of highly reactive gases including nitrogen dioxide (NO_2), nitrous acid (HNO_2) and nitric acid (HNO_3) which are emitted in the combustion exhaust from cars, trucks and buses, power plants, and off-road equipment.

NOx and volatile organic compounds react in the presence of heat and sunlight to form ozone. Children, the elderly, people with lung diseases such as asthma, and people who work or exercise outside are at risk for adverse effects from ozone. These include reduction in lung function and increased respiratory symptoms as well as respiratory-related emergency department visits, hospital admissions, and possibly premature deaths.

NOx also react with ammonia, moisture, and other compounds to form small particles. These small particles penetrate deeply into sensitive parts of the lungs and can cause or worsen respiratory disease, such as emphysema and bronchitis, and can aggravate existing heart disease, leading to increased hospital admissions and premature death.

In addition to contributing to the formation of ground-level ozone and fine particle pollution, NO_2 is linked with a number of adverse effects on the respiratory system. Current scientific evidence links short-term NO_2 exposures, ranging from 30 minutes to 24 hours, with adverse respiratory effects including airway inflammation in healthy people and increased respiratory symptoms in people with asthma. Also, studies show a connection between breathing elevated short-term NO_2 concentrations, and increased visits to emergency departments and hospital admissions for respiratory issues, especially asthma. (summarized from http://www.epa.gov/air/nitrogenoxides/health.html and http://www.epa.gov/airquality/ozonepollution/health.html).

The U.S. Environmental Protection Agency has set ambient air quality standards for NO_2, ozone, and particulate matter to protect public health, including protecting the health of "sensitive" populations such as asthmatics, children, and the elderly. (*See* http://www.epa.gov/air/criteria.html).

Regards,
Petra Pless

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Petra Pless, D.Env.
Pless Environmental, Inc.
~~~~~~~~~~~~~~~~~~~~~~~~~~~~

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SAN FRANCISCO
PLANNING DEPARTMENT

Planning Commission Motion No. 18588

EIR CERTIFICATION

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Date:	April 12, 2012
Case No.:	2005.0555E
Project Title:	California Pacific Medical Center Long Range Development Plan
Project Address:	Cathedral Hill Campus: 1100 & 1101 Van Ness Avenue; 1255 Post Street; 1020, 1028-1030, 1034-1036, 1040-1052, 1054-1060, and 1062 Geary Street; 1375 Sutter Street St. Luke's Campus: 3555, 3615 Cesar Chavez Street; 1580 Valencia Street Davies Campus: 601 Duboce Avenue Pacific Campus: 2315 & 2333 Buchanan Street; 2300 California Street; 2330, 2340-2360, 2351, 2400, & 2405 Clay Street; 2315, 2323, 2324, 2329, & 2395 Sacramento Street; 2018, 2100 & 2200 Webster Street California Campus: 3698, 3700, 3838 & 3848-3850 California Street; 3801, 3905, 3773 & 3901 Sacramento Street; 460 Cherry Street
Zoning/Ht. & Blk.:	Cathedral Hill Campus: RC-4, Van Ness Special Use District/130-V; NC-3/130-V St. Luke's Campus: RH-2/105-E, 65-A Davies Campus: RH-3/65-D, 130-E Pacific Campus: RM-1, RM-2; 40-X, 160-F California Campus: RH-2, RM-2; 40-X, 80-E
Assessor's Block/Lot:	Cathedral Hill Campus: 0695/005, 006; 0694/005, 006, 007, 008, 009, 009A, 010; 0690/016 St. Luke's Campus: 6575/001, 002; 6576/021 and a portion of San Jose Avenue between Cesar Chavez Street and 27th Street Davies Campus: 3539/001 Pacific Campus: 0612/008; 0613/002, 029; 0628/013, 014; 0629/041, 044; 0636/033; 0637/014, 015, 016, 017, 018, 019 California Campus: 1015/001, 016, 052, 053, 054; 1016/001, 002, 003, 004, 005, 006, 007, 008, 009; 1017/027, 028
Staff Contact:	Devyani Jain - (415) 575-9051 Devyani.jain@sfgov.org
Recommendation:	Certify Final Environmental Impact Report

ADOPTING FINDINGS RELATED TO THE CERTIFICATION OF A FINAL ENVIRONMENTAL IMPACT REPORT, FILE NUMBER 2005.0555E, FOR THE CALIFORNIA PACIFIC MEDICAL CENTER LONG RANGE DEVELOPMENT PLAN ("PROJECT").

MOVED, that the San Francisco Planning Commission ("Commission") hereby CERTIFIES the Final Environmental Impact Report identified as Case No. 2005.0555E, California Pacific Medical Center ("CPMC") Long Range Development Plan ("Project"), based upon the following findings:

1. The City and County of San Francisco, acting through the Planning Department ("Department") fulfilled all procedural requirements of the California Environmental Quality Act (Cal. Pub. Res. Code Section 21000 *et seq.)*, ("CEQA"), the State CEQA Guidelines (Cal. Admin. Code title 14, Section 15000 *et seq.*, ("CEQA Guidelines"), and Chapter 31 of the San Francisco Administrative Code ("Chapter 31").

   A. The project sponsor, CPMC, applied for environmental review of the Long Range Development Plan ("LRDP") on June 10, 2005. The Department determined that an Environmental Impact Report ("EIR") was required and pursuant to and in accordance with the requirements of Section 21094 of CEQA and Sections 15063 and 15082 of the CEQA Guidelines, the Department, as lead agency, published and circulated a Notice of Preparation ("NOP") on July 1, 2006, that solicited comments regarding the scope of the EIR for the proposed project. The NOP and its 30-day public review comment period were advertised in the San Francisco Examiner and mailed to public agencies, organizations and nearby property owners, and other individuals likely to be interested in the potential impacts of the proposed project, all in accordance with law. A public scoping meeting was held at the Cathedral Hill Hotel on July 18, 2006.

   B. As planning for the LRDP continued, the project sponsor added additional components to the LRDP, and filed revised Environmental Evaluation Applications on February 28, 2008, and December 8, 2008. The Department revised and re-issued the NOP for a 30-day public review period on May 27, 2009, and held an additional public scoping meeting on June 9, 2009, to accept oral comments on the revised and refined LRDP proposal. In addition, the City extended the public review period an additional 30 days to July 26, 2009.

   C. The NOP was distributed to the State Clearinghouse (State Clearinghouse Number 2006062157) and mailed to: governmental agencies with potential interest, expertise, and/or authority over the project; interested members of the public, including to those on the Department's list of persons requesting such notice; and occupants and owners of real property surrounding CPMC's four existing campuses and the proposed Cathedral Hill Campus location. Notices were also posted on the LRDP project sites, in the Department and on the Department's website. The Department published the Draft EIR on July 21, 2010, and circulated the Draft EIR to local, state, and federal agencies, and to interested organizations and individuals for review and comment beginning July 21, 2010. The Department provided notice in a newspaper of general circulation of the availability of the Draft EIR for public review and comment, and the date and time of the Commission public comment hearing. This notice was mailed to residents within a 300 foot radius of the four campuses and one proposed campus, the Department's list of persons/organizations requesting such notice, and to government agencies, both directly and through the State Clearinghouse.

   D. Notices of the date and time of the public hearing were posted at approximately 65 locations in and around the four campuses and one proposed campus, and the Draft EIR was posted on the Department's website. Copies of the Draft EIR were mailed or otherwise delivered to a list of persons/organizations requesting it and to government agencies (either through the State Clearinghouse or directly). Copies of the Draft EIR were also made available at the Department's information counter.

   E. A Notice of Completion was filed with the State Secretary of Resources via the State Clearinghouse.

2. The Commission held a public hearing to solicit testimony on the Draft EIR during the public review period on September 23, 2010. A court reporter, present at the public hearing, transcribed the oral comments verbatim, and prepared written transcripts. The Planning Department also received written comments on the Draft EIR, which were sent through mail, fax, hand delivery, or email. The

public review period was initially 60 days but was then extended to 90 days, ending on October 19, 2010.

3. The Department prepared responses to comments on the environmental issues received at the public hearing and in writing during the 90-day public review period for the Draft EIR, provided additional, updated information, clarification and modifications on issues raised by commenters, and prepared Department staff-initiated text changes. The Department presented this material in a Comments and Responses ("C&R") document, published on March 29, 2012, and distributed to the Commission and all parties who commented on the Draft EIR and made available to others upon request at the Department.

4. The Department has prepared a Final EIR, which includes the Draft EIR, the C&R document and any Errata Sheets, (the Appendices to the Draft EIR and C&R document), Department staff testimony and responses to questions and comments at the Commission's April 26, 2012, public hearing regarding certification of the Final EIR, and all of the supporting information that has been reviewed and considered by the Department.

5. Project Environmental Impact Report files have been made available for public review at the Planning Department offices at 1650 Mission Street, Suite 400, and are part of the record before the Planning Commission.

6. On April 26, 2012, at a public hearing, the Commission reviewed and considered the Final EIR, and the Commission hereby does find the contents of said report and the procedures through which the Final EIR was prepared, publicized and reviewed, comply with the provisions of CEQA, the CEQA Guidelines and Chapter 31.

7. The project sponsor has indicated that the presently preferred project is the proposed Project, as described in the Final EIR, with the St. Luke's Campus Cesar Chavez Street Utility Line Alignment Variant to the Project, as described in the Draft EIR at pages 2-186 to 2-187 and in Figure 2-61 on page 2-201 of the Draft EIR. Under this variant, most of the existing utilities located within the San Jose Avenue right-of-way (other than water, which would remain the same) would be relocated to different alignments than under the proposed LRDP. This variant was included to provide flexibility in considering the appropriate routes for relocating utilities from vacated San Jose Avenue.

   Under this variant, electrical lines would be rerouted south on San Jose Avenue, east on Duncan Street, north on Valencia Street, and west on 26th Street to a substation at the corner of San Jose Avenue and 26th Street. An additional electrical line would connect from the intersection of San Jose Avenue and Cesar Chavez Street and continue east on Cesar Chavez Street (connecting to the line described above). The utility relocation for the combined storm-sewer would follow a similar (but not identical) route as the electrical lines, as described above, and would be coordinated with the SFPUC, to be included in the SFPUC's Cesar Chavez Street Sewer System Improvement Project ("CCSSIP").

   The variant is preferred over the alignment in the LRDP project description. It would not have any associated significant impacts, except as described in the Final EIR for the LRDP alignment, but would not substantially reduce nor eliminate any significant impacts of the St. Luke's Campus project. The electrical line is proposed to follow the alignment described in this variant. The water line would follow the alignment as described, without changes, in both the LRDP and in this variant. The combined storm-sewer line relocation alignment has been superseded by and somewhat modified by the final CCSSIP. The combined storm-sewer has been incorporated into the SFPUC's CCSSIP and was subject to independent review by SFPUC, which confirmed there are no further associated significant impacts related to the CCSSIP alignment.

8. The Planning Commission hereby does find that the Final EIR concerning File No. 2005.0555E: CPMC Long Range Development Plan reflects the independent judgment and analysis of the City and County of San Francisco, is adequate, accurate and objective, and that the Comments and Responses document contains no significant revisions to the Draft EIR. The Commission further finds that the Final EIR, including without limitation, the C&R documents and appendices and all supporting information, and any Errata sheets and/or responses to late comments, do not add significant new information to the Draft EIR that would individually or collectively require recirculation of the EIR under CEQA, because the Final EIR contains no information revealing (1) any new significant environmental impact that would result from the Project or from a new mitigation measure proposed to be implemented, (2) any substantial increase in the severity of a previously identified environmental impact, (3) any feasible project alternative or mitigation measure considerably different from others previously analyzed that would clearly lessen the environmental impacts of the Project, but that was rejected by the Project's proponents, or (4) that the Draft EIR was so fundamentally and basically inadequate and conclusory in nature that meaningful public review and comment were precluded, and hereby does CERTIFY THE COMPLETION of said Final Environmental Impact Report in compliance with CEQA, the CEQA Guidelines, and Chapter 31.

9. The Planning Commission, in certifying the completion of said Final EIR, hereby does find that the Project and St. Luke's Campus Cesar Chavez Street Utility Line Alignment Variant described in the Final EIR and the project preferred by the project sponsor will have the following significant unavoidable environmental impacts that could not be mitigated to a level of non-significance:

Transportation

a) **Impact TR-1: Implementation of the Cathedral Hill Campus project would result in a significant impact at the intersection of Van Ness/Market.**

LRDP project trips at the Cathedral Hill Campus during the p.m. peak hour would degrade operations at the signalized intersection of Van Ness/Market from LOS D under 2015 Modified Baseline No Project conditions, to LOS E under 2015 Modified Baseline plus Project conditions. This impact would remain significant and unavoidable even with implementation of an expanded Transportation Demand Management ("TDM") program.

b) **Impact TR-2: Implementation of the Cathedral Hill Campus project would result in a significant impact at the intersection of Polk/Geary.**

LRDP project trips at the Cathedral Hill Campus would degrade operations at the signalized intersection of Polk/Geary from LOS D under 2015 Modified Baseline No Project conditions, to LOS E under 2015 Modified Baseline plus Project conditions during the a.m. peak hour, and from LOS C under 2015 Modified Baseline No Project conditions to LOS E under 2015 Modified Baseline plus Project conditions during the p.m. peak hour. This impact would remain significant and unavoidable even with implementation of an expanded TDM program.

c) **Impact TR-19: If the proposed Van Ness Avenue BRT and Geary Corridor BRT projects are implemented, the Cathedral Hill Campus project's contribution to the combined impact of the Cathedral Hill Campus and BRT projects would be significant at the intersection of Polk/Geary.**

The LRDP's contributions to the critical movements at the intersection of Polk/Geary, which would operate at LOS E under 2015 Modified Baseline plus Project conditions with the proposed BRT during both the a.m. and p.m. peak hours, were determined to be less than significant. However, this intersection was identified in Impact TR-2 as a significant and unavoidable impact, and this impact determination would similarly apply to the combined LRDP and BRT projects context. This impact would remain significant and unavoidable even with implementation of an expanded TDM program.

d) **Impact TR-20: If the proposed Van Ness Avenue BRT and Geary Corridor BRT projects are implemented, the Cathedral Hill Campus project's contribution to the combined impact of the Cathedral Hill Campus and BRT projects would be significant at the intersection of Van Ness/Market.**

The LRDP would result in a significant and unavoidable impact at the intersection of Van Ness/Market under 2015 Modified Baseline plus Project conditions and the LRDP's contribution to the traffic impact identified for the combined impact of the Cathedral Hill Campus and BRT projects at the intersection of Van Ness/Market would also be significant and unavoidable. This impact would remain significant and unavoidable even with implementation of an expanded TDM program.

e) **Impact TR-29: Implementation of the Cathedral Hill Campus project would increase congestion and ridership along Van Ness Avenue, which would increase travel times and impact operations of the 49-Van Ness-Mission bus route.**

Under 2015 Modified Baseline plus Project conditions, implementation of the proposed Cathedral Hill Campus project would result in an increase in travel time on the northbound 49-Van Ness-Mission, and an additional bus would be needed on that route during the a.m. and p.m. peak hours. The payment of the fee to provide for an additional bus on the 49-Van Ness bus route would reduce the LRDP's impact on the operation of the 49-Van Ness-Mission bus route to a less than significant level, but the ability of SFMTA to provide the additional service on this line needed to accommodate the Cathedral Hill project for the life of the project is uncertain and the proposed LRDP's impacts on the operation of the 49-Van Ness-Mission bus route would remain significant and unavoidable.

f) **Impact TR-30: Implementation of the Cathedral Hill Campus project would increase congestion and ridership along Geary Street, which would increase travel times and impact operations of the 38/38L-Geary bus routes.**

An additional bus would be required to maintain peak period headways on the 38/38L-Geary during the a.m. peak hour and two additional buses would be required on that route during the p.m. peak hour. The payment of the fee would provide for two additional buses, which would reduce the LRDP's impact on the operation of the 38/38L-Geary bus route to a less than significant level. However, because the ability of SFMTA to provide the additional service on this line needed to accommodate the Cathedral Hill Campus project for the life of the project is uncertain, the feasibility of the mitigation measure is unknown and project's impacts on the operation of the 38/38L-Geary bus route would remain significant and unavoidable.

g) Impact TR-31: Implementation of the Cathedral Hill Campus project would increase congestion and ridership along Polk Street, which would increase travel times and impact operations of the 19-Polk bus route.

Under 2015 Modified Baseline plus Project conditions, the proposed Cathedral Hill Campus project would increase travel time on the southbound 19-Polk bus route requiring a new bus to maintain peak period headways during the p.m. peak hour. The payment of a fee to provide for another bus on the 19 Polk would reduce the LRDP's impact on the operation of the 19-Polk bus route to a less than significant level. However, because the ability of SFMTA to provide the additional service on this line needed to accommodate the Cathedral Hill Campus project is uncertain, the feasibility of the mitigation measure is unknown and the project's impacts on the operation of the 19-Polk bus route would remain significant and unavoidable.

h) Impact TR-55: Implementation of the Cathedral Hill Campus project would result in a transportation impact in the project vicinity resulting from construction vehicle traffic and construction activities that would affect the transportation network.

The LRDP's construction would (1) significantly impact intersection operations at nine study intersections for a four-month period when there is overlap in excavation between the proposed Cathedral Hill Hospital and Cathedral Hill MOB; (2) necessitate temporary closure of a number of sidewalks adjacent to the proposed Cathedral Hill Hospital and Cathedral Hill MOB sites; (3) require closure of bus-only lanes on eastbound Post Street between Franklin Street and Van Ness Avenue and on westbound Geary Boulevard/Street between Polk Street and Franklin Street during construction at the Cathedral Hill Campus, causing buses to merge into the mixed-flow traffic lanes for the one-block segment on Post Street, and the two-block segment on Geary Street; (4) require sequential closures of two lanes of Van Ness Avenue at a time in approximately 100-foot long segments, significantly degrading traffic conditions at certain times ranging between 7 p.m. and midnight at Van Ness/Geary, Van Ness/Post, and Van Ness/O'Farrell; and (5) require closure during the evening and overnight hours on Van Ness Avenue of temporary walkways provided within the parking lane to compensate for temporary sidewalk closures for construction activities. Implementation of a construction transportation management plan would help reduce the Cathedral Hill Campus project's contribution to construction-related traffic, transit, and pedestrian impacts, however, this impact would remain significant and unavoidable.

i) Impact TR-75: Implementation of the Davies Campus project would have a significant impact at the intersection of Church/Market/14th Street that would operate at LOS F under 2020 Modified Baseline No Project conditions.

The increase in vehicle trips that would occur as a result of full buildout of the Davies Campus (near and long-term projects) under the LRDP would contribute considerably to critical movements operating at LOS E or LOS F at this intersection. This impact would remain significant and unavoidable even with implementation of an expanded TDM program.

j) Impact TR-99: Implementation of the Cathedral Hill Campus project LRDP would result in significant project and cumulative impacts at the intersection of Van Ness/Market.

The Cathedral Hill Campus project would result in a significant impact under 2015 Modified Baseline plus Project Conditions at the Van Ness/Market intersection during the p.m. peak hour. This impact would remain significant and unavoidable even with implementation of an expanded TDM program.

k) **Impact TR-100: Implementation of the Cathedral Hill Campus project would result in a significant cumulative impact at the intersection of Van Ness/Pine.**

The addition of trips generated by the Cathedral Hill Campus during the p.m. peak hour would degrade operations at the signalized intersection of Van Ness/Pine from LOS D under 2030 Cumulative No Project conditions to LOS E under 2030 Cumulative plus Project conditions. This impact would remain significant and unavoidable even with implementation of an expanded TDM program.

l) **Impact TR-101: Implementation of the Cathedral Hill Campus project would result in significant project and cumulative impacts at the intersection of Polk/Geary.**

The addition of trips generated by the Cathedral Hill Campus project during the p.m. peak hour would degrade operations at the signalized intersection of Polk/Geary from LOS D under 2030 Cumulative No Project conditions to LOS E under 2030 Cumulative plus Project conditions. In addition, the proposed project would result in a significant impact under 2015 Modified Baseline plus Project conditions. This impact would remain significant and unavoidable even with implementation of an expanded TDM program.

m) **Impact TR-117: If the proposed Van Ness Avenue and Geary Corridor Bus Rapid Transit projects are implemented, the Cathedral Hill Campus project's contribution to the combined cumulative impacts of the Cathedral Hill Campus and BRT projects at the intersection of Polk/Geary would be significant.**

The Cathedral Hill Campus project's contribution to the impacts identified for the combined effect of the Cathedral Hill Campus project and the BRT projects at the intersection of Polk/Geary would be significant and unavoidable under 2015 Modified Baseline conditions for which there is no feasible mitigation. Therefore, the contribution of the Cathedral Hill Campus project to the combined cumulative impacts at the intersection of Polk/Geary would also be significant and unavoidable.

n) **Impact TR-118: If the proposed Van Ness Avenue and Geary Corridor Bus Rapid Transit projects are implemented, the Cathedral Hill Campus project's contribution to the combined cumulative impacts of the Cathedral Hill Campus and BRT projects at the intersection of Van Ness/Market would be significant.**

The Cathedral Hill Campus project's contribution to the impacts identified for the combined effect of the Cathedral Hill Campus project and the BRT projects at the intersection of Van Ness/Market would be significant and unavoidable under 2015 Modified Baseline conditions, for which there is no feasible mitigation. Therefore, the contribution of the Cathedral Hill Campus project to the combined cumulative impacts at the intersection of Van Ness/Market would also be significant and unavoidable.

o) Impact TR-127: Implementation of the Davies Campus project would have significant impacts at the intersection of Church/Market/14th Street, which would operate at LOS F under 2030 Cumulative No Project conditions and 2030 Cumulative plus Project conditions.

Under 2030 Cumulative plus Project conditions, the increase in vehicle trips generated by the Davies Campus project would contribute considerably to critical movements operating at LOS E or F, and therefore would be significant. No feasible mitigation measures have been identified for impacts at the intersection of Church/Market/14th Street. Therefore, this impact would remain significant and unavoidable.

p) Impact TR-133: Implementation of the Cathedral Hill Campus project would increase congestion along Van Ness Avenue under 2030 Cumulative plus Project conditions, which would increase travel times and impact operations of the 49-Van Ness-Mission bus route.

Under 2030 Cumulative plus Project conditions, implementation of the proposed Cathedral Hill Campus project would result in increases in travel time on the northbound 49-Van Ness-Mission by about five minutes during the a.m. peak hour of five minutes, which would be more than half of the proposed headway of 7½ minutes, necessitating an additional bus on that route during the a.m. and p.m. peak hours. The payment of the fee to provide for an additional bus on the 49-Van Ness bus route would reduce the LRDP's impact on the operation of the 49-Van Ness-Mission bus route to a less than significant level. However, because SFMTA's ability to provide additional service on this line is uncertain, the feasibility of implementing the mitigation measure is unknown and cumulative impacts on the 49-Van Ness-Mission bus route resulting from implementation of the Cathedral Hill Campus project would remain significant and unavoidable.

q) Impact TR-134: Implementation of the Cathedral Hill Campus project would increase congestion along Van Ness Avenue under 2030 Cumulative plus Project conditions, which would increase travel times and impact operations of the 47-Van Ness bus route.

As a result of the proposed Cathedral Hill Campus project, under 2030 Cumulative plus Project conditions an additional bus would be required on the 47-Van Ness to maintain peak period headways during the p.m. peak hour. Therefore, project-related transit delays resulting from congestion on study area roadways and passenger loading delays associated with increased ridership on operation of the 47-Van Ness bus route during the p.m. peak hour would be a significant impact. The payment of the fee to provide for an additional bus on the 47-Van Ness bus route would reduce the LRDP's impact on the operation of the 47-Van Ness-Mission bus route to a less than significant level. However, because SFMTA's ability to provide additional service on this line is uncertain, the feasibility of implementing the mitigation measure is unknown and cumulative impacts on the 47-Van Ness bus route resulting from implementation of the Cathedral Hill Campus project would remain significant and unavoidable.

r) Impact TR-135: Implementation of the Cathedral Hill Campus project would increase congestion along Geary Street under 2030 Cumulative plus Project conditions, which would increase travel times and impact operations of the 38/38L-Geary bus routes.

As a result of the proposed Cathedral Hill Campus project, under 2030 Cumulative plus Project conditions an additional bus would be required on the 38/38L-Geary to maintain peak period headways during the a.m. peak hour, and two additional buses would be required on that route during the p.m. peak hour. The payment of the fee to provide for additional buses on this route would reduce the LRDP's impact on the bus route to a less than significant level. However, because SFMTA's ability to provide additional service on this line is uncertain, the feasibility of implementing the mitigation measure is unknown and cumulative impacts on the 38/38L-Geary bus route resulting from implementation of the Cathedral Hill Campus project would remain significant and unavoidable.

s) **Impact TR-136: Implementation of the Cathedral Hill Campus project would increase congestion along Polk Street under 2030 Cumulative plus Project conditions, which would increase travel times and impact operations of the 19-Polk bus route.**

Under 2030 Cumulative plus Project conditions, the Cathedral Hill Campus project would result in increases in travel time on the southbound 19-Polk bus route by about 8 minutes during the p.m. peak hour, which would necessitate an additional bus during the p.m. peak hour. The payment of the fee to provide for an additional bus on the route would reduce the LRDP's impact on the operation of the bus route to a less than significant level. However, because SFMTA's ability to provide additional service on this route is uncertain, the feasibility of implementing the mitigation measure is unknown and cumulative impacts on the 19-Polk bus route resulting from implementation of the Cathedral Hill Campus project would remain significant and unavoidable.

t) **Impact TR-137: Implementation of the Cathedral Hill Campus project would increase congestion along Post Street under 2030 Cumulative plus Project conditions, which would increase travel times and impact operations of the 3-Jackson bus route.**

As a result of the proposed Cathedral Hill Campus project, under 2030 Cumulative plus Project conditions an additional bus would be required on the 3-Jackson bus route to maintain peak period headways during the p.m. peak hour. The payment of the fee to provide for an additional bus would reduce transit delay impacts to the 3-Jackson bus route to a less-than-significant level. However, because SFMTA's ability to provide additional service on this line is uncertain, the feasibility of implementing the mitigation measure is unknown and cumulative impacts on the 3-Jackson bus route resulting from implementation of the Cathedral Hill Campus project would remain significant and unavoidable.

u) **Impact TR-152: Implementation of CPMC LRDP construction of the Cathedral Hill Campus would contribute to cumulative construction impacts in the Cathedral Hill Campus vicinity.**

The construction of the Cathedral Hill Campus may overlap with the proposed Van Ness Avenue BRT and Geary Corridor BRT projects, should they be approved and funded. The potential for overlapping construction activities would increase the number of construction worker vehicles and trucks traveling to and from the vicinity of the Cathedral Hill Campus. In addition, implementation of the BRT improvements on Van Ness Avenue would require travel lane closures that would temporarily and permanently affect roadway capacity. Impact TR-55, discussed above, identified

significant and unavoidable impacts on the transportation network related to the construction activities at the Cathedral Hill Campus. Implementation of a construction transportation management plan would minimize impacts associated with the Cathedral Hill Campus project and reduce the project's contributions to cumulative impacts in overlapping areas but significant construction-related transportation impacts on local roadways in the vicinity of the Cathedral Hill Campus would still occur and cumulative construction impacts would be significant and unavoidable.

Noise

v) Impact NO-5: Groundborne vibration levels attributable to construction activities could exceed the threshold of significance for exposing noise- and vibration-sensitive land uses to vibration levels that exceed applicable thresholds.

Near-Term Projects at Cathedral Hill, Davies and St. Luke's Campuses

In the vicinity of the Cathedral Hill, Davies, and St. Luke's Campuses, groundborne noise and vibration may exceed the Federal Transit Administration's ("FTA") standard for human response at nearby off-site vibration-sensitive uses. Implementation of mitigation through construction contract requirements for: operational restrictions on vibratory rollers; community liaison; evaluation of recurring complaints by qualified acoustical consultant; and a construction vibration management plan would reduce excessive vibration; however, this impact would remain significant and unavoidable.

Air Quality

w) Impact AQ-3: Operation of the LRDP would exceed BAAQMD CEQA significance thresholds for mass emissions of criteria pollutants and would contribute to an existing or projected air quality violation at full buildout under the 1999 BAAQMD Guidelines.

Cathedral Hill, Davies, and St. Luke's Campuses

The net change in operational PM_{10} emissions from implementation of the LRDP (128 pounds/day, 23 tons/year) would exceed applicable daily and annual emission significance criteria under the 1999 BAAQMD CEQA Guidelines (80 pounds/day, 15 tons/year). Thus, under the 1999 BAAQMD CEQA significance criteria, operation of the proposed LRDP would result in or contribute to a violation of air quality standards. All feasible measures to reduce operational impacts related to PM_{10} emissions, which are primarily attributable to mobile sources (vehicles), have been incorporated into the proposed LRDP as part of CPMC's proposed enhanced TDM program. No additional feasible mitigation is available to reduce this impact to a less-than-significant level. Therefore, this impact would be significant and unavoidable.

x) Impact AQ-7: The LRDP's long-term operational criteria air pollutant emissions would contribute to a cumulatively considerable impact under the 1999 BAAQMD Guidelines.

Long-term operations at the Cathedral Hill, Davies, and St. Luke's Campuses after completion of the near-term projects would cause a permanent net increase in criteria air pollutant and precursor emissions. The 1999 BAAQMD CEQA Guidelines consider a project to result in a cumulatively considerable impact if operational criteria air pollutant and precursor emissions would exceed the

project-level emissions thresholds of significance. The near-term projects under the LRDP would exceed the project-level thresholds of significance for operational PM_{10} emissions. Thus, the project would contribute to a cumulatively considerable impact and would, therefore, result in a significant cumulative impact. All feasible measures to reduce operational impacts related to PM_{10} emissions, which are primarily attributable to mobile sources (vehicles), have been incorporated into the proposed LRDP as part of CPMC's proposed enhanced TDM program. No additional feasible mitigation is available to reduce this impact to a less-than-significant level. Therefore, this impact would be significant and unavoidable.

y) Impact AQ-9: Near-term construction activities associated with the LRDP would exceed 2010 BAAQMD CEQA significance thresholds for mass criteria pollutant emissions and would contribute to an existing or projected air quality violation.

Under the proposed LRDP emissions of oxides of nitrogen ("NO_x") associated with near-term projects at the Cathedral Hill, Davies, and St. Luke's Campuses would exceed the 2010 BAAQMD CEQA Guidelines significance criterion for construction-related NO_x emissions. As a result, this impact would be significant under the 2010 BAAQMD CEQA Guidelines significance criterion.

Implementation of all feasible mitigation would not reduce this impact to a less than significant level and impacts associated with mass criteria pollutant emissions from near-term construction activities would remain significant and unavoidable.

Impact AQ-10: Construction activities associated with the near-term projects at the Cathedral Hill and St. Luke's Campuses would result in short-term increases in emissions of diesel particulate matter that exceed the 2010 BAAQMD CEQA significance criteria and expose sensitive receptors to substantial concentrations of toxic air contaminants and $PM_{2.5}$.

Cathedral Hill Campus

TAC and $PM_{2.5}$ emissions from construction at the Cathedral Hill Campus under the proposed LRDP would be significant under the 2010 BAAQMD CEQA Guidelines significance criteria. Even with implementation of all feasible mitigation, impacts related to the exposure of sensitive receptors to substantial amounts of TACs and $PM_{2.5}$ from construction activities at the Cathedral Hill Campus under the proposed LRDP would remain significant and unavoidable.

St. Luke's Campus

TAC emissions from construction activities at the St. Luke's Campus would exceed the 2010 BAAQMD CEQA Guidelines significance threshold, which would be a significant impact. Even with implementation of all feasible mitigation, impacts related to the exposure of sensitive receptors to substantial amounts of TACs and $PM_{2.5}$ from construction activities at the St. Luke's Campus under the proposed LRDP would remain significant and unavoidable.

z) Impact AQ-11: Operation of the LRDP would exceed the 2010 BAAQMD CEQA significance thresholds for mass criteria pollutant emissions and would contribute to an existing or projected air quality violation at full build out.

Near-Term Projects at Cathedral Hill, Davies, and St. Luke's Campuses

The net change in operational emissions resulting from implementation of the LRDP's near-term projects at the Cathedral Hill, Davies, and St. Luke's Campuses would exceed the 2010 BAAQMD CEQA Guidelines daily and annual emission significance criteria for PM_{10}. Therefore, operation of these campuses under the proposed LRDP would result in or contribute to a violation of PM_{10} air quality standards. Even with implementation of all feasible measures to reduce operational impacts related to PM_{10} emissions, through CPMC's proposed enhanced TDM program, this impact would remain significant and unavoidable.

aa) **Impact AQ-14: The proposed LRDP's construction emissions of toxic air contaminants would potentially contribute to a cumulatively considerable impact on sensitive receptors under the 2010 BAAQMD Guidelines.**

Cathedral Hill Campus

Construction $PM_{2.5}$ emissions at the Cathedral Hill Campus would have a significant impact on off-site receptors under the 2010 BAAQMD CEQA Guidelines significance thresholds, even after all feasible mitigation is incorporated. Thus, the Cathedral Hill Campus construction emissions would also have a potentially cumulatively considerable impact on off-site receptors, a significant and unavoidable impact.

Davies Campus

Construction $PM_{2.5}$ emissions at the Davies Campus would have a significant impact on off-site receptors, under the 2010 BAAQMD CEQA Guidelines significance thresholds, even after all feasible mitigation is incorporated. Thus, construction emissions from the near-term project at the Davies Campus would also have a potentially cumulatively considerable impact on off-site receptors, a significant and unavoidable impact.

St. Luke's Campus

Construction $PM_{2.5}$ emissions at the St. Luke's Campus would have a significant impact on off-site receptors, under the 2010 BAAQMD CEQA Guidelines significance thresholds, even after all feasible mitigation is incorporated. Thus, the St. Luke's Campus construction emissions would also have a potentially cumulatively considerable impact on off-site receptors, a significant and unavoidable impact.

Greenhouse Gas Emissions

bb) **Impact GH-3: Direct and indirect CPMC LRDP–generated GHG emissions would have a significant impact on the environment or conflict with an applicable plan, policy, or regulation adopted for the purpose of reducing GHG emissions under the 2010 BAAQMD Guidelines.**

Cathedral Hill, Davies and St. Luke's Campuses

The 2010 BAAQMD CEQA Guidelines identified the following three alternative thresholds for determining whether a project's GHG emissions are significant:

1) Compliance with a Qualified Greenhouse Gas Reduction Strategy; or

2) Whether a project's GHG emissions exceed 1,100 metric tons of carbon dioxide equivalent per year ("$MTCO_2e/yr$"); or

3) Whether a project's GHG emissions exceed 4.6 $MTCO_2e/yr$ per service population.

On December 14, 2010, after the Draft EIR had been published and following BAAQMD's approval of a Qualified GHG Reduction Strategy for San Francisco, the Environmental Planning Division determined that the proposed CPMC LRDP would be in compliance with the City's Qualified GHG Reduction Strategy. Because it has been determined to be consistent with the BAAQMD-approved GHG Reduction Strategy, the proposed LRDP has been shown to satisfy BAAQMD's mitigation guidance and to have identified all applicable, feasible mitigation measures. However, the Planning Department has determined that because the significance conclusion in the Draft EIR regarding operational GHG emissions was made prior to a determination of equivalency with a Qualified GHG Reduction Strategy, and the LRDP would exceed the 2010 BAAQMD GHG quantitative threshold of significance (which the Planning Department had previously determined applied), the proposed LRDP should conservatively be considered to result in a significant and unavoidable impact, despite the implementation of all feasible GHG reduction measures. Therefore, this impact would remain significant and unavoidable.

I hereby certify that the foregoing Motion was ADOPTED by the Planning Commission on April 26, 2012.

Linda D. Avery
Commission Secretary

AYES: President Fong, Commissioner Antonini, Commissioner Sugaya, Commissioner Borden, and Commissioner Miguel (5)

NAYS: Commissioner Moore (1)

ABSENT: Commissioner Wu (1)

ACTION: Certification of Final EIR

ADOPTED: April 26, 2012

Application to Request a Board of Supervisors Appeal Fee Waiver

CASE NUMBER (For Staff Use Only):

APPLICATION FOR
Board of Supervisors Appeal Fee Waiver

1. Applicant and Project Information

APPLICANT NAME: Cathedral Hill Neighbors Association / Marlayne Morgan, Pres.

APPLICANT ADDRESS: 1200 Gough St #17A, San Francisco, CA 94109

TELEPHONE: (415) 658-7458

EMAIL: marlayne16@gmail.com

NEIGHBORHOOD ORGANIZATION NAME: Cathedral Hill Neighbors Association

NEIGHBORHOOD ORGANIZATION ADDRESS: 1 Daniel Burnham Ct, Ste 151(2), San Francisco, CA 94109

TELEPHONE: N/A

EMAIL: N/A

website chna.org

PROJECT ADDRESS: Post / Sutter / Van Ness - CPMC

PLANNING CASE NO.: 2005.0555E

BUILDING PERMIT APPLICATION NO.:

DATE OF DECISION (IF ANY): 4/26/12

2. Required Criteria for Granting Waiver

(All must be satisfied; please attach supporting materials)

☒ The appellant is a member of the stated neighborhood organization and is authorized to file the appeal on behalf of the organization. Authorization may take the form of a letter signed by the President or other officer of the organization.

☒ The appellant is appealing on behalf of an organization that is registered with the Planning Department and that appears on the Department's current list of neighborhood organizations.

☒ The appellant is appealing on behalf of an organization that has been in existence at least 24 months prior to the submittal of the fee waiver request. Existence may be established by evidence including that relating to the organization's activities at that time such as meeting minutes, resolutions, publications and rosters.

☒ The appellant is appealing on behalf of a neighborhood organization that is affected by the project and that is the subject of the appeal.

For Department Use Only
Application received by Planning Department:

By: _____ Date: _____

Submission Checklist:

- ☐ APPELLANT AUTHORIZATION
- ☐ CURRENT ORGANIZATION REGISTRATION
- ☐ MINIMUM ORGANIZATION AGE
- ☐ PROJECT IMPACT ON ORGANIZATION

☐ WAIVER APPROVED ☐ WAIVER DENIED

SAN FRANCISCO PLANNING DEPARTMENT

FOR MORE INFORMATION:
Call or visit the San Francisco Planning Department

Central Reception
1650 Mission Street, Suite 400
San Francisco CA 94103-2479

TEL: 415.558.6378
FAX: 415.558.6409
WEB: http://www.sfplanning.org

Planning Information Center (PIC)
1660 Mission Street, First Floor
San Francisco CA 94103-2479

TEL: 415.558.6377
Planning staff are available by phone and at the PIC counter. No appointment is necessary.

CHNA
Cathedral Hill
Neighbors Association

Cathedral Hill Neighbors Association

MEMBERSHIP DRIVE

June 16, 2009

Dear Neighbor,

Cathedral Hill Neighbors (CHNA) will be four years old this autumn! In July of 2005, the proposal to build **California Pacific Medical Center's (CPMC)** Cathedral Hill mega campus inspired our neighborhood to form it's own association, which was formalized in 2006. CHNA has since expanded its scope by our involvement in the Japantown Better Neighborhood Plan, the Coalition of San Francisco Neighborhoods and the Neighborhood Network so we can work with others to encourage responsible development in our city.

Thanks to members like you, we now have a viable organization with the ability to represent our concerns before the Planning Commission with the many new major developments proposed for our neighborhood. **However, right now a very critical process will begin in June of 2009, with the scoping hearings for the new CPMC Institutional Master Plan (IMP), and we need your help and participation.**

CHNA has consistently urged **CPMC** to rebuild their new seismic structures on several campuses- not just on Cathedral Hill. To this end, we have joined the **Coalition for Health Planning- San Francisco**, which includes other neighborhood associations, patient advocates, medical providers, labor organizations and land use planners. Our Coalition's goal is to ensure that new hospital facilities and services are fairly and equitably divided among CPMC's five San Francisco campuses.

Cathedral Hill Neighbors Association is a group of residents; business and churches that is invested in the future of Cathedral Hill and that advocates for responsible development. Our goals include:

- ✓ **Ensure compliance with height, density and land use restrictions, without exemptions;**
- ✓ **Maintain and enhance safe air quality, noise levels and environmental health standards;**
- ✓ **Limit unreasonable traffic and parking congestion in our critical transit corridors.**

All our officers are volunteers and we keep our expenses to a very strict minimum. However, our neighborhood is facing extremely well financed and connected interests and we are building our reserves for legal help as we go into these scoping hearings. This is why we are asking you to join our association, or renew your dues ($25 a year or $15 for seniors) or make a contribution towards our upcoming representation costs.

Thank you for your support.

Sincerely,

Marlayne Morgan

Marlayne Morgan
President, Cathedral Hill Neighbors Association

BOARD of SUPERVISORS

City Hall
Dr. Carlton B. Goodlett Place, Room 244
San Francisco 94102-4689
Tel. No. 554-5184
Fax No. 554-5163
TDD/TTY No. 544-5227

May 18, 2012

Gloria D. Smith
The Law Offices of Gloria D. Smith
48 Rosemont Place
San Francisco, CA 94103

Subject: Appeal of Planning Commission's Certification of the Final Environmental Impact Report - California Pacific Medical Center Long Range Development Plan Project

Dear Ms. Smith:

The Office of the Clerk of the Board is in receipt of your appeal filed on May 16, 2012, on behalf of the California Nurses Association/National Nurses United, Council of Community Housing Organizations, Cathedral Hill Neighbors Association, Bernal Heights Neighborhood Center, Jobs with Justice San Francisco, and San Franciscans for Healthcare, Housing, Jobs, and Justice from the decision of the Planning Commission's April 26, 2012, Certification of a Final Environmental Impact Report identified as Planning Case No. 2005.0555E, through its Motion No. 18588, for the proposed California Pacific Medical Center Long Range Development Plan Project.

A hearing date has been scheduled on **Tuesday, June 12, 2012, at 4:00 p.m.,** at the Board of Supervisors meeting to be held in City Hall, Legislative Chamber, Room 250, 1 Dr. Carlton B. Goodlett Place, San Francisco, CA 94102.

Please provide 18 copies to the Clerk's Office by:

8 days prior to the hearing: any documentation which you may want available to the Board members prior to the hearing;

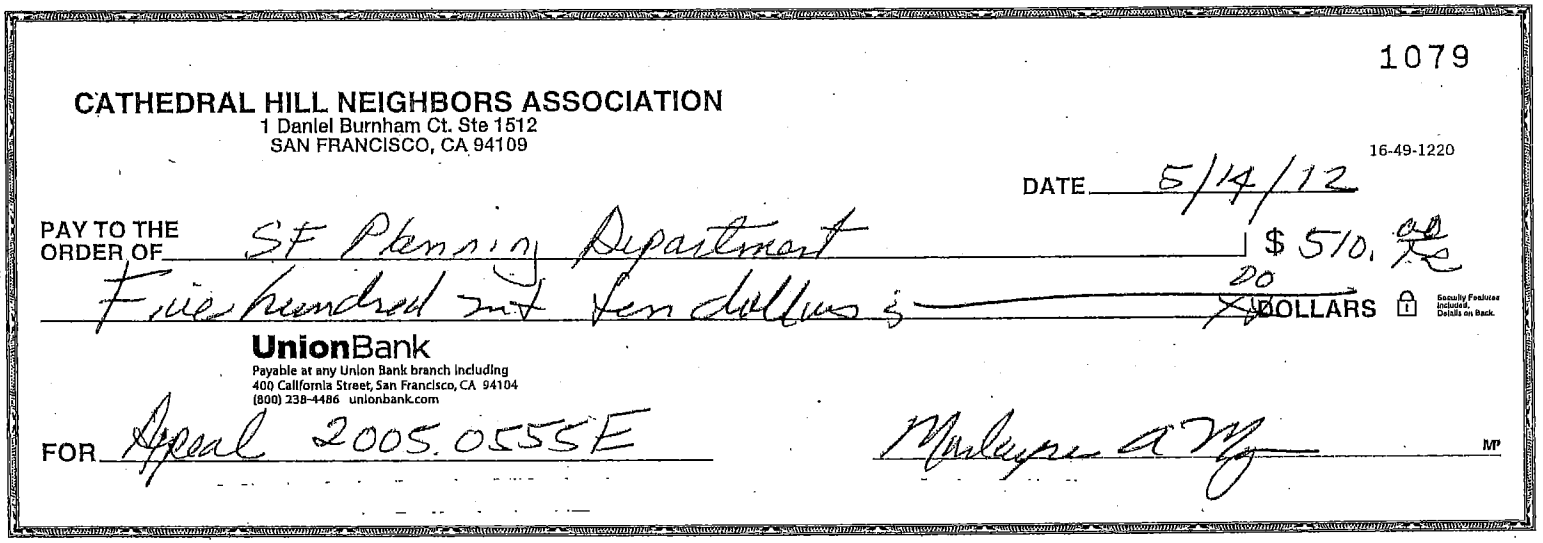
11 days prior to the hearing: names of interested parties to be notified of the hearing in label format.

If you have any questions, please feel free to contact Legislative Deputy Director, Rick Caldeira, at (415) 554-7711 or Legislative Clerk, Joy Lamug, at (415) 554-7712.

Sincerely,

Angela Calvillo
Clerk of the Board

c:
Cheryl Adams, Deputy City Attorney
Kate Stacy, Deputy City Attorney
Marlena Byrne, Deputy City Attorney
Scott Sanchez, Zoning Administrator, Planning Department
Bill Wycko, Environmental Review Officer, Planning Department
AnMarie Rodgers, Planning Department
Tina Tam, Planning Department
Joy Navarrete, Planning Department
Devyani Jain, Planning Department
Elizabeth Watty, Planning Department
Linda Avery, Planning Commission Secretary
Project Sponsor, Geoffrey Nelson, California Pacific Medical Center, 633 Folsom Street, 6th Floor, San Francisco, CA 94107



1079

CATHEDRAL HILL NEIGHBORS ASSOCIATION
1 Daniel Burnham Ct. Ste 1512
SAN FRANCISCO, CA 94109

16-49-1220

DATE 5/14/12

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FOR Appeal 2005.0555E

Marlayne A Morgan

MP

2099

PLANNING DEPARTMENT RESPONSE TO
APPEAL OF EIR CERTIFICATION
CPMC/LRDP PROJECT

DATE:	July 9, 2012
TO:	Angela Calvillo, Clerk of the Board of Supervisors
FROM:	Bill Wycko, Environmental Review Officer – (415) 575-9048 Devyani Jain, Environmental Planning Division, Project Manager (415) 575-9051
RE:	Planning Department Case Nos. 2005.0555E; 2009.0886EMTZCBRKS; 2009.0885EMTZCBRKS; 2004.0603EC; 2012.0403W California Pacific Medical Center Long Range Development Plan
HEARING DATE:	July 17, 2012
EXHIBITS:	Appeal Letter from Gloria Smith, dated May 16, 2012, on behalf of the California Nurses Association/National Nurses United, Council of Community Housing Organizations, Cathedral Hill Neighbors Association, Bernal Heights Neighborhood Center, Jobs with Justice San Francisco, and San Franciscans for Healthcare, Housing, Jobs, and Justice
PROJECT SPONSOR:	California Pacific Medical Center ("**CPMC**")
APPELLANTS:	Gloria Smith on behalf of the California Nurses Association/National Nurses United, Council of Community Housing Organizations, Cathedral Hill Neighbors Association, Bernal Heights Neighborhood Center, Jobs with Justice San Francisco, and San Franciscans for Healthcare, Housing, Jobs, and Justice ("**Appellants**")

INTRODUCTION

The decision before the Board is whether to uphold the Planning Commission's decision to certify the Final EIR or to reverse the Commission's decision and return the EIR to the Planning Department for additional analysis.

On April 26, 2012, the Planning Commission by Motion No. 18588, found that the Final EIR was adequate, accurate, and objective, reflected the independent judgment of the Planning Commission, that the Comments and Responses document contains no significant revisions to the Draft EIR, and adopted findings of significant impact associated with the Project and certified the completion of the Final EIR for the Project in compliance with CEQA, and the CEQA Guidelines and Chapter 31. The Planning Department also prepared and the Planning Commission later adopted proposed findings (Planning Commission Motion No. 18589), as required by CEQA, regarding the alternatives, mitigation measures, and significant impacts analyzed in the Final EIR and overriding consideration for approving the Near-Term Projects, including all of the actions listed in **Exhibit A** thereto, and a proposed mitigation monitoring and reporting program, attached as Attachment 1 to **Exhibit A** to said CEQA findings.

APPEAL AND PLANNING DEPARTMENT RESPONSES

On May 16, 2012, Gloria Smith, on behalf of Appellants, filed with the Clerk of the Board of Supervisors a letter appealing certification of the Final EIR for the CPMC LRDP (**Exhibit A**). The principal issues raised by Appellants in the May 16, 2012 appeal are summarized below, followed by a brief Planning Department response. The Department's more detailed responses to the Appellants' appeal letter (and accompanying materials) are included in **Exhibit A**.

All of the issues raised by Appellants in the May 16, 2012 appeal letter were either (1) previously raised by Appellants in the comments submitted to the Draft EIR and were addressed in the C&R document, or (2) in the late comment letters on the Draft EIR submitted to the Planning Commission on April 25, 2012 and April 26, 2012. The Department's responses to those late comments are attached hereto in **Exhibit B**. For the convenience of the Board, where applicable, cross-references to the Department's more detailed responses to similar Draft EIR comments in the C&R document, and to the Department's responses to the late comments received on the Draft EIR, are also provided in the summary responses below.

ORGANIZATION OF APPEAL RESPONSE

The Department's response to the appeal of the EIR certification is organized as follows:

- **Project Description:** This section provides a summary of the CPMC LRDP near-term and long-term projects in Sections A and B, respectively.
- **Environmental Review, Draft Environmental Impact Report, Comments and Responses:** This section provides a summary of the CPMC LRDP environmental review process including the Notice of Preparation, Draft EIR, Comments and Responses, and associated public hearings that have been held.
- **Summary of Concerns Raised by Appellants:** This section responds to seven general grounds for the appeal identified by the Appellants, summarizes seven principle areas of concern raised by Appellants, and provides are response to each, with cross-references to detailed responses. The appeal letter is included as **Exhibit A.**
- **Exhibit A:** Exhibit A consists of the Department's responses to the Appellants' appeal letter and accompanying materials. The appeal letter has been assigned a number, and comments are bracketed and assigned a response category code and secondary comment-specific number. Responses to the appeal

letter are grouped by topic and numbered in consecutive order within each topic section (e.g., Response INTRO 1-4, Response PH 1-1). The Response Category Codes for the appeal letter include the following:

- INTRO: Introduction
- PH: Population, Employment, and Housing
- TR: Transportation and Circulation
- AQ: Air Quality
- GHG: Greenhouse Gas Emissions
- ALT: Alternatives
- HC: Healthcare

The appeal letter is presented in its entirety at the end of **Exhibit A.**

- **Exhibit B:** Exhibit B consists of the Department's responses to the five late comment letters that were submitted to the Planning Commission on April 25, 2012 and April 26, 2012. Each of the five comment letters has been assigned a number, and comments in each letter are bracketed. The comments within the late letters are followed immediately by responses in consecutive order to all the substantive comments brought up in that particular comment letter. The late comment letters are presented in their entirety at the end of **Exhibit B.**

PROJECT DESCRIPTION

The CPMC Long Range Development Plan ("LRDP") is a multi-phased development strategy to meet state seismic safety requirements for hospitals mandated originally in 1994 by Senate Bill ("SB") 1953, as modified through successor legislation, and to create a 20-year framework for CPMC's four existing medical campuses and for construction of a proposed new medical campus in San Francisco.

The four existing CPMC medical campuses are the St. Luke's Campus in the Mission District, Pacific Campus in the Pacific Heights area, California Campus in the Presidio Heights area, and Davies Campus in the Duboce Triangle area. The proposed new medical campus is the Cathedral Hill Campus, located along Van Ness Avenue in the vicinity of the intersection of Van Ness Avenue and Geary Boulevard/Geary Street.

The LRDP includes Near-Term Projects, including actions at CPMC's St. Luke's, Cathedral Hill, and Davies Campuses, that have been analyzed at a project-specific level for purposes of CEQA compliance; and Long-Term Projects, including future actions at the Davies and Pacific Campuses, which would commence after 2015 and which are analyzed at a program level for purposes of CEQA compliance. There are no Near-Term Projects or Long-Term Projects proposed for the California Campus. The Near-Term Projects and Long-Term Projects are defined and described in more detail in Sections A and B, respectively. The approvals include a Development Agreement. That Agreement includes certain provisions that relate to the Long-Term Projects, but neither the Development Agreement nor the other approvals authorize physical development of the Long-Term Projects.

A. LRDP Near-Term Projects Description.

1. St. Luke's Campus.

The following describes Project components proposed for the St. Luke's Campus under the LRDP. All activities described below would occur in the near term.

a. St. Luke's Replacement Hospital.

The CPMC LRDP would result in the construction of the approximately 146,410-gross-square-foot ("g.s.f.") seismically compliant St. Luke's Replacement Hospital, adjacent to and west of the

existing St. Luke's Hospital tower. Specifically, the St. Luke's Replacement Hospital would occupy the site of the existing 3615 Cesar Chavez Street Surface Parking Lot. A portion of the new St. Luke's Replacement Hospital would also be constructed across the vacated section of San Jose Avenue, between the existing 1957 Building and the existing 3615 Cesar Chavez Street Surface Parking Lot. The new, five-story St. Luke's Replacement Hospital would be approximately 99 feet in height.[1] The Redwood Administration Building would be demolished before the start of hospital construction. The proposed St. Luke's Replacement Hospital would be open for patient care by about the beginning of 2017.

The St. Luke's Replacement Hospital would contain a total of 80 acute beds and an emergency department. It may include, but is not limited to, inpatient medical care, diagnostic and treatment space, surgical care, critical care, labor and delivery, post-partum care, cafeteria, loading area, and central utility plant space.

The proposed St. Luke's Replacement Hospital would be designed to achieve a LEED®-Certified rating, including plans for reduced energy use associated with heating, cooling, ventilation, hot water, and lighting.

Parking for the St. Luke's Replacement Hospital would be accommodated through valet parking at the existing Duncan Street Parking Garage, increasing the garage's capacity to about 60 spaces. An additional 220 parking spaces for the St. Luke's Replacement Hospital would be provided at the new parking garage to be located in the proposed medical office building ("MOB")/Expansion Building, described below. These two parking garages, plus 15 surface parking spaces (located throughout the campus), would provide a total of 450 parking spaces at the St. Luke's Campus. Loading (three spaces) for the St. Luke's Replacement Hospital would be located within the hospital, at Cesar Chavez Street between Guerrero and Valencia Streets.

b. Hospital Demolition and Plaza Pedestrian Improvements.

After the existing 12-story St. Luke's Hospital tower is vacated and services have been relocated to the St. Luke's Replacement Hospital, the tower would be demolished. After demolition of the tower, an entry plaza, courtyard, and pedestrian pathway would be constructed in the portion of the former San Jose Avenue right-of-way between Cesar Chavez Street and 27th Street that is not occupied by the St. Luke's Replacement Hospital.

c. Medical Office Building/Expansion Building.

After demolition of the existing St. Luke's Hospital tower, a new, approximately 104,008 g.s.f., five-story MOB/Expansion Building would be constructed at the site of the former hospital tower. The new five-story MOB/Expansion Building would be approximately 100 feet in height. The MOB/Expansion Building would include medical offices, diagnostic and treatment space, outpatient care, retail, hospital administration, cafeteria, education/conference space, and four below-ground parking levels that would provide approximately 220 parking spaces.

The building would be required to conform to Chapter 13C of the City's Building Code (San Francisco Green Building Requirements), which requires a LEED® Silver rating for the MOB/Expansion Building.

d. San Jose Avenue Street Vacation and Utilities Relocation.

[1] All heights are measured using Planning Code methodology for measurement, unless otherwise specified.

As described above, a portion of the new St. Luke's Replacement Hospital would be located on the portion of San Jose Avenue between 27th Street and Cesar Chavez Street that bisects the St. Luke's Campus and is used as surface parking by CPMC under an encroachment permit issued by the City in 1968. This portion of San Jose Avenue is closed to public use, is frequently chained at its northern end where it meets Cesar Chavez Street, and is not generally open to through traffic. For the St. Luke's Replacement Hospital to be constructed, the City would be required to approve a street vacation for this portion of San Jose Avenue, and existing utilities located within the San Jose Avenue right-of-way would be relocated.

e. 1957 Building.

After the opening of the new St. Luke's Replacement Hospital, the existing, approximately 31,700-sq.-ft. 1957 Building would be decommissioned from its status as a licensed hospital, and renovated and reused for administrative offices, storage, and conference space. The Emergency Department and surgical suites (operating rooms) currently within the 1957 Building would be replaced by new facilities in the new St. Luke's Replacement Hospital. The exterior 1957 Building connector to the existing St. Luke's Hospital tower would be closed.

f. MRI Trailer.

The existing, currently operational MRI Trailer and the enclosed passageway connecting the MRI Trailer to the existing 1912 Building are proposed to be removed upon completion of the MOB/Expansion Building. Services offered at the MRI Trailer would be moved to the MOB/Expansion Building. Upon removal of the MRI Trailer and passageway, the resulting opening in the exterior wall of the 1912 Building would be closed, in accordance with the Secretary of the Interior's Standards for the Treatment of Historic Properties.

g. Streetscape Design, Landscaping, Open Space and Infrastructure.

Streetscape and landscape plans for the St. Luke's Campus have been developed as part of CPMC's community and neighborhood outreach program, and in conjunction with the City's proposed Cesar Chavez Street Design Improvement Plan. The improvements include various sidewalk replacements and widenings, pedestrian bulbouts, tree planting replacements, and other streetscape improvements, bus stop relocation, and installation of underground storage tanks on the hospital site adjacent to the St. Luke's Replacement Hospital.

h. Proposed St. Luke's Campus Site Access.

i. St. Luke's Replacement Hospital.

The main entrance to the St. Luke's Replacement Hospital would be from a central plaza area. The plaza would provide access to the hospital at Level 1 from Cesar Chavez Street and at Level 2 from San Jose Avenue/27th Street. A staircase would be constructed along a portion of the San Jose Avenue right-of-way proposed for vacation between the St. Luke's Replacement Hospital and the MOB/Expansion Building, to maintain a pedestrian connection between Cesar Chavez Street and 27th Street. Passenger drop-off to the main entrance of the St. Luke's Replacement Hospital would be from a white-zone drop-off area located along Cesar Chavez Street at midblock between Guerrero and Valencia Streets. Emergency vehicle ingress and egress to the Emergency Department's ambulance bay (emergency vehicle parking) would be from 27th Street near its intersection with San Jose Avenue. Service vehicles would enter and exit the loading area for the St. Luke's Replacement Hospital from Cesar Chavez Street. The CPMC shuttle stop for the hospital (currently located at Cesar Chavez Street) would be relocated to the northeast corner of San Jose Avenue and 27th Street.

ii. MOB/Expansion Building and Underground Parking Garage.

The MOB/Expansion Building would have two entrances, at the building's northwest corner (near the current intersection of San Jose Avenue and Cesar Chavez Street) and the southwest corner. A separate access point for retail uses would be provided at the corner of Valencia and Cesar Chavez Streets. Vehicular access to the underground parking garage at the MOB/Expansion Building would be available from both Cesar Chavez Street and Valencia Street. The existing bus stop for the 36-Teresita line, located outside the existing St. Luke's Hospital on Valencia Street, would be relocated to a new location, just south on Valencia Street, in front of the 1957 Building. Approximately 10 on-street parking spaces would be removed to accommodate both the relocation of the bus stop and the City's proposed Valencia Streetscape Improvement Project.

2. Cathedral Hill Campus.

Development at the proposed Cathedral Hill Campus would involve: the proposed Cathedral Hill Hospital, Cathedral Hill MOB, Van Ness Avenue pedestrian tunnel (connecting the Cathedral Hill Hospital and Cathedral Hill MOB), 1375 Sutter MOB conversion, streetscape improvements, and conversion of Cedar Street to a two-way street west of the MOB garage entrance.

a. Cathedral Hill Hospital.

CPMC would demolish the existing 10-story, approximately 445,400-sq.-ft. former Cathedral Hill Hotel building at the northwest corner of Geary Boulevard and Van Ness Avenue, and the existing 11-story, approximately 209,700-sq.-ft. office building located on the northwest corner of the same block at Post and Franklin Streets. CPMC would then construct a new, approximately 875,378-g.s.f., 555-bed state-of-the-art acute care hospital on the hotel and office site that would fully comply with requirements of Senate Bill ("SB") 1953, as modified by successor legislation, concerning the seismic safety of acute care facilities. The acute care services currently offered at the Pacific Campus and the California Campus would be relocated to the proposed Cathedral Hill Hospital.

The 15-story (plus two-story basement) hospital tower would be approximately 265 feet in height. The proposed hospital's building length and diagonal dimensions, respectively, would be approximately 385 and 405 feet for the tower floors, and 385 and 466 feet for the podium floor (as measured 50 feet above grade). The proposed Cathedral Hill Hospital would include three levels of at- or below-grade parking, which would contain 513 off-street parking spaces. Under the LRDP, a proposed CPMC intercampus shuttle stop serving the hospital, the Cathedral Hill MOB, and the 1375 Sutter Street MOB would be located on Post Street, adjacent to the hospital. The proposed Cathedral Hill Hospital would be designed to attain a LEED®-Certified rating. Other building design elements would include implementation of green roof elements on portions of the proposed Cathedral Hill Hospital's podium roof area.

The proposed Cathedral Hill Hospital's emergency generators would be located on the roof of the 15-story hospital tower. The generators would be served by fuel storage tanks that would be located beneath the sidewalk and street along Geary Boulevard.

The main pedestrian entrance would be from Van Ness Avenue. The vehicular entrance to the proposed Cathedral Hill Hospital's Emergency Department would be from Franklin Street, and would allow private vehicles to drop off patients inside the building. Ambulance access would be through a dedicated loading area containing three bays off of Post Street.

The main vehicular access to the hospital would be from the south side of the building along Geary Boulevard, with a one-way (south to north) drive-through lane that would connect Geary Boulevard to Post Street at midblock. Drivers would either turn off at the adjacent non-emergency passenger drop-off area or descend to the 513-space parking garage. Vehicular access would also be provided from Post Street via the mid-block access road. Egress from the hospital (other than egress onto Geary Boulevard for emergencies only) would be restricted to a right-turn exit (eastbound) onto Post Street.2

The main service vehicle and loading entrance would be accessed from Franklin Street. Larger vehicle deliveries would use the enclosed loading area. Smaller vehicles would use a secondary loading area within the sub-grade parking garage (access described above).

The proposed Cathedral Hill Hospital may include, but would not be limited to, inpatient medical care; labor and delivery and post-partum care; specialized programs such as organ transplantation, interventional cardiology and newborn intensive care; and an emergency department. It would also include retail space, cafeteria, education and conference space, and a central utility plant.

b. Cathedral Hill Medical Office Building.

In conjunction with construction of the proposed hospital, CPMC proposes to demolish seven existing buildings directly across Van Ness Avenue from the proposed Cathedral Hill Hospital site, between Geary and Cedar Streets, and construct an approximately 261,691-g.s.f. medical office building in their place. The proposed Cathedral Hill MOB would provide offices for doctors affiliated with the Cathedral Hill Hospital. Uses in the building would include, but would not be limited to medical office, retail, education and conference, diagnostic and treatment, and parking.

The proposed nine-story Cathedral Hill MOB would be approximately 130 feet tall to the top of the roof. The proposed MOB would be approximately 265 feet long with a diagonal dimension of 290 feet.

The proposed MOB would be required to conform to Chapter 13C of the City's Building Code (San Francisco Green Building Requirements), which requires that the building achieve a LEED® Silver rating. Other building design elements would include implementation of green roof elements on portions of the MOB's roof.

The main pedestrian entrance would be from Van Ness Avenue. The proposed Cathedral Hill MOB would contain seven below-grade parking levels that would provide a total of 542 parking spaces and reach approximately 75 feet below street grade. Vehicular ingress to the MOB parking structure would be from Geary Street (from the east) and Cedar Street (from the west). The proposed Cathedral Hill MOB would provide two loading spaces, both of which would accommodate trucks up to 25 feet long. Any delivery vehicle longer than 25 feet would be accommodated on street or, if necessary, at the loading dock at the proposed Cathedral Hill Hospital. All loading dock entries on Cedar Street would be right turns (eastbound). Egress from the proposed Cathedral Hill MOB would be restricted to a right turn (eastbound) or left turn (westbound) onto Cedar Street. No egress would be provided onto Geary Street.

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[2] The EIR also analyzed a Two-Way Post Street Variant under which access to the Cathedral Hill Hospital would be available to eastbound and westbound traffic on Post Street, but vehicular exit points would remain similar to those under the proposed LRDP. (See Draft EIR at page 2-38).

c. Van Ness Avenue Pedestrian Tunnel.

A pedestrian tunnel beneath Van Ness Avenue would connect the eastern portion of the proposed Cathedral Hill Hospital to the western portion of the proposed Cathedral Hill MOB. The tunnel would be used by patients, visitors, physicians, and CPMC staff members, allowing them direct connection between the two buildings. It would also be used for the movement of records and materials.

d. 1375 Sutter Medical Office Building.

Since 2008, the approximately 85,356-g.s.f. Pacific Plaza Office Building at 1375 Sutter Street (on the southeast corner of the intersection of Sutter and Franklin Streets) has been undergoing a phased interior renovation as existing tenants vacate and new physicians lease space in the building. Ultimately, all office space within the building would be converted from a mix of office and medical office use to exclusively medical office use. The physical improvements would be limited to interior renovation. The 1375 Sutter MOB site currently contains a partially below-grade self-park garage that provides 172 parking spaces, which would be retained with implementation of the proposed LRDP. The remainder (60) of the 232 parking spaces required by the Planning Code for the 1375 Sutter Street MOB would be provided at the proposed Cathedral Hill Hospital parking garage, along with 116 accessory parking spaces for the 1375 Sutter Street MOB, all of which are included in the total of 513 parking spaces for that garage.

Pedestrian and vehicular access is currently available along Sutter Street and Franklin Street. This access would remain the same with implementation of the proposed LRDP.

e. Cedar Street Conversion to Two Way.

Cedar Street would become a two-way street west of the MOB garage ramp upon implementation of the LRDP.

f. Cathedral Hill Campus Streetscape Design, Landscaping, and Open Space.

CPMC proposes to upgrade the pedestrian environment by improving the street frontages of the area in the vicinity of the proposed Cathedral Hill Campus. To achieve this objective, walkway widths would be expanded and substantial landscaped areas would be added to provide a buffer between pedestrians and traffic lanes. Proposed sidewalk widening and other pedestrian improvements would result in the displacement of 26 standard metered parking spaces, one handicapped-accessible space, and 10 commercial vehicle loading/unloading spaces. For the proposed Cathedral Hill Hospital, improvements include sidewalk widening on Van Ness Avenue (west side, between Post Street and Geary Boulevard), Geary Boulevard (north side, between Van Ness Avenue and Franklin Street), and Post Street (south side, between Franklin Street and the Level 2 ingress/egress at mid-block); a pedestrian bulbout at Van Ness Avenue on Post Street, south side; a paving program, tree planting, landscape, hardscape seating, lighting, and other streetscape improvements along Van Ness Avenue (west side, Post Street to Geary Boulevard), Franklin Street (east side, Geary Boulevard to Post Street), Post Street (south side, Franklin Street to Van Ness Avenue), and Geary Boulevard (north side, Van Ness Avenue to Franklin Street); a paved entry plaza at the Van Ness Avenue and Geary Boulevard entrance; replacement and modification of the existing Van Ness Avenue crosswalk at Geary Street north side; and relocation of existing 38/38L Geary Line bus stop from west end of Geary Street, north side, between Van Ness Avenue and Polk Street to east end of Geary Boulevard, north side, between Franklin Street and Van Ness Avenue, and construction of new bus bulb-out and benches.

An outdoor courtyard for patients, visitors, and CPMC staff (approximately 6,600 sq. ft.) would be located on the podium section of the proposed Cathedral Hill Hospital, with access from Level 5.

For the proposed Cathedral Hill MOB, improvements including pedestrian bulbout modifications on Van Ness Avenue (east side, at Geary Street and Cedar Street); removal and improvement/replacement of north side Cedar Street sidewalk from Van Ness Avenue to Polk Street; pedestrian bulbout at Cedar Street on Polk Street, west side; replacement of all other sidewalks abutting the proposed Cathedral Hill MOB site (all frontages, and extending to Polk Street on Cedar Street, south side); raised crosswalks across Cedar Street at Van Ness Avenue and Polk Street; paving replacement/upgrade, tree planting, landscape, hardscape, seating, lighting and other streetscape improvements along portions of Van Ness Avenue (east side, Geary Street to Cedar Street), Cedar Street (Van Ness Avenue to Polk Street) and Geary Street (north side, Van Ness Avenue to Polk Street); and a Cedar Street west end entry plaza, including a drop-off area.

g. Near-Term Project Implementation Activities.

Upon opening of the proposed Cathedral Hill Hospital or shortly thereafter, all of the existing inpatient acute care and emergency department functions at the California Campus and the Pacific Campus Hospitals would be transferred to the proposed Cathedral Hill Hospital. The 2333 Buchanan Street building will undergo renovation and reuse as an ambulatory care center as part of the Near-Term implementation activities. Certain existing uses at the California and Pacific Campuses that are not transferred to the proposed Cathedral Hill Hospital would be transferred to the 2333 Buchanan Street building after its renovation. The building may include uses such as, but not limited to outpatient care, diagnostic and treatment services, Alzheimer's residential care, medical support services such as pre- and post-ambulatory surgery, outpatient laboratory services, and physical and occupational therapy, hospital administration and/or cafeteria uses.

3. Davies Campus.

Under the CPMC LRDP, the Davies Campus would focus on neurosciences and the complementary areas of rehabilitation and skilled nursing. Existing medical uses in the North and South Towers would continue. The existing Emergency Department would remain in the North Tower, along with inpatient care, with the focus on neuroscience-related treatment, microsurgery, and acute rehabilitation. The inpatient care uses at the North Tower would include 63 acute care beds and 48 acute rehabilitation beds. The existing South Tower would continue to be used for skilled nursing (38 beds), outpatient care, and diagnostic and treatment space.

a. Neuroscience Institute.

The approximately 46,006-g.s.f. Neuroscience Institute building is proposed for construction on the portion of the Davies Campus currently occupied by the 206-space surface parking lot at the corner of Noe Street and Duboce Avenue. Approximately 70 parking spaces in the surface parking lot would be eliminated. No new parking is proposed for the Davies Campus in the near term.

Completion of the Neuroscience Institute building would allow CPMC to consolidate complementary neuroscience departments (including neuroscience/neurosurgery, microsurgery, and acute rehabilitation) at the Davies Campus. The Neuroscience Institute may include, but is not limited to, medical office use, expanded care and services for patients with neurological conditions, enhanced rehabilitation services to allow patients to receive same-site treatment and

follow-up care, ambulatory care, pre- and post-operative care, retail use, and a pedestrian drop-off area on Level 3.

The four-story Neuroscience Institute building would be approximately 40 feet in height. The fourth floor of the Neuroscience Institute building would extend over the proposed service drive and connect to the North Tower. The main entrance would be located on the south side of the building, toward 14th Street. The proposed building would have a secondary entrance across from Duboce Park.

The design of the Davies Campus includes features that are intended to connect the campus to the surrounding neighborhood by providing a transition between the medical buildings on campus and the neighborhood's residential buildings. The fourth floor of the proposed Neuroscience Institute building would be set back from both Noe Street and Duboce Avenue. Along the west side of Noe Street, the building would appear to be three stories, similar to the existing two- and three-story buildings on the east side of Noe Street.

b. Near-Term Streetscape Design, Landscaping, and Open Space.

Landscape improvements on the eastern edge of the Davies Campus along Noe Street would include renovation and improvement of approximately 500 linear feet of campus frontage along Noe Street. A landscaped open space would also be located immediately south of the building (serving as an entry court) as well as a smaller, private open space just north of the proposed Neuroscience Institute.

The new publicly accessible entry plaza immediately south of the proposed Neuroscience Institute building would incorporate varying pavement surfaces, plantings, and trees. East of the campus, along Noe Street, the sidewalk would be widened and would also receive improved surfaces, plantings, and new trees.

c. Site Access.

With construction of the proposed Neuroscience Institute building in the near term, a new passenger drop-off area would be located on the service drive, under the proposed connection to the Davies Hospital North Tower. All existing site access, including vehicular access and parking and passenger drop-off areas, would remain as present, with one exception—the existing entrance to the surface parking lot at the corner of Noe and Duboce Streets would be removed. Truck loading for the Neuroscience Institute would occur in the campus's existing loading area southwest of the proposed Neuroscience Institute building, accessible via the existing service drive from Duboce Avenue at 14th Street.

Site access to the Davies Hospital South Tower, Parking Garage, and the Davies Hospital North Tower's Emergency Department would remain available from the main entrance off Castro Street and Duboce Avenue.

B. Long-Term Projects.

The Long-Term Projects are future components of the LRDP that would commence after 2015. No approvals are being sought for physical development of the Long-Term Projects. The EIR analyzed the Long-Term Projects at a programmatic level.

1. Davies Campus.

At the Davies Campus, the existing 283-space parking garage at 14th and Castro Streets would be demolished. In its place, an approximately 80,900 sq. ft., 45-foot-tall, three-story Castro Street/14th Street MOB is proposed to be constructed to meet the future need for medical space at this campus, including, but not limited to, retail, diagnostic and treatment uses, and approximately 184,000 square feet of parking use in four below-grade levels, totaling approximately 490 spaces (replacement of the existing 283 spaces in the 14th and Castro Streets garage plus construction of approximately 207 new parking spaces).

Vehicular access to the proposed Castro Street/14th Street MOB would be provided from the main entrance off Castro Street and the parking entrance from 14th Street. Pedestrian site access to this building would be from the entrance drive.

2. Pacific Campus.

Under the proposed CPMC LRDP, a new outpatient ACC Addition would be constructed along with parking and other facilities as follows:

a. Underground Parking and ACC Addition.

The Stanford Building (2351 Clay Street) and the 2324 Sacramento Clinic would be demolished to accommodate the proposed Webster Street/Sacramento Street Underground Parking Garage and ACC Addition (discussed below). The site of the former Stanford Building would be excavated to construct the "L"-shaped, two-level, 22-foot-deep, approximately 113,100-sq.-ft. Webster Street/Sacramento Street Underground Parking Garage, which would provide about 248 parking spaces.

The 138-foot-tall, nine-story, approximately 205,000 g.s.f. ACC Addition would be built above the Webster/Sacramento Streets Underground Parking Garage, on the site of the current Stanford Building and 2324 Sacramento Clinic, which would be demolished. The ACC Addition site is bounded by Clay Street to the north, the 2333 Buchanan Street Hospital (to be renovated and reused as an ACC, as described in Section I.A above) to the east, Sacramento Street to the south, and the 2100 Webster MOB to the west, on the central portion of the Pacific Campus.

The new ACC Addition would be located immediately west of the ACC. The ACC and ACC Addition buildings would both be nine stories and would be connected at three lower floors, with no connection on the upper floors. ACC Addition uses may include education and conference space, outpatient space, support space, diagnostic and treatment space, medical offices and outpatient care, and mechanical space.

b. North-of-Clay Aboveground Parking Garage.

CPMC would construct an approximately 172,500-sq.-ft. North-of-Clay Aboveground Parking Garage above the northern portion of the proposed Webster Street/Sacramento Street Underground Parking Garage, on the area currently occupied by the Annex MOB (2340-2360 Clay Street) and Gerbode Research Building (2200 Webster Street), which would be demolished, and part of the existing Buchanan Street surface parking lot (2315 Buchanan Street). This parking garage would be six stories (plus top deck), with a height of 70 feet.

A total of 715 new structured and surface parking spaces (Webster Street/Sacramento Street Underground Parking Garage and North-of-Clay Aboveground Parking Garage combined: 688

spaces; Buchanan Street surface parking lot: 27 spaces) would be provided at the Pacific Campus. This would bring the parking total at the Pacific Campus to 1,587 spaces.

c. Pacific Campus Proposed Site Access.

Several new or relocated access points are proposed for the Pacific Campus's existing and new buildings and parking garages via California, Buchanan, Sacramento, Webster, and Clay Streets. The main pedestrian entry to both the ACC and the ACC Addition would be located at the north end of the proposed Campus Drive near Clay Street. The main entry to the former 2333 Buchanan Street Hospital would be converted into a secondary entrance for the proposed ACC.

A new street, Campus Drive (located between the existing Pacific Professional Building and the ACC Addition), would be built to support existing vehicular access to the campus from Webster Street, provide vehicular access to and from Clay Street for the proposed Webster Street/Sacramento Street Underground Parking Garage, and allow egress from Sacramento Street for loading and unloading.

Vehicular traffic serving the ACC and ACC Addition would be routed to Clay Street east of Webster Street or Sacramento Street between Buchanan and Webster Streets. The entry/exit for the North-of-Clay Aboveground Parking Garage and for the Webster Street/Sacramento Street Underground Parking Garage would be located on Clay Street and Campus Drive, respectively. Vehicles dropping off passengers would utilize the drop-off area at the ground floor of the North-of-Clay Aboveground Parking Garage, and would exit onto Clay Street and turn right onto Webster Street. Vehicles exiting either garage would be directed onto Clay Street to exit. A secondary means of vehicular egress would be provided on Campus Drive, leading to Sacramento Street.

Other passenger drop-off areas would be located on Webster Street south of Clay Street near the Pacific Professional Building (existing), and on Buchanan Street near the north end of the ACC building (existing, renovated and reused). The ambulance entrance would remain on the north side of Sacramento Street (at the south end of the ACC building) near Buchanan Street. Four off-street loading spaces would be located on Campus Drive near the entrance/exit on Sacramento Street.

The CPMC shuttle stop, currently located on Buchanan Street, would be relocated to the drop-off area located within the proposed North-of-Clay Aboveground Parking Garage, which would be closer to the new main entry at the proposed Campus Drive near Clay Street.

3. California Campus.

The majority of CPMC uses and programs, other than acute care inpatient and emergency care uses, which would have been transferred to the proposed Cathedral Hill Hospital as part of the Near-Term project implementation activities described in Section A above, would continue at the California Campus until completion of the proposed ACC and ACC Addition at the Pacific Campus, at which time the Pacific Campus would absorb almost all of the remaining CPMC-related uses at the California Campus. No new construction is anticipated at the California Campus, although a limited amount of existing on-site medical activities would continue at the California Campus.

CPMC plans to sell the California Campus as soon as possible after the transfer of acute care and non-acute care patients to the proposed Cathedral Hill Hospital and Pacific Campus ACC and ACC Addition, as described above. A small amount of CPMC-operated space (approximately 2,400 sq. ft.) will remain at the existing 3838 California Street MOB (primarily outpatient imaging and blood

drawing) and would be leased from the buyer of the California Campus indefinitely. It is expected that by about 2020, almost all CPMC-related use of the California Campus would cease.

ENVIRONMENTAL REVIEW

CPMC applied for environmental review of the LRDP on June 10, 2005. Pursuant to and in accordance with the requirements of Section 21094 of CEQA and Sections 15063 and 15082 of the CEQA Guidelines, the San Francisco Planning Department, as lead agency, published and circulated a Notice of Preparation ("NOP") on July 1, 2006, that solicited comments regarding the scope of the environmental impact report ("EIR") for the LRDP. The NOP and its 30-day public review comment period were advertised in the San Francisco Examiner and mailed to public agencies, organizations and nearby property owners, and other individuals likely to be interested in the potential impacts of the LRDP. A public scoping meeting was held on July 18, 2006, at the Cathedral Hill Hotel, located at 1101 Van Ness Avenue, San Francisco, CA 94109.

As planning for the LRDP continued, additional components were added to the LRDP, and revised Environmental Evaluation Applications were filed on February 28, 2008, and December 8, 2008. The NOP was revised and re-issued for a 30-day public review period on May 27, 2009. An additional public scoping meeting was held on June 9, 2009, to accept oral comments on the revised and refined LRDP proposal. In addition, the City extended the public review period an additional 30 days to July 26, 2009.

The NOP was distributed to the State Clearinghouse and mailed to governmental agencies with potential interest, expertise, and/or authority over the project; interested members of the public; and occupants and owners of real property surrounding CPMC's four existing campuses and the proposed Cathedral Hill Campus location. The June 9, 2009, public scoping meeting was held at the Grand Ballroom of the Cathedral Hill Hotel. A total of 96 comment letters were received regarding the revised and re-issued NOP, in addition to the verbal comments received at the scoping meeting. Commenters identified the following topics to be evaluated in the Draft EIR: Land Use and Planning; Aesthetics; Population and Housing; Cultural and Paleontological Resources; Transportation and Circulation Noise; Air Quality; Greenhouse Gas Emissions; Wind and Shadow; Recreation; Public Services; Utilities and Service Systems; Geology and Soils; Hazards and Hazardous Materials; Demolition and Construction Effects; and Project Alternatives.

DRAFT ENVIRONMENTAL IMPACT REPORT

The San Francisco Planning Department then prepared the Draft EIR, which describes the LRDP and the environmental setting, analyzes potential impacts, identifies mitigation measures for impacts found to be significant or potentially significant, and evaluates alternatives to the proposed LRDP. In assessing construction and operational impacts of the Project, the Draft EIR considers the potential impacts of the LRDP on the environment, and the potential cumulative impacts associated with the proposed LRDP in combination with other past, present, and future actions with potential for impacts on the same resources. The analysis of potential environmental impacts in the Draft EIR utilizes significance criteria that are based on the San Francisco Planning Department Environmental Planning (formerly Major Environmental Analysis) Division guidance regarding the environmental effects to be considered significant. The Environmental Planning Division's guidance is, in turn, based on CEQA Guidelines Appendix G, with some modifications.

The Planning Department published the Draft EIR on July 21, 2010. The Draft EIR was circulated to local, state, and federal agencies, and to interested organizations and individuals for review and comment beginning July 21, 2010. The public review period was initially 60 days, but was extended to 90 days, ending on October 19, 2010. The Commission held a public hearing to solicit testimony on the Draft EIR during the public review period on September 23, 2010. A court reporter, present at the public hearing, transcribed the oral comments verbatim, and prepared written transcripts. The Planning Department also received written comments on the Draft EIR.

COMMENTS AND RESPONSES

The San Francisco Planning Department then prepared the Comments and Responses ("C&R"). The C&R document was published on March 29, 2012, and includes copies of all of the comments received on the Draft EIR and written responses to each comment. The C&R provided additional, updated information, clarification and modifications on issues raised by commenters, as well as Planning Department staff-initiated text changes. The Final EIR, which includes the Draft EIR, the C&R document and errata, (the appendices to the Draft EIR and C&R document), and all of the supporting information, has been reviewed and considered.

SUMMARY OF CONCERNS RAISED BY APPELLANTS

a. Summary Responses to Appellants' Statement of Grounds for Appeal

Appellants identify seven general grounds for the appeal; see Appellants' letter at page A-2. These grounds are identified and brief responses provided below. More detailed responses can be found in the following summary of issues raised on appeal and in **Exhibit A,** Responses to Appeal Letter.

- Violated CEQA's most basic informational requirements by omitting adequate facts and evidence to support the EIR's conclusions:

  This is a complex EIR, providing project- and program-level analyses with respect to five existing or proposed CPMC campuses. The EIR was prepared in accordance with CEQA and City requirements. All of Appellants' previous specific comments regarding the adequacy of the Final EIR were addressed in the C&R document and the Responses to Late Comments.

- Failed to accurately describe the Project and its environmental setting.

  The environmental setting for the LRDP is fully described in the Final EIR. Appellants argue in the appeal letter that the environmental setting should have included health care facilities and programs throughout the Bay Area and the City. Because the LRDP would not adversely contribute to health care gaps that might exist elsewhere and would not result in direct or indirect physical environmental impacts related to such health care facilities and programs, such analysis is not required.

- Employed misleading and illegal baselines, especially concerning traffic and public transportation impacts as they relate to the proposed Cathedral Hill facility.

  The Draft EIR appropriately used 2006 baseline data for the transit impact analysis because it was the most current and best available data at the time the Draft EIR was prepared. Supplemental analysis performed based on data that became available after the Draft EIR was published confirmed the efficacy of the baseline data utilized.

- Deferred requiring measures to mitigate impacts on traffic and public transportation and air quality.

  The Final EIR does not defer mitigation measures in any of these areas. All feasible mitigation measures are required, including transit mitigation fees and detailed construction and operational air quality mitigation measures.

- Omitted effective and enforceable mitigation for significant Project impacts, especially concerning the proposed Cathedral Hill facility.

The Final EIR includes effective and enforceable mitigation measures, including for air quality and greenhouse gas impacts. The project incorporates design features to increase energy efficiency, reduce impacts, and meet LEED® certification goals. The project also complies with the City's Qualified Greenhouse Gas Reduction Strategy and, therefore, under Bay Area Air Quality Management District guidance, is considered to have implemented all applicable, feasible measures. Appellants have not provided evidence of feasible mitigation measures that have not already been adopted or included in the project.

- Adopted a statement of overriding considerations for some 30 significant impacts without first imposing all feasible measures or alternatives to mitigate those impacts.

  The Board of Supervisors will review and determine whether to adopt a statement of overriding considerations with respect to significant but unmitigated impacts. The Final EIR analyzed and incorporates all feasible mitigation measures and provides an adequate analysis of a reasonable range of alternatives as required by CEQA.

- Failed to adequately and accurately investigate and disclose numerous environmental impacts for the proposed Cathedral Hill Hospital and MOB, thereby sidestepping the CEQA requirement to mitigate such impacts

The EIR adequately and accurately investigated and disclosed all of the significant environmental impacts of the proposed Cathedral Hill Hospital and MOB, including those in respect to traffic, transit, noise, air quality, and greenhouse gases.

b. Summary of Principal Concerns

The following summarizes some of the principal concerns raised by Appellants in the Appeal and the Department's responses. A complete and more detailed response to all of the issues raised in the Appeal is provided in **Exhibit A.**

1. Complex EIR.

Appellants state that the EIR is confusing and uses unconventional terminology.

As reflected in the Project Description above, this is a complex project with multiple campuses and phases. There is no "right way" to organize an EIR for a complicated project like the LRDP. Appellants may have other preferences, but the organization of the Final EIR, its terminology, and methodology are clear and consistently applied in compliance with CEQA.

For more detailed responses please see Response INTRO 1-2 and TR 1-1 to this Appeal below, Response INTRO-8 (page 3.1-18) and TR-128 in the C&R document, and Response 2-2 in Response to Late Comments, **Exhibit B.**

2. Alternatives.

A. 3A Plus.

Appellants state that the Final EIR did not include a reasonable range of alternatives, and specifically, that it should have included a modified Alternative 3A (referred to by Appellants as "Alterative 3A Plus"). Similar to Alternative 3A, Alternative 3A Plus would increase the size of St. Luke's Campus and decrease the size of Cathedral Hill Campus, but Alternative 3A Plus would include a different mix of services at St. Luke's Campus than was proposed under 3A (Relocating the Women's and Children's Hospital).

CEQA requires that an EIR analyze a reasonable range of alternatives. CEQA does not require that the EIR analyze every possible variant to a proposed alternative. Moreover, the environmental impacts associated with an Alternative 3A Plus were adequately analyzed by the review of Alternative 3A.

For a more detailed response, please see Response ALT 1-2 and ALT 1-4 to this Appeal, Response ALT-1 (pages 3.22-11 to 3.22-18 of the C&R document) and Responses 2-6 and 2-17 in Responses to Late Comments, **Exhibit B**, hereto.

B. Project Objectives.

Appellants also state that the range of alternatives was artificially limited by the Project objectives identified in the Final EIR, which were too narrow (and thus artificially limited the alternatives and analysis). Appellants also argue that the project objectives should have been based on the City's objectives, rather than those of the project sponsor, and thus, the range of Alternatives is inadequate.

The EIR addressed a reasonable range of five different alternatives, including two "no project," alternatives, a four campus rebuild/retrofit/redevelopment alternative that would not include any development at the Cathedral Hill Campus (Alternative 2), a reduced Cathedral Hill Campus with an increased St. Luke's Campus (Alternative 3A) and with an increased California Campus (Alternative 3B).

The EIR determined that Alternatives 2 and 3 were potentially feasible and would obtain most of the objectives of the Project, although to a lesser extent than the proposed LRDP. Thus, the Project objectives did not cause the failure to analyze a reasonable range of alternatives. Further, the objectives in the Final EIR are appropriately based on the Project sponsor's desire to implement the LRDP, not on the City's objectives. While more specific than objectives for a generic commercial development project, these include Project sponsor objectives related to the need to replace existing facilities with seismically compliant facilities prior to state deadlines, while continuing to provide medical services during construction and objectives designed to meet the program goals established by the Blue Ribbon Panel, consisting of leaders from the health, business, and labor fields. The Blue Ribbon Panel's recommendations for the St. Luke's Campus were endorsed by the Board of Supervisors Resolution 478-08, and the San Francisco Health Commission.

For a more detailed response, please see Response ALT 1-3 to this Appeal, Response ALT-1, and Response PD-7 (page 3.2-11 of the C&R), and Response 2-15 in Responses to Late Comments, **Exhibit B**, hereto.

C. Disruption of Continuum of Care.

Appellants comment that, in analyzing the feasibility of Alternative 3A (or 3A Plus), concern over disruption in the continuum of care to patients is unnecessary because other hospitals have been able to obtain extensions of SB 1953 retrofit or replacement deadlines.

Although the legislature has provided for various extensions to SB 1953, CPMC does not currently qualify for any further extensions under existing law. The Final EIR analysis is appropriately based on existing law and not on the possibility of subsequent legislative amendments. Due to site constraints related to existing buildings on the St. Luke's Campus, an enlarged St. Luke's Hospital under Alternative 3A would require additional time for re-design, permitting, and construction of a second phase of the hospital. Therefore, SB 1953 compliance at

existing facilities that house those to-be-transferred services would have lapsed under existing statutory deadlines and their status would be even more tenuous.

For a more detailed response, please see Response ALT 1-6 to this Appeal, and Response 2-18 in Responses to Late Comments, **Exhibit B**, hereto.

3. Traffic and Transit Analysis.

Appellant's traffic and transit analysis concerns have all been raised in prior comments.

A. Adjustment of Peak Hour Factor.

Appellants restate their point that the City erred in analyzing the traffic impacts at two intersections, 8th/Market and Franklin/Sutter by increasing the so-called "peak hour factor" for those intersections.

The Planning Department's practice of adjusting the peak hour factor is a standard practice for an urban environment like San Francisco. In summary, increasing the peak hour factor represents more consistent congestion during the peak hour. This is a methodology the City has used in other recently completed EIR analyses and is appropriate for an urban environment.

For more detailed responses please see Response TR 1-8 and TR 1-9 to this Appeal below, Response TR-8 (at page 3.7-10) in the C&R document, and Response 2-21 in Responses to Late Comments, **Exhibit B** hereto.

B. Emergency Response Time.

Appellants restate their point that the EIR did not adequately consider the impacts of delays to emergency vehicles seeking access to the proposed Cathedral Hill Hospital caused by traffic congestion.

The Final EIR analyzes in great detail the traffic impacts associated with the proposed Cathedral Hill Campus, and also analyzes the potential for impacts to emergency vehicles. The Final EIR analysis considered the location of the proposed Cathedral Hill Hospital (closer to the Tenderloin than the facilities it would replace and on two major transportation corridors), the protocols used by emergency vehicles in choosing travel routes and destinations during periods of congestion, and that most emergency transports would occur during non-commute hours, to determine that the impact would be less than significant.

For a more detailed response, please see Response TR 1-3 to this Appeal, Major Response HC-5 (pages 3.23-9, 20, and 25) and Response TR-100 (beginning at page 3.7-170) in the C&R document, and Response 2-24 in Response to Late Comments, **Exhibit B**, hereto.

C. Transit Impact.

Appellants restate their point that the Final EIR minimized the public transit impact on the proposed Cathedral Hill Campus by using 2006 (rather than 2009) passenger data, thereby assuming that more transit capacity exists.

However, the 2006 data was the best available data at the time of analysis. Further, subsequent data (for 2011) obtained by SFMTA after the Draft EIR was published was nonetheless reviewed and showed only slight changes from the 2006 data that did not alter any of the conclusions in the Final EIR.

For a more detailed response, please see Response TR 1-5 to this Appeal, Response TR-17 and Table 3.7-10 in the C&R document, and Response 2-20 in Responses to Late Comments, **Exhibit B**, hereto.

D. Adequacy of Traffic Mitigation.

Appellants restate their point that traffic mitigation measures such as reduction in the size of proposed Cathedral Hill Hospital and roadway improvements were ignored.

However, the EIR, for example, provides a detailed analysis of Alternative 3A that reduces the size of the proposed Cathedral Hill Campus and increased the size of the St. Luke's Campus. The analysis determined that significant and unavoidable impacts at only one intersection (Van Ness/Market) would be reduced to a less than significant level under Alternative 3A, and impacts at that intersection would remain significant and unavoidable under Alternative 3A in the likely scenario that the City's Van Ness and Geary Bus Rapid Transit projects are developed. Further, the EIR examined the potential for roadway improvements and determined they were not feasible.

For a more detailed response, please see Response TR 1-6 and TR 1-7 to this Appeal, and Responses TR-34 through TR-44 (pages C&R 3.7-58 to C&R 3.7-68) in the C&R document, and Response 2-23 in Responses to Late Comments, **Exhibit B**, hereto.

E. Transportation Demand Management (TDM) Program.

Appellants are concerned that the LRDP's enhanced TDM program might not be required or enforceable.

The enhanced TDM program is a component of the LRDP, is described in detail in the C&R document under Response TR-45 (page C&R 3.7-69), and is required to be implemented by a separate enforceable condition of approval attached to the conditional use authorizations for the proposed Cathedral Hill, St. Luke's, and Davies Campuses approved by the Planning Commission. Therefore, no separate mitigation measure necessary.

For a more detailed response, please see Response TR-45 (page C&R 3.7-69) and Response AQ-11 (page C&R 3.9-27) in the C&R document, and Response 2-24 in Responses to Late Comments, **Exhibit B**, hereto.

4. Jobs/Housing Relationship and Impacts.

A. Survey Data.

Appellants challenge the use of survey data from 2001–2003 that showed that 50 percent of CPMC's employees live in San Francisco.

The Planning Department confirmed that the 2001–2003 survey data taken at the California, Pacific, and Davies Campuses remains a valid and appropriate predictor of future conditions because employment numbers at these campuses has remained relatively stable.

For a more detailed response, please see Response PH 1-1 to this Appeal, Response TR-25, beginning at page 3.7-47 and PH-10, to the C&R document, and Response 2-13 in Responses to Late Comments, **Exhibit B**, hereto.

B. Housing Demand.

Appellants state that the City's city-wide, comprehensive approach, relying on the Housing Element and City policies and programs to meet housing demand, rather than analyzing the impacts of individual projects, is inconsistent with CEQA. The EIR quantified the housing demand that would be created under the proposed LRDP and analyzed its impact as an individual project by comparing this demand to the projected housing capacity within the City, which is an appropriate measure for determining the significance of this impact. The EIR used ABAG projections and the adopted Housing Element in the San Francisco General Plan to evaluate the degree to which the proposed LRDP's share of increased population, employment, and housing over existing conditions in San Francisco compared to the increases over existing conditions that have been planned, and whether the City has the capacity to accommodate the growth conservatively projected for the proposed CPMC LRDP. Comparing the change from existing conditions developed for the proposed CPMC LRDP to the ABAG projections of changes from existing conditions appropriately indicates whether the proposed LRDP would lead to unplanned growth not anticipated by City and regional planning organizations.

The Final EIR used a number of measures to determine if the project would result in indirect impacts from population and household growth and determined that population, employment and household projections for the LRDP were within housing projections and the LRDP would not induce substantial population growth relative to the City's existing population and household numbers.

The C&R document included additional analysis with the more recently adopted 2009 Housing Element and the 2009 ABAG projections. The original data were more conservative in the number of people, jobs, and housing in San Francisco, and the City's capacity to supply sufficient housing to accommodate the projected population. The more recent documents actually lower the LRDP's proportional share of growth within San Francisco, while adding to the available supply of housing to accommodate new workers at CPMC campuses.

Thus, projected growth totals would fall within the City's projected growth plan. This methodology has consistently been used by the City on-other projects.

For a more detailed response, please see Response PH 1-2 to this Appeal and Responses PH-6 and PH-7 (beginning on pages 3.5-17 and 3.5-22 of the C&R document. See also Response PH-27 and Response 2-13 in the Responses to Late Comments, **Exhibit B**, hereto.

C. Van Ness Area Plan (VNAP) and Van Ness Special Use District (VNSUD).

Appellants restate their point that the Final EIR fails to consider the loss of previously contemplated housing under the VNAP and VNSUD, or the demand for housing from CPMC's proposed Cathedral Hill Campus.

The proposed Cathedral Hill Hospital site was not assumed or planned for housing in the VNAP. The EIR for the VNAP assumed that the existing buildings on site would remain. The VNAP EIR considered the Cathedral Hill MOB site to be potentially available for housing. However, under the 2009 Housing Element, none of the CPMC development sites were assumed to be available for residential development.

The City's Jobs Housing Linkage Program ("JHLP") excludes medical and hospital uses from the requirements to create housing either directly or by payment of an in lieu fee. Nevertheless, the CPMC Development Agreement includes the obligation that CPMC provide approximately $62 million in payments for replacement housing, affordable housing and for a down payment assistance program (under which initial loans would be recaptured and used by the City for affordable housing). These payments and programs exceed the support that would be provided

even if the JHLP applied. Because the proposed CPMC LRDP comprises development of non-residential projects on primarily nonresidential sites that were not identified for residential development in the Housing Element (or, in the case of the proposed Cathedral Hill Hospital site, in the VNAP and VNSUD), the proposed LRDP would not conflict with the ability to comply with Objective 1 of the Housing Element. Furthermore, the voluntary contribution of funds by CPMC to the Mayor's Office of Housing at a level that would be at least equivalent to the JHLP fee would facilitate the construction of housing in the City.

For a more detailed response, please see Response PH 1-3 to this Appeal, Responses LU-3, LU-5, LU-9, LU-21, to 23, LU-25-26, PH 1-1, PH-6 and PH-7 of the C&R document, and Response 2-14 in Responses to Late Comments, **Exhibit B**, hereto

D. Down Payment Loan Assistance Program (DALP).

The CPMC Development Agreement includes a program for down-payment assistance for CPMC employees. Appellants argue that the amount of down-payment assistance ($200,000) under the Development Agreement DALP program should be limited to $100,000, and that the program should not be limited to CPMC employees.

Appellants' socioeconomic policy concerns regarding the DALP program in the proposed Development Agreement are not CEQA issues and are not appropriate grounds for this EIR appeal, but may be considered by the Board when reviewing the proposed Development Agreement.

The following excerpt from explanations of the proposed DALP program that the Mayor's Office and Department, in response to questions from the Planning Commission, is provided for the Board's information:

The CPMC Down Payment Loan Assistance Program (DALP) is patterned on an existing program operated by the Mayor's Office of Housing (MOH). The program's goal is to support first-time homebuyers in San Francisco to purchase a single-family home. The additional goal here is to encourage and enable CPMC employees to live where they work, promoting the city's long term commitment to greater environmental sustainability and bring us one step closer to fulfillment of SB 375 goals.

The CPMC DALP program is available to first time homebuyers that are CPMC employees with a household income between 100 and 60 percent of the Area Median Income (AMI) for a single person 100% AMI is $72,100 and 60% AMI is $43,250 annually; for a family of four, 100% AMI is $103,000 and 60% AMI is $61,800.

With the DALP program, middle- to low-income CPMC employees' options for accessing ownership opportunities in San Francisco are significantly expanded. The borrower can use the DALP as a down payment against the purchase price, but does not have to pay monthly debt service on the DALP. As a result, the DALP is effectively "silent" for the duration of the borrower's occupancy and only has to be repaid at resale. At resale, the borrower must repay 100% of the loan proceeds plus a portion of the home appreciation equal to the ratio of the DALP to the original purchase price.

. . .

MOH will then use this recaptured DALP revenue to create permanently affordable housing. MOH projects that it will recapture at least $35 million after the DALP loans are repaid. . . .

For a more detailed response, please see Response PH 1-4 to this Appeal, Response PH-17 in the C&R document and Response 2-14 in Responses to Late Comments, Exhibit B, hereto.

5. Impacts of Air Quality and Greenhouse Gases.

A. NOX Emissions from Stationary Sources.

Appellants restate their point that the EIR failed to consider, and therefore, failed to mitigate near term impacts from NO_x emissions from stationary sources.

Contrary to the concerns expressed in the comment, the Draft EIR identified operational emissions of mass criteria pollutants, including NO_x, as a significant and unavoidable impact. The impact was conservatively identified as such even though air quality emissions associated with stationary sources are regulated through BAAQMD's permitting process, which requires the use of Best Available Control Technology (BACT) at the time the equipment is permitted, because the extent of emissions reductions are not known. No additional mitigation measure is necessary in order to make the BACT requirement enforceable and applicable to the LRDP. In addition, the enhanced TDM program, which is incorporated as part of the proposed LRDP and which the Planning Commission required as a condition of approval for the Near-Term Projects under the LRDP, would reduce operational emissions of toxic air quality contaminants including PM_{10} and NO_x, and no further feasible mitigation measures are available.

For a more detailed response, please see Response AQ 1-1, AQ 1-2, and AQ 1-3 to this Appeal.

B. Air Quality Mitigation Construction Emissions.

Appellants state that the Final EIR construction emissions mitigation is improperly vague or incomplete. This is not correct.

In fact, the mitigation measures specify the most stringent feasible mitigation (known as Tier 4 standards) for long term projects. Near term projects specify in detail the required mitigation measures based on a refined construction plan and an extensive feasibility analysis. Appellants have not suggested any additional feasible mitigation measures.

For a more detailed response, please see Response AQ 1-2 to this Appeal, and Response 2-3 to the Responses to Late Comments, **Exhibit B**, hereto.

C. Reliance on City's Green House Gas (GHG) Reduction Strategy.

Appellants argue that the Final EIR cannot rely on the City's recently adopted BAAQMD-qualified GHG reduction plan to claim that GHG impacts will be less than significant or to mitigate GHG impacts because of various alleged deficiencies in the City's plan. Appellants also argue that additional mitigations should be required.

The City's qualified GHG Reduction Strategy meets the BAAQMD criteria for a qualified plan. It consists of numerous strategies, including regulations previously adopted in compliance with CEQA. The FEIR does not rely on consistency with the GHG Reduction Strategy to conclude that the project would have less than significant impacts. Rather, and notwithstanding BAAQMD regulations to the contrary, the FEIR conservatively concludes that the projects' GHG emissions would remain significant, because the emission reductions associated with emission reduction measures included in the LRDP, cannot be projected with sufficient certainty.

The project has committed to numerous GHG reduction measures and will seek LEED® certification. Projects such as the proposed LRDP that are built in conformance with the City's qualified GHG Reduction Strategy are considered under the 2010 BAAQMD CEQA Guidelines to have implemented applicable, feasible measures and to be less than significant. However, because BAAQMD did not complete its determination that the GHG Reduction Strategy met its criteria to qualify until after publication of the Draft EIR, and because the reductions in GHG emissions associated with the measures/programs to which CPMC has committed cannot be projected with sufficient certainty, the impact was conservatively determined to remain significant and unmitigated. The additional off-site measures proposed by Appellants were determined by the Department not to be feasible mitigation measures.

For a more detailed response, please see Response GHG 1-1 and GHG 1-2 to this Appeal, Response GH-1 (page 3.10-3) in the C&R document, and Responses 2-28 and 2-29 to the Responses to Late Comments, **Exhibit B**, hereto.

6. Health Care.

Appellants stated health care concerns are largely socioeconomic comments that reflect Appellants' view that the Project, as proposed, is inappropriate. The Project reflects the project sponsor's objectives. Alternatives, including a smaller Cathedral Hill Hospital and a larger St. Luke's Hospital, as advocated for by Appellants, were adequately considered as part of the Final EIR's alternative analysis.

Appellants' concerns are further summarized as follows:

A. Regional Setting.

Appellants argue that the project description is flawed because the Final EIR did not adequately describe "the overall availability of general and specialized services in the Bay Area."

However, the record indicates that approximately 25-30 percent of CPMC's patients currently come from outside of San Francisco. The LRDP is primarily a hospital replacement project to comply with state seismic requirements whereby the proposed Cathedral Hill Hospital will replace the existing hospitals at the California and Pacific Campuses, the St. Luke's Hospital would be replaced, and medical office services will be consolidated at the Pacific Campus and at the sites of the new hospitals. No major transfer of services is anticipated to or from CPMC that would significantly change the established pattern and it is beyond the scope of the EIR to undertake the kind of analysis of health care services in the Bay Area as suggested in the appeal. There is no evidence of environmental impacts associated with any regional shifts of services. The record instead shows that the LRDP will provide adequate capacity to meet CPMC's existing and projected demand, and therefore the LRDP project would not contribute to any city-wide or regional healthcare "gaps" that may exist elsewhere.

For a more detailed Response, please see Response HC 1-1 to this Appeal, Major Response HC-2 (C&R page 3.13-6-7), and Responses 2-15 and 2-18 in Responses to Late Comments, **Exhibit B,** hereto.

B. Corporate Organization.

Appellants contend that Sutter Health is going through a process of corporate "regionalization" and "large scale closure of services [reduction of beds] and increased transfer of patients between cities in the Bay Area" and that the Final EIR for the LRDP should have analyzed the cumulative effects of these plans throughout the Bay Area.

However, as noted in the Response 6.A., above, there is no evidence the LRDP replacement program will have substantial effects on the pattern of patient care or transfers. A reduction in licensed beds at Sutter Health/CPMC facilities due to seismic safety replacement projects does not translate into a reduction in capacity, because existing multi-bed rooms are being replaced with single-patient rooms with significantly higher occupancy rates. The record shows that substantial excess capacity (in low utilization multi-bed rooms) has been or is being reduced, and that the LRDP is anticipated to provide adequate capacity to meet existing and anticipated future growth in patient demand. Further, the proposed Cathedral Hill Hospital is being located closer to a vulnerable population in the Tenderloin area than the hospitals it replaces, and St. Luke's Hospital will be replaced on site and is sized consistent with the recommendation of the Blue Ribbon Panel. CPMC is already significantly regional with 30 percent of patients receiving inpatient services and 25 percent of patients receiving outpatient services travelling from outside of San Francisco, and the EIR's analysis of environmental impacts assumes CPMC will continue to serve a regional patient base at similar levels. Actual transfers of services or patients would be very limited, and any marginal increase in patient transfers that could occur due to changes in services would not result in significant environmental impacts. There is no evidence that the LRDP would contribute to a region-wide reduction of hospital beds that would in turn create adverse effects on other private services or have indirect environmental effects. There is no evidence that Sutter Health's corporate structure would alter these conclusions and therefore is not part of the LRDP.

For a more detailed response, please see Response HC 1-2 to this Appeal, Major Response HC-1 (C&R page 3.23-6-7), and Responses 2-15, 2-18 and 2-19 in Responses to Late Comments, **Exhibit B** hereto. See also Response HC 1-3 and HC 1-4 to this Appeal regarding SNF, sub-acute care, and psychiatric patients, and Major Response HC-4 regarding psychiatric beds and Major Response HC-6 re garding SNF beds and sub-acute care, in the C&R document.

C. St. Luke's Status.

Appellants state that the EIR improperly states that St. Luke's is not sufficiently centrally located to justify a bigger hospital, and that this finding relegated St. Luke's to "marginal" status, which will neglect the service needs of underserved South of Market residents.

The geography of San Francisco and location of CPMC's patients currently served by the California or Pacific Campuses support the statement that the proposed Cathedral Hill Hospital would be more centrally located and is an appropriate location for construction of the replacement hospital for the California and Pacific Campus hospitals. Notably, St. Luke's size is, based on the recommendations of the Blue Ribbon Panel for a community hospital, integrated in the CPMC system, providing a broad range of services with specialized senior care, low risk obstetrics, and children's health services.

For a more detailed response, please see Response ALT 1-5 to the Appeal.

D. Efficacy of Larger Hospital.

Appellants state that the Final EIR improperly states that larger hospitals result in improved medical success rates and that, based thereon, CPMC will pursue the largest hospital possible at the proposed Cathedral Hill location at the expense of a smaller St. Luke's hospital. The C&R document notes that a larger hospital is appropriate where, as here, it is consolidating services from other facilities that do not comply with the seismic requirements of SB 1953, as amended, and to achieve the benefits of co-locating services and service lines in one location, particularly for delivery of highly specialized complex tertiary services. The proposed Cathedral Hill Hospital would serve as a "hub" hospital for the system's community hospitals at St. Luke's and Davies

Campuses. The size of the LRDP hospitals is driven by area demand, which for Cathedral Hill is based on the demand at the hospitals (Pacific and California) being replaced. The size of St. Luke's Hospital is based on existing hospital demand and the recommendations of the Blue Ribbon Panel.

For a more detailed response, please see Response ALT 1-5 and HC 1-6 to the Appeal and Responses 2-15, 2-18 and 2-19 in Responses to Late Comments, **Exhibit B**, hereto.

CONCLUSION

The Department conducted an in-depth and thorough analysis of the potential physical environmental effects of the proposed CPMC LRDP, consistent with CEQA, the CEQA Guidelines, and Chapter 31 of the San Francisco Administrative Code. Because of the intense interest on other socioeconomic issues, including healthcare issues, the Final EIR also includes information responding to comments on these typically non-CEQA issues, and analysis of potential physical environmental effects that might be associated with those socioeconomic issues.

Appellants have not demonstrated that the Final EIR is insufficient as an informational document, or that the Planning Commission's findings and conclusions are unsupported by substantial evidence. The Planning Department conducted all necessary studies and analysis, and provided to the Planning Commission all necessary information and documents in accordance with the Department's environmental checklist and Consultant Guidelines, and pursuant to CEQA and the CEQA Guidelines. Substantial evidence supports the Planning Commission's findings and conclusions.

For the reasons provided in this response to the appeals, the Planning Department believes that the Final EIR complies with the requirements of CEQA and the CEQA Guidelines, and provides adequate, accurate, and objective analysis of the potential impacts of the proposed Project.

Therefore, the Department respectfully recommends that the Board uphold the Planning Commission's certification of the Final EIR.

Exhibit A: Appeal Letter and Responses

Exhibit B: Late Comment Letters and Responses

** Complete copy of document is located in

File No. 120549B

Exhibit A

-Responses to Appeal Letter

-Appeal Letter from Gloria Smith (May 16, 2012)

** Complete copy of document is located in

File No. 120549B

Exhibit B

-Late Letter Responses

-Late Letter Comments

CALIFORNIA NURSES ASSOCIATION

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July 9, 2012

Angela Calvillo, Clerk of the Board
San Francisco City Hall
1 Dr. Carlton B. Goodlett Place, Room 244
San Francisco, Ca 94102-4689

RE: California Pacific Medical Center – Long Range Development Plan
File No. 120549

Dear Ms. Calvillo:

Introduction

These comments are submitted on behalf of the California Nurses Association in anticipation of the public hearing set for July 17, 2012, concerning objections to the Planning Commission's decision dated April 26, 2012, certifying the Final Environmental Impact Report relating to the proposed California Pacific Medical Center Long Range Development Plan Project (Planning Commission Case No. 2005.0555E). We very much appreciate the Board of Supervisors taking into account the perspective and concerns of the California Nurses Association (CNA) and the thousands of registered nurses it represents who reside in San Francisco and care for its citizens around the clock, seven days a week, in hospitals throughout the city.

We have reviewed with our legal department the warnings that have reportedly been raised about the lawfulness of attempts by unions representing workers employed by CPMC to influence decisions relating to the proposed project and want to assure you that we understand and do not seek to circumvent the ruling of the US Supreme Court in its decision in *Golden State Transit Corp. v. City of Los Angeles* (1986) 475 U.S. 608. As you know, that case involved actions by the Los Angeles City Council in which a taxi cab company's franchise renewal was expressly conditioned upon settlement of a labor dispute between the company and its drivers. The City Council's placement of conditions on renewal of the employer's operating franchise was directly intended to force the employer's hand in the dispute and was, therefore, determined to be impermissible interference with federal labor law.

The Court reasoned that "the city's insistence on a settlement [of a labor dispute] is pre-empted if the city entered into the substantive aspects of the bargaining process to an extent Congress has not countenanced," concluding that "federal law intended to leave the employer and the union free to use their economic weapons against one another" and "that a city cannot condition a franchise renewal in a way that intrudes into the collective-bargaining process." *Golden State, supra*, 475 U.S. 475 at 615-16 and 619-20. The

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economic weapons referred to by the Court were, of course, the union's right to strike and the company's right to lock employees out.

Thus, the reasoning in *Golden State Transit* prohibits a municipality from premising approval of a project directly upon resolution of a labor dispute due to federal labor law preemption, but actions which regulate activity only peripherally related to labor policy, without placing conditions on the conduct of the parties to a labor dispute, are not subject to preemption. Both unions and employers regularly engage in advocacy on a range of issues far broader than the rules of labor organizing and collective bargaining. Over the years CNA and its members have pressed for reform at every level of government on wide ranging issues, including access to the health care system, stronger environmental laws and more equitable taxation policies. These types of engagements simply reflect the basic fact that union members' concerns and interests extend beyond the workplace.

The *Golden State* decision in no way undermines or limits the protected First Amendment right of unions to lobby government in connection with approval of a project that may impact members of their organizations, either in terms of their working conditions or, more generally, as citizens affected by a decision either to approve or disapprove permit requests. Many major urban development projects in recent years have incorporated job security and labor peace concerns for the benefit of the parties and the public. For example, the City of New Haven, the Yale-New Haven Hospital, and the New Haven hospital workers' union engaged in three-way negotiations over the construction of a new cancer facility. The union wanted new rules for organizing and the hospital needed zoning and development permits from the City. Following a series of meetings mediated by the New Haven mayor, a package deal was reached: the City issued the permits in exchange for the hospital's agreement on rules of organizing. In another example, the Communications Workers of America and two telecom firms tied new organizing rules to state approval of the companies' merger. Simply put, it remains the law that actions which regulate activity without placing conditions on the conduct of the parties to the dispute, are not subject to preemption.

We believe it is undeniable that the registered nurses who staff hospitals in this city 24/7 and who -- by operation of the statute pursuant to which they are licensed owe a constant duty of patient advocacy -- have unique insights and hold important stakes in the outcome of this project that deserve consideration. Recent revelations concerning the impact that CPMC's financial projections may have on the continuing operation of St. Luke's Hospital as well as the projected layoff of hundreds of CPMC employees heighten the concerns raised by CNA before the Planning Commission. The proposed Development Agreement between the City and Sutter/CPMC would allow Sutter to build a downsized St. Luke's woefully inadequate to compete on its own, then discontinue operations of that facility in the event its operating margin falls below a specified percentage, creating the risk of loss of acute care hospital beds in the underserved neighborhoods South of Market. Moreover, the proposed plan does not guarantee a single RN now working for Sutter in San Francisco a job in the new facilities, representing a very real threat that the

experienced nursing staff currently at CPMC who have witnessed and spoken out against the reckless commodification of healthcare, will be replaced.

We urge you to reject the proposed Development Agreement, as it will impact the complex socioeconomic factors involved in the delivery of healthcare in a way that is clearly insufficient to ensure that hospital facilities competing with Sutter Health will remain viable and critical healthcare services will be preserved for all San Franciscans.

The CPMC Project

As you may know, CNA has been actively engaged in review of the CPMC Project. We submitted extensive comments accompanied by expert reports on the Draft Environmental Impact Report (Draft EIR) that outlined a series of legal defects in the Draft EIR's environmental analysis, which we believe violate the California Environmental Quality Act (CEQA). Unfortunately, the Final EIR (FEIR) failed to remedy and adequately respond to many of the concerns we raised in the Draft EIR, prompting us to submit comments to the Planning Commission accompanied by further expert reports. (A copy of our comments with those expert reports is Attachment 1 to this letter.)

Briefly, the Final EIR continues to omit and understate impacts to traffic and air quality, fails to adopt all feasible mitigation for these and other impacts, such as greenhouse gases, and fails to ensure that mitigation that is identified is enforceable and well-defined. Just taking traffic as one example:

- The EIR uses a legally incorrect baseline for MUNI ridership which results in improperly minimizing the Project's impacts on transit;
- Our traffic expert found that improper modifications were made to modeling inputs that allowed the EIR nonsensically to conclude that, absent any physical improvements, MORE TRAFFIC would result is *less congestion* at the intersections of 8th and Market and Franklin and Sutter; and
- The EIR continues to fails to acknowledge significant delays to emergency vehicles that will occur due to frequent grid lock conditions on the Van Ness Corridor.

Even with many impacts understated or omitted altogether from the FEIR, it is clear that the Project would have serious detrimental consequences for the area around the proposed Cathedral Hill Campus. The Final EIR recognizes that building a hospital of the size and magnitude of the Cathedral Hill campus would result in 30 significant and unavoidable traffic impacts alone. Moreover, building the Cathedral Hill Hospital would require creating an exception to the land use designations and mitigations of the existing Special Use District. These designations and policies were designed to limit impacts to traffic, air quality and greenhouse gas pollution through promotion of housing and restrictions on vehicles.

Under the exemptions created for this Project, there will now be substantially more commuter car trips and car-based regional visitors on the most congested traffic corridor in the city. The Project's many significant and unavoidable impacts and disruption to the existing community plan underscores the importance of a rigorous alternatives analysis. But instead of complying with CEQA and providing a meaningful analysis of Project alternatives, the EIR sets forth an impermissibly narrow set of Project objectives, fails to analyze a reasonable range of alternatives, and fabricates disingenuous objections to anything but the project as proposed.

Under CEQA, "a lead agency may *not* give a project's purpose an artificially narrow definition."
But this is exactly what the EIR does. The EIR states than a project objective is to consolidate specialized hospital services and Women's and Children's services into *one* centralized acute-care hospital. While there are certainly efficiencies in consolidating a specific type of care in one place, there is no legitimate reason to consolidate all types of specialized services in one location. The only function of this project objective is to improperly favor the project as proposed.

CEQA also requires the EIR to set forth "a reasonable range of potentially feasible alternatives." CEQA Guidelines § 15126.6(a). The EIR violates this requirement by setting up a small set of straw alternatives that are not feasible. Then, when CNA proposed an environmental superior and feasible modified alternative that would reduce the size of the Cathedral Hill Campus and consolidate some specialized services at St. Luke's, the EIR refused to evaluate the alternative on the grounds that a reasonable range had already been considered. Given that the initial set of alternatives were both limited and infeasible, the EIR was required to fully evaluate the viability of the alternative proposed by CNA.

Finally, the Final EIR raises disingenuous objections to why alternatives to the Project are not feasible. For example, the FEIR claims that St. Luke's could not be expanded and the size of the Cathedral Hill Campus reduced because additional construction at St. Luke's would disrupt the continuum of care due to the timing of required hospital retrofits at the California and Pacific Campuses. What the EIR fails to disclose is that hundreds of extensions of time for hospital retrofits have been granted across the state and could be granted here.

At every level – the project objectives, the reasonable range of alternatives, and objections of feasibility, the EIR's alternatives analysis fails. The analysis has been unlawfully skewed to achieve one outcome and one outcome only, maximum building of the Cathedral Hill campus. Given the severe impacts this Project will have, we believe the Planning Commission failed to take necessary action to correct the EIR's deficiencies and failed to give good-faith consideration to feasible, environmentally superior alternatives such as that proposed by CNA and other interested constituents.

Unintended Consequences of CPMC's Project

It is no secret that CPMC's parent corporation, Sutter Health, has engaged in business practices designed to consolidate hospital services and eliminate competition in order to leverage control in price setting in the health care market. In light of the favorable terms Sutter/CPMC received in the proposed Development Agreement (DA) for reimbursement through the City's HSS, their pricing practices should be heavily scrutinized. The ability to charge patients higher fees for out of network services, as allowed under the DA, is consistent with Sutter's aggressive corporate strategy to drive prices higher.

An article published in the Los Angeles Times last year (Attachment 2 hereto), compared hospital stay costs between Northern and Southern California and attributed the considerably higher prices in Northern California to the market dominance of a few large hospital systems. According to the article:

> In Northern California, analysts say, ***much of the reason for higher costs lies with Sutter***, which has medical groups throughout the region. The operation collects higher daily revenues from privately insured patients than any of the state's 16 other hospital chains -- $6,942 on average for each patient, state records show. The state average is $5,042. (Emphasis added.)
>
> "They are a very powerful hospital system that has proved very successful," said Dr. Robert Berenson, a fellow at the Urban Institute in Washington who has studied California's healthcare markets. "They are in a position to drive hard bargains. I don't think there are many hospitals systems in the country that have that kind of market power."

Another expert quoted in the article, health economist Glenn Melnick of the University of Southern California, ***described Sutter's consolidation as "a really serious problem."*** In an earlier article published in the Journal of Health Economics coauthored with RAND economist Emmett Keeler, Professor Melnick described results of a study funded in part by the California Health Care Foundation, explaining the strategies by which hospital consolidation drives up prices. Among those strategies is formation of a multi-hospital system that includes one or more hospitals with significant market power, then using this power to extract higher prices from health plans for other hospitals in the system, including those located in more competitive markets. "Under this approach, multi-hospital systems who have hospitals with market power may feel that there are social constraints on the prices they can charge at monopoly facilities but use that power to minimize discounts elsewhere in the system. Removing key hospitals from a plans' network can substantially raise the operating cost of the health plan if the plan is forced to pay higher prices to an out of network provider." (A copy of the Journal of Health Economics article is Attachment 3 hereto.)

CNA submits that the new Cathedral Hill mega-hospital proposed by the CPMC project is designed to create consumer demand, such that health insurance plans that do not include the hospital in their provider networks will be disfavored. This has the direct effect of forcing plans to submit to the higher reimbursement rates demanded by Sutter, or lose plan participants and the absolutely essential number of insured lives in the pool necessary to offset risks and provide affordable coverage. That same objective was evident when Sutter Health fought to purchase and merge Summit Hospital in Oakland with Alta Bates Medical Center in Berkeley. Despite an effort by the California Attorney General to block the merger, a federal District Court judge ruled that opponents "failed to prove a well-defined geographic market and thereby has failed to prove its prima facie case of anticompetitive effect." The judge concluded that "[a]llowing Summit and Alta Bates to merge will assure that Summit can continue to serve its community, while enjoining the proposed merger will have the effect of causing the third largest hospital in the East Bay to cease to exist." *State of California v. Sutter Health System*, 84 F. Supp. 2d 1057, 1086 (2000).

Whether that court decision was correct or not has been the subject of much debate and some suggest that Sutter deliberately engineered a dynamic by which the community was up against a wall with no good alternatives. Following the merger of those East Bay hospitals, the Federal Trade Commission conducted a retrospective study to assess whether antitrust enforcement efforts -- unsuccessful though they were -- had been justified. Its study, issued in late 2008, concluded that "Summit's price increase was among the largest of any comparable hospital in California, indicating this transaction may have been anticompetitive." (See FTC Working Paper No. 293, titled "The Price Effects of Hospital Mergers: A Case Study of the Sutter-Summit Transaction," a copy of which is Attachment 4 hereto.) Sutter Health now holds a commanding market share of acute care beds in Alameda County where it continues to enjoy very impressive annual net revenues.

In addition to the concerns described above, CNA believes that CPMC's insistence on radically reducing the size of St. Luke's hospital to only 80 beds – a mere 35% of its current size – is deliberately designed to eliminate future competition. The design of the new St. Luke's as a small "feeder" hospital to the specialized care units planned for the Cathedral Hill campus virtually ensures that the future owner of that facility will be not be able to operate a competitive, full service facility. Not only is the "guarantee" that Sutter will operate St. Luke's for the benefit of the underinsured citizens residing South of Market for 20 years a paltry timeline in the life of a hospital, it provides another example of the calculating approach Sutter exhibits time and again under the guise of "investing in the community."

CPMC has attempted to justify the downsizing of St. Luke's by pointing to its currently low average daily patient census, which, according to the comments of Dr. Edward Kersh, Chief of Staff of St. Luke's, at the Planning Commission hearing on April 26, was an average of only 59 patients per day over the past 15 years. That low average census, however, was expressly *created* by Sutter Health as part of its deliberate scheme to gain

market share for insured health care services in San Francisco. Prior to Sutter's acquisition in 2001, St. Luke's was run as a charitable Episcopalian hospital. As set forth in a study commissioned by the State Attorney General immediately prior to Sutter's acquisition, data filed with the Office of Statewide Health Planning and Development (OSHPD) showed that over the seven year period from 1994 to 2000, the lowest average daily patient census was 131 (in 1996) and the highest was 151 (in 2000), for a seven-year average daily inpatient census of 142. (See study titled "Effect of Affiliation of St. Luke's Hospital with Sutter Health on the Availability and Accessibility of Health Care Services" prepared by the Lewin Group, Inc. at the request of the California Attorney General's Office (Attachment 5 hereto), at p. 13.) Subsequent OSHPD data shows a sharp drop in census at St. Luke's beginning in 2002, the year after Sutter assumed control.

It need hardly be mentioned that St. Luke's has historically served a less moneyed, less white and less insured population than CPMC. Many of the public concerns summarized in the Lewin Group report (at pp. 4-5 of the study) related to a distrust of Sutter's intensions and a fear of loss of charity care for less advantaged San Franciscans living South of Market. Not only have those fears come to pass, approval of a project that will allow Sutter to completely abandon St. Luke's in 20 years and very possibly sooner than that, leaving a hospital reduced to only 80 beds from the current capacity of 228 would be a terrible mistake. If the proposed project is approved, that mistake will shape the future of healthcare in San Francisco for a very long time. Intervention is essential to ensure a fair and responsible rebuild project.

Sutter's Business Practices in Other Bay Area Locations

San Leandro Hospital

Sutter's business practices in other location leaves little doubt about its intentions with respect to St. Luke's. One need only look across the Bay to the saga befalling San Leandro Hospital for affirmation of Sutter's intentions when it offers an infusion of cash to gain control over financially challenged hospitals. As part of its effort to expand market share in well-to-do suburban communities in Alameda County, Sutter Health proposed a transaction with the Eden Township Healthcare District ("ETHD"), a public entity created in 1948 to build and operate a hospital for the benefit of citizens leaving in and around Castro Valley, a bedroom community located near Dublin, Pleasanton and San Ramon. When the District was forced to confront the hospital's seismic vulnerability, Sutter proposed the formation of a joint public/private corporation to rebuild the hospital. A ballot measure was put to the voters in 1997, describing a new 11-member hospital board that would include the five elected District Board members and the then CEO of Eden Hospital -- a majority – plus District approval of the remaining five members so as to assure continuing public control. The measure passed, creating Eden Medical Center, a joint public/private corporation.

In 2004 the ETHD purchased San Leandro Hospital using public funds owned by the District. The District then signed a lease agreement with Sutter, pursuant to which Sutter agreed to operate San Leandro Hospital for twenty years for the benefit of the residents in the community surrounding that facility. The lease required Sutter to provide funding for certain physical plant and equipment upgrades, in exchange for which Sutter received an option to purchase the facility. Those who questioned this lease arrangement were assured that it was negotiated for the express purpose of ensuring funding from Sutter for continued operation of the hospital as an acute care facility. Sutter, however, negotiated a provision in the lease by which it had the option to cease its operating commitment if net revenues fell below a certain level, which was to be determined after accounting for operating losses to be calculated by Sutter, itself.

As set forth in the May 2004 "Term Sheet" Between Sutter Health, Eden Medical Center (EMC) and the Eden Township Healthcare District:

> 6(a) EMC shall agree to lease and operate San Leandro Hospital from the District, which lease shall commence upon acquisition of said facility from Triad. The initial lease term shall be twenty (20) years. However, EMC may terminate the lease before the expiration upon completion of construction of the Replacement Facility. The provision of services at San Leandro Hospital during the lease period prior to completion of the Replacement Facility shall be in accordance with subparagraph 6(b) below. Upon expiration or termination of the lease San Leandro Hospital shall cease to provide general acute care hospital services except as otherwise may be agreed by the parties, and the building, including all transferred non-current assets, shall be returned to the District.
>
> 6(b) During the lease period prior to the completion of the Replacement Facility, it is anticipated that certain of the healthcare services provided at EMC and San Leandro Hospital may be consolidated and relocated as between the two hospital campuses in order to benefit the community by improving access, care, quality of services and cost-efficiencies. Without intending to restrict any subsequent decisions regarding the optimum services configuration at either campus, the initial service configuration for the two hospital campuses during this period is anticipated to be as follows:
>
> - San Leandro Hospital
>   - Acute and Outpatient Psychiatric Services
>   - Partial Psychiatric Hospitalization
>   - ECT
>   - Acute Rehabilitation
>   - Physical, Occupational and Speech Therapy
>   - Outpatient Surgery
>   - GI Laboratory

- Laser Optics
- Upper Extremity Clinic
- Cardiac Rehabilitation Program
- Standby Emergency Services

6(c): Notwithstanding the provisions of subsection (b) hereof, for the first three (3) years of the initial lease term, EMC shall maintain an acute care license and medical/surgical and basic emergency services, physician on duty, at San Leandro Hospital.

Like St. Luke's, San Leandro Hospital serves a less affluent population than the related hospital in Castro Valley. Rather than stand by its assurances that it would operate San Leandro hospital until at least 2024, Sutter has now made known its intention to close San Leandro Hospital in a matter of months, rather than years, leaving the City and its residents scrambling to find options for keeping the facility open and operating as an acute care hospital.

In the years since the 1997 ballot measure passed, Sutter has solidified control of the Hospital District Board and it now can move forward with plans to rebuild an expanded state-of-the-art facility in Castro Valley without the burden of operating a less profitable hospital in the already underserved community of San Leandro. Sutter's move toward closure of San Leandro hospital has prompted recent inquiries by members of the Legislature and the California Board of Equalization about Sutter's continuing status as a tax exempt "charitable" entity. As observed by Assembly Member Wilma Chan at a June 22, 2012 hearing, "[t]hese tax breaks come with responsibilities." (See East Bay Citizen articles dated May 3 and June 23, 2012 (Attachment 6 hereto).)

Sutter Medical Center of Santa Rosa

In November 1995 the Board of Supervisors of Sonoma County voted to lease the County-owned hospital then known as Community Hospital to Sutter Health for 20 years. Less than a year later, in March 1996, Sutter Health negotiated a "Health Care Access Agreement," pursuant to which it guaranteed a certain level of access to healthcare for the community and the indigent in exchange for Sonoma County relinquishing direct control of the hospital.

Several cuts in patient services followed. In 1998, Sutter was cited by regulators for insufficient registered nurse staffing and for flawed record keeping. During 2002-2003, Sutter closed the Senior Health Center and the pediatric intensive care units at the former Community Hospital, claiming that financial difficulty forced the closures. The citizens of Sonoma County protested the cuts as inconsistent with the negotiated agreement and Sutter responded by announcing plans in 2007 to close the hospital altogether and to transfer its obligations under the Health Care Access Agreement to another facility. Sutter was criticized by patients and residents for secretly negotiating the transfer and in 2008 Sutter announced that it would remain in Santa Rosa, close the county-owned facility and build a new hospital, which it would own outright.

The new hospital, which is currently under construction, is now the subject of litigation initiated by the North Sonoma County Healthcare District, the Palm Drive Health Care District and the Sierra Club. Opponents of the new Sutter-owned facility contend, among other things, that the new hospital with its expanded size and increased number of beds will negatively impact the delivery of health care throughout the County, possibly resulting in the closure of district hospitals to the detriment of local residents and in violation of the 1996 County Health Care Access Agreement. (See September 26, 2011 article from the North Bay Business Journal, "Sutter, county reject settlement offer in lawsuit over new hospital, a copy of which is Attachment 7.)

Sutter Auburn Faith

In March 2008, the Chief Administrative Officer (CAO) of Sutter Auburn Faith, Mitch Hanna, publically proclaimed to the Auburn Community that Sutter had a long-term commitment to providing health care services locally:

> "Sutter Health's renovation approval is a reflection of the long-term commitment that Sutter has to ensuring that excellent health care provided in an environment conducive to healing is available locally," said Mitch Hanna, Sutter Auburn's Chief Administrative Officer. (March 21, 2008, Press Release, Sutter Auburn Faith "Sutter Health Approves Major Renovation Plans for Sutter Auburn Faith Hospital," copy included as one of several press releases comprising Attachment 8 hereto.)

Less than 6 months later, Sutter shuttered the Acute Rehabilitation Unit at that facility, forcing local patients to transfer to Sutter's larger and more profitable facility in Roseville, creating expense and inconvenience for the families of patients who now have to travel a considerable distance to visit and assist with the care of their loved ones. (Sept. 5, 2008 Sutter Auburn Faith Press Release, "Acute Rehab Transitions to Region," copy included as one of several press releases comprising Attachment 8 hereto.)

The Birthing Center at Sutter Auburn Faith suffered a similar fate. CAO Hanna repeatedly announced to the Auburn community that Sutter was committed to keeping the Auburn Faith Birth Center open. In April 2008 he said:

> "We want to continue providing Auburn area residents with access to outstanding women's health services close to home…We are committed to doing everything possible in order to maintain an inpatient Family Birth Center at Sutter Auburn Faith Hospital." (April 17, 2008 Sutter Auburn Faith Press Release, "Sutter Auburn Confirms Commitment to Local Women's and Children's Services," copy included as one of several press releases comprising Attachment 8.)

In July of that same year, Hanna released another press statement, this one titled "Sutter Auburn Confirms Commitment to Local Women's and Children's Services." The release heralded the arrival of a new obstetrician and gynecologist and sought to reassure the community that Hanna and Sutter Health were working to ensure that the birthing center "continues to be strong and thrive." (July 1, 2008 Sutter Auburn Faith Press Release, "New Auburn OB/GYN Plans to Stay Put," copy included as one of several press releases comprising Attachment 8 hereto.) The July statement emphasized Sutter's commitment to keeping their promise to the Auburn community.

> "[Earlier this year] CAO Mitch Hanna told the community that Sutter Health was committed to keeping the hospital's well-regarded Family Birth Center open by recruiting at least two new OB/GYNs to the area, with one arriving in July. So far, he has kept that promise."

Despite these repeated promises, Sutter Health ultimately reneged on its commitments to the Auburn community, announcing in May of last year "the decision to close the Sutter Auburn Faith Birthing Center and provide all inpatient labor and delivery services at Sutter Roseville Medical Center." (May 3, 2011 Sutter Auburn Faith Press Release, "Expectant Mothers to Receive Care in Auburn, Deliver in Roseville Under New Plan," copy included as one of several press releases comprising Attachment 8 hereto.)

Even the considerable spin on these events provided by Sutter's public relations specialists cannot hide a corporate agenda for achieving ever higher profits at the expense of essential patient care.

Yet another example of Sutter Health eliminating services in the Auburn area involved critical mental health services for underserved residents of Sacramento County. In October of 2010 Sutter Health Auburn Faith's CEO told Inside HealthCare magazine that "...there is a strong need for the mental health program because Sacramento County recently closed many of its psychiatric facilities, leading to an increase in psychiatric patients in area Emergency Departments." ("Changing with the times: this California hospital is updating its buildings to keep up with the changing face of healthcare" Inside Healthcare, October 1, 2010, Pg. 144(4) Vol. 6 No. 6, a copy of which is Attachment 9.)

Just 3 month later Sutter Health announced the termination of a program in operation for 40 years that, at that time, served 299 low-income and special needs youth under contract with Sacramento County. Rather than offer a genuine explanation for why it was abandoning this high need and underserved community of Medi-Cal patients, Sutter offered only empty and meaningless rhetoric: "Sutter's commitment to providing health care to the whole person will remain unchanged," John Boyd, chief administrative officer at Sutter Center for Psychiatry told the Sacramento Business Journal. (See article by Kathy Robertson of the Sacramento Business Journal dated December 3, 2010, "Sutter Ends Longtime County Mental Health Contract; Parents Question Why," a copy of which is Attachment 10 hereto.)

Mills Peninsula Medical Center

In 1985, the Peninsula Healthcare District, a publically owned hospital entity serving residents from South San Francisco to San Mateo, leased Peninsula Hospital and the land upon which it stands to private nonprofit Mills-Peninsula Health Services for a 30-year term expiring in 2015. In 1995, Mills-Peninsula Health Services found itself in financial trouble and affiliated with Sutter Health. Thus, Sutter became the beneficiary of that lease, which, according to a 2009 article in the Examiner:

> [I]ncluded some peculiar items such as the a large cash payment from the district to the private entity, the transfer of several ancillary properties at the end of the lease to the private lessee around the hospital worth millions of dollars and a no-cash rent deal for the hospital itself, substituting instead improvements and investments made by Sutter in lieu of rent. It was this deal that later became the basis for a lengthy and difficult lawsuit brought forth by newly elected activist board majority against Sutter to stop the transfer of public assets to the corporate entity that now operated the hospital. (See April 15, 2009 Examiner article, "Shakeup with the Peninsula Health Care District Board," Attachment 11 hereto.)

According to a news article in the San Mateo County Times, "In 1998, Mills-Peninsula [by then, Sutter] told the district it was using $4.5 million of district funds to move in-patient rehabilitation from Mills Hospital to Peninsula Hospital. This never happened! Patients are being transferred to Mills Hospital for in-patient rehabilitation." In 2010, Sutter announced a plan to sell off several units at Mills-Peninsula, including the skilled nursing (long-term care) and dialysis units because they were not profitable. Those units employed 219 people. After the sale and resulting patient service and job losses, Sutter's profits at Mill-Peninsula soared nearly 30 percent, from $677 million in 2009, to $878 million in 2010.

Marin General Hospital

The details of the still unfolding drama involving Sutter's effort to grab the assets of this publically owned hospital are too complex to discuss at length here, but the modus operandi was similar to Sutter's approach with other hospital districts. As described at length in pleading filed in the litigation involving that facility, Sutter signed a 30-year lease to operate Marin General Hospital (MGH), heavily infiltrated the Healthcare District Board and depleted the assets. When the North Bay community affected by Sutter's moves filed a lawsuit to regain control of the hospital, it is alleged that Sutter deliberately protracted the litigation, so as to remain in control of the hospital as long as possible in order to slowly choke MGH of their reserves. As Sutter was well aware, MGH did not have sufficient "days of cash on hand" to allow for operation as a free standing community-owned hospital. After the litigation was filed, Sutter purchased property near the facility to position itself to compete with MGH after ownership was

returned to the public hospital district, an effort to establish market dominance in the North Bay region and deliver a final blow to the community hospital.

A recent arbitration conducted pursuant to terms of the parties "Transfer Agreement" in the ongoing litigation resulted in an interim award dated June 19, 2012, requiring Sutter Health to turnover certain files and to pay Marin General Hospital Corporation $21,593,459 for improper charges for cost of capital, breach of agreements relating to physician recruitment, restoration of excess contributions MGH made to the Sutter Retirement Plan and to reimburse charges MGH incurred due to Sutter's failure to cooperate with providing data for operation of information systems. (A copy of the June 19, 2012 Interim Award in the Marin Healthcare District v. Sutter Health and Marin General Hospital Corporation v. Sutter Health, et al. JAMS Arbitration Matter No. 1100065277 is Attachment 12, hereto.) Sutter has touted the outcome of the arbitration as a victory because the award was far smaller than the hospital district sought, but it is undeniable evidence of business practices this so called "charitable nonprofit" corporation will resort to in its quest to shape the healthcare industry in Northern California to serve its strategy of market dominance, selective patient care delivery and pricing control.

Conclusion

Sutter has reaped $4 *billion* in profits in California over the past five years while enjoying tax exempt status based on its purported commitment to provide charity care. CPMC has a notoriously abysmal record on charity care, devoting only 1% of its total annual revenue to serving the medically indigent, far less than the amount of charity care provided by its less moneyed competitors, the continued existence of some of whom (particularly St. Francis Medical Center) will most definitely be threatened if Sutter is given a green light to build the project it is currently proposing for Cathedral Hill. (See SFGate.com article dated December 9, 2011, titled "CPMC spends far less on poor, S.F. report says" (Attachment 13 hereto), and December 2011 report of the University of California Hastings College of the Law Community Economic Development Clinic, titled "Profits & Patients. The Financial Strength and Charitable Contributions of San Francisco Hospitals," Attachment 14 hereto.)

CNA recognizes the need to build seismically sound hospitals in San Francisco and, in fact, has fought hard for legislation requiring exactly that. Sutter Corporation, however, has consistently supported extensions of seismic retrofit deadlines. It is ironic, therefore, that Sutter would use those deadlines as an excuse to hurry consideration of this flawed project.

We believe that approval of the rebuilding of CPMC must be done with sensitivity to the people served by those hospitals and with appropriate scrutiny of the motives of the project sponsor. Our comments on the Final Environmental Impact Report outline in some detail suggestions for shifting some of the capacity currently proposed for the new CPMC facility to the proposed rebuild of St. Luke's. We believe a more balanced

division of beds between the two facilities will not only address many of the serious environmental concerns raised by the proposed Cathedral Hill project, it will result in long term viability of an improved facility serving the South of Market community and provide some hedge against the unbridled growth of a hospital system that threatens to burden all individuals and employers in San Francisco -- including the City, itself -- with prohibitively escalating health care costs through the elimination of competition for what we can only hope will one day be recognized as a basic human right to access to quality health care.

Thank you for considering the nurses' concerns about the CPMC project. We urge you to scrutinize Sutter's motivations and its record for integrity and require revision of the project to protect the interests of all San Franciscans now and for the next generation.

Please do not hesitate to contact me, or to have members of your staff contact me if you have questions or if you would like additional information. My direct line number is (510) 273-2242. My email address is mlighty@calnurses.org.

Very truly yours,

Michael Lighty

Michael Lighty
Director of Public Policy
California Nurses Association

Attachments

BOS-11 1 page
File 120549

San Francisco Tomorrow

Since 1970, Working to Protect the Urban Environment

June 15, 2012

David Chiu
President, San Francisco Board of Supervisors
City Hall
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102
Sent via electronic mail

Re: Support of Appeal by California Nurses Assoc., et. al., Challenges to Proposed EIR Certification, Development Agreements and Development Approvals of the CPMC Long Range Development Plan.

Dear President Chiu and Supervisors:

We are writing on behalf of San Francisco Tomorrow in support of the appeal of the certification of the CEQA document for the California Pacific Medical Center (CPMC) project. However, we would like to make the point that the issues relating to CEQUA and certification of the CPMC Development Plan are presented as inter-related and similar with regard to community impact and mitigation requirements. We offer the following comments and related attachments in support of the appeal.

COMMULATIVE IMPACTS: An EIR needs to consider the cumulative effects of the projects, taken together with other past, present, and reasonably foreseeable future projects. If the cumulative impact is found significant, appropriate mitigation needs to be proposed and required. Pertinent legal requirements are appended "A" (San Franciscans For Reasonable Growth vs. City and County of San Francisco; Friends of Eel River v. Sonoma County Water Agency; Kings County Farm Bureau vs. City of Hanford, et. al.).

As previously noted, the City proposed EIR ignored impact effects entailed by City approval of tax abatements contiguous to the Cathedral Hill CPMC development site. With the CPMC developments, the contiguous areas will be severely affected by these cumulative impacts on the quality and costs of housing, inter-related enterprises, employment and services. These impacts will be much larger than the City acknowledges and, therefore, will require significantly larger mitigations and much more complex means for its implementation than presented. This will require professional, objective analysis by entities that have not been legally compromised by the current city propositions.

FEASIBILITY: "The EIR failed to consider a reasonable range of feasible alternatives that could reduce the projects impacts." Regardless of investor's profit margins, costs to others including the public entities must be the basis for analysis of feasibility of mitigation requirements. The legal

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requirements are appended "B" and are taken from the SFT versus Park Merced, et. al. legal challenge. Suggestions as to mitigation possibilities were made with the April 4 submission. They include a joint public/private development thru the aegis of an Urban Development Corporation and area wide use of "ground rents" as the basis for contiguous tax abatement benefits.

HEALTH, WELFARE AND SAFETY: These criteria are the basis for national constitutional government interventions.

SAFETY: Two thirds of the geographic city will not be served by current health facilities in the certain event of a seismic disaster. Sutter Health provides a substantial portion of the areas health and urgent response needs and, therefore, should be required, with all health response providers, to provide shared resources to the areas' disaster response prior to any present commitment to development use of its current resources. The approval of these projects must be subject to a Health Master Plan now and not five years hence. Because the city/county has a broad resource and institutional mandate to meet such urgent needs, the city/county with Sutter Health must commit now to collective mitigations and means prior to any other commitment of resources for the attainment of this proposed project.

The Cathedral Hill site has the possibility, on Franklin, of contiguity to a volatile PGE 30" gas line, map appended. Preliminary research by Sutter Health did not entail digging a trench to actually test for the presence of this dangerous gas line. The authority for such an encroachment lies with DPW that on May 9, 2012, DPW Order No: 180211, refused a challenge by Bernard Choden, to provide such a test as a requirement of its liabilities. Note that that hearing involved a permit by CPMC to provide two 30,000 gallon diesel fuel tanks near the possible Franklin 30" gas line. Granting of the encroachment permit singularly considered an unapproved development plan without alternatives or safer placements.

At the above DPW hearing, encroachment request were also made for a tunnel under Van Ness between the CPMC developments. Alternative project possibilities were not considered including a smaller hospital between Van Ness and Polk or a bridge connection over Van Ness in lieu of a tunnel that would have less interference with emergency access to the hospital and less interference with traffic projections and utilities on Van Ness.

HEALTH: The community's access to affordable and urgent health care requires a prior Health Master Plan now and not five years hence. The postponed Master Plan does not account for the need to pool all health resources and means to provide both affordability and urgent care were and when needed. Given the diversion of CPMC and city resources presently, it is unlikely that future mitigations and means will be available. Further, state requirements for seismic upgrades of hospitals will result in significant new health facility investments within the next five years rendering the proposed Health Master Plan ineffective.

Received Time Jun. 14. 2012 2:08PM No. 0303

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WELFARE: As noted previously, EIR impacts cumulatively on the quality and affordability of housing, inter-related enterprise investments, including employment, services and accessibility; these development impacts have been critically ignored.

These are impoverished areas. As a very recent article in the New York Times indicated concerning government policy, employment and investment in this area, the costs of housing within the city has risen by over 17% in one year. As a result, such cumulative development has caused housing displacement of families and their laborers to move out of the city. This is further exemplified by the need for approximately 85% of the unionized construction workers to live outside of the city; therefore, the costs of labor will rise for construction or your plumber. Furthermore, the revenues due the city will decline.

Politically circumscribing the development areas by zoning severely limits mitigation possibilities that address the problems of this development. This is not an ideological question; it is an imperative mandate for government action.

Sincerely,

Jennifer Clary
President

Will you want to live in San Francisco – tomorrow?

41 Sutter Street, Suite 1579 . San Francisco CA 94104-4903 . (415) 566-7050

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ATTACHMENT A:

The first is from *San Franciscans for Reasonable Growth v. City and County of San Francisco* (1984) 151 Cal.App.3d 61, 76-77:

Projects under review are independent endeavors, and their developers aggressively seek individual approval. This independence and individualized potential approval makes it all the more important that they be cumulatively considered because, unlike the development of geothermal resources, which involves a fairly unified and concerted coordination of individual projects (e.g., wells, pipelines, production units, storage facilities), the development of downtown San Francisco generally occurs bit by bit. No one project may appear to cause a significant amount of adverse effects. However, without a mechanism for addressing the cumulative effects of individual projects, there could never be any awareness of or control over the speed and manner of downtown development. Without such control, piecemeal development would inevitably cause havoc in virtually every aspect of the urban environment.

This is from *Friends of the Eel River v. Sonoma County Water Agency* (2003) 108 Cal.App.4th 859, 868-869:

The Guidelines require the Agency to consider "past, present, and probable future projects producing related or cumulative impacts ...." (Guidelines, § 15130, subd. (b)(1)(A).) The Agency must interpret this requirement in such a way as to "afford the fullest possible protection of the environment." (Citizens Assn. for Sensible Development of Bishop Area v. County of Inyo (1985) 172 Cal.App.3d 151, 168 [217 Cal.Rptr. 893]; see also Friends of Mammoth v. Board of Supervisors (1972) 8 Cal.3d 247, 259 [104 Cal.Rptr. 761, 502 P.2d 1049]; San Franciscans for Reasonable Growth, supra, 151 Cal.App.3d 61, 74.)

And finally this from *Kings County Farm Bureau v. City of Hanford* (1990) 221 Cal.App.3d 692 (1990) 221 Cal.App.3d 692, 721:

We find the analysis used in the EIR and urged by GWF avoids analyzing the severity of the problem and allows the approval of projects which, when taken in isolation, appear insignificant, but when viewed together, appear startling. Under GWF's "ratio" theory, the greater the overall problem, the less significance a project has in a cumulative impacts analysis. We conclude the standard for a cumulative impacts analysis is defined by the use of the term "collectively significant" in Guidelines section 15355 and the analysis must assess the collective or combined effect of energy development. The EIR improperly focused upon the individual project's relative effects and omitted facts relevant to an analysis of the collective effect this and other sources will have upon air quality.

6/9/12 12:37 AI

Bottom line: An EIR needs to consider the cumulative effects of the project, taken together with other past, present, and reasonably foreseeable future projects. If the cumulative impact is found significant, appropriate mitigation needs to be proposed and required.

Received Time Jun. 14. 2012 2:08PM No. 0303

ATTACHMENT B:

As was stated in *California Oak Foundation v. The Regents of the University of California* (2010) 188 Cal.App.4th 227, 274, "If the EIR is the 'heart' of CEQA, the mitigation and alternatives discussion forms the EIR's 'core'." "One of an EIR's major functions is to ensure that all reasonable alternatives to proposed projects are thoroughly assessed by the responsible official." (*Citizens of Goleta Valley v. Board of Supervisors ("Goleta II")* (1990) 52 Cal.3d 553, 565.) "[A]n EIR must describe a range of reasonable alternatives to the project, or to the location of the project, which could feasibly attain the basic objectives of the project, and evaluate the comparative merits of the alternatives." (*Id.*, quoting from CEQA Guidelines §15126(d).) In particular, the alternatives discussion should focus on alternatives that offer substantial environmental advantages over the project proposal. (*Id.*, citing Public Resources Code §21002.) However, there is no categorical imperative as to the scope of alternatives that must be analyzed. Rather, each case must be evaluated on its own facts. (*Id.*)

To: San Francisco Planning Commission
San Francisco Board of Supervisors
Fr: Bernard Choden
Re: CPMC Development Agreement and DEIR concerns:

April 4, 2012

The proposed city Development Agreement with CPMC must be a very significant portion of the comprehensive mitigations required of the DEIR CPMC development approvals. Therefore, analysis and disposition of a DEIR must precede the finalization of a proposed Development Agreement. Cited relevantly is the California legal decision regarding Albany's seashore decision Citizens for Responsible Growth versus the City of Albany, 1997, citation 56, CALAPT forth series, page 1199. To clarify the issues raised, scope and measurement of mitigation and the means to effect mitigations must be known beforehand. For example:

1. The city and region needs a committed and effective disaster plan, as for a seismic event, now containing committed resource shares from and by all health facilities. Therefore, the city must effectuate a disaster Master Plan prior to determining the extent of CPMC mitigation requirement. Because CPMC has a substantial portion of the region's health resources, the city must require a Development Agreement to require CPMC's commitment to its participation with other health resource institutions, including the city's health facilities, in advance of approving either the agreement or a DEIR. There is even the question of whether the Cathedral Hill site can provide disaster relief at the proposed CPMC location.
2. The cumulative environment impacts mitigations must be determined as to scope, measures and means on both CPMC sites. Particularly pressing will be increased costs of housing and services that must be mitigated. Given the unquestionable fact that this city, with New York City, share the onus of having the highest costs of housing in the nation, it is obvious that mitigation requires public and private institutional commitments to preserve affordable housing and services to these low income areas. No approvals should be considered before the city has a fully prescriptive, effective and legal Housing Element conjunctive with the General Plan.
3. The Cathedral Hill CPMC site is bordered by a possibility volatile PG&E 30" gas pipeline of San Bruno lineage. Prior to any private or public resource commitments it is critical that the city seek "injunctive relief" requiring tests for safety immediately.

The question then is "what's rush?"

Received Time Jun. 14. 2012 2:08PM No. 0303

To: SFBOS
Fr: Bernard Choden
Re: Record Supplement to My Testimony Per CPMC Hearing, Dec. 13.

Dec. 15, 2011

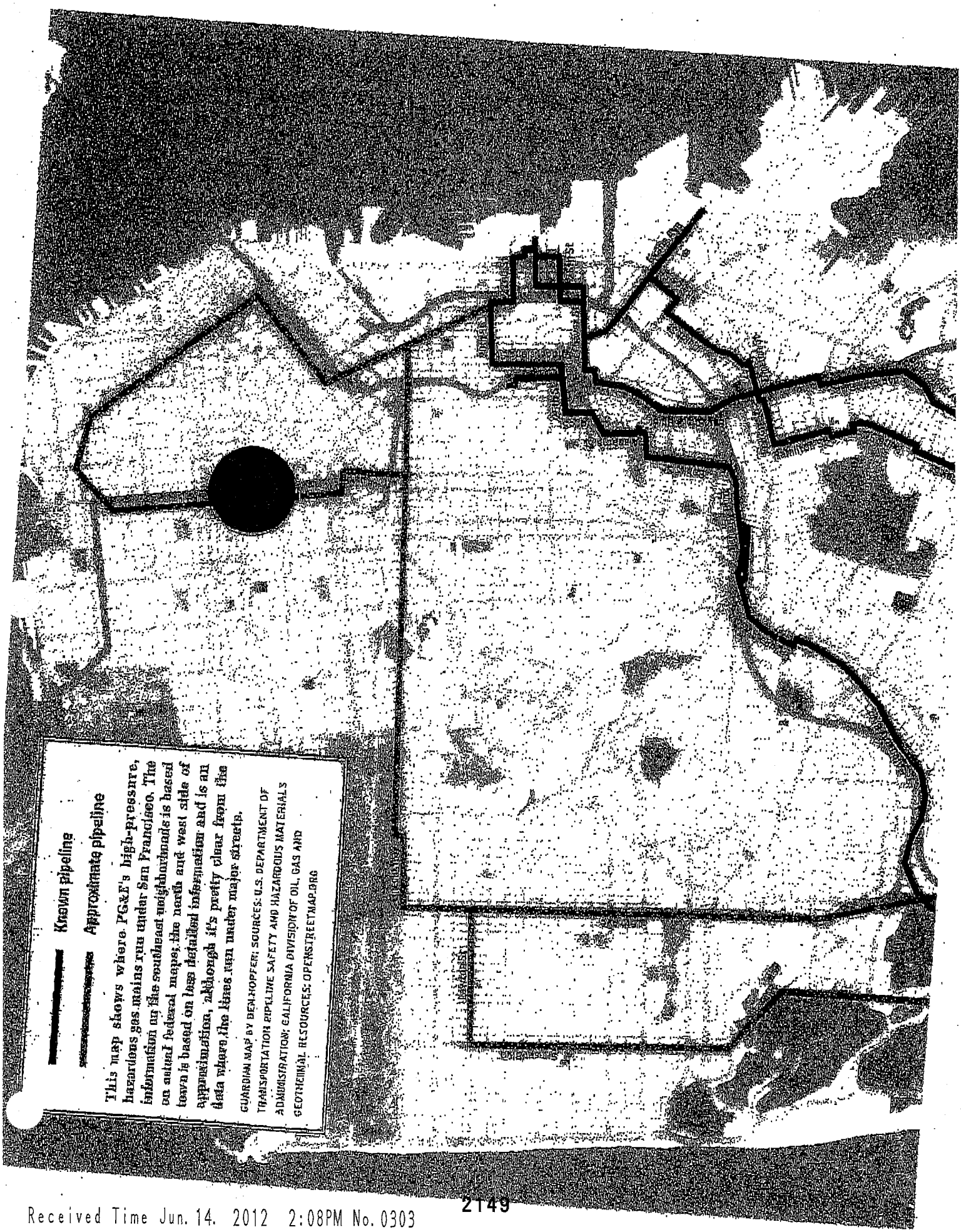
To enable "Community Benefits" and mandated mitigation of CEQUA, the following normative financial means are suggested:

1. Require CPMC to exchange fee simple title for the right to develop their sites.
   a. The City would gain a vested equity in the quality of use and obligations forever.
   b. The City would retain "ground rents" revenue rights to guarantee "Public Benefits".
2. Enable a community development district for both CPMC areas.
   a. Create an "Urban Development Corporation" as a public/private partner with NGO's and a fully participant community as an enabling institution.
   b. Include within the development areas all cumulative development that impacts the CEQUA conditions. Included, therefore, would be the hi-tech "Twitter" Market St. proposals.
   c. All investments would be protected as continued developments through use of exchange of titles for development rights. The revenues from "ground rents" would form an underpinning UDC trust fund.
   d. The trust fund could enable low cost private investment through government backed "Letters of Participation" and other frontend support such as insurance and seed money.
   e. Investors, including CPMC, would provide their vested collateral that would become city property should they fail to perform.
   f. The process would enable larger, more flexible footprints for CPMC and other development while highly protective of the contiguous communities rights to affordable, environmentally pleasant residencies and services.
3. Require CPMC to post a "Performance Bond" to guarantee third party scrutiny of the adequacy of the mitigation agreements and performance.
4. Require the testing of the PG&E 30" gas pipeline on Franklin prior to any site approval by "injunctive Relief."

To: SF Board of Supervisors
Fr: Bernard Choden
Re: Hearing on CPMC Status, Committee/BOS Agenda
Dec. 13, 2011

1. **CEQUA:** The California Environmental Quality Act (CEQUA) mandates that development impacts be mitigated for cumulative effects on the availability and affordability of housing and related community services. Regard to the Tenderloin and adjacent area by an existing, approved "hi-tech" (Twitter) district to the south and the proposed CPMC hospital development to the West indicates an onerous community burden on the availability of affordable housing and related community services for which government has not provided adequate clarification, means or resources that would mitigate these EIR impacts.
2. **DISASTER SAFETY:** A citywide "Health Master Plan" should require that CPMC and all other health providers collectively provide all areas of the city with emergency services especially in the event of a seismic disaster when over one million people will be endangered for as long as one month. Given the scale and locations of the CPMC proposals, the collective commitments of all health providers must be made now prior to a CPMC development approval not five years later.
3. **PIPELINE DANGER:** The U.S. Dept. of Transportation Pipeline Safety and Hazardous Materials Adm. And the Calif. Div. of Oil Gas and Geothermal Resources Open Street Map. Org clearly indicates that contiguous to the CPMC Franklin St. site a possibly volatile PG&E 30" gas pipeline of the San Bruno vintage. This danger must be assessed now by the City, perhaps by a State Declarative Injunction, prior to approvals of CPMC and city investments and development on that site.
4. **SANCTIONS:** Proposed community benefits and effective community EIR mitigations are functionally mutually supportive. They are not inimical to each other.
5. **PLANNING:** Both the Franklin St. and St. Lukes (Mission St.) community areas require effective, community supportive planning that becomes institutionally protective of their communities affordability and functions that will result from the environmental impacts of the sizable CPMC proposals. This is a State mandated requirement that has been quite inadequately pursued by the planning process or the BOS.

Received Time Jun. 14. 2012 2:08PM No. 0303



Received Time Jun. 14. 2012 2:08PM No. 0303

File 120549: CPMC APPEAL OF EIR 12 June 2012 Comments to support appeal

Board of Supervisors to: Rick Caldeira 06/13/2012 11:42 AM

From: Li Chapman <licwa@yahoo.com>
To: "david.chiu@sfgov.org" <david.chiu@sfgov.org>, "John.Avalos@sfgov.org" <John.Avalos@sfgov.org>, "Malia.Cohen@sfgov.org" <Malia.Cohen@sfgov.org>, "Mark.Farrell@sfgov.org" <Mark.Farrell@sfgov.org>, "David.Campos@sfgov.org" <David.Campos@sfgov.org>, "Carmen.Chu@sfgov.org" <Carmen.Chu@sfgov.org>, "Sean.Elsbernd@sfgov.org" <Sean.Elsbernd@sfgov.org>, "Jane.Kim@sfgov.org" <Jane.Kim@sfgov.org>, "Eric.L.Mar@sfgov.org" <Eric.L.Mar@sfgov.org>, "Christina.Olague@sfgov.org" <Christina.Olague@sfgov.org>, "Scott.Weiner@sfgov.org" <Scott.Weiner@sfgov.org>, "Board.of.Supervisors@sfgov.org" <Board.of.Supervisors@sfgov.org>,
Date: 06/12/2012 03:43 PM
Subject: CPMC APPEAL OF EIR 12 June 2012 Comments to support appeal

Attached are my comments on the DEIR, submitted for BOS, in support of the appeal.
Please add my comments to the appeal record.
Please consider these issues before voting on entitlements, Development Agreement, and any other CPMC actions

Linda Chapman
1316 Larkin St
94109

516-5063 cell

Comments for CPMC DEIR.docx

FOR: Bill Wycko, Environmental Review Officer

FROM: Linda Chapman

1316 Larkin St

San Francisco CA 94109

licwa@yahoo.com

Comments for CPMC EIR

1. Consistency with General Plan, area plan, zoning, other policies.

The CPMC proposal is inconsistent with applicable policies of the Van Ness Area Plan (VNAP). It flies in the face of a long-established area plan that is progressively achieving objectives. A traffic-inducing medical use is precluded for the Van Ness Corridor by a plan that considered traffic impacts, the special role of Van Ness as a transit corridor for Muni and Golden Gate Transit, and conflicts for a city street with inter-city traffic from Highway 101.

Exemption from the zoning for housing and limited commercial uses envisaged by the area plan is a huge demand, where that plan comprises a well integrated set of policies that further interdependent objectives. VNAP objectives include:

Transform a commercial corridor into an imposing boulevard, by adding residential development and landscaping;

Use height limits to create the consistent profile appropriate for a grand boulevard, following topography by stepping up building heights from the waterfront to a mid-rise profile along the high ridge of the boulevard;

Allow sufficient height to encourage dense housing while avoiding traffic-inducing high rise development;

Foster preservation of architecturally significant commercial buildings, and consider permitted heights to avoid visual incongruity with classic buildings;

Promote residential development on a transit corridor (especially affordable housing), by encouraging high density and small units;

Prevent traffic-generating commercial development, such as offices;

Limit new commercial space to lower stories of residential development, where it buffers street noise;

Limit bulk and potential wind/shadow/view impacts of mid-rise buildings, using design features like set-backs and podiums;

Break up wide building frontages;

Improve traffic circulation and transit on a major highway and transit artery (contemplating subway construction as the long-range goal to avoid transit conflicts).

The current project undermines the purpose of an area plan elegantly designed to produce housing instead of business that generates housing demand. The proposed use creates housing demand that will put pressure on availability and prices in surrounding neighborhoods.

There could be consistency with other planning policies not in the area plan (which should be treated as the governing document in case of conflict). Locating a hospital where it will not displace existing housing and where there is transit access could be arguments for the proposal. If a change of use is therefore allowed (in what is designed to be a residential-commercial district), then maximum adherence to other objectives and policies of the area plan must be sought.

The Housing Mitigation strategy proposed below could address an overarching VNAP objective to produce centrally located affordable housing. In addition to new construction, funding for nonprofit CDCs to acquire and manage existing buildings as affordable housing would be appropriate ways to mediate the 3:1 housing requirement established for the Special Use District (SUD). Funding rehabilitation is consistent with later policies encouraging sustainable development.

Removal of residential hotel units to make way for the MOB is governed by the Residential Hotel Unit Demolition and Control Ordinance. Reducing scarce housing resources is a situation where renovation cannot substitute for funding construction of replacement SRO units or efficiency apartments. Mitigation for a few dwelling units proposed for demolition together with the SRO could fund the same project.

The EIR notes that exceeding the 130-foot height limit would exacerbate environmental impacts (which include traffic and transportation, housing and economic impacts below).

Additionally, it must be acknowledged that the 130-foot limit for this section of the Van Ness Corridor implements these VNAP policies:

Allows building envelopes intended to meet a city-wide need for large numbers of *housing units;*

Aims to prevent overdevelopment of housing where high rises could exacerbate traffic problems;

Promotes a consistent profile for one of the city's two grand boulevards;

Aims to prevent out-of-scale buildings that would dwarf historic commercial buildings.

Visual effects, wind and shadow impacts of the proposed hospital should be compared to neighborhood impacts of the Holiday Inn (which VNAP policies were designed to prevent in new development).

2. Housing demand and economic impacts.

The proposed campus would take land in the Van Ness Corridor from uses that benefit the area. A hotel provided customers for two commercial districts and placed less pressure on neighborhood housing stock. The Van Ness Plan identified this area as an ideal location to supply future housing demands, where new construction will not cause significant residential displacement.

Development of this residential-commercial district is intended to focus on small households and favor affordable housing. Residential development allows commercial space only at lower stories. The VNAP accommodates retail, or local services, not traffic inducing institutional development.

The CPMC proposal defeats the purpose of the SUD, which mandates 3:1 square feet (minimum) of housing to commercial space for development in the Van Ness Corridor. Generally, new construction will accommodate this requirement. If housing is not built on site (e.g., existing commercial building is expanded), then the same 3:1 ratio mandates housing construction elsewhere in the SUD.

The proposed campus reduces potential sites for housing construction (the area plan's primary objective). Moreover, it concentrates new workers in an institutional use that VNAP land use policies do not accommodate. It multiplies the impacts of commercial enterprises because this nonconforming use will schedule hundreds of workers around the clock. A purpose of the area plan was to limit non-residential use.

CPMC operations must be considered for housing impacts, not only city-wide, but those likely to intensify local demand. Workers in small households, especially those expecting to come and go at night, will likely put pressure on the housing stock of central city neighborhoods, where prevalent forms are studios and 1-2 bedroom units. Rental tenure dominates most neighborhoods near the site, with condominiums an increasing proportion of new construction.

Historic impacts on Nob Hill housing of St Francis Hospital, documented over a number of years, demonstrated significant effects, even from a smaller hospital. The hospital acquired rental buildings, on 2-3 blocks, to demolish for an office building; to house specialties like Sports Medicine (illegally); then (defeating enforcement actions) to house residents and interns when on call at night. Tenants, if not forced out, endured years of pressure. Hospital and office staff doubtless competed with other residents for centrally located rental housing in the regular market. An independent laboratory located near the hospital likewise reduced potential housing supply.

Households in neighborhoods near the proposed campus (lower Nob Hill, Civic Center, Tenderloin) have average incomes lower than the city-wide average. Competition from CPMC staff will result in reduced housing opportunities for current and prospective residents: fewer units available to rent; upward pressure on rents; pressures to terminate tenancies. Households with higher incomes will experience housing pressure in increased rents and competition for apartments available for purchase.

Housing Mitigation:

Housing impacts near a Cathedral Hill campus (or in neighborhoods easily accessible by transit) can be reduced, but not eliminated, by relocating some proposed operations to the existing campuses, thereby reducing staff concentration at one problem site.

The area plan's intent to meet housing requirements within SUD boundaries cannot be met for a development like CPMC (even environmentally preferred Alternative 3). Van Ness Plan policies for affordable housing must be adapted to mitigate development—else the Cathedral Hill project must not proceed. CPMC has the option to build hospital facilities on existing campuses, or to accept requirements applied to development of the Van Ness Corridor for decades since adoption of the area plan.

Mitigation through payment for new housing construction must be required at ratios reasonably related to VNAP objectives. Both rental and for-sale housing should be produced, taking into consideration needs generated by CPMC for its own staff.

Funding non-profit developments on the many in-fill sites in Polk Gulch, Tenderloin, and South of Market should be the priority. New construction and the rehabilitation of needed housing (such as

SROs) in districts where non-profits can acquire structures or infill sites can partly mitigate impacts from altering the permitted use and housing ratio mandated for the Van Ness Corridor. One of the few advantages of an institutional use is the opportunity to direct funding to below-market ownership and rental housing.

Because this developer has no objective to profit from housing, the ratio of below-market units does not affect project feasibility like the ratio of affordable to market-rate units in for-profit residential development. It is therefore appropriate to fund a high proportion of rental housing and plan other units for sale at "affordable" rates.

Requirements to contribute substantial housing elsewhere must be imposed in return for exemptions from policies limiting the Van Ness Corridor to residential construction. Funding needed housing and amenities like parks in surrounding areas could in part mitigate the more intense environmental and economic impacts of nonresidential development, when they cannot be eliminated. (However, housing contributions cannot obviate efforts to reduce significant neighborhood impacts like traffic and noise.)

Funding predominantly affordable housing and green spaces could justify reducing the VNAP 3:1 ratio for housing (the minimum required in for-profit residential-commercial development). A rationale to reduce the 3:1 ratio would be funding housing types that the private market does not support (e.g., SROs, studios, apartments with "efficiency" kitchens suited for one or two occupants).

VNAP objectives to produce affordable housing, with high-density small units (two bedrooms or less), can be met-- in substance-- by means not specified in the area plan: Fund a large number of small units, for construction or rehabilitation by non-profit developers, outside the SUD. As a proxy for the 3:1 square foot ratio imposed for residential-commercial construction in the Van Ness Corridor, this alternative can efficiently produce and manage housing for long-term affordability.

A community proposal for Nob Hill Senior Housing exemplifies how funding that multiplies community benefits can justify reducing the 3:1 ratio predicated on market-rate housing. Numerous infill sites for affordable housing can be identified in the vicinity of Polk Gulch: Among them, in a neighborhood lacking community facilities, is an abandoned church with adjacent parking lot, suitable for a senior housing development to incorporate space for community activities and a senior center or children's program. Tenderloin Neighborhood Development Corporation will evaluate the proposal for low-income housing and community amenities. An identified funding source could encourage the property owner to reconsider a previous stalled development plan.

3. Economic impact of development at Van Ness and Geary on neighborhood retail and services.

Impacts that a hospital "monoculture" can have on the economy of surrounding neighborhoods require attention.

Based on observations elsewhere, neighbors and merchants suggest that staff and visitors to a hospital and its medical office buildings will purchase subsidized food, instead of walking to restaurants and other local food vendors. From family experience, I expect a hospital's subsidized public food service to take some local customers for convenience meals away from small businesses.

Hospital visitors and staff are expected to generate less retail traffic for the Polk Gulch/Van Ness shopping districts, where small businesses were patronized by guests of a hotel the project would supplant.

Compared to housing development, proposed rezoning for institutional use can be predicted to generate low customer traffic for neighborhood businesses. The Van Ness Area Plan would allow construction for hundreds of residents on the land proposed for a hospital and related uses.

Mitigation

Measures that directly reduce economic impacts for neighborhood businesses are not easy to identify. Mitigation could include funding to improve pedestrian experiences on shopping streets beyond project perimeters, but near enough for businesses and residents to experience impacts. Neighborhood residents, and visitors from beyond the Van Ness and Polk residential/commercial districts, would increasingly frequent the two shopping areas if street environments were more inviting.

Sidewalk beautification for the Van Ness and Polk commercial corridors (greening, and attractive street furniture) would enhance pedestrian environments.

Funding for small parks and plazas in a neighborhood that offers no recreational open space could transform underused public land in Polk Gulch alleys, and some underutilized commercial sites, to outdoor living rooms. Pedestrians would be encouraged by opportunities to pass public art or green space that would relieve the experience of a dense urban environment.

Public spaces located in shopping areas would attract people to meet out of doors, relax with food or reading matter, gather for scheduled performances. Sites to create significant open space were identified in public alleys, and at large lots with minimal private improvements (one by the intersection of Polk and Geary; two adjacent lots close to Polk on the California Street cable car line).

4. Traffic and transportation

The stated purpose for building on Van Ness Avenue is easy access for drivers from the North Bay, patients and doctors. Adding Highway 101 drivers to the Van Ness Corridor is sufficient reason to downsize a hospital campus, if it is to locate there at all.

From my experience, traffic congestion on Highway 101 spills over from Van Ness to Polk Street, clogging two Muni preferential streets. Traffic circulating around a hospital, medical office buildings, and garages will impede through traffic on Van Ness (Highway 101), on Geary Boulevard, and other major automobile routes like Franklin, Gough and Post.

Circulation on streets of the Polk Street Neighborhood Commercial District (NCD), lower Nob Hill, and the Tenderloin will be affected by cars driving to the hospital and MOB, by adding emergency vehicles, by increasing service vehicles at the site, including trucks.

The campus is ideally situated for its vehicle traffic to impede transit service: Golden Gate Transit and two major Muni lines on Van Ness; the 38 on Geary and O'Farrell (the nation's most heavily traveled line); two lines running on Post and Sutter. Autos that slow traffic as they enter and exit garages, or execute turns onto streets with garage entries, cannot fail to affect transit on the same streets.

EXAMPLE OF EXISTING CONDITIONS:

Absent CPMC impacts, one morning this year when Van Ness was congested, it took me two hours to catch a 49 at Pine and travel to 22d Street. With traffic at a standstill, the driver advised passengers heading for Market Street to get off and walk several blocks in the rain. After waiting about an hour to board at Pine, I saw the driver of this packed vehicle leave passengers stranded at subsequent stops-- maybe waiting an hour for the next 49 (after waiting the hour I'd waited for this one).

Regardless of traffic studies based on LOS (selected intersections at a particular point in time), those who regularly travel city streets can report that tremendous transit delays, due to congestion around the Van Ness Corridor, are not uncommon. Viewing intersections a few times may be sufficient to estimate normal conditions (but only for hours studied). Congestion that is irregular, but not infrequent, is evidence that the proposed location cannot tolerate traffic inducing uses.

Where seemingly insignificant temporary conditions (like rain, illegal parking, or holiday events) cause paralyzing congestion, the result shows how vulnerable the Van Ness Corridor is to traffic disruption. Inadequate impact analysis could saddle the area with permanent results from hospital development.

Drivers converging on the campus will circulate through surrounding streets, some hoping to park at off-site garages or curbside, others navigating the one-way street patterns to reach hospital and MOB entries. The more drivers depend on campus garages, the more those garages will tie up traffic when cars waiting for entry back up into the street, and the more drivers will circle surrounding streets when unable to stop in traffic waiting for garage entry. A Polk Gulch resident recounted this condition at an existing CPMC garage, which results in his circling through the neighborhood. Absent other evidence, it is reasonable to assume that conditions at a location *already* more congested than CPMC's problem garage will be worse.

Garage entries on Geary require drivers approaching from the west to navigate various one-way streets. Drivers forced to turn onto Van Ness or Polk in order to head west at Geary will add congestion to several transit preferential streets.

Converting Cedar Alley to garage access creates traffic conflicts. This street is narrow, now lightly used– and accessed from two transit preferential streets that are sometimes congested, without added traffic from a CPMC campus. Cars turning east from the garage would enter Polk at midblock, interrupting traffic flow (including buses) on a relatively narrow street. Results could be delays, and unexpected conflicts confusing drivers, as cars emerge in mid-block. Drivers exiting on Polk intending to head east or north would circulate among one-way streets in Polk Gulch.

Similar conflicts are predictable if significant numbers of cars use the mid-block alley at Van Ness for garage access. Alleys running between Van Ness and Polk are little used for auto traffic.

Mitigation

Converting Cedar Alley to access for the MOB garage cannot be allowed.

Alternative 3 proposes reducing the Cathedral Hill campus— essential for traffic impacts. However, with proposed garages, traffic impacts will inevitably remain significant.

Traffic impacts can be reduced by limiting CPMC parking, on-site and off-site. CPMC proposes spaces for 1,055 cars at the Van Ness/Geary site-- where the existing hotel and office building total 405. Two large garages are not needed, in addition to spaces for CPMC at the Sutter Street MOB.

The Legislative Analyst found that Manhattan limits hospitals to 100 parking spaces. Therefore: What is the rationale for this city to require many times more spaces for any hospital campus? What medical need could justify outsized garages in a transit-rich area with severe traffic impacts? What conditions made it possible for hospitals in other cities to offer less public parking?

Even the reduced Alternative 3 proposes more than one-third increase in square footage for parking, compared to existing conditions. This is unacceptable in the transit-rich central city-- when city policy has advanced to contemplating auto use limited to out of town trips and grocery shopping. The Planning Code eliminated obsolete 1:1 residential requirements for downtown and additional parts of the northeast quadrant, Octavia Boulevard, and some other transit-rich areas. The VNAP should be updated consistent with newer area plans (inasmuch as its intent was to produce a transit-rich residential district). Meanwhile, it is inconsistent with recent policy direction for a planning rule to impose minimum parking spaces for new medical campuses.

For the Cathedral Hill campus, there should be no approval to build parking, beyond replacing spaces from the hotel and office site. If CPMC wants suburban amenities, they cannot locate a campus in the central city. Attracting autos disrupts not just transit and circulation, but the pedestrian environment and living environment of residents already subjected to urban density and commute traffic.

CPMC articulated a desire to relocate to a transit-rich area. They need to encourage customers and staff to use this amenity. CPMC argues (inconsistently) that people need auto transport to get medical care. The reality for this transit-rich area is that residents found about two-thirds of Nob Hill households had no vehicle. People living in such areas take public transit to medical providers-- including Kaiser and CPMC, where garages invite car owners to drive regardless of need (like that Polk Gulch resident who described circling all over another neighborhood when he uses a CPMC garage).

Parking to serve Cathedral Hill construction must not exceed 405 spaces. Further reduction is desirable, to reduce adverse impacts in the overburdened Van Ness Corridor and surrounding neighborhoods. Compared to hotel and office use, auto traffic to CPMC garages could drive through our neighborhood many more times (for patient appointments all day, for staff turnover day and night). In contrast to this intense use for round-the-clock medical operations, commuters are likely to enter and leave the neighborhood once a day, hotel guests may just store cars overnight, hotels rarely rent rooms to capacity, and garage spaces rented for evening events likely won't turn over like CPMC garages.

5. Pedestrian environment, neighborhood livability: wind, shadow, noise, pollution

For wind, shadow, and aesthetic impacts, the proposed hospital calls for comparison to neighborhood impacts of the Holiday Inn.

Impacts of increasing ambient traffic noise on pedestrians and residents of our dense neighborhoods, already subjected to downtown commute traffic, must be considered, in addition to the concerns raised about sirens. Using sidewalks, or rooms with windows facing the street, is a different quality of experience, at times of heavy traffic. Economic impacts of traffic congestion and noise for small

businesses and the already stressed NCD require consideration. As the pedestrian environment declines, customers from outlying neighborhoods can take their business elsewhere.

Automobile noise and air pollution will multiply when cars are trapped in congestion, or circulate in residential areas

6. Impact on service availability, public safety.

Supporters of the current proposal argued prompt medical intervention for birthing and emergency conditions as justification for locating a campus in the Van Ness Corridor. In view of congestion impacts described above, public safety could be the best reason to decentralize emergency and critical care units.

Transportation impediments between the Cathedral Hill campus and the city's southern sector include long Muni trips, traffic delays and meltdowns like an experience described above, which would equally affect patients (or the all important doctors) heading for Cathedral Hill from Marin.

In the event of a disaster, it threatens public safety to concentrate medical services on the north side of the city. After the 1906 earthquake, people resorted to traversing the city on foot. CPMC proposes to build seismically safe hospitals that much of the population may be unable to reach.

7. Pedestrian tunnel

The proposal conflicts with the long-range VNAP goal for a subway to reduce traffic conflicts and transit delays. The CPMC plan would divide the right-of-way and could pose conflicts for subway entries near the Van Ness/Geary intersection.

MTA's current proposal for "Bus Rapid Transit," is a cheaper, less effective alternative. The VNAP is still the planning document that identifies long-range goals for the corridor.

The BRT alternative, still in the planning stage, is dismissed by some transportation planners, and observers of traffic conditions in the corridor. BRT cannot fix street networks paralyzed by congestion. A subway could avoid notorious problems transit riders face on Van Ness.

A pedestrian tunnel would affect a published goal for resolving conflicts affecting Highway 101, traffic in densely populated central city neighborhoods, heavily travelled arteries, Muni and Golden Gate Transit. CPMC's plan cannot be allowed to prejudice the outcome, when a published long-range goal was deferred for funding consideration.

Tunnels for Muni Metro and BART make a subway now considered for Stockton Street expensive to build and less practical for users because a deep route is required to avoid underground structures. The same impediment to a VNAP goal is posed by a pedestrian tunnel.

File 120549
Cpage

To: Rick Caldeira/BOS/SFGOV,
Cc:
Bcc:
Subject: File 120549: CPMC APPEAL OF EIR 12 June 2012 Comments to support appeal

From: Li Chapman <licwa@yahoo.com>
To: "david.chiu@sfgov.org" <david.chiu@sfgov.org>,"John.Avalos@sfgov.org" <John.Avalos@sfgov.org>, "Malia.Cohen@sfgov.org" <Malia.Cohen@sfgov.org>, "Mark.Farrell@sfgov.org" <Mark.Farrell@sfgov.org>, "David.Campos@sfgov.org" <David.Campos@sfgov.org>, "Carmen.Chu@sfgov.org" <Carmen.Chu@sfgov.org>, "Sean.Elsbernd@sfgov.org" <Sean.Elsbernd@sfgov.org>, "Jane.Kim@sfgov.org" <Jane.Kim@sfgov.org>, "Eric.L.Mar@sfgov.org" <Eric.L.Mar@sfgov.org>, "Christina.Olague@sfgov.org" <Christina.Olague@sfgov.org>, "Scott.Weiner@sfgov.org" <Scott.Weiner@sfgov.org>, "Board.of.Supervisors@sfgov.org" <Board.of.Supervisors@sfgov.org>,
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Subject: CPMC APPEAL OF EIR 12 June 2012 Comments to support appeal

Attached are my comments on the DEIR, submitted for BOS, in support of the appeal.
Please add my comments to the appeal record.
Please consider these issues before voting on entitlements, Development Agreement, and any other CPMC actions

Linda Chapman
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Comments for CPMC DEIR.docx

FOR: Bill Wycko, Environmental Review Officer

FROM: Linda Chapman

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Comments for CPMC EIR

1. Consistency with General Plan, area plan, zoning, other policies.

The CPMC proposal is inconsistent with applicable policies of the Van Ness Area Plan (VNAP). It flies in the face of a long-established area plan that is progressively achieving objectives. A traffic-inducing medical use is precluded for the Van Ness Corridor by a plan that considered traffic impacts, the special role of Van Ness as a transit corridor for Muni and Golden Gate Transit, and conflicts for a city street with inter-city traffic from Highway 101.

Exemption from the zoning for housing and limited commercial uses envisaged by the area plan is a huge demand, where that plan comprises a well integrated set of policies that further interdependent objectives. VNAP objectives include:

Transform a commercial corridor into an imposing boulevard, by adding residential development and landscaping;

Use height limits to create the consistent profile appropriate for a grand boulevard, following topography by stepping up building heights from the waterfront to a mid-rise profile along the high ridge of the boulevard;

Allow sufficient height to encourage dense housing while avoiding traffic-inducing high rise development;

Foster preservation of architecturally significant commercial buildings, and consider permitted heights to avoid visual incongruity with classic buildings;

Promote residential development on a transit corridor (especially affordable housing), by encouraging high density and small units;

Prevent traffic-generating commercial development, such as offices;

Limit new commercial space to lower stories of residential development, where it buffers street noise;

Limit bulk and potential wind/shadow/view impacts of mid-rise buildings, using design features like set-backs and podiums;

Break up wide building frontages;

Improve traffic circulation and transit on a major highway and transit artery (contemplating subway construction as the long-range goal to avoid transit conflicts).

The current project undermines the purpose of an area plan elegantly designed to produce housing instead of business that generates housing demand. The proposed use creates housing demand that will put pressure on availability and prices in surrounding neighborhoods.

There could be consistency with other planning policies not in the area plan (which should be treated as the governing document in case of conflict). Locating a hospital where it will not displace existing housing and where there is transit access could be arguments for the proposal. If a change of use is therefore allowed (in what is designed to be a residential-commercial district), then maximum adherence to other objectives and policies of the area plan must be sought.

The Housing Mitigation strategy proposed below could address an overarching VNAP objective to produce centrally located affordable housing. In addition to new construction, funding for nonprofit CDCs to acquire and manage existing buildings as affordable housing would be appropriate ways to mediate the 3:1 housing requirement established for the Special Use District (SUD). Funding rehabilitation is consistent with later policies encouraging sustainable development.

Removal of residential hotel units to make way for the MOB is governed by the Residential Hotel Unit Demolition and Control Ordinance. Reducing scarce housing resources is a situation where renovation cannot substitute for funding construction of replacement SRO units or efficiency apartments. Mitigation for a few dwelling units proposed for demolition together with the SRO could fund the same project.

The EIR notes that exceeding the 130-foot height limit would exacerbate environmental impacts (which include traffic and transportation, housing and economic impacts below).

Additionally, it must be acknowledged that the 130-foot limit for this section of the Van Ness Corridor implements these VNAP policies:

Allows building envelopes intended to meet a city-wide need for large numbers of *housing units;*

Aims to prevent overdevelopment of housing where high rises could exacerbate traffic problems;

Promotes a consistent profile for one of the city's two grand boulevards;

Aims to prevent out-of-scale buildings that would dwarf historic commercial buildings.

Visual effects, wind and shadow impacts of the proposed hospital should be compared to neighborhood impacts of the Holiday Inn (which VNAP policies were designed to prevent in new development).

2. Housing demand and economic impacts.

The proposed campus would take land in the Van Ness Corridor from uses that benefit the area. A hotel provided customers for two commercial districts and placed less pressure on neighborhood housing stock. The Van Ness Plan identified this area as an ideal location to supply future housing demands, where new construction will not cause significant residential displacement.

Development of this residential-commercial district is intended to focus on small households and favor affordable housing. Residential development allows commercial space only at lower stories. The VNAP accommodates retail, or local services, not traffic inducing institutional development.

The CPMC proposal defeats the purpose of the SUD, which mandates 3:1 square feet (minimum) of housing to commercial space for development in the Van Ness Corridor. Generally, new construction will accommodate this requirement. If housing is not built on site (e.g., existing commercial building is expanded), then the same 3:1 ratio mandates housing construction elsewhere in the SUD.

The proposed campus reduces potential sites for housing construction (the area plan's primary objective). Moreover, it concentrates new workers in an institutional use that VNAP land use policies do not accommodate. It multiplies the impacts of commercial enterprises because this nonconforming use will schedule hundreds of workers around the clock. A purpose of the area plan was to limit non-residential use.

CPMC operations must be considered for housing impacts, not only city-wide, but those likely to intensify local demand. Workers in small households, especially those expecting to come and go at night, will likely put pressure on the housing stock of central city neighborhoods, where prevalent forms are studios and 1-2 bedroom units. Rental tenure dominates most neighborhoods near the site, with condominiums an increasing proportion of new construction.

Historic impacts on Nob Hill housing of St Francis Hospital, documented over a number of years, demonstrated significant effects, even from a smaller hospital. The hospital acquired rental buildings, on 2-3 blocks, to demolish for an office building; to house specialties like Sports Medicine (illegally); then (defeating enforcement actions) to house residents and interns when on call at night. Tenants, if not forced out, endured years of pressure. Hospital and office staff doubtless competed with other residents for centrally located rental housing in the regular market. An independent laboratory located near the hospital likewise reduced potential housing supply.

Households in neighborhoods near the proposed campus (lower Nob Hill, Civic Center, Tenderloin) have average incomes lower than the city-wide average. Competition from CPMC staff will result in reduced housing opportunities for current and prospective residents: fewer units available to rent; upward pressure on rents; pressures to terminate tenancies. Households with higher incomes will experience housing pressure in increased rents and competition for apartments available for purchase.

Housing Mitigation:

Housing impacts near a Cathedral Hill campus (or in neighborhoods easily accessible by transit) can be reduced, but not eliminated, by relocating some proposed operations to the existing campuses, thereby reducing staff concentration at one problem site.

The area plan's intent to meet housing requirements within SUD boundaries cannot be met for a development like CPMC (even environmentally preferred Alternative 3). Van Ness Plan policies for affordable housing must be adapted to mitigate development—else the Cathedral Hill project must not proceed. CPMC has the option to build hospital facilities on existing campuses, or to accept requirements applied to development of the Van Ness Corridor for decades since adoption of the area plan.

Mitigation through payment for new housing construction must be required at ratios reasonably related to VNAP objectives. Both rental and for-sale housing should be produced, taking into consideration needs generated by CPMC for its own staff.

Funding non-profit developments on the many in-fill sites in Polk Gulch, Tenderloin, and South of Market should be the priority. New construction and the rehabilitation of needed housing (such as

SROs) in districts where non-profits can acquire structures or infill sites can partly mitigate impacts from altering the permitted use and housing ratio mandated for the Van Ness Corridor. One of the few advantages of an institutional use is the opportunity to direct funding to below-market ownership and rental housing.

Because this developer has no objective to profit from housing, the ratio of below-market units does not affect project feasibility like the ratio of affordable to market-rate units in for-profit residential development. It is therefore appropriate to fund a high proportion of rental housing and plan other units for sale at "affordable" rates.

Requirements to contribute substantial housing elsewhere must be imposed in return for exemptions from policies limiting the Van Ness Corridor to residential construction. Funding needed housing and amenities like parks in surrounding areas could in part mitigate the more intense environmental and economic impacts of nonresidential development, when they cannot be eliminated. (However, housing contributions cannot obviate efforts to reduce significant neighborhood impacts like traffic and noise.)

Funding predominantly affordable housing and green spaces could justify reducing the VNAP 3:1 ratio for housing (the minimum required in for-profit residential-commercial development). A rationale to reduce the 3:1 ratio would be funding housing types that the private market does not support (e.g., SROs, studios, apartments with "efficiency" kitchens suited for one or two occupants).

VNAP objectives to produce affordable housing, with high-density small units (two bedrooms or less), can be met– in substance– by means not specified in the area plan: Fund a large number of small units, for construction or rehabilitation by non-profit developers, outside the SUD. As a proxy for the 3:1 square foot ratio imposed for residential-commercial construction in the Van Ness Corridor, this alternative can efficiently produce and manage housing for long-term affordability.

A community proposal for Nob Hill Senior Housing exemplifies how funding that multiplies community benefits can justify reducing the 3:1 ratio predicated on market-rate housing. Numerous infill sites for affordable housing can be identified in the vicinity of Polk Gulch: Among them, in a neighborhood lacking community facilities, is an abandoned church with adjacent parking lot, suitable for a senior housing development to incorporate space for community activities and a senior center or children's program. Tenderloin Neighborhood Development Corporation will evaluate the proposal for low-income housing and community amenities. An identified funding source could encourage the property owner to reconsider a previous stalled development plan.

3. Economic impact of development at Van Ness and Geary on neighborhood retail and services.

Impacts that a hospital "monoculture" can have on the economy of surrounding neighborhoods require attention.

Based on observations elsewhere, neighbors and merchants suggest that staff and visitors to a hospital and its medical office buildings will purchase subsidized food, instead of walking to restaurants and other local food vendors. From family experience, I expect a hospital's subsidized public food service to take some local customers for convenience meals away from small businesses.

Hospital visitors and staff are expected to generate less retail traffic for the Polk Gulch/Van Ness shopping districts, where small businesses were patronized by guests of a hotel the project would supplant.

Compared to housing development, proposed rezoning for institutional use can be predicted to generate low customer traffic for neighborhood businesses. The Van Ness Area Plan would allow construction for hundreds of residents on the land proposed for a hospital and related uses.

Mitigation

Measures that directly reduce economic impacts for neighborhood businesses are not easy to identify. Mitigation could include funding to improve pedestrian experiences on shopping streets beyond project perimeters, but near enough for businesses and residents to experience impacts. Neighborhood residents, and visitors from beyond the Van Ness and Polk residential/commercial districts, would increasingly frequent the two shopping areas if street environments were more inviting.

Sidewalk beautification for the Van Ness and Polk commercial corridors (greening, and attractive street furniture) would enhance pedestrian environments.

Funding for small parks and plazas in a neighborhood that offers no recreational open space could transform underused public land in Polk Gulch alleys, and some underutilized commercial sites, to outdoor living rooms. Pedestrians would be encouraged by opportunities to pass public art or green space that would relieve the experience of a dense urban environment.

Public spaces located in shopping areas would attract people to meet out of doors, relax with food or reading matter, gather for scheduled performances. Sites to create significant open space were identified in public alleys, and at large lots with minimal private improvements (one by the intersection of Polk and Geary; two adjacent lots close to Polk on the California Street cable car line).

4. Traffic and transportation

The stated purpose for building on Van Ness Avenue is easy access for drivers from the North Bay, patients and doctors. Adding Highway 101 drivers to the Van Ness Corridor is sufficient reason to downsize a hospital campus, if it is to locate there at all.

From my experience, traffic congestion on Highway 101 spills over from Van Ness to Polk Street, clogging two Muni preferential streets. Traffic circulating around a hospital, medical office buildings, and garages will impede through traffic on Van Ness (Highway 101), on Geary Boulevard, and other major automobile routes like Franklin, Gough and Post.

Circulation on streets of the Polk Street Neighborhood Commercial District (NCD), lower Nob Hill, and the Tenderloin will be affected by cars driving to the hospital and MOB, by adding emergency vehicles, by increasing service vehicles at the site, including trucks.

The campus is ideally situated for its vehicle traffic to impede transit service: Golden Gate Transit and two major Muni lines on Van Ness; the 38 on Geary and O'Farrell (the nation's most heavily traveled line); two lines running on Post and Sutter. Autos that slow traffic as they enter and exit garages, or execute turns onto streets with garage entries, cannot fail to affect transit on the same streets.

EXAMPLE OF EXISTING CONDITIONS:

Absent CPMC impacts, one morning this year when Van Ness was congested, it took me two hours to catch a 49 at Pine and travel to 22d Street. With traffic at a standstill, the driver advised passengers heading for Market Street to get off and walk several blocks in the rain. After waiting about an hour to board at Pine, I saw the driver of this packed vehicle leave passengers stranded at subsequent stops-- maybe waiting an hour for the next 49 (after waiting the hour I'd waited for this one).

Regardless of traffic studies based on LOS (selected intersections at a particular point in time), those who regularly travel city streets can report that tremendous transit delays, due to congestion around the Van Ness Corridor, are not uncommon. Viewing intersections a few times may be sufficient to estimate normal conditions (but only for hours studied). Congestion that is irregular, but not infrequent, is evidence that the proposed location cannot tolerate traffic inducing uses.

Where seemingly insignificant temporary conditions (like rain, illegal parking, or holiday events) cause paralyzing congestion, the result shows how vulnerable the Van Ness Corridor is to traffic disruption. Inadequate impact analysis could saddle the area with permanent results from hospital development.

Drivers converging on the campus will circulate through surrounding streets, some hoping to park at off-site garages or curbside, others navigating the one-way street patterns to reach hospital and MOB entries. The more drivers depend on campus garages, the more those garages will tie up traffic when cars waiting for entry back up into the street, and the more drivers will circle surrounding streets when unable to stop in traffic waiting for garage entry. A Polk Gulch resident recounted this condition at an existing CPMC garage, which results in his circling through the neighborhood. Absent other evidence, it is reasonable to assume that conditions at a location *already* more congested than CPMC's problem garage will be worse.

Garage entries on Geary require drivers approaching from the west to navigate various one-way streets. Drivers forced to turn onto Van Ness or Polk in order to head west at Geary will add congestion to several transit preferential streets.

Converting Cedar Alley to garage access creates traffic conflicts. This street is narrow, now lightly used-- and accessed from two transit preferential streets that are sometimes congested, without added traffic from a CPMC campus. Cars turning east from the garage would enter Polk at midblock, interrupting traffic flow (including buses) on a relatively narrow street. Results could be delays, and unexpected conflicts confusing drivers, as cars emerge in mid-block. Drivers exiting on Polk intending to head east or north would circulate among one-way streets in Polk Gulch.

Similar conflicts are predictable if significant numbers of cars use the mid-block alley at Van Ness for garage access. Alleys running between Van Ness and Polk are little used for auto traffic.

Mitigation

Converting Cedar Alley to access for the MOB garage cannot be allowed.

Alternative 3 proposes reducing the Cathedral Hill campus— essential for traffic impacts. However, with proposed garages, traffic impacts will inevitably remain significant.

Traffic impacts can be reduced by limiting CPMC parking, on-site and off-site. CPMC proposes spaces for 1,055 cars at the Van Ness/Geary site-- where the existing hotel and office building total 405. Two large garages are not needed, in addition to spaces for CPMC at the Sutter Street MOB.

The Legislative Analyst found that Manhattan limits hospitals to 100 parking spaces. Therefore: What is the rationale for this city to require many times more spaces for any hospital campus? What medical need could justify outsized garages in a transit-rich area with severe traffic impacts? What conditions made it possible for hospitals in other cities to offer less public parking?

Even the reduced Alternative 3 proposes more than one-third increase in square footage for parking, compared to existing conditions. This is unacceptable in the transit-rich central city-- when city policy has advanced to contemplating auto use limited to out of town trips and grocery shopping. The Planning Code eliminated obsolete 1:1 residential requirements for downtown and additional parts of the northeast quadrant, Octavia Boulevard, and some other transit-rich areas. The VNAP should be updated consistent with newer area plans (inasmuch as its intent was to produce a transit-rich residential district). Meanwhile, it is inconsistent with recent policy direction for a planning rule to impose minimum parking spaces for new medical campuses.

For the Cathedral Hill campus, there should be no approval to build parking, beyond replacing spaces from the hotel and office site. If CPMC wants suburban amenities, they cannot locate a campus in the central city. Attracting autos disrupts not just transit and circulation, but the pedestrian environment and living environment of residents already subjected to urban density and commute traffic.

CPMC articulated a desire to relocate to a transit-rich area. They need to encourage customers and staff to use this amenity. CPMC argues (inconsistently) that people need auto transport to get medical care. The reality for this transit-rich area is that residents found about two-thirds of Nob Hill households had no vehicle. People living in such areas take public transit to medical providers-- including Kaiser and CPMC, where garages invite car owners to drive regardless of need (like that Polk Gulch resident who described circling all over another neighborhood when he uses a CPMC garage).

Parking to serve Cathedral Hill construction must not exceed 405 spaces. Further reduction is desirable, to reduce adverse impacts in the overburdened Van Ness Corridor and surrounding neighborhoods. Compared to hotel and office use, auto traffic to CPMC garages could drive through our neighborhood many more times (for patient appointments all day, for staff turnover day and night). In contrast to this intense use for round-the-clock medical operations, commuters are likely to enter and leave the neighborhood once a day, hotel guests may just store cars overnight, hotels rarely rent rooms to capacity, and garage spaces rented for evening events likely won't turn over like CPMC garages.

5. Pedestrian environment, neighborhood livability: wind, shadow, noise, pollution

For wind, shadow, and aesthetic impacts, the proposed hospital calls for comparison to neighborhood impacts of the Holiday Inn.

Impacts of increasing ambient traffic noise on pedestrians and residents of our dense neighborhoods, already subjected to downtown commute traffic, must be considered, in addition to the concerns raised about sirens. Using sidewalks, or rooms with windows facing the street, is a different quality of experience, at times of heavy traffic. Economic impacts of traffic congestion and noise for small

businesses and the already stressed NCD require consideration. As the pedestrian environment declines, customers from outlying neighborhoods can take their business elsewhere.

Automobile noise and air pollution will multiply when cars are trapped in congestion, or circulate in residential areas

6. Impact on service availability, public safety.

Supporters of the current proposal argued prompt medical intervention for birthing and emergency conditions as justification for locating a campus in the Van Ness Corridor. In view of congestion impacts described above, public safety could be the best reason to decentralize emergency and critical care units.

Transportation impediments between the Cathedral Hill campus and the city's southern sector include long Muni trips, traffic delays and meltdowns like an experience described above, which would equally affect patients (or the all important doctors) heading for Cathedral Hill from Marin.

In the event of a disaster, it threatens public safety to concentrate medical services on the north side of the city. After the 1906 earthquake, people resorted to traversing the city on foot. CPMC proposes to build seismically safe hospitals that much of the population may be unable to reach.

7. Pedestrian tunnel

The proposal conflicts with the long-range VNAP goal for a subway to reduce traffic conflicts and transit delays. The CPMC plan would divide the right-of-way and could pose conflicts for subway entries near the Van Ness/Geary intersection.

MTA's current proposal for "Bus Rapid Transit," is a cheaper, less effective alternative. The VNAP is still the planning document that identifies long-range goals for the corridor.

The BRT alternative, still in the planning stage, is dismissed by some transportation planners, and observers of traffic conditions in the corridor. BRT cannot fix street networks paralyzed by congestion. A subway could avoid notorious problems transit riders face on Van Ness.

A pedestrian tunnel would affect a published goal for resolving conflicts affecting Highway 101, traffic in densely populated central city neighborhoods, heavily travelled arteries, Muni and Golden Gate Transit. CPMC's plan cannot be allowed to prejudice the outcome, when a published long-range goal was deferred for funding consideration.

Tunnels for Muni Metro and BART make a subway now considered for Stockton Street expensive to build and less practical for users because a deep route is required to avoid underground structures. The same impediment to a VNAP goal is posed by a pedestrian tunnel.

To: BOS Constituent Mail Distribution,
Cc:
Bcc:
Subject: File 120549: APPEAL OF CPMC EIR (please support)

From: "Evy Pearce" <evy@bottomline.comcastbiz.net>
To: <board.of.supervisors@sfgov.org>,
Date: 06/08/2012 02:44 PM
Subject: APPEAL OF CPMC EIR (please support)

As a resident in the vicinity of the proposed building of a new CPMC hospital, I am concerned there will be a negative
Impact on our neighborhood.
We are already experiencing much too much traffic, noise and exhaust pollution.
Additionally, the wind tunnel on Franklin Street makes it very unpleasant to cross the street at Pine, Sutter, Post or Geary.
One takes their life in their hands while crossing Van Ness Ave at any cross street, and the wind is extreme at any crossing.
Bicycles are often on the sidewalks now. There, no doubt, will be more bicycles taking to the sidewalks once construction starts.
In my opinion, CPMC could not have picked a worse site to build a hospital on. I find it hard to believe there is not another
site where there would be much less congestion.
You would be doing the citizens of San Francisco a great favor by voting against this project at this location.

Sincerely,

Evy Pearce, 1777 Pine St, #402, San Francisco, CA 94109. 415-441-7302

To: BOS Constituent Mail Distribution,
Cc:
Bcc:
Subject: File 120549: APPEAL OF CPMC EIR please support!

From: Patricia Lovelock <patricialovelock@sbcglobal.net>
To: board.of.supervisors@sfgov.org,
Date: 06/08/2012 12:10 AM
Subject: APPEAL OF CPMC EIR please support!

I am writing to support the appeal of the CPMC EIR. As a resident in the area of the proposed Cathedral Hill campus I am extremely concerned about the massive impacts that apparently cannot and will not be mitigated. Issues such as transportation, air quality and noise need to be reconsidered and if they cannot be successfully mitigated changes to the project must be made. Our neighborhood health and safety and our access to transportation should be of utmost importance.

Our neighborhood has waited a long time for the BRT transit improvements on Van Ness and Geary. We have put up with slow and unreliable buses that are often so crowded we cannot even board. CPMC's impacts will cause the hoped for improvements to be nullified. The hundreds of vehicles carrying staff, patients, families and deliveries will cause additional congestion to streets such as the arterials of Franklin, Gough, Pine and Bush, Van Ness and Polk Street. The Van Ness BRT with no left turn access from Mission to Broadway will further increase traffic on these streets. We currently have periods of gridlock in this area and commonly see unsafe driving maneuvers. I often see emergency vehicles unable to move through traffic due to cars unable or unwilling to yield. I have seen an ambulance on a Saturday afternoon need to travel upon the sidewalk to bypass stopped cars. LOS as the main way to measure traffic impact is inadequate to capture the true nature of impacts in this traffic-dense residential neighborhood. The addition of two enlarged ERs and their ambulance traffic is also of great concern.

The SFDPH has mapped out the areas of high vehicle-pedestrian injuries in San Francisco. The area surrounding the Cathedral Hill site is one of these high intensity areas. The Tenderloin, Van Ness from Market to Union and nearby sections of Polk, Pine, Sutter, Post, Franklin, Bush and Gough are all parts of high-injury density corridors needing pedestrian safety improvements. The EIR neglects to consider the plan's additional negative impacts on these already identified hazardous areas. No mitigations are considered for impacted streets west of Van Ness.

Increase in hazardous air quality is of special concern in our neighborhood due to the already very high levels of contaminants resulting from Van Ness and the surrounding arterials. Daily I have to clean vehicle emissio particles from plants on my deck. Our neighborhood may have one of the city's greatest concentrations of residences for seniors and the disabled. Within blocks of the Cathedral site there are more than a dozen such complexes, some very large. Additional pollution during both construction and build-out will be of great me harm to these "sensitive receptors".

The SFDPH has also mapped areas of unhealthy traffic noise. Again, the area of the Cathedral site already suffers from these noxious impacts. The density of the project and its traffic and operations will add heavily to this problem. We will also have to endure added numbers of emergency vehicle sirens, car honking and de

I am certainly not against the building of earthquake-safe hospitals but I do believe the plan as set forth in th current LRDP and EIR needs much further consideration. It includes a large number of significant negative i many poorly analyzed and mitigated, in a densely populated residential (zoned residential) area. We have alr had to endure some of these same impacts from the current Pacific campus and the terrible CPMC maintenan of the vacant hotel site. We want to see a LRDP and EIR with real and substantial mitigations and a develop agreement that fairly addresses ALL neighborhood areas negatively impacted, that greatly improves health ca access for even the least fortunate and that fairly compensates the city for this very detrimental "spot zoning". Please support the appeal of the CPMC EIR.

Sincerely,

Patricia Lovelock 1777 Pine St. Apt. 401
San Francisco CA 94109
(415) 440-4909

Requests for CPMC LRDP FEIR (CD) and for Commenters

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	SFPUC - Urban Watershed Magagement Program	1145 Market Street, 5th Floor	San Francisco	CA	94103	1
Sheila Mahoney and James Frame		25 Duncan Street	San Francisco	CA	94110	1
Stephanie Barton, et. al	Hastings Civil Justice Clinic for the Good	100 McAllister Street, Suite 300	San Francisco	CA	94102	1
Ted Weber		1400 Geary Blvd., Apt 1409	San Francisco	CA	94109	1
Trudy Lionel		664 Noe Street	San Francisco	CA	94114	1
	Unitarian Universalist CPMC Task Force	1187 Franklin Street	San Francisco	CA	94109	1
Wallace Cleland		347 Oak Park Drive	San Francisco	CA	94131	1

CDs for Planning Commission Hearing Speakers who Provided Addresses

Marianna Ferris	Lost Block Association	3631 Cesar Chavez	San Francisco	CA	94110	1
Joe Kim		123 Van Ness Avenue	San Francisco	CA	94102	1
Joel Koppell	San Francisco Electrical Construction Industry	55 Fillmore	San Francisco	CA	94117	1
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