AdventHealth Asheville
CON for a New Acute Care Hospital in Buncombe County
Project ID B-012233-22
Opposition on Behalf of MH Mission Hospital, LLLP

Introduction

The 2022 SMFP identified a need for 67 acute care beds in the acute care planning area that includes Buncombe, Graham, Madison, and Yancey Counties. The need was generated by the high occupancy of Mission Hospital, currently the only hospital provider in the service area as three counties are small rural areas that could not support a hospital. Mission is the regional tertiary and quaternary medical center. In response to demand for its services, Mission applied for the addition of 67 beds on its existing campus to address the specific needs of its patients for high acuity and specialized ICU and medical/surgical ("med/surg") services.

Two applicants have applied for new acute care hospitals using the acute care bed need quantified in the 2022 SMFP. Both AdventHealth Asheville, Inc. ("Advent"), Project I.D. No. B-012233-22, and Novant Health Asheville Medical Center, LLC ("Novant"), Project ID B-012230-22, have applied to construct and develop new 67-bed acute care hospitals in Buncombe County.

Advent's application focuses heavily on the claimed need for competition. Advent asserts, without any support, that Mission Health has faced limited competition since it was acquired by HCA in 2019. In fact, nothing has changed about the competitive landscape in western North Carolina since HCA's acquisition of Mission. There have been no changes in the number or location of hospitals in the service area since that time. Mission did not have a monopoly in 2019, and it has no monopoly today. HCA's acquisition of the Mission Health System was reviewed by and subject to conditions agreed to with the North Carolina Attorney General. There is an independent monitor that ensures that the conditions of the asset purchase agreement are met.[1] HCA is in compliance with these agreements.[2]

Advent claims that patients need a choice for acute care services but ignores the fact that AdventHealth Hendersonville Medical Center ("Advent Hendersonville") is an existing provider approximately 16 miles away from the proposed site with significant excess bed capacity, operating at just 49.0 percent capacity in fiscal year ("FY") 2021. Moreover, the 2022 LRA for Advent Hendersonville shows that 30.5 percent of its total FY 2021 admissions were from the planning area (Buncombe, Graham, Madison, and Yancey). Advent Hendersonville already provides a choice, is already actively providing competition in the service area, and already serves the second highest number and percent of service area acute care patients.

If the Advent application is approved, Mission will continue to operate at exceedingly high occupancy rates, and AdventHealth will operate two minimally-utilized hospitals with excess bed capacity. This is not the intention of the "competition" factor set forth in the North Carolina CON statute and in the CON application form.

[1] HCA and Mission are independently monitored by the Dogwood Trust.
https://dogwoodhealthtrust.org/independent-monitor/
[2] https://www.independentmonitormhs.com/hca-commitments

Most importantly, the application filed by Advent cannot be approved and is fatally flawed. The project does not propose an operating room ("OR") and cannot qualify as a "qualified" hospital applicant without an OR within the definition of "qualified applicant" included in the 2022 State Medical Facilities Plan ("SMFP"). Advent proposes 5 "procedure rooms," a C-Section room, and no ORs. The surgical services proposed by Advent do not include any licensed ORs:

The 2022 SMFP is clear—any applicant proposing to develop a new hospital must meet the definition of "qualified applicant" set forth on page 37 of the SMFP, which is part of the official acute care bed methodology. That section states, in pertinent part:

> *"Any qualified applicant may apply for a CON to acquire the needed acute care beds. A qualified applicant is a person who proposes to operate the additional acute care beds in a hospital that will provide:*
>
> 1. *a 24-hour emergency services department;*
> 2. *inpatient medical services to both surgical and non-surgical patients."*

The CON Section has a long history of properly interpreting this SMFP language to require that any "qualified application" proposing to develop a new hospital using acute care beds identified as needed in the annual SMFP must include one or more general ORs in that application. The Agency has also been consistent for years that the inclusion of a C-Section OR does not meet that requirement because, per the SMFP, C-section ORs are:

1. Excluded from the annual inventory of ORs;
2. Therefore, not counted when assessing need for additional ORs;
3. Not available for use with patients needing any type of surgery unrelated to labor and delivery.

In fact, page 54 of the 2022 SMFP itself states the need methodology for ORs as follows:

> *"The need methodology [for ORs] excludes dedicated C-Section ORs and associated cases from the calculation of need determinations. A dedicated C-section OR shall only be used to perform C-sections and other procedures performed on the patient in the same visit to the C-section operating room, such that a patient receiving another procedure at the same time as the C-section would need to be moved to a different OR for the second procedure."*

Finally, the Agency has long taken the position that any hospital proposing to develop Procedure Rooms must have at least one licensed OR before doing so, which is also consistent with applicable standards of care. In short, per the SMFP, a C-section OR cannot act as or fulfill the requirement that all new hospitals have licensed ORs in providing both medical and surgical services.

AdventHealth spends several pages of its CON application discussing CMS standards for hospitals; unrelated historical N.C. DHSR rulings on certain licensure aspects of procedure rooms, and other smoke and mirrors to obfuscate one glaring reality – it is applying under the 2022 SMFP, and it cannot meet the express definition of a "qualified applicant" for a new hospital.

AdventHealth's proposal to develop a C-section OR and multiple Procedure Rooms which, per AdventHealth's application language, will essentially be unlicensed ORs, is inappropriate and inconsistent with long-held Agency positions on new hospitals, ORs, and C-section rooms, and it would set a dangerous precedent for future CON applications and reviews if accepted by the Agency. This proposal:

- Manipulates the laws governing hospitals, the CON Statute and the annual SMFP;
- Would essentially abolish the CON regulation of ORs if accepted by the Agency; and
- Would be entirely at odds with the highly-regulated CON aspects of ORs in this state and would allow AdventHealth to do what no other hospital or hospital system in North Carolina has ever been allowed to do – build a CON-regulated hospital without a general OR.

The term "OR," which is defined in G.S. 131E-176(18c), means "*A room used for the performance of surgical procedures requiring one or more incisions and that is required to comply with all applicable licensure codes and standards for an operating room."*

Either the "surgical" cases Advent proposes to perform are not truly surgical cases as they will be performed in a procedure room, or Advent is going to surreptitiously develop an unlicensed OR with the "C-Arm" unit in the "surgical" department it discloses. This is simply not acceptable and contrary to the plain language of the SMFP with regard to the development of a new hospital.

As will be discussed below, not only is Advent disqualified as a "qualified applicant," but also, the inappropriate inclusion of surgical cases that cannot and should not be performed in a "procedure room" renders the projected utilization, need analysis, and financial feasibility analysis unreasonable and undocumented. Advent's project is quite simply not approvable and should be denied.

Criterion (1) Consistency with State Health Plan - Advent is Not a Qualified Applicant

Advent's application cannot be found conforming with Criterion (1) because based on the SMFP, Advent is not a qualified applicant. Advent claims it will offer surgical services as required for a new hospital applicant, but Advent's proposal does not include any ORs. Worse than this flaw is Advent's claim that it will "safely perform major surgical cases in a procedure room." This suggestion is completely inappropriate and raises significant questions about the quality of care for the proposed hospital.

Because Advent's project does not have an OR, it cannot project to serve sufficient surgical patients to qualify as an acute care hospital. Its projected surgical utilization on page 25 relies on performing cases in a procedure room that can only be performed appropriately in an OR. (Please also see discussion under Criterion (3) and the Acute Care Beds Performance Standards). The counter to this would be that Advent is revealing its plans to operate an unauthorized operating room. Neither of these conclusions is acceptable.

Because Advent's project is not approvable as a qualified applicant under the SMFP, it cannot be found conforming with Policy GEN-3. Advent's project cannot promote safety and quality and, in

fact, is proposing to provide major surgical cases in a procedure room in direct contravention of hospital licensure requirements and Facility Guideline Institute ("FGI") guidelines.

According to the American Society of Heating and Refrigeration Engineers ("ASHRE"), the FGI Guidelines indicate that:

Operating room. *The OR has the most restrictive and robust minimum infrastructure requirements of the basic room types and is a restricted area that can only be accessed from a semi-restricted area.*

An OR is defined as a room "that meets the requirements of a restricted area, is designated and equipped for performing surgical or other invasive procedures, and has the environmental controls for an OR as indicated in ASHRAE 170." An aseptic field is required for all procedures, which results in the requirement for the unidirectional diffuser array.

Procedures in this room typically meet the definition of "invasive procedure" and need to be performed in the cleanest environment. Examples of invasive procedures performed in an OR include joint replacement surgery, open heart surgery, mastectomy, hysterectomy, appendectomy, cataract surgery, burn excision and arthroscopy.[3]

Based on Advent's definition of surgical MSDRGs that it has included in its projections, specific high acuity DRG groups are left out, but the only other limiting factor was a case weight of less than 3.5. See page 61.[4] This definition specifically includes procedures included in the list above that must be performed in an Operating Room, including the MSDRGs listed in **Figure 1**:

[3] https://www.hfmmagazine.com/articles/3764-design-distinctions-for-exam-procedure-and-operating-rooms

[4] Note: Advent does not provide a list of MSDRGs included in its projections but it defines several tertiary categories of services not included and notes the exclusion of DRGs with a case weight threshold of 3.5 or higher.

Figure 1
MSDRGs Included in Definition of "Appropriate" Discharges for Advent Asheville

MS-DRG	MDC	TYPE	MS-DRG Title	Weights
734	13	SURG	PELVIC EVISCERATION, RADICAL HYSTERECTOMY AND RADICAL VULVECTOMY WITH CC/MCC	2.2228
735	13	SURG	PELVIC EVISCERATION, RADICAL HYSTERECTOMY AND RADICAL VULVECTOMY WITHOUT CC/MCC	1.4135
582	09	SURG	MASTECTOMY FOR MALIGNANCY WITH CC/MCC	1.6416
583	09	SURG	MASTECTOMY FOR MALIGNANCY WITHOUT CC/MCC	1.5416
338	06	SURG	APPENDECTOMY WITH COMPLICATED PRINCIPAL DIAGNOSIS WITH MCC	2.7988
339	06	SURG	APPENDECTOMY WITH COMPLICATED PRINCIPAL DIAGNOSIS WITH CC	1.6950
340	06	SURG	APPENDECTOMY WITH COMPLICATED PRINCIPAL DIAGNOSIS WITHOUT CC/MCC	1.2284
341	06	SURG	APPENDECTOMY WITHOUT COMPLICATED PRINCIPAL DIAGNOSIS WITH MCC	2.3162
342	06	SURG	APPENDECTOMY WITHOUT COMPLICATED PRINCIPAL DIAGNOSIS WITH CC	1.4331
343	06	SURG	APPENDECTOMY WITHOUT COMPLICATED PRINCIPAL DIAGNOSIS WITHOUT CC/MCC	1.1094
509	08	SURG	ARTHROSCOPY	1.6738
469	08	SURG	MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY WITH MCC OR TOTAL ANKLE REPLACEMENT	3.0844
470	08	SURG	MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY WITHOUT MCC	1.8999

These MSDRGs are just a small sample of the surgical cases that Advent includes in its utilization projections that must be appropriately performed in an OR. Advent cannot be found conforming with Policy GEN-3 in terms of promoting safety and quality if it admittedly projects to perform surgical cases in a "procedure room" that should be performed in an OR.

Advent's project also does not maximize healthcare value for the resources expended. Advent's project essentially creates a duplication of its AdventHealth Hendersonville facility in the immediately adjoining county. Advent Hendersonville reported operating at just 49 percent occupancy of its 62 beds in FY 2021. If approved, Advent Health will have spent over $250 million to operate two poorly utilized hospitals in adjoining counties. This does not maximize healthcare value.

In its CON application at pages 40-43, Advent states that "NC DHHS DHSR has determined that procedure rooms will be regulated in licensed hospitals only to the extent such procedure rooms meet the Federal Life Safety Code Requirements." In support of this statement, Advent attaches to its application a November 27, 2012 letter from then-Director of the N.C. Division of Health Service Regulation, Drexdal Pratt, to Frank Kirschbaum, who is currently counsel for Advent but, at the time of the 2012 DHSR letter, was representing a different client. Advent uses this letter to suggest that DHSR has previously, somehow, given a wink and a nod to the use of procedure rooms as operating rooms. That is not what the 2012 DHSR letter stated or implied. Rather, that letter was produced in response to specific questions about the State's role in regulating unlicensed procedure rooms and reflected the State's limited ability to regulate procedure rooms (e.g., limited

to life safety code compliance inspections). Nothing in that letter stated or suggested that unlicensed procedure rooms were the equivalent of licensed ORs or the reverse, though that is the use Advent is trying to make of the DHSR correspondence in this review. To the contrary, the 2012 DHSR letter simply recited the State's limited ability to regulate procedure rooms in the absence of regulations designed for that purpose and precisely because they are not licensed ORs, for which State regulations already exist.

Far from supporting Advent's attempt to equate ORs and procedure rooms in this review, in which Advent attempts to circumvent the lack of need for any new ORs to support its hospital application, the DHSR 2012 letter makes the opposite point – procedure rooms are not regulated by the state, not subject to licensure regulations, and are not subject to rigorous state oversight and inspection. They are not operating rooms and cannot be used, standing alone, to develop a general surgical suite not supported by a general operating room. To suggest that procedure rooms are the equivalent of, or a safe substitute for, ORs to support a major surgical suite is absurd. Yet Advent's entire CON application rests upon that faulty premise and upon its material misrepresentation of a DHSR letter written a decade ago for a very different purpose.

Taken to its illogical extreme, Advent's position is that any hospital or ambulatory surgery center can develop as many procedure rooms as it wants, without a supporting general operating room, and perform large numbers of complex surgical procedures in these unregulated, un-surveyed, and unlicensed rooms in addition to holding itself out as being a "surgical services provider."

If the Agency permits this charade in which a new acute care hospital can operate without an Operating Room and such hospitals can blatantly operate a procedure room as an unlicensed OR, then such a precedent will entirely gut the regulation of ORs in North Carolina and render the SMFP OR need methodology meaningless. In effect, any facility, hospital, or ambulatory surgery center could build an unlimited number of unlicensed ORs and call them procedure rooms, and they would become completely fungible. Once the difference between procedure rooms and ORs is gutted, any regulation of ORs may as well be thrown out. For these reasons, Advent must be found to be an unqualified applicant and its application must be denied.

It is very clear that Advent cannot be found conforming with Criterion (1).

Criterion (3) There is No Documented Need for Advent's Project

Advent entirely fails to appropriately document the need for the project and utilization thereof and cannot be found conforming with Criterion (3). Its failure to document need for the project stems from:

- Advent's inconsistent statements regarding the need for healthcare services in the Candler area;
- Advent's failure to improve access to care;
- Advent's failure to consider the services of AdventHealth Hendersonville to the service area, the excess bed capacity at AdventHealth Hendersonville, and the impact of this project on that facility; and
- Advent's unreasonable and undocumented utilization projections including:

- The flawed assumption that inpatient and outpatient surgical patients can be served appropriately in a hospital without an OR; and
- Unsupported market share assumptions.

Each of these factors will be discussed in detail below. Please also see discussion of the acute care and surgical services performance standards below.

Advent Believes Candler is Not in Need of Additional Healthcare Services

It is wholly inconsistent that Advent chose a site in Candler for its proposed hospital. Recently, Mission filed a CON application for a new freestanding emergency department ("FSED") in the Candler area with a location less than a mile from Advent's proposed site.[5] AdventHealth Hendersonville opposed Mission's project, which was approved in May 2022 for a 12-room FSED. Advent is currently appealing the CON Section's decision to approve the Mission FSED in Candler and alleges, among other arguments, that there is no need for emergency department services in Candler, while simultaneously proposing via this application to develop ED services there. In its opposition, Advent suggests that Mission should have placed its FSED in the northern part of Buncombe County because Madison and Yancey Counties to the north of Buncombe County have no local access, and that would increase access to these two counties. Despite such claims, Advent chose to place its hospital within a mile of Mission's approved FSED, duplicating approved healthcare services. As will be shown, Advent does not increase access to care with its proposed hospital.

Advent Will Not Increase Geographic Access to Care

Figures 2 and 3 present maps of the local areas surrounding the proposed new Advent hospital and the broader western North Carolina region with the planning area counties of Buncombe, Graham, Madison, and Yancey. The location of AdventHealth Asheville does not increase access to Madison and Yancey to the north, for which Mission will remain the closest hospital. Nor does the Advent location improve access for Graham County. It is inappropriate that Advent did not consider Haywood County in its analysis or projections, given that the proposed hospital is approximately 13 miles and approximately 15 minutes straight down I-40 from the Haywood County line. This is much closer than the proximity of this site to either Graham, Madison, or Yancey Counties, and yet Advent ignored Haywood County and the fact that there is an existing similar hospital in Haywood County.

A drive time analysis demonstrates that Advent will not increase access to hospital services for any of the four planning area counties (Buncombe, Graham, Madison, and Yancey) and, in fact, does not increase access to the adjoining counties of Haywood and Henderson to the west and south of Buncombe County as shown below. AdventHealth Asheville will not be the closest hospital to the major city/town in any of these counties as shown in **Figure 4**. Most importantly, Advent's project does not increase access to care for residents of Graham, Madison, and Yancey County – the planning area counties that currently do not have a local acute care hospital.

[5] Project ID #B-012192-22.

Figure 2
Acute Care Planning Area Map and Location of New Hospital Applicants

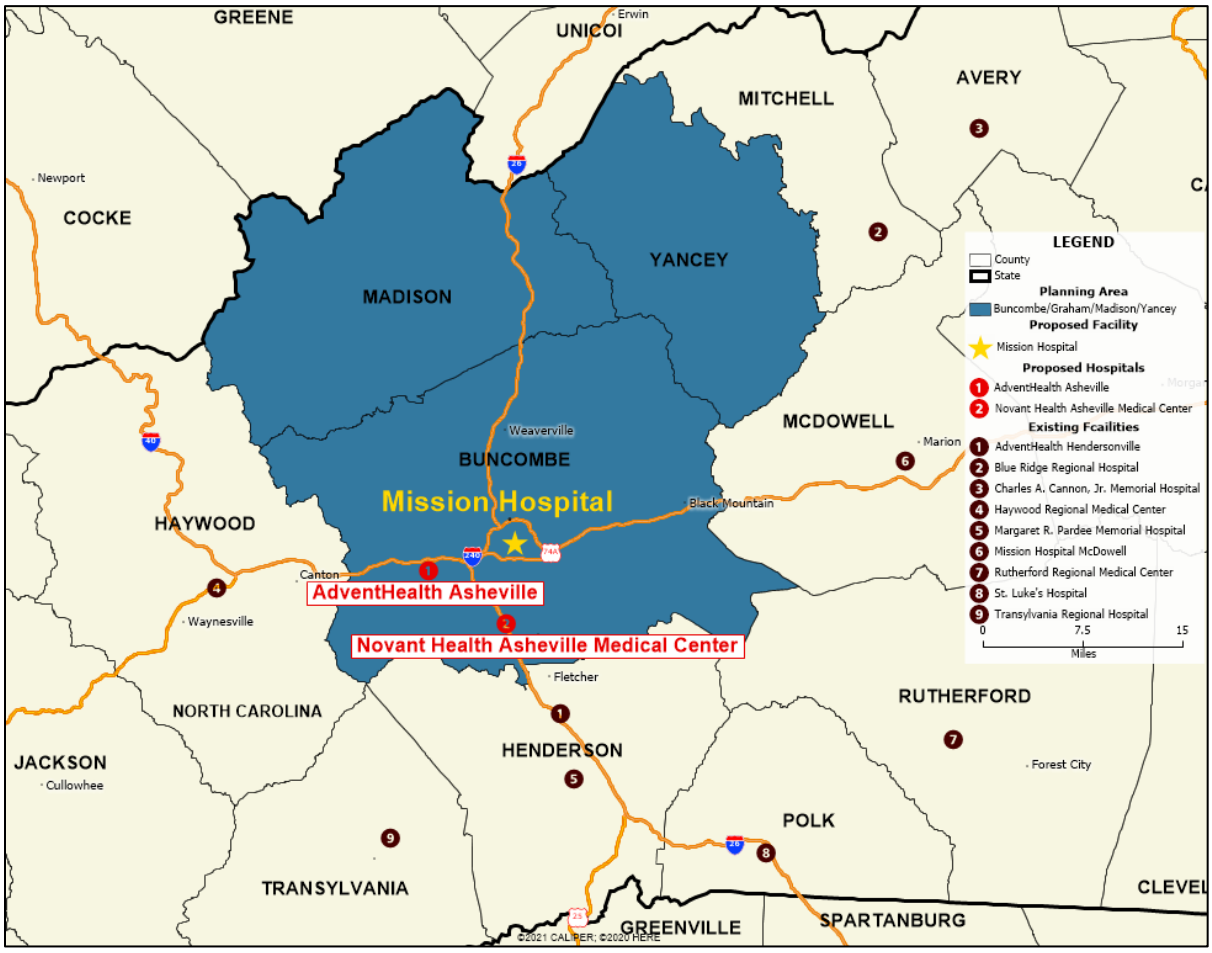


Figure 3
Acute Care Planning Area with Existing and New Hospital Locations

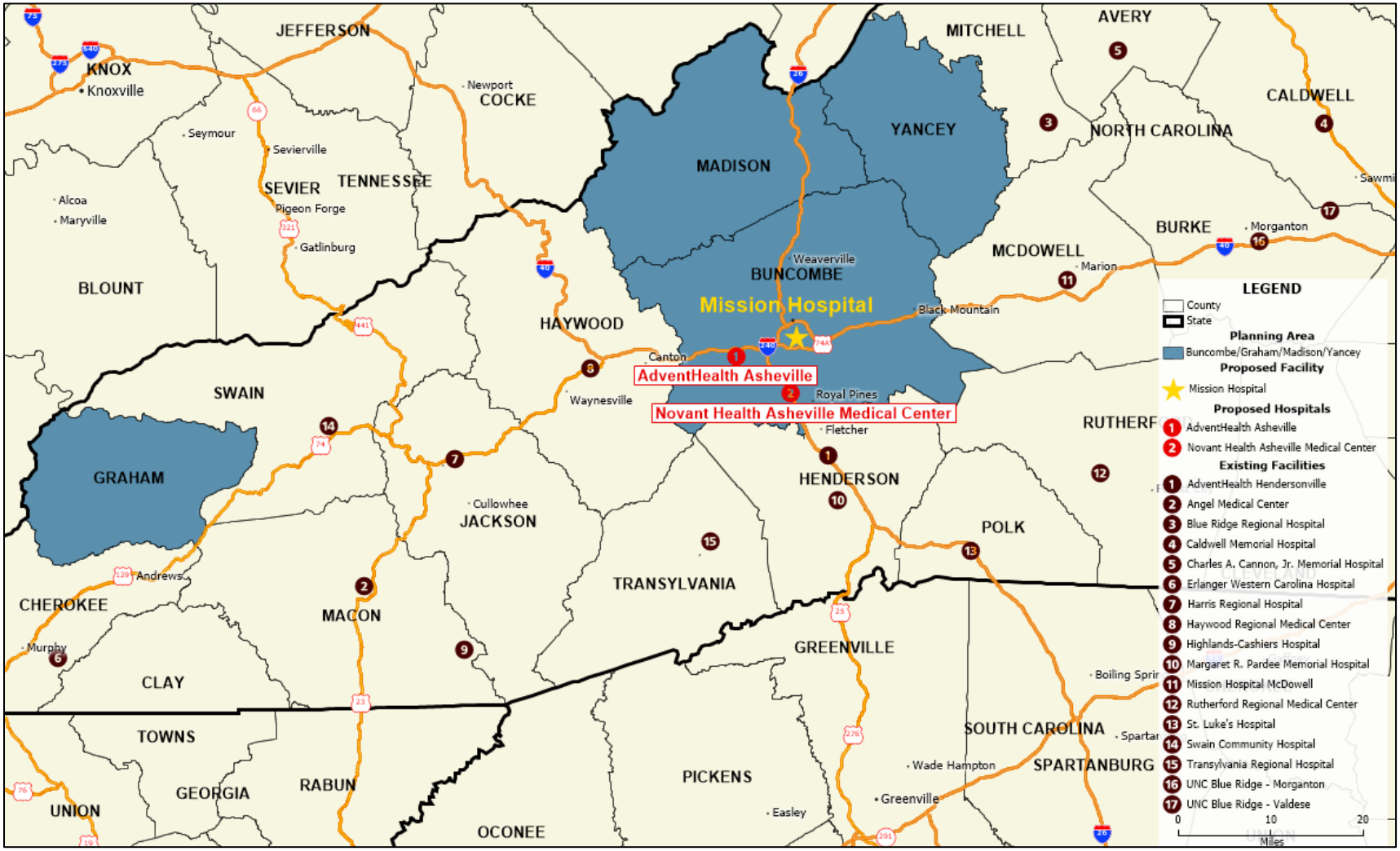


Figure 4

Drive Time Analysis (Minutes)

Hospital:	Mission	Haywood	Advent Hendersonville	Margaret Pardee	Advent Asheville	Novant
County (City, State)						
Buncombe (Asheville, NC)	5-8	28-35	24-35	28-40	12-18	16-24
Graham (Robbinsville, NC)	90-120	70-85	100-130	110-140	85-110	90-120
Madison (Marshall, NC)	26-40	50	40-55	45-65	30-40	35-45
Yancey (Burnsville, NC)	40-55	60-75	55-60	60-80	45-55	45-65
Henderson (Hendersonville, NC)	30-45	40-55	12-20	4	26-40	18-26
Haywood (Waynesville, NC)	35-50	10-16	40-55	45-60	28-40	35-50

Drive Distance Analysis (Miles)

Hospital:	Mission	Haywood	Advent Hendersonville	Margaret Pardee	Advent Asheville	Novant
County (City, State)						
Buncombe (Asheville, NC)	1.4	26.5	20.1	24.8	7.3	12.7
Graham (Robbinsville, NC)	93.1	67.4	102.0	107.0	87.5	94.7
Madison (Marshall, NC)	21.9	32.7	37.2	41.9	24.5	29.9
Yancey (Burnsville, NC)	37.8	59.7	53.2	57.9	40.5	45.9
Henderson (Hendersonville, NC)	25.9	41.7	6.5	0.7	24.0	15.3
Haywood (Waynesville, NC)	31.4	4.7	39.6	44.3	25.0	32.2

Source: Goggle 2022

Note: Depart time 8:00am

To the extent that Advent Asheville is closer to some counties than Advent Hendersonville, Advent's application does not reflect that it has considered any shift of patient volume from Advent Hendersonville to Advent Asheville as part of its projections.

Advent Fails to Consider Advent Hendersonville in its Analysis of Need and Utilization

As shown above, Advent Asheville is closer than Advent Hendersonville to several counties/cities in the area including Asheville, Marshall/Madison, and Burnsville/Yancey. Advent entirely fails to consider Advent Hendersonville in its demonstration of need and its utilization projections. Advent does not provide patient origin for Advent Hendersonville in its application; however, its 2022 LRA shows that 30.5 percent of its total FY 2021 admissions were from the planning area (Buncombe, Graham, Madison, and Yancey). Another 1.2 percent were from Haywood County, which is immediately adjacent to the proposed Advent location in Candler. See **Figure 5**. Despite this history, Advent did not project any shift in patient volume from Advent Henderson to Advent Asheville as part of the basis for its projected utilization. This is wholly unreasonable given that at minimum the proposed hospital would be more accessible for Buncombe County residents who choose Advent Asheville for care.

Figure 5

Advent Hendersonville FY 2021 Inpatient Origin and Occupancy

County	Admissions	% of Total
Buncombe	835	27.8%
Madison	55	1.8%
Yancey	29	1.0%
Graham	-	0.0%
Total Planning Area	919	30.5%
Haywood	36	1.2%
All Other	2,054	68.3%
Total Admissions	3,009	100.0%
Patient Days	11,096	
ALOS	3.69	
ADC	30	
Beds	62	
Occupancy	49.0%	

Source: 2022 LRA

In FY 2021, Advent Hendersonville operated at just 49 percent occupancy of its 62 beds. If just a portion of the historical patient base in these counties shifted to Advent Asheville, the Hendersonville facility would operate at such a low occupancy rate that its financial performance would be highly questionable. If the Advent Hendersonville patient volume from the counties above shifts, as would be expected based on the new hospital's location, then Advent Hendersonville's utilization would drop precipitously low as shown in the example set forth in **Figure 6** below. This simple analysis shows that Advent's project is highly duplicative of its existing hospital and will result in two poorly utilized, small community hospitals if Advent's project is approved. Just for an example, if Advent Hendersonville's patients from each county are grown at the county population CAGR to 2025 and then 75 percent of patients are shifted (25 percent remain), Advent Hendersonville would operate at only 39 percent occupancy.

Figure 6

Advent Hendersonville FY 2025 Projected Inpatient Origin and Utilization

County	FY 2021 Admissions	FY 2025 Admissions	% Shift	FY 2025 After Shift
Buncombe	835	855	75%	214
Madison	55	56	75%	14
Yancey	29	29	75%	7
Graham	-	-	0%	-
Total Planning Area	919	940	75%	235
Haywood	36	37	75%	9
All Other	2,054	2,146		2,146
Total Admissions	3,009	3,123		2,390
Patient Days	11,096			8,814
ALOS	3.69			3.69
ADC	30			24
Beds	62			62
Occupancy	49.0%			38.9%

Source: 2022 LRA

Admissions projected to grow based on the CAGR of Advent's service area population on page 13

Haywood County and Henderson County CAGR based on Claritas Spotlight.

Henderson County served as a surrogate for "all other".

Advent Failed to Consider Haywood Regional in its Analysis of Need and Utilization

Advent's proposed location is just 15 minutes from the Haywood County line. Nevertheless, Advent failed to consider Haywood County and any impact it might have on the existing provider in Haywood County – Haywood Regional Medical Center ("Haywood Regional"). Haywood Regional is a community hospital with 121 acute care beds and 33 behavioral health beds. Its service offerings are similar to, but more extensive than, those proposed by Advent in western Buncombe County. For example, Haywood Regional has 6 licensed ORs, and Advent will have none. Haywood has 2 fixed MRI units while Advent will only have a mobile MRI. In FY 2021, Haywood Regional operated its 121 acute beds at just 38 percent occupancy or an average daily census of just 46.8. This level of utilization and available bed capacity points to two flaws in Advent's application. First, Advent's utilization projections are unreasonably high relative to Haywood Regional's actual utilization of a larger, more robust, facility serving an immediately adjacent county. Second, any significant loss of patient volume from eastern Haywood County to Advent's proposed hospital could have a significant impact on this community hospital, which plays an important role in ensuring access to Haywood County residents needing acute care services.

Advent's Utilization Projections are Unreasonable and Undocumented

There are numerous unsupported and unreasonable assumptions contained in Advent's projections, and as a result, they are completely flawed. As noted above, Advent does not reasonably identify the MSDRGs that it will appropriately serve with no actual ORs in the hospital or how inpatient and outpatient surgical patients can be served appropriately in a hospital without

an OR. This significantly overstates the base of "appropriate" patients that serve as a starting point for Advent's projections starting on page 132 with Table Q1.

Advent's MSDRG Definition of "Appropriate" Patients is Flawed

The chosen MSDRG case weight cutoff of 3.5 relative weight is also completely inappropriate for projection purposes for a small community hospital, particularly one without a full-service surgical department containing ORs. Advent Hendersonville, as a 62-acute care bed hospital in an adjoining county, provides an excellent example of why the Advent Asheville projections are overstated with respect to acuity. Analysis of HIDI state market data for CY 2019 for Advent Hendersonville, leaving out OB and psych services, has a case mix index (CMI) of just 1.77. As shown in **Figure 7**, approximately 90 percent of admissions were for patients with DRGs less than 3.0 weight. In fact, 87 percent of patients has a weight of under 2.5, which serves as a much more appropriate benchmark to identify the patients appropriate to be served in the proposed hospital. It is entirely inconsistent with Advent's own experience to use a weight of 3.5 for the proposed new small community hospital.

Figure 7

Advent Hendersonville - DRG Weight Distribution- CY 2019

Weight Range	Admissions	% of Admissions	Cumulative %
Admissions< 1.0	479	18.3%	18.3%
Admissions 1.0 < 1.5	697	26.6%	44.9%
Admissions 1.5 < 2.0	935	35.7%	80.6%
Admissions 2.0 < 2.5	167	6.4%	87.0%
Admissions 2.5 < 3.0	57	2.2%	89.2%
Admissions 3.0 < 3.5	89	3.4%	92.6%
Admissions 3.5+	195	7.4%	100.0%
Total Medical/Surgical	**2,619**	100.0%	
Medical/Surgical CMI	***1.77693***		

Source: NC data HIDI Analytics.

Advent's use of a 3.5 case weight cutoff is even more inappropriate given that the proposed facility does not have an operating room. Advent Hendersonville has 5 licensed ORs as reported on its 2022 LRA and still has a non-OB case mix index of only 1.77. **Figure 8** further examines this point reviewing the Advent Hendersonville patients with DRG weights between 2.5 and 3.5. Please note that all but three DRGs, representing 9 patients, were surgical in nature. It is not reasonable to assume that patients in these DRGs who are included in the Advent Asheville inpatient projections could receive these complex surgeries in a hospital without an OR. Not only is this unreasonable, but it implies an inappropriate and poor quality of care.

It is clear that Advent has overstated the base of its "appropriate" inpatient admissions by including such high acuity cases. Once this starting point for the inpatient admissions is determined to be inappropriate, the rest of Advent's projections simply fall apart.

Figure 8

Advent Hendersonville - Cases Between 2.5 and 3.5 Case Weight - CY 2019

DRG	Type	Description	Cases	Weight
27	SURG	CRANIOTOMY AND ENDOVASCULAR INTRACRANIAL PROCEDURES WITHOUT CC/MCC	3	2.5118
330	SURG	MAJOR SMALL AND LARGE BOWEL PROCEDURES WITH CC	19	2.539
473	SURG	CERVICAL SPINAL FUSION WITHOUT CC/MCC	3	2.5402
982	SURG	EXTENSIVE O.R. PROCEDURES UNRELATED TO PRINCIPAL DIAGNOSIS WITH CC	1	2.5412
208	MED	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT <=96 HOURS	9	2.5423
327	SURG	STOMACH, ESOPHAGEAL AND DUODENAL PROCEDURES WITH CC	4	2.6096
164	SURG	MAJOR CHEST PROCEDURES WITH CC	2	2.6392
659	SURG	KIDNEY AND URETER PROCEDURES FOR NON-NEOPLASM WITH MCC	2	2.6648
963	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA WITH MCC	1	2.7242
468	SURG	REVISION OF HIP OR KNEE REPLACEMENT WITHOUT CC/MCC	10	2.804
406	SURG	PANCREAS, LIVER AND SHUNT PROCEDURES WITH CC	1	2.877
654	SURG	MAJOR BLADDER PROCEDURES WITH CC	1	2.9002
464	SURG	WOUND DEBRIDEMENT AND SKIN GRAFT EXCEPT HAND FOR MUSCULOSKELETAL AND CONNECTIVE TISS	1	2.9745
480	SURG	HIP AND FEMUR PROCEDURES EXCEPT MAJOR JOINT WITH MCC	20	3.0245
472	SURG	CERVICAL SPINAL FUSION WITH CC	1	3.0532
26	SURG	CRANIOTOMY AND ENDOVASCULAR INTRACRANIAL PROCEDURES WITH CC	7	3.058
469	SURG	MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY WITH MCC OR T	37	3.0844
515	SURG	OTHER MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE O.R. PROCEDURES WITH MCC	1	3.137
462	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCEDURES OF LOWER EXTREMITY WITHOUT MCC	16	3.1442
840	MED	LYMPHOMA AND NON-ACUTE LEUKEMIA WITH MCC	1	3.2157
264	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	2	3.2478
29	SURG	SPINAL PROCEDURES WITH CC OR SPINAL NEUROSTIMULATORS	2	3.295
492	SURG	LOWER EXTREMITY AND HUMERUS PROCEDURES EXCEPT HIP, FOOT AND FEMUR WITH MCC	2	3.4682

Source: NC data HIDI Analytics.

The Agency has reviewed multiple applications for small, new community hospitals in recent years. These applications provide an additional measure to test the reasonability of the "appropriate" patient MSDRG assumptions provided by Advent. For example:

- Project ID J-12029-21 Duke Green Level Hospital
  - New 40 Bed hospital with 4 ICU beds and 2 ORs.
  - Includes MSDRGs with case weights less than 2.0.[6]
- Project ID F-12084-21 Atrium Health Steele Creek
  - New 40 Bed hospital with no ICU beds and 1 OR
  - Provided a detailed MSDRG list with only 161 MSDRGs considered appropriate. Only 7 of the 161 MSDRGs had a case weight over 2.0.

The applicants in these recently approved projects provided a detailed DRG table to define appropriate patients, which Advent did not. All had at least 1 licensed OR. All defined appropriate patients with a case weight of far less than the 3.5 used by Advent. This demonstrates that Advent overstated the size of the market before it even began its projection methodology. With this faulty baseline volume, all other parts of the projection methodology are invalidated.

[6] See project findings pages 11, 22

Unreasonable and Unsupported Market Share

Once Advent projects its overstated patient base into future years, it then applies a market share assumption to this base of patients. See page 137. There is no actual quantitative basis for these market shares, which range between 10 and 20 percent in the third full year of operation. The qualitative reasoning behind the market shares discussed on page 139 is unconvincing. In particular, there are assumptions that rely on Advent Hendersonville such as:

- Privileges for physicians who care for patients in the service area, and
- AdventHealth's experience providing high quality acute care services in western North Carolina.

It is clear that Advent's historical physician base and support is not substantial enough to capture the market share it claims it will capture at the new hospital **Figure 9** demonstrates Advent Henderson's historical market share of "appropriate" patients, which was not calculated in the CON application, as well as its projected market share of Advent Asheville by county.[7] Advent projects its projected market share to triple or even quadruple its historical market presence based on the same physicians, patient base, and "quality acute care services" it already provides to the service area. This is unrealistic and unreasonable particularly given the minimal service offerings Advent can provide with no operating rooms.

Figure 9

Advent Hendersonville FY 2019 Market Share of "Appropriate" Patients

County	FY 2019 Patients Served	FY 2019 "Appropriate Patients"	Historical Advent Market Share	Projected Advent Market Share FY 2027
Buncombe	871	17,270	5.04%	18.9%
Madison	46	1,613	2.85%	15.0%
Yancey	23	1,580	1.46%	15.0%
Graham	5	678	0.74%	11.9%
Total Planning Area	945	21,141	4.47%	18.1%

Source: 2020 LRA, note Buncombe patients appear to inadvertently be listed as Beaufort patients. Advent's FY 2027 market share by county is calculated based on application pages 136 to 139.

Advent's Average Length of Stay is Overstated

Advent projects an ALOS of 3.9 days for the proposed new hospital. This is unreasonable for two reasons. First, Advent Hendersonville, with established and broader services, has an ALOS of just 3.7 based on its 2020 LRA. Second, with no actual ORs at AdventHealth Asheville versus 5 full ORs in Hendersonville, it is quite clear that lower acuity patients would have to be served at Advent Asheville, and the ALOS would be correspondingly lower. With a lower ALOS, Advent will not meet its patient day and occupancy projections or the acute care performance standards.

[7] LRA data does not breakout OB discharges in the inpatient patient origin table. In reality, Advent Hendersonville's general acute care (M/S and ICU) is even lower than presented if OB were removed.

Advent's ICU Patient Days are Overstated

Page 140 of the Advent application shows that Advent Hendersonville's ICU days have been trending downward. Despite this trend, Advent chose to use a figure of 20% of all patient days as ICU days. This is actually higher than the average of 19.5% from FY 2017 to FY 2019 and far higher than the 15.2% actually experienced in FY 2019 at AdventHealth Hendersonville. This percentage is undermined further by the fact that many ICU patients require surgery in operating rooms, which Advent will not have. Advent's assumption of the percentage of patient days in ICU beds is unreasonable and unsupported.

Advent's Surgical Projections are Flawed

Advent projects both inpatient and outpatient "surgical" cases despite the fact that the project will admittedly not have ORs. By year 3, Advent projects it will serve 3,228 surgical cases despite having no OR. This projection includes 1,093 inpatient surgical cases in year 3, which is more than Advent Hendersonville reported for FY 2021 with 6 licensed ORs (877 cases). It is absolutely unreasonable and inappropriate to project that more than 1,000 inpatients who require surgery would be admitted to a hospital that has no OR. Advent goes to great lengths to justify its assumptions of the ratio of inpatient surgical versus medical patients and inpatient to outpatient surgery patients on pages 151-153; however, it neglects the fact that all of the facilities on which its assumptions are based have licensed ORs. The ratios applied are irrelevant to a hospital with no ORs. Advent's assumptions are unreasonable and unsupported.

Advent's Emergency Department Utilization is Flawed

Like all of Advent's other projections, its ED utilization is flawed by the very same fact that it will not offer surgical services required to be provided in a licensed OR. Advent relies on various ratios of inpatient admissions and ED patient volume for existing Buncombe County residents but fails to consider that these patients are being admitted to hospitals with ORs. There are many patients who are admitted through the ED who need emergency surgery, which Advent clearly cannot provide. Advent Hendersonville's own experience further undermines Advent Asheville's projections. Based on FY 2021 data, 81.5 percent of Advent Hendersonville's admissions came through the ED, and its ratio of admissions to ED visits was 17.5 percent. As shown in **Figure 10**, this is completely inconsistent with the projections for Advent Asheville, a similarly sized hospital with even less capabilities.

Figure 10
Inconsistent ED Admission Assumptions

	Advent Hendersonville	**Advent Asheville**
ED Visits	22,567	12,706
ED Admissions	3,212	2,033
Admissions	3,943	4,899
% of Admissions from the ED	81.5%	41.5%
Ratio of Admissions to ED Visits	17.5%	38.6%

Sources: CON page 154, 2022 LRA

Advent's ED utilization projections are simply inconsistent with its own experience and fail to recognize that the proposed facility will not offer surgery as needed by many ED patients. Advent's assumptions are unreasonable and unsupported.

Advent's Other Imaging and Ancillary Services Projections are Flawed

It is quite clear that Advent's inpatient, surgery, and ED utilization projections are highly flawed. As a result, all other projections of imaging and ancillary services that rely on these basic building blocks would also be similarly flawed. Advent's assumptions are unreasonable and unsupported.

In anticipation that Advent Asheville will try to argue that its proposed location in and projected patient population from Buncombe County somehow distinguishes its proposed hospital from its existing one in Henderson County, which is belied by Advent's recent attempts to interject itself into Mission applications for freestanding EDs in Buncombe County. At every turn during those application processes, and now in appeals of those approvals, AdventHealth has claimed that it has a legal interest in those matters because it serves "the same or similar" patients as Mission in the Buncombe and Henderson County areas and offers the same or similar services. Further, for its Asheville application, Advent has relied extensively on the historical utilization experience of its Advent Hendersonville hospital. Such historical utilization has long been relied upon by the CON Section as a key, reliable, and almost indisputable measure of future projections. In the current review, Advent Asheville proposes to build a smaller hospital, with fewer services and fewer surgical capabilities than at its Hendersonville facility yet proposes to outperform its existing Hendersonville hospital on almost every meaningful metric. Such assertions are simply unrealistic.

Criterion (3) Conclusion

Advent proposes a hospital that lacks operating rooms, it does not improve geographic access, and it is not capable of admitting the range of patients it claims. As a result, it does not meet the need for this service area. Advent's projections are highly flawed for multiple reasons, but heavily based on the simple fact that it unreasonably and inappropriately assumes that the hospital will serve patients who it should not serve without an OR.

Advent's project cannot be found conforming with Criterion (3) and should be denied.

Criterion (4) Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed.

Advent fails to demonstrate that its project is either the least costly or most effective alternative. From a cost standpoint, it is clear that adding beds to an existing facility is the more cost-effective option because it only requires building the actual beds/patient care units and the associated costs. Building an entirely new hospital not only requires constructing the beds (the only service identified as needed in the SMFP), but also requires the cost to build all required ancillary and support services needed to operate a new hospital. The same is true for operating costs. Operating incremental beds in an existing hospital only requires the staff directly associated with the additional beds as opposed to the clinical, administrative, support staff, services, and overhead

required to support an entirely new hospital operation. The CON Statute sets forth a clear mandate to control costs. Approving large capital cost and operating cost projects when a much less costly alternative is available is inconsistent with this directive. If approved, Advent will operate two small hospitals, neither of which will be well utilized. This is not a less costly alternative.

Please see discussion under Criterion (12) regarding the cost of construction of a large surgical department for a hospital that does not have an OR and will not offer surgery services, which is clearly not the least costly alternative.

In terms of effectiveness, Advent's project clearly cannot operate as an effective hospital without operating rooms as discussed above. It cannot offer the range of services required nor projected. For these reasons and the associated discussion in Criterion (1), (3), (5), (12), and (20), Advent cannot be found conforming with Criterion (4).

Criterion (5) Financial Feasibility

Project Cost

As will be discussed in additional detail under Criterion (12), Advent fails to provide sufficient documentation to determine that it has appropriately included all costs required to develop the proposed hospital in the identified location. There is insufficient documentation of the costs of the land and the associated utilities and site preparation necessary to make this location suitable for a hospital. The land documentation in Exhibit K.4 does not identify a cost for the site. See further discussion under Criterion (12). Site preparation is not identified as a distinct cost by the architect and without support, Advent simply pulls out $10 million from the architect's specified construction costs and allocates this for site preparation. See Exhibit K.3 and form F.1.a.

While a number of equipment quotes are provided for larger pieces of equipment, there is no list of overall equipment provided that reconciles to the $23 million for medical equipment included in Form F.1.a. In fact, there is no other documentation for any other line item on Form F.1.a and no assumptions provided to this form. With just $193 million of the $254 million project costs documented, the total project cost is entirely speculative.

Due to the insufficiency of the documentation for a project of this magnitude, Advent should be found non-conforming with Criteria (5) and (12) on this basis alone.

Projected Utilization

As discussed in detail in Criterion (3), Advent's projected utilization is unreasonable and unsupported given that the project does not include any ORs. The surgical patients that Advent proposes to serve cannot be and should not be appropriately served in a hospital without an OR. This fact alone completely undermines Advent's utilization projections. As a result, Advent's financial projections are wholly unreasonable and undocumented.

Even if the utilization was reasonable and supported, the project is only projected to breakeven in the third year of operation with a dismal net income of just $2.6 million. The removal of just a few surgical cases from the projections or the slight underestimation of any expense, and the project will be operating at a loss.

Payor Mix

Advent claims its payor mix projections are based on the experience of Advent Hendersonville. A comparison of the actual payor mix for Advent Hendersonville reported on its 2022 LRA reveals that this is not accurate. See **Figure 11** below. These inaccuracies raise further questions regarding the payor mix assumptions that were actually utilized. The bases for the payor mix projections are unclear and undocumented. This calls into question the overall revenue assumptions and the feasibility of the project as a whole.

For these reasons and the associated discussion in Criterion (3), (8), and (12), Advent cannot be found conforming with Criterion (5).

Criterion (6) Unnecessary Duplication

Advent's project clearly duplicates the small community hospital it currently operates in Henderson County where it already serves patients from the proposed planning area. The existing Advent Hendersonville hospital is not well utilized and has significant underutilized bed capacity, as noted previously in **Figures 5** and **6**. Advent did not consider that some of its patients will shift to the proposed hospital, and that if approved, Advent's new hospital will simply be a second duplicative small community hospital with similar or lesser capabilities. Such duplication is clearly unnecessary given that both small hospitals will be only moderately utilized and have excess bed capacity.

For these reasons and the associated discussions regarding Criterion (1), (3), (4), and (18a), Advent should be found non-conforming with Criterion (6).

Criterion (7) Availability of Resources.

It is clear that the healthcare industry is facing a considerable staffing shortage in the wake of COVID. The proposed project will place further demands on the availability of staff in the planning area and region and will require Advent to compete for staff with its affiliated hospital in Henderson County. According to Advent's proposal, the development of a new duplicative hospital will require over 400 incremental FTEs by the third year of operation. This includes over 185 nursing staff and over 85 technical and therapy staff, all of whom are in high demand and in short supply. See Section Q, Form H. Advent does not clearly document how it will obtain such high levels of staffing without impacting existing providers in the service area and region.

Advent should be found non-conforming with Criterion (7).

Criterion (8) Ancillary and Support Services and Coordination

Advent's project cannot meet this criterion because a required ancillary service, namely surgery, is not appropriately proposed and should not be provided as described because the project will not include a licensed and CON-approved OR. With this omission, the project cannot be approved.

The multiple ancillary and support services proposed by Advent and required to be provided to operate a new hospital are completely duplicative of Advent's existing small community hospital already serving the planning area. Moreover, the required resources to provide all such required ancillary and support services for a new hospital are not cost effective and further exacerbate existing clinical staffing shortages.

Advent should be found non-conforming with Criterion (8).

Criterion (12) Cost and Design

Timing

It does not appear that Advent has adequately planned for the timing of the project. Advent claims that its full architectural drawings will be complete within two months of CON approval. See page 125. It is highly unlikely that Advent will incur the full cost of architectural design -- projected to be $9.5 million-- prior to approval of the CON application. In order for construction contracts to be signed just 10 weeks following approval, full drawings must be completed.

Site Entitlement, Conditions, and Utilities

Advent does not demonstrate that it has entitlement to any site despite the claim of a planned location in Candler, ZIP code 28715. The application only includes a letter from a landowner, Martin Lewis, in this area stating that up to 45 acres is available for sale in this area. Mr. Lewis of the letter is a partner in a company named Enka Partners of Asheville, LLC. No deed or further documentation is provided to either identify the site or demonstrate that Advent has any entitlement to the "Enka Partners' site." See page 104 and Exhibit K.4. The site is located on a road that has not yet been constructed and it is unclear how Advent identified a street address. The site in question is a 45-acre parcel owned by Enka Partners of Asheville, LLC. Perhaps Advent was intentionally vague about the site location as it is highly undesirable and potentially unsuitable for the development of a hospital. **Attachment A** provides an article that describes the history of the environmental contamination of the Enka Partners site and Mr. Lewis' failed attempts to develop the property for various uses.

According to the North Carolina Department of Environmental and Natural Resources ("DENR"), the proposed hospital site is adjacent to a closed landfill, also the subject of a Brownfield project. According to the DENR, a "brownfields site" is an abandoned, idled, or underused property where the threat of environmental contamination has hindered its redevelopment.[8] Also, according to the DENR, the Advent proposed site was previously used in manufacturing (production of rayon yarn) and is subject to a 1997 Brownfield Property Reuse Act remediation requirement due to the presence of environmental contamination. Please see **Attachment B**. The DENR notice for the site contains significant restrictions associated with the adjacent closed landfill, including possible groundwater issues, possible soil contamination, and below grade construction (basement). It is expressly stated that the property cannot be used for a playground, childcare center, or school and may not be used for a kennel, private animal pens, or horse-riding. With such limitations, it hardly seems possible that the site could be safely used to develop and operate a hospital.

[8] https://deq.nc.gov/about/divisions/waste-management/brownfields-program/program-information

There is no documentation provided regarding the availability of any utilities as required. See page 105. Advent has failed to appropriately document the specifics of its proposed site as required by the CON form and rules. Given the limitation of the site noted above, the ability to bring utilities to the site, the cost of such, and timing are clearly critical and undocumented in the CON.

Given that G.S. 131E-181(a) states *"A certificate of need shall be valid only for the defined scope, **physical location**, and person named in the application,"* Advent has failed to document with sufficiency its ability to acquire and construct a hospital on the identified site.

Undocumented Project Costs

Given that the architect has not drawn the proposed facility on the proposed site and no plot plan or even a legal description of the plat is provided, it is impossible to determine whether the architectural design can even be accommodated on proposed site. See Exhibit K.1 and K.2. The architect simply provides a round figure of $183,500,000 for construction and $9.5 million for architectural and engineering fees. It is unclear what this includes and if site work is sufficiently included at $10 million in Figure F.1.a.

Furthermore, the inclusion of cost estimates rounded to the nearest million, in most instances, does not reflect any site-specific, informed costing or planning by an architect who has fully investigated the cost of a new hospital on the specific proposed site. Given that other industries and uses have ultimately rejected this site due to the environmental risk associated with the history of the site, it is unclear why Advent thinks it is appropriate to build a hospital on this site. With the significant unknowns surrounding the site, it is also impossible to determine that Advent has adequately included costs for the land and associated development activities required to construct a hospital in this location, and it does not appear that Advent has done the appropriate due diligence for this location.

Unnecessary Project Costs

Finally, Advent includes in its design a full surgical department clearly meant to offer "major surgical cases" inappropriately in procedure rooms. For example, Advent's architectural drawings show two large "procedure rooms," four smaller "procedure rooms," and a large "procedure room storage" all clearly meant to be ORs. In addition, Advent's architectural drawing shows 15 post anesthesia care unit ("PACU") beds and 24 pre-op bays. In addition, large staff and physician lounges, large prep/pack area, and decontamination areas combined with the aforementioned rooms, beds, and bays take up an entire floor of the proposed hospital (total floor area 55,887 square feet). This represents approximately a quarter of the total size of the hospital, and with finishes and equipment represents some of the most expensive space within a typical hospital. See Advent Application Exhibit K.1, page 4. This exceedingly large surgical department is proposed despite the fact that there is no OR need in the service area, that Advent is not proposing to include an OR, and that Advent therefore cannot perform surgical services in an operating room environment. As the surgical department represents a quarter of the hospital square footage, it can be assumed to represent a quarter of the total cost, or over $60 million. This expenditure is proposed to provide 1,093 inpatient procedures (not surgical cases) and 1,967 outpatient procedures (not surgical cases) for a total of 3,060 total procedures. This is equal to 12.25 procedures per day in 6 procedure rooms or approximately 2 procedures (no surgery cases) per room per day. In a best-case scenario, the proposed procedure rooms are barely utilized.

Advent is proposing construction of exceedingly expensive space which cannot be used for the services it proposes (including general surgeries) and for which it has not demonstrated reasonable and reliable utilization or cost projections.

Advent should be found non-conforming with Criterion (12) for numerous reasons.

Criterion (13) Medically Underserved Population

Despite the fact that Advent purportedly used the payor mix of Advent Hendersonville as the basis for the proposed new hospital, Advent failed to actually provide any historical payor mix data for Advent Hendersonville to support its basis for comparison on this factor. A comparison of Advent Hendersonville's actual payor mix to Advent Asheville's projection demonstrates that Advent overstates its care to underserved groups. In reality, Advent will likely be far less accessible than it projects. As demonstrated below, Advent Henderson provides far less care to self-pay, charity, and Medicaid patients (collectively low-income patients) than projected in the application for Asheville as shown in **Figure 11**. This calls into question the reasonability of the payor mix projection, the true level of access that will be afforded by Advent's project, and also the financial feasibility of the proposed new hospital. See also Criterion (5).

Figure 11
Comparison of Actual and Projected Payor Mix

	Impatient Admission		Total	
Payor	**Hendersonville Actual**	**Asheville Projected**	**Hendersonville Actual**	**Asheville Projected**
Self Pay	5.3%	7.1%	3.9%	6.7%
Charity Care	0.0%	0.0%	0.2%	0.0%
Medicare	58.3%	48.7%	50.8%	44.2%
Medicaid	9.1%	15.5%	9.0%	11.1%
Insurance	24.4%	26.6%	31.4%	32.2%
Other	2.9%	2.1%	4.7%	5.7%
Total	100%	100%	100%	100%
Low Income*	**14.4%**	**22.6%**	**13.1%**	**17.8%**

Source: 2022 LRA, CON page 109-110

**Low income defined as Medicaid, self-pay, and charity.*

Criterion (18a) Advent's Project Will Not Promote Cost Effectiveness, Offer Quality Care, Increase Access, or Improve Competition

As discussed in detail above regarding Criteria (1), (3), (4), (5), (6), (7), (8), (12), (13), and below regarding Criterion (20), it is very clear that Advent does not propose a cost-effective project. The proposed new hospital does not represent the most cost-effective way in which to develop the 67 needed beds. Moreover, Advent has not justified the project cost for its project nor the associated operating costs as the project is not needed. In fact, Advent has the potential to reduce the cost-effectiveness of existing providers as it attempts to recruit over 400 new staff positions in an already constrained and highly competitive labor market.

The quality of care proposed by Advent is highly questionable since it admits that it will provide major surgical cases in unlicensed procedure rooms. This is inconsistent with licensure regulations, FGI guidelines, and the intent of the SMFP in requiring a hospital to provide surgical services. Most importantly, this willingness to flout regulations should raise major quality concerns that apparently were not revealed to the service area residents and leaders that appear to support the project. As noted above, the project will not increase access either geographically or financially to the service area.

It is important to consider the exact language of G.S. 131E-183(a)(18a) in review of the Advent application:

> *(18a) The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact.*

As discussed above, Advent's project will not create competition or increase access in three of the four service area counties: Graham, Madison, and Yancey Counties. Advent projects minimal service to these counties, which are critical as rural communities with the least access to care. Further, Advent chooses to ignore the impact of competition on immediately adjacent Haywood and Henderson Counties. Each county has existing community hospitals that Advent's proposal would duplicate, including its affiliate, Advent Hendersonville.

While Advent has the potential to add competition for a limited set of services in Buncombe County, it clearly will not have a positive impact on cost effectiveness, quality, and access to services as noted above. The applicant did not claim or demonstrate that the application is for a service on which competition will not have a favorable impact and did not address this part of Criterion (18a).

The 2022 SMFP provides further guidance to the CON Section related to interpretation of the CON statute. Specifically, the SMFP discusses balancing the notion of competition with the following public health and public policy considerations:

- A competitive marketplace should favor providers that deliver the highest quality of care and best value, but only in circumstances where all competitors deliver like services to similar populations. SMFP p. 2.
- Small and rural communities that are distant from comprehensive urban medical facilities warrant special consideration. SMFP p. 3.
- The CON Section is directed to balance competition, collaboration, and innovation in health care. SMFP p. 3.
- The Agency should focus on "reducing duplicative and conflicting care." SMFP P. 3.
- "The SHCC also recognizes the importance of balanced competition and market advantage in order to encourage innovation, insofar as those innovations improve safety, quality, access and value in health care." SMFP p. 4

Based on this directive, the notion of simply approving a new provider to a market under the guise of competition is simply wrong. The Agency must carefully review the facts of each competing proposal and consider whether in this specific review, in light of all the factors and the specific facts of each competing proposal, is there any reason to believe that a new competitor will improve safety, quality, cost and access.

Finally, the CON Section must carefully weigh what competition means in this instance. It is short-sighted to simply approve another hospital in a county just to say there are "two choices". Such a decision would overlook the following facts:

- The need was generated by the utilization of beds at a major tertiary medical center and trauma center and the approval of a basic, small community hospital will not meet that need.
- The proposed hospital is affiliated with an existing hospital in the immediately adjacent county caring for the service area, which already provides competition and choice.
- The proposed, second hospital for the Advent system will simply represent a costly duplication of the same small facility that is operating with excess bed capacity in the adjoining county.
- A second hospital represents a myriad of duplicative services and costs that simply are not needed.
- The SMFP identifies a need for beds alone and not additional "surgical" services or any other imaging, ancillary, or support services.
- The proposed hospital does not meet the requirements of a qualified hospital applicant and plainly admits it will risk quality patient care to offer "major surgical cases" without licensed ORs.
- A second hospital will require duplicative staff and will add increasing demand for clinical staff that are already in short supply. This will harm existing hospitals in the service area and the region.

Approving a new facility does not represent positive competition when there are so many harmful aspects to the introduction of a new facility in this specific review related to unnecessary costs, duplicative services, lesser or even poor quality, and a further dilution of limited clinical staff.

Advent should be found non-conforming with Criterion (18a)

Criterion (20) Quality

Advent's entire premise for the proposed hospital relies on the fact that it proposes to provide major surgical procedures in procedure rooms that are not licensed as ORs. This fact is plainly stated on page 69-70 of the application:

> ***"AdventHealth Asheville will include a dedicated C-Section OR and procedure rooms that are designed to safely accommodate major surgical procedures."***

Advent all but admits it is planning to operate an unlicensed ORs in direct contravention of the licensing requirements that require a hospital to provide surgical services, not minor procedures. According to the North Carolina licensure regulations for hospitals found at 10A NCAC 13B Section .3000 10A NCAC 13B .2102:

(i)(3) "Community Hospital," means a general acute hospital that provides diagnostic and medical treatment, either surgical or nonsurgical, to inpatients with a variety of medical conditions, and that may provide outpatient services, anatomical pathology services, diagnostic imaging services, clinical laboratory services, operating room services, and pharmacy services, that is not defined by the categories listed in this Subparagraph and Subparagraphs (i)(1), (2), or (5) of this Rule.[9]

It clearly does not represent quality care to provide major surgical procedures in a "procedure room" as opposed to the required OR, which is the standard of care.

Criteria and Standards – Advent's Project Does Not Conform to the Performance Standards for Acute Care Beds and Operating Rooms

Acute Care Bed Performance Standards
SECTION .3800 - CRITERIA AND STANDARDS FOR ACUTE CARE BEDS
10A NCAC 14C .3803 PERFORMANCE STANDARDS

(a) An applicant proposing to develop new acute care beds shall demonstrate that the projected average daily census (ADC) of the total number of licensed acute care beds proposed to be licensed within the service area, under common ownership with the applicant, divided by the total number of those licensed acute care beds is reasonably projected to be **at least 66.7 percent when the projected ADC is less than 100 patients**, 71.4 percent when the projected ADC is 100 to 200 patients, and 75.2 percent when the projected ADC is greater than 200 patients, in the third operating year following completion of the proposed project or in the year for which the need determination is identified in the State Medical Facilities Plan, whichever is later.

Advent's assumptions and basis for its utilization projections are fundamentally flawed by the inclusion of surgical DRGs that it cannot appropriately perform without a licensed OR. On page 131, Advent describes the adjustments it made to the MSDRG list of med/surg discharges "appropriate" to be served at the proposed new hospital. Several tertiary service lines are excluded that Advent does not propose to provide, including some services that the new hospital cannot perform without additional CON approval such as open-heart surgery, burns, trauma, cardiac surgery, cardiac cath, and cardiac defibrillator, inpatient rehabilitation, and behavioral health. Advent also adjusted for MSDRGs with a case weight greater than 3.5. However, these two adjustments are unreasonable for the scope of services appropriately provided in the proposed hospital for two reasons:

[9] Paragraphs (1), (2), and (5) of this rule reference the definitions for Academic Medical Center Teaching Hospital, Teaching Hospital, and Mental Health Hospital, respectively.

- There is no adjustment to remove surgical DRGs for procedures that are only appropriately provided in an OR, which Advent will not have; and
- The case weight is too high for the size of the proposed community hospital, particularly a hospital without any actual ORs.

From this point forward, the remainder of the projection methodology is clearly flawed because the starting point is unreasonable. As discussed in detail above under Criterion (3), there are numerous additional flaws with Advent's utilization projections. As a result, Advent does not meet the required Acute Care Bed Performance Standards.

OR Requirements and Performance Standards

SECTION .2100 – CRITERIA AND STANDARDS FOR SURGICAL SERVICES AND OPERATING ROOMS

10A NCAC 14C .2101 DEFINITIONS

The following definitions apply to all rules in this Section:

(1) "Approved operating rooms" means those operating rooms that were approved for a certificate of need by the CON Section prior to the date on which the applicant's proposed project was submitted to the CON Section, but that have not been licensed.

(2) "Dedicated C-section operating room" means an operating room as defined in Chapter 6 in
the annual State Medical Facilities Plan.

(3) "Existing operating rooms" means those operating rooms in ambulatory surgical facilities and hospitals that were reported in the Ambulatory Surgical Facility License Renewal Application Form or in the Hospital License Renewal Application Form submitted to the Acute and Home Care Licensure and Certification Section of the Division of Health Service Regulation, and that were licensed prior to the beginning of the review period.

(4) "Health System" shall have the same meaning as defined in Chapter 6 in the annual State Medical Facilities Plan.

(5) "Operating room" means a room as defined in G.S. 131E-176(18c).

Advent does not propose to provide any operating rooms that meet this definition. Therefore, Advent cannot appropriately respond to these criteria and standards for surgical services. However, Advent claims it will operate "procedure rooms" that are designed to safely accommodate major surgical procedures. Advent basically admits it will operate unlicensed ORs without CON approval and call them procedure rooms. See page 70.

(6) "Operating Room Need Methodology" means the Methodology for Projecting Operating Room Need in Chapter 6 in the annual State Medical Facilities Plan.

(7) "Service area" means the Operating Room Service Area as defined in Chapter 6 in the annual State Medical Facilities Plan.

10A NCAC 14C .2103 PERFORMANCE STANDARDS

(a) An applicant proposing to increase the number of operating rooms, excluding dedicated C-section operating rooms, in a service area shall demonstrate the need for the number of proposed operating rooms in addition to the existing and approved operating rooms

in the applicant's health system in the applicant's third full fiscal year following completion of the proposed project based on the Operating Room Need Methodology set forth in the annual State Medical Facilities Plan. The applicant is not required to use the population growth factor.

Advent is proposing 6 procedures rooms at least one of which will have a C-arm. At minimum, Advent is proposing to add one physical OR to the service area without a need in the area. Advent cannot have it both ways:

(1) Either it is not offering surgical services in a licensed OR and therefore cannot meet the SMFP requirements for a new acute care hospital applicant; OR
(2) It is adding at least one if not more ORs to the number of operating rooms in a service area and has not and cannot demonstrate the need for these ORs under the SMFP Operating Room Need Methodology.

Under no circumstances can Advent Health be found conforming with these standards and thus cannot be approved.

(b) The applicant shall provide the assumptions and methodology used for the projected utilization required by this Rule.

The assumptions for surgical projections included in Advent's application are wholly based on the inappropriate use of procedure rooms to provide surgeries that should be appropriately performed in a licensed operating room. Advent admits so on page 70 of its application and then expressly relies on surgical DRGs that include cases performed appropriately in an OR in its assumption for inpatient surgery projections. Likewise, Advent relies on a ratio of inpatient to outpatient operating room cases performed at Advent Hendersonville, which has 6 operating rooms and no general procedure room.

To put a finer point on the unreasonable nature of Advent's projections, Advent Hendersonville reported 6 ORs in FY 2021 on its LRA. In this actual licensed surgical department, 1,048 inpatient cases were provided, and 4,962 outpatient cases were provided in FY 2021. In the third year of operation, Advent projects to provide 1,093 inpatient surgical cases in 6 procedure rooms, more than Advent Hendersonville, despite not actually operating any licensed ORs. This is unreasonable and inappropriate for the patients who need surgical care in ORs that Advent proposes to serve.

On page 69, Advent claims the OR need methodology is not applicable and does not complete this table despite developing surgical capabilities that it claims are appropriate for "major surgical procedures" that should clearly be performed in a licensed OR. See page 70.

Advent cannot meet the surgical services performance standards that must be met if in fact, Advent will be providing surgical services in a licensed operating room, which it is required to do to develop a new acute care hospital under the 2022 SMFP.

Criteria and Standard Conclusion

First, Advent is not an appropriate applicant for a new hospital because it should not offer surgical services without an OR. If the Agency recognized Advent as approvable, it would change the very definition of a hospital within the context of health planning and CON in North Carolina. It is also very clear that Advent fails to conform with multiple review criteria both because it will not have an OR and offer surgery it is not an appropriate applicant and for numerous additional reasons and flaws that plague the application. Quite simply, Advent's project cannot be approved.

Comparative Review of Buncombe County
Acute Care Bed CON Applications

Pursuant to G.S. 131E-183(a)(1) and the 2022 State Medical Facilities Plan (SMFP), no more than 67 acute care beds may be approved for the Buncombe/Graham/Madison/Yancey County service area in this review. Because the applications in the review collectively propose to develop 201 additional acute care beds in Buncombe County, all applicants cannot be approved for the total number of beds proposed. Therefore, after considering all review criteria, Mission conducted a comparative analysis of each proposal to demonstrate why Mission is the best applicant and should be approved.

Below is a brief description of each project included in the Acute Care Bed Comparative Analysis.

- Project ID B-012233-22/**AdventHealth Asheville, Inc. ("Advent")**/ Develop a new hospital with 67 acute care beds pursuant to the 2022 SMFP Need Determination.
- Project ID B-012230-22/ **Novant Health Asheville Medical Center, LLC ("Novant")**/ Develop a new hospital with 67 acute care beds pursuant to the 2022 SMFP Need Determination.
- Project ID B-012230-22/ MH **Mission Hospital, LLLP ("Mission")**/ Develop 67 additional acute care beds at Mission's existing hospital in Asheville pursuant to the 2022 SMFP Need Determination.

As the above description of each proposed project indicates, two applicants are seeking to develop a new hospital with 67 acute care beds, while one applicant is proposing to add 67 acute care beds to its existing tertiary care hospital. Advent proposes a new small acute care hospital with 67 beds, no ORs, and 6 procedure rooms. Advent also plans to develop a C-section room, which plainly does not qualify as an OR for the purposes of a new acute care hospital. Advent's proposed small hospital plans to treat patients with low acuity levels and projects 18,287 acute care patient days and 4,889 discharges in its third full fiscal year (FY2027). Novant also proposes a new small acute care hospital with 67 beds, one dedicated C-section OR, and one OR to be relocated from the Outpatient Surgery Center of Ashville and used as a shared OR within the hospital. Novant projects18,680 acute care days and 6,531 admissions in its third full fiscal year (FY2029). Mission proposes to add 67 acute care beds to better serve its Level II trauma and tertiary care patients, resulting in a total of 800 acute care beds with 241,663 acute care patient days and 43,568 discharges in its third full fiscal year (FY2029) for the hospital as a whole, with the addition of 67 acute care beds.

In the following analysis, Mission describes the relative comparability of each competing applicant regarding those comparative criteria typically used by the CON Section and further indicates which such factors cannot be effectively compared in this review because of differences among the competing applicants.

Conformity with Review Criteria

Among the competing applicants, only the **Mission** application conforms with all applicable statutory and regulatory review criteria. **Advent** and **Novant** do not conform to several statutory and regulatory review criteria. Please see detailed discussion under each criterion that confirms:

- Advent and Novant are not conforming with the SMFP - Criterion (1).
- Neither Advent nor Novant demonstrates a need for its project or that its project will enhance geographic access – Criterion (3).
- The utilization projections for Novant and Advent are both riddled with inappropriate and unreasonable assumptions rendering them highly flawed – Criterion (3) and Acute Care Bed Performance Standards.
- Advent and Novant's projects are not the least costly or most effective alternative, as both would result in poorly utilized, limited, and small acute care hospitals and leave Mission with continuingly high occupancy rates – Criterion (4).
- Due to the flawed utilization projections and many other critical financial assumptions, neither Advent nor Novant are financially feasible as presented – Criterion (5).
- Both Novant and Advent represent unnecessary duplication of other small community hospitals already serving the service area and in particular duplicate OB services that are not well utilized at these existing, similar small hospitals – Criterion (6).
- Advent and Novant each project to hire over 400 new FTEs of clinical, support, and administrative staff, which are required to support an entirely new hospital but are not required to simply add 67 new beds to Mission's existing hospital. By creating a new hospital with redundant and unneeded ancillary, support, and administrative services, each new hospital will place extraordinary demands on already constrained staffing resources in the service area and region – Criterion (7).
- Likewise, Novant and Advent propose duplicative and redundant ancillary and support services that are not needed as only beds are identified as needed in the SMFP and neither has appropriately demonstrated the need for other proposed services. Moreover, Advent and Novant proposes OB beds that are clearly not needed based on flat to declining population and growth trends relevant to this service line – Criterion (8).
- The presented cost of the new hospitals proposed by Advent and Novant are exceedingly high, and not well documented. Advent's site is not usable as proposed and Novant's site is not appropriate for a hospital location – Criterion (12).
- Both Advent and Novant project a payor mix that is not reflective of the demand of the service area. Advent projects far less Medicaid and charity care, in particular, than the historical experience of service area hospitals, while Novant's payor mix is flawed as it claims to rely on existing providers, but its projections do not in fact equal or otherwise comport with existing providers. – Criterion (13).
- Any supposed competition that might be interjected by the hospitals proposed by Novant and Advent is offset by the fact that the proposed new hospitals will not offer the range of services that actually created the bed need in the SMFP. They will duplicate costly services,

place additional demands on already constrained staffing resources, and add costs to the system – Criterion (18a).

- Advent cannot meet the quality of care criterion or the requirements of the State's acute care licensure standards since it will not have an OR, and Advent wrongly suggests that it is appropriate to offer "major surgical cases" in procedure rooms as opposed to ORs. Likewise, Novant projects that 90 percent of its outpatient surgery cases will be performed in unlicensed procedure rooms and not in ORs as required. This similarly results in significant quality of care concerns – Criterion (20).

Therefore, **Mission** is the most effective alternative with regards to conformity with review criteria, and neither Advent nor Novant are approvable.

Scope of Services

Generally, the application proposing to provide the broadest scope of services is the most effective alternative regarding this comparative factor.

Mission is an existing tertiary care provider that offers a broad range of medical and surgical services. **Mission** provides a comprehensive range of inpatient and outpatient services, including cardiology and cardiovascular surgery, general and urologic surgery, pediatrics, orthopedics, oncology, women's services, neurology, and trauma. Among the specialized programs and referral services offered at **Mission** are a state-designated high-risk pregnancy center, interventional cardiology (including cardiac catheterization, electrophysiology, and stents), cardiac surgery (including transcatheter aortic valve replacement, left ventricular assist device placement, structural heart, and bypass surgeries), inpatient dialysis, advanced imaging, and many others.

Both **Advent** and **Novant** propose a new community hospital. However, as a smaller community hospital, neither will provide as many types of medical services as **Mission**, a Level II Adult trauma center, and a tertiary care provider. **Novant and Advent** will not offer the range of services offered by **Mission**.

Proposed Acute Care Beds (Not Including NICU)

	ICU	Step Down	Med/Surg	OB	Pediatric	Total Beds	ORs***
Mission (Incremental)	22	-	45	-	-	67	0
Mission Total*	113	160	404	44	28	749	44
Novant	8		53	6	-	67	1
Advent**	12		42	13	0	67	0

**Mission's ICU beds include Cardiac/Cardiovascular, Truama, Neuro and Med/Surg. Mission's Med/Surg beds include specialized orthpedic and oncology units. With NICU, Mission will have 800 acute care beds at the end of the project.*

***Advent proposes only a C-Section room and procedure rooms, niether of which meets the definition of an OR.*

**** Does not include C-Section Rooms*

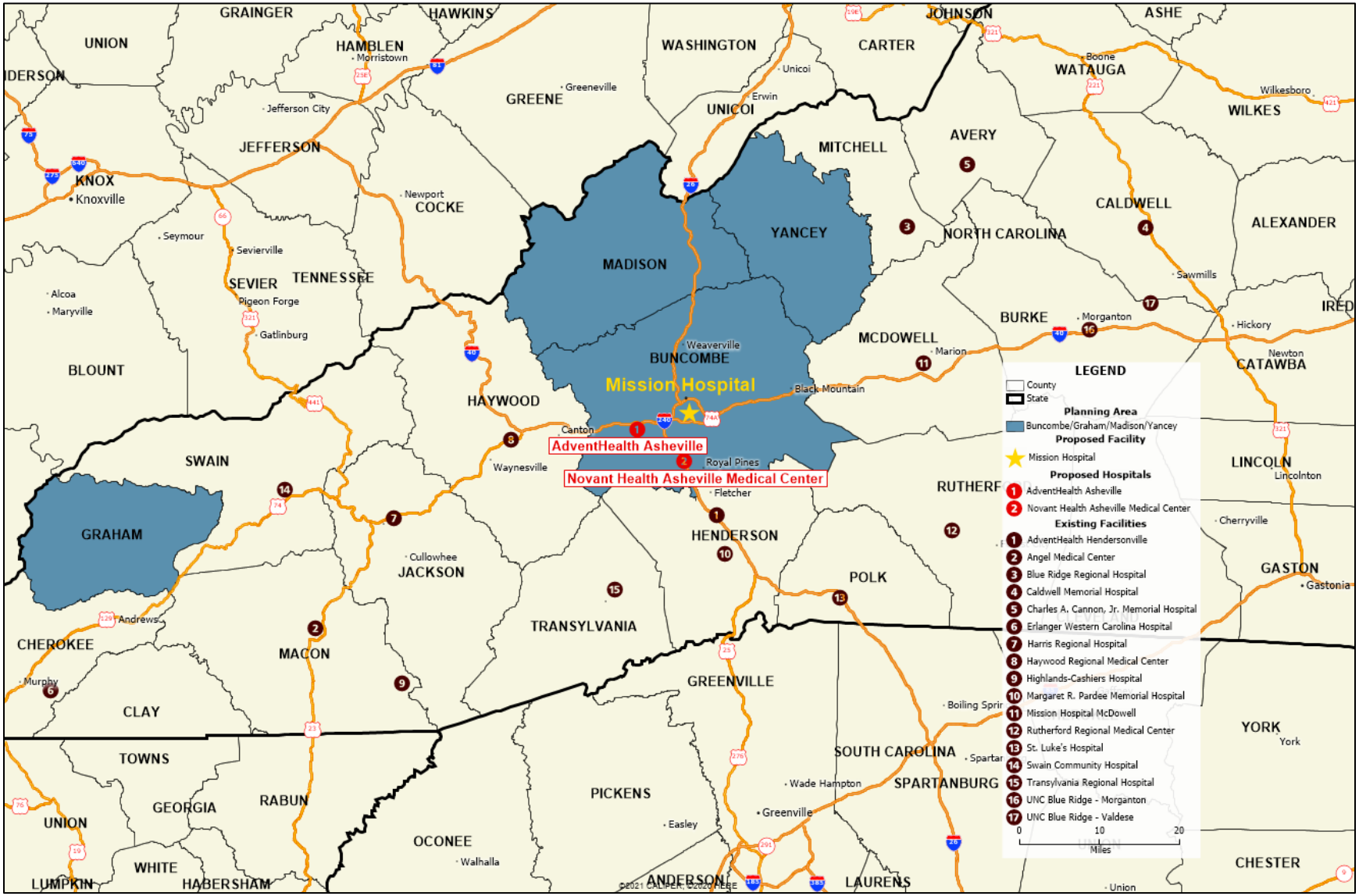
As shown in the table above, the distributions of the proposed beds for **Novant** and **Advent** include OB beds though there is no need for OB-specific services. In fact, births across the service area have declined over recent years. All nearby facilities except Mission Hospital McDowell and Harris Regional Hospital have experienced a decline in deliveries over the past 5 years. Three hospitals closed their OB services during this time, which largely contributed to the increase of births at Mission Hospital McDowell and Harris Regional Hospital. This is important because as birth rates decline, the need for OB and NICU services will also decline, which further supports the conclusion that Med/Surg and ICU beds are driving the need for additional beds in the service area, not any OB-specific beds.

Therefore, **Mission** projects the broadest range of services, specifically including those that drove the SMFP need for acute care beds in the service area, making it the most effective alternative with respect to this comparative factor. **Advent** and **Novant** are the least effective alternatives.

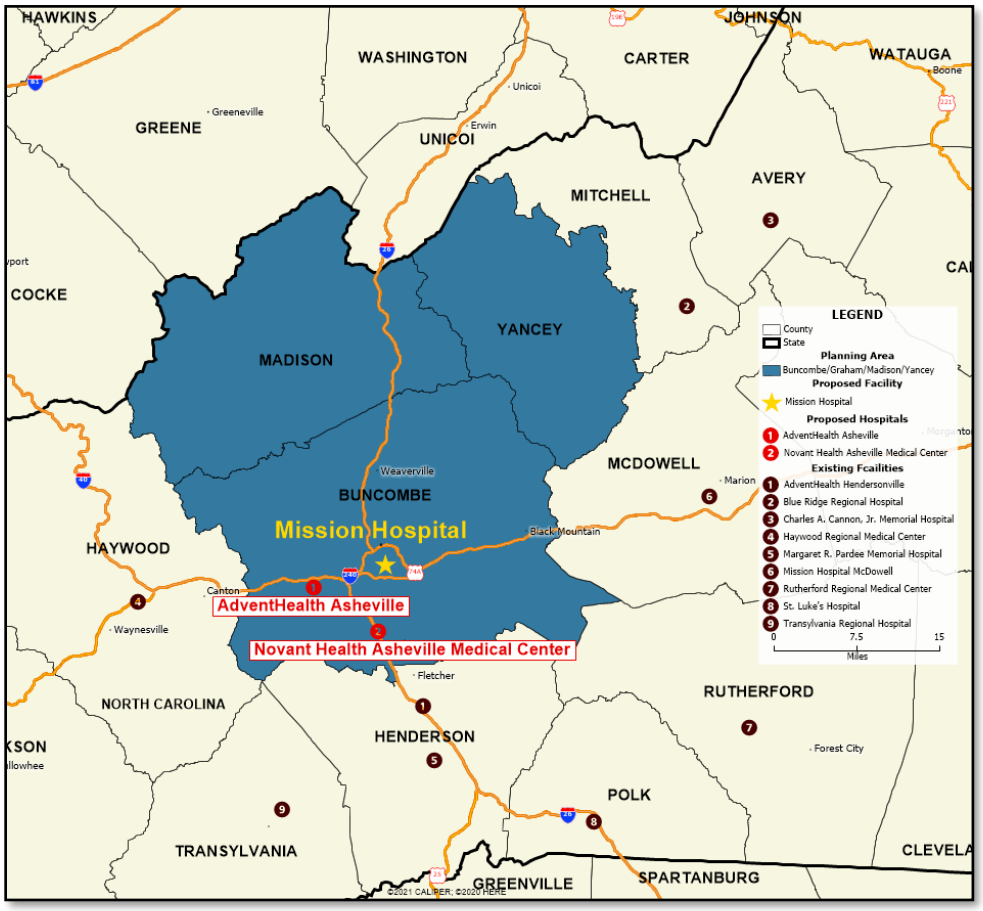
Geographic Access

There are 682 existing and approved acute care beds (not including NICU) in Buncombe County and none in Graham, Madison, and Yancey Counties, all part of the acute care planning area that generated the need. As shown in the map below, there is only one existing hospital located in Buncombe County—Mission Hospital. **Mission** proposes to add 67 acute care beds to its existing facility in Buncombe County. **Advent** and **Novant** both propose a new community hospital in Buncombe County. The following maps show the locations of **Mission** and the proposed locations of **Advent** and **Novant** as well as the other hospitals in the highlighted 4-county, SMFP defined planning area and the surrounding areas of western North Carolina region.

Buncombe, Graham, Madison and Yancey Planning Area with Existing and Approved Hospitals



Buncombe, Madison, and Yancey Counties with Existing and Proposed Hospitals



All 3 applicants proposed to develop the acute beds in Buncombe County, within 10 miles of one other. In addition, the following table shows the Drive Time Analysis in minutes and miles and demonstrates how long it will take residents from the major city in each of the acute care planning area counties and other adjacent counties to get to each of the three applicants' proposed location and other nearby facilities. The Drive Time Analysis shows that of all the hospitals, **Mission** is the most accessible to the residents of 3 of the 4 counties in the planning area (Buncombe, Madison, and Yancey). In comparison, neither **Advent** nor **Novant** improve access for any of the counties in the planning area.

Drive Time Analysis (Minutes)

Hospital:	Mission	Haywood	Advent Hendersonville	Margaret Pardee	Advent Asheville	Novant
County (City, State)						
Buncombe (Asheville, NC)	5-8	28-35	24-35	28-40	12-18	16-24
Graham (Robbinsville, NC)	90-120	70-85	100-130	110-140	85-110	90-120
Madison (Marshall, NC)	26-40	50	40-55	45-65	30-40	35-45
Yancey (Burnsville, NC)	40-55	60-75	55-60	60-80	45-55	45-65
Henderson (Hendersonville, NC)	30-45	40-55	12-20	4	26-40	18-26
Haywood (Waynesville, NC)	35-50	10-16	40-55	45-60	28-40	35-50

Drive Distance Analysis (Miles)

Hospital:	Mission	Haywood	Advent Hendersonville	Margaret Pardee	Advent Asheville	Novant
County (City, State)						
Buncombe (Asheville, NC)	1.4	26.5	20.1	24.8	7.3	12.7
Graham (Robbinsville, NC)	93.1	67.4	102.0	107.0	87.5	94.7
Madison (Marshall, NC)	21.9	32.7	37.2	41.9	24.5	29.9
Yancey (Burnsville, NC)	37.8	59.7	53.2	57.9	40.5	45.9
Henderson (Hendersonville, NC)	25.9	41.7	6.5	0.7	24.0	15.3
Haywood (Waynesville, NC)	31.4	4.7	39.6	44.3	25.0	32.2

Source: Goggle 2022

Note: Depart time 8:00am

Therefore, none of the applicants meaningfully change geographic access to the Buncombe/Graham/ Madison/Yancey County service area. **Mission** will continue to be the most proximate provider to Madison and Yancey County. Geographic access should be found to be inconclusive or that **Mission** is the most effective applicant.

Historical Utilization

The table below shows acute care bed utilization for existing facilities based on acute care beds and days reported on the 2022 LRAs, excluding NICU services days and beds. Generally, the applicant with the higher historical utilization is the more effective alternative with regards to this comparative analysis factor.

Historical Acute Care Bed Utilization Comparison*

Hospital/Applicant in Market	Beds	Patient Days	ADC	% Occupancy
Mission	682	210,716	577	84.6%
Advent Hendersonville	62	11,096	30	49.0%
Novant	NA	NA	NA	NA

Source: 2022 LRAs

**Acute care beds not including NICU services*

As shown in the Table above, **Mission's** historical utilization **is** higher than **Advent's** existing facility, Advent Hendersonville, near Buncombe County. **Novant** does not have an existing facility near nor in the Buncombe County service area and thus has no historical utilization.

Therefore, a comparison of historical utilization cannot be effectively conducted between all three applicants. However, **Mission** is the most effective alternative among the two comparable applicants.

Projected Utilization and Bed Capacity

The following table shows each facility's projected acute care bed utilization, excluding NICU services days and beds. Generally, the applicant with the higher projected utilization is the more effective alternative regarding this comparative analysis factor in terms of the effectiveness of use of the proposed beds.

Projected Acute Care Bed Utilization Comparison*

Hospital/Applicant in Market	Beds	Admissions	Patient Days	ADC	% Occupancy
Mission	800	43,568	243,078	665.97	83.2%
Advent Hendersonville**	67	4,899	18,287	50.10	74.8%
Novant	67	6,531	18,680	51.18	76.4%

Source: 2022 LRAs

**Acute care beds not including NICU services*

***Advent's projections are not reasonable as they include surgical inpatients with surgical cases that cannot be appropriately performed without an OR.*

As shown in the table above, **Mission's** projected utilization is higher than **Advent's** and **Novant's.** As discussed above, there are also numerous flaws in the utilization assumptions of both **Advent** and **Novant**, which result in inaccurate projected utilization. Therefore, with regard to projected utilization, **Mission** is the most effective alternative; **Advent** and **Novant** are the least effective alternatives.

Service to the Planning Area Counties (Access by Service Area Residents)

On page 33, the 2022 SMFP defines the service area for acute care beds as *"... the single or multicounty grouping shown in Figure 5.1."* Figure 5.1, on page 38, shows the multicounty grouping of Buncombe/Graham/Madison/Yancey Counties as the acute bed service area. Thus, the service area for this review of acute care beds is Buncombe/Graham/Madison/Yancey Counties. Facilities may also serve residents of counties not included in the service area. Generally, the application projecting to be the most accessible to Buncombe/Graham/Madison/Yancey County residents is the most effective alternative with regards to this comparative factor.

Inpatient Admissions of Patients from the Acute Care Planning Area

	Advent*		Novant		Mission	
	3rd Full FY		3rd Full FY		3rd Full FY	
Buncombe	3,782	85.8%	5,450	97.0%	20,412	86%
Madison	267	6.1%	90	1.6%	1,961	8%
Yancey	265	6.0%	65	1.2%	1,213	5%
Graham	95	2.2%	16	0.3%	276	1%
Total Planning Area	4,409	100.0%	5,621	100.0%	23,862	100%
Henderson	?	?	910		3,196	

Sources: Applications, Section C, Question 3.
**Advent's projections are flawed by the inclusion of surgical cases that cannot be performed without and OR. Advent unreasonably does not identify any projected patients from either Henderson County or immediately adjacent Haywood County.*

The table above shows the patient origin for admissions from the acute care planning area for each proposed facility. It is important that the agency look beyond a simple percentage when evaluating this factor and not ignore the services actually needed by the projected patients and the various roles that hospitals play, especially a regional tertiary provider and trauma center like Mission. This is because such a simplistic analysis ignores this significant role and can in fact penalize the applicant serving in this role as it serves a significant percentage of patients from outside the planning area. The table shows that **Mission** is projected to serve the most patients in the planning area counties, including the most patients from Madison, Yancey, and Graham Counties. In comparison, both **Advent** and **Novant** serve only a small fraction of the patients projected by **Mission,** particularly for Madison, Yancey, and Graham Counties.

Therefore, with regard to service to the planning area, **Mission** is the most effective alternative, and **Novant** and **Advent** are the least effective alternatives.

Historical Financial Access

Two of the applicants, **Mission** and **Advent**, are already serving the planning area directly or through an affiliated hospital (e.g., Advent Hendersonville). A review of the historical level of financial accessibility for these two providers gives an indication of the likely projected financial accessibility of each applicant. The following table provides a comparison of the historical payor mix for all services reported on the 2022 LRAs for Mission and Advent Hendersonville.

Facility Total Historical Payor Mix			
Historical	**Mission**	**Advent**	**Novant**
Self Pay	4.3%	3.9%	NA
Charity Care	2.4%	0.2%	NA
Medicare	47.3%	50.8%	NA
Medicaid	16.5%	9.0%	NA
Insurance	26.1%	31.4%	NA
Other	3.4%	4.7%	NA
Total	100.0%	100.0%	NA
Total Low Income*	**23.2%**	**13.1%**	NA

Source: 2022 LRAs

Mission serves a significantly larger percentage of self-pay, charity care, and Medicaid patients, collectively low-income patients, than Advent Hendersonville. Thus, **Mission** is most effective in this comparative factor.

Projected Financial Access (Access by Underserved Groups)

"Underserved groups" is defined in G. 131E-183(a)(13) as follows:

> *"Medically underserved groups, such as medically indigent or low income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and handicapped persons, which have traditionally experienced difficulties in obtaining equal access to the proposed services, particularly those needs identified in the State Health Plan as deserving of priority."*

For access by underserved groups, the applications in this review are compared with respect to three underserved groups: charity care patients (i.e., medically indigent, or low-income persons), Medicare patients, and Medicaid patients. Access by each group is treated as a separate factor.

Projected Charity Care

The following table shows projected charity care during the third full fiscal year following the completion of the project for each applicant. Generally, the application projecting to provide the most charity care is the more effective alternative with regard to this comparative factor.

Projected Charity Care - 3rd Full Fiscal Year				
Applicant	**Total Facility Charity Care**	**Admissions**	**Estimated Charity Admissions**	**% of Total Gross Patient Revenue**
Mission	$ 347,713,911	43,568	1,676	3.85%
Advent*	$ 8,718,032	4,899	138	2.83%
Novant**	$ 40,356,776	6,531	347	5.32%

**Advent projects 1,405 charity care patients in Section L but the equivalent of only 138 patients in Section Q. Form F.2B*

***Novant's charity care projections are suspect as they are equal to more than double the self pay payor mix.*

Based on the pro forma financial statements, **Mission**'s percentage of charity care to gross patient revenue is estimated to be 3.85 percent. **Advent**'s projected charity care is 2.83 percent, meaning they are proposing to provide less charity care than **Mission**. **Novant** is projecting to provide more charity care than **Mission** and **Advent**, with 5.32 percent of charity care to gross patient revenue. However, **Novant**'s charity care projections appear unrealistic since its charity care projection is more than double its self-pay percentage projection. It should be noted that **Novant** claims in its application that it based its projected charity care on Mission's experience, with no other basis, but then substantially exceeds **Mission**'s actual and projected charity care without any explanation as to why or any supporting assumptions. **Novant**'s projections are rendered unreliable as a result.

Therefore, regarding charity care, **Mission** is the most effective applicant. **Novant** and **Advent** are the least effective alternatives.

Projected Medicare

The following table shows projected Medicare revenue during the third full fiscal year following project completion for each applicant. Generally, the applicant projecting the highest Medicare revenue is the more effective alternative with regard to this comparative factor.

Projected Medicare Revenue - 3rd Full Fiscal Year				
Applicant	**Total Facility Medicare Revenue**	**Admissions**	**Estimated Medicare Admissions**	**% of Total Gross Patient Revenue**
Mission	$ 4,481,645,969	43,568	21,605	49.59%
Advent	$ 145,422,843	4,899	2,309	47.13%
Novant	$ 365,749,147	6,531	3,149	48.21%

Based on its proforma, **Mission's** percentage of Medicare revenue to gross patient revenue is estimated to be 49.59 percent. **Advent's** percentage of projected Medicare revenue to gross revenue is 47.13 percent, and **Novant's** percentage of projected Medicare revenue to gross revenue is 48.21 percent. Both Advent and Novant project less Medicare revenue than **Mission.**

Therefore, regarding Medicare Revenue, **Mission** is the most effective applicant. **Novant** and **Advent** are the least effective alternatives.

Projected Medicaid

The following table shows projected Medicaid revenue during the third full fiscal year following project completion for each applicant. Generally, the applicant projecting the highest Medicaid revenue is the more effective alternative with regards to this comparative factor.

Projected Medicid Revenue - 3rd Full Fiscal Year				
Applicant	**Total Facility Medicaid Revenue**	**Admissions**	**Medicaid Revenue per Admission**	**% of Total Gross Patient Revenue**
Mission	$ 1,577,929,797	43,568	7,607	17.46%
Advent	$ 40,334,818	4,899	640	13.07%
Novant	$ 118,220,399	6,531	1,018	15.58%

Based on its pro forma, **Mission's** percentage of Medicaid revenue to gross patient revenue is estimated to be 17.46 percent. **Advent's** projected percentage of Medicaid revenue to gross patient revenue is estimated to be 13.07 percent. **Novant's** percentage of Medicaid revenue to gross patient revenue is estimated to be 15.58 percent. Both Novant and Advent project less Medicaid revenue than **Mission.** This is particularly notable given that both **Advent** and **Novant** propose to offer OB services, which is typically a high Medicaid service line.

Therefore, in regard to Medicaid Revenue, **Mission** is the most effective applicant. **Novant** and **Advent** are the least effective alternatives.

Projected Average Net Revenue per Admission

The following table shows the projected average net revenue per patient in the third full fiscal year following project completion for each applicant. Generally, the application projecting the lowest average net revenue per patient is the more effective alternative with regard to this comparative factor. However, differences in the acuity level of patients at each facility, the level of care (community hospital, tertiary care hospital, etc.) at each facility, and the number and types of surgical services proposed by each facility significantly impacts the simple averages shown in the table below.

Projected Case Mix Adjusted Net Revenue per Admission

Applicant	**Total Admissions**	**Gross Revenue**	**Average Net Rev per Admission**
Mission	43,568	1,627,733,826	$ 37,361
Advent	4,899	106,965,286	$ 21,834
Novant	6,531	174,997,647	$ 26,795

Such a comparison can be performed using publicly available Case Mix Index (CMI) data for existing and comparable hospitals. Mission's projections can be evaluated based on its historical CMI. Novant's projections can be evaluated based on the CMI for Novant Health Mint Hill Hospital, which was used as a basis for many of Novant's projections. Advent Hendersonville could be considered as a CMI surrogate for Advent; however, Advent Hendersonville has 6 ORs and provides a range of surgical cases that Advent's proposed facility will not be able to offer, thus resulting in a CMI that would be too high for the proposed Advent Hospital. Noting that Advent cannot function as a licensed hospital without an OR, the SMFP listing of licensed hospitals

includes several small hospitals operating with just 1 or 2 ORs. The vast majority of these are Critical Access Hospitals ("CAH"). There are no non-CAH facilities in North Carolina that are operating without an OR. There is one non-CAH facility in North Carolina that operates 1 OR.[10] This hospital, Atrium Health Anson, was used as a surrogate for Advent.

Hospital	CMI
Mission Hospital	2.0133
Advent Hendersonville	1.7405
Novant Health Mint Hill	1.2227
Atrium Health Anson	1.1304

Source: https://www.cms.gov/medicare/acute-inpatient-pps/fy-2022-ipps-final-rule-home-page
2022 LRAs and SMFP

When the average net revenue per admission is case mix adjusted, **Mission's** CMI average adjusted net revenue per admission is lower than both **Advent** and **Novant.**

Projected Case Mix Adjusted Net Revenue per Admission

Applicant	Total Admissions	Gross Revenue	Average Net Rev per Admission	CMI	CMI Adjusted Net per Admission
Mission	43,568	1,627,733,826	$ 37,361	2.0133	$ 18,556.98
Advent*	4,899	106,965,286	$ 21,834	1.1300	$ 19,322.22
Novant**	6,531	174,997,647	$ 26,795	1.2227	$ 21,914.55

Source: https://www.cms.gov/medicare/acute-inpatient-pps/fy-2022-ipps-final-rule-home-page
**Advent Health - Atrium Health Anson used as a surrogate based on the operation of just 1 OR.*
***Novant Health - Mint Hill used for surrogate*

Therefore, with regard to projected average net revenue per admission, given the extreme variation in service offerings and acuity levels between the applicants, this comparative factor is inconclusive. If acuity is considered and the projections are case mix adjusted, **Mission** is the most effective proposal.

Projected Average Expenses per Admission

Total Expense
The following table shows the projected average expense per admission in the third full fiscal year following project completion for each applicant. Generally, the application projecting the lowest average total expense per surgical case is the more effective alternative with regard to this comparative. However, in this instance the service offerings cannot be compared between a regional tertiary trauma provider and two small community hospitals, which renders a simple comparison inconclusive. As noted above, when the projections for the three applicants are case-

[10] This does not include specialty or LTACH facilities.

mix adjusted for acuity, then an appropriate comparison can be rendered. As shown below, **Mission** is the most effective provider based on CMI adjusted projected average expense per admission.

Projected Average Expense per Admission - 3rd Full FY

Applicant	Total Admissions	Total Expense	Average Expense per Admission	CMI	CMI Adjusted Expense per Admission
Mission	43,568	1,281,326,998	$ 29,410	2.0133	$ 14,608
Advent*	4,899	104,301,203	$ 21,290	1.1304	$ 18,834
Novant**	6,531	158,897,293	$ 24,330	1.2227	$ 19,898

Source: https://www.cms.gov/medicare/acute-inpatient-pps/fy-2022-ipps-final-rule-home-page

**Advent Health - Atrium Health Anson used as a surrogate based on the operation of just 1 OR.*

***Novant Health - Mint Hill used for surrogate*

Project Costs

The table below shows the projected cost for each project. Generally, the applicant who projects the lowest project cost should be found to be the most effective alternative regarding this comparative analysis factor based on the clear directive of the CON Statute to contain costs. The Agency does not always consider project cost in the comparatives analysis, but cost containment is a basic premise of CON statue. In this instance there are three proposals to bring 67 beds to the community and 3 vastly different costs. Thus, the cost effectiveness of the project should be considered in this comparative analysis.

Applicant	Project Cost	Variance from Low Cost Option
Mission	$ 125,045,000	
Advent	$ 254,125,000	$ 129,080,000
Novant	$ 328,729,394	$ 203,684,394

As displayed in the table above, **Mission** has the lowest project cost. **Advent** has the second lowest cost, which is a little over double the project cost of **Mission**. **Novant** has the largest project cost, which is almost triple that of **Mission**'s project cost.

Therefore, in regard to cost, **Mission** has the lowest project cost making it the most effective applicant. **Novant** and **Advent** are the least effective alternatives.

Project Timing

The table below shows the date when the acute care beds will come online (when beds will be available for use) as reported in each applicant's proposal. Generally, the applicant who can have beds available the soonest is the most effective alternative regarding this comparative analysis factor.

Beds Online and Available

Mission	12 beds January 2023	45 beds 6/1/2026
Advent*		1/1/2025
Novant		1/1/2027

**Advent's projected timeline is unreasonable given the planning involved in a new hospital, the global supply chain issues, and the site work required for an inappropriate and undesirable site.*

As shown in the table above, **Mission** will be the first to get beds online. Upon approval of its application, Mission will be able to bring 12 beds online in January 2023. As mentioned in **Mission's** application, **Mission** is experiencing incredibly high occupancy rates and a growing demand for its high acuity services, factors that actually generated the bed need in the 2022 SMFP. **Mission** projects to have all 67 beds online on 6/1/2026, which is sooner than **Novant's** projection date of 1/1/2027, but later than **Advent's** date of 1/1/2025. However, **Advent's** timing is unrealistic for multiple reasons including the fact that there is no confirmed entitlement to any site and the site identified has serious issues relating to potential mitigation of hazardous material. As a result, **Advent** has included insufficient time to complete due diligence on the site between approval and prior to its proposed 1/15/2023 acquisition, no time allotted for site mitigation and site prep, and insufficient time for full architectural and engineering drawings.

Therefore, with regard to timing, **Mission** will have beds online more quickly than the other applicants, making it the most effective applicant. Although **Advent's** projection indicates that its total number of beds will be available sooner, Advent's proposed project schedule does not appear realistic for the reasons regarding its site detailed in Mission's comments on the Advent application. Mission is the most effective alternative regarding this comparative factor.

Staffing Resources and Needs

Often, the Agency compares projected FTE per admissions, case, or other measure of utilization. In this instance, such a comparison is not conclusive because two applicants proposed new facilities and all new FTEs, and one applicant is an existing provider adding incremental FTEs. Given the severe staffing shortages, particularly clinical staff, which are impacting the healthcare industry in the wake of COVID-19, it is critical to evaluate in this review the impact of staff recruitment on already short supplies and the potential for resultant increases in staffing costs that may impact existing providers in the entire region. In this instance, a more relevant measure for this review is the total new FTEs to be recruited to support the need, which is simply for 67 acute care beds.

The table below shows the sum of the total FTEs proposed by each applicant for the third fiscal year. For **Mission**, this reflects the incremental FTEs only associated with the opening of the 67 new beds. This comparative measure demonstrates the impact of the project in terms of total FTEs and types of positions that will need to be recruited in today's highly competitive job market. Generally, the applicant who has the lowest number of new FTEs will have the least impact on the competitive job market, while the applicant with a greater FTE need will have the greatest potential

to impact existing providers by recruiting away staff through competition for these limited resources and driving up costs for all existing providers.

Incremental Staffing Requirements

	Advent	Novant	Mission Incremental
Nursing, CRNA, and Nursing Supervision	188	260	75.5
Technical Staff (Surgical, Imaging, Therapy, Pharmacy, Other)*	89	159	
Support Staff	80	43	
Administrative and Clerical Staff**	44.9	2.0	
Total	401.7	464.4	75.5

**Note: Advent's staffing plan does not show any therapists except for respiratory.*

*** Note: Novant's staffing plan only shows 1.0 FTE President, an executive assistant, and no other senior administrative leadership.*

As shown in the table above, **Mission** will require the smallest number of newly recruited positions/FTEs and can therefore staff its project most efficiently with the lease potential impact on existing providers**.** Therefore, in regard to staffing resources, **Mission** is the most effective applicant. **Novant** and **Advent** are the least effective alternatives.

Competition (Impact on Quality, Safety, Access, Cost Effectiveness, and Value)

There are 733 existing and approved acute care beds located in Buncombe County and no acute care hospital beds in Graham, Madison, and Yancey Counties. Graham, Madison, and Yancey Counties are included in the planning area for the calculation of the bed need methodology due to their reliance on Mission as the regional tertiary care and trauma provider. However, planning area residents utilize numerous other community and rural hospitals in the region including UNC Pardee Hospital, Advent Hendersonville, Haywood Regional Medical Center, Blue Ridge Regional Hospital, Swain County Community Hospital, and Harris Regional Hospital, to name a few.

In terms of regional tertiary and trauma services, **Mission** is the only existing provider and the only applicant offering this range of services that are critical to the region. In terms of small community hospitals with a limited range of services, there are multiple competing hospitals already offering the same services as those proposed by **Advent** and **Novant**. **Advent**'s project simply duplicates its similarly sized existing hospital, Advent Hendersonville, located approximately 4 miles from the Buncombe County line, and does not enhance competition. **Novant**'s project proposes the development of a new provider in the planning area, but it simply duplicates the existing community hospitals already serving the planning area. Novant's project does not increase geographic access given that it is less than 10 miles from Advent Hendersonville.

In the past, the Agency has taken a rather one-dimensional approach to competition, often concluding that any new provider represents beneficial competition and ignoring the fact that the high and often specialized utilization of existing providers generated the need in the SMFP for a given review. This approach ignores the fact that quite often the provider generating the need offers

more complex and diverse services than those which can be offered by a new provider. Moreover, the cost to establish a new provider or facility is often far more than simply adding the needed service to existing facilities that created the SMFP need, as is the case in this review. In such cases, approving a new provider simply because they represent new "competition" represents a costly duplication of services. Mission encourages the Agency to consider the competition factor in combination with other equally important CON Statutory criteria, such as unnecessary duplication of services, limiting costs, and serving the needs of the service area population based on the scope of services provided, not just additional beds proposing to serve types of patients for which adequate services already exist. This balancing of criteria is specifically directed by the SHCC on page 3 of the 2022 SMFP.

It is important to note that competition can only be evenly measured when the competitors are delivering like services to a similar population. In this instance, the proposed two new community hospitals will not be offering like services to those already offered by Mission, which Mission proposes to expand. However, there are aspects of each proposal that can be compared for the various competitive factors including quality, safety, access, cost effectiveness and value. The table below provides such a comparison.

In this review, it is clear that the two applicants proposing new hospitals, **Advent** and **Novant,** do not represent beneficial competition and will actually have a negative impact on competition. **Mission**'s project is the least costly and offers the highest acuity and broadest range of services. **Mission** also provides the most positive impact on competition without the negative impacts associated with the costly and duplicative services proposed by the other two applicants. For these reasons, the Agency should find that competition is either inconclusive, due to fact that "like services" are not proposed or find that **Mission** will have the most positive (or least negative) impact on competition.

Summary of Impact of Competition			
Factor:	**Mision**	**Advent**	**Novant**
Impact of Competition on Quality:	Expands existing high quality services including access to tertiary and trauma care.	- Proposes only basic community hospital service that already exist. - Proposes to inappropriately offer "major surgical cases" in unlicensed procedure rooms.	- Proposes only basic community hospital service that already exist. - Proposes to inappropriately to provide 90% of outpatient surgery cases in unlicensed procedure rooms.
Impact of Competition on Safety:	- Mission is known for its safety score ratings. - The project will expand care to such services.	- Proposal to inappropriately offer "major surgical cases" in unlicensed procedure rooms is a significant safety concern.	- Proposal to inappropriately to provide 90% of outpatient surgery cases in unlicensed procedure rooms is a significant patient safety concern.
Impact of Competition on Access to Care:	- Serves the most patients within the four-county service area. - Provides the broadest range of services. - Provides the most favorable access to low income and underserved patients.	- Serves minimal patients from Graham, Madison, and Yancey Counties. - Provides only basic community hospital services that duplicate existing hospitals. - Does not provide favorable access to low income and underserved patients.	- Serves minimal patients from Graham, Madison, and Yancey Counties focusing instead on Henderson County. - Provides only basic community hospital services that duplicate existing hospitals. - Does not provide reasonable projections of access to low income and underserved patients.
Impact of Competition on Cost Effectiveness:	- Proposes the lowest capital cost project. - Does not add costly ancillary and support services that are not needed. - Does not duplicate existing and costly administrative and support services.	- Proposes the second highest capital cost project. - Proposes to add numerous ancillary and support services that are not needed. - Proposes costly and duplicative administrative and support services.	- Proposes the highest capital cost project. - Proposes to add numerous ancillary and support services that are not needed. - Proposes to shift a cost effective freestanding OR to more costly hospital-based use. - Proposes costly and duplicative administrative and support services.
Impact of Competition on Staffing:	- Proposes to recruit only 75 incremental direct patient care staff to support the proposed beds. - No duplication of ancillary and support staff will occur. - Least impact of cost of recruiting and retaining limited clinical staff in an already limited labor market. - Provides the greatest contribution to training future care givers in western NC.	- Proposes to recruit over 400 incremental staff including direct care clinical personnel, ancillary staff, support staff and administrative staff. - Staff will directly duplicate the existing ancillary and support services provided by other community hospitals. - Has the potential to impact the cost of staff and staffing shortages at existing area hospitals.	- Proposes to recruit over 460 incremental staff including direct care clinical personnel, ancillary staff, support staff and administrative staff. - Staff will directly duplicate the existing ancillary and support services provided by other community hospitals. - Has the potential to impact the cost of staff and staffing shortages at existing area hospitals.
Impact of Competition on Duplication:	- Expands only the existing service that generated the need. - Does not unnecessarily duplicate existing ancillary and support services.	- Directly duplicates the services of existing community hospitals including Haywood Regional and Advent's affiliate Advent Hendersonville. - Proposes to duplicate numerous ancillary and support services that it has not demonstrated are needed.	- Directly duplicates the services of existing community hospitals including the two hospitals in Henderson County, which have surplus bed capacity. - Proposes to duplicate numerous ancillary and support services that it has not demonstrated are needed.
Impact of Competition on Value:	- Value is created by cost effectively adding the specific service only that generated the need determination. - Value is created through the most cost effective project from a capital and operating cost perspective.	- Value is not created due to high capital and operating cost expenditure to add unnecessary and duplicative services	- Value is not created due to high capital and operating cost expenditure to add unnecessary and duplicative services

Conclusion

G.S. 131E-183(a)(1) states that the need determination in the SMFP is the determinative limit on the number of acute care beds that can be approved by the Healthcare Planning and Certificate of Need Section. Approval of all applications submitted during the review would result in acute care beds in excess of the need determination in Buncombe/Graham/Madison/Yancey County service area. Only **Mission's** project can be approved as it is the only applicant that conforms to all project review criteria and applicable performance standards. However, if all applicants were approvable, **Mission's** project is still the most effective alternative to meet the need based on the summary below. As such, **Mission's** project should be approved.

Summary of Comparative Factors

Meaure/Analysis	**Mission**	**Advent**	**Novant**
Conformity with Review Criteria	Yes	No	No
Scope of Services	Most Effective	Least Effective	Least Effective
Geographic Access	No difference or Most Effective	Least Effective	Least Effective
Historical Utilization	Most Effective	Least Effective	NA
Projected Utilization / Use of Beds	Most Effective	Least Effective	Least Effective
Competition/Access to New Provider	Inconclusive	Inconclusive	Inconclusive
Service to the Planning Area Counties (a)	Most Effective	Least Effective	Least Effective
Historical Financial Access	Most Effective	Least Effective	NA
Projected Financial Access	Most Effective	Least Effective	Least Effective
Projected Charity Care	Most Effective	Least Effective	Least Effective
Projected Medicare	Most Effective	Least Effective	Least Effective
Projected Medicaid	Most Effective	Least Effective	Least Effective
Projected Average Net Revenue per Admission	Inconclusive	Inconclusive	Inconclusive
CMI Adjusted Net Revenue per Admission	Most Effective	Least Effective	Least Effective
Projected Average Expense per Admission	Inconclusive	Inconclusive	Inconclusive
CMI Adjusted Expense per Admission	Most Effective	Least Effective	Least Effective
Effective Staffing Resources	Most Effective	Least Effective	Least Effective
Project Cost	Most Effective	Least Effective	Least Effective
Project Timing	Most Effective	Least Effective (b)	Least Effective

(a) Given the variation in types of projects (small community hospitals v. regional tertiary medical center), the most reasonable method to compare service to the planning area counties is the number of patients served.

(b) Advent's project timing would be the second most effective but the timing appears to be highly unlikely to be achievable.

Attachment A
Article Regarding Advent Site Location

Citizen Times

NEWS

77 years of industrial waste threatens Enka ballfields

Emily Patrick epatrick@citizen-times.com

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Buncombe County officials have earmarked more than $3 million for baseball and softball fields compromised by legal restrictions and environmental uncertainties.

The proposed site, a grassy knoll with panoramic mountain views, looks like a movie set — a meadow for cavorting or picnicking.

But the 50-foot-tall knoll isn't natural, and its pastoral outlook belies its history as an industrial waste area.

For 77 years, a sprawling factory heaped as many as 30 tons of waste a day on the 41-acre property, according to EPA records. For the majority of that time, the site was unregulated since the agencies that now oversee it didn't yet exist.

This long history of environmental contamination complicates the land that could become Enka Sports Complex near the intersection of Sand Hill Road and Smokey Park Highway.

And property rights pose a legal hurdle.

The property's deed prohibits playgrounds and similar facilities. If it's violated, the property could be repossessed, according to the deed, along with any publicly funded portions of the facility.

Furthermore, environmental groups have filed a court challenge to the project, arguing the North Carolina Department of Environmental Quality has failed to collect sufficient data on the landfill site, its contents and the streams that nearly encircle it.

Amelia Burnette, an attorney at the Southern Environmental Law Center, said the state hasn't been up front with the public about the site's known contaminants.

For example, in 2006, a consultant linked levels of carbon disulfide that exceeded state standards for soil by 3,700 percent to an explosion and fire, according to a report filed with the state.

But the state couldn't locate a record of a follow-up, and the incident was not disclosed as part of the public process for creating a brownfield agreement that would allow redevelopment at the property.

“The landfill housed industrial waste pits and an unlined dump for decades, long before laws restricted what kinds of toxic chemicals could be buried there," Burnette said. "DEQ has ignored the site’s toxic history. While putting blighted property to good use is a worthy goal, DEQ cannot turn a blind eye to the site’s contamination as a means to achieve that goal.”

Meanwhile, the project developers say the sports fields will transform an underused property into an attraction for traveling youth sports teams with money to spend in the local economy.

"The project began with an idea — developing a flat, beautiful green space for ballfields to serve the community and the region on land that otherwise would sit unused," said Martin Lewis, a member of Enka Partners and Enka Youth Sports Organization, two groups involved in building the fields.

Enka Partners has raised about $5 million in public and private funds to build the sports fields, which would adjoin a shopping center the group is planning to build.

"We knew from the beginning that environmental issues would need to be addressed," Lewis said. "We have worked closely with the state since purchasing the property in 2008 to make sure that any development of the former landfill will be protective of the public health."

The remains of a regional giant

The story of the Enka ballfields begins with the founding of the Enka community west of Asheville. The unincorporated area is named for American Enka, a subsidiary of a Dutch fabric manufacturer.

In 1928, American Enka bought 2,100 acres on Hominy Creek and built a rayon manufacturing facility that employed thousands of people, making it one of the region's largest employers. Later, it would add nylon production.

The company created an entire community, including Enka Lake, houses and a fire department.

But it also created waste. Rayon manufacturing is an intensive process that requires toxic chemical components and abundant energy. American Enka generated its power by burning coal.

From the beginning, American Enka needed a place to put waste from chemical and energy-producing processes. In 1929, it created a landfill that would grow to comprise 41 acres on the northern corner of its expansive site.

According to EPA records, the landfill contains fly ash created from burning coal, alum sludge, nylon reactor bottoms that contain phosphoric acid, construction materials and other substances.

Fly ash is a health concern because it can leach heavy metals like lead and cadmium that are toxic or carcinogenic. More generally, industrial wastes can travel through water and soil and sometimes create volatile reactions with the air.

As many as 30 tons of fly ash entered the landfill each day, according to a 1989 EPA record, although waste was sometimes relocated to Alabama and Virginia.

In 1985, BASF Corporation bought the Enka facility, including the landfill, and used it for nylon manufacturing and research activities.

By the late '90s, textile production was declining, and BASF began selling property. Biltmore Farms bought land that would become the Biltmore Lake neighborhood. Other parcels sold to Colbond manufacturing and Fletcher Partners development group.

Enka Partners, a company with the same principals as Fletcher Partners, would eventually purchase the landfill property for the ballfields project.

However, BASF's obligations did not end with the sale of its property.

As the permit holder for the landfill, BASF retained legal responsibility. It must send twice yearly water- and methane-monitoring reports to the state for the landfill site.

BASF also is required to maintain the two-foot layer of dirt that covers the waste. The maintenance is a battle against the elements. As falling trees, rain and wind dislodge soil, the dirt cover slides away, revealing coal ash, bits of metal and plastic.

In 2010 and 2014, according to state records, the North Carolina Division of Waste Management reported patches of waste had been exposed after erosion removed dirt from the landfill's slopes.

Because of its ongoing liability, BASF wrote the deed restrictions, prohibiting houses, day care centers, playgrounds and similar uses.

"The property shall not be used for any residential use, in whole or in part," the deed reads. "Residential use shall mean and include any structure or dwelling used for living accommodations (single or multi-family occupancy), day care facility (whether infant, children, infirm or elderly), grade/elementary school, playground or senior citizen housing or similar or like use."

If this condition is violated, the deed continues, BASF can retake the property and everything on it.

It would not have to reimburse taxpayers or other groups invested in the property. According to the deed, BASF "shall not be required to pay any compensation for any buildings or other improvements on the property and shall not incur any liability for damages or losses of any kind in connection with or resulting from such re-entry."

Playground versus ground for play

The project proposal to which Buncombe County pledged $1.3 million included an area called "adventure play" in addition to softball fields.

Following the county commitment, the Tourism Development Authority pledged $2 million to the project, the largest grant award it had ever issued.

Developer Lewis said he has known about the land use restriction prohibiting playgrounds and similar uses since his group purchased the property in 2008, but he doesn't think it's relevant to his project.

He did not mention it in the meeting when the commissioners approved the funds, and he did not include it in the application to the TDA.

"We're interpreting that it is allowed," he said.

His group does not think the deed restriction applies to commercial facilities, he said. Also, only some of the sports fields — the ones for softball — are on the landfill. Baseball fields are planned for an adjacent piece of land.

Regardless, he said, the playground is not a central component of the project. He prefers to focus on the baseball and softball fields. He does not think sports fields violate the deed

restriction that prohibits playgrounds and similar uses.

"This is softball and baseball," he said. "As far as playgrounds, if that makes a pretty picture on a drawing, it gets added."

Fletcher Partners removed the playgrounds from the plan after BASF wrote an October letter to the North Carolina Department of Environmental Quality protesting both the playgrounds and the ballfields as violations of the land use restriction.

"The proposed project indicates a land use that is specifically prohibited," wrote attorney Nancy Lake Martin. "The development serves to improperly and unfairly impose additional risks upon BASF, based upon the unknown impacts arising from a project whose goal is to place large numbers of the public in frequent and immediate proximity of the former BASF industrial landfill."

A representative from BASF said the company continues to protest the plans for sports fields, even though playgrounds have been eliminated from the project.

"We remain concerned about how to reconcile our responsibilities under the existing landfill closure permit and other associated requirements with a project that includes ballfields for recreational use," said Bob Nelson, spokesperson for BASF.

In the October letter, BASF indicated it would not oppose the sports complex if Enka Partners would take over the landfill permit, eliminating BASF's connection to the site.

Lewis said his group refuses to take over the landfill permit. It doesn't want to be liable for the waste.

"Enka Partners believes BASF is attempting to avoid ongoing monitoring and reporting requirements and potential long term liability for the landfill," he said. "Taking on the landfill permit would subject Enka Partners, LLC to ongoing monitoring and reporting requirements and potential long term liability for the landfill which is properly the responsibility of BASF."

Refocusing the debate on safety — and explosions

Deed restriction aside, environmental groups say the state hasn't done enough to make sure the site is safe.

"The reason for that requirement is common sense, whether or not BASF ultimately enforces its deed restriction to block the project," said Southern Environmental Law Center attorney Burnette. "When it comes to children's safety, we shouldn't be debating what the minimum legal requirements are; we should be going above and beyond to confirm there is no risk — something these parties have avoided doing."

Both the law center and environmental nonprofit MountainTrue disagree with the state about the safety of the site, but everyone agrees the property is contaminated.

Groundwater contaminants include chromium, cobalt, sulfate and vanadium, according to the N.C. Department of Environmental Quality. It determines those contaminants by reviewing BASF-submitted test results from four groundwater wells, 10 gas monitoring wells and water samples from Hominy Creek.

Environmental groups contend the contamination is much more extensive and that the state isn't asking enough questions about soil, surface water and tributaries on the 41-acre property.

Burnette points to unresolved reports of contamination.

For example, in 2006, the state received a report of spontaneously combusting soil near a creek east of the landfill, near the landfill permit boundary and the property line. The creek runs between the proposed softball fields and a proposed Enka Partners shopping center. A road will eventually connect these areas.

An environmental consultant hired to investigate the 2006 incident, DeWitt Whitten of Froehling & Robertson, documented the story of a contractor who had been working on the site in a report to the state.

"A fire occurred in one area of the soils apparently as a result of spontaneous combustion," Whitten wrote. "The contractor moved to another location and resumed excavation activities; at one point when the excavator started to remove a bucket of soil from the drainage feature, an explosion and flames reportedly erupted from the water."

The consultant tested five soil samples near the ditch and found concentrations of carbon disulfide that exceeded state standards more than 37 times over in one spot.

Carbon disulfide is one of the main chemicals used to produce rayon, according to the EPA. The consultant characterized it as a "dangerous fire hazard" with vapors that "form an explosive mixture with air within a wide range, 1.3 - 50.0% by volume in air."

Enka Partners commissioned a 2008 report from Altamont Environmental that included the spontaneously combusting soil incident. Lewis and partner Bill Newman said they do not recall reading about it.

The state could not locate any information about regulatory follow-up.

The explosion isn't the only red flag that's unresolved.

In 2015, MountainTrue performed testing in Hominy Creek and its tributaries, which nearly encircle the landfill. The state never required testing at those sites, and it doesn't require sediment testing.

MountainTrue found barium, cadmium, lead, zinc and iron exceeded EPA sediment screening values. Because of the way these heavy metals behave in water, sediment testing is essential, said Hartwell Carson, river keeper for MountainTrue.

“The problem with looking for coal ash constituents is that you won’t always find them in the water column," he said. "You’ll often find them in the sediment because a lot of them are heavy metals that will drop out of suspension, and when it rains it will stir them back up."

Carson found iron, selenium and zinc above state standards for surface water. He also discovered manganese and boron, although there are no state standards for these materials in surface water.

Information about boron is particularly valuable because it's a coal tracer, meaning it provides information about how coal contamination moves, how much there might be and whether there are more toxins in soil and sediment.

In the stream closest to the softball fields, boron registered 5,910 micrograms per liter.

"The levels of boron found were higher than those reported in seeps and streams draining the coal ash lagoons at the Asheville power plant," Burnette said, referencing the Duke Energy plant at Lake Julian.

The Department of Environmental Quality has never required or reviewed test results for boron at the potential softball site.

Burnette said the findings in the soil, sediment and surface water indicate more testing is necessary.

"Uninvestigated hazards around an old industrial site can be risky business, especially to the

removed from a stream unexpectedly exploded, and yet, DEQ requires no testing of the stream's soil, much less disclosure of the explosion from carbon disulfide."

Jamie Kritzer, public information officer for the department, said its testing requirements are based on historical information.

"The state requires testing for the constituents that are associated with the stream of waste materials that were placed in the landfill for industrial landfills such as the former BASF landfill," he said.

Burnette, whose firm reviews state regulation at other environmentally sensitive sites around the region, said the state usually responds to reports of boron and other contaminants by completing its own testing or by requiring permit holders to perform additional testing. Its seeming indifference to testing at the proposed ball fields is inconsistent with its regulatory activities at other locations, she said.

"In public documents around Duke (Energy)'s water quality permitting and the coal ash lagoons, the division has said there are certain things you have to test for because that helps us understand the extent of contamination, and one of those constituents is boron," she said. "There seems to be a disconnect between the level of testing of coal ash lagoons required at Duke Energy, for example, versus the testing of coal ash at BASF."

The state, meanwhile, maintains that any contamination that exists beneath the ballfields will be buried, rendering it innocuous. It requires the developers to apply an additional two feet of soil beneath the proposed softball fields.

"If there's no exposure, there's no risk," said Michael Scott, speaking for the Department of Environmental Quality in a March interview. "(The requirement) thoroughly addresses that basically through improvement of the landfill cap."

The developers will add additional dirt to many spots atop the landfill to create a level grade, according to developer Newman.

But the dirt barrier requirement only applies to the landfill cap. Adjacent areas, such as the ditch where the explosion was reported in 2006 and the tributary where MountainTrue detected boron, will not receive this buffer, and remediation is not required anywhere on the property.

Burnette said the responsibility for the health of the streams falls to landfill permit holder BASF, regardless of whether the softball fields move ahead.

Testy future

In March, the Department of Environmental Quality issued a brownfields agreement with the developers in which it codified the fill dirt requirement and other conditions for redevelopment of the landfill.

During the 30 days that followed, Hartwell Carson, riverkeeper at MountainTrue, said he tried to reach the developers to create a testing plan that would answer some of the questions about the site.

The state allows a 30-day window in which parities can file suit against a brownfield agreement. Carson said his group tried to avoid a legal battle, but because they hadn't made progress with the developers within that period, Southern Environmental Law Center filed a challenge to the agreement on behalf of MountainTrue.

That case will be adjudicated in North Carolina's Office of Administrative Hearings.

Lewis said his group has agreed to work with MountainTrue to obtain additional test results.

The developers don't plan to formalize the expanded testing plan with the state. The group has already submitted a different testing plan, as it was required to do in the 30-day period that followed the agreement.

However, the brownfields agreement requires the developer to report any contaminants that exceed state standards, even if those tests aren't included in the formal plan.

"If the tests come back, and they're not good, we're not going forward," Lewis said. "I like to think our intentions are good."

In the brownfields agreement, the state responded to BASF's complaint that the project violates its land use restriction with the following: "The restrictive conditions contained in the deed exist independently of this agreement and are matters between private parties."

BASF has not filed suit to contest the project, but the use of the property has not changed, so an actual violation hasn't occurred.

County officials said public funds for the project have not changed hands. The TDA and the county government are holding the money pledged for the project.

“I think we have to let the legal staff figure all those things out and go forward from there," said county manager Wanda Greene. “The county citizens’ money is safe as the lawyers sort it

all out. We'll figure out what the next steps are."

Burnette said the way forward is clear: Clean up the property, resolve the deed restriction and build the sports fields. BASF remains responsible for contamination on the site, so the burden of remediation wouldn't necessarily fall to Enka Partners.

"Enka Partners could join with other people in the community and ask BASF to do this," she said. "It's not that we're sort of without options here."

Did county funders know what they were buying?

Enka Partners, the developers behind the sports complex, say they are are confident a lawsuit about the land use restriction would be settled in their favor.

But do public funders — and by extension, taxpayers — share their certainty?

Stephanie Brown, representing the Tourism Development Authority, said she did not know about the land use restriction when the developers signed a contract to receive $2 million in funding.

Wanda Greene, county manager, said she knew a restriction prohibited housing on the site.

Developer Martin Lewis and the Buncombe County commissioners did not discuss BASF's involvement or land use restrictions at the meeting where $1.3 million in funding was committed to the project on Sept. 2, 2014.

The project did not go through the county's nonprofit funding process, which includes a formal application and a public hearing.

In 2015, the county allocated $2.6 million for nonprofits, and the largest payment was $350,000, far less than the $1.3 million the sports complex will receive.

Instead, Lewis delivered a short powerpoint presentation at the September 2014 meeting, and the commissioners discussed the project for nearly an hour. About 10 minutes of that conversation involved safety and the environment.

The project was not subject to a formal public hearing.

"Public hearing is not required on it," Greene said in a May interview. "This was one capital project that was tied to needing a match for some TDA funding. It's not something that people apply for on a recurring basis."

"It is a bigger step than we usually take, but it’s also going to give us more resource than we’ve had for ballfields ever," Greene said at the September 2014 meeting.

She said the county had made investments of a similar size in Pack Square Park, which is maintained by a nonprofit conservancy, and public housing projects.

The commissioners voted unanimously to approve funding for the project with several conditions in place, including local approval of environmental conditions at the site.

"It just looks like you’ve got your heart in the right place, and knowing you personally for many years, I know you do, so as long as you’re there, I’m good," said David Gantt, chairman of the board of commissioners, addressing Lewis at the 2014 meeting. "I just like to hear it on the record that that’s the principles.”

Buncombe County has a long history of working closely with Martin Lewis and the other members of Fletcher Partners and Enka Partners, two groups with the same members.

In fact, the $1.3 million the county allocated for the ballfields comes from the sale of a building that Fletcher Partners built and donated to the county.

As part of a 2006 economic development initiative, Buncombe County partnered with Fletcher Partners to construct a spec building on the development group's land on Jacob Holm Way.

Buncombe County agreed to pay interest on the Fletcher Partners loan for the construction for two years. County payments would eventually total just over $200,000, Greene said.

Fletcher Partners contracted with Cooper Enterprises and now-defunct Taylor & Murphy Construction Company to create the building, according to county records. Kenneth Murphy was a principal in both Taylor & Murphy Construction Company and Fletcher Partners.

In 2013, Fletcher Partners donated the building to Buncombe County. No money changed hands.

"At that time, we thought that was a good idea, a good move," said Martin Lewis of Fletcher Partners.

In 2014, Buncombe County agreed to sell the building to Wicked Weed for $1.3 million and donate the money to nonprofit Enka Youth Sports Organization.

Matin Lewis is a principal in Fletcher Partners, Enka Partners and Enka Youth Sports

“When we took the building, we didn’t have any idea when we’d sell that building or what we’d do with the proceeds," Greene said.

In June 2010, the county authorized a nonbinding resolution to provide reimbursements to Enka Partners for the development of Enka Center, which would contain the fields, although they aren't mentioned in the resolution.

However, this agreement was not referenced by anyone during the request for $1.3 million for the sports complex.

Greene said the county followed protocol while working with the developers.

“We have attorneys sitting there to determine whether or not it’s legal," she said. “I think we have a lot of oversight into all these projects.”

Names to know in connection with the Enka Sports Complex

Enka Partners This private development group owns the closed industrial landfill on which it proposes to build softball fields. It plans to build a shopping center and office park on an adjacent property. Members include Martin Lewis, Kenneth Murphy, Kenneth Wilson, Robert Lewis Jr. and Bill Newman.

Fletcher Partners This private development group owns property in Enka and comprises the same members as Enka Partners.

Enka Youth Sports Complex This nonprofit will own the sports complex and receive the public funding. Enka Partners will donate the landfill property to the nonprofit after environmental agreements are finalized. Martin Lewis of Fletcher Partners and Enka Partners is one of the founders and members.

BASF This textile manufacturer owned the Enka landfill from 1985 until 2001. It retains the landfill closure permit as well as liability for the waste. As the holder of the permit, it must submit environmental testing to the state twice a year.

Mountain True The Asheville-based nonprofit environmental group is contesting a March brownfield agreement the North Carolina Department of Environmental Quality issued for the softball fields project on the landfill site. The organization hopes to work with developers to create an in-depth testing plan for the landfill.

Southern Environmental Law Center This regional firm is representing Mountain True in the administrative suit contesting the brownfield agreement.

Buncombe County commissioners This public body pledged $1.3 million to the sports complex in September 2014. The total cost of the complex is $5.4 million.

Buncombe County Tourism Development Authority This public body pledged $2 million in grant funding to the sports complex in 2014.

Attachment B
Advent Site Location
NCDENR Notice of Brownfields Property

Workflow No. 0000206456-0001

Doc ID: 026108080036 Type: CRP
Recorded: 02/14/2014 at 03:08:30 PM
Fee Amt: $110.00 Page 1 of 36
Workflow# 0000206456-0001
Buncombe County, NC
Drew Reisinger Register of Deeds
BK5185 PG1280-1315

Property Owner: Enka Partners of Asheville, LLC
Recorded in Book 4590, **Page** 161
Associated plat recorded in Plat Book 140, **Page** 1-2

NOTICE OF BROWNFIELDS PROPERTY

This documentary component of a Notice of Brownfields Property ("Notice"), as well as the plat component, have been filed this 14th **day of** February, 2014 **by Enka Partners of Asheville, LLC (hereinafter "Prospective Developer").**

The Notice concerns contaminated property.

A copy of this Notice certified by the North Carolina Department of Environment and Natural Resources (hereinafter "DENR") is required to be filed in the Register of Deeds' Office in the county or counties in which the land is located, pursuant to North Carolina General Statutes (hereinafter "NCGS"), Section (hereinafter "§") 130A-310.35(b).

This Notice is required by NCGS § 130A-310.35(a), in order to reduce or eliminate the danger to public health or the environment posed by environmental contamination at a property (hereinafter the "Brownfields Property") being addressed under the Brownfields Property Reuse Act of 1997, NCGS § 130A, Article 9, Part 5 (hereinafter the "Act").

Pursuant to NCGS § 130A-310.35(b), the Prospective Developer must file a certified copy of this Notice within 15 days of Prospective Developer's receipt of DENR's approval of the Notice or Prospective Developer's entry into the Brownfields Agreement required by the Act, whichever is later. Pursuant to NCGS § 130A-310.35(c), the copy of the Notice certified by DENR must be recorded in the grantor index under the names of the owners of the land and, if Prospective Developer is not the owner, also under Prospective Developer's name.

The Brownfields Property is located at Sand Hill Road, Asheville, Buncombe County, North Carolina. It comprises 56.64 acres, it was a former BASF Corporation property. The property was first operated by American Enka Corporation, the facility has historically manufactured continuous filament yarn, nylon textile yarn and carpet yarn. Prospective Developer intends to redevelop the Property for retail shopping center, associated roadways and, if DENR issues prior written approval, other commercial and office purposes.

Return to: William Clarke, Roberts & Stevens, P.A., Box 39

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The Brownfields Agreement between Prospective Developer and DENR is attached hereto as Exhibit A. It sets forth the use that may be made of the Brownfields Property and the measures to be taken to protect public health and the environment, and is required by NCGS § 130A-310.32. The *Brownfields Agreement's Exhibit 3 consists of one or more data tables reflecting the concentrations of* and other information regarding the Property's regulated substances and contaminants.

The plat component of this Notice is recorded at the plat book and page number shown at the top of this documentary component of the Notice. **Exhibit B** to this Notice is a reduction, to 8 1/2" x 11", of said plat. The plat shows areas designated by DENR, has been prepared and certified by a professional land surveyor, and complies with NCGS § 130A-310.35(a)'s requirement that the Notice identify:

(1) The location and dimensions of the areas of potential environmental concern with respect to permanently surveyed benchmarks.

(2) The type, location and quantity of regulated substances and contaminants known to exist on the Brownfields Property.

Attached hereto as **Exhibit C** is a legal description of the Brownfields Property that would be sufficient as a description of the property in an instrument of conveyance.

LAND USE RESTRICTIONS

NCGS 130A-310.35(a) also requires that the Notice identify any restrictions on the current and future use of the Brownfields Property that are necessary or useful to maintain the level of protection appropriate for the designated current or future use of the Brownfields Property and that are designated in the Brownfields Agreement. **The restrictions shall remain in force in perpetuity unless canceled by the Secretary of DENR (or its successor in function), or his/her designee, after the hazards have been eliminated, pursuant to NCGS § 130A-310.35(e). All references to DENR shall be understood to include any successor in function. The restrictions are hereby imposed on the Brownfields Property, and are as follows:**

1. No use may be made of the Property other than for a retail shopping center, associated roadways and, if DENR issues prior written approval, other commercial and office purposes. For purposes of this restriction, the following definitions apply:

a. "*Retail Shopping Center*" refers to a group of commercial establishments, planned and developed as a unit, with common parking, pedestrian movement, ingress and egress, where sale to the public of services not covered by subparagraph 20.a.iii. below and merchandise occurs.

b. "Commercial" refers to a business enterprise.

c. "Office" refers the provision of business or professional services.

2. No physical redevelopment of the Property may occur unless and until DENR's Brownfields and Solid Waste programs conclude in writing that the proposed redevelopment will not negatively affect the cover, structural integrity and monitoring systems at the closed landfill facility located on adjacent property.

3. The owner of the Property shall, at its own expense, correct any impacts to the Property or the adjacent landfill, as determined by DENR, that increase the cost of compliance or ability to comply with rules and regulations for environmental protection, or adversely affect environmental permits

regarding the Property or the adjacent landfill that are caused by development on the Property or landfill. Said corrections must be made with prior DENR approval to the written satisfaction of DENR's Brownfields Program and Solid Waste Section.

4. No activities that encounter, expose, remove or use groundwater (for example, installation of water supply wells, fountains, ponds, lakes or swimming pools, or construction or excavation activities that encounter or expose groundwater) or surface water may occur on the Property without any prior sampling (and sampling analysis) DENR deems desirable, and any remediation DENR deems desirable based on the analysis, to ensure the Property is suitable for the uses specified in subparagraph 1.a. above and that public health and the environment are fully protected.

5. Soil in the areas designated "Area of Possible Soil Contamination" on the plat component of this Notice, and soil underlying paved and other impervious surfaces and buildings at the Property, may not be disturbed unless and until DENR approves in writing a plan with a schedule, and its implementation, that requires:

a. capping (with asphalt, concrete, stone, brick, terrazzo, roofing, ceramic tile, two (2) feet of clean soil or other impervious material approved in writing in advance by DENR), remediation and/or removal of sufficient soil to satisfy DENR that the Property is suitable for the uses specified in subparagraph 1.a. above and that public health and the environment are fully protected despite any remaining soil contamination, as determined by sampling of each excavation's side walls and bottom; and

b. a written report regarding implementation of the plan, submitted no later than 30 days following its implementation, and correction of any deficiencies DENR identifies in the report or in implementation of the plan within 30 days after DENR provides written notice of such deficiencies.

6. No building may be constructed on the Property until:

a. DENR determines in writing, based on submittals from the building's proponent, that the building's users, and public health and the environment, would be fully protected from the Property's contaminated soil; or

b. vapor mitigation measures approved in writing by DENR in advance are installed to the satisfaction of a professional engineer licensed in North Carolina, as evidenced by said engineer's seal, and photographs illustrating the installation and a brief narrative describing it are submitted to DENR and deemed satisfactory in writing by that agency.

7. No mining may be conducted on or under the Property, including, without limitation, extraction of coal, oil, gas or any other minerals or non-mineral substances.

8. No basements may be constructed on the Property unless they are, as determined in writing by DENR, vented in conformance with applicable building codes.

9. None of the contaminants known to be present in the environmental media at the Property, including those listed in Exhibit 3 hereto, may be used or stored at the Property without the prior written approval of DENR, except in *de minimis* amounts for cleaning and other routine housekeeping activities.

10. The Property may not be used for agriculture, grazing, timbering or timber production.

11. The Property may not be used as a playground, or for child care centers or schools.

12. The Property may not be used for kennels, private animal pens or horse-riding.

13. The owner of any portion of the Property where any existing, or subsequently installed, DENR-approved monitoring well is damaged shall be responsible for repair of any such wells to DENR's written satisfaction and within a time period acceptable to DENR.

14. Neither DENR, nor any party conducting environmental assessment or remediation at the Property at the direction of, or pursuant to a permit, order or agreement issued or entered into by DENR, may be denied access to the Property for purposes of conducting such assessment or remediation, which is to be conducted using reasonable efforts to minimize interference with authorized uses of the Property.

15. During January of each year after the year in which this Notice is recorded, the owner of any part of the Property as of January 1st of that year shall submit a notarized Land Use Restrictions Update ("LURU") to DENR, and to the chief public health and environmental officials of Buncombe County, certifying that, as of said January 1st, the Notice of Brownfields Property containing these land use restrictions remains recorded at the Buncombe County Register of Deeds office and that the land use restrictions are being complied with, and stating:

a. the name, mailing address, telephone and facsimile numbers, and contact person's e-mail address of the owner submitting the LURU if said owner acquired any part of the Property during the previous calendar year; and

b. the transferee's name, mailing address, telephone and facsimile numbers, and contact person's e-mail address, if said owner transferred any part of the Property during the previous calendar year.

For purposes of the land use restrictions set forth above, the DENR point of contact shall be the DENR official referenced in paragraph 39.a. of Exhibit A hereto, at the address stated therein.

ENFORCEMENT

The above land use restrictions shall be enforceable without regard to lack of privity of estate or contract, lack of benefit to particular land, or lack of any property interest in particular land. The land use restrictions shall be enforced by any owner of the Brownfields Property. The land use restrictions may also be enforced by DENR through the remedies provided in NCGS 130A, Article 1, Part 2 or by means of a civil action; by any unit of local government having jurisdiction over any part of the Brownfields Property; and by any person eligible for liability protection under the Brownfields Property Reuse Act who will lose liability protection if the restrictions are violated. Any attempt to cancel any or all of this Notice without the approval of the Secretary of DENR (or its successor in function), or his/her delegate, shall be subject to enforcement by DENR to the full extent of the law. Failure by any party required or authorized to enforce any of the above restrictions shall in no event be deemed a waiver of the right to do so thereafter as to the same violation or as to one occurring prior or subsequent thereto.

FUTURE SALES, LEASES, CONVEYANCES AND TRANSFERS

When any portion of the Brownfields Property is sold, leased, conveyed or transferred, pursuant to NCGS § 130A-310.35(d) the deed or other instrument of transfer shall contain in the description section, in no

smaller type than that used in the body of the deed or instrument, a statement that the Brownfields Property has been classified and, if appropriate, cleaned up as a brownfields property under the Brownfields Property Reuse Act.

IN WITNESS WHEREOF, Prospective Developer has caused this instrument to be duly executed this 11 day of Feb., 2014.

Enka Partners of Asheville, LLC

By: _____
Kenneth D. Murphy
Managing Member

NORTH CAROLINA
Buncombe COUNTY

I certify that the following person(s) personally appeared before me this day, each acknowledging to me that he or she voluntarily signed the foregoing document for the purpose stated therein and in the capacity indicated: Kenneth D. Murphy

Date: 2-11-14

_____
Official Signature of Notary

Jill B. Caldwell
Notary's printed or typed name, Notary Public
My commission expires: Oct. 14, 2017

JILL B. CALDWELL NOTARY PUBLIC BUNCOMBE COUNTY, NC (Official Seal) MY COMMISSION EXPIRES 10/14/2017

APPROVAL AND CERTIFICATION OF NORTH CAROLINA DEPARTMENT OF ENVIRONMENT AND NATURAL RESOURCES

The foregoing Notice of Brownfields Property is hereby approved and certified.

North Carolina Department of Environment and Natural Resources

By: _____
Linda M. Culpepper
Deputy Director, Division of Waste Management

February 4, 2014
Date

****

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CERTIFICATION OF REGISTER OF DEEDS

The foregoing documentary component of the Notice of Brownfields Property, and the associated plat, are certified to be duly recorded at the date and time, and in the Books and Pages, shown on the first page hereof.

Register of Deeds for Buncombe County

By: _____ _____
Name typed or printed: _____ Date
Deputy/Assistant Register of Deeds

EXHIBIT A

NORTH CAROLINA DEPARTMENT OF ENVIRONMENT AND NATURAL RESOURCES

IN THE MATTER OF: Enka Partners of Asheville, LLC

UNDER THE AUTHORITY OF THE	)	BROWNFIELDS AGREEMENT re:
BROWNFIELDS PROPERTY REUSE ACT	)	Former BASF Site
OF 1997, N.C.G.S. § 130A-310.30, et seq.	)	Sand Hill Road
Brownfields Project # 12012-08-11	)	Asheville, Buncombe County

I. INTRODUCTION

This Brownfields Agreement ("Agreement") is entered into by the North Carolina Department of Environment and Natural Resources ("DENR") and Enka Partners of Asheville, LLC (collectively the "Parties") pursuant to the Brownfields Property Reuse Act of 1997, N.C.G.S. § 130A-310.30, et seq. (the "Act").

Enka Partners of Asheville, LLC is a North Carolina member-managed limited liability company whose business address is 1091 Hendersonville Road, Asheville, North Carolina 28803. This Agreement pertains to 56.64 acres of the former BASF Corporation property at Sand Hill Road, Asheville, Buncombe County, North Carolina, which in total comprised approximately 228.4 acres. The subject 56.64 acres lies on the north side of the plant property, with the former research and development portion to the west and the former landfill to the east. A map showing the location of the acreage is attached hereto as Exhibit 1. Enka Partners of Asheville, LLC intends to reuse the property for the purposes set forth in paragraph 20.a. below.

The Parties agree to undertake all actions required by the terms and conditions of this Agreement. The purpose of this Agreement is to settle and resolve, subject to reservations and limitations contained in Section VIII (Certification), Section IX (DENR's Covenant Not to Sue and Reservation of Rights) and Section X (Prospective Developer's Covenant Not to Sue), the potential liability of Enka Partners of Asheville, LLC for contaminants at the property which is the subject of this Agreement.

The Parties agree that Enka Partners of Asheville, LLC's entry into this Agreement, and the actions undertaken by Enka Partners of Asheville, LLC in accordance with the Agreement, do not constitute an admission of any liability by Enka Partners of Asheville, LLC

The resolution of this potential liability, in exchange for the benefit Enka Partners of Asheville, LLC shall provide to DENR, is in the public interest.

II. DEFINITIONS

Unless otherwise expressly provided herein, terms used in this Agreement which are defined in the Act or elsewhere in N.C.G.S. 130A, Article 9 shall have the meaning assigned to them in those statutory provisions, including any amendments thereto.

1. "Property" shall mean the Brownfields Property which is the subject of this Agreement, and which is depicted in Exhibit 1 to the Agreement.

2. "Prospective Developer" shall mean Enka Partners of Asheville, LLC.

III. STATEMENT OF FACTS

3. The Property comprises 56.64 acres. Prospective Developer has committed itself to redevelopment for no uses other than those set forth in paragraph 20.a. below.

4. The Property is bordered to the north by Hominy Creek, beyond which lies Smokey Park Highway; to the south by a portion of the original BASF facility owned by Colbond Acquisition I, Inc.; to the east by property owned by Buncombe County used for recreational purposes and a portion of buffer for the closed BASF landfill facility owned in part by Prospective Developer and in part by Fletcher Partners that is the subject of a different proposed Brownfields project; and to the west by land owned by Enka Water Control Corp., beyond which lie remote Western Carolina University and Asheville-Buncombe Technical Community College

campuses.

5. Prospective Developer obtained or commissioned the following reports, referred to hereinafter as the "Environmental Reports," regarding the Property:

Title	Prepared by	Date of Report
Preliminary Site Assessment Report Main Plant – Enka Facility	ENSR Consulting and Engineering (NC), Inc.	July 2000
Phase 2 Limited Site Assessment Report (LSA2) – Area M1/M2 BASF Corporation, Inc.	ENSR Consulting and Engineering (NC), Inc.	August 2000
Workplan for Soil Removal Activities Areas B, C, and D – Main Plant Area	ENSR Consulting and Engineering (NC), Inc.	October 2000
Main Plant Area D October 2005 Groundwater Monitoring Report BASF Corporation	ENSR Consulting and Engineering (NC), Inc.	March 7, 2006
Preliminary Facility Evaluation – Colbond, Inc., Formers BASF Corporation	Altamont Environmental, Inc.	May 24, 2006
Limited Site Assessment of the Former Carbon Disulfide Rail Car Loading and Unloading – Area G – BASF Enka Main Plant	ENSR Consulting and Engineering (NC), Inc.	August 7, 2008
BASF Industrial Wastewater Lagoon #1 Closure Report	ENSR Consulting and Engineering (NC), Inc.	September 18, 2008
Site Closure Request and Light Non-Aqueous Phase Liquid Investigation Area D and Area M1/M2 Former BASF Corporation	AECOM Enviroment	December 19, 2008
Summary of Identified Environmental Issues in Soil and Groundwater – Former BASF Corporation	Altamont Environmental, Inc.	April 30, 2008
Former Caustic Tank Area Confirmation Sampling Report – Former BASF Corporation	Altamont Environmental, Inc.	April 1, 2011
Brownfield Site Assessment	Altamont Environmental, Inc.	April 27, 2011

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Report – Former BASF Corporation		
BASF Enka Site – Closed Industrial Landfill Facility Permit No. 11-02 Semi-Annual Sampling Report (October 2012 Sampling Event)	CDM Smith	January 2013

6. For purposes of this Agreement, DENR relies on the following representations by Prospective Developer as to use and ownership of the Property:

a. Prior to 1928 the Property was undeveloped; in 1929 American Enka Corp. opened a facility there that produced rayon yarn.

b. BASF Corporation purchased American Enka Corp. in 1985 and continued to operate the facility until 2001.

c. Throughout its history, the facility primarily manufactured continuous filament yarn, nylon textile yarn and carpet yarn.

d. In 2001 the Property was acquired by Colbond, Inc. (formerly known as Colbond Acquisition I, Inc.).

e. On July 8, 2008, Prospective Developer acquired the Property. As noted elsewhere in this Agreement, Prospective Developer plans to effect redevelopment of the Property as a retail shopping center and, if DENR issues prior written approval, other commercial and office purposes; and redevelopment of the closed BASF Industrial Landfill Facility (Permit #11-02, permittees: BASF Corporation and Colbond Inc.) adjoining the Property to the east as part of a different Brownfields project. A portion of the former landfill's buffer is included in this agreement, Prospective Developer is currently seeking DENR approval

to construct a road across this portion of the Property. Information regarding the closed landfill facility is as follows: It encompasses 41.08 acres immediately south of Hominy Creek, including most of the parcel designated "Parcel D," part of that designated "Parcel E" and a small portion of that designated "Parcel C," on a plat recorded at Plat Book 118, Page 147 of the Buncombe County Registry. Property which includes the landfill is described in a deed from BASF Corporation to Colbond, Inc. recorded at Book 2644, Pages 427-430 in the Buncombe County Registry and in a later deed from Colbond, Inc. to Colbond Acquisition I, Inc. recorded at Book 3520, Pages 826-828. In 2008, Colbond, Inc. sold property including "Parcel D" to Prospective Developer by deed recorded at the Buncombe County Registry's Book 4590, Pages 161-166, and sold property including "Parcel E" to Fletcher Partners, Inc. by deed recorded at Book 4590, Pages 156-160. The 41.08-acre property comprising the landfill is depicted on a Map entitled "Gas Monitoring Well Location Map" dated April 22, 2010, prepared by ELM Site Solutions, Inc. A copy of the map is attached hereto as Exhibit 2.

7. The Site Evaluation and Removal Branch of DENR's Superfund Section transmitted a Site Re-Assessment letter dated August 7, 2001 to the U.S. Environmental Protection Agency ("EPA") regarding the Property and, in certain cases, adjoining land (U.S. EPA ID: NCD 052 813 250). The letter recommended "No Further Remedial Action Planned" status for the site based on these activities completed there:

a. excavation and removal of lead-impacted soil from "Area B" and PCB-impacted soil from "Area C" (see plat component of Notice referenced in paragraph 25 below);

b. confirmation samples from Areas B and C showing that contaminant concentrations in the remaining soil are below the applicable soil remediation goals of the

Inactive Hazardous Sites Branch of DENR's Superfund Section;

c. collection of sediment and surface water samples that did not exceed the applicable standards.

8. EPA assigned the site "No Further Remedial Action Planned" status on September 12, 2001.

9. DENR's Groundwater Section issued a "No Further Action" letter, dated November 16, 2001, for the areas of the site designated "Area B" and "Area C" on the plat component of the Notice referenced in paragraph 25 below).

10. DENR's Aquifer Protection Section issued a "No Further Action" letter, dated May 29, 2009, for the former BASF Industrial Wastewater Lagoon #1.

11. On October 2, 2009, DENR's UST Section issued "Notices of No Further Action" regarding "Incidents" numbered 21696 and 21608. Related "Notices of Residual Petroleum" were recorded stating that the area involved is suitable for industrial/commercial use only.

12. On March 24, 2010, DENR's Hazardous Waste Section issued an Immediate Action Notice of Violation (Docket #2010-067) to Prospective Developer regarding concerns in and around the area of the BASF site where caustic tanks were located, including a former storage building labeled "Flammable Solvents." Corrective action was taken and, on April 14, 2011, DENR's HWS issued a "No Further Action" letter. An August 9, 2011 Compliance Order with Administrative Penalty resulted, which settled for $2,500 in penalties and $2,126.37 in investigative/inspection costs in February 2012.

13. a. Groundwater at the Property is contaminated with Volatile Organic Compounds ("VOCs"), Polycyclic Aromatic Hydrocarbons ("PAHs") and metals above

applicable limits. Soil at the Property is contaminated with VOCs and PAHs above applicable limits.

b. Data tables reflecting the concentrations of and other information regarding the Property's regulated substances and contaminants appear in Exhibit 3 to this Agreement.

14. For purposes of this Agreement DENR relies on Prospective Developer's representations that Prospective Developer's involvement with the Property has been limited to obtaining or commissioning the Environmental Reports, preparing and submitting to DENR a Brownfields Property Application dated May 22, 2008, and acquiring the Property on July 18, 2008.

15. Prospective Developer has provided DENR with information, or sworn certifications regarding that information on which DENR relies for purposes of this Agreement, sufficient to demonstrate that:

a. Prospective Developer and any parent, subsidiary, or other affiliate has substantially complied with federal and state laws, regulations and rules for protection of the environment, and with the other agreements and requirements cited at N.C.G.S. § 130A-310.32(a)(1);

b. as a result of the implementation of this Agreement, the Property will be suitable for the uses specified in the Agreement while fully protecting public health and the environment;

c. Prospective Developer's reuse of the Property will produce a public benefit commensurate with the liability protection provided Prospective Developer hereunder;

d. Prospective Developer has or can obtain the financial, managerial and

technical means to fully implement this Agreement and assure the safe use of the Property; and

e. Prospective Developer has complied with all applicable procedural requirements.

16. Prospective Developer has paid the $2,000 fee to seek a brownfields agreement required by N.C.G.S. § 130A-310.39(a)(1), and shall make a payment to DENR of $3,500 at the time Prospective Developer and DENR enter into this Agreement, defined for this purpose as occurring no later than the last day of the public comment period related to this Agreement. The Parties agree that the second payment shall constitute, within the meaning of N.C.G.S. § 130A-310.39(a)(2), the full cost to DENR and the North Carolina Department of Justice of all activities related to this Agreement.

IV. BENEFIT TO COMMUNITY

17. The redevelopment of the Property proposed herein would provide the following public benefits:

a. a return to productive use of the Property;

b. a spur to additional community redevelopment, through improved neighborhood appearance and otherwise;

c. a total of 900 to 1,000 jobs throughout the project;

d. tax revenue for affected jurisdictions;

e. additional retail, office, and other commercial space for the area; and

f. "smart growth" through use of land in an already developed area, which avoids development of land beyond the urban fringe ("greenfields").

V. WORK TO BE PERFORMED

18. In redeveloping the Property, Prospective Developer shall consider the application of sustainability principles at the Property, using the six (6) areas incorporated into the U.S. Green Building Council Leadership in Energy and Environmental Design certification program (Sustainable Sites, Water Efficiency, Energy & Atmosphere, Materials & Resources, Indoor Environmental Quality and Innovation in Design), or a similar program.

19. Based on the information in the Environmental Reports, and subject to imposition of and compliance with the land use restrictions set forth below, and subject to Section IX of this Agreement (DENR's Covenant Not to Sue and Reservation of Rights), DENR is not requiring Prospective Developer to perform any active remediation at the Property.

20. By way of the Notice of Brownfields Property referenced below in paragraph 25, Prospective Developer shall impose the following land use restrictions under the Act, running with the land, to make the Property suitable for the uses specified in this Agreement while fully protecting public health and the environment. All references to DENR shall be understood to include any successor in function.

a. No use may be made of the Property other than for a retail shopping center, associated roadways and, if DENR issues prior written approval, other commercial and office purposes. For purposes of this restriction, the following definitions apply:

i. "Retail Shopping Center" refers to a group of commercial establishments, planned and developed as a unit, with common parking, pedestrian movement, ingress and egress, where sale to the public of services not covered by subparagraph 20.a.iii. below and merchandise occurs.

ii. "Commercial" refers to a business enterprise.

iii. "Office" refers the provision of business or professional services.

b. No physical redevelopment of the Property may occur unless and until DENR's Brownfields and Solid Waste programs conclude in writing that the proposed redevelopment will not negatively affect the cover, structural integrity and monitoring systems at the closed landfill facility located on adjacent property.

c. The owner of the Property shall, at its own expense, correct any impacts to the Property or the adjacent landfill, as determined by DENR, that increase the cost of compliance or ability to comply with rules and regulations for environmental protection, or adversely affect environmental permits regarding the Property or the adjacent landfill that are caused by development on the Property or landfill. Said corrections must be made with prior DENR approval to the written satisfaction of DENR's Brownfields Program and Solid Waste Section.

d. No activities that encounter, expose, remove or use groundwater (for example, installation of water supply wells, fountains, ponds, lakes or swimming pools, or construction or excavation activities that encounter or expose groundwater) or surface water may occur on the Property without any prior sampling (and sampling analysis) DENR deems desirable, and any remediation DENR deems desirable based on the analysis, to ensure the Property is suitable for the uses specified in subparagraph 20.a. above and that public health and the environment are fully protected.

e. Soil in the areas designated "Area of Possible Soil Contamination" on the plat component of the Notice referenced in paragraph 25 below, and soil underlying paved and other impervious surfaces and buildings at the Property, may not be disturbed unless and until DENR

approves in writing a plan with a schedule, and its implementation, that requires:

i. capping (with asphalt, concrete, stone, brick, terrazzo, roofing, ceramic tile, two (2) feet of clean soil or other impervious material approved in writing in advance by DENR), remediation and/or removal of sufficient soil to satisfy DENR that the Property is suitable for the uses specified in subparagraph 20.a. above and that public health and the environment are fully protected despite any remaining soil contamination, as determined by sampling of each excavation's side walls and bottom; and

ii. a written report regarding implementation of the plan, submitted no later than 30 days following its implementation, and correction of any deficiencies DENR identifies in the report or in implementation of the plan within 30 days after DENR provides written notice of such deficiencies.

f. No building may be constructed on the Property until:

i. DENR determines in writing, based on submittals from the building's proponent, that the building's users, and public health and the environment, would be fully protected from the Property's contaminated soil; or

ii. vapor mitigation measures approved in writing by DENR in advance are installed to the satisfaction of a professional engineer licensed in North Carolina, as evidenced by said engineer's seal, and photographs illustrating the installation and a brief narrative describing it are submitted to DENR and deemed satisfactory in writing by that agency.

g. No mining may be conducted on or under the Property, including, without limitation, extraction of coal, oil, gas or any other minerals or non-mineral substances.

h. No basements may be constructed on the Property unless they are, as

determined in writing by DENR, vented in conformance with applicable building codes.

i. None of the contaminants known to be present in the environmental media at the Property, including those listed in Exhibit 3 hereto, may be used or stored at the Property without the prior written approval of DENR, except in *de minimis* amounts for cleaning and other routine housekeeping activities.

j. The Property may not be used for agriculture, grazing, timbering or timber production.

k. The Property may not be used as a playground, or for child care centers or schools.

l. The Property may not be used for kennels, private animal pens or horse-riding.

m. The owner of any portion of the Property where any existing, or subsequently installed, DENR-approved monitoring well is damaged shall be responsible for repair of any such wells to DENR's written satisfaction and within a time period acceptable to DENR.

n. Neither DENR, nor any party conducting environmental assessment or remediation at the Property at the direction of, or pursuant to a permit, order or agreement issued or entered into by DENR, may be denied access to the Property for purposes of conducting such assessment or remediation, which is to be conducted using reasonable efforts to minimize interference with authorized uses of the Property.

o. During January of each year after the year in which the Notice referenced below in paragraph 25 is recorded, the owner of any part of the Property as of January 1st of that year shall submit a notarized Land Use Restrictions Update ("LURU") to DENR, and to the chief public health and environmental officials of Buncombe County, certifying that, as of said

January 1st, the Notice of Brownfields Property containing these land use restrictions remains recorded at the Buncombe County Register of Deeds office and that the land use restrictions are being complied with, and stating:

i. the name, mailing address, telephone and facsimile numbers, and contact person's e-mail address of the owner submitting the LURU if said owner acquired any part of the Property during the previous calendar year; and

ii. the transferee's name, mailing address, telephone and facsimile numbers, and contact person's e-mail address, if said owner transferred any part of the Property during the previous calendar year.

21. The desired result of the above-referenced land use restrictions is to make the Property suitable for the uses specified in the Agreement while fully protecting public health and the environment.

22. The guidelines, including parameters, principles and policies within which the desired results are to be accomplished are, as to field procedures and laboratory testing, the Guidelines of the Inactive Hazardous Sites Branch of DENR's Superfund Section, as embodied in their most current version.

23. The consequences of achieving or not achieving the desired results will be that the uses to which the Property is put are or are not suitable for the Property while fully protecting public health and the environment.

VI. ACCESS/NOTICE TO SUCCESSORS IN INTEREST

24. In addition to providing access to the Property pursuant to subparagraph 20.n. above, Prospective Developer shall provide DENR, its authorized officers, employees, representatives,

and all other persons performing response actions under DENR oversight, access at all reasonable times to other property controlled by Prospective Developer in connection with the performance or oversight of any response actions at the Property under applicable law. While Prospective Developer owns the Property, DENR shall provide reasonable notice to Prospective Developer of the timing of any response actions to be undertaken by or under the oversight of DENR at the Property. Notwithstanding any provision of this Agreement, DENR retains all of its authorities and rights, including enforcement authorities related thereto, under the Act and any other applicable statute or regulation, including any amendments thereto.

25. DENR has approved, pursuant to N.C.G.S. § 130A-310.35, a Notice of Brownfields Property for the Property containing, inter alia, the land use restrictions set forth in Section V (Work to Be Performed) of this Agreement and a survey plat of the Property. Pursuant to N.C.G.S. § 130A-310.35(b), within 15 days of the effective date of this Agreement Prospective Developer shall file the Notice of Brownfields Property in the Buncombe County, North Carolina register of deeds' office. Within three (3) days thereafter, Prospective Developer shall furnish DENR a copy of the documentary component of the Notice containing a certification by the register of deeds as to the Book and Page numbers where both the documentary and plat components of the Notice are recorded, and a copy of the plat with notations indicating its recordation.

26. This Agreement shall be attached as Exhibit A to the Notice of Brownfields Property. Subsequent to recordation of said Notice, any deed or other instrument conveying an interest in the Property shall contain the following notice: "The property which is the subject of this instrument is subject to the Brownfields Agreement attached as Exhibit A to the Notice of

Brownfields Property recorded in the Buncombe County land records, Book 5185, Page 1280." A copy of any such instrument shall be sent to the persons listed in Section XV (Notices and Submissions), though financial figures related to the conveyance may be redacted.

27. The Prospective Developer shall ensure that a copy of this Agreement is provided to any current lessee or sublessee on the Property as of the effective date of this Agreement and shall ensure that any subsequent leases, subleases, assignments or transfers of the Property or an interest in the Property are consistent with this Section (Access/Notice To Successors In Interest), Section V (Work to be Performed) and Section XI (Parties Bound & Transfer/Assignment Notice) of this Agreement.

VII. DUE CARE/COOPERATION

28. The Prospective Developer shall exercise due care at the Property with respect to regulated substances and shall comply with all applicable local, State, and federal laws and regulations. The Prospective Developer agrees to cooperate fully with any remediation of the Property by DENR and further agrees not to interfere with any such remediation. In the event the Prospective Developer becomes aware of any action or occurrence which causes or threatens a release of contaminants at or from the Property, the Prospective Developer shall immediately take all appropriate action to prevent, abate, or minimize such release or threat of release, and shall, in addition to complying with any applicable notification requirements under N.C.G.S. 130A-310.1 and 143-215.85, and Section 103 of CERCLA, 42 U.S.C. § 9603, or any other law, immediately notify DENR of such release or threatened release.

VIII. CERTIFICATION

29. By entering into this agreement, the Prospective Developer certifies that, without

DENR approval, it will make no use of the Property other than that committed to in the Brownfields Property Application dated May 22, 2008 by which it applied for this Agreement (except as may be modified herein). That use is as set forth in subparagraph 20.a. above. Prospective Developer also certifies that to the best of its knowledge and belief it has fully and accurately disclosed to DENR all information known to Prospective Developer and all information in the possession or control of its officers, directors, employees, contractors and agents which relates in any way to any regulated substances at the Property and to its qualification for this Agreement, including the requirement that it not have caused or contributed to the contamination at the Property.

IX. DENR'S COVENANT NOT TO SUE AND RESERVATION OF RIGHTS

30. Unless any of the following apply, Prospective Developer shall not be liable to DENR, and DENR covenants not to sue Prospective Developer, for remediation of the Property except as specified in this Agreement:

a. The Prospective Developer fails to comply with this Agreement.

b. The activities conducted on the Property by or under the control or direction of the Prospective Developer increase the risk of harm to public health or the environment, in which case Prospective Developer shall be liable for remediation of the areas of the Property, remediation of which is required by this Agreement, to the extent necessary to eliminate such risk of harm to public health or the environment.

c. A land use restriction set out in the Notice of Brownfields Property required under N.C.G.S. 130A-310.35 is violated while the Prospective Developer owns the Property, in which case the Prospective Developer shall be responsible for remediation of the Property to

unrestricted use standards.

d. The Prospective Developer knowingly or recklessly provided false information that formed a basis for this Agreement or knowingly or recklessly offers false information to demonstrate compliance with this Agreement or fails to disclose relevant information about contamination at the Property.

e. New information indicates the existence of previously unreported contaminants or an area of previously unreported contamination on or associated with the Property that has not been remediated to unrestricted use standards, unless this Agreement is amended to include any previously unreported contaminants and any additional areas of contamination. If this Agreement sets maximum concentrations for contaminants, and new information indicates the existence of previously unreported areas of these contaminants, further remediation shall be required only if the areas of previously unreported contaminants raise the risk of the contamination to public health or the environment to a level less protective of public health and the environment than that required by this Agreement.

f. The level of risk to public health or the environment from contaminants is unacceptable at or in the vicinity of the Property due to changes in exposure conditions, including (i) a change in land use that increases the probability of exposure to contaminants at or in the vicinity of the Property or (ii) the failure of remediation to mitigate risks to the extent required to make the Property fully protective of public health and the environment as planned in this Agreement.

g. The Department obtains new information about a contaminant associated with the Property or exposures at or around the Property that raises the risk to public health or the

environment associated with the Property beyond an acceptable range and in a manner or to a degree not anticipated in this Agreement.

h. The Prospective Developer fails to file a timely and proper Notice of Brownfields Property under N.C.G.S. 130A-310.35.

31. Except as may be provided herein, DENR reserves its rights against Prospective Developer as to liabilities beyond the scope of the Act, including those regarding petroleum underground storage tanks pursuant to Part 2A, Article 21A of Chapter 143 of the General Statutes.

32. This Agreement does not waive any applicable requirement to obtain a permit, license or certification, or to comply with any and all other applicable law, including the North Carolina Environmental Policy Act, N.C.G.S. § 113A-1, et seq.

X. PROSPECTIVE DEVELOPER'S COVENANT NOT TO SUE

33. In consideration of DENR's Covenant Not To Sue in Section IX of this Agreement and in recognition of the absolute State immunity provided in N.C.G.S. § 130A-310.37(b), the Prospective Developer hereby covenants not to sue and not to assert any claims or causes of action against DENR, its authorized officers, employees, or representatives with respect to any action implementing the Act, including negotiating, entering, monitoring or enforcing this Agreement or the above-referenced Notice of Brownfields Property.

XI. PARTIES BOUND

34. This Agreement shall apply to and be binding upon DENR, and on the Prospective Developer, its officers, directors, employees, and agents. Each Party's signatory to this Agreement represents that she or he is fully authorized to enter into the terms and conditions of

this Agreement and to legally bind the Party for whom she or he signs.

XII. DISCLAIMER

35. This Agreement in no way constitutes a finding by DENR as to the risks to public health and the environment which may be posed by regulated substances at the Property, a representation by DENR that the Property is fit for any particular purpose, nor a waiver of Prospective Developer's duty to seek applicable permits or of the provisions of N.C.G.S. § 130A-310.37.

36. Except for the Land Use Restrictions set forth in paragraph 20.a., above and N.C.G.S. § 130A-310.33(a)(1)-(5)'s provision of the Act's liability protection to certain persons to the same extent as to a prospective developer, no rights, benefits or obligations conferred or imposed upon Prospective Developer under this Agreement are conferred or imposed upon any other person.

XIII. DOCUMENT RETENTION

37. The Prospective Developer agrees to retain and make available to DENR all business and operating records, contracts, site studies and investigations, and documents relating to operations at the Property, for ten years following the effective date of this Agreement, unless otherwise agreed to in writing by the Parties. At the end of ten years, the Prospective Developer shall notify DENR of the location of such documents and shall provide DENR with an opportunity to copy any documents at the expense of DENR.

XIV. PAYMENT OF ENFORCEMENT COSTS

38. If the Prospective Developer fails to comply with the terms of this Agreement, including, but not limited to, the provisions of Section V (Work to be Performed), it shall be

liable for all litigation and other enforcement costs incurred by DENR to enforce this Agreement or otherwise obtain compliance.

XV. NOTICES AND SUBMISSIONS

39. Unless otherwise required by DENR or a Party notifies the other Party in writing of a change in contact information, all notices and submissions pursuant to this Agreement shall be sent by prepaid first class U.S. mail, as follows:

a. for DENR:

Tracy Wahl
N.C. Division of Waste Management
Brownfields Program
Mail Service Center 1646
Raleigh, NC 27699-1646

b. for Prospective Developer:

Kenneth D. Murphy
Enka Partners of Asheville, LLC
1091 Hendersonville Road
Asheville, NC 28806

Notices and submissions sent by prepaid first class U.S. mail shall be effective on the third day following postmarking. Notices and submissions sent by hand or by other means affording written evidence of date of receipt shall be effective on such date.

XVI. EFFECTIVE DATE

40. This Agreement shall become effective on the date the Prospective Developer signs it, after receiving it, signed, from DENR. Prospective Developer shall sign the Agreement within seven (7) days following such receipt.

XVII. TERMINATION OF CERTAIN PROVISIONS

41. If any Party believes that any or all of the obligations under Section VI

(Access/Notice to Successors in Interest) are no longer necessary to ensure compliance with the requirements of the Agreement, that Party may request in writing that the other Party agree to terminate the provision(s) establishing such obligations; provided, however, that the provision(s) in question shall continue in force unless and until the Party requesting such termination receives written agreement from the other Party to terminate such provision(s).

XVIII. CONTRIBUTION PROTECTION

42. With regard to claims for contribution against Prospective Developer in relation to the subject matter of this Agreement, Prospective Developer is entitled to protection from such claims to the extent provided by N.C.G.S. § 130A-310.37(a)(5)-(6). The subject matter of this Agreement is all remediation taken or to be taken and response costs incurred or to be incurred by DENR or any other person in relation to the Property.

43. The Prospective Developer agrees that, with respect to any suit or claim for contribution brought by it in relation to the subject matter of this Agreement, it will notify DENR in writing no later than 60 days prior to the initiation of such suit or claim.

44. The Prospective Developer also agrees that, with respect to any suit or claim for contribution brought against it in relation to the subject matter of this Agreement, it will notify DENR in writing within 10 days of service of the complaint on it.

XIX. PUBLIC COMMENT

45. This Agreement shall be subject to a public comment period of at least 30 days starting the day after the last to occur of the following: publication of the approved summary of the Notice of Intent to Redevelop a Brownfields Property required by N.C.G.S. § 130A-310.34 in a newspaper of general circulation serving the area in which the Property is located,

conspicuous posting of a copy of said summary at the Property, and mailing or delivery of a copy of the summary to each owner of property contiguous to the Property. After expiration of that period, or following a public meeting if DENR holds one pursuant to N.C.G.S. § 130A-310.34(c), DENR may modify or withdraw its consent to this Agreement if comments received disclose facts or considerations which indicate that this Agreement is inappropriate, improper or inadequate.

IT IS SO AGREED:
NORTH CAROLINA DEPARTMENT OF ENVIRONMENT AND NATURAL RESOURCES
By:

February 4, 2014
Linda M. Culpepper Date
Deputy Director, Division of Waste Management

IT IS SO AGREED:
ENKA PARTNERS OF ASHEVILLE, LLC
By:

2-11-14
Kenneth D. Murphy Date
Managing Member

29

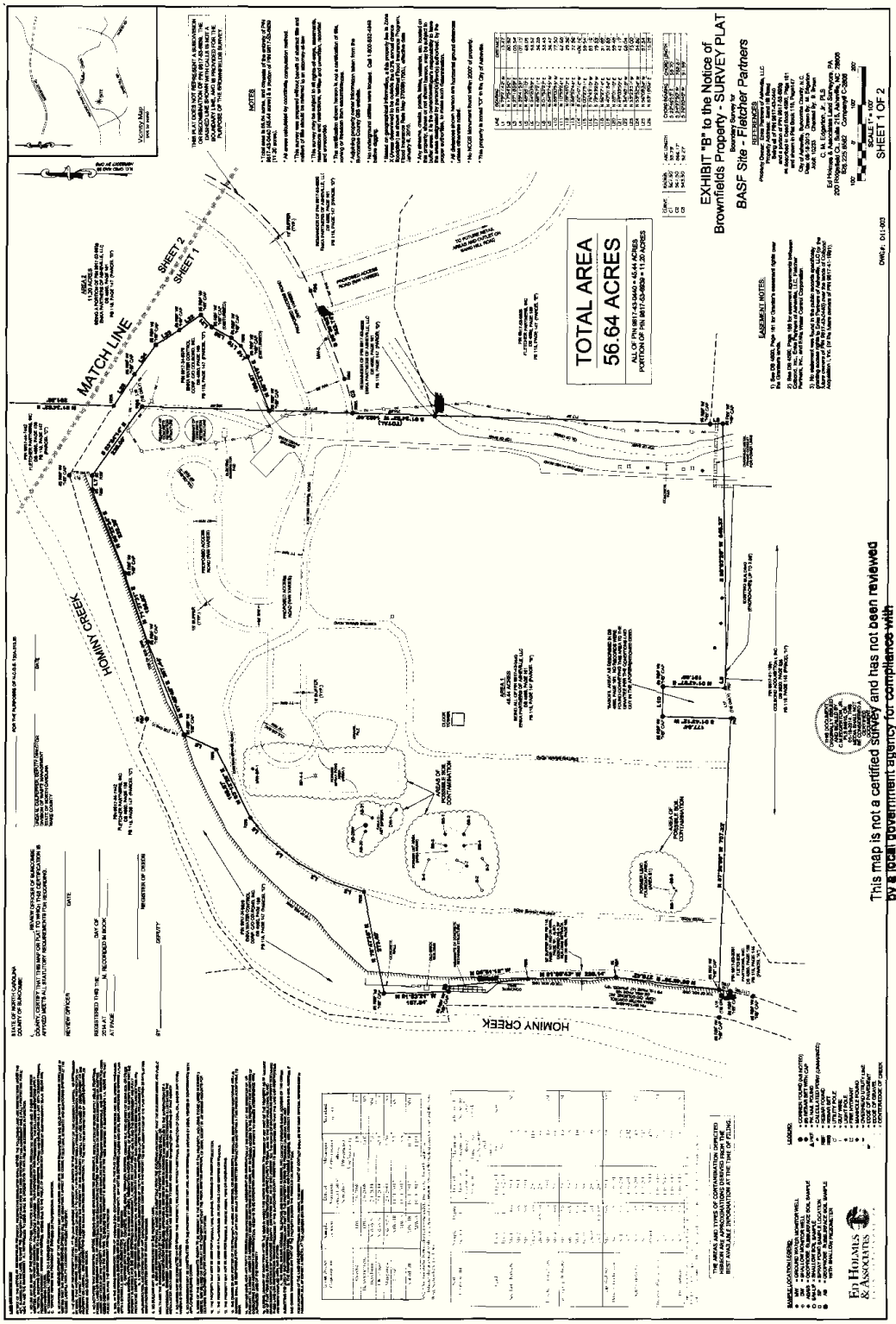
EXHIBIT "B" to the Notice of
Brownfields Property - SURVEY PLAT
BASF Site - Fletcher Partners
TOTAL AREA
56.64 ACRES
ALL OF PIN 9617-63-9940 = 45.44 ACRES
PORTION OF PIN 9617-63-9659 = 11.20 ACRES
MATCH LINE
SHEET 2
SHEET 1
HOMINY CREEK
HOMINY CREEK
This map is not a certified survey and has not been reviewed by a local government agency for compliance with any applicable land development regulations
SHEET 1 OF 2

30

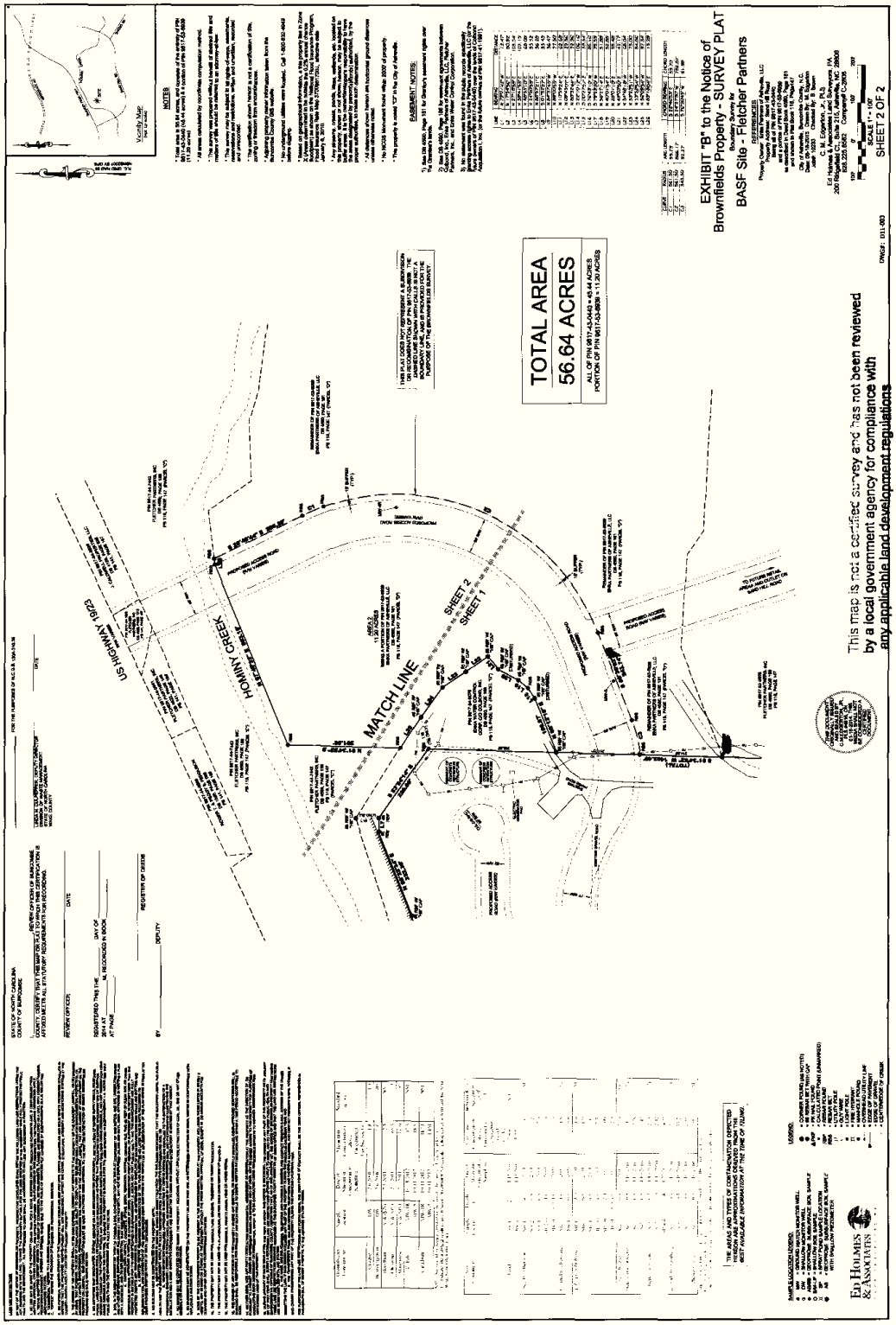
EXHIBIT "B" to the Notice of
Brownfields Property - SURVEY PLAT
BASF Site - Fletcher Partners
Boundary Survey for
SHEET 2 OF 2
TOTAL AREA
56.64 ACRES
ALL OF PIN 9617-53-0440 = 45.44 ACRES
PORTION OF PIN 9617-53-9699 = 11.20 ACRES
MATCH LINE
SHEET 2
SHEET 1
US HIGHWAY 1925
HOMINY CREEK
This map is not a certified survey and has not been reviewed
by a local government agency for compliance with
any applicable land development regulations
ED HOLMES
& ASSOCIATES

EXHIBIT C
LEGAL DESCRIPTION

AREA 1: Lying in the City of Asheville, Buncombe County, North Carolina, and being more particularly described as follows:

Beginning at a #5 rebar with cap found at the northwesternmost of Parcel "A" as shown in PB 118, Page 145, said rebar lying N 88°32'44" E 72.96 feet from a #5 rebar with cap found in the western line of Parcel "G" as shown in PB 118, Page 147; running thence from said Point of Beginning with the eastern and southern boundary line of said Parcel "G", N 06°45'38" E 270.42 feet to a #5 rebar found; thence N 01°00'43" W 229.14 feet to a #5 rebar set with cap; thence N 05°51'18" W 205.18 feet to a point; thence N 79°21'42" W 13.47 feet to a #5 rebar with cap; thence N 01°53'21" W 167.64 feet to a #5 rebar with cap; thence N 78°47'35" E 273.40 feet to a #5 rebar set with cap; thence N 17°54'56" E 80.92 feet to a point; thence N 27°18'39" E 103.54 feet to a point; thence N 39°41'53" E 107.15 feet to a point; thence N 48°35'10" E 68.05 feet to a #5 rebar set with cap; thence N 63°12'26" E 195.87 feet to a #5 rebar set with cap; thence N 24°20'59" E 93.52 feet to a #5 rebar with cap found, said rebar lying S 22°10'12" W 106.16 feet from a #5 rebar found in the northern line of Parcel "G"; thence N 67°48'45" E 257.44 feet to a #5 rebar with cap found; thence N 71°37'31" E 188.52 feet to a #5 rebar with cap found; thence N 68°22'34" E 232.36 feet to a #5 rebar found; thence N 88°57'21" E 36.28 feet to a #5 rebar found; thence S 53°54'14" E 220.09 feet to a #5 rebar set with cap; thence continuing with the boundary line of Parcel "G" in a southerly direction on a bearing of S 01°34'52" W , (passing a #5 rebar with cap found at 332.58 feet, said rebar being a common corner of Parcels "D" and "G" as shown in PB 118, Page 147; and passing a #5 rebar set with cap at 550.30 feet, said rebar being the southwesternmost corner of "Area 2" as described below; and passing a #5 rebar with cap found at 764.86 feet, said rebar being the common westernmost corner of Parcels "D" and "E" as shown in PB 118, Page 147) a total distance of 1482.46 feet to a #5 rebar with cap found, said rebar being the common corner of Parcel "E" as shown in PB 118, Page 147 and Parcel "H" as shown in PB 118, Page 145; thence S 01°52'27" E 33.43 feet to a #5 rebar with cap found; thence S 89°03'26" W 648.32 feet to a point; thence N 84°37'45" W 36.47 feet to a PK nail found; thence N 01°43'07" E 161.69 feet to a #5 rebar with cap found; thence N 89°00'55" W 77.50 feet to a #5 rebar with cap found; thence S 01°43'12" W 177.64 feet to a PK nail found; thence N 87°38'50" W 707.22 feet to the Point of Beginning; containing 45.44 acres and being all of "Area 1" as shown on the plat titled "Exhibit B to the Notice of Brownfields Property - Survey Plat for BASF Site - Fletcher Partners" by Ed Holmes & Associates Land Surveyors and dated June 7, 2013. Also being all of Parcel "B" as shown in Plat Book 118, Page 147.

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AREA 2: Lying in the City of Asheville, Buncombe County, North Carolina, and being more particularly described as follows:

Beginning at a #5 rebar with cap found at the common corner of Parcels "B", "D", and "G" as shown in PB 118, Page 147, said rebar lying S 01°34'52" W 332.58 feet from a #5 rebar set with cap at the terminus of the 17th call in the description of "AREA 1" above; running thence from said Point of Beginning with the boundary line of said Parcel "G", N 68°12'19" E 150.67 feet to a #5 rebar with cap found; thence N 56°27'14" E 31.89 feet to a #5 rebar set with cap; thence N 40°01'34" E 32.83 feet to a #5 rebar with cap found; thence N 28°01'10" E 59.48 feet to a #5 rebar with cap found; thence N 49°03'50" E 42.17 feet to a #5 rebar with cap found; thence N 34°48'18" W 68.04 feet to a #5 rebar with cap found; thence N 33°23'51" W 73.00 feet to a #5 rebar with cap found; thence N 53°32'54" W 94.86 feet to a #5 rebar with cap found; thence N 56°09'34" W 97.34 feet to a #5 rebar set with cap at the common corner of Parcels "C", "D", and "G" as shown in PB 118, Page 147; thence with the boundary line of said Parcel "C", N 01°34'52" E 291.86 feet to a #5 rebar set with cap near the southern bank of Hominy Creek; thence more or less along the bank of the creek N 67°45'33" E 503.15 feet to a #5 rebar set with cap in the eastern R/W of a proposed access road; thence N 83°18'04" E 15.29 to a #5 rebar set with cap on the 15' buffer of said proposed access road; thence leaving the creek bank and the boundary line of Parcel "C", on a new line along the 15' road buffer, S 25°49'44" E 255.29 feet to a #5 rebar set with cap; thence on a curve to the right with a radius of 561.50 feet, an arc length of 59.73 feet, and a chord bearing and length of S 22°46'53" E 59.70 feet to a #5 rebar set with cap; thence on a curve to the right with a radius of 561.50 feet, an arc length of 866.17 feet, and a chord bearing and length of S 24°27'30" W 782.81 feet to a #5 rebar set with cap; thence S 68°39'02" W 243.74 feet to a #5 rebar set with cap; thence on a curve to the right with a radius of 343.50 feet, an arc length of 92.27 feet, and a chord bearing and length of S 76°20'45" W 91.99 feet to a #5 rebar set with cap in the eastern boundary line of Parcel "B"; thence S 01°34'52" W 217.72 feet to the Point of Beginning; containing 11.20 acres and being all of "Area 2" as shown on the plat titled "Exhibit B to the Notice of Brownfields Property - Survey Plat for BASF Site - Fletcher Partners" by Ed Holmes & Associates Land Surveyors and dated June 7, 2013. Also being a portion of Parcel "D" as shown in Plat Book 118, Page 147.

ALTAMONT ENVIRONMENTAL, INC.
ENGINEERING & HYDROLOGY
231 HAYWOOD STREET, ASHEVILLE, NC 28801
TEL.828.281.9350 FAX.828.251.5251
WWW.ALTAMONTENVIRONMENTAL.COM

SITE LOCATION MAP

COLBOND FACILITY /
FORMER BASF CORPORATION FACILITY
ENKA, NORTH CAROLINA

FIGURE
1

DRAWN BY: EVAN YURKOVICH
PROJECT MANAGER: CHRIS GILBERT
CLIENT: ENKA PARTNERS
DATE: 12/06/2010

SCALE
0 500 1,000 2,000
Feet

P:\ENKA PARTNERS\FIGURES\GIS\FIG 1-ENKA PARTNERS SITE LOCATION MAP.MXD

EXHIBIT 2

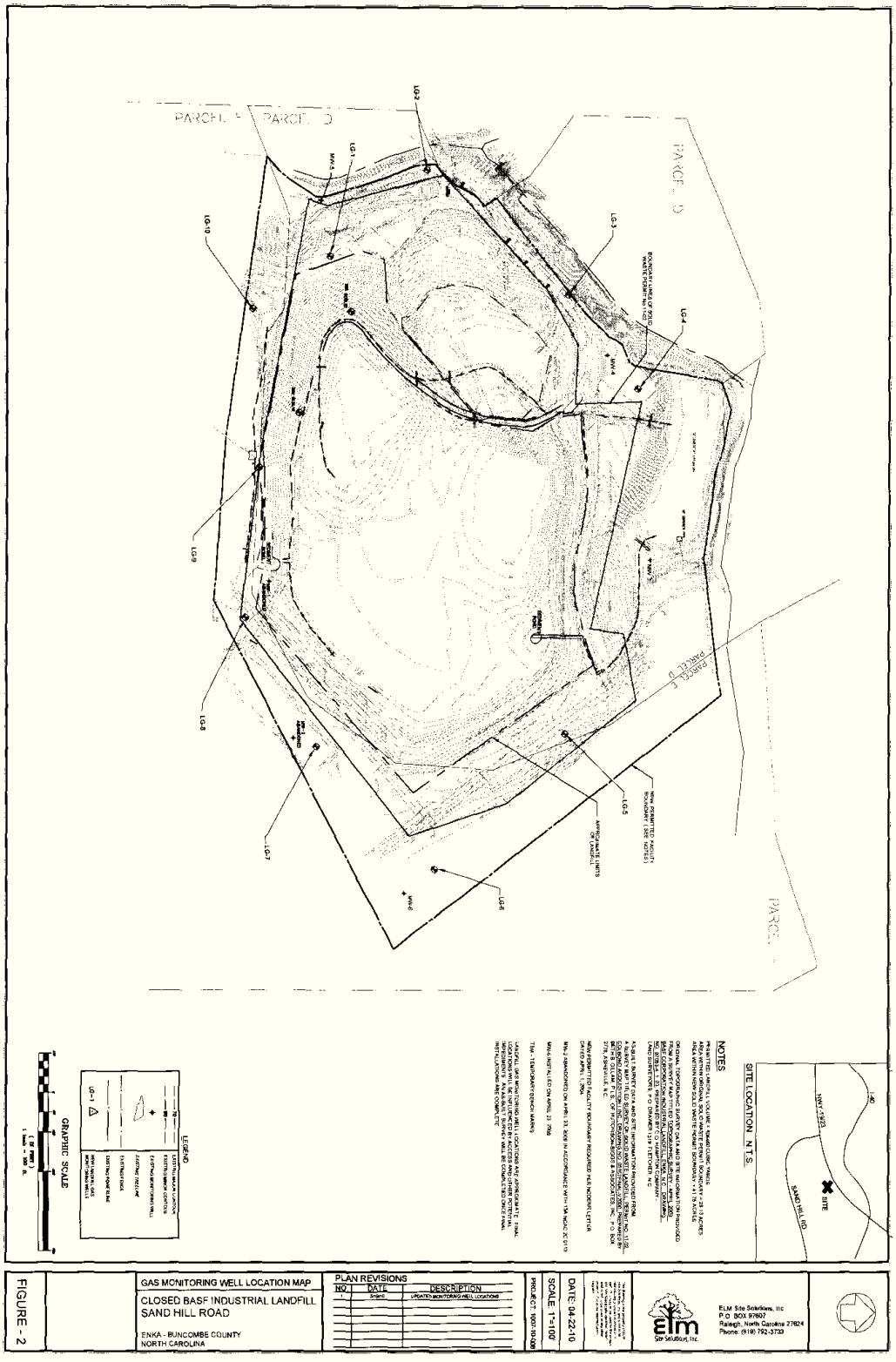

FIGURE - 2	GAS MONITORING WELL LOCATION MAP CLOSED BASF INDUSTRIAL LANDFILL SAND HILL ROAD ENKA - BUNCOMBE COUNTY NORTH CAROLINA	PLAN REVISIONS NO. DATE DESCRIPTION 1 3/19/10 UPDATED MONITORING WELL LOCATIONS	PROJECT: 1007-10-006	SCALE: 1"=100'	DATE: 04-22-10

ELM Site Solutions, Inc
P.O. BOX 97607
Raleigh, North Carolina 27624
Phone: (919) 792-3733

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Exhibit 3

The most recent environmental sampling at the Property reported in the Environmental Reports occurred on October 11, 2012. The following tables set forth, along with other information, the contaminants that sampling has shown to be present at the Property above unrestricted use standards and/or screening levels. The contaminant-specific standard and/or screening level shown in the right-hand column is presented for reference purposes only and does not necessarily represent the cleanup goal under the Land Use Restrictions contained in this Agreement.

Groundwater contaminants (in micrograms per liter, the equivalent of parts per billion), the standards for which are contained in Title 15A of the North Carolina Administrative Code, Subchapter 2L, Rule .0202 (April 1, 2013 version):

Groundwater Contaminant	Sample Location	Date of Maximum Concentration Sampling	Maximum Concentration above Unrestricted Use Std. (µg/L)	Standard (µg/L)
Benzene	DW-1	2/6/2008	1.8	1.0
Benzo(a)pyrene	DW-1	2/6/2008	<10.0	.005
Beryllium	MW-SP-1	2/1/2011	2.3	NSE
Chromium	MW-SP-1	2/1/2011	65.3	10
Manganese	MW-SP-1	2/1/2011	3170	50
Cobalt	MW-4R	10/11/2012	17.3	NSE
	MW-5	10/11/2012	18.5	
Vanadium	MW-4R	10/11/2012	11.7J	NSE
	MW-5	10/11/2012	1.45J	

NSE = No standard has been established for the analyte, thus any level must be addressed.
J – Indicates the analytical result is an estimated concentration between the method detection limit and the Solid Waste Section Reporting Limit.

Soil contaminants (in milligrams per kilogram, the equivalent of parts per million), the screening levels for which are derived using the Preliminary Industrial Health- Based Soil Remediation Goals of the Inactive Hazardous Sites Branch of DENR's Superfund Section (February 2013 version):

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Soil Contaminant	Sample Location	Depth (ft.)	Date of Maximum Concentration Sampling	Maximum Concentration above Unrestricted Use Screening Level (mg/kg)	Industrial Use Screening Level[1] (mg/kg)
Lead	BS-1	2	1/15/2001	3900	800
	BS-6	4	1/15/2001	1700	
Sec-Butylbenzene	SB-1	4-6	2001	3.0	NSL
	SB-2	6-8	2001	3.5	
	SB-4	6-8	2001	7.0	
	AB-29w	4-6	2003	11.0	
	AB-31	0.5-1.0	2003	3.6	
1,3-Dichlorobenzene	SB-3	4-6	2001	4.8	NSL
	SB-4	6-8	2001	6.0	
p-Isopropyltoluene	SB-1	4-6	2001	1.8	NSL
	SB-2	6-8	2001	1.9	
	SB-4	6-8	2001	4.0	
	AB-29w	4-6	2003	7.5	
	AB-30	2-4	2003	.09	
	AB-31	0.5-1.0	2003	2.9	
Naphthalene	SB-2	6-8	2001	31.0	18.0
Benzo(a)anthracene	S-3	0.5	4/16/2010	31.3	2.1
	S-4	0.5	4/16/2010	2.28	
	S-7	0.5	4/16/2010	2.42	
Benzo(a)pyrene	S-3	0.5	4/16/2010	24.5	0.21
	S-7	0.5	4/16/2010	2.42	
	SP-4-4	4	1/27/2011	.479	
Benzo(b)fluoranthene	S-2	0.5	4/16/2010	55.1	2.1
	S-3	0.5	4/16/2010	33.2	
	S-7	0.5	4/16/2010	2.55	
Phenanthrene	S-2	0.5	4/16/2010	103	NSL

[1]http://portal.ncdenr.org/c/document_library/get_file?uuid=5539ecfb-739f-4345-9459-b514508135f1&groupId=38361

NSL = No screening level has been established for this analyte, thus any level must be addressed.