Comments on
Competing Applications for Acute Care Beds in the Buncombe/Graham/Madison/Yancey County Service Area

December 1, 2025

Competitive Comments on Buncombe Multicounty Service Area

Acute Care Bed Applications

submitted by

UNC Health West Medical Center, Inc.

In accordance with N.C. GEN. STAT. § 131E-185(a1)(1), UNC Health West Medical Center, Inc. (UNC Health) hereby submits the following comments related to the competing applications filed by AdventHealth, Novant Health (Novant), and HCA Mission Hospital (HCA Mission) to add licensed acute care beds in response to the need identified in the *2025 State Medical Facilities Plan* (*SMFP*) for 129 acute care beds for the multicounty area including Buncombe, Graham, Madison, and Yancey counties. UNC Health's comments include "*discussion and argument regarding whether, in light of the material contained in the application and other relevant factual material, the application complies with the relevant review criteria, plans and standards*." *See* N.C. GEN. STAT. § 131E-185(a1)(1)(c).[1] In order to facilitate the Agency's ease in reviewing these comments, UNC Health has organized its discussion by applicant and issue, specifically noting the general Certificate of Need (CON) statutory review criteria and regulations creating the non-conformity of each issue, as they relate to the applications submitted. UNC Health's comments include issue-specific comments on the following applications as well as a comparative analysis related to all submitted applications:

- AdventHealth Asheville, add 129 acute beds, Project ID # B-012716-25
- Novant Health Asheville, add 34 acute beds, Project ID # B-12709-25
- HCA Mission Hospital, add 129 acute beds, Project ID # B-12720-25

As detailed above, given the number of proposed additional acute beds, not all the applications submitted can be approved as proposed. The comments below include substantial issues that UNC Health believes render the competing applications non-conforming with applicable statutory criteria and regulatory review criteria. However, as presented at the end of these comments, even if one or more of these applications is found conforming, the UNC Health application is comparatively superior to the other applications filed and represents the most effective alternative for expanding access to acute care services in the Buncombe multicounty service area.

UNC Health has demonstrated a longstanding commitment to developing projects that increase geographic and financial accessibility to healthcare services for residents of North Carolina, provide cost-effective and efficient patient care services, and incorporate the research and medical education missions of the UNC Health system. As detailed in its application, UNC Health believes that the most effective way to meet the need for additional acute care resources identified in the *2025 SMFP* is to develop UNC Health West Medical Center, a new general acute care community hospital. The UNC Health application is the result of a comprehensive healthcare planning process intended to provide

[1] UNC Hospitals is providing comments consistent with this statute; as such, none of the comments should be interpreted as an amendment to its application filed on October 15, 2025 (Project ID # B-12708-25).

greater access to hospital-based services that will address the growing need for acute care capacity and coordinated care that spans the continuum of clinical services.

ISSUE-SPECIFIC COMMENTS ON ADVENTHEALTH ASHEVILLE HOSPITAL

AdventHealth Asheville's change of scope application to develop 129 additional acute care beds should not be approved. AdventHealth's application contains unreasonable assumptions and unsupported utilization projections that do not demonstrate a need for the proposed project. UNC Health has summarized these issues below, each of which contributes to AdventHealth's non-conformity. Please note that relative to each issue, UNC Health has identified some of the statutory review criteria and specific regulatory criteria and standards creating the non-conformity of the AdventHealth Asheville application.

1. AdventHealth fails to demonstrate why it needs to develop the proposed 129 additional beds.

   AdventHealth's application fundamentally fails to justify why its proposed expansion from 93 approved beds to a total of 222 proposed beds is necessary. Throughout the application, AdventHealth makes assertions that this larger scale will enable it to treat more complex patients and provide more comprehensive services. However, these claims are contradictory and unsupported.

   On pages 52, 65, and 82 of the application, AdventHealth contends that the additional 129 beds will allow it to serve higher-acuity patients and expand specialty services. Specifically, AdventHealth states on page 51:

   > *"To the extent that Mission argues the 2025 SMFP bed need is predominantly for high-acuity patients, it is crucial to understand that any increase in acute care beds in the service area, including those at AdventHealth Asheville, would help mitigate capacity issues at Mission Hospital. The addition of 129 acute care beds at AdventHealth Asheville would help reduce the strain on Mission Hospital, allowing it to better allocate its existing resources for higher acuity cases when necessary."*

   When compared to AdventHealth's approved change of scope application from 2024, the instant application does not justify the significant expansion – more than doubling – of its approved bed complement. In attempting to justify its proposed increase, the application includes services that are merely aspirational, but which are not included in the proposed project or otherwise a certainty, such as trauma and neonatal services. While additional beds would allow AdventHealth to treat a greater number of patients, if demand warranted, the application fails to demonstrate what services it would be unable to provide without the proposed expansion, particularly since the majority of the additional beds are proposed as general med/surg beds. Furthermore, and as will be discussed later in the comments, AdventHealth uses an inflated assumption for average length of stay that results in overstated total patient days of care and the average daily census for the facility, and ultimately shows a lack of need for the proposed number of beds. Although UNC Health agrees that additional acute beds in the service area could help alleviate the alleged capacity issues at Mission Health, AdventHealth does not demonstrate that it should be awarded all the available beds in this review. AdventHealth can increase its licensed bed inventory by a much smaller number and have sufficient capacity for its projected utilization, while also realizing the economies of scale it describes and expanding its clinical capabilities. This would allow another market entrant such as UNC Health to serve the projected demand for acute care services.

   More critically, there is no regulatory or operational requirement that ties bed capacity to service complexity or acuity level. AdventHealth can expand its medical staff, recruit specialists, and add new specialty care services at its facility without requiring all 129, or indeed *any*, additional acute care beds. The ability to provide higher-acuity care is determined by physician expertise,

equipment, protocols, and clinical capabilities – not by the number of licensed beds. Many community hospitals with fewer than 200 beds successfully provide complex surgical procedures, interventional cardiology, advanced orthopedic care, and other specialty services.

AdventHealth also argues on page 64 that increased scale will result in operational efficiencies and lower average costs per patient. However, its projections demonstrate significantly higher costs per patient, not lower. As calculated below in the comparative analysis, AdventHealth's projected operating cost per discharge in its instant application is $20,041; in the 2024 review, it was $13,076. Thus, in reality, AdventHealth projects to increase its cost per patient by nearly $7,000 or 53.3 percent. Similarly, its average charge per patient in this application is $22,469, an increase of 85.7 percent over its projected charge of $12,100 in the 2024 review.[2] As such, these data demonstrate that AdventHealth fails to justify its project based on a faulty expectation that its increased scale will lower costs for patients.

The Agency conditionally approved AdventHealth's change of scope to a 93-bed facility in 2024, based on a thorough review of need and conformity with all applicable criteria. The application fails to demonstrate that the approved hospital cannot add services without being approved for 129 additional beds. The *2025 SMFP* bed need determination does not require that any single applicant receive all 129 beds, nor does it establish that a 222-bed hospital is the appropriate solution for the service area's acuity-specific needs. AdventHealth's assertion that a 222-bed hospital is the most effective alternative is therefore unsupported.

Based on these issues, the AdventHealth Asheville application is non-conforming with Criteria 1, 3, 4, 5, 6, and 18a, and should not be approved.

2. AdventHealth's methodology incorporates unreasonable assumptions about average length of stay that inflate projected patient days and occupancy rates.

Average length of stay (ALOS) is a critical variable in projecting acute care utilization. Minor changes in ALOS assumptions produce large differences in projected patient days, which directly determine the number of beds needed. AdventHealth Asheville's ALOS assumptions are inconsistent, inadequately supported, and appear designed to inflate projected utilization rather than reflect realistic expectations.

Medical/Surgical ALOS

On page 138, AdventHealth projects an ALOS of 5.12 days for medical/surgical patients, based on CY 2024 service area med/surg discharges, noting its assumption that "[t]o project patient days for the projected med/surg discharges, AdventHealth utilized the CY 2024 average length of stay (ALOS) for the service area med/surg discharges appropriate to be served AdventHealth Asheville."

This 5.12-day ALOS is substantially higher than comparable community hospital experience and national benchmarks for non-tertiary facilities. For comparison, according to AHA data the national average length of stay for community hospitals is between 4.5 and 4.7 days. AdventHealth Hendersonville's ALOS in FY 2024 was approximately 3.9 days (14,991 patient days ÷ 3,816 discharges = 3.93). Of note, AdventHealth relied heavily on its experience at Fletcher

[2] See Agency Findings for the 2024 review: https://info.ncdhhs.gov/dhsr/coneed/decisions/2024/nov/findings/2024%20Buncombe-Graham-Madison-Yancey%20Acute%20Care%20Bed%20Competitive%20Review%20Findings.pdf

Hospital for most of its projections, yet utilized a different approach for ALOS, which ultimately inflates its patient day projections.

AdventHealth attempts to justify the 5.12-day ALOS by calculating it from service area data, but this approach is fundamentally flawed. The service area's overall ALOS includes discharges not only at HCA Mission Hospital, a 682-bed tertiary medical center that is a regional referral facility for complex care, but also academic medical centers and tertiary facilities in other major cities. It is not reasonable for a Buncombe County patient to travel to Charlotte or Durham for a lower acuity admission when this would require bypassing not only HCA Mission Hospital, the only local hospital provider, but also numerous community hospitals in western North Carolina that are much closer and more convenient. The reason that many patients from the service area leave western North Carolina to receive acute care services at facilities in the Raleigh-Durham and Charlotte markets is that they have specialized or complex care needs that require additional care expertise and treatment resources, which result in longer lengths of stay, even for the same DRGs that will be included in the scope of services at AdventHealth Asheville. Likewise, HCA Mission Hospital has a similar role for patients in other counties and communities where the local hospital is limited in the scope of services and clinical expertise. HCA Mission Hospital therefore sees a higher proportion of complex cases and receives many transfers from lower acuity facilities in the region that cannot offer the same level of clinical services. It is therefore not appropriate for AdventHealth to use all of the hospitals that patients in its service area receive care at for its calculation of an appropriate length of stay, as there are significant differences between community hospitals versus regional medical centers with high inmigration.

The following table summarizes the number of patient days and discharges by facility for inpatients from the AdventHealth Asheville service area ZIP codes with a DRG code included on the list of procedures AdventHealth states it will provide at the proposed Asheville hospital:

AdventHealth Asheville Service Area Historical Patient Days by Facility, CY 2024

Hospital Name	*Patient Days*	*Discharges*	*ALOS*	*Licensed Acute Care Beds*
Duke University Hospital	1,208	164	7.4	981
Atrium Health Carolinas Med Center	932	125	7.5	979
Atrium Health Wake Forest Baptist	1,059	173	6.1	722
Mission Hospital	97,862	18,921	5.2	682
UNC Health Blue Ridge	56	21	2.7	289
UNC Health Pardee	2,068	550	3.8	201
Haywood Regional Med Center	883	217	4.1	120
Harris Regional Hospital	766	157	4.9	82
Mission Hospital McDowell	252	69	3.7	65
AdventHealth Hendersonville	5,485	1,296	4.2	62
Blue Ridge Regional Hospital	2,070	642	3.2	46
CarePartners Rehabilitation Hospital^	5,210	402	13.0	--
Asheville Specialty Hospital^	2,364	69	34.3	--
All Others	3,137	548	5.7	n/a
Total – Acute Hospitals ≤201 Beds	**11,524**	**2,931**	**3.9**	**n/a**

Source: HIDI data. Includes all DRGs appropriate for AdventHealth Asheville hospital (per Applicant's DRG list in Exhibit C.8-9) for patients in AdventHealth's primary service area ZIP codes.

^ CarePartners and Asheville Specialty hospitals are post-acute care facilities that do not have licensed acute beds. However, because of the inpatient stays and DRG codes for these patients, AdventHealth includes these patient days and discharges in its total market ALOS, resulting in a miscalculated longer length of stay than the correct total for acute care facilities.

Based on the data shown above, AdventHealth clearly appears to include patients at these relatively higher-acuity facilities in its length of stay assumption. In particular, it projects its ALOS to be essentially the same as the ALOS for HCA Mission Hospital, which is unreasonable given the types of patients that AdventHealth states that it will not serve. Additionally, two post-acute facilities, CarePartners Rehabilitation Hospital and Asheville Specialty Hospital, are also included in the list of facilities that treated patients from the service area with a DRG code on AdventHealth Asheville's list of facility-eligible procedure codes. These two facilities had lengths of stay that were significantly higher than smaller community hospitals; as shown above, the ALOS for CarePartners was 13.0 in CY 2024, while Asheville Specialty Hospital's was more than 34 days. The result of including these facilities in AdventHealth's methodology is an assumption that inaccurately captures the longer lengths of stay from tertiary and quaternary facilities instead of projecting patient days based on the lower-acuity patients appropriate for a community hospital.

A reasonable ALOS for AdventHealth Asheville should be based on the actual patient population it will serve—predominantly lower-acuity medical/surgical patients appropriate for a community hospital. If only those patients that received care at a similar-sized community hospital (less than 201 licensed acute beds) are used for the length of stay calculation, the benchmark would be 3.9 days, rather than 5.12 days.

The impact of this overstated ALOS is substantial. Recalculating patient days with a more reasonable ALOS of 4.0 days (still aggressive compared to the peer facility average) produces the following comparison:

Recalculated AdventHealth Asheville Patient Days with Adjusted ALOS

Project Year	*Discharges (Med/Surg)*	*ALOS*	*Recalculated ALOS*	*AdventHealth P. Days*	*Recalculated P. Days*	*Difference*
PY1 CY2030	4,097	5.12	4.00	20,971	16,388	-4,583
PY2 CY2031	7,528	5.12	4.00	38,533	30,112	-8,421
PY3 CY2032	11,287	5.12	4.00	57,773	45,148	-12,625

Using a more realistic ALOS reduces projected patient days by 12,625 days in PY3, equivalent to a reduction in average daily census of 34.6 patients. This suggests that AdventHealth could serve its projected annual discharge volumes with substantially fewer beds than proposed.

Impact on Occupancy Projections

The inflated ALOS directly drives AdventHealth's occupancy projections. In PY3, AdventHealth projects 74.4 percent occupancy (page 150). However, using a more realistic ALOS of 4.0 days would reduce total patient days to approximately 47,700 (including obstetrics), resulting in an ADC of 130.7 patients and occupancy of only 58.9 percent in a 222-bed facility.

This would fall well below the target occupancy percentage required by the Criteria and Standards for Acute Care Beds, demonstrating that the proposed project is inappropriately sized for the

actual number of patient days that could be expected under the best scenario, and AdventHealth has not demonstrated the need for its proposed number of beds.

Conclusion on ALOS Assumptions

AdventHealth's ALOS assumptions are unreasonably high, inconsistent with its comparable facility's actual experience, and appear designed to inflate projected utilization rather than reflect realistic expectations. The 5.12-day ALOS cannot be reconciled with:

- The community hospital service model AdventHealth proposes
- The exclusion of high-acuity tertiary services from projected discharges
- National benchmarks for community hospital ALOS
- Outmigration of complex patients to tertiary and quaternary facilities outside the service area

By overstating ALOS, AdventHealth inflates its projected patient days and occupancy rates, creating an amplification of actual need. This fundamental flaw undermines the entire utilization methodology and demonstrates that the application is based on unreasonable assumptions.

Based on these issues, the AdventHealth Asheville application is non-conforming with Criteria 3, 4, 5, 6, and 12, as well as the Criteria and Standards for Acute Care Beds, and should not be approved.

3. AdventHealth's utilization projections rely on unreasonably aggressive market share growth that is inconsistent with typical market entry patterns for new hospitals.

AdventHealth's projected utilization assumes dramatic growth rates based on market share gains that are not realistic for a new hospital entering a market dominated by a single provider, particularly given that AdventHealth's only existing hospital in the area is a much smaller community hospital and it has no larger regional or statewide footprint other than management of a critical access hospital outside the service area. On page 150 (Table Q.24), AdventHealth projects the following acute care utilization:

AdventHealth Asheville Projected Acute Care Utilization, Project Years 1-3

Metric	*CY 2029 (Interim Yr)*	*CY 2030 (PY1)*	*CY 2031 (PY2)*	*CY 2032 (PY3)*
Total Discharges	2,696	4,638	8,254	12,212
Total Days of Care	13,137	22,419	40,479	60,251
% Occupancy	38.7%	27.7%	50.0%	74.4%

Source: AdventHealth application, p. 150.

These projections show extraordinary growth rates:

- 78 percent increase in discharges from PY1 to PY2 (4,638 to 8,254)
- 80 percent increase in patient days from PY1 to PY2 (22,419 to 40,479)
- 48 percent increase in discharges from PY2 to PY3 (8,254 to 12,212)
- 49 percent increase in patient days from PY2 to PY3 (40,479 to 60,251)

These dramatic year-over-year increases are not realistic for a new hospital, particularly one developed by an applicant that owns a small community hospital in a contiguous county, which does not provide the same services proposed for the new hospital. While AdventHealth discusses the community outreach that it has undertaken, since the new hospital is not yet developed, it

cannot demonstrate that these efforts have resulted in it being able to successfully develop new service lines in a new facility. Even if AdventHealth had the experience providing the same services in the area, achieving such dramatic growth in such a short time is not reasonable. AdventHealth's projections assume that it will nearly triple its patient volume from 2030 (its second year of operations) to 2032, which defies both experience with market entry dynamics and basic logic about how healthcare markets function.

The unrealistic growth trajectory is particularly apparent when comparing the interim year (CY 2029) to the first project year (CY 2030). AdventHealth projects that it will nearly double discharges (from 2,696 to 4,638) in a single year while simultaneously expanding from 93 to 222 beds. This assumption ignores the operational complexity of opening a new facility, recruiting and training staff, establishing new clinical programs, and integrating substantially expanded operations.

For these reasons, the AdventHealth Asheville application is non-conforming with Criteria 1, 3, 4, 5, 6, and 18a, as well as the Criteria and Standards for Acute Care Beds, and should not be approved.

4. AdventHealth's ICU utilization projections do not support the need for 129 additional beds.

AdventHealth repeatedly emphasizes that the proposed expansion will enable it to serve higher-acuity patients requiring intensive care services. However, AdventHealth's own utilization projections directly contradict this assertion.

On page 138, AdventHealth states:

> *"Sixteen (16) of the additional acute care beds will be developed as intensive care unit (ICU) beds, three (3) of the additional beds will be developed as Labor, Delivery, Recovery, and Postpartum (LDRP) beds, and 110 of the beds will be developed as general med/surg beds."*

This results in a total of 32 ICU beds at the 222-bed facility (16 originally approved + 16 additional). However, just as AdventHealth has overstated the total med/surg acute patient days based on its use of an inflated ALOS, this same methodology overstates the need for ICU beds. The fundamental problem with AdventHealth's ICU projections is the methodological basis for its calculations. AdventHealth assumes that ICU days will represent a percentage of total acute care days, increasing from 10.0% in project year one to 15 percent in the third project year.[3] However, as described above, AdventHealth uses an unreasonably high ALOS of 5.12 days to calculate total acute care days. Because ICU days are a percentage of this total, the ICU days are similarly overstated. Assuming a more reasonable overall ALOS of 4.0 days per discharge, the number of ICU days at AdventHealth Asheville can be recalculated as shown in the following table:

AdventHealth Asheville Recalculated ICU Occupancy

Metric	*CY 2030 (PY1)*	*CY 2031 (PY2)*	*CY 2032 (PY3)*
Total Med/Surg and ICU Days – AdventHealth Application	20,971	38,533	57,773
Recalculated Med/Surg & ICU Days*	16,388	30,112	45,148
ICU % of Total	10.0%	12.0%	15.0%
Recalculated ICU Days	1,639	3,613	6,772

[3] AdventHealth application, page 138.

ICU ADC	4.5	9.9	18.6
ICU Beds	32	32	32
ICU Occupancy %	14.1%	30.9%	58.1%

* Med/Surg and ICU Patient Days recalculated using an ALOS of 4.0 days.

AdventHealth's assertion on page 51 that "the proposed project will enhance access for many patients requiring ICU services that can appropriately be served at AdventHealth Asheville" is not supported by the projected utilization. With ICU occupancy at 30 percent in PY2 and below 60 percent in PY3, there is no demonstrated need for 32 ICU beds, much less a 222-bed facility.

Although these ICU occupancy percentages are not significantly lower than those at UNC Health's proposed Asheville hospital (which projects 39.2 percent ICU occupancy in PY2, increasing to 64.1 percent in PY3), a lower occupancy rate is expected for a unit with a much smaller number of beds. The UNC Health West ICU will have only 12 beds and will therefore have greater variation in daily census. Having additional ICU capacity will allow UNC Health West to maintain the ability to admit patients during peak periods. The actual number of beds not being utilized during low occupancy periods at UNC Health West will be comparatively lower than the AdventHealth ICU, with nearly three times the number of beds.

Based on these issues, the AdventHealth Asheville application is non-conforming with Criteria 1, 3, 6, and 18a, and the Criteria and Standards for Acute Care Beds, and should not be approved.

5. AdventHealth inappropriately uses Fletcher Hospital as a comparable facility despite significant differences in scale, service complexity, and market characteristics.

Throughout its application, AdventHealth relies heavily on Fletcher Hospital as a comparable facility for developing utilization assumptions and financial projections. Specifically, AdventHealth states on page 172:

> *"Patient Services Gross Revenue is based on patient volumes as referenced in Form C and AdventHealth Hendersonville's CY 2024 gross revenue per patient volume, inflated by 1 percent annually. AdventHealth confirmed the scope of DRGs served at AdventHealth Hendersonville is comparable to the DRGs projected for the proposed project."*

AdventHealth also uses Fletcher Hospital's historical data to project:

- Charity care adjustments (3.0% for inpatient, 10.8% for ED)
- Bad debt percentages (1.1% for inpatient, 3.2% for ED)
- Contractual adjustments (66.7% for inpatient, 60.1% for ED)
- Payor mix for all service components
- ICU utilization patterns (24% of total patient days)
- C-section rates (30% of deliveries)
- Average length of stay assumptions

However, Fletcher Hospital is not an appropriate comparative for a 222-bed hospital in Buncombe County due to fundamental differences in scale, service mix, market dynamics, and patient demographics. The following analysis demonstrates why AdventHealth's reliance on Fletcher Hospital data produces unreliable projections:

Scale Differential

Fletcher Hospital is a hospital with only 62 acute care beds with the following licensed bed complement (from 2025 License Renewal Application):

- 37 Medical/Surgical beds
- 12 ICU beds
- 13 Obstetric beds (including LDRP)

In addition, Fletcher Hospital also operates 41 behavioral health beds.

The proposed AdventHealth Asheville facility will have 222 acute care beds:

- 174 Medical/Surgical beds
- 32 ICU beds
- 16 Obstetric beds

AdventHealth Asheville proposes a facility with an acute care bed complement that is more than 2.5 times larger than Fletcher Hospital, while proposing to operate no behavioral health beds, which comprise 40 percent of the overall bed complement at the existing hospital in Fletcher. The scale and scope difference is not merely quantitative; it fundamentally changes the hospital's operational model, service capabilities, and market position. Larger hospitals typically serve broader geographic areas with more diverse patient populations, offer more specialized services with unique utilization patterns, have different staffing models, experience different payor mix and reimbursement patterns, and face different competitive dynamics in their markets. Extrapolating financial and utilization data from a small community hospital with 62 acute beds and 41 behavioral health beds to a 222-bed facility with a significantly different mix of services is methodologically unsound and produces unreliable projections.

Service Mix Differences

As noted previously, Fletcher Hospital includes 41 psychiatry beds (40 percent of total licensed beds), which fundamentally alters its operational profile, payor mix, and financial performance. Psychiatric services have distinctly different characteristics compared to acute medical/surgical care. These differences include longer average lengths of stay, different reimbursement models, different payor mix (typically a higher Medicaid proportion), and different staffing requirements and operational costs. AdventHealth's proposed Asheville facility will not include psychiatry beds, yet according to the revenue assumptions in Form F.2b, AdventHealth uses Fletcher Hospital's overall financial metrics – including payor mix, contractual adjustments, and revenue per patient – as the basis for its projections. This is inappropriate because Fletcher Hospital's financial performance reflects a blended model that includes substantial psychiatric services, while AdventHealth Asheville will offer only acute care services.

For example, AdventHealth projects that its payor mix will mirror Fletcher Hospital's CY 2024 experience (page 172). However, Fletcher Hospital's payor mix for CY 2024 includes 6,845 psychiatric patient days (33% of total non-neonatal patient days).[4] Psychiatric patients typically have higher Medicaid representation than general medical/surgical patients, which distorts the projected payor mix for the Asheville facility and therefore revenue projections.

[4] See 2025 HLRA. 3,644 ICU days + 9.982 med/surg days + 6,845 psychiatric days = 20,471 days.

Furthermore, the list of DRG's for the Asheville facility is not representative of the DRGs treated at Fletcher Hospital. AdventHealth claims that the list of clinically appropriate DRG codes for AdventHealth Asheville is modeled on the "scope of DRGs served at AdventHealth Hendersonville."[5] However, in the list of DRGs used to project market volume for the Asheville facility,[6] there are 126 DRG codes where Fletcher Hospital had no inpatient cases that originated from six counties in the Asheville region (Buncombe, Henderson, Madison, Yancey, Graham, and McDowell) in the CY 2022 to 2024 time period. These 126 DRG codes represent 22 percent of the entire list of potential DRGs used to project utilization at the Asheville facility. This list includes numerous codes in major clinical service lines that represent significant financial activity, such as cardiovascular, orthopedics, and oncology. Without having a historical reference for modeling, AdventHealth's projections are not adequately supported.[7]

Payor Mix Differences

On page 173, AdventHealth states that payor mix for the proposed Asheville hospital is identical to the payor mix at Fletcher Hospital, reasoning that "Henderson County is contiguous to Buncombe County and residents of Buncombe County travel to Henderson County to receive acute care services at AdventHealth Hendersonville." According to 2024 DHSR Patient Origin Report data, 44.2 percent of Fletcher Hospital's acute inpatients were from Henderson County, while 40.2 percent were from Buncombe County.[8] However, the patient origin table in Section C.3 of the 2024 AdventHealth acute bed application shows that Buncombe County will account for over 71 percent of admitted patients, while Henderson County[9] will represent at most 10 percent of acute care patients:

Acute Care Beds	AdventHealth Asheville Hospital *					
	1st Full FY		2nd Full FY		3rd Full FY	
	10/01/2027 to 09/30/2028		10/01/2028 to 09/30/2029		10/01/2029 to 09/30/2030	
County or other geographic area such as ZIP code	Number of Patients **	% of Total	Number of Patients **	% of Total	Number of Patients **	% of Total
Buncombe	1,650	73.4%	3,188	72.9%	4,360	71.2%
Graham	27	1.2%	54	1.2%	103	1.7%
Madison	184	8.2%	370	8.5%	556	9.1%
Yancey	162	7.2%	324	7.4%	488	8.0%
Other^	225	10.0%	437	10.0%	612	10.0%
Total	**2,247**	**100.0%**	**4,373**	**100.0%**	**6,120**	**100.0%**

^Other includes >1 percent patient origin from the remaining counties in North Carolina and other states.
* This should match the name provided in Section A, Question 4.
** Home health agencies should report the number of unduplicated clients.

5 AdventHealth application, page 172.
6 AdventHealth application, Exhibit C.8-9.
7 For descriptions of these DRGs, please refer to Attachment A with a list of the DRG codes that Fletcher Hospital had no cases for during this three-year period.
8 2025 Patient Origin by Facility, https://info.ncdhhs.gov/dhsr/mfp/pdf/por/2025/02-Facility_Acute-2025.pdf
9 Henderson County is not specifically listed as a county in the projected patient origin table, but the total for Other Counties, including those in North Carolina and other states, is 10.0 percent.

Source: Project ID # B-012526-24, page 70.

AdventHealth's assumption that the payor mix will be identical for two distinct patient populations is not reasonable. The payor mix that was originally presented in AdventHealth's 2022 acute beds application has Medicare representing 48.7 percent of patients, and commercially insured patients as 26.6 percent:

AdventHealth Asheville: Acute Care Beds	
Payor Source	**Percentage of Total Patients Served**
Self-Pay	7.1%
Charity Care	
Medicare *	48.7%
Medicaid *	15.5%
Insurance *	26.6%
Workers Compensation	
TRICARE	
Other^	2.1%
Total	100.0%

* Including any managed care plans.

^Other includes VA, Tricare, Workers Comp, and other government payors

Source: Project ID # B-012233-22, p. 109.

Fletcher Hospital operates in Henderson County, which has fundamentally different demographic, economic, and competitive characteristics compared to Buncombe County. These differences directly impact multiple statistics used by AdventHealth, including payor mix.

Comparative Demographics: Henderson County vs. Buncombe County

Demographic Measure	***Henderson***	***Buncombe***	***Data Source***
Population (2023)	120,000	270,000	U.S. Census Bureau
Median Household Income	$51,000	$62,000	U.S. Census Bureau, ACS 2023
Median Age	50.2 years	42.8 years	U.S. Census Bureau, ACS 2023
Population 65+	28.5%	18.9%	U.S. Census Bureau, ACS 2023
Poverty Rate	12.8%	13.2%	U.S. Census Bureau, ACS 2023
Medicare Beneficiaries	~35,000	~52,000	CMS County Data
Primary Economic Sectors	Retirement/Services	Healthcare/Tourism/ Education	BLS Regional Data
Market Type	Rural/Suburban	Urban (Asheville MSA)	OMB Metropolitan Designation

As summarized in the preceding table, Henderson County is characterized by an older, retirement-oriented population with significantly higher median age (50.2 years versus 42.8 years) and substantially greater proportion of residents age 65 and older (28.5 percent versus 18.9 percent). This demographic profile has profound implications for healthcare utilization patterns, payor mix, and service needs. An older population generates higher Medicare representation and less commercial insurance coverage in the payor mix, different case mix intensity (more chronic disease management, orthopedics, cardiology), and different utilization patterns compared to a younger, more economically diverse population.

Buncombe County, by contrast, is an urban market centered on Asheville, a regional economic and healthcare hub. The county has a younger, more diverse population with median household income approximately 21% higher than Henderson County. Buncombe County's economy is driven by healthcare services, tourism, higher education, and technology sectors, creating a more complex payor landscape with a larger commercial insurance representation.

The demographic differences also affect projected payor mix and revenue patterns. Henderson County's older population (28.5 percent age 65+) results in higher Medicare representation, which AdventHealth inappropriately applies to Buncombe County where only 18.9 percent of residents are age 65 and older. A younger population typically generates higher commercial insurance representation, a lower Medicare percentage, different service utilization (e.g., fewer chronic disease admissions, more maternity, different surgical mix), and different revenue per case due to payor mix variations.

By contrast, UNC Health bases its inpatient and outpatient payer mix and acute care ALOS on HIDI market data, with the specific facility-appropriate DRGs for the defined service areas as described in Form C. In other words, UNC Health used the available market data for the patients it actually proposes to serve, not for a different set of patients.[10] This approach is different from Advent's, which utilizes AdventHealth Hendersonville's payor mix. However, the Fletcher hospital is not an appropriate comparison due to significant differences in services and patient composition; out of the 553 total DRGs included in the AdventHealth Asheville list, 126 of these codes (22 percent) are not included in Advent Hendersonville's market data for patients originating from Buncombe, Henderson, Madison, Yancey, Graham, and McDowell counties in the three years between CY 2022 and 2024. In other words, for nearly one-quarter of the patients by service proposed for AdventHealth Asheville, there is no data available for Fletcher Hospital. As a result of this significant difference, the payor mix assumption for AdventHealth Asheville—based on a much different set of patients at Fletcher—is not representative of the patient population that the facility will serve.

In summary, using Henderson County demographic data and Fletcher Hospital's payor mix experience to project AdventHealth Asheville's performance in Buncombe County ignores these fundamental demographic, economic, and competitive differences. The markets are not comparable, and therefore Fletcher Hospital is not an appropriate basis for payor mix assumptions, or financial forecasts.

ICU and Higher Acuity Services

As previously discussed, Fletcher Hospital's ICU utilization patterns are inconsistent with AdventHealth's claims about the Asheville facility. Fletcher Hospital has 12 ICU beds that generated 3,644 patient days in FY 2024, representing 24.3 percent of total acute care days. Using Fletcher Hospital's ICU experience (24 percent of days) as a starting point and then conservatively reducing it to 15 percent for AdventHealth Asheville suggests that the hospitals will serve fundamentally different patient populations, making Fletcher Hospital an inappropriate comparable for other utilization assumptions as well.

[10] As noted in its application, UNC Health did use data from UNC Health Pardee when market data were not available or for statistics for which UNC Health Pardee was a reasonable proxy. Of note, UNC Health Pardee is much more similar in size and scope of services to the proposed UNC Health West than Fletcher Hospital is to the proposed AdventHealth Asheville.

According to LRA data, Buncombe County's existing acute care hospital, HCA Mission Hospital, experienced 24,724 ICU days of care in FY 2024, representing just 10.9 percent of all acute care days.[11] In its application, AdventHealth states that the expansion of its Asheville hospital by 129 beds is necessary to support higher acuity care and will "facilitate the treatment of patients with more complex conditions."[12] On page 52, AdventHealth states that it will pursue Level III trauma center designation for the facility in order to strengthen trauma services available in the service area and allow for the delivery of "tertiary-level care in a resilient, high-performing environment."[13] However, HCA Mission Hospital is currently a Level II trauma center and as such serves a relatively higher percentage of high-acuity patients than the proposed AdventHealth facility. As a Level II trauma center with an expanded range of clinical services, HCA Mission Hospital had less than 11 percent of total acute patient days that were assigned to ICU units in FY 2024. Therefore, it is not reasonable for AdventHealth Asheville, as a smaller hospital that will not serve as a regional referral facility like HCA Mission Hospital, to have a higher percentage of ICU days. AdventHealth has therefore overstated its higher-acuity patient population, with a corresponding effect on length of stay and financial projections.

Geographic and Patient Origin Differences

Fletcher Hospital serves a plurality of Henderson County residents, with predictable patient origin patterns based on proximity and existing competition. The 2025 DHSR patient origin report shows relatively concentrated service area utilization, with Henderson and Buncombe counties representing over 84 percent of all acute care patients at Fletcher Hospital.[14]

AdventHealth Asheville, by contrast, projects patient origin across four counties (Buncombe, Madison, Yancey, Graham) plus 10 percent immigration. Henderson County is not listed in the projected patient origin table on page 73 but can be no higher than 10 percent. The Asheville facility projects that over 70 percent of its acute care patients will originate from Buncombe County in the third project year.[15] This represents a significant variation from the patient origin at Fletcher Hospital. The discrepancy in patient origin can reasonably be expected to contribute to differences in payor mix. AdventHealth therefore inappropriately bases its financial assumptions on Fletcher Hospital data when other alternatives would be more appropriate for modeling accuracy.

Financial Projection Flaws

Perhaps most critically, AdventHealth uses Fletcher Hospital's gross revenue per patient and contractual deduction percentages to project gross and net revenues for Asheville.[16] This assumption is inappropriate for the following reasons:

- Case mix differences – The application specifically states that the proposed hospital will serve a broad range of patients, including services that are not provided at Fletcher Hospital; these differences should certainly generate different average revenue per case. AdventHealth

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11 See Mission Hospital 2025 HLRA, page 19. 24,724 ICU days of care ÷ 227,011 acute days of care = 10.9%. ICU and total acute care day totals do not include neonatal (Levels I-IV) days.

12 AdventHealth application, page 52.

13 Id., page 53.

14 2025 DHSR Acute Care Hospital Admissions reports, Patient Origin by Facility, https://info.ncdhhs.gov/dhsr/mfp/pdf/por/2025/02-Facility_Acute-2025.pdf

15 AdventHealth application, page 73.

16 Id., Form F.2b Assumptions, page 172.

states that the application of Fletcher Hospital's historical gross revenue per patient is reasonable because the range of DRGs between the two hospitals is comparable.[17] However, AdventHealth itself states that the Asheville facility will be developed with the intent to serve relatively higher acuity cases, and the particular mix of patients by DRG will therefore vary accordingly. While there may be some overlap in the occurrence of DRG codes for patients at Fletcher Hospital vis-à-vis the Asheville hospital, the *frequency* and *overall percentages* of these DRGs will likely show wide variation. As noted above, Fletcher Hospital had no patients from six area counties for 126 of the 553 total DRG codes that AdventHealth Asheville lists as facility-appropriate inpatient procedures. With 22 percent of the DRG codes unique to the proposed hospital, the assumption that mix of patients will be the same for both facilities is not supported.

- Service intensity – AdventHealth maintains the same assumptions used in its 2022 CON application to calculate the utilization of imaging and ancillary services. These projections are based upon Fletcher Hospital's FY 2019 ratio of the imaging modality or ancillary service volume to inpatient discharges.[18] The use of these ratios for the instant application is not reasonable for multiple reasons. First, AdventHealth could have updated the data from Fletcher Hospital with more recent utilization data to verify that these ratios are still accurate five years later. However, AdventHealth neglected to do so. Second, larger hospitals can be expected to provide more ancillary services per admission, changing revenue patterns. The Asheville acute care facility as proposed will be more than three times the size of Fletcher Hospital, and it is not reasonable to apply the same ratios at a facility that will have a significantly greater scale and average acuity level.

Using Fletcher Hospital's historical financial performance to project AdventHealth Asheville's results produces unreliable financial projections that do not reflect the actual operating environment of a 222-bed facility in a competitive market. By comparison, UNC Health West does not use the specific payor mix from UNC Health Pardee but instead applies the total market payor mix for its service area, adjusted to include only the specific acuity-appropriate DRG codes for the facility. This approach is a more accurate estimate of payor mix that can be expected for the facility that is based on the projected patient population.

These differences are not minor adjustments; they fundamentally alter every aspect of hospital operations, utilization, and financial performance. AdventHealth has failed to demonstrate that Fletcher Hospital is an appropriate comparable, and therefore its utilization projections and financial assumptions are unreliable and unsupported.

Based on these issues, the AdventHealth Asheville application is non-conforming with Criteria 3, 4, 5, 6, and 18a, and should not be approved.

6. <u>AdventHealth's cost-effectiveness arguments primarily benefit the applicant rather than patients and do not demonstrate that this proposal represents the most effective alternative.</u>

Throughout its application, AdventHealth argues that developing a larger 222-bed facility will achieve economies of scale and lower per-unit operating costs compared to the originally approved 93-bed hospital.[19] However, these cost-effectiveness claims fail to demonstrate

17 Ibid.

18 See AdventHealth 2022 application (Project ID # B-012233-22), pages 155-56.

19 AdventHealth application, pages 117-118.

benefits for its patients and do not establish that the proposed expansion represents the most effective alternative for meeting the service area's needs.

AdventHealth asserts that "[t]he expanded 222-bed hospital will be a destination of health and healing, where every person has the capacity to feel whole in body, mind, and spirit."[20] While this aspirational statement has emotional appeal, it does not constitute a demonstration of cost-effectiveness for medically underserved groups, or any improvements in quality and access to services with a benefit to patients. More importantly, AdventHealth's stated cost-effectiveness is not demonstrated by its projected costs, as noted previously.

Lower Operating Costs are Not Supported

While achieving economies of scale through a larger facility is a theoretical benefit posited by AdventHealth, nothing in the application demonstrates that these cost savings will actually occur, nor that patients will benefit from the proposed change in costs. To the contrary, as noted previously, the instant application projects average operating costs per patient that are significantly higher than those projected in its most recently approved 2024 application, which is the opposite of what the instant application states will result from the proposed project.

Criterion 4 requires applicants to demonstrate that the proposal "is the least costly or most effective alternative" for meeting the needs of the population to be served. AdventHealth has not demonstrated that developing a 222-bed facility is more cost effective at serving patient needs than other available alternatives. These include proceeding with the originally approved 93-bed facility, developing the 93-bed facility with the capability to expand in the future if demand materializes, or allowing a different applicant to develop a portion of the 129 beds in the *2025 SMFP* need determination in a different location that provides additional geographic diversity and expanded patient choice of providers. In Section E, AdventHealth's application lacks any meaningful comparison of alternatives. The application does not explain how proceeding with the approved 93-bed facility as originally planned "perpetuates Mission Hospital's dominant control over acute care capacity in the service area and limit[s] patient choice,"[21] while these drawbacks disappear when the Asheville facility is expanded to 222 beds. AdventHealth also has the option to develop additional unlicensed space as part of the planned project, with 93 licensed acute beds upon opening supplemented by shell space for future expansion if needed. This alternative would allow AdventHealth to expand through incrementally phased development that is based on actual demand, rather than the more drastic expansion of more than 238 percent that it proposes. AdventHealth could employ this option to avoid overbuilding in advance of demonstrated demand while validating its assumptions about market share, referral patterns, and patient preferences that are described in its two previous applications.

Instead, AdventHealth simply asserts that bigger is better without demonstrating why 222 beds is the optimal size or why such a vast expansion is superior to phased development. This failure to analyze alternatives is a fundamental deficiency under Criterion 4.

Unproven Assertions About Complexity and Acuity

As previously discussed, AdventHealth claims that a larger facility will enable it to serve more complex, higher-acuity patients. However, bed capacity does not determine clinical capability. The factors that enable a hospital to provide complex care include:

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20 Id., page 64.

21 Id., page 83.

- Physician expertise and subspecialty availability
- Advanced equipment and technology
- Clinical protocols and quality systems
- Nursing skill mix and training
- Support service capabilities (lab, radiology, pharmacy)
- Established referral relationships

None of these factors are dependent on having 222 beds rather than 93 beds. Many community hospitals with fewer than 200 beds successfully provide complex orthopedic surgery, interventional cardiology, advanced GI procedures, and other services that AdventHealth claims require a larger facility. AdventHealth could recruit specialists, invest in advanced equipment, and develop clinical protocols at the approved 93-bed facility without requiring 129 additional beds. As discussed above, AdventHealth could reasonably develop additional clinical services and capabilities to serve more complex patients with fewer additional beds than proposed, allowing another provider to serve the need for additional acute care resources identified in the *SMFP*.

Criterion 18a: No Demonstrated Positive Impact on Competition

AdventHealth argues that its larger facility will enhance competition in the market. However, the application fails to demonstrate how expanding from 93 to 222 beds will have a positive impact on cost-effectiveness, quality, or access that could not be achieved with the originally approved facility.

Competition is enhanced by having a choice of alternative providers, not by having an oversized alternative provider. A well-operated 93-bed community hospital can effectively compete with Mission Hospital by offering a convenient location for residents of Buncombe County while enhancing access for residents of Graham, Madison, and Yancey counties. An appropriately sized community hospital can offer shorter wait times and more personalized service, and a focus on clinical quality that optimizes patient outcomes and customer satisfaction. A robust community hospital also can serve as an alternative for those patients that do not require tertiary and highly complex care. Increasing the size of the AdventHealth Asheville facility to 222 beds, as AdventHealth proposes, does not guarantee a correlated increase in competition. It simply creates a larger competitor that may underdeliver on the promised benefits if it fails to achieve the projected utilization.

Based on these issues, the AdventHealth Asheville application is non-conforming with Criteria 3, 4, 5, 6, and 18a, and should not be approved.

In summary, based on these issues, the AdventHealth Asheville application is non-conforming with Criteria 1, 3, 4, 5, 6, 12, and 18a, and the Criteria and Standards for Acute Care Beds, and should not be approved.

ISSUE-SPECIFIC COMMENTS ON NOVANT HEALTH ASHEVILLE

Novant's application to develop Novant Health Asheville (NH Asheville), a new acute care hospital with 34 beds, should not be approved. The application contains numerous miscalculations, overstatements, and inconsistencies. UNC Health has grouped these by issue below, each of which contributes to Novant's non-conformity. Please note that, relative to each issue, UNC Health has identified the statutory review criteria and specific regulatory criteria and standards creating the non-conformity.

1. Utilization projections for NH Asheville contain critical errors and unreasonable assumptions.

   Novant provides utilization projections for the proposed services at NH Asheville, as well as all assumptions used to provide those projections, in its Form C. Throughout these utilization projections, there are multiple calculation errors, as well as assumptions that are not reasonable. These issues are discussed below.

   Inpatient Days

   Messino Cancer Centers

   In establishing a baseline for the acute care days that it states can be shifted to its proposed acute care facility, Novant analyzes the historical, service-appropriate (which Novant refers to as core acute care, or CAC) inpatient days for the existing hospitals in Buncombe and Henderson counties – HCA Mission, AdventHealth Hendersonville, and UNC Health Pardee – as originating from five providers from which Novant has garnered support. While Novant utilizes the historical inpatient days for the providers that have documented support for its application, Novant assumes that the majority of these inpatient days will originate from Messino Cancer Centers (Messino), a practice consisting of five locations across western North Carolina that provides outpatient cancer care and blood disease services. Specifically, Novant projects that 70 percent of the inpatient days of care from its affiliated providers that it expects to serve in its third project year will originate from Messino (4,603 ÷ 6,526 = 0.70 = 70 percent as calculated from the table below).

Step 2: Determine Affiliated Provider Total Inpatient Days at NH Asheville, PY1-PY3

Affiliated Provider Inpatient Days at NH Asheville, CY 2030 – CY 2032

	% Shift	PY1 2030	PY2 2031	PY3 2032
NH Surgical Biltmore	85%	1,785	1,800	1,816
Messino	75%	4,524	4,563	4,603
Biltmore Plastic	85%	43	43	43
Carolina Hand	85%	32	32	32
NH Woman's	85%	32	32	32
Total		**6,416**	**6,470**	**6,526**

Source: Step 1, Letters of Support

Source: Novant application, p. 167.

Additionally, 50 percent of the total inpatient days of care at NH Asheville in its third project year (i.e., including all admission sources) will originate solely from Messino (4,603 ÷ 9,192 = 0.50 = 50 percent as calculated from the table below).

Projected Inpatients at NH Asheville

	PY1 2030	PY2 2031	PY3 2032
Affiliated Provider Days	6,416	6,470	6,526
Non-Affiliated Provider Days (ED Capture)	2,611	2,638	2,666
Total Inpatient Days	**9,027**	**9,108**	**9,192**
ADC (Total / 365 or 366 Days)	24.73	24.95	25.11
Occupancy on 34 Beds	72.74%	73.39%	73.87%

Affiliated Provider Discharges	1,020	1,029	1,037
Non-Affiliated Provider Discharges (ED Capture)	517	523	528
Total Inpatient Discharges	1,537	1,552	1,565

Source: Step 2, Step 4, HIDI

Source: Novant application, p. 171.

In other words, Novant assumes that patients from Messino will account for half of the inpatient volume at its new acute care facility in its first three years of operation. While Messino has provided a letter of support confirming the assumptions in Novant's application,[22] a more detailed analysis demonstrates that Novant's projections and assumptions themselves are incorrect and unreasonable for multiple reasons.

First, Novant makes a critical error in its assessment of the baseline inpatient days from Messino for its first three project years. In Step 1 of its projections, Novant grows the base year inpatient days at all of its five affiliated practices – CY 2024 for four of the five practices and CY 2023 for Messino – by the projected compound annual growth rate (CAGR) for the population of the counties in its proposed hospital's service area, which, from 2024 through 2032, is 0.87 percent.[23] While this growth rate is utilized for the majority of the Novant-affiliated providers, it is not utilized for Messino. From 2024 to 2025, the inpatient days at Messino grow from 3,297 to 5,776 – a 75 percent growth rate in that single year – then continue to increase at Novant's stated 0.87 percent CAGR from 2025 through 2032.

22 Included in NH Asheville Exhibits, pages 156-7. Notably, Messino also provided a letter of support for UNC Health West's competing application to develop a new acute care facility in Buncombe County, stating that it "anticipate[s] referring patients… and supporting the services offered at UNC Health West Medical Center." See page 227 of NH Asheville Exhibits.

23 Novant application, page 167.

Step 1: Determine Base Year (CY 2024) and Projected CY CAC Inpatient Days for Affiliated Providers

Affiliated Provider CAC Inpatient Days at Area Hospitals, CY 2024 – CY 2032

Affiliated Provider	2024	2025	2026	2027	2028	2029	2030	2031	2032
NH Surgical Biltmore	1,994	2,011	2,028	2,046	2,064	2,082	2,100	2,118	2,136
Messino*	3,297	5,776	5,826	5,877	5,928	5,980	6,032	6,084	6,137
Biltmore Plastic	51	51	51	51	51	51	51	51	51
Carolina Hand	38	38	38	38	38	38	38	38	38
NH Woman's	38	38	38	38	38	38	38	38	38
Total Patient Days	**5,418**	**7,914**	**7,981**	**8,050**	**8,119**	**8,189**	**8,259**	**8,329**	**8,400**

*Source: HIDI, NCOSBM, *Messino Base Year = YE June 2023*

Source: Novant application, p. 166.

This results in total inpatient days from Messino growing *not* at a CAGR of 0.87 percent from 2024 through 2032, but at a CAGR of 8.08 percent – a rate of growth nearly *ten times higher* than the rate used across Novant's other affiliated physician groups.

Projected Core Acute Care Inpatient Days – Messino Cancer Centers

	2024	*2025*	*2026*	*2027*	*2028*	*2029*	*2030 (PY1)*	*2031 (PY2)*	*2032 (PY3)*	*CAGR*
Days Included in Application	3,297	5,776	5,826	5,877	5,928	5,980	6,032	6,084	6,137	8.08%

Source: Novant application, p. 166.

Novant provides no explanation for this dramatic increase in inpatient days from 2024 to 2025 (a year-over-year increase of 75.2 percent). In fact, Novant explicitly states that these inpatient days account for a full year of care at Messino, noting that "the twelve months (emphasis added) from July 2022 to June 2023 were used as the basis for projecting future inpatient volume."[24] Further, Novant does *not* grow its projected *outpatient* days from Messino by the same means, utilizing an annual growth rate of 0.87 percent from 2024 through 2032, as shown in its table below, clearly demonstrating that its inpatient projections are erroneous and grossly overstated.

Step 1: Determine Base Year (CY 2024) and Projected CY Total Outpatient Volume for Affiliated Providers

Affiliated Provider Total Outpatient Volume at Area Hospitals, CY 2024 – CY 2032

Affiliated Provider	2024	2025	2026	2027	2028	2029	2030	2031	2032
Messino	2,820	2,845	2,870	2,895	2,920	2,945	2,971	2,997	3,023
NH Woman's	2,632	2,655	2,678	2,701	2,724	2,748	2,772	2,796	2,820
NH Surgical Biltmore	1,561	1,575	1,589	1,603	1,617	1,631	1,645	1,659	1,673
Carolina Hand	1,069	1,078	1,087	1,096	1,106	1,116	1,126	1,136	1,146
Biltmore Plastic	471	475	479	483	487	491	495	499	503
NH Endocrinology	439	443	447	451	455	459	463	467	471
Total	**8,992**	**9,071**	**9,150**	**9,229**	**9,309**	**9,390**	**9,472**	**9,554**	**9,636**

Source: HIDI, NCOSBM

Source: Novant application, p. 182.

This error significantly impacts the total acute care days that can realistically be projected to be served at NH Asheville. As stated above, half of the total acute care days at Novant's proposed

[24] Id., page 165.

hospital are projected to originate solely from Messino. If – as stated in Novant's methodology – a 0.87 percent growth rate is used to grow Messino's baseline of inpatient acute care days from 2024 through 2032, rather than 2025 through 2032, Novant would instead project a total of 3,534 inpatient days from Messino in NH Asheville's third project year.

Projected Core Acute Care Inpatient Days – Messino Cancer Centers
Including Corrected Days

	2024	*2025*	*2026*	*2027*	*2028*	*2029*	*2030 (PY1)*	*2031 (PY2)*	*2032 (PY3)*	*CAGR*
Days Included in Application	3,297	5,776	5,826	5,877	5,928	5,980	6,032	6,084	6,137	8.08%
Corrected Acute Care Days	**3,297**	**3,326**	**3,355**	**3,384**	**3,413**	**3,443**	**3,473**	**3,503**	**3,534**	**0.87%**

Source (Days Included in Application): Novant application, p. 166.

Further, when applying Novant's assumed shift rate of 75 percent from Messino for its first three full project years, this results in 2,650 inpatient acute care days originating from Messino in CY 2032 – just over half (57.6 percent) of the total inpatient acute care days that Novant erroneously projected from Messino.

Projected Inpatient Days – Messino Cancer Centers
Application and Corrected Days

	2030 (PY1)	*2031 (PY2)*	*2032 (PY3)*
Total Messino Inpatient Days – Application	6,032	6,084	6,137
Total Messino Inpatient Days – Corrected	3,473	3,503	3,534
Shift Percentage	75%	75%	75%
Messino Inpatient Days Following Shift – Application*	4,524	4,563	4,603
Messino Inpatient Days Following Shift – Corrected*	2,605	2,628	2,650

Source: Novant application, p. 166-7.
* Messino Inpatient Days Following Shift = Total Messino Inpatient Days x 75 percent.

Critically, this correction of inpatient days from Messino results in the projected total acute care days in NH Asheville's third full project year decreasing to 7,239 days, rather than the 9,192 provided on its application's page 171. These projected acute care days do *not* meet the performance standard for acute care beds, equating to an occupancy rate of only 58.3 percent in the hospital's third full project year, significantly lower than the 66.7 percent threshold as promulgated in the Criteria and Standards for Acute Care Hospital Beds (see 10A NCAC 14C .3803(3)), as shown in the table below.

Projected Inpatient Days – NH Asheville
Application and Corrected Days

	2030 (PY1)	*2031 (PY2)*	*2032 (PY3)*
Non-Affiliated Provider Days (ED Capture)	2,611	2,638	2,666
Affiliated Provider Days – Novant Application	6,416	6,470	6,526
Total Inpatient Days – Novant Application	9,027	9,108	9,192
Occupancy % – Novant Application	72.7%	73.4%	73.9%
Affiliated Provider Days – Corrected	4,498	4,536	4,574
Total Inpatient Days – Corrected	7,109	7,174	7,239
Occupancy % – Corrected	**57.3%**	**57.8%**	**58.3%**

Source: Novant application, p. 171.

This error alone renders Novant's application non-conforming with multiple criteria and standards, including Criteria 1, 3, 4, 5, 6, 13, and 18a, and the performance standards for acute care beds.

Even if this critical error is discounted – which it cannot be, given Novant's heavy reliance on Messino's acute care days as stated in Novant's application – other assumptions regarding the patient base attributable to Messino are not supported by Novant's application, nor are they reasonable assumptions with respect to care provided at Messino, and the inpatient referrals that would typically be made by that practice. As stated above, Novant assumes that 75 percent of the appropriate inpatient days projected for Messino will ultimately shift to its new acute care facility in its first three full project years. As also stated above, this assumption is reliant on a letter of support from Messino affirming this assumption.[25] Despite this claim by Novant and Messino, UNC Health believes this assumption is not reasonable, considering Messino's multiple locations as well as the type of care for which Messino may refer a patient for inpatient services.

First, as stated on its website, Messino operates five total practices in western North Carolina: one in Asheville (Buncombe County), one in Brevard (Transylvania County), one in Franklin (Macon County), one in Marion (McDowell County), and one in Sylva (Jackson County).[26] With the exception of its Asheville location, which is seven miles from NH Asheville's proposed location,[27] all other Messino practices are a significant distance from NH Asheville. In fact, of its four other practices, only one – its location in Brevard – is within a 30-minute drive of NH Asheville, as shown in the table below. More significantly, all Messino locations are within a 10-minute drive of an existing hospital, with two practices located on the same medical campus as an existing hospital.

25 NH Asheville Exhibits, pages 156-7.

26 "Locations." Messino Cancer Centers. Accessed November 5, 2025, at https://messinocancercenters.com/location/locations/.

27 Via Google Maps.

Messino Cancer Centers Locations Distance and Drive Time to Closest Hospital and NH Asheville

Messino Practice Location (County)	*Closest Hospital (County)*	*Distance/Drive Time to Closest Hospital*	*Distance/Drive Time to NH Asheville*
Asheville (Buncombe)	HCA Mission (Buncombe)	4.7 miles 10-16 minutes	7.2 miles 10-16 minutes
Brevard (Transylvania)	Transylvania Regional Hospital (Transylvania)	2.0 miles 5-8 minutes	18.3 miles 22-35 minutes
Franklin (Macon)	Angel Medical Center (Macon)	0.1 mile 1 minute	67.9 miles 65-85 minutes
Marion (McDowell)	Mission Hospital McDowell (McDowell)	1.0 mile 4 minutes	43.6 miles 40-55 minutes
Sylva (Jackson)	Harris Regional Hospital (Jackson)	0.1 mile 1 minute	47.5 miles 45-60 minutes

Source: Google Maps. Distances and times approximated using estimates for November 10, 2025, at 8:00AM.

UNC Health believes that it is unreasonable to assume that the majority of patients who are more than 30 minutes away from NH Asheville's location will choose to seek care at NH Asheville, largely due to the significant distance from their homes to the proposed hospital. Rather, it is more likely that they will seek care at the in-county facilities that are almost certainly closer to where those patients live and are effectively next door to their existing outpatient oncology practice.

Further compounding the unsupported projections above, Novant does not project inpatients originating from Messino by practice location. As such, it is impossible to discern how many total inpatient days will originate from each of Messino's five locations, which renders its assumption of 75 percent of its total referred inpatient days to be treated at NH Asheville unsupported. For this assumption to hold, the majority of Messino's inpatient referrals would have to originate from its Asheville practice, which, as stated above, is the only Messino location reasonably close to NH Asheville. Even if this were the case, Novant does not account for the presence of HCA Mission in Buncombe County, a hospital that may be currently utilized by Messino's chronically ill patient population – a population that, given their treatment for cancer or blood disorders, is likely to have complex care needs or co-morbidities that necessitate hospitalization at a higher-acuity facility. The providers at Messino must ultimately consent to patient preferences; UNC Health believes that the preference of most of its Buncombe County patients, given the conditions for which they will seek care, will be to continue receiving care at this higher-acuity inpatient service provider. As such, Novant's assumption that 75 percent of Messino inpatients will receive care at NH Asheville is not reasonable.

Second, UNC Health believes that the types of care for which Messino's patients may require inpatient hospitalization do not necessitate treatment specifically at Novant's proposed hospital and are not supported by the major diagnostic category (MDC) projected inpatient acute care days as provided by Novant. In Exhibit C-1.2, Novant projects a breakout of inpatient days by MDC as shown below.

Estimated Year 3 Average Daily Census by MDC

MDC	Description	Year 3 Estimated Inpatient Days	Year 3 Average Daily Census
01	Nervous System	103	0.28
03	Ear, Nose, Mouth, And Throat	10	0.03
04	Respiratory System	1,128	3.09
05	Circulatory System	174	0.48
06	Digestive System	2,316	6.35
07	Hepatobiliary System and Pancreas	442	1.21
08	Musculoskeletal System and Connective Tissue	390	1.07
09	Skin, Subcutaneous Tissue, and Breast	180	0.49
10	Endocrine, Nutritional, and Metabolic System	308	0.84
11	Kidney and Urinary Tract	540	1.48
12	Male Reproductive System	24	0.07
13	Female Reproductive System	49	0.13
16	Blood and Blood Forming Organs and Immunological Disorders	376	1.03
17	Myeloproliferative Diseases and Disorders (Poorly Differentiated Neoplasms)	1,797	4.92
18	Infectious and Parasitic Diseases and Disorders	1,195	3.27
21	Injuries, Poison, and Toxic Effect of Drugs	103	0.28
23	Factors Influencing Health Status	55	0.15
25	Human Immunodeficiency Virus (HIV) Infection	2	0.01

Source: HIDI Inpatient Database, Section Q Patient Day Projections, Year 3

Source: NH Asheville Exhibits, p. 129.

These projected inpatient days by MDC align with Novant's total projected inpatient acute care day total of 9,192 in project year three. As such, the share of total inpatient days accounted for within each MDC can be calculated as shown below.

Total Inpatient Days – NH Asheville
By MDC

MDC	*Description*	*Year 3 Estimated Inpatient Days*	*Share of Total*
06	Digestive System	2,316	25.2%
17	Myeloproliferative Diseases and Disorders (Poorly Differentiated Neoplasms)	1,797	19.5%
18	Infectious and Parasitic Diseases and Disorders	1,195	13.0%
04	Respiratory System	1,128	12.3%
11	Kidney and Urinary Tract	540	5.9%
07	Hepatobiliary System and Pancreas	442	4.8%
08	Musculoskeletal System and Connective Tissue	390	4.2%
16	Blood and Blood Forming Organs and Immunological Disorders	376	4.1%
10	Endocrine, Nutritional, and Metabolic System	308	3.4%
09	Skin, Subcutaneous Tissue, and Breast	180	2.0%
05	Circulatory System	174	1.9%
01	Nervous System	103	1.1%
21	Injuries, Poison, and Toxic Effect of Drugs	103	1.1%
23	Factors Influencing Health Status	55	0.6%
13	Female Reproductive System	49	0.5%
12	Male Reproductive System	24	0.3%
03	Ear, Nose, Mouth, And Throat	10	0.1%
25	Human Immunodeficiency Virus (HIV) Infection	2	0.0%
	Total	**9,192**	**100.0%**

Source: NH Asheville Exhibits, p. 129.

As shown above, 1,797 of NH Asheville's projected inpatient days are associated with MDC 17, which includes many procedures related to oncological care. UNC Health believes it is reasonable to assume that many of these inpatient days, given their association with cancer care, are related to those that Novant projects to originate from Messino. However, even assuming that all of these 1,797 inpatient days related to MDC 17 originate from Messino – an unlikely scenario – this still means that 2,806 of the inpatient days originating from Messino must be associated with other non-cancer MDCs.

Total Inpatient Days – NH Asheville
By MDC

Category	*Inpatient Days*
Total Projected Inpatient Days	9,192
Inpatient Days Associated with MDC 17	1,797
Inpatient Days Originating from Messino	4,603
Inpatient Days Unaccounted for from Messino Assuming All MDC 17 Days Originated from Messino*	**2,806**

Source: Novant application and Exhibits, p. 129 and p. 167.

Given its projection of inpatient days by MDC for NH Asheville above, it is dubious that 2,806 inpatient days will originate from Messino for MDCs other than MDC 17. For example, MDC 18, which includes infectious diseases, accounts for the third-highest number of projected inpatient days at NH Asheville in its third full project year, and comprises post-surgical infections, sepsis, and bacterial, parasitical, and viral infections.[28] Given that these are conditions much more likely to originate either from non-affiliated inpatient days through NH Asheville's ED or from one of Novant's five other affiliated providers – most likely NH Surgical Biltmore, which will account for 1,816 inpatient days at NH Asheville in the hospital's third full project year – this leaves a majority of days originating from Messino that cannot be associated with an MDC that would reasonably be treated at those facilities.

Third, Novant's assumptions regarding its expected inpatient days originating from Messino are not reasonable given that Novant will not meet the entirety of the need determination for acute care beds in the *2025 SMFP*. Specifically, and as discussed above, Novant has applied to develop NH Asheville as a 34-bed acute care facility – far fewer beds than the 129 acute care beds needed in the Buncombe/Graham/Madison/Yancey multicounty service area. Assuming that all 129 acute care beds are awarded following review of the competing applications, this means that another provider – or providers – will be allocated some or all of the remaining 95 acute care beds at a minimum. These beds could very well be awarded to UNC Health West, which, notably, also received a letter of support from Messino Cancer Centers that states Messino "anticipate[s] referring patients… and supporting the services offered at UNC Health West Medical Center."[29] If UNC Health West is approved, even for fewer than its proposed beds, it is at least equally reasonable that Messino patients will be referred there as to the proposed Novant hospital, rendering its 75 percent capture rate overly optimistic and unreasonable.

Because patients referred by Messino are oncology patients who, given their conditions, require higher acuity care, it is not reasonable to assume that 75 percent of these patients will be referred to what would be the smallest, and therefore lowest acuity, hospital in the service area. It is far more likely, particularly given Messino's simultaneous support for UNC Health West's proposed facility, that a plurality of Messino's patients will be referred to a provider that offers a greater scope of services and can likely better meet these patients' care needs.

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[28] For a complete list, of MDCs and their associated DRGs, please see the following resource as provided by the Centers for Medicare & Medicaid Services, https://www.cms.gov/icd10m/version372-fullcode-cms/fullcode_cms/P0001.html.

[29] UNC Health West Exhibits, page 227.

In short, the projection of the inpatient days at NH Asheville by MDC does not align with the source of those inpatient days, rendering its projection of inpatient days unsupported.

Non-Affiliated Provider Inpatient Days

Novant assumes that a portion of the projected inpatient days at NH Asheville will also come from capture of existing inpatient market days for patients originating from its home ZIP code of its proposed facility (28704), as well as ZIP codes adjacent to the home ZIP code (28715 and 28759). Specifically, of the projected inpatient market days at those hospitals, Novant assumes a capture rate of 30.43 percent within ZIP code 28704, while the capture percentages are 8.19 and 9.65 for ZIP codes 28715 and 28759, respectively.

Step 4: Determine Non-Affiliated Provider Total Inpatient Days at NH Asheville, PY1-PY3

Non-Affiliated Provider Inpatient Days at NH Asheville, CY 2030 – CY 2032

	Expected Capture	PY1 2030	PY2 2031	PY3 2032
28704 – Home ZIP	30.43%	1,440	1,455	1,470
28715 – Adjacent ZIP	8.19%	603	609	616
28759 – Adjacent ZIP	9.65%	176	178	180
Sub Total		*2,219*	*2,242*	*2,266*
Add 15% In-Migration		*392*	*396*	*400*
Total Non-Affiliated Days		**2,611**	**2,638**	**2,666**

Source: Step 3, Exhibit Q-1

Source: Novant application, p. 169.

Specifically for the capture rate of ZIP code 28704, Novant utilizes a market analysis included in detail in its Exhibit Q-1,[30] which "found that the 25th percentile of home ZIP code ED market share among North Carolina general acute care hospitals was 36.20 percent."[31] It then adjusts this value to 30.43 percent "by subtracting the base year market share for Affiliated Providers (5.8 percent)."[32] Ultimately, this calculation results in 1,470 total inpatient days resulting from market capture of inpatients from ZIP code 28704 by CY 2032, or the third full project year following the development of NH Asheville.

UNC Health believes that using a capture rate of 30 percent of the total inpatient acute care days from the 28704 ZIP code is unreasonable for multiple reasons. First, Novant explicitly states that its assumed market capture rate comes from an analysis of emergency department market share for all general acute care hospitals in North Carolina.[33] In other words, these market shares are exclusively for emergency department patients, not for all inpatients presenting to those facilities. It is likely that the market capture rate of North Carolina hospitals for ED inpatients from their home ZIP code will be higher than that of all inpatients, given that patients will almost certainly

30 NH Asheville Exhibits, pages 1416-9.
31 Novant application, page 170.
32 Ibid.
33 Ibid.

seek emergency care at whichever facility is nearest to their homes.[34] In this way, the use of these rates inflates the potential market share assumption utilized by Novant for its proposed hospital.

Second, the market analysis included in Novant's Exhibit Q-1 utilizes a wide range of facilities across all 100 North Carolina counties – from small community hospitals to Level I trauma centers, including urban as well as rural counties. This ultimately results in a range of the value for "market share of all residents from Home ZIP" from 0.9 percent (for Swain Community Hospital) to 97.0 percent (for HCA Mission). Many of the counties for these hospitals differ significantly from Buncombe County, both in population, geographic density, socioeconomic status, insurance coverage patterns, and the existence of established hospital providers. By example, the hospital with the closest market share of all residents from its home ZIP to that of ZIP code 28704 for NH Asheville is UNC Health Johnston – Clayton Campus, which is one of two hospitals in Johnston County, a county that itself borders Wake County, the largest county in the state by population and home to multiple large hospitals, including a Level I Trauma Center in WakeMed. Buncombe County, meanwhile, is *the* destination for care in western North Carolina, as well as the most populous county in the region. Given this, a complete aggregation of all hospitals in North Carolina is not a reasonable means of calculating a potential capture rate of the home ZIP code of NH Asheville, even with the additional step of creating quartile averages.

Third, UNC Health believes that Novant's assumption it will capture nearly one-third of all existing acute care days in ZIP code 28704 is not reasonable, given the scope of services that it proposes to provide at its facility. As discussed at length above, NH Asheville, if developed as proposed, will be a 34-bed acute care hospital. This hospital will have a much smaller scope of services than the existing HCA Mission Hospital, which is a Level II trauma center that is licensed for 682 licensed acute care beds according to the *2026 SMFP*, as well as the approved but currently under appeal AdventHealth Asheville, which is approved for 93 acute care beds. NH Asheville will also – as evidenced from the collected letters of support from physicians for both application – have a smaller scope of services that those proposed to be provided at UNC Health West. Given this, UNC Health West believes that it is unreasonable for NH Asheville to provide inpatient care to one-third of all patients from its home ZIP code within only three years of operation, as many of its patients – including those who present to its ED – may require treatment at a facility with the resources to provide a wider range of high acuity care. As such, NH Asheville's projected share of approximately 30 percent of all inpatient services provided for its home ZIP code does not properly account for either the relatively limited scope of NH Asheville or the established acute care providers near its proposed location, which makes its projected market capture rate unreasonable and unsupported.

Fourth, the Novant application contains letters of support from physicians in only five specialties. The narrow range of clinical specialties for which there is documented support will limit the types of patients that can be admitted and treated at NH Asheville and thus will limit the potential market share. UNC Health believes that, given this limited breadth of specialty support for

[34] Studies have shown that patients travel, on average, approximately 17 minutes for emergency department services. See Tolpadi, Anagha; Elliott, Marc N.; Waxman, Daniel; Becker, Kirsten; Flow-Delwiche, Elizabeth; Lehrman, William G.; Stark, Debra; and Parast, Layla. "National travel distances for emergency care." *BMC Health Services Research*, 2022, 22. Accessed at https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-022-07743-7, which notes an average ED travel time among patients of 17.3 minutes.

Novant's proposed facility, it is unreasonable to assume that there will be the volume of physician referrals or physicians on the medical staff to treat a sufficiently broad range of patients to achieve a 30 percent market share.

Major Medical Equipment

Ratios Used to Calculate Imaging Utilization

Novant provides projections for all "major medical equipment" at its proposed acute care facility, which includes fixed X-ray, portable X-ray, SPECT, ultrasound, MRI, and CT services.[35] To do this, Novant calculates "the ratio[s] of [CT, MRI, X-ray, and ultrasound] procedures to inpatient surgical and inpatient medical (non-surgical) discharges for patients treated at NH hospitals in the Greater Charlotte and Greater Winston-Salem regions in 2024."[36]

NH Grater Charlotte and Greater Winston-Salem Hospitals' Ratios of Ancillary Services to Inpatient Discharges and Outpatient Cases, CY 202

	Inpatients Medicine	Inpatients Surgery	OP Cases - Surgery	OP Cases - Emergency	OP Cases - All Other
CT Scans	1.3995	0.8291	0.0394	0.5127	0.1324
MRI Scans	0.2019	0.1225	0.0026	0.0273	0.0798
X-Ray	1.5709	1.5077	0.5090	0.5591	0.2526
Ultrasound	0.1846	0.2561	0.0424	0.0700	0.0677

Source: Novant Health Internal Data, CY 2024

Source: Novant application, p. 176.

Novant does not specifically state what facilities this includes, although it can be assumed that it includes all Novant facilities in these two markets: Novant Health Ballantyne Medical Center (NH Ballantyne), Novant Health Huntersville Medical Center (NH Huntersville), Novant Health Matthews Medical Center (NH Matthews), Novant Health Mint Hill Medical Center (NH Mint Hill), and Novant Health Presbyterian Medical Center (NH Presbyterian) in Mecklenburg County; and Novant Health Forsyth Medical Center (NH Forsyth) and Novant Health Medical Park Hospital (NH Medical Park) in Forsyth County. These seven facilities all differ significantly in terms of size, ranging from 842 licensed acute care beds at NH Forsyth to only nine licensed acute care beds at NH Medical Park; many of these hospitals also function as smaller community hospitals, such as NH Ballantyne and NH Mint Hill, both of which are licensed for 36 acute care beds, yet Novant inexplicably does not specifically identify their ratios to demonstrate whether the selected ones are reasonable for a small, limited service facility like Novant proposes. Given the differences among the facilities that Novant utilizes to project these ratios, it is unreasonable for Novant to utilize the ratios for these facilities in aggregate to calculate the total procedures for its medical equipment at the proposed NH Asheville facility. In fact, by utilizing these facilities Novant likely significantly overstates the imaging procedures that will be performed at NH Asheville, as some of the seven facilities above – particularly NH Presbyterian and NH Forsyth – are large acute care facilities that are able to provide high acuity services, including a large range of imaging procedures. This breadth of procedures is not applicable to the services proposed to be offered at NH Asheville.

[35] Novant application, page 175.

[36] Id., page 176.

Emergency Department Services

To project emergency department (ED) utilization at NH Asheville, Novant assumes that a portion of its ED utilization will come from capturing existing market ED visits for patients originating from the home ZIP code of its proposed facility (28704), as well as ZIP codes adjacent to its home ZIP code (28715 and 28759). Specifically, for its projected ED visits, Novant assumes a capture rate of 53.37 percent within ZIP code 28704, as well as capture rates of 10 percent for both ZIP codes 28715 and 28759.

Step 5: Determine Non-Affiliated Provider Total Outpatient Volume at NH Asheville, PY1–PY3

Non-Affiliated Provider Outpatient Volume (ED Only) at NH Asheville, CY 2030 – CY 2032

	Expected Capture	PY1 2030	PY2 2031	PY3 2032
28704 – Home ZIP	53.37%	3,265	3,299	3,333
28715 – Adjacent ZIP	10.00%	658	665	672
28759 – Adjacent ZIP	10.00%	187	189	191
Sub Total		*4,111*	*4,153*	*4,196*
Add 15% In-Migration		725	733	741
Total Non-Affiliated ED Capture		**4,836**	**4,886**	**4,937**

Source: Step 4, Exhibit Q-2

Source: Novant application, p. 184.

To calculate the capture rate of ZIP code 28704, Novant utilizes a market analysis included in detail in its Exhibit Q-2,[37] which "found that the 25th percentile of home ZIP code ED market share among North Carolina general acute care hospitals was 53.37 percent."[38]

As with the capture rate for inpatient days, UNC Health West believes that this capture rate of 53.37 percent of the total outpatient acute care days from ZIP code 28704 is unreasonable. First, the market analysis included in Novant's Exhibit Q-2 utilizes a wide range of facilities across all North Carolina counties, including many facilities that are the only providers of emergency department services in their respective service areas. Given this, a complete aggregation of the ED market shares across all North Carolina hospitals likely overestimates the share of outpatient ED visits that NH Asheville can expect to achieve, particularly given that there are not only other hospital campus emergency departments in Buncombe County and bordering counties, but also freestanding ED facilities that will further dilute share.[39] Next, NH Asheville will have a much smaller scope of services than the existing HCA Mission Hospital, which is a Level II trauma center that is licensed for 682 licensed acute care beds according to the *2026 SMFP*, as well as the approved but currently under appeal AdventHealth Asheville, which has previously been approved for 93 acute care beds. It will also – as evidenced from the collected letters of support from physicians for both application – have a smaller scope of services than those proposed to be provided at UNC Health West. As such, its assumption of ED market share is not aligned with its

37 NH Asheville Exhibits, pages 1420-5.

38 Novant application, pages 184-5.

39 See Project ID # B-012380-23, in which HCA Mission proposed, and was approved, to develop a freestanding emergency department in Buncombe County.

proposed scope of services. Given this, NH Asheville's projected share of over 50 percent of all outpatient ED visits in its home ZIP code is not reasonable and is unsupported.

Lack of Ramp-Up for Services

Novant states that it will begin services on January 1, 2030, and as such its first full project year will be CY 2030.[40] Across nearly all of its projected services – with the exception of only nuclear medicine imaging services – Novant assumes no ramp-up of the delivery of care, instead assuming that its new hospital will be able to deliver services at full capacity upon opening, and that this will continue for the entirety of its first full project year.

This assumption is unreasonable. Given that Novant has limited existing healthcare services in the service area and *no* hospitals in the service area, it is unlikely that it will be able to hire all necessary staff and suitably begin operations such that it will not experience some ramp-up for at least its first year. Additionally, and as discussed at length above, much of Novant's inpatient and outpatient base originates from the shifting of existing patients in the service area. It is reasonable to assume that, if NH Asheville is approved, this shifting of volume will occur gradually, and will not immediately be realized within months of NH Asheville's initiation of operations.

Novant's own experience opening new acute care hospitals indicates that it is reasonable to assume a ramp-up period. NH Mint Hill, which opened on October 1, 2018, provided only 6,618 inpatient days of care in 2019, according to data included with the *2021 SMFP*. By 2021, NH Mint Hill provided 11,231 inpatient days of care, representing a 69.7 percent growth rate in inpatient days from its first year of operation. In contrast, the projected inpatient days at NH Asheville are projected to grow by only 1.8 percent from its first full project year to its third full project year – indicating a lack of ramp-up in acute care services.

Inpatient Days of Care – NH Mint Hill

Facility	*PY1*	*PY2*	*PY3*	*% Change PY1-PY3*
NH Mint Hill	6,618	7,530	11,231	69.7%
NH Asheville (Projected)	9,027	9,108	9,192	1.8%

Source: *2021-2023 SMFPs*, Novant Application, p. 171.
Note: Reporting years are October 1 through September 30. NH Mint Hill opened on October 1, 2018, and its first three full project years are 2019, 2020, and 2021.

In other words, it is evident from the data above that NH Mint Hill "ramped up" its inpatient acute care days from its first year of operation, particularly over its first three full operating years. As Novant itself utilizes NH Mint Hill as a proxy to calculate the utilization of multiple services for its proposed hospital, its failure to use its historical pattern of growth in acute care days to model realistic utilization projections for its services in its first full project year results in an unrealistic estimation of its facility utilization. This is particularly true given its experience developing new hospitals in Mecklenburg County, where Novant has a strong, established presence. NH Mint Hill was itself developed through the relocation of existing beds from other hospitals yet still experienced a substantial ramp up in operations. In short, it is dubious that NH Asheville would

[40] Novant application, page 163.

essentially fill up its beds in the first year and experience no ramp up of services over its first three full project years, which renders its projections unreasonable and unsupported.

In conclusion, Novant's utilization projections contain errors and are unreasonable and unsupported. As such, its application is non-conforming with Criteria 1, 3, 4, 5, 6, 13, 18a, and the performance standards for acute care beds.

2. Novant's financial capacity to complete the proposed project is questionable given its extensive concurrent capital commitments and limited liquid reserves.

Novant's application raises serious questions regarding financial feasibility, given the system's significant portfolio of concurrent capital projects and the limited liquid reserves available to support them. While Novant claims to have adequate accumulated reserves, a closer examination of the system's financial position reveals concerning patterns of capital overextension that call into question whether the system has demonstrated adequate financial resources to complete all proposed projects, including NH Asheville.

Over the past several years, Novant has proposed an unprecedented volume of major capital projects across the Carolinas. As documented in Novant Health's FY 2024 audited financial statements, the system has committed substantial accumulated reserves to fund numerous hospital facility developments, expansions, and other capital initiatives. The cumulative scale of these commitments is substantial: Novant has approximately three billion dollars in capital projects from CONs in recent years that represent 67 percent of its total accumulated reserves of approximately 4.5 billion dollars. When combined with total working capital commitments of approximately 79 million dollars, Novant has committed or proposed to commit 69 percent of its accumulated reserves to these recent CON projects.

Novant Capital Project Commitments

	Amount
Total Capital Projects	$ 3,007,345,473
Total Working Capital	$ 78,994,473
Net Total + Total Outstanding Working Capital	$ 3,086,339,946
Net Accumulated Reserves	$ 4,480,255,000

In addition to these CON projects, Novant Health has made significant hospital acquisitions that further strain its financial position. In February 2024, Novant completed a $2.4 billion purchase of three Tenet Healthcare hospitals and associated facilities in South Carolina, financed through debt rather than reserves. This acquisition increased Novant's long-term debt from $2.6 billion to $5.2 billion and raised its debt-to-total capitalization ratio from 30.2 percent to 42.6 percent. More recently (October 2025), Novant acquired Northern Regional Hospital with $137 million in commitments and a 10-year guarantee.

Funding the proposed development of NH Asheville – along with the system's other concurrent capital commitments – would likely require Novant to liquidate substantial portions of its long-term investment portfolio. While health systems routinely include long-term investments when demonstrating available capital, the scale of liquidation required here – combined with the concurrent timing of multiple major projects – raises questions about financial prudence.

Questions remain about whether converting such significant portions of long-term investments would impact the system's financial stability, bond covenants, or ability to maintain adequate reserves for unexpected operational challenges. Long-term investments typically serve critical strategic purposes including maintaining bond ratings, providing financial reserves for operational challenges, and generating investment income that supports ongoing operations.

The proposed development of NH Asheville does not exist in isolation but represents one component of an extensive portfolio of major capital projects that Novant is attempting to develop simultaneously or in rapid succession. The cumulative effect of these overlapping projects creates a compounding financial burden that raises questions about the risk of capital overextension.

The application does not provide an analysis of how the cumulative capital requirements and initial operating losses across Novant's various concurrent projects may affect the system's overall financial position, its ability to maintain investment-grade bond ratings, or its capacity to continue funding all approved projects and projects under appeal while also completing new projects like NH Asheville. The absence of such analysis is particularly concerning given the magnitude of capital at risk and the extended timeline over which these projects will require ongoing financial support.

Given the scale of Novant 's concurrent capital commitments, the limited liquidity of the system's reserves, and the absence of analysis addressing how the cumulative burden of multiple simultaneous projects affects financial feasibility, Novant has not adequately demonstrated compliance with Criterion 5.

3. <u>The proposed staffing for NH Asheville is unreasonable.</u>

Novant provides proposed staffing for NH Asheville for its first three full project years in Form H, in which it notes 223.3 total FTEs needed across all hospital services for each of its first three full project years.[41]

Novant's assumption that it will have 223.3 FTEs at NH Asheville in only its first full project year is not reasonable. As discussed in part above, Novant's presence in western North Carolina is limited, with only a small handful of surgical practices and three established urgent care practices in Buncombe County and the surrounding areas.[42] Given this, it will almost certainly have to recruit providers and staffing in order to account for its 223.3 projected FTEs in its first full project year.

Despite this, however, in Section H of its application, Novant states that it will "recruit through its established regional and corporate human resources department, *should any recruitment be necessary* (emphasis added)."[43] Recruitment will almost certainly be necessary, given Novant's limited presence in the area. Novant will not be able to entirely staff the proposed facility through only its existing Novant western North Carolina physician practices. The mechanisms through

41 Id., page 206.

42 See Novant application, page 36, which lists three Novant practices, as well as page 89, which notes three Novant Health-GoHealth urgent care locations.

43 Id., page 124.

which Novant will enact this recruitment are also unsupported; while Novant states that "NH corporate and regional human resources personnel will be available to recruit needed team members…[as well as] open houses [to] help attract staff,"[44] it likely does not have either "corporate or regional" HR in a county where it has no hospital presence, and only a limited healthcare presence overall. It also does not have the space to hold "open houses," as it has no existing hospital, and therefore no physical location at which to use such a recruiting tool. Additionally, as NH Asheville is not applying to meet the entirety of the 129-bed acute care need in the *2025 SMFP,* it will have to potentially compete with other new providers, including UNC Health West – which will be a new acute care facility if approved – and AdventHealth Asheville – which is approved but currently under appeal – for staffing, as well; these two providers are established in the greater western North Carolina area through hospitals in adjacent counties, and therefore have a much stronger means by which to recruit staffing for a new acute care facility, as well as established training and professional development program partnerships with area educational programs. Because Novant does not have existing training partnerships in the area, such as with MAHEC and other professional education programs, and because it does not have existing nearby facilities from which it may transfer employees, it is not reasonable for Novant to expect that it will be fully staffed and able to essentially operate above its target occupancy rate upon the start date of its services.

As such, Novant's proposed staffing is unreasonable and unsupported, rendering its application non-conforming with Criteria 5, 7, and 18a.

4. Novant does not meet the criteria and standards for GI endoscopy services.

In Section A.5.c and A.5.d, Novant indicates that NH Asheville will provide GI endoscopy services.[45] 10A NCAC 14C .3903, Criteria and Standards for Gastrointestinal Endoscopy Procedure Rooms in Licensed Health Service Facilities, sets forth the rules that must be met if an applicant will be offering GI endoscopy services at its facility. Despite this, Novant does not respond to the rules for GI endoscopy services, nor does it provide GI endoscopy projections in its Form C.[46] Given that MDC 6, Digestive System, accounts for over one-quarter of Novant's projected volume, it is certainly likely that at least some of these patients would require "the insertion of a flexible endoscope…for diagnostic or therapeutic purposes," which defines a GI endoscopy room per NCGS 131E-176(7d).

Novant's inconsistent representations regarding its GI endoscopy services, including its lack of projections and responses to GI endoscopy criteria and standards despite stating it will provide these services renders its application non-conforming with Criteria 1, 3, 4, 5, 6, 13, 18a, and the performance standards for GI endoscopy services.

5. NH Asheville does not meet the specific healthcare needs of the service area.

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44 Id.

45 Novant application, page 21.

46 Id., page 99.

In Section C.4 of its application, Novant lists the ten leading causes of deaths for the service area of NH Asheville. According to its application, the two leading causes of death in the service area are heart disease and cancer, accounting for over 38 percent of service area deaths in 2023.

NH Asheville Service Area Counties: Ten Leading Causes of Death, 2023 (All Ages)

Rank	Cause of Death	# of Deaths	% of Deaths
1	Heart Disease	1,435	19.7%
2	Cancer - All Sites	1,379	18.9%
3	All Other Unintentional Injuries	586	8.0%
4	Cerebrovascular Disease	400	5.5%
5	Chronic Lower Respiratory Diseases	399	5.5%
6	Alzheimer's Disease	204	2.8%
7	Diabetes Mellitus	196	2.7%
8	COVID-19	135	1.8%
9	Suicide	124	1.7%
10	Chronic Liver Disease and Cirrhosis	121	1.7%
	All Other Deaths	2,319	31.8%
	Total Deaths-All Causes	**7,298**	**100.0%**

Source: North Carolina State Center for Health Statistics / https://schs.dph.ncdhhs.gov/data/vital/lcd/2023/

Source: Novant application, p. 64.

Novant proceeds to discuss heart disease among patients living in the proposed service area of the hospital, noting that "NH Asheville will be integrated with Novant Health Hospital-Based Medicine Institute."[47] However, Novant has included no letters of support from cardiologists for the proposed project, which makes any comprehensive treatment of heart disease or cardiovascular issues at its hospital questionable.[48] Although it highlights heart disease as a leading cause of death in the service area, it is unclear that NH Asheville will have the support to provide care for this disease.

It is also questionable whether NH Asheville will provide any support for cancer care that is not already provided in the service area. As discussed above, Novant states throughout its application that it proposed hospital will specialize in cancer care. However, it also notes its partnership with Messino, an existing provider of oncology services with multiple practices across western North Carolina. The majority of cancer care can be provided on an outpatient basis;[49,50] with some studies noting that 80 percent of cancer treatment is conducted in an outpatient setting.[51] The existing providers partnering with Novant for its application – particularly Messino – have the

47 Novant application, page 65.

48 See NH Asheville Exhibits, Exhibit C-4.2, pp. 622-649, which includes no cardiologist letters of support.

49 "Inpatient vs Outpatient Care." American Cancer Society. Last revised August 11, 2025, accessed at https://www.cancer.org/cancer/preparing-for-treatment/inpatient-vs-outpatient-care.html.

50 *A Consumer's Guide to Cancer Insurance*. NC Department of Insurance. Accessed November 5, 2025, at https://www.ncdoi.gov/documents/consumer/publications/consumer-guide-cancer-insurance/open#:~:text=COVERING%20TREATMENT%20RECEIVED%20ONLY%20IN,might%20not%20meet%20your%20needs, p. 3.

51 "Cancer care migrates to outpatient setting." *The Journal of Healthcare Contracting*. Accessed November 5, 2025, at https://www.jhconline.com/cancer-care-migrates-to-outpatient-setting-2.html.

ability to provide this outpatient care; there is no reason why a hospital must be established to supplement this care. As discussed above, Novant's attestation of the potential inpatient days from Messino is dubious and not supported. It follows, given these unsupported inpatient days, that most of the cancer care that would be provided at NH Asheville would be outpatient care, and therefore would be services that are duplicative of those that already exist in the service area.

Given this, there is no demonstrated need for the proposed hospital, and as such Novant's application is non-conforming with Criteria 1, 3, 4, 6, and 18a.

ISSUE-SPECIFIC COMMENTS ON HCA MISSION HOSPITAL

HCA Mission Hospital's (HCA Mission's) application to develop 129 additional acute care beds should not be approved. The application contains notable overstatements, miscalculations, and omissions that render it non-conforming. UNC Health has grouped these by issue below, each of which contributes to HCA Mission's non-conformity. Please note that, relative to each issue, UNC Health has identified the statutory review criteria and specific regulatory criteria and standards creating the non-conformity.

1. <u>HCA Mission Hospital does not sufficiently demonstrate it is a provider of high-quality care to the residents of western North Carolina.</u>

   HCA Mission is one of the largest providers of healthcare in the State of North Carolina. As stated in its application, HCA Mission "has a rich, deeply-rooted history of providing hospital care in western North Carolina…[as] the tertiary-quaternary flagship hospital…[and] the region's only Level II trauma center and children's hospital."[52] Additionally, as a hospital that is licensed for 853 total beds – 733 acute care beds and 120 psychiatric beds, according to its application[53] – HCA Mission Hospital is the largest hospital in western North Carolina.

   However, recurring issues related to the provision of quality care, largely coinciding with the hospital's ownership and operations being assumed by HCA Healthcare in 2019, have shown that HCA Mission has conceded its role as the region's premier healthcare provider. Additionally, it does not provide sufficient evidence in its application to demonstrate an appropriate connection to the larger western North Carolina region, a region that faces numerous hardships, among them recovery from the catastrophic damage done by Hurricane Helene in 2024. Finally, its application lacks documented support from those who live in the communities it purports to serve. These issues are discussed in detail below.

   Provision of Quality Care

   In Section O of its application, HCA Mission notes the identification of immediate jeopardy at HCA Mission Hospital on September 25, 2025. It states that, despite not yet receiving a CMS-2567 survey document at the time of the filing of the application, "the hospital has already implemented corrective action for all items identified in the state's letter and has proactively provided documentation of its plans to both DHSR and CMS."[54]

   UNC Health does not suggest that HCA Mission has not provided a sufficient response to this finding. It also does not believe that a single instance of immediate jeopardy alone renders HCA Mission's application non-conforming with Criterion 20. However, this most recently documented immediate jeopardy incident is one in a series of immediate jeopardy findings at HCA Mission Hospital that suggest a pattern of the careless provision of healthcare services.

   Since its acquisition by HCA Healthcare in 2019, HCA Mission Hospital alone has undergone *three* immediate jeopardy investigations: one in 2021, one in 2024, and the immediate jeopardy

52 HCA Mission application, page 24.

53 Ibid.

54 Id., page 155.

documented in its application, which occurred in September 2025.[55] Perhaps most alarmingly, its 2024 immediate jeopardy was evidenced from nine total incidents that occurred over a 19-month period from April 2022 through November 2023, in which 18 patients were harmed, and four patients died, as a result of violations of federal standards of care related to the hospital's emergency and oncology services.[56] These three immediate jeopardy findings, while critical and concerning unto themselves, do not include other indicators of negligent care, including, most prominently, litigation from the North Carolina Attorney General in 2025 that remains ongoing.[57]

The finding of immediate jeopardy for a hospital is rare. Out of all citations issued by CMS to hospitals within a typical year, only approximately 2.4 percent result in a situation of immediate jeopardy.[58] For a single hospital to have three immediate jeopardy findings in only a five-year period, in other words, is exceptional. For such a hospital to be "the tertiary-quaternary flagship hospital" of western North Carolina, and the facility for which hundreds of thousands of patients across western North Carolina and beyond must utilize for high-acuity and life-saving care, is deeply concerning.

UNC Health believes that this abnormally high number of grave quality of care findings at HCA Mission Hospital indicates a pattern in the provision of healthcare services that is unlikely to be broken, given HCA Healthcare's continued ownership and operation of HCA Mission Hospital.[59] While its application ultimately addresses its ongoing immediate jeopardy in a sufficient manner, UNC Health West believes that the rewarding of additional acute care capacity to HCA Mission Hospital is unwarranted and unwise, given its repeated incidents where it failed to provide safe and effective care.

Letters of Support

HCA Mission includes 114 letters of support for its application. The majority of these letters are from providers or administrators affiliated with HCA Mission Hospital or other HCA Healthcare

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55 As noted by Campbell, Keith, and Evans, Jack. "Mission Hospital placed in immediate jeopardy; sanction is third since sale to HCA." *Asheville Watchdog*. October 21, 2025. Accessed at https://avlwatchdog.org/mission-hospital-placed-in-immediate-jeopardy-sanction-is-third-since-sale-to-hca/.

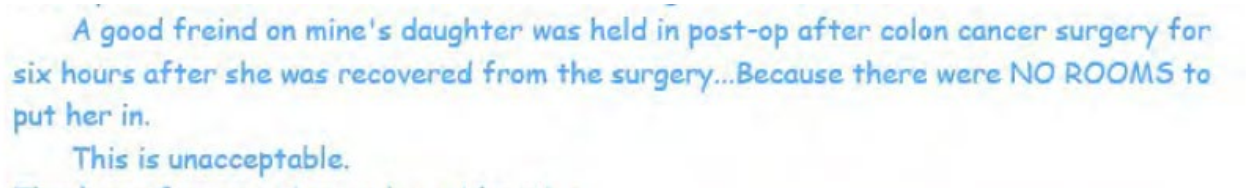
56 Evans, Jack, and Jones, Andrew. "Mission Hospital faces new immediate jeopardy recommendation as state agency flags major safety risks." *Blue Ridge Public Radio*. October 17, 2025. Accessed at https://www.bpr.org/health/2025-10-17/mission-hospital-faces-new-immediate-jeopardy-recommendation-as-state-agency-flags-major-safety-risks. Also see Jones, Andrew. "Feds cite Asheville's Mission Hospital for 'immediate jeopardy,' HCA division president tells staff." *Asheville Watchdog*. February 2, 2024. Accessed at https://avlwatchdog.org/feds-cite-ashevilles-mission-hospital-for-immediate-jeopardy-hca-regional-president-tells-staff/.

57 Sartwell, Jane Winik. "AG agrees with findings of possible compliance problems at HCA's NC hospitals." *Carolina Public Press*. August 28, 2025. Accessed at https://carolinapublicpress.org/72325/attorney-general-jackson-nc-hca-mission-health-noncompliance/.

58 Antognini, Joseph F. "Hospital Surveys by the Centers for Medicare and Medicaid Services: An Analysis of More Than 34,000 Deficiencies." *Journal of Patient Safety*. June 1, 2021, 17(4). Accessed at https://pubmed.ncbi.nlm.nih.gov/30896558/.

59 In addition to the immediate jeopardy violations at HCA Mission Hospital, two *additional* hospitals owned and operated by HCA Healthcare also incurred immediate jeopardy determinations: Blue Ridge Regional Hospital in Spruce Pine in 2023, and Mission Hospital McDowell in Marion in 2021. See Campbell and Evans, cited above.

hospitals in North Carolina. Across these 114 letters, only *one* letter is from a member of the community not affiliated with HCA Healthcare. Further, this solitary letter of community support is written in a tone that does not entirely suggest support for HCA Mission Hospital or the quality of care it provides. This letter contains the following:


A good freind on mine's daughter was held in post-op after colon cancer surgery for six hours after she was recovered from the surgery...Because there were NO ROOMS to put her in.

This is unacceptable.

Source: HCA Mission Exhibits, p. 92.

While this letter is ostensibly framed by HCA Mission Hospital as a letter of support, the actual amount and enthusiasm of support from this community member is questionable. Indeed, it is curious that HCA Mission, as a large provider of healthcare that treats hundreds of residents across western North Carolina each day, secured *no* support from any community members or leaders in Buncombe County or other western North Carolina communities for its CON application. UNC Health cannot opine the reasons for this, although it certainly follows that HCA Healthcare's numerous regulatory citations highlighted above and the significant negative public image it appears to have engendered in recent years may have contributed to this lack of documented community support for its proposal to expand its acute care services.

By contrast, the UNC Health West application contains more than 60 letters from members of the community and organizations and institutions in Buncombe and other western North Carolina counties. These letters include expressions of support from not only residents but also schools and educational institutions, businesses, community health organizations, and municipal government leadership. These letters acknowledge UNC Health's reputation as a high quality provider of healthcare services and demonstrate widespread support and enthusiasm for UNC Health's proposed project in Buncombe County.

In summary, HCA Mission has not demonstrated the need for its proposed project. Its numerous quality and patient safety violations, its inability to articulate the challenges that beset its community, and its lack of community support despite its significant stature in the community demonstrate that it should not be approved for additional acute care beds. **As such, HCA Mission has not demonstrated the need for the proposed project, rendering its application non-conforming with Criteria 3 and 18a.**

2. HCA Mission's claim that the need for acute care beds cannot be met by another provider is unfounded.

In Section C.4 of its application, HCA Mission discusses its decision to develop all 129 of its proposed acute care beds as medical/surgical (med/surg) beds. To do so, it cites an increase in patient days across its med/surg beds, as well as the fact that "[a]dult Med/Surg beds also include stepdown units for post-ICU care."[60] Expounding on this, HCA Mission states the following:

> *…for Mission to fulfill its role as the regional trauma center and tertiary care center it must have ICU capacity and capacity to serve these highly acute patients*

[60] HCA Mission application, page 84.

> *as they recover in stepdown in General Med/Surg beds. A community hospital cannot meet this need. Past competitive applications have erroneously suggested that Mission Hospital can use available beds in the community as the ICU patients are ready to step down. For appropriate continuum of care during an inpatient stay, these beds need to be available at Mission Hospital so its high acuity patients can easily access a lower level of care without transport, disruption, or coordination with a new provider that is not involved in the patient's recent care history*.[61]

HCA Mission's explanation for its decision to develop med/surg beds specifically, as well as its justification for why a new provider cannot meet the need for lower acuity med/surg beds, is unsupported. Specifically, this explanation does not account for the relative growth in ICU days at HCA Mission Hospital, the overall ability of community hospitals to serve the majority of patients seeking acute care services, as well as the ways in which patient access will increase through development of a new hospital in Buncombe County, a large county with a documented need for additional acute care services. Moreover, even assuming that HCA Mission needs additional non-ICU beds for patients stepping down from tertiary level care, the approval of UNC Health West will allow for a significant portion of inpatient DRGs to be treated there, freeing up capacity at HCA Mission for the small percentage of patients in DRGs that only it will provide. As such, the approval of UNC Health West will meet the overall need in the service area and will have a positive impact on any alleged capacity constraints at HCA Mission.

Growth of ICU Utilization at HCA Mission Hospital

As stated above, HCA Mission in part justifies the need for additional med/surg beds "to create additional capacity in the ICU" by enabling stepdown patients from its ICU to receive care in one of its med/surg beds, rather than remaining in an ICU unit.[62] Nowhere in its application, however, does HCA Mission discuss the alternative of developing a portion of its existing or proposed med/surg beds as ICU beds,[63] which would, assumedly, lessen the capacity issues for HCA Mission Hospital's ICU. According to its own data, the ICU days at HCA Mission Hospital from FY 2018 through FY 2024 grew at a faster rate than med/surg days over the same period of time, with ICU days growing at 58.3 percent compared to a growth in med/surg days of 24.7 percent.

Figure 20

FY 2018 – FY 2024 Mission Hospital Occupancy of Bed by Unit Type

	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2018-FY 2024 % Growth	FY 2018-FY 2024 CAGR
Total Adult Med/Surg									
Beds	512	512	519	519	519	519	519	1.4%	0.2%
Days	143,724	153,806	149,303	168,608	166,246	170,807	179,274	24.7%	3.8%
% Occupancy	76.9%	82.3%	78.8%	89.0%	87.8%	90.2%	94.6%	23.1%	3.5%
Total Adult ICU									
Beds	86	86	91	91	91	91	91	5.8%	0.9%
Days	18,567	18,866	20,849	26,601	26,674	27,381	29,395	58.3%	8.0%
% Occupancy	59.1%	60.1%	62.8%	80.1%	80.3%	82.4%	88.5%	49.6%	6.9%

61 Ibid.

62 Id., page 85.

63 Id., Section E, pages 112-4.

Source: HCA Mission Application, p. 84.

Despite this significantly higher historical growth, and despite HCA Mission itself stating a need for additional ICU capacity, HCA Mission does not propose developing additional ICU capacity, which would appear to be a more effective alternative for its proposed project.

Acute Care Days Suitable for a Community Hospital

Next, HCA Mission states that it is the only provider that can meet the need for additional med/surg beds, and that, in fact, "[a] community hospital cannot meet this need." As stated above, it justifies this through the need for additional stepdown care for its ICU patients. While HCA Mission Hospital is in fact able to deliver higher acuity care that is typically not provided in a community hospital, most patients who are admitted as hospital inpatients can be appropriately treated at a "community" hospital, such as the one UNC Health West proposes to develop. As a point of comparison, in UNC Health West's CON application, UNC Health West found that the scope of services at its proposed hospital would account for the majority of the historical market days within its proposed primary service area (PSA) and secondary service area (SSA); specifically, it found that the DRGs it proposed to serve at its hospital accounted for 91.2 percent of all market DRGs in its proposed PSA and SSA in 2024.

Table 2-2: Historical Service-Appropriate Acute Care Days
UNC Health West Service Area

	2022	*2023*	*2024*	*CAGR**
PSA Service-Appropriate Acute Care Days	61,769	64,406	66,285	3.6%
SSA Service-Appropriate Acute Care Days	120,506	118,405	126,389	2.4%
Total Service-Appropriate Days	**182,275**	**182,811**	**192,674**	**2.8%**
Total Acute Care Days – All DRGs	197,727	200,557	211,190	3.3%
Service-Appropriate Days % of Total	92.2%	91.2%	91.2%	

Source: Hospital Industry Data Institute (HIDI). Please note the HIDI data above is reported using a June 30 – July 1 fiscal year.
* Compound annual growth rate.

Source: UNC Health West application, p. 158.

UNC Health acknowledges that the above percentages account for only those patients originating from the ZIP codes that UNC Health West defined as its service area, and that HCA Mission Hospital has historically provided care to a larger base of patients by geographic origin. Nevertheless, UNC Health believes this finding, which utilizes market data, is a reasonable proxy that demonstrates that, contrary to HCA Mission's claim, a community hospital can meet the needs of most of the patients requiring hospital services, which leaves HCA Mission's assertion of its need for the proposed acute care services unsupported.

Erroneous Use of Rural Hospitals as a Point of Comparison

Further, HCA Mission, in its discussion of the alternative of developing a separate 129-bed "freestanding hospital in Buncombe County," states that this alternative "was not the best option" in part because of the reasoning below:

> *The data clearly shows that smaller, lower acuity community hospitals in the region already operate with lower occupancy rates and have excess capacity*

> *because of the limited services they provide…[T]he occupancy of smaller community hospitals is consistently far lower than tertiary centers like Mission. Even excluding the eight critical access hospitals ("CAH") with beds capped at 25, the remaining smaller community hospitals in the service area had a total* surplus *of 428 beds per the 2025 SMFP…[i]n FY 2024, these same community hospitals averaged only 34.1% occupancy.*[64]

This description mischaracterizes the position of a newly developed hospital in the service area, and particularly that of a newly developed hospital in Buncombe County. The occupancy rate cited by HCA Mission presumably includes multiple hospitals in very rural areas of western North Carolina; however, rural hospitals generally have lower occupancy rates than non-rural hospitals.[65] A new hospital in the service area would not fit into this categorization, as it would almost certainly be developed in the more densely populated Buncombe County. While it may be surrounded by largely rural counties, Buncombe County itself is the largest population hub in western North Carolina. According to the North Carolina Office of State Budget and Management (NC OSBM), it is the 7th most populous county in the state. Additionally, and as shown in HCA Mission's own application, Buncombe County has the second-highest projected population growth for those age 65 and older of all counties in HCA Mission Hospital's stated service area from 2025 to 2030.

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64 Id., page 113.

65 "Occupancy Rates in Rural and Urban Hospitals: Value and Limitations in Use as a Measure of Surge Capacity." North Carolina Rural Health Research Program. March 2020. Accessed November 11, 2025 via The Cecil G. Sheps Center for Health Services Research at the University of North Carolina, at https://www.shepscenter.unc.edu/product/occupancy-rates-in-rural-and-urban-hospitals-value-and-limitations-in-use-as-a-measure-of-surge-capacity/.

Figure 14

Projected Service Area Population Growth – Percent

County	Age 0-17	Age 18-44	Age 45-64	Age 65+	Total	Total Adult
			2025-2035			
Buncombe	-3.9%	6.2%	17.6%	20.2%	10.6%	13.5%
Haywood	-2.6%	8.4%	1.9%	15.0%	6.6%	8.5%
Henderson	2.0%	11.4%	6.1%	22.2%	11.4%	13.4%
Jackson	-1.2%	8.9%	4.8%	18.3%	8.5%	10.3%
Macon	0.4%	12.3%	4.5%	15.9%	9.3%	11.3%
Madison	1.6%	6.7%	-1.4%	7.5%	3.9%	4.4%
McDowell	-6.5%	5.4%	-9.0%	9.0%	0.2%	1.7%
Swain	-0.3%	2.2%	-5.8%	-3.7%	-1.5%	-1.8%
Transylvania	-1.9%	2.6%	-3.3%	6.8%	1.9%	2.6%
Yancey	2.6%	5.1%	-8.7%	7.1%	1.7%	1.4%
Primary Service Area	***-1.9%***	***7.5%***	***7.9%***	***17.0%***	***8.3%***	***10.5%***
Avery	0.8%	-4.4%	-3.3%	9.2%	0.0%	-0.1%
Burke	-4.5%	4.1%	-9.4%	14.0%	1.1%	2.4%
Caldwell	-3.7%	7.0%	-11.8%	11.2%	0.8%	1.8%
Cherokee	7.0%	6.9%	-5.5%	18.5%	7.6%	7.7%
Clay	8.8%	28.8%	4.3%	4.5%	11.8%	12.4%
Graham	8.2%	2.7%	-9.2%	2.4%	0.7%	-1.0%
Mitchell	-9.2%	7.5%	-11.7%	-1.2%	-2.8%	-1.4%
Polk	-0.4%	13.6%	-15.3%	0.8%	0.0%	0.1%
Rutherford	2.3%	7.7%	-11.8%	5.6%	1.1%	0.7%
Secondary Service Area	***-1.1%***	***6.6%***	***-9.8%***	***9.7%***	***1.7%***	***2.3%***
Total Service Area	**-1.6%**	**7.2%**	**1.9%**	**14.6%**	**6.1%**	**7.8%**
North Carolina	**1.2%**	**6.4%**	**2.3%**	**14.2%**	**5.7%**	**6.9%**

Source: North Carolina Office of State Budget and Management, 2024

Source: HCA Mission application, p. 73.

In short, the assertion that a new acute care facility in Buncombe County would have the same low occupancy rate as a hospital in a more rural county is inaccurate and unsupported.

Access to Acute Care Services

Lastly, while the proposed project may in fact create additional capacity for HCA Mission's existing ICU and med/surg patients, it will not increase access to acute care services across the service area to the same extent that a new acute care hospital would, given that there is only one existing provider of acute care services – HCA Mission Hospital – in the service area today. While HCA Mission discusses the ways in which its proposed project will increase access to acute care services in Section N.1 of its application, it only states that the proposed project "will have a positive effect on competition in the service area through greater access to beds supported by high-acuity services that are most needed in the service area."[66] As discussed above, a community hospital will be able to provide acute care services to most of the inpatients that HCA Mission Hospital treats today, which would likely increase access more than the development of more acute care services at one location, particularly one location that already acts as the only provider of acute care services in the service area. A new community hospital at a different location would also enable patients closer to that location to access hospital-based services more easily, as opposed to having to rely solely on HCA Mission Hospital for care within Buncombe County.

66 HCA Mission application, page 149.

The factors discussed above do not sufficiently demonstrate that HCA Mission's proposal represents the most effective alternative, rendering its application non-conforming with Criteria 1, 3, 4, 5, 6, and 18a.

COMPARATIVE ANALYSIS

Pursuant to G.S. 131E-183(a)(1) and the *2025 SMFP* (page 47), no more than 129 acute care beds may be approved for the Buncombe/Graham/Madison/Yancey service area in this review. The UNC Health West Medical Center (Project ID # B-012708-25), the Novant Health Asheville Medical Center (Project ID # B-012709-25), the Advent Health Asheville (Project ID # B-012716-25), and the HCA Mission Hospital (Project ID # B-012720-25) applications each propose to develop acute care beds in response to the *2025 SMFP* need determination for the multicounty service area. Collectively, the four applicants propose the development of 421 additional acute beds.

Given that multiple applicants propose to meet all or part of the need for the 129 additional acute care beds in the service area, not all can be approved. To determine the comparative factors that are applicable in this review, UNC Health examined recent Agency findings for competitive acute care bed reviews. Based on that examination and the facts and circumstances of the competing applications in this review, UNC Health considered the following comparative factors:

- Conformity with Review Criteria
- Scope of Services
- Historical Utilization
- Geographic Accessibility
- Competition (Patient Access to a New Provider)
- Access by Service Area Residents
- Access by Underserved Groups
    - Projected Medicare
    - Projected Medicaid
- Projected Average Net Revenue per Discharge
- Projected Average Operating Expense per Discharge

UNC Health believes that the factors presented above and discussed in turn below should be used by the Project Analyst in reviewing the competing applications. In addition, UNC Health believes that a discussion on care quality and safety should be considered in this review, in accordance with G.S. 131E-183(a)(20). A comparison of provider support is also appropriate in this review, given the inclusion of new facility proposals and the need discussion pertaining to the HCA Mission application.

Conformity with Applicable Statutory and Regulatory Review Criteria

An application that is not conforming or conforming as conditioned with all applicable statutory and regulatory review criteria cannot be approved.

UNC Health West's application adequately demonstrates that its acute care bed proposal conforms to all applicable statutory and regulatory review criteria. In contrast, the HCA Mission, AdventHealth, and Novant applications do not adequately demonstrate that their proposals are conforming to all applicable statutory review criteria. An application that is not conforming to all applicable statutory and regulatory review criteria cannot be approved. Therefore, with regard to conformity, the UNC Health West application is more effective than all three competing applications.

Scope of Services

Mission Hospital operates as a tertiary care facility and offers the broadest scope of services among the four applicants.

While other applications assert that they will provide high acuity services, UNC Health West uniquely demonstrates through its utilization projections, financial pro formas, and provider support letters that attest it will provide high acuity services including interventional cardiac catheterization, inpatient dialysis, and interventional radiology—services not typically found in community hospitals. Additionally, UNC Health West is the only proposed hospital to combine the local knowledge and presence of UNC Health Pardee with the resources and capabilities of UNC Health, the state's public academic medical center. This affiliation enhances UNC Health West's ability to recruit and retain staff across multiple specialties and subspecialties needed to support the proposed services, along with a focus on meeting the needs of all patients. This combination brings a unique mission and perspective to developing a new competitive hospital in Buncombe County.

Therefore, Mission Hospital offers the most effective alternative with regard to scope of services. UNC Health West offers a more effective alternative than AdventHealth Asheville and Novant Health Asheville.

The two types of projects in the review, and the facilities in these categories, are summarized in the following table:

2025 Buncombe Acute Beds Applications

Applicant	*Existing/ Approved*	*New Facility*	*Hospital Type*	*Comparative Factor*
UNC Health West		X	Robust Community	More Effective
AdventHealth Asheville	X		Community	Less Effective
NH Asheville		X	Specialty*	Least Effective
HCA Mission Hospital	X		Tertiary	Most Effective

* The Novant proposal meets the definition of a hospital as described in N.C.G.S. 131E-176(13) and N.C.G.S. 131E-183(a)(1), but is positioned as an inpatient specialty cancer care facility based on the limited range of physician specialties that have documented their support for the project and Novant's disproportionate utilization projections for cancer-related services.

Historical Utilization

Historical utilization reflects past performance but does not determine future need or comparative effectiveness in all circumstances. HCA Mission Hospital's existing utilization demonstrates demand within its current system but does not establish that HCA Mission is the most appropriate applicant to be awarded new capacity. New entrants like UNC Health West are specifically intended to provide alternatives and enhance competition, which cannot be evaluated through historical utilization.

In this particular review, the historical utilization of the service area's only existing provider does not provide material value to the comparative analysis with three competing applicants with no historical utilization. HCA Mission Hospital currently controls 88 percent of the acute care bed capacity[67] in the

[67] Including 93 approved acute beds for AdventHealth in the *2022* and *2024 SMFP* need determinations that are currently under appeal.

service area. There is well-documented public concern regarding access to care, cost, quality, and patient experience at HCA Mission Hospital. Additionally, there is currently no operational not-for-profit competitor in the service area to provide patient choice, though AdventHealth has been approved to develop a new acute care hospital. Under these circumstances, HCA Mission's historical utilization reflects a lack of alternatives rather than competitive performance, and past utilization patterns do not demonstrate which applicant would most effectively serve the community's future needs.

Therefore, this comparative factor does not provide value in this review and should be determined to be inconclusive.

Geographic Accessibility

Geographic accessibility should be evaluated based on the location of proposed services relative to underserved geographic areas and the facility's ability to serve residents throughout the service area. However, geographic distribution within the service area and the extent to which new capacity enhances access in underserved areas should be considered.

HCA Mission Hospital is located in central Asheville. While centrally located, adding capacity to Mission's existing campus does not enhance geographic distribution within the service area. AdventHealth's approved campus is in Weaverville, located in northern Buncombe County, and has already been approved for 93 beds at that location. AdventHealth will provide access to the northern portion of the service area once operational.

Both UNC Health West and Novant Health Asheville are located in southern Buncombe County, south of I-40 and south of HCA Mission's existing campus. This geographic positioning provides enhanced access to residents of southern Buncombe County and represents an area where new acute care capacity would improve geographic distribution.

Therefore, with regard to geographic accessibility, UNC Health West and Novant are more effective alternatives. AdventHealth, as a provider that has already been approved, will not expand geographic access in this review and is therefore a less effective alternative. HCA Mission Hospital is a less effective alternative for similar reasons.

2025 Buncombe Acute Beds Applications – Proposed Bed Locations

Applicant	*Proposed Location*	*Comparative Factor*
UNC Health West	South Buncombe County	More Effective
AdventHealth Asheville	North Buncombe County	Less Effective
NH Asheville	South Buncombe County	More Effective
HCA Mission Hospital	Central Buncombe County	Less Effective

Competition (Patient Access to a New Provider)

At the time of this review, HCA Mission Hospital controls 682 of the 775 existing and approved acute care beds in the service area (88.0 percent), with AdventHealth controlling the remaining 93 approved beds (12.0 percent). Neither UNC Health West nor Novant Health Asheville currently operate acute care beds in the multicounty service area.

If HCA Mission's application is approved, Mission would control 811 of 904 acute care beds in the service area (89.7 percent), further concentrating acute care resources. If UNC Health West's application is approved, UNC Health West would control 129 of 904 beds (14.3 percent), introducing a new competitor with sufficient scale and scope of services to meaningfully compete with Mission in its home county. If Novant's application is approved, Novant would control only 34 beds (3.8 percent of existing, approved, and proposed inventory).

While Novant represents a new entrant, its proposed scale of 34 beds, combined with its limited scope of services as a small cancer-focused community hospital and lack of connection to other hospitals in the region, limits its ability to provide meaningful competitive pressure. The proposed Novant project also would not offer an alternative provider of obstetric services for service area residents, with only a limited range of medical and surgical specialties available to patients.

In some competitive reviews, applicants are constrained by the number of beds available in the *SMFP* need determination. However, in this review, the 129-bed need determination allows the Agency to approve a much larger, more robust competitor. UNC Health West is the only new entrant proposing both the scale (129 beds) and the scope of services (high acuity capabilities including interventional cardiac catheterization, inpatient dialysis, and interventional radiology, combined with its academic medical center affiliation and access to subspecialty-trained care providers) that are necessary to provide genuine competition to HCA Mission Hospital in Buncombe County.

Importantly, approving UNC Health West rather than expanding AdventHealth's already-approved capacity of 93 beds would create two competitors of relatively comparable scale (UNC Health West at 14.3 percent and AdventHealth at 10.3 percent once operational), strengthening the overall competitive environment by establishing multiple viable alternatives to HCA Mission rather than further concentrating capacity in the existing duopoly.

Therefore, with regard to competition, UNC Health West is the most effective alternative, Novant Health Asheville is a more effective alternative, AdventHealth is a less effective alternative, and Mission Hospital is the least effective alternative.

2025 Buncombe Acute Beds Applications – % of Service Area Acute Bed Inventory

Applicant	*% of Acute Beds (if Approved)*	*Comparative Factor*
UNC Health West	14.3%	Most Effective
AdventHealth Asheville	24.6%	More Effective
NH Asheville	3.8%	Less Effective
HCA Mission Hospital	89.7%	Least Effective

Access by Service Area Residents

The *2025 SMFP* defines the service area for acute care beds as the Buncombe/Graham/Madison/Yancey multicounty grouping. While this factor is sometimes used to determine the most effective application based on the number or percentage of service area residents proposed to be served by the competing applications, UNC Health West believes that this comparative factor is not applicable for this review. The need for additional acute bed capacity in the Buncombe/Graham/Madison/Yancey service area is driven not only by residents of these four counties, but also by patients from surrounding counties in western North Carolina and adjoining states who seek care in Buncombe County. Buncombe County, as discussed in the UNC Health West application, is a healthcare destination for many residents of western North Carolina that have limited

access to acute care services, and the percentage of patient origin from outside the service area is likely to correlate with the scope of services and types of specialty care available at the facility. This is illustrated by HCA Mission Hospital's projection that only 57.2 percent of its patients will originate from the service area, demonstrating that 42.8 percent of demand comes from outside the defined service area. Without this regional demand, there would not be a need for additional acute care bed capacity; in fact, there would be significant excess capacity.

The acute care bed need determination methodology in the *2025 SMFP* is based on the utilization of all patients that utilize acute care beds in the service area and is not limited to patients originating from the four-county service area. Under these circumstances, it would not be appropriate to determine the comparative effectiveness of an applicant based solely on service to service area residents when the need determination itself is based on broader regional utilization patterns.

Additionally, the competing applications present patient origin data for the four service area counties in different formats and use different methodologies, making the calculation of total service area residents difficult or unreliable.

Project Development Timelines

In Section C.1 of its application, HCA Mission notes that, to develop its proposed 129 acute care beds, it "will construct four new floors in the 'J' Tower of Mission Hospital's main campus."[68] Following this, in Section P of its application, it lists a start date for services of January 1, 2031.[69] Given that it is an existing provider of acute care services that already operates a hospital campus, UNC Health West believes this is a relatively lengthy period of time to develop additional acute care resources. In fact, this timeline of development is largely in line with the proposed projects in the three competing applications, all of which propose to develop new acute care hospitals.

Services Offered Date for Each Project
2025 Buncombe/Graham/Madison/Yancey Acute Care Beds

Applicant	*Proposed Acute Care Beds*	*New or Existing Hospital*	*Services Offered Date*
AdventHealth	129	New	01/01/2030*
HCA Mission	129	Existing	01/01/2031
Novant	34	New	01/01/2030
UNC Health West	129	New	07/01/2031

Source: Section P of respective applications.
* AdventHealth notes that its previously-approved 93 bed acute care hospital will be fully operational on January 1, 2029 (Project ID # B-012716-25, p. 133). It anticipates that its additional 129 acute care beds will be fully operational on January 1, 2030 (Ibid).

As shown in the table above, HCA Mission's proposed project is anticipated to take nearly as long to develop as the entire construction of UNC Health West's new acute care facility, and *longer* than the development of both Novant's proposed acute care facility and AdventHealth's approved but under appeal acute care facility. UNC Health recognizes that new construction requires a relatively longer design and development timeline than operationalizing additional beds in existing space. However,

[68] HCA Mission application, page 48.
[69] Id., page 157.

while HCA Mission notes that the proposed acute care beds are "urgently needed,"[70] its relatively slow development of those beds contradicts this claim. The relatively similar timelines for operationalizing the proposed additional beds result in no significant differences between applicants for this factor.

Therefore, this comparative factor should be found to be inconclusive for this review.

Access by Underserved Groups

The following table shows projected Medicare and Medicaid percentages of gross revenue for the inpatient acute care service component in the third project year following completion of the project, based on the information provided in Form F.2 of each application.

Inpatient Services Medicare and Medicaid Payor Mix – Project Year 3

Applicant	*Medicare % of Gross Revenue*	*Medicaid % of Gross Revenue*	*Total*
UNC Health West	54.5%	16.8%	71.3%
AdventHealth Asheville	67.3%	8.6%	75.9%
NH Asheville	59.5%	11.8%	71.3%
HCA Mission Hospital	57.8%	11.5%	69.3%

Source: Form F.2b of the respective applications.

However, the applications involve fundamentally different facility types—Mission as a tertiary care facility, UNC Health West as a robust community hospital with high acuity services and academic affiliation, AdventHealth as a community hospital expansion, and Novant as a small community hospital with a predominantly cancer-focused patient population. Even if the applications provided pro forma financial statements using identical methodologies, there are differences in the acuity level of patients at each facility and the level of care at each facility that result in a negligible value for this factor, as the Agency has consistently found in recent acute care bed reviews.

Therefore, consistent with previous Agency reviews and findings that include 2024 Mecklenburg County acute beds and 2025 Durham County acute beds, this comparative factor is inconclusive. If the Agency does compare the applications, UNC Health West is the most effective regarding Medicaid access. While AdventHealth Asheville appears to be the most effective regarding Medicare access, its payor mix projections are based on flawed and unreasonable assumptions, as described previously, and should not be used as a basis for comparing its application with others.

Projected Average Net Revenue per Discharge

The following table shows the projected net revenue per inpatient discharge in the third year of operation based on the total net revenue information provided in each applicant's pro forma financial statements (Form F.2).

[70] Id., page 48.

Average Net Revenue per Discharge – Project Year 3

Applicant	*Discharges*	*Net Revenue*	*Average Net Revenue Per Discharge*
UNC Health West	8,262	$269,033,814	$32,563
AdventHealth Asheville	12,212	$274,387,605	$22,469
NH Asheville	1,565	$87,721,008	$56,052
HCA Mission Hospital	47,818	$1,467,076,661	$30,680

Source: Forms C.1 and F.2 of the respective applications.

There is high variation in the average net revenue per discharge for the competing applicants. Some of this is attributable to the different facility types. The applications involve fundamentally different facility types – HCA Mission as a tertiary care facility, UNC Health West as a robust community hospital with high acuity services and academic affiliation, AdventHealth as a community hospital expansion, and Novant as a small community hospital. Additionally, HCA Mission's economies of scale with 47,818 projected discharges differ substantially from smaller facilities. New facility startup considerations versus existing facility expansion also affect financial projections. These differences in acuity level, scale, and operational status diminish the value of this comparative factor.

Notably, Novant's average net revenue per discharge of $56,052 is 2.5 times higher than AdventHealth's projection and nearly double UNC Health West's projection. This substantial variance—representing a multiple rather than a modest difference—suggests either significant methodological inconsistencies or a cost structure that is demonstrably less effective than other applicants.

Therefore, consistent with Agency findings in previous acute bed reviews, including the 2024 Mecklenburg County review, 2024 Wake County review, and 2025 Durham County review, this comparative factor is inconclusive. UNC Health would note that Novant Health Asheville is the exception due to its significantly higher net revenue and is therefore the least effective alternative with regard to this factor.

Projected Average Operating Expense per Discharge

The following table shows the projected average total operating expense per inpatient discharge in the third year of operation for each of the applicants, based on information provided in the applicants' pro forma financial statements (Form F.3).

Average Operating Expense per Discharge – Project Year 3

Applicant	*Discharges*	*Operating Expenses*	*Average Oper Expense Per Disch*
UNC Health West	8,262	$238,929,459	$28,919
AdventHealth Asheville	12,212	$244,735,290	$20,041
NH Asheville	1,565	$86,351,333	$55,177
HCA Mission Hospital	47,818	$848,339,409	$17,741

Source: Forms C.1 and F.3 of the respective applications.

For the same reasons discussed regarding average net revenue per discharge, the applications involve fundamentally different facility types with varying acuity levels, services provided, facility and organizational scale, and startup versus expansion considerations. HCA Mission's economies of scale with 47,818 projected discharges differ substantially from smaller-sized facilities. These differences interfere with any meaningful comparison of this factor.

Again, Novant's average operating expense per discharge of $55,177 is more than three times higher than HCA Mission's projection and nearly double UNC Health West's projection. This significant variation suggests either a distinct difference in methodology or a cost structure that is demonstrably less effective than other applicants.

Therefore, consistent with the acute bed reviews cited above, this comparative factor is inconclusive.

Quality of Care

N.C.G.S. 131E-183(a)(20) requires that "[a]n applicant already involved in the provision of health services shall provide evidence that quality care has been provided in the past." While this criterion is a pass/fail review criterion rather than a comparative factor, the quality of care provided by existing healthcare systems is relevant to evaluating which applicant would be the most effective alternative for providing new acute care capacity in the service area.

While any hospital may periodically experience transient quality of care issues, the frequency and severity of quality concerns should be considered in comparative reviews. HCA Mission Hospital has experienced significant and repeated quality issues in recent years since its 2019 acquisition by HCA Healthcare, including repeated instances of being placed in "immediate jeopardy" due to serious safety risks. HCA Mission Hospital received an immediate jeopardy recommendation following a Department of Health and Human Services inspection in September 2025, its third immediate jeopardy designation since 2021.[71] Additionally, critics and former employees have alleged that HCA Mission has reduced staffing levels, resulting in patients experiencing neglect and delayed care. Specific concerns include inadequate staffing in the emergency and oncology departments.[72]

In contrast, UNC Health and UNC Health Pardee—the two members of UNC Health West—have demonstrated consistent excellence in quality of care across their facilities statewide, including the following recognitions:

UNC Health Quality Recognition:

- CMS's 2025 hospital quality ratings listed three UNC Health hospitals as receiving five-star ratings (UNC Health Pardee, UNC Health Rex Hospital, and UNC Hospitals at Chapel Hill). Only eight hospitals in North Carolina received a five-star rating, and UNC Health was the only provider to have multiple facilities receive such recognition.
- GHX Xcellence Awards (2024): Innovation Award and Community Impact Award, given in recognition of organizations that go above and beyond to support patients and communities.

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71 https://www.northcarolinahealthnews.org/2025/10/19/mission-hospital-faces-new-immediate-jeopardy-recommendation-as-state-agency-flags-major-safety-risks/#:~:text=Mission%20Hospital%2C%20the%20largest%20healthcare%20provider%20in,on%20the%20floor%20of%20her%20hospital%20room.

72 https://www.bpr.org/bpr-news/2025-07-29/latest-hca-oversight-report-highlights-outstanding-mission-er-oncology-care-issues

- Becker's Hospital Review (2023): Named one of the "Top 150 Places to Work in Healthcare," honoring health systems committed to diversity, work-life balance, and employee engagement.

UNC Health Pardee Quality Recognition:

- Leapfrog Hospital Safety Grade: Earned straight "A" grades since Spring 2023 (Spring 2023, Fall 2023, Spring 2024, Fall 2024, Spring 2025), making it one of only 346 hospitals nationwide and 18 in North Carolina to achieve this consistent excellence in patient safety.
- CMS Five-Star Rating: Received a top five-star rating for quality of care and safety in 2024. Only 14 hospitals in North Carolina received five stars.
- Healthgrades: America's 100 Best Hospitals (2022-2025); #1 Stroke Care in State - North Carolina (2023-2024); Outstanding Patient Experience (2024, 2025); Five-star recipient for treatment of Heart Attack, Heart Failure, and Stroke.
- Premier: 100 Top Hospitals (2025)
- American Heart Association/American Stroke Association: Get With The Guidelines-Stroke Gold Plus Quality Achievement Award (2019-2024)
- Best of Asheville: Best Hospital (2021-2025) – Notable because UNC Health Pardee is located in Henderson County, not Asheville (Buncombe County).

This record of quality excellence across UNC Health's statewide network demonstrates the organization's commitment to providing high-quality, safe patient care. As a member of UNC Health West, UNC Health Pardee will bring this quality infrastructure, policies, and culture to the proposed hospital in Buncombe County.

While neither AdventHealth nor Novant Health Asheville lack quality in their existing operations, their statewide experience differs significantly. UNC Health operates 16 acute care hospitals across North Carolina with a demonstrated history of quality excellence at multiple facilities statewide. AdventHealth operates only one existing hospital in North Carolina, limiting its statewide quality history. Novant Health has broader statewide experience operating multiple facilities across North Carolina.

Therefore, with regard to quality of care as demonstrated through both historical performance and statewide quality metrics, UNC Health West and Novant are the most effective alternatives based on their demonstrated statewide operational experience and provision of quality care. AdventHealth is a more effective alternative but with limited statewide experience in North Carolina. HCA Mission Hospital is a less effective alternative due to recent significant quality concerns.

Provider Support

Documentation of support from healthcare providers in the service area is an important factor in evaluating acute care bed proposals, and especially for new hospitals without established medical staff. Provider support demonstrates professional confidence in the proposed project and indicates the likelihood of successful implementation and an ability to achieve utilization projections.

The UNC Health West application includes more than 215 support letters from physicians and other healthcare providers, representing physician practices in five counties in western North Carolina, as well as system-level physician leadership. UNC Health West has commitments from physicians in 33

clinical specialties and hospital-based services, indicating the capabilities to provide a much broader range of clinical care than most community hospitals, with multiple disciplines represented. These letters include attestations that these providers will obtain medical staff privileges and refer patients to the UNC Health West facility. Supporting providers include key medical and surgical specialties for a general acute care hospital of moderate size; these specialties include primary care, cardiology, orthopedics, neurosciences, hematology-oncology, obstetrics and gynecology, general surgery, urology, hospital medicine, emergency medicine, and radiology. Many letters specifically commit to referring patients to and utilizing the proposed facility upon opening.

The AdventHealth Asheville application includes provider support letters from physicians and advanced practice providers in 15 specialties. Although the AdventHealth provider letters express support for the proposed project in principle, there is no statement included in these letters specifically affirming that the signatory will refer patients to the facility or perform surgeries at the AdventHealth facility.

Novant Health Asheville's support letter exhibit includes letters from physicians in five specialties. As noted in the issue-specific comments, Novant assumes that one practice, Messino Cancer Centers, will account for 50 percent of acute care patient days at the proposed hospital, despite most types of cancer care occurring in an outpatient setting. The four remaining practices are Novant-owned specialty care practices. The five physician practices that offer support for the Novant project include estimates of the percentage of patients that will be referred, which is reflected in the Form C Assumptions and Methodology description. The Novant application has significantly fewer specialties represented than either UNC Health or AdventHealth.

HCA Mission Hospital provided letters of support from physicians, but limited to only hospitalists that care for admitted inpatients. This would presumably mean that the HCA Mission bed expansion will not result in the expansion of clinical services or specialty care, as hospitalists normally manage the inpatient stays of patients admitted by primary care physicians or through the emergency department. HCA Mission includes multiple letters from staff members and physician administrators at its affiliated hospitals but offers limited independent community support. The HCA Mission exhibit noticeably lacks letters from primary care providers and other specialists for whom HCA Mission's hospitalists would manage their admitted patients. Provider support is particularly significant in this review given the well-documented concerns about HCA Mission Hospital's provider staffing and community relationships. The breadth and depth of independent provider support for UNC Health West demonstrates strong professional confidence in the proposed alternative to HCA Mission's current dominance in the market. The following table summarizes the types of physician support letters represented by the respective applicants:

Physician Support for Proposed Projects

	UNC Health West	***AdventHealth***	***NH Asheville***	***HCA Mission Hospital***
Primary Care Support	X	X	X	
Specialist Support	X	X	X	X
# of Specialties	33	15	6	1
Documentation of Referrals/Admissions	X		X	

Therefore, with regard to provider support, UNC Health West is the most effective and AdventHealth Asheville is a more effective alternative. Novant Health Asheville is a less effective alternative, with limited provider support. HCA Mission Hospital is the least effective alternative with regard to provider support, with a small number of letters from hospitalists but no referring physicians.

Summary of Comparative Analysis

The following table summarizes the comparative factors and identifies which applications are the most, more, less, or least effective alternative with respect to that comparative factor.

2025 Comparative Factors Across Applications

Comparative Factor	*UNC Health West*	*AdventHealth*	*NH Asheville*	*HCA Mission Hospital*
Conformity with Review Criteria	**Yes**	Non-Conforming	Non-Conforming	Non-Conforming
Scope of Services	**More Effective**	Less Effective	Least Effective	Most Effective, but Non-Conforming
Geographic Accessibility	**More Effective**	Less Effective	More Effective, but Non-Conforming	Less Effective
Historical Utilization	Inconclusive	Inconclusive	Inconclusive	Inconclusive
Competition (Patient Access to a New Provider)	**Most Effective**	More Effective, but Non-Conforming	Less Effective	Least Effective
Access by Service Area Residents	Inconclusive	Inconclusive	Inconclusive	Inconclusive
Access by Underserved Groups - Medicare	Inconclusive	Inconclusive	Inconclusive	Inconclusive
Access by Underserved Groups - Medicaid	Inconclusive	Inconclusive	Inconclusive	Inconclusive
Average Net Revenue per Discharge	Inconclusive	Inconclusive	Inconclusive	Inconclusive
Average Expense per Discharge	Inconclusive	Inconclusive	Inconclusive	Inconclusive
Quality and Safety	**Most Effective**	More Effective, but Non-Conforming	Most Effective, but Non-Conforming	Less Effective
Physician Support	**Most Effective**	More Effective, but Non-Conforming	Less Effective	Least Effective

Please note that the table above does not imply that all of the applications are approvable; as noted above, the Novant, AdventHealth, and HCA Mission applications are non-conforming. However, even

assuming that all the applications were conforming, the UNC Health West application is the most effective alternative for the following reasons:

- Addresses a geographic access gap by establishing the first acute care facility in southern Buncombe County, an area currently requiring residents to travel significant distances for hospital services;
- Offers the broadest scope of community hospital services among new facility proposals, including obstetrics and Level II neonatal services, interventional radiology capabilities, inpatient dialysis treatment, cardiac catheterization procedures, behavioral health hospitalization and support, and comprehensive surgical capabilities; and
- Has significant provider support for its proposed project.

SUMMARY

In summary, UNC Health believes that its application represents the most effective proposal for the 129 additional acute care beds in the *2025 SMFP* need determination for the Buncombe/Graham/Madison/Yancey multicounty service area. UNC Health is also fully conforming with all applicable statutory and regulatory review criteria and is comparatively superior in terms of the relevant factors in this review. As such, the UNC Health West application should be approved.

Please note that in no way does UNC Health intend for these comments to change or amend its application filed on October 15, 2025. If the Agency considers any of these comments to be amending the UNC Health application, those responses should not be considered.

AdventHealth Hendersonvillle

DRG Codes not included in CY 2022 - CY 2024 Historical Data

DRG Code	Service Line	DRG Code - Description
28	Neurosurgery	028 - Spinal Procedures With MCC
39	Vascular Surgery	039 - Extracranial Procedures Without CC/MCC
41	Neurosurgery	041 - Peripheral, Cranial Nerve And Other Nervous System Procedures With CC Or Peripheral Neurostimulator
42	Neurosurgery	042 - Peripheral, Cranial Nerve And Other Nervous System Procedures Without CC/MCC
79	Neurology	079 - Hypertensive Encephalopathy Without CC/MCC
80	Neurology	080 - Nontraumatic Stupor And Coma With MCC
81	Neurology	081 - Nontraumatic Stupor And Coma Without MCC
82	Neurology	082 - Traumatic Stupor And Coma >1 Hour With MCC
87	Neurology	087 - Traumatic Stupor And Coma <1 Hour Without CC/MCC
90	Neurology	090 - Concussion Without CC/MCC
96	Neurology	096 - Bacterial And Tuberculous Infections Of Nervous System Without CC/MCC
98	Neurology	098 - Non-Bacterial Infection Of Nervous System Except Viral Meningitis With CC
102	Neurology	102 - Headaches With MCC
121	Ophthalmology	121 - Acute Major Eye Infections With CC/MCC
122	Ophthalmology	122 - Acute Major Eye Infections Without CC/MCC
168	Thoracic Surgery	168 - Other Respiratory System O.R. Procedures Without CC/MCC
182	Medical Oncology	182 - Respiratory Neoplasms Without CC/MCC
185	Pulmonary	185 - Major Chest Trauma Without CC/MCC
188	Pulmonary	188 - Pleural Effusion Without CC/MCC
198	Pulmonary	198 - Interstitial Lung Disease Without CC/MCC
246	Vascular Surgery	246 - Percutaneous Cardiovascular Procedures With Drug-Eluting Stent With MCC Or 4+ Arteries Or Stents
247	Vascular Surgery	247 - Percutaneous Cardiovascular Procedures With Drug-Eluting Stent Without MCC
249	Vascular Surgery	249 - Percutaneous Cardiovascular Procedures With Non-Drug-Eluting Stent Without MCC
250	Vascular Surgery	250 - Percutaneous Cardiovascular Procedures Without Intraluminal Device With MCC
251	Vascular Surgery	251 - Percutaneous Cardiovascular Procedures Without Intraluminal Device Without MCC
252	Vascular Surgery	252 - Other Vascular Procedures With MCC
253	Vascular Surgery	253 - Other Vascular Procedures With CC
254	Vascular Surgery	254 - Other Vascular Procedures Without CC/MCC
256	Vascular Surgery	256 - Upper Limb And Toe Amputation For Circulatory System Disorders With CC
257	Vascular Surgery	257 - Upper Limb And Toe Amputation For Circulatory System Disorders Without CC/MCC
264	Vascular Surgery	264 - Other Circulatory System O.R. Procedures
284	Cardiology	284 - Acute Myocardial Infarction, Expired With CC
285	Cardiology	285 - Acute Myocardial Infarction, Expired Without CC/MCC
286	Cardiology	286 - Circulatory Disorders Except Ami, With Cardiac Catheterization With MCC
287	Cardiology	287 - Circulatory Disorders Except Ami, With Cardiac Catheterization Without MCC
289	Cardiology	289 - Acute And Subacute Endocarditis With CC
294	Cardiology	294 - Deep Vein Thrombophlebitis With CC/MCC
297	Cardiology	297 - Cardiac Arrest, Unexplained With CC
301	Cardiology	301 - Peripheral Vascular Disorders Without CC/MCC
302	Cardiology	302 - Atherosclerosis With MCC
316	Cardiology	316 - Other Circulatory System Diagnoses Without CC/MCC
344	General Surgery	344 - Minor Small And Large Bowel Procedures With MCC
347	General Surgery	347 - Anal And Stomal Procedures With MCC
376	Medical Oncology	376 - Digestive Malignancy Without CC/MCC
382	Gastroenterology	382 - Complicated Peptic Ulcer Without CC/MCC
406	General Surgery	406 - Pancreas, Liver And Shunt Procedures With CC
409	General Surgery	409 - Biliary Tract Procedures Except Only Cholecystectomy With Or Without C.D.E. With CC
410	General Surgery	410 - Biliary Tract Procedures Except Only Cholecystectomy With Or Without C.D.E. Without CC/MCC
412	General Surgery	412 - Cholecystectomy With C.D.E. With CC
413	General Surgery	413 - Cholecystectomy With C.D.E. Without CC/MCC
422	General Surgery	422 - Hepatobiliary Diagnostic Procedures Without CC/MCC
428	Spine Surgery	428 - Multiple Level Combined Anterior And Posterior Spinal Fusion Except Cervical Without CC/MCC
437	Medical Oncology	437 - Malignancy Of Hepatobiliary System Or Pancreas Without CC/MCC
476	Orthopedic Surgery	476 - Amputation For Musculoskeletal System And Connective Tissue Disorders Without CC/MCC
477	Orthopedic Surgery	477 - Biopsies Of Musculoskeletal System And Connective Tissue With MCC
479	Orthopedic Surgery	479 - Biopsies Of Musculoskeletal System And Connective Tissue Without CC/MCC
487	Orthopedic Surgery	487 - Knee Procedures With Principal Diagnosis Of Infection Without CC/MCC
499	Orthopedic Surgery	499 - Local Excision And Removal Of Internal Fixation Devices Of Hip And Femur Without CC/MCC
500	Orthopedic Surgery	500 - Soft Tissue Procedures With MCC
503	Orthopedic Surgery	503 - Foot Procedures With MCC
506	Orthopedic Surgery	506 - Major Thumb Or Joint Procedures
510	Orthopedic Surgery	510 - Shoulder, Elbow Or Forearm Procedures, Except Major Joint Procedures With MCC
515	Orthopedic Surgery	515 - Other Musculoskeletal System And Connective Tissue O.R. Procedures With MCC
533	Orthopedics - Medical	533 - Fractures Of Femur With MCC
538	Orthopedics - Medical	538 - Sprains, Strains, And Dislocations Of Hip, Pelvis And Thigh Without CC/MCC
544	Medical Oncology	544 - Pathological Fractures And Musculoskeletal And Connective Tissue Malignancy Without CC/MCC

AdventHealth Hendersonvillle

DRG Codes not included in CY 2022 - CY 2024 Historical Data

DRG Code	Service Line	DRG Code - Description
550	Rheumatology	550 - Septic Arthritis Without CC/MCC
553	Orthopedics - Medical	553 - Bone Diseases And Arthropathies With MCC
555	Orthopedics - Medical	555 - Signs And Symptoms Of Musculoskeletal System And Connective Tissue With MCC
566	Orthopedics - Medical	566 - Other Musculoskeletal System And Connective Tissue Diagnoses Without CC/MCC
575	Plastic Surgery	575 - Skin Graft For Skin Ulcer Or Cellulitis Without CC/MCC
578	Plastic Surgery	578 - Skin Graft Except For Skin Ulcer Or Cellulitis Without CC/MCC
583	Surgical Oncology	583 - Mastectomy For Malignancy Without CC/MCC
585	Plastic Surgery	585 - Breast Biopsy, Local Excision And Other Breast Procedures Without CC/MCC
595	Dermatology	595 - Major Skin Disorders With MCC
597	Medical Oncology	597 - Malignant Breast Disorders With MCC
598	Medical Oncology	598 - Malignant Breast Disorders With CC
606	Dermatology	606 - Minor Skin Disorders With MCC
618	General Surgery	618 - Amputation Of Lower Limb For Endocrine, Nutritional And Metabolic Disorders Without CC/MCC
622	General Surgery	622 - Skin Grafts And Wound Debridement For Endocrine, Nutritional And Metabolic Disorders With MCC
624	General Surgery	624 - Skin Grafts And Wound Debridement For Endocrine, Nutritional And Metabolic Disorders Without CC/MCC
625	General Surgery	625 - Thyroid, Parathyroid And Thyroglossal Procedures With MCC
630	General Surgery	630 - Other Endocrine, Nutritional And Metabolic O.R. Procedures Without CC/MCC
663	Urology - Surgical	663 - Minor Bladder Procedures With CC
664	Urology - Surgical	664 - Minor Bladder Procedures Without CC/MCC
667	Urology - Surgical	667 - Prostatectomy Without CC/MCC
670	Urology - Surgical	670 - Transurethral Procedures Without CC/MCC
688	Medical Oncology	688 - Kidney And Urinary Tract Neoplasms Without CC/MCC
693	Urology - Medical	693 - Urinary Stones With MCC
709	Urology - Surgical	709 - Penis Procedures With CC/MCC
716	Surgical Oncology	716 - Other Male Reproductive System O.R. Procedures For Malignancy Without CC/MCC
718	Urology - Surgical	718 - Other Male Reproductive System O.R. Procedures Except Malignancy Without CC/MCC
723	Medical Oncology	723 - Malignancy, Male Reproductive System With CC
724	Medical Oncology	724 - Malignancy, Male Reproductive System Without CC/MCC
725	Urology - Medical	725 - Benign Prostatic Hypertrophy With MCC
738	Surgical Oncology	738 - Uterine And Adnexa Procedures For Ovarian Or Adnexal Malignancy Without CC/MCC
739	Surgical Oncology	739 - Uterine And Adnexa Procedures For Non-Ovarian And Non-Adnexal Malignancy With MCC
745	Gyn Surgery	745 - D&C, Conization, Laparoscopy And Tubal Interruption Without CC/MCC
750	Gyn Surgery	750 - Other Female Reproductive System O.R. Procedures Without CC/MCC
755	Medical Oncology	755 - Malignancy, Female Reproductive System With CC
756	Medical Oncology	756 - Malignancy, Female Reproductive System Without CC/MCC
802	Hematology	802 - Other O.R. Procedures Of The Blood And Blood Forming Organs With MCC
803	Hematology	803 - Other O.R. Procedures Of The Blood And Blood Forming Organs With CC
804	Hematology	804 - Other O.R. Procedures Of The Blood And Blood Forming Organs Without CC/MCC
816	Hematology	816 - Reticuloendothelial And Immunity Disorders Without CC/MCC
821	Surgical Oncology	821 - Lymphoma And Leukemia With Major O.R. Procedures With CC
823	Surgical Oncology	823 - Lymphoma And Non-Acute Leukemia With Other Procedures With MCC
825	Surgical Oncology	825 - Lymphoma And Non-Acute Leukemia With Other Procedures Without CC/MCC
826	Surgical Oncology	826 - Myeloproliferative Disorders Or Poorly Differentiated Neoplasms With Major O.R. Procedures With MCC
827	Surgical Oncology	827 - Myeloproliferative Disorders Or Poorly Differentiated Neoplasms With Major O.R. Procedures With CC
829	Surgical Oncology	829 - Myeloproliferative Disorders Or Poorly Differentiated Neoplasms With Other Procedures With CC/MCC
830	Surgical Oncology	830 - Myeloproliferative Disorders Or Poorly Differentiated Neoplasms With Other Procedures Without CC/MCC
836	Medical Oncology	836 - Acute Leukemia Without CC/MCC
845	Medical Oncology	845 - Other Myeloproliferative Disorders Or Poorly Differentiated Neoplastic Diagnoses Without CC/MCC
855	General Surgery	855 - Infectious And Parasitic Diseases With O.R. Procedures Without CC/MCC
869	Infectious Diseases	869 - Other Infectious And Parasitic Diseases Diagnoses Without CC/MCC
901	Plastic Surgery	901 - Wound Debridements For Injuries With MCC
902	Plastic Surgery	902 - Wound Debridements For Injuries With CC
903	Plastic Surgery	903 - Wound Debridements For Injuries Without CC/MCC
939	General Surgery	939 - O.R. Procedures With Diagnoses Of Other Contact With Health Services With MCC
940	General Surgery	940 - O.R. Procedures With Diagnoses Of Other Contact With Health Services With CC
950	Rehabilitation	950 - Aftercare Without CC/MCC
969	General Surgery	969 - Hiv With Extensive O.R. Procedures With MCC
970	General Surgery	970 - Hiv With Extensive O.R. Procedures Without MCC
976	Infectious Diseases	976 - Hiv With Major Related Condition Without CC/MCC
999		999 - Ungroupable

October 15, 2025

Ms. Micheala Mitchell, Chief
Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

Dear Ms. Mitchell,

I am writing to express my strong support for the application to develop UNC Health West Medical Center, a new 129-bed acute care hospital in Buncombe County. As a resident of western North Carolina, I am familiar with the challenges that face many of our communities in this part of the state. The proposed acute care hospital, if approved, would significantly improve access to healthcare services in the region, while also ensuring those services are provided in conjunction with the only state-owned, full-service healthcare system and the state's largest academic health system. Additionally, it will be a welcome addition to the local provider market and will enhance access to a full range of hospital-based services that replicate the high quality and advanced clinical expertise that UNC Health is known for.

Over the last year, and particularly in the wake of Hurricane Helene, I have witnessed the vitality and strength of our communities in this part of the state. Unfortunately, the storm exacerbated many of the geographic, demographic, and socioeconomic adversities faced by residents in the region, including access to healthcare resources.

UNC Health was a visibly committed partner through recovery efforts from Hurricane Helene, particularly through its relationship with Asheville's Mountain Area Health Education Center (MAHEC), which hosted numerous free clinics and provided essential healthcare resources for residents across western North Carolina in the storm's wake. Through this and other partnerships – including its relationship with UNC Health Pardee in Henderson County, which itself operates multiple healthcare practices in the area – UNC Health has proven its dedication to the residents of western North Carolina, and is well-positioned to be an integral part of the local acute care continuum in Buncombe County and the surrounding areas. Through their long history of delivering excellent clinical care and expanding access to meet the needs of communities, UNC Health and UNC Health Pardee are the best choice of providers to develop a new acute care hospital in Buncombe County.

I appreciate UNC Health's and UNC Health Pardee's commitment to soliciting support from the members of the western North Carolina communities it will serve. I strongly support the development of a new acute care hospital in Buncombe County, which will expand accessible services and enhance UNC Health's ability to serve the patients of western North Carolina.

Sincerely,

Signature: George F. Goosmann III

Name:

Title:

Mayor, Biltmore Forest, N.C.

October 15, 2025

Ms. Micheala Mitchell, Chief
Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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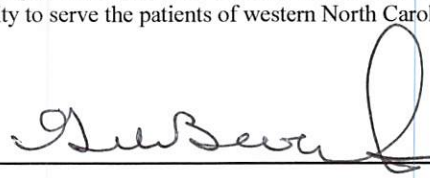
Sincerely,

Signature: 

Name: George Beverly

Title: President Beverly Development

October 15, 2025

Ms. Micheala Mitchell, Chief
Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

Dear Ms. Mitchell,

I am writing to express my support for the application to develop UNC Health West Medical Center, a new 129-bed acute care hospital in Buncombe County. As a provider currently practicing in Buncombe County, I am familiar with the healthcare landscape in our county and the surrounding area, which includes the need for additional inpatient acute care services. The proposed hospital would significantly improve access to healthcare services in our part of the state and would be a welcome addition to the local provider market.

As an area provider, I have been proud to provide care for patients from Buncombe County and the surrounding areas. Upon the development of the proposed facility, I anticipate referring patients to the services available at that hospital and based on the reputation of both UNC Health and UNC Health Pardee, I am sure my patients will be grateful for the opportunity to receive needed healthcare services there. Given the overall growth of western North Carolina, as well as the many socioeconomic and demographic challenges faced by our patients, I believe that the approval of the UNC Health West Medical Center would be especially welcome and would enhance the choice of healthcare providers while expanding access to hospital-based services. Furthermore, I believe that UNC Health is well-positioned to quickly become an integral part of the local acute care continuum, particularly through its partnership with UNC Health Pardee and based on its extensive familiarity with the region through its multiple existing healthcare practices, as well as a range of educational and clinical resources throughout the region. Through a long history of delivering excellent clinical care and expanding access to meet the needs of communities, UNC Health and UNC Health Pardee are the best choice of providers to develop a new acute care hospital in Buncombe County.

I appreciate UNC Health's and UNC Health Pardee's commitment to supporting physicians' goals in improving our patients' health, and I support the development of a new acute care hospital, UNC Health West Medical Center, in Buncombe County, which would bring accessible services and enhance the ability of UNC Health to serve the patients of our county and western North Carolina.

Sincerely,

Signature: David L. Cappiello M.D.

Name:

Practice Emerge Ortho Name/Specialty:

McGUIRE
WOOD &
BISSETTE
LAW FIRM

November 11, 2025

Ms. Micheala Mitchell, Chief
Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

Dear Ms. Mitchell:

I am writing to express my strong support for the application to develop UNC Health West Medical Center, a new 129-bed acute care hospital in Buncombe County. As a resident of western North Carolina and a former Mayor of Asheville, I am familiar with the challenges that face many of our communities in this part of the state. The proposed acute care hospital, if approved, would significantly improve access to healthcare services in the region, while also ensuring those services are provided in conjunction with the only state-owned, full-service healthcare system and the state's largest academic health system. Additionally, it will be a welcome addition to the local provider market and will enhance access to a full range of hospital-based services that replicate the high-quality and advanced clinical expertise that UNC Health is known for.

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I appreciate UNC Health's and UNC Health Pardee's commitment to soliciting support from the members of the western North Carolina communities it will serve. I strongly support the

PHONE 828.254.8800 / FAX 828.252.2438
PHYSICAL ADDRESS Drhumor Building / 48 Patton Avenue / Asheville, NC 28801
MAILING ADDRESS P.O. Box 3180 / Asheville, NC 28802
mwblawyers.com

development of a new acute care hospital in Buncombe County, which will expand accessible services and enhance UNC Health's ability to serve the patients of western North Carolina.

Sincerely,

W. Louis Bissette, Jr.
Of Counsel

WLB/cfc

October 15, 2025

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Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

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Sincerely,

Signature: _____

Name: JOHN G. WINKENWERDER, MANAGING PARTNER

Title: SOUTH ASHEVILLE HOTEL ASSOCIATES, LLC