STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

DOCKET NO. GMCB-016-19con

IN RE: SILVER PINES AT STOWE
MEDICALLY SUPERVISED WITHDRAWAL
TREATMENT CENTER FOR SUBSTANCE
USE DISORDERS

March 25, 2020
9:30 a.m.

By Skype

Hearing held before the Green Mountain Care Board, by Skype, on March 25, 2020, beginning at 9:30 a.m.

P R E S E N T

BOARD MEMBERS: Kevin Mullin, Chair
Maureen Usifer
Jessica A. Holmes, Ph.D.
Robin Lunge, JD, MHCDS
Tom Pelham

STAFF: Michael Barber, General Counsel

CAPITOL COURT REPORTERS, INC.
P.O. BOX 329
BURLINGTON, VERMONT 05402-0329
(802) 863-6067
Email: info@capitolcourtreporters.com

I N D E X

Also present:
Amerin Aborjaily
Alena Berube
Abigail Connolly
Donna Jerry
Jessica Mendizabal
Janeen Morrison
Douglas Moses
Kaili Kuiper
Jennifer Collins
Gregg Beldock

Public Comment:
None

CHAIRMAN MULLIN: Again, my name is Kevin Mullin, Chair of the Green Mountain Care Board. We are about to enter a Certificate of Need hearing for Silver Pines, and at this point in time I am going to designate Michael Barber, General Counsel for the board, as the hearing officer and turn the meeting over to him.

And before I do, Mike, is there some kind of attendance that would be required that Abigail should take, or are you going to handle that?

MR. BARBER: I'll handle that.

CHAIRMAN MULLIN: Thank you.

(Telephone noise).

MR. BARBER: So I don't know whose line that is, if it's possible to figure that out and maybe try calling in again or something. We will just kind of proceed and see if it works itself out.

So as the Chair said, my name is Michael Barber. I'm General Counsel. I'll be serving as the hearing officer for today's hearing. It is a hearing in the application of Silver Pines Partners LLC for a Certificate of Need to develop a medically supervised withdrawal treatment center in Stowe, Vermont. The Docket Number for the case is GMCB-016-19CON.

We are holding this hearing primarily remotely in light of the ongoing public health emergency and the Governor's executive orders, the most recent of which directed Vermonters to stay at home and leave only for essential reasons.

We do have a physical location for this hearing in compliance with the open meetings law. That is our offices at 144 State Street, and we do have someone there in case someone shows up. So given that all the board members are participating remotely, I do need to start by making sure that the board members and actually all participants can hear and be heard.

So I'm going to start with the board members. Mr. Chair. Can you hear okay?

CHAIRMAN MULLIN: Everything is fine on my end.

MR. BARBER: Member Holmes, can you hear okay?

MS. HOLMES: Yes, I can.

MR. BARBER: Member Lunge, can you hear okay?

MS. LUNGE: Yes. Thank you.

MR. BARBER: Member Usifer, can you hear okay?

MS. USIFER: Yes, I can.

MR. BARBER: And member Pelham, can you hear okay?

MR. PELHAM: I can.

MR. BARBER: Okay. Thank you. So representing the applicant today is Dr. William Cats-Baril, the CEO and managing partner of Silver Pines Partners LLC.

Dr. Cats-Baril, can you hear okay?

MR. CATS-BARIL: Very well. Thank you, Mike.

MR. BARBER: We also have a court reporter on the line, Kim Sears, who will be transcribing today's proceedings. Ms. Sears, can you hear okay?

THE COURT REPORTER: I can, thank you.

MR. BARBER: Great. So as the Chair alluded to, normally we would have a sign-in sheet documenting who is in attendance today. We can't do that remotely obviously, but I can see the people or the telephone numbers of the people who are on the call. So what I'm going to do is I'm just going to go down the list of people that I see and ask if each person I call on state their name, and if they are here representing an organization, the name of your

organization. So I see Amerin Aborjaily.

MS. ABORJAILY: Yes. Amerin Aborjaily. Green Mountain Care Board.

MR. BARBER: Myself. Susan Barrett? Susan is the Executive Director of the Green Mountain Care Board. Maybe she stepped away for a minute.

Alena Berube?

MS. BERUBE: Alena Berube, Green Mountain Care Board.

MR. BARBER: Abigail Connolly?

MS. CONNOLLY: Abigail Connolly, Green Mountain Care Board.

MR. BARBER: Donna Jerry?

MS. JERRY: Donna Jerry, Green Mountain Care Board.

MR. BARBER: Jessica Mendizabal.

MS. MENDIZABAL: Jessica Mendizabal. Green Mountain Care Board.

MR. BARBER: Thanks. Janeen Morrison.

MS. MORRISON: Janeen Morrison, Green Mountain Care Board. And there are no members of the public present at the time.

MR. BARBER: Thank you. I'm going to phone numbers, people who don't come up as names for me. So a phone number with the last four digits

8646.

MR. MOSES: Mr. Doug Moses. William Cats-Baril invited me to the meeting. I'm not exactly sure. Do you want me part of this?

MR. CATS-BARIL: Just for everybody, there is a primary construction, and Doug works for Beldock Corporation who is in charge of the refitting of the building that we will eventually lease from them. So Doug, you don't have to be here. I appreciate you joining in. More than welcome to have you.

If there are questions about construction and construction -- potential construction delays because of the COVID-19 situation, it may be helpful to have you on board.

CHAIRMAN MULLIN: Mike, I think it would be helpful if he stayed on, because there may be questions.

MR. MOSES: No problem.

MR. BARBER: Okay. Thank you. So phone number now 4 digits, 4028.

MS. KUIPER: This is Kaili Kuiper from the office of Health Care Advocate.

MR. BARBER: Thank you. Phone number last four digits 2505.

MS. COLLINS: Hi. This is Jennifer Collins, government relations, UVM Medical Center.

MR. BARBER: Thank you. Last four digits 1970.

CHAIRMAN MULLIN: I think that might be our office, Mike.

MR. BARBER: Got it. Thank you.

MS. MORRISON: Yes. I'm sorry. That's our conference room phone.

MR. BARBER: 9314.

COURT REPORTER: That's me, the court reporter.

MR. BARBER: And last four 7000.

MR. BELDOCK: Gregg Beldock from Bullrock Corporation also.

MR. BARBER: I see ORCA Media is on, and the rest we have already gone through. So now that I've asked literally everyone on the phone to unmute themselves and speak, if you could please just check and make sure that you have your lines muted again, that would be great.

So the order of today's proceedings will be first the applicant will be going through a presentation. He will be sharing this presentation with the board members and others participating via

Skype. Copies of the presentation have been posted on the Green Mountain Care Board's website for members of the public to follow along.

The easiest way to access those documents is by going to the 2020 board meeting information tab and finding the documents for today's meeting.

Dr. Cats-Baril, as you go through your presentation if you could please just identify the page number of the slide you're on so that anyone who doesn't have this kind of electronic Skype access and who is on just by phone can follow along.

MR. CATS-BARIL: I will. Thank you very much.

MR. BARBER: All right. For the sake of the court reporter, and others, I'll also ask board members to please hold your questions until after the presentation is finished. After the presentation is finished, I will be calling on board members individually to see if they have questions. Following board member questions, we will take public comments. And then following public comment, I will adjourn the meeting or adjourn -- sorry -- adjourn the hearing and turn the meeting back over to the Chair.

So Dr. Cats-Baril, if you want to start your presentation.

MS. LUNGE: Mike, do you need to swear in the witnesses?

MR. BARBER: I'm getting there.

MS. LUNGE: Okay.

MR. BARBER: If you could please raise your right-hand.

THE WITNESS: Can you see it?

MR. BARBER: I do. Thank you.

WILLIAM CATS-BARIL

having been duly sworn, testified as follows:

THE WITNESS: I do.

MR. BARBER: Thank you. Okay. I'll turn it over to you to start sharing and start your presentation.

MR. CATS-BARIL: Thank you, Mike. Can everybody see it? Not yet?

CHAIRMAN MULLIN: We can.

MR. CATS-BARIL: Excellent. Thank you so much. Again, thank you for the opportunity. Appreciate very much everybody being here. Most of you have seen this material before. The presentation that I am going to go through is a summary of the original CON application that we submitted on November 5, 2019, and then three sets of responses to the Green Mountain Care Board questions, any questions in total in three sets. And I'm going to do this a couple of times through the presentation, I really want to thank Donna Jerry, Michael Barber. I know there were other reviewers that I'm unaware of their names, but I have to thank them for the very, very quick turnaround and the very, very close read of the proposal. I think the questions that they

asked were terrific, and they made the project much more solid. So I appreciate the care that they took in reviewing the proposal, the complex proposal. And they did it very, very quickly and very thoroughly. So with lots of thanks.

And the summary here just would like to give you an overview of what I want to do. I think that everybody on this call is very much aware of the epidemic of addiction that we are in the midst of now joined by another epidemic. I would like to move through that rather quickly. It's background material that I believe everybody on this call is more or less aware of, and then concentrate on Silver Pines; the vision that we have, the mission that we have developed for ourselves, the specifics of the project, focusing on the very individualized clinical care process that we are suggesting, the team that I hope we'll actually assemble, the time line that we have in mind. The time line that is on this presentation was pre-COVID-19, so clearly will have to be modified.

And then I don't know if you all had an opportunity to see the formal response that I submitted to the series of concerns from ADAP and the Department of Mental Health questions that came in in

the last round. So I have added them as an Appendix. Happy to go through them if you feel like you want me to address those specifically.

I'm planning, as Mike suggested, to go through the presentation until the summary. At that point I'll stop for questions. If you want me to proceed and go through the specific answers to the questions shown in the Appendix, I'll be happy to do so. So I'm starting the presentation now. I'm going to -- this is slide number 5, 5 out of a total of 46 slides. We are in the -- again, a lot of the language here I just need to capture obviously in relative terms given what's happening today with COVID-19.

But addiction is raging, as you all know. We have a crisis that I think is going to get unfortunately worse because of COVID-19. My guess is that the social distancing is going to actually lead to the problem getting worse rather than better certainly in the short term. And one of the reasons that we suggest that the epidemic has not abated, it has been raging for at least the last decade, is that the treatment of addiction has not been particularly effective.

And one of the reasons that we suggest

that that's the case, is that the treatment has been fragmented, not particularly in the individualized. It's basically a one-size-fits-all approach. And we think that that's one of the reasons that we haven't been really all that effective decreasing the incidence of this chronic condition. The numbers are enormous.

Again, I believe that you are more or less familiar with the magnitude of the problem. What is interesting is not so much the size of the problem, which is depressing in many ways, but the fact that very, very few people, actually around 11 percent, get the treatment in a specialized facility. And that is where I believe Silver Pines is adding to the landscape of treating addiction in Vermont and nationally.

The consequences, as you know, in terms of human life is staggering. If we add individuals that die from drug overdoses to the people that die from alcohol-related causes, we are looking at almost 160,000 people in this country. And Vermont actually does contribute to that total in terms of number of deaths per hundred thousand inhabitants of Vermont is on the high end of the spectrum. And you can see from this slide I announce like 8, showing the trend

of overdose deaths, they have tripled in the last 10 years. And it is particularly an affliction, a chronic condition for males, but the trend is actually across the population. And it doesn't seem, as you can see from this graph, to be slowing down on the country. It seems to be accelerating. And it is across the nation. It is particularly bad in the mid western states; in New England.

This red circle that I have on slide number 9 is the radius, the circle of catchment area for Silver Pines. As you can see, unfortunately in the middle or fortunately from the point of view of the need, that we are trying to address, in the middle, the eye of the storm, right? And this circle is -- has a radius of 800 miles. And we chose that thinking that we are going to address patients within a two-hour flight of Burlington, Vermont. I'll talk a little bit more about that, the incidence of this chronic condition.

I would like to address a little bit how in Vermont we are prepared to deal with it. There is only one other facility in Vermont that has a level of medical supervision that we are going to be offering. For those of you who are familiar with the classifications, the ASAM 3.7, only the

Brattleboro Retreat offers that level of care in Vermont. And it is a level of care that we believe is cost effective. It is expensive care to provide. But in terms of the downstream costs that it saves, it's a very good investment.

So that's the background. That's what actually led us to think about this project being a good addition to Vermont. And the vision that we develop for this facility is to develop one of what used to be called a center of excellence, a place that will be known for the quality of the treatment that we provide. We want to be known as one of the best treatment centers for addiction, medically supervised treatment in the country.

And we have a very specific mission, and for us it is to create an inflection point in the trend line that we showed you, nationally would be a little bit too ambitious, but certainly in Vermont would like to see us having a role to play, as many other people are already in the community trying to do so, to add to the efforts by providing an evidence based, individualized, this is important, coordinated medical care treatment.

Physically the project is in Stowe, Vermont. Has 16 double rooms. 32-bed facility. It

is a very, very pretty, private, very discreet, very nicely landscaped location. It's a building that used to be a hockey academy for those of you who are familiar with Mountain Road in Stowe. Used to be the North American Hockey Academy. This is a building that has been purchased by Bullrock Corporation. They are refitting it. They are working with us to create a world-class facility. Bullrock Corporation has a long history of experience in building healthcare facilities in the memory business. They have nursing homes. They understand very well the type of care that needs to be put into delivering to patients a peaceful, a centering experience. The treatment again will be a 24-hour medically supervised treatment. We will actually work with opioid, alcohol and substance use disorders. We will have counseling and coordination of care in a community-based setting. We are providing a stabilization treatment program that is 7 to 10-day treatments. It's important -- I know that it was an issue that raised some questions, and we will be very happy to talk about why we chose this length of time. But it's a 7-day treatment modality with a very intense customized post-discharge planning and support that we are planning to provide. And we will

have a systematic tracking of medical outcomes.

This is a key component of our concept, medical outcomes is one of the areas that I have been involved for more than 25 years. I understand the importance of tracking what we do in order to improve the operations that we have in place. So this is part of this organizational learning that is an integral part of the values of Silver Pines.

The idea is to have eventually a national reputation. Again, we are going to target the northeast, all the way to the midwest; Chicago being a two-hour direct flight to Burlington, Vermont. And the southern part of Quebec and Ontario. Specifically and intensively within that 800-mile circle will be addressing a 300-mile area that contains Montreal, Boston and New York City and Albany. We are going to be focusing on that area, and we are, as part of our program, providing transportation. That is, we are going to provide patients and their families, for us, to go and get the patient back into the clinic if that's what they need.

The facility is privately funded. We are not asking the state for any sort of contributions or subsidies. All the proceeds that we

are raising through the private fund will go directly to operations, and as some of you may have seen from our P&L projections, we hope to break even by the end of the second year.

We have made a commitment also, being an important part of the environment and community in Vermont that treats addiction, we have made the commitment to allocate 1 percent of our profits as grants to community-based organizations. The idea is to create an independent board of seven individuals that will actually receive this 1 percent in profits, and then allocate it as the board sees fit without any intervention from the partners in Silver Pines.

The reimbursement model is private pay only. Again, I know that that has raised some questions which we will be happy to address. But as private-pay-only model allows us to deliver the highest level of care with one of the highest staff-to-patient ratios in the country. And to provide a lot of other ancillary services that we believe will make the treatment of Silver Pines nationally recognized.

We are investing in state-of-the-art technology. We are developing a series of mathematical models that will help us, we believe,

fine-tune the effectiveness of the treatments. Very, very importantly, particularly right now in the state of free fall that the economy is going through, we are planning to create 55 very well-paying jobs in Vermont by year 3. And this private pay model allows us to have, we believe, a long-term sustainability.

So in terms of the State of Vermont, I think we are going to create jobs. We are going to add to tax revenues, and we are asking really for nothing in return, obviously other than the Certificate of Need, but no financial contribution.

I am moving now to slide number 16 which shows you the expected admissions. We are expecting a total of 365 admissions in year one. The number in parenthesis, 31 percent, represents the percentage of total capacity. So we are planning to be basically a third full in year 1. And as you can see, year 2 and year 3 our capacity goes from 31 percent in year 1 to 79 percent in year 3. And we expect the number of Vermont residents that will be treated at the facility to go from 39 in year one to 90.

And it's -- if you look at the bottom of this table, we show you the calculations that we performed, the assumptions that we made in

determining those percentages. I would like talk a little bit about the process of clinical care that we are going to be delivering now.

This is slide number 18. And I think there are three basic points I would like to make. One is that we have constructed the clinical process to deliver what we expect is going to be better outcomes, better outcomes as measured by increased long-term abstinence, higher rates of sobriety, decreased rates of relapse, and fewer medical and psychological complications.

Again, I want to reiterate that we are going to be systematically tracking the outcomes for every single patient that enters our facility. The economics of the detoxification and civilization of patients has been documented several times. The yield cost savings. Addiction is or creates frequent use, much higher frequency of use of other medical services. And we believe that by effectively decreasing rates of relapse, we will have a long -- long-term impact on saving, savings for the healthcare system as a whole.

And then part of what we do very well, you know, I teach a course and continued improvement here in the business school at UVM is this notion of

organizational learning. Understanding what's working, what's working best, what is not working. And having a very, very quick feedback loop that allows us to improve continuously.

I am on slide number 19. Just showing again this notion that we add intervention, substance use disorders lead to much higher costs in medical care. We hope to have a major impact, again, locally at least on the incidence of substance use disorders.

I want to go through this table in great detail on page 20. It shows you the break down step by step of what we are planning to do. We have gone through the process. On the left-hand side under Silver Pines process, you see the six stages of the clinical process pre-admission all the way through post discharge. And we have identified critical success factors to each and every one of those phases. And this is what will drive our training. This is what will drive our hiring. And this is what will drive our assessment of quality.

We will actually measure each and every one of these phases to make sure that we are delivering the specific metrics that we have identified as being critical. There are some questions as to our -- the length of our treatment

being short, 7 to 10 days. It obviously then raises the question of follow up, and we have concentrated a lot of our energies in thinking about how we are going to make sure that we are providing a continuity of care to our patients and providing them with placement and treatment post discharge. And here are some of the follow-up activities that we will be performing.

On slide 22 is the type of data that we are going to be collecting. As you know, we have made the offer of sharing our data with the appropriate government agencies that are interested in following addiction. We will be sharing our outcome measures. We will be actually reporting them, and we will be, as I said before, tracking them systematically.

Slide number 23. Reiterating that our length of stay on average will be between 7 and 10 days. The program will be totally voluntary. And we will make sure that every single patient will actually go through the full treatment and has a very well-planned, structured, supported departure from treatment.

The team -- I apologize for this introduction as it is a little bit longish about who

I am. Donna Jerry very nicely suggested that I should give the board a sense of who I am. So what I think I would like to say very quickly just to summarize all the bullet points is that I have been in Vermont for 37 years. I live in Stowe. Vermont has been extremely good to me. And I would like to be very good to Vermont.

I have had the opportunity to engage in other businesses that I think have contributed to the well-being of the state. One of my major contributions was the redesign of the MBA program here at the Grossman School of Business. We created in 2015 totally new MBA. I was the founding director and major designer of that program. It is now ranked number 1 in the country for sustainability and innovation. So I do have a commitment to quality, to excellence.

You may actually wonder how a professor of business goes into addiction treatment. I had a lot of working with a group of psychiatrists on developing a -- what is now a nationally-recognized risk of suicide prediction tool. My background in artificial intelligence, in expert systems, in neural networking overlap with their interest in trying to do something that nobody has done before, which was a

prediction of short-term risk of suicide, what were called imminent risk of suicide. And through that work which has won several awards including some national awards of note, I started to realize the tremendous public health problem that suicide represented. And through my work in suicide, as we have tried to apply this tool to several different populations, and we started to look at the rate of suicide in the substance use disorder populations, we note that some of the data that basically pointed to half of the death by overdose being intentional. And that really was to me, surprising, because it immediately doubled the number of suicides in this country. The official number of people that died by suicide is 42,000 per year. But there are close to a hundred thousand deaths by drug overdose. So if you take half of those as being intentional, that would be 50. And that would make 92,000 deaths by suicide. And that would be -- it is a staggering number.

And I started to put together here at UVM a group of faculty interested in what I called the death of despair. Overdose and suicide. Look at the social determinants of those deaths of despair. And that led me to the question of how can it be? How can we have such a high incidence of death? This

is -- I would really suggest -- unacceptable.

And I started to ask questions of people that are experts in this area about addiction treatment. And this is how I got involved in thinking about developing a clinic that could deliver, that could make a difference. Small grain of, you know, sand in the big beach of despair here. But at least trying to address it on a personal level in an effective way. So that's the background as to what brought me to think about addiction.

What brought me to actually do something about addiction. I am putting my money where my mouth is, where my intentions are. I really would like to make a difference, and I'm making a difference, I hope, assuming that you will consider the Certificate of Need in a positive light in my backyard. Right? I really would like Stowe to become known for treatments of addiction.

Happy to answer any other questions about my background when I'm done. The team that I'm hoping to hire is described on slide 26. We will have, as you know, 24/7 medical supervision. We will have a chief medical officer that will be trained in addiction, and will have a board certification in psychiatry. We will have -- we think this is -- the

numbers that you have in front of you are numbers that deal with year 3, right? So we will have three top level executives. We will have 37 clinical positions. We will have eight admins. Not here, but the -- part of the team will be a teaching staff. Part of what we hope to do is a farm-to-table program that again will highlight some of the strength of Vermont, farming community. Altogether by year 3, we hope, we expect to have 55 employees working at Silver Pines.

The time line, much easier to look back. That's what we know has happened. We started November 5. The last response to the set of questions was sent on February 20th. I believe that the process was closed on March 5th. We are now having the hearing on March 25th. And so that's what brought us here.

I'm going to slide 29. We are hoping to start credentialing with private insurance as soon as the Certificate of Need is awarded. We were hoping of hiring, licensing and credentialing critical staff on June 1. All of this was really based on the presumption that construction of the building was going to be done by July 15. Construction, as you know right now, has stopped

across Vermont in most cases. We are pausing to -- for we don't know how long. Certainly we hope no more than a couple of months, but nobody obviously knows.

So much of these dates have to be adjusted in this COVID-19 world that we are living in today to recognize the reality of delays. And we are still committed, we hope, to open this year, September 1 was what we had in mind. We had actually already started to identify individuals that would actually join the team and so forth. Everything is a little bit on hold now. I certainly hope that we will be able to open our doors in 2020.

I do believe that in a couple of months we will have much greater visibility as to whether opening in 2020 is still realistic. The goal is there, and it's just a matter of being able to have the facility in place and the team in place.

So in summary, I would like to close by saying that we have built what I believe is a clinical process that will give us distinction. And it will give us distinction because we are going to have better outcomes that we will be able to report and -- for us to be successful. We need to demonstrate effectiveness. It is an individualized,

an integrated treatment modality, that we hope is going to make Silver Pines a nationally known facility.

We are planning, as you are able to see from our financial reporting, that we will have a model in place that will allow us to run a very, very high quality clinical care process in a sustainable fashion.

The benefits to Vermont. This is on slide 32, my last slide, unless you want me to go through the specific answers to the last set of questions and concerns from ADAP and DMH. We are offering a treatment option that does not currently exist in Vermont. We believe that we are going to be treating up to 90 Vermonters per year. It may not sound like much, but it's 90 Vermonters that will have access to the best possible treatment that maybe doesn't exist right now. So 90 is better than none. We will treat 55 well paying jobs. We will be providing the financial grants, if we are running with the level of success that we believe, we'll have a profitable operation and give to those community organizations. We will make minimal demands on the Vermont healthcare system, and we believe that we will be adding substantial tax revenues to the state.

So with that, again I am at your disposal, your discretion. And I can go on to talk specifically about the concerns of the ADAP and DMH or stop here and take questions on other subjects. So --

MR. BARBER: Thank you. Is there any board member who would like Dr. Cats-Baril to proceed with the remainder, addressing the concerns of ADAP and DMH?

CHAIRMAN MULLIN: I think a quick run through of those would be actually helpful.

MR. CATS-BARIL: With pleasure. So there were five concerns from ADAP, one concern from DMH. Basically ADAP was concerned, first of all, with Silver Pines creating a work force shortage or creating pressures on the work force environment in Vermont. And if you look at the numbers, people that we are going to hire, though we have a very high ratio of staff to patients, we are going to be hiring around 1 percent -- 1.5 percent by year 3 of the existing, and maybe by year 3 there will be even more than the 424 staff that are in Vermont today.

So we believe that we are not creating any undue pressures on what is considered to be insufficient staff to provide services in Vermont.

We are aware that that may be a concern, but certainly Silver Pines is not going to contribute in any significant way to those pressures.

The second concern was a concern of Silver Pines distorting in some way the salaries of professionals in Vermont. My philosophy has always been in every business that I've run that you pay the people that work for you the best possible salary. It's the smartest, and seems to be the most cost effective way, to run a business. You pay them well, employees are going to work hard. I want the best possible employees at Silver Pines. I want to have the best possible staff at Silver Pines.

I am proud of the fact that we are going to pay as well as we can to get the best possible skill level. So having said that, the numbers that we have proposed in our financial -- in our P&L is completely in line with the Blueprint for Health guidelines. We are right in the middle of that range.

What we are going to do is offer abundance of performance and certainly motivate individuals to work hard and produce the best possible outcomes. But the salary base that we are providing or that we are planning to provide is in

line with the market in Vermont.

The third concern from ADAP was this lack of connection to the rest of the specialty treatment system. And here I want to make sure that we all realize that there is a continuity of care. Right? We are not doing everything in addiction treatment. We are doing a very specific aspect of it; a narrow one. We think we are going to do it very, very well, possibly as well as anybody else in the country. But we are providing a very limited service. And this service, I think, is important, will be connected.

We are going to make a tremendous effort to connect our clinic to all the community organizations that are already doing a terrific job in Vermont. I think that, you know, it's a little bit of the chicken and the egg. I mean we don't have a Certificate of Need, and so we have an idea for a project. And I think once we have a Certificate of Need, once we know that this clinic is going to be a reality, it's going to be all hands on deck to create all of the connections to ensure this continuity of care. So we are totally aware that this is a chain. We are only a link in that chain.

We will be connecting, I am convinced,

from conversations that I have had with individuals in this environment, the ability to create those connections.

Again same, the next -- I'm on slide 39. One of the concerns from ADAP was that we were offering too short of a treatment, that there was no real evidence that these treatments were effective. We very respectfully disagree with that statement. Our thorough review of the literature, our conversations with experts in addiction tells us that the 7 to 10 day is the sweet spot, if you will. It is the number of days that seem to provide equal or better effectiveness of intervention for the least amount of time and expense. And we actually have given in our response -- but we had already provided in our original Certificate of Need application -- evidence for this.

I want to make sure again, very respectfully to the board, that the 7 to 10-day detox program that we propose was not just a whim. We could have offered 14, 21. We could have gone into rehab. I mean we chose this treatment modality because we believe that this treatment modality's extremely effective. And we provided some of the evidence in the response as well as in the original

Certificate of Need.

And finally, one other concern that ADAP brought up was not all states have access to medication-assisted treatment for opioid use disorders. That is true. But it's changing extremely quickly. As of 2018, which is the last reported statistic, more than 92 percent of the population live in a place with at least one Bupe-promotional prescriber. And the number of prescribers are increasing, the number of opiate treatment centers and programs in the country is increasing, so we believe that the individuals that will be discharged from Silver Pines with a 7-day treatment have no higher risk of overdose than any other treatment. And we believe actually that they will be at a much lower risk of overdose because of the care that we will take in placing our patients into a post-discharge treatment.

And then the last concern of ADAP is about neural network model that we are using. It's a relevant concern. Machine learning and neural network models that we have proposed have not been fully tested on the population they will be serving. Absolutely true. But it's not the way that we are going to deliver care.

We have a parallel system. We are going to have experts, individuals that have been trained at the highest level of addiction treatment in this country, coming from the best fellowship programs in this country on addiction. We will have terrific nursing staff, and they will be delivering the care, not the neural model.

What I'm doing, and this is very close to my heart, this is part of my life work, is we are going to test in parallel a model that will try to replicate the expertise of these individuals. So that eventually not only can we increase the consistency, that is we will actually be training staff that has a much less level of experience, expertise and skills with this model, but that we can contribute nationally to a treatment of addiction that will be much more effective.

The neural network works in two levels. The first one is by identifying patients. We've talked about this individualized treatment that Silver Pines is going to deliver. The individualized treatment is going to be drawn by physicians and will actually be tracked by the neural network. And eventually we hope that the neural network will be performing quote unquote, just as well as the

physicians. We will be actually adding a level of patient safety through this neural network. It will be basically a model that says, okay, physician, here's a patient. Here's how he presents. The patient has a certain history of addiction, a certain history of rehabilitation. This is the substance that they abuse. Here is the type of treatment that best fit them. And the model will actually confirm or disagree with that selection.

And we believe that in that the model is actually providing an extra layer of safety, an extra layer of quality of care. That same logic applies to how we are going to place patients into -- how we discharge them, and how are we going to actually place this patient once they are done with our clinic. We will have a post discharge, discharge experts, that will be handling that, but we will be building a mathematical model to basically confirm that those choices make sense. And over time, we hope the model will be performing just as well as the physicians.

So yes, they haven't been fully tested. We are not using them as the main source of care. We do hope, however, that by year two or three; right? This model, I don't know if we have some people on

the line that understand or have worked with neural networks and how they work, but as the patient base increases, the intelligence of the model increases. And we hope that by year 3, when we will have treated hopefully more than a thousand patients, the models will start behaving in a way that would be of help, support for the clinical staff.

And by the way, on slide 43, I'm sorry I just went fast through it. I'm sorry. 42. Just mention the work. This is the very similar work I've done in several conditions, chronic conditions, low back pain being one. Chronic conditions we have done and follow the same level with the imminent risk of suicide project that I mentioned a second ago. So those are the concerns from ADAP.

And from the Department of Mental Health their main concern was that we were going to possibly increase, put pressure on local medical and psychiatric emergency departments in the state. That non Vermonters were going to come into the state and actually divert some of these resources. The numbers that we are planning to have, if we execute perfectly on our plan, as you can see, the numbers are insignificant in terms of the total annual ED visits, both at Copley, to the hospital that is closest to

the clinic, or to UVMMC where they may actually need inpatient psychiatric care.

So the, you know, very good snowfall in the middle of winter will bring more people to Vermont and will bring more people possibly to the emergency room because they break a leg or they hit a tree skiing than what we are going to do at Silver Pines. The numbers that we -- the numbers that we are predicting may require emergency department attention, are all based on the literature across national programs. And the numbers would be very, very small.

The last thing I would like to say to that effect is that we believe that on the contrary; right? If we are going to bring up to 90 Vermonters to Silver Pines and treat them effectively on an SUD, that we will decrease the impact, the pressure on the healthcare system in Vermont. We believe that the more Vermonters we treat, the less impact we are going to have in the state's medical system, certainly emergency medical system.

So taken altogether, we believe that the impact that we are going to have is not really one of increasing pressure on emergency departments in the community. But that ultimately what we will

do is have a beneficial effect and free resources in emergency departments across the state; certainly in the northern part of the state.

Happy to expand on any aspect of the presentation or the responses to the concerns from ADAP and DMH.

MR. BARBER: Okay. Thank you. I'm going to turn it over to board members for questions. And like I said earlier, I will just -- to keep things understandable for folks and the court reporter, be calling on board members one at a time.

So board member Lunge, do you want to kick things off? Do you have questions for the presenter?

MS. LUNGE: Sure. Yeah, happy to. Thank you very much for your presentation and the materials. There is a lot of good information in the packet, and I appreciated getting the thorough information.

My first couple questions related to your reimbursement model. So I wondered if you could give me a little more detail around the self pay versus interaction with insurance. When I was going through the materials, I did note that in answers to the questions related to bad debt you had indicated

that you're expecting self pay up front which would obviously minimize the bad debt.

And in reviewing your patient financial policy form which was page 23 in response to question 3, it does look like your plan is for folks to individually ask for reimbursement from their insurance company after paying with whatever documentation you provide. But I also noted in some of your other materials where you were explaining what would be included in the up-front cost versus what would be billed separately, that you had indicated that labs, for example, might be billed to insurance.

So I just wanted to get you to expand a little bit on how that's going to work.

MR. CATS-BARIL: Well I think that, you know, we hope that the charge that we are going to make will include every service that we deliver, including lab services, including medication. So it is, as you said, self pay. They will actually pay up front. We will provide all the communication needed with their insurance company of choice. But all the lab costs are going to be included in our original charge.

MS. LUNGE: Okay. And so could you

explain a little bit then why -- about why you would be credentialing with insurance companies. That's so when a patient submits the reimbursement information that you're already credentialed?

MR. CATS-BARIL: That's exactly right. Yes. To facilitate the process of reimbursement to the patient.

MS. LUNGE: Okay. And who on your staff would be working on that?

MR. CATS-BARIL: Well we are going to have the Executive Director, that is going to be -- let me just go back.

Mike, do you still want me to keep the slides up? I don't know what the process is here in terms of if you want to see my face. If you rather see the slides. I mean I don't know what the protocol is.

MS. LUNGE: I can actually see both, so I'm okay. Whatever Mike proposes.

MR. BARBER: It's up to you. I mean I think it's helpful for me at least to have you be able to go through the presentation, but I can see your face. And it might be weird if you can't see board members' faces as they are asking questions, so it's really your preference.

MR. CATS-BARIL: Right. Well I cannot see you. So there you go. Because the slides are taking over all the screen.

So, you know, as you look at our team, the executive director, we have a -- will have an accountant that will actually be tracking the -- all our relationships with the insurance companies. And we will have what I hope is a good relationship with the insurance companies. There is not going to be that many. But we will have actually the Executive Director in charge of credentialing.

MS. LUNGE: Okay. And who would be in charge of the reimbursement, like getting the paperwork together for the patient for reimbursement?

MR. CATS-BARIL: Yeah. Again, you know, we will have most likely our accountant who, you know, the accountant is going to deal with all aspects financial.

The business at the beginning is not going to be all that busy and complicated. And so the accountant will be the person that manages that process.

MS. LUNGE: Okay. Thank you. I wondered if you could speak a little bit more generally about why you chose the self-pay model as

opposed to being open to all payors.

MR. CATS-BARIL: You know, it's a matter of a business model, that what we started, the concept from the beginning was a concept of providing the highest level of care. For me that was absolutely critical.

You know, after discussing what was needed in Vermont, in particular, but across the country, you know, I actually went and visited many -- I think I visited 14 different detox clinics across the country, seeing all sorts of models. And I realized that the ones that I wanted to emulate were fully 24/7 medically-supervised clinics. It is an expensive model to sustain. There aren't many across the country because of that.

And to me, in order to be able to sustain the highest possible level of quality when it comes to clinical care, we just needed to have the cash flow to sustain that. And, you know, for us, the point that there is, as you said so well, no bad debt, that we really don't need to be worrying about cash flow from that point of view; engages investors into this facility a level of understanding of how we could be sustainable in the long term.

MS. LUNGE: Thank you. My next

question is around the up-front patient payment. So I know that your model has a real emphasis on individualized treatments. And could you explain a little bit about how you're going to know prior to someone getting to your facility how much to charge them? Whether it's 7 days, 10 days, 12 days, 8 days.

MR. CATS-BARIL: Well, you know, thank you. This is a good question. The idea here is that we are going to assume that the treatment is going to take 10 days. And we are going to plan on a charge for 10 days. If the patient, for whatever reason whether from, you know, a voluntary decision that they want to leave halfway through, we would actually pro rate what we charge them. But the assumption is going to be that they are going to be with us for 10 days. And we are going to structure the treatment on that basis.

Does that answer your question?

MS. LUNGE: Yes. Thank you. All right. Well just one second. I've got to shuffle some papers around for my other notes.

MR. CATS-BARIL: Thank you.

MS. LUNGE: So my next question is about the discharge planning.

MR. CATS-BARIL: Yeah.

MS. LUNGE: And it's really a follow up on some of the ADAP concerns.

MR. CATS-BARIL: Yes.

MS. LUNGE: So I hear what you said about ensuring that you're just a link in the chain, and understanding that your service is specific and narrowly tailored for its particular purpose, but I was a little concerned when I looked at the projections around -- that you had provided around the number of hours that people would be spending post discharge with your patients.

So hold on just one second. There was a chart that you provided in response to question 3 that is on page 5. And it indicates that in year 1 you would expect that the average number of follow up per person would be an hour for the first month, half an hour for the next 2 to 6 months, and then less after that for a total of 5 hours. And it just seems like when you're trying to work with providers within a two-hour flight radius, that that may be challenging to do in that little time.

So could you speak a little bit more about how you came up with those hour estimates?

MR. CATS-BARIL: Again, you know, thank you for the question. The question is, for us,

whether we specifically know how long it's going to take. I ask how much time is being used to discharge. You know, again I talk to other operators that do this type of discharge planning. We have got an estimate of that amount. For us, it is a very -- we believe that we are going to distinguish ourselves on the way we actually discharge patients and we place them. That is going to be a priority for what we do.

It may be that the number of hours may be greater than 5. What I can tell you is that early on we are going to have only 30 percent capacity. We are going to have a lot of time on staff hands to actually do placement. It may be longer than 5 hours. We will actually assess them after year one. These numbers that we showed are numbers that were based on interviewing people that have spent time on discharge. So if you need an estimate, I think it's an estimate that makes sense for us and that reflects the type of care that we want to put on that task.

We may have to -- I think your implication is that it may be low. You may be very -- you may be right. We will know very quickly. But we think they are reasonable based on what we heard from other operators.

MS. LUNGE: Okay. Thank you. I'm good for now, Mike. I might have one follow-up question later. But I suspect somebody else will ask it. So --

MR. BARBER: Okay. Thank you.

MR. CATS-BARIL: Thank you.

MR. BARBER: Next we will go to board member Usifer. Do you have questions?

MS. USIFER: I do. First really glad to see the MBA program is going so well. I was on the inaugural board of that in 2015 so --

MR. CATS-BARIL: Yes. Yes.

MS. USIFER: Yes. Good to see that took off. You know, clearly there is a need for additional addiction treatment in the U.S. And you know, we would like to see success here in Vermont. But I definitely have some concerns on the success of this model, you know, based on some of the assumptions. And that's really going to drive, you know, a bunch of my or several of my questions.

So first I want to look at the landscape in both Vermont and in -- nationally. So just first going back to something that Robin was talking about about reimbursement. There was something on page 21 of the original -- of the

original CON talking about contracting with Blue Cross Blue Shield of Vermont for patients.

And so is there -- are you planning for Vermont residents to do that or what was that?

MR. CATS-BARIL: You know, again, what we wanted to do, and this has evolved, but yes, I mean for us having relationships with insurance companies, right? Looking for this credentialing of our program with Blue Cross Blue Shield of Vermont is important. I mean we believe that they will be one of the main insurers in Vermont, and being credentialed by them will be important for us. So the answer is yes.

Again, we will support patients by providing all of the documentation required by the insurance companies. But we will not take insurance directly. No.

MS. USIFER: Okay. And then some of your comparisons and benchmarks were against Brattleboro, the Brattleboro Retreat or the Brattleboro Addiction Center. And you talked about the 10,500 was kind of the average there. And just wanted to get an idea, is that gross or net, or do you have any idea of the mix of payors that they have in Brattleboro? How many are really self pay versus

Medicaid, Medicare or commercial?

MR. CATS-BARIL: No. You know, I really don't know the break down. That is a published rate for the type of medically-supervised treatment that they offer. So we will be offering our services at a very similar -- their published rate. Whether that's a published rate that they negotiate, that they lower, you know, I really can't tell you. I don't know what the payor mix is for them, but it is their published rate.

MS. USIFER: Okay. Typically what we see when we deal with published rates, and I can't speak specifically, you know, we can talk about in the hospitals, but typically a published rate the insurance company would pay about 70 percent of that. Medicare would pay about 45, and Medicaid would pay about 35. So just from a perspective -- it's probably lower what they expect -- what they actually get.

MR. CATS-BARIL: Yes.

MS. USIFER: So you're basing it on that. Again, for Vermonters, do we -- do you have any idea what percent of Vermonters are self pay for detox versus, you know, using their -- you know, going to a place that uses their commercial insurance

or --

MR. CATS-BARIL: You know, that is a question that we tried to answer. I looked everywhere. If some of you have a tip to give me here of what may be a good source of information, we look very, very hard at how many Vermonters leave Vermont to actually get this type of care since it is not available in Vermont. The type of, you know, very personalized, individual care, high staff-to-patient ratio type of care. And we didn't find any information. You know, the information that we actually -- the assumptions are based on conjecture as I show you on the table. You know, the percentages that we think individuals are looking for, specialty facilities, specialized facilities. And that's the extent of it.

I am not aware, and again I would love for one of you to suggest where I could look, at the number of Vermonters that leave the state to get that type of care. You cannot get it in Vermont. So for those individuals who are interested in that type of care, where do they go.

MS. USIFER: Yeah. And I think that's, you know, kind of what the underlying things from Vermonters and nationally, where I just have concern

about whether you'll achieve your revenues that you're projecting which is, you know, how many people for a detox 7 to 10-day type facility pay self pay knowing that right now the current model, and I know you're changing the model a little bit, but the current model may be that they would go to that type of facility, you know, at a Betty Ford or something, and then go into, you know, continue on in that facility for another 30, 60, 90 days. And so I'm not sure how many stand-alone detox are not affiliated with something like a Betty Ford or a Hazelton, you know, how many of those exist. Because for many families, this might be the first expense of a much bigger expense if they are doing it, you know, if they are looking at it as a detox and then moving into maybe a 30-day or 60 days which could be another 30 or $45,000 for somebody --

MR. CATS-BARIL: Yes.

MS. USIFER: -- that's kind of my concern about this model, is that you're expecting the majority of the people to come from out of state.

MR. CATS-BARIL: Yes.

MS. USIFER: For 7 to 10 days, and then need to filter back into their communities either into a longer term or something like that.

The concern would be as people research this, are you going to be able to make that case so much early on, right? Right now before you have evidence yet, and we don't have a facility for them to go to right after.

So, you know, the question is really, you know, how many stand-alone detoxes are there that are completely self pay that do not affiliate with somebody else?

MR. CATS-BARIL: Yeah. There are many. There are many. There are also obviously a majority out of state.

Also again, you know, not everybody needs a 30 or 60-day rehab program afterwards. I mean we -- we believe that our program will stabilize patients to the point where they may actually have access to an outpatient clinic or some other sort of non residential, you know. Not everybody needs to go to a 30 and 60-day.

Obviously, we will have arrangements, depending on where the patient comes from and what their preference and their family preference is to placing in other states. There is no doubt that this is going to be an expensive first step. But, you know, for us, again, the whole notion behind the

business model and the treatment model is that it is expensive, but it's great value. And that we are -- how long is it going to take us to collect the data to prove that is obviously an excellent question.

From my point of view, you know, the sooner the better. This is why we are going to be prioritizing and putting a lot of resources on tracking medical outcomes, because we need to prove effectiveness. We need to prove though this is an expensive 10-day stay, in the overall treatment of your chronic disease, it's a very effective first step. But, you know, we all know the proof of the pudding is in the eating, and we need to actually collect data to support that statement.

MS. USIFER: And then, you know, that brings me to really some of the financial statements. And I know there is a bunch of the model changed a bit, so I'm not sure, you know, if you can kind of help with answering some. But it looks like at the start it looked like there was going to be maybe a million capital contributed. Now it looks like it's going to be 2.650; is that correct?

MR. CATS-BARIL: That is correct. So, you know, it's been a process of refining the model, the business model; the debt component; the extent of

the work that is being done to retrofit the building; the type of facility that we want to build; type of facility that is going to compete with facilities across the country at the highest level requires a much bigger investment in the rebuilding, and therefore, the rent that we have to pay.

So, you know, for the contractor to actually engage in the risk of rebuilding that facility, we needed to sign a lease with a rent that was required for the first year. And that's what actually then changed the rates for capital. And you know, the amount now has no debt, and a capital rate of 2.6 million dollars.

MS. USIFER: Okay. When you talk about the retrofit of the building and the rent, and I know there were two leases in there. So are we now at a lease where it's about 500,000 a year? Because there was a lease that was 600 and then 600 prepay.

MR. CATS-BARIL: No. The amount -- there is only one lease. I think there was an early lease that was just a model of it. The second one that came, I believe, with the third set of questions is --

MS. USIFER: Okay.

MR. CATS-BARIL: -- the one that

actually applies. And yes. We are paying $50,000 per month, I believe. That's the amount.

MS. USIFER: And are you still paying up front?

MR. CATS-BARIL: We are paying. And this is what I think is important; right? That the 2.6 million is really -- the proceeds are going to be used all for operations. There is absolutely not a single cent that is going to the partners of this LLC. So the money goes for rent, it goes for salaries to start the operations, and we have, as you saw from our projections, we need around 400 some thousand dollars as a cushion in the first four months of operations.

So all of the proceeds are going to go directly for working capital. And nothing of it goes to the founding partners of the venture.

MS. USIFER: And do you know how much the retrofit of the building is going to cost?

MR. CATS-BARIL: I have -- I think we have Doug Moses -- I know Doug -- are you still on the line, Doug?

MR. MOSES: I'm here. Yeah.

MR. CATS-BARIL: Or Gregg. Beldock. They will be my landlords. And they are the ones

that are keeping track of construction costs. So Gregg, I don't know if you want to comment on the cost of retrofitting the building please.

MR. BARBER: Before you start, Gregg. Sorry. This is Michael Barber. I'm happy to have you answer the question. But I do need to swear you in if you're going to be providing any sort of evidence. So do you mind doing that?

MR. BELDOCK: Absolutely. Michael. Be the second time I lifted my hand as Willy was sworn earlier, but not on screen. So let's do it again.

MR. BARBER: All right.

GREGG BELDOCK

Having been duly sworn, testified as follows:

MR. BELDOCK: I do.

MR. BARBER: Thank you.

MR. BELDOCK: Gregg Beldock. B-E-L-D-O-C-K. As we have done in the past, and we have built similar facilities, independent living facilities, and we are innovative in the memory care, the cost of memory care and the change in the way memory care treatment was done throughout the country, beginning with the facilities. We suggested and offered to Willy that the most successful way for his financial plan to move forward, that would provide the greatest likelihood, would be is if the landlord provided all the internal fit up to the building, including the medical equipment, the software systems, the phone system which speaks to attenuation system, which also allows for scheduling models. And all of that will be provided by the landlord. It's about a 3.6 million dollar internal fit up.

MS. USIFER: Okay. That makes sense then in what the rent payment is. I was looking at the purchase of the building.

MR. BELDOCK: In addition to the

purchasing of the real estate. The real estate would be on top of that.

MS. USIFER: Pardon?

MR. BELDOCK: Yes.

MS. USIFER: 1.2 million for the real estate, right?

MR. BELDOCK: It was 1.25. We are talking about a 4.7 million dollar capital event. A good portion of that is very specific. The furniture is high end. The beds are specific. And obviously the software system and the attenuation tracking system, when I say tracking, we are actually tracking labor as they enter into the rooms, not unlike we do in the memory care facilities which has now been adopted nationally.

MS. USIFER: Okay. Thanks. And we are -- the last question that brings me to then is the financial statements where -- and Will, you just referred to it a little bit, about the additional cash that you have. And, you know, just that's where there is concern for me looking at your financials where -- and I was looking at your three year pro forma balance sheet as of 2/20 under question 1. I don't know if that's since changed. But it had you sort of -- I'm sure the timing has changed -- but it

had cash getting down to about 214,000 in month 4. And that's assuming that you had generated already about a million dollars in accounts receivable. You know, that's going to offset that.

So what is your ability going to be to raise additional capital or to fund, you know, a shortfall in cash if you don't hit the revenue assumptions that you have in here?

MR. CATS-BARIL: You know, it's pre-COVID19 I would have told you that my ability to raise capital was absolutely excellent. I cannot tell you how motivated -- I have raised money for many ventures. You know, I have been lucky enough to be successful in those ventures. And my investors have always been very, very loyal to me.

This project is a project that people understand as doing very well by doing a lot of good. And I do think that the COVID-19, you know, situation, has made everything a little bit more muddled. I can tell you that I continue to -- because there are individuals that have backed me in other ventures -- the ability to go back to them for extra cash. Again, I am under oath, so before COVID-19, a hundred percent sure. Now a little bit less sure.

But I do think that this is the type of project that has always generated a tremendous amount of excitement, and people that want to make money, and this is a model that eventually will have, I believe, attractive returns for investors, but more importantly, are committed to make a difference. And I think that, you know, again I have been involved in a lot of business, lots of them have had this do well, do good. People have always been very responsive for, you know, a capital call that is an emergent situation, you know, for reasons that are not predictable at this point. We have a shortfall, I feel that my investors are going to be there.

One other point that I wanted to make is that I have no debt. Right? And so at this time I mean talking about again, a post COVID-19 world, I think banks are going to be so incredibly pushy trying to get people to borrow money, they are going to -- you know, everything is right now leading to much greater liquidity. And I believe that loans are going to be aplenty at ridiculously low rates.

So although I have built the model on a hundred percent equity, no debt, in case that there are some issues with a capital call, given what has happened with the markets right now, I feel that

banks are going to be extremely pliable and will have plenty of funding available for us.

MS. USIFER: I do have one follow up on that piece, which is, I guess, you know, talking a little about your corporate structure and how investors will get a return and when you see that happening. Being as it's going to be, you know, at some point you're going to start distributing dividends to them or liquidation event ultimately down the road, where, you know, people will get their money back, or how do you see that playing out?

MR. CATS-BARIL: Yeah. Its strategy is very typical, you know, we are going to give back to investors 80 percent of profits until they get completely paid out. And then after that, they will get 20 percent of the profits down the road. So, you know, they get the financial treatment until their investment is paid out.

MS. USIFER: Okay. Thank you. That's all I have.

MR. CATS-BARIL: Thank you.

MR. BARBER: Okay. Next, member Pelham, do you have any questions?

MR. PELHAM: I do. Let's see. I'm looking at some of the data that is on slide 6 and

slide 16. You know, where there is the top side numbers of -- in Vermont of 54,000 people older than 12 with a substance abuse disorder and only 13 percent of them in treatment.

And then for your third year in -- on, I think it was by 16, you expect there to be 90 Vermonters in that population when you're fully up and running. And I'm just wondering where you think those 90 people are coming from. Are they coming from existing providers in Vermont that would be diverted toward your program, or would they be coming -- or would these be new people to that kind of care?

My sense would be that they wouldn't be new people if they could afford to pay cash or pay up front. This benefit -- they are probably getting it somewhere. So I'm just trying to get a sense -- I know it's at the margin. But, you know, the focus -- part of the focus here is is this helpful to Vermonters. And I would like your sense of whether or not those 90 people are new to the system, bringing fresh money into Vermont. Or is it just rearranging the provider?

MR. CATS-BARIL: Right. Again, you know, I appreciate the question. The answer is that we don't know. You know, we don't know how many

Vermonters are leaving Vermont to get this type of care. I mean that's the bottom line. I wish I could actually tell you.

And again, if any of you could guide me to where I could find that out. But where do individuals who are looking for a high staff-to-patient ratio, small facility, with individualized care go? You know, what is the number of patients that leave Vermont? Because that number would be very helpful. I could actually say that we would retain those. Right? Let's say a hundred people leave Vermont every year to get this kind of treatment, I could argue that I would then bring that money that they are spending in other facilities out of state to Vermont. But we don't have that number.

The number 90, you know, is based on looking at the percentage of people that -- and we know that here in Vermont -- have actually private -- paid with private insurance or cash. And they actually have gone to a residential treatment facility. So the number 90 is what we expect to treat given who has seeked treatment in Vermont. And when you say is it new, is it a reshuffle of the number, you know, what we hope is that 90 patients in Vermont will get the best treatment possible. Are

those 90, 90 that were treated before by someone else, somewhere else? And they are coming back after a relapse to see us? I don't know. I don't know if there are going to be 90 patients that are totally new. There are going to be some that are actually trying us, you know, because it's the third or fourth time that they attempt to get treatment for this chronic disease.

So I really cannot answer your questions specifically. What I do know is that I'm hoping we are going to treat 90 patients in Vermont very, very effectively. And could we treat more? I hope that more Vermonters would come, but we expect that those 90 patients will be treated as well as anywhere else here in Vermont.

So again, the key answer to your question, the key data to answer your question unfortunately I don't have. We have looked. And that is how many individuals go out of state for this kind of treatment.

MR. PELHAM: Thank you for that. I think it's pretty certain though that those 90 patients are ones that can afford to pay up front.

MR. CATS-BARIL: I mean it's going to be a condition; right? For us to treat them. So

yes. You're absolutely correct.

MR. PELHAM: Okay. Next, do you have any -- you mentioned I think is -- you mentioned -- bad Internet out here. I'm sorry. I'll speak slowly if I can.

So I think the reference was to the Brattleboro Retreat as the only other ASAM 3.7 class facility in Vermont. Do you have any sense of their patient load of that --

MR. CATS-BARIL: It's again, a very, very good question. They don't report it. So we don't know. You know, they offer, as I'm sure you're very well aware, several different treatment modalities. And they don't break down their number of patients in each of those modalities. So they offer the highest level of medical supervision, but they don't report how many patients they have at that level.

MR. PELHAM: Thank you. You mentioned, I think, when we were looking at slide 14, that your intent is to build a world-class facility that would attract people who have world-class expectations. And had a staff analysis awhile back, it may have changed, that your fixed cost investment in the first year would be about 1.2 million dollars, which

divided by 32 is 36 thousand dollars per bed. And I just -- but the range of what we will call fixed cost, property taxes, et cetera, I'm just wondering; do you have any sense from a construction point of view how much per bed will be invested in making this facility a world-class facility?

MR. CATS-BARIL: Again, you know, we have no role in construction, but -- and Gregg Beldock, who is the CEO of Bullrock Corporation in charge of construction is on the line, so he may correct me, but he mentioned; right? If you don't take the price of the real estate, which was 1.2 million dollars, and you look at the construction, which is 3.6 million dollars, it is -- if you divide it by 32, you're talking about $120,000 per bed basically. And $240,000 per room. 16 rooms.

So if you want to make the calculation based -- I don't know if it is a fair calculation, because there are so many other facilities, I mean spaces, kitchen and so forth. But if you actually look at the total amount of construction cost which I understand from Gregg is 3.6 million, then you're looking at $120,000 or so per bed.

MR. PELHAM: Thank you for that.

MR. BELDOCK: This is Gregg Beldock.

Really if you're looking at your operating costs and the initial loss of the first 19 months, and you add your capital costs in total, depreciable capital costs, it's identical to a memory care facility. It's about $160,000 a bed before your cash flow.

MR. PELHAM: Thank you. On page 15 you referenced that 1 percent of profits will be grants to a community-based organization addressing addiction. And I'm just wondering in year 3 when you're fully up and running in terms of dollars what does 1 percent equal?

MR. CATS-BARIL: That's a very good question. I mean again, from my lips to the ears of God, as they say, if we are successful in the way that we want to be successful, we are going to -- 1 percent is going to be -- to represent in terms of profitability -- is going to represent around 60 to 70 thousand dollars.

MR. PELHAM: And that distribution would be before distributions to investors?

MR. CATS-BARIL: Sure. I mean this will be actually a built-in distribution that will be seen as a basic, you know, let me just call it a cost of doing business; right? So we will actually be investing that 1 percent. We think that obviously it

will be to everybody's benefit here.

It's very important, again, I don't know if I was clear in the description of how that money is going to be spent, right? That 1 percent will go to an independent board. We are going to invite people from the community. We have names already that have been suggested to us. And that board will actually have full authority and independence on spending and allocating those monies as they see fit.

We will have a mission, and the mission is that it has to be invested in community organizations, those that deal with the treatment of addiction, and that we will actually earmark northern Vermont as the area where we would like that investment to happen. But that's the extent of it. Then the board, independently of us, will be spending and allocating those monies.

MR. PELHAM: Thank you. You did make that clear during your presentation.

The next question I have maybe just a follow up, a reiteration of, I think, one Robin raised. Which was in the responses to question -- the third response to questions on page 5. You showed a distribution of the types of benefit that,

you know, after care or benefits -- services that people would get after discharge.

And I just want to make the point that not only were there time amounts on that chart, page 5, but dollar amounts. And the dollar amount was $131 per patient, you know, for the entire year after discharge. And I just -- so it's interesting to look at time, but it's also, you know, what the expenditure is, the benefit is associated with the time.

And I can't get my arms around $131 per patient on average. So if you could speak to that a little bit more, I would appreciate it.

MR. CATS-BARIL: Yeah. You know, it's a little bit difficult to really put a number of dollars, because ultimately we have staff that is working full 40-hour shifts a week. And they will spend whatever time they need to spend on making sure that the placement and discharge of our patients is appropriate.

The number that we actually provide, and this was in response to a question. You know, it's -- we responded to the question not really questioning whether the question made sense when we actually responded to it. But, you know, we are not

allocating a separate amount of money to the follow up. This is going to be an integral responsibility of our aftercare specialists. This is going to be a responsibility of the executive director. I am sure that some patients will require less. There is going to be some patients that require more.

So I do want to put the caveat that the dollar amount was really based on an average salary of an aftercare specialist, but it's most likely undercounting the salary, for example, of the clinical and execute directors that may get involved. Maybe the direct case staff and the counselors will get involved.

So the number that we provided was based on the question that we were asked, and basically they said how much time do you think that you're going to spend as, you know, from Robin's questions, it was 5 hours on average per patient. And then the question was, how much money do you think that represents. And then we multiply it by the hourly rate of an aftercare specialist. And that's how we came up with the $130. So if you're interested in the mechanics of how we got there, that's how we did it.

I believe that because this is such a

high priority for the reputation of Silver Pines, for the success of Silver Pines, for the effectiveness of our treatment, that it's basically a floor. $130 or 5 hours per patient is maybe the minimum amount that we are going to spend, but it's a good estimate.

And just as I answered before, I think with time, we will be able to refine this estimate much more specifically.

MR. PELHAM: Thank you. Just to go back a little bit in terms of this 90 Vermonter number. That is on slide 16, I think, and as well as on slide 42.

What is your definition of a Vermonter?

MR. CATS-BARIL: Do I even attempt to define a Vermonter? You know, I have been here for 37 years. I know that not a lot of people consider me a Vermonter. Might have been with my accent from Charlotte here. So, you know, we consider them residents of Vermont, you know, right? That would be the definition of a Vermonter is someone that actually is a resident of the state.

MR. PELHAM: Thank you. I -- just as a side note -- the Chair of our Board because he comes from Rutland, I came from Arlington. He does not consider me a Vermonter. I'm from Massachusetts in

his mind.

The last question I have is on slide 36. And I note that kind of the way you did the math in terms of 424 LADCs, and then you have projection in the first year --

MR. BARBER: You're breaking up.

MR. PELHAM: Okay. Let me try again. So you reference on slide 36, 424 LADCs in Vermont, and that you in year 1 would be employing three of those, plus or minus; in year 3, six. And so the percentages that you derive are quite low. It's 7/10ths of 1 percent and 1.4 percent. But the actual incidents of those hires would probably be -- not be spread evenly across the entire state, and that they might have a much more localized impact on service providers that are in your same field that are, you know, more closely located to Stowe.

So I'm just wondering if you have a concern that in the more immediate area of Stowe that your ability to pay more would be detrimental to any of the specific organizations locally.

MR. CATS-BARIL: Right. Yeah. You know, again, we are thinking here of a zero sum game. You know, we think that we cannot attract more licensed alcohol and drug counselors to Vermont.

I am confident that if we have the type of facility that we want to, people will actually come to work here. They will come to Vermont. They will come to Stowe. You know, part of the reason that we decided to create this clinic in Stowe is that we do think that it's an attractive destination not only for patients but for people to work.

You know, this notion there is a -- only 424 counselors in the State of Vermont, and it's a zero sum game, and there will be no additions, I mean this is an area that we all know is getting worse; addiction that is, addiction treatment. I think people are looking for work and jobs. And this is an area where I can bet we will have more individuals coming into this area.

I haven't really done a census of where those counselors live and deliver services in the State of Vermont. I do believe that given the quality of what we are attempting to do, the quality of the staff that we are going to have, that people will actually move to be close to this job. We are going to pay well. We are going to make them proud of what they are doing. They are going to be associated with one of the premiere treatment centers in the country. I think people will drive from, you

know, from Bennington if need be to be associated with us. So, you know, being a professor here I have a little bit of trouble seeing how the work force is static; right? I think that there will be some dynamics here that will make the numbers that we are hiring really not particularly significant in establishing pressures within the state.

MR. PELHAM: Thank you for that. I just raised that because -- so that many of Vermont hospitals are running red ink significantly. And so these small, marginal impacts are of much more significance because they don't have cushions in their bottom line. And so I think one perspective would be that you're projecting a very -- at least by the second year -- and a very healthy relatively third year, and with net revenues that are in the black in an environment where healthcare providers in Vermont are in the red.

And it's just a thought that I want to keep in mind. That's the end of my questions.

MR. BARBER: Okay. So do you want to respond to that?

MR. CATS-BARIL: Well I mean I think the point is very well taken. And I understand it. And the, you know, the reason that we have this model

is precisely to avoid being in the red if we can.

So I understand the challenges and difficulties of the hospital setting in Vermont for sure. And our pay model is based on trying to avoid those pressures, those financial pressures. But the point is very well taken, and I hear you.

Thank you.

MR. BARBER: Okay. Next we are going to go to board member Holmes. Member Holmes, it looks like you're -- may be muted still.

MS. HOLMES: I'm on mute. Sorry. Now can you hear me?

MR. BARBER: Yes.

MS. HOLMES: Thank you very much. It's nice to meet you virtually.

MR. CATS-BARIL: Yes. Thank you.

MS. HOLMES: I'm going to start -- I think I'm going to try and be somewhat brief given we have had a lot of time and a lot of my questions have been asked already. But I wanted to focus on Vermont need a bit, which some my colleagues on the board have already addressed a little bit, but I want to take it from a different angle.

That focus really is whether this project meets Vermont's need. That's one large part

of the focus. There is one other ASAM 3.7 facility in Vermont that's available. So one of your comments, this would be a good addition to Vermont, a second facility, and you claimed earlier in the presentation you want to have a major impact locally.

When I look at your numbers that you gave, you know, the 9,634 that was on slide 16, those would be admitted patients 18 and above, and we look at your 18 percent of that number that needs residential treatment, which had been about 1,734 Vermonters that need help on an annual basis.

MR. CATS-BARIL: Yes.

MS. HOLMES: And you're building capacity for about a thousand; right? If you look at your three-year capacity, it's over a thousand, although you're only going to have 900 or so.

MR. CATS-BARIL: Yes.

MS. HOLMES: You're only taking 90 of the 1,734. So that's about 5 percent, roughly speaking, of the actual need in Vermont.

MR. CATS-BARIL: Right.

MS. HOLMES: Despite the fact that you're building capacity much more than that. I recognize that that's largely because of your pay model; right? Because of the self pay. As soon as

you add in Medicare, Medicaid, as a payor, that's not your business model, that eliminates a large fraction of the need in the state; is that right?

MR. CATS-BARIL: That is right. I just would like to make sure that when you say take, right? I mean we will take anybody that wants to pay. So the 90 is what we think is the floor; right? And it's based on the census data that we have. But it could be much more.

How much more, again, I don't think anybody really knows. But yes, what you said is absolutely true.

MS. HOLMES: You had put in there about 14 percent of patients admitted are either private insurance or cash. That means 85 percent are probably either uninsured, unable to pay, or on Medicare or on Medicaid, right? From your estimate.

MR. CATS-BARIL: Yes.

MS. HOLMES: Okay. And I understand the financial model that you've designed is to avoid the financial pressures, you know, by having self pay and pay up front. But I'm wondering if you considered externalities that you may be generating. And the way I'm thinking about it is you had talked about in the first year having about 15 percent of

the market share of self pay, up to by year 3 having 35 percent of the market share of self pay. And this was just in Vermont. So we are talking about just the Vermont self pay market.

MR. CATS-BARIL: Correct.

MS. HOLMES: Is that right?

MR. CATS-BARIL: That is correct.

MS. HOLMES: Okay. So my concern is that as you increase market share, there are other facilities in the state that rely on the self-pay population to cross subsidize the underpayment of our public payors.

MR. CATS-BARIL: That's not -- I think that's a statement that is not proven. What you just said is possibly true, but possibly not. We don't know how many people that actually are willing to pay, leave the state.

So your assumption that -- again, it's a zero sum game that I'm going to actually have all of the patients that self pay from other facilities come to Silver Pines may be true, but what we think we are doing really is providing something that the state doesn't have, and that the individuals in the state that currently go out of state will stay in state.

So it's not like I'm actually taking patients away from Brattleboro Retreat specifically. I am actually hoping to keep Vermonters from going out of state for the type of treatment that we are offering in state. So it's a net gain.

MS. HOLMES: And what evidence do you have that you will not be taking any patients from Brattleboro Retreat?

MR. CATS-BARIL: We have actually, again, the question is how many -- to answer your question directly, I have no evidence. Because Brattleboro Retreat really doesn't publish how many individuals are actually going for ASAM 3.7 treatment modalities. The numbers that they treat, may again, I don't know if they self pay, so the question that you're asking me we don't have data on, right? What I would need to know from the Brattleboro Retreat, and they don't publish this and don't share this data, is how many individuals are being treated as ASAM 3.7 are actually self paying.

MS. HOLMES: Right.

MR. CATS-BARIL: And that number, we may or may not obviously attract them. But again, the whole concept here is to bring individuals that are leaving the state and taking their dollars

elsewhere to keep them in Vermont.

MS. HOLMES: I guess this is the same line of questioning around your -- and this has been talked about a little bit before, but you referred to the creation, your words, of 55 well-paying jobs.

MR. CATS-BARIL: Yeah.

MS. HOLMES: And you know, I think that I understand your point that it may not be a zero sum game, and the labor force is dynamic, and there may be some out-of-state employees who are willing to come to Vermont to work at a high quality facility that's paying well. But there is also the possibility, and I think ADAP brings this up, that you could be depleting, you know, some of our much needed work force that's caring for the more vulnerable population, largely those in Medicaid and Medicare.

But I think there is a concern about that, and I hear what you say, and I hope that if this CON is approved you can bring in folks from other states. Certainly we need an increase in the work force in the State of Vermont. But there is a concern that you would be taking, you know, your -- you have 37 clinical providers; that's 4 providers, 12 nurses, and 4 counselors, and that combined group

of individuals will be serving 36 to 90 Vermonters.

My question would be if those even 20 providers were deployed in other Vermont addiction settings, could they serve more Vermonters and have more impact? Again, I know it's a hard question to answer. But I look at the number of clinical staff that you're going to have. I think about the provider-to-Vermonter ratio, and I think about it that way a little bit. And it concerns me, especially when we are getting, you know, letters from ADAP and the Department of Health that are concerned about the impact on the Vermont system.

MR. CATS-BARIL: Yeah. The question again is a very complex question that you're asking. This is a philosophical level; right? That is, whose responsibility is it to provide that kind of care? I mean it's hard to argue; right? That you want to keep salaries low so that you don't put pressure on the state. It is actually hard to argue from an economical development point of view that creating jobs, and good paying jobs, is bad for the state. In terms of actually providing jobs that serve the underserved, underprivileged, socially challenged, economically speaking population, whose responsibility is that? Right?

We have a model that is doing what I think, in addition to the environment in Vermont; we are not detracting. We are adding. Are there some needs that we are not addressing? Absolutely. I mean we are not trying to serve everybody in Vermont. We have made a choice. We think that we are going to deliver a service that is in great need in Vermont to maybe some very few individuals. But it's a need that they don't right now fulfill in Vermont. And the responsibility for taking care of a lot of other patients may fall on to someone else.

The notion that we are going to create some pressures by hiring 20 people, if I take the numbers that you mention which are the numbers in year 3, so this is not like it's going to happen like a switch from one day to the other, but it's going to happen over 36 months.

There is a lot of graduates of programs around the country, certainly around Vermont, certainly University of Vermont, that would be looking for jobs. And I hope that the state, and I hope that other entities in the state, will take the responsibility to develop jobs for those individuals. We need them to stay in Vermont. And, you know, the argument that we are going to create -- and yes, I'm

using that word because right now they don't exist, those jobs. I can hardly understand why that has a negative impact. I mean I think that if I hear what our Governor is saying, what we need is jobs. Good jobs. Jobs that actually address, you know, a very important need. So --

MS. HOLMES: I appreciate what you're saying. I think the issue is we are currently facing a work force shortage in the State of Vermont. So if we were not currently facing a work force storage in Vermont, it might be a different story. I hear what you're saying.

MR. CATS-BARIL: This is important because this is really economic policy here. So you mean that because we have a work force shortage, we shouldn't create new businesses? Are you saying that because we have a work force shortage in healthcare, we shouldn't come up with new treatments that could help people? I mean again, for me, this is thinking zero sum game.

If we believe in the ability of an economic system to grow, it will create jobs. It will create really great jobs. And you talk about externalities. For me the ability to create 55 very good paying jobs in a little town like Stowe, Vermont

where I live, I can tell you that that will have a huge impact on convenience stores, on gas stations, on grocery stores. I mean we are talking about making an impact not only on the addiction population here, but to add to the economic landscape. And this notion that we have a work force shortage, so please don't open anything else because we may actually create a negative result, you know, it's a hard argument for me to understand. I hear it, I understand it is a challenge. And I do think that this is public policy much more than, you know, a Certificate of Need for a new business.

MS. HOLMES: Well we just have to ensure that what we -- the decisions we make don't compromise access to other healthcare. So the line of questioning is around that.

I just want to ask you a little bit though, you talk about the cost of non Vermonters draining the emergency rooms and inpatient psych capacity would be less than the benefit of avoided ED visits that Vermonters would gain if they bought the treatment at the Silver Pines center facility.

MR. CATS-BARIL: Yes.

MS. HOLMES: I didn't really see an attempt to try and quantify that cost/benefit

analysis. My guess is that would be challenging. I just want to say that, you know, even 8 inpatients, psych, non-Vermonter needs, you know, 8 non Vermonters needing 8 beds in an inpatient psych facility seems small, but it's actually significant.

We have a huge issue with mental health boarders in our emergency rooms and not enough psych capacity in the state. It may seem like a small number, but I just want to articulate to you this is an area where we are really struggling in Vermont, and I'm concerned about exacerbating it.

MR. CATS-BARIL: I am fully aware of that. I want you to know that, again, I am extremely familiar with inpatient psychiatry treatment. I have, again, in my work from suicide worked with 3 of the best psychiatrists in the state, so I know the challenges that they face every day. I'm very much aware of that challenge.

I want you to know that the timing was not right. We have a letter of support from Dr. Toby Horne who is the director of inpatient psychiatric services at UVMMC, and Dr. Horne very specifically would be very -- I don't know, Mike, what the limitations protocol are here of adding information and so forth, but this letter came in at the

beginning of the week, and it was beyond the deadline of Friday when I needed to submit the presentation and documentation to the board. But in that letter, he actually supports the creation of an entity like Silver Pines for the reasons I was speaking of. And that is that, you're right, the cost effectiveness, the cost/benefit of how many people are you actually helping to avoid emergency department services is challenging. Toby is saying, hey, you know, I think the impact that you're going to have on the substance use disorder population is significant.

The only other thing I want to say, and again, you know, that goes to my research and other work that I do, so I need to quote just the sources in the literature, is that a dollar that is spent in detox environments, actually generates 12 dollars of savings in the emergency services down the road. You know, that's a number that has been used. So it's a number that, you know, I am actually quoting in the presentation. And again, I have not experience with that, but I am actually using that as a point of reference as to what the impact of our services will be.

MS. HOLMES: Okay. My last question is actually on the slide that you have up on the screen

now. Your chief medical officer. Can you just clarify addiction fellowship trained and/or board certified psychiatrist or primary care physician. I ask that because I know you had mentioned in the application that that's best practice is really integrate mental health services into the treatment. So it seems to me having a psychiatrist would be really important --

MR. CATS-BARIL: Yes.

MS. HOLMES: -- if you're going to be administering medications and/or could be a primary care physician. Seems like a big difference in primary care physician and a psychiatrist. Could you just clarify that for me?

MR. CATS-BARIL: Yeah. Again, let me just tell you what my preference is. Board certified psychiatrist with addiction fellowship. I mean that would be what we are going to be looking for and trying to recruit for. Again, we all just -- to your question -- to your previous question, this is Vermont. There aren't a lot of individuals that actually have that profile.

The key for me is the addiction fellowship is to have the specialty in addiction. There are many primary care physicians, there are

many family practices in this country that are dealing with addiction directly. And if there is a primary care physician that we will hire, would be someone that has extensive addiction training. We will then have a board certified psychiatrist on the staff. But maybe not as a chief medical officer. But ideally, right, I would like to have a board certified psychiatrist with addiction fellowship. That would be my ideal candidate.

MS. HOLMES: Okay. Thank you.

MR. CATS-BARIL: Thank you so much.

MR. BARBER: You asked about the procedure for submitting the letter of support. You can do that after the hearing, send that to Donna. We typically consider those as essentially public comments which -- so yeah, just send it to Donna after the hearing.

MR. CATS-BARIL: Thank you. I will do so. Thank you so much.

MR. BARBER: Mr. Chair, do you have questions?

You're on mute, if you're talking.

CHAIRMAN MULLIN: Okay. Can you hear me now?

MR. CATS-BARIL: Yes, I can.

CHAIRMAN MULLIN: Great. So it's -- like I started to say, it's always good to be last because my colleagues have focused on some real key areas that I had been trying to hone in on, especially as it relates to the impact on other facilities in Vermont and other work force, and also the financial conditions. So my questions will just be some tweaks around the edges of what you've already discussed previously.

And I want to start by saying I truly appreciate your confidence in this venture. If I were in your shoes, I would be probably a lot more trepid about moving forward under the current conditions. And also I think I would have a lot more fear of success.

But with that being said, first let's start with the financial end of it. Your monthly lease payment, is that gross or is that triple net?

MR. CATS-BARIL: Triple net.

CHAIRMAN MULLIN: And what confidence do you have moving forward that there won't be significant increase on the additional charges? So once -- I mean that is public record. Once listers in Stowe see how much money is being put into the facility, it's likely that there will be additional

assessment.

Have you calculated those type of assumptions into your projections?

MR. CATS-BARIL: So again, just to make sure that we all understand; right? I'm just a tenant. And the implications of change in property taxes, valuation of the property and so forth, will be absorbed by the developer. Right?

And I believe Gregg Beldock is on the line, so if you can address that directly for us, you know, we have a lease that actually sets our rent very specifically; right? We have a limit on the amount that they can increase that rent for the first three years.

So, you know, and Kevin, I appreciate your comments about the courage that it takes to start a venture. You know entrepreneurs are sometimes seen as foolish, but it is a business that I believe will sustain the projections that we have based on the need. There is no doubt to your comment that in this particular environment raising capital is challenging. There is absolutely no doubt in my mind, the mind of the people that I've spoken to, Kevin, that says that addiction will get worse because of the circumstances that we are going

through. So nothing in the environment since November when we put together this application has actually changed in a way that tells me that the assumptions that we have made on demand for the service has in any way diminished.

In all the conversations with professionals that I have had through this four months, it's been a confirmation that the need is there. And so I hope that we are right, and it certainly in this COVID-19 world has made financing -- private financing -- private equity financing more challenging, I think all the assumptions on demand have been actually strengthened.

CHAIRMAN MULLIN: Okay. So there's been a lot of questions that focused on the impact on the Brattleboro Retreat. I'm more concerned about also the impact it could have on other facilities. As you know, I'm a former legislator, and a lot of times I had to go to the math to try to make sure that there was assistance to programs like Serenity House and other recovery programs in the area that I represented. And I'm not so sure that this is strictly a Silver Pines versus Brattleboro Retreat as far as the type of patients. I think people enter into recovery programs for a number of reasons, and

most importantly based on what they think their personal success rate will be.

So I'm curious if you've really given thought, you know, you spent a lot of time talking about do well but do good. And I just want to make sure that, you know, 1 percent for recovery is great. It would be greater if it was 1 percent of revenues, not 1 percent of profits, because as you know, profits are an elusive target at times. But with that being said, are you confident that you're really not impacting existing programs in the State of Vermont?

MR. CATS-BARIL: We are offering such a different program. You know, I do believe that we are offering something that is not being offered right now. When you talk about courage, Kevin, to start this venture, and again a lot of people on this board have started ventures of their own, I know. You need to find service, a product that has not been offered. Right? The chances of success are always, I think, in my experience as an entrepreneur based on a need that is not being fulfilled.

And I believe that we are offering in Silver Pines an addition, and this is, you know, when you actually mentioned the word against Brattleboro

Retreat, you know, I really don't think -- I don't see the Brattleboro Retreat, to be very fair, as my competitor. I don't want to beat Brattleboro Retreat. Because I think we are looking for different types of patients. And, you know, our service is going to be very different from anything else that is offered in Vermont.

So, you know, I see it as additive. Some of the comments that we have heard and that we have had is that we are detracting, that we are going to take away from, and I cannot tell you how from where I started this vision and this venture was about adding. It was an additive to Vermont. And you know, you know better the state, I will -- you know, in no way I will question that you have a much greater understanding of the needs of some of the Serenity House, Turning Point, you know. I really don't know the financial status and state of those organizations. But I do think that it will help.

And look, you know, you mentioned that 1 percent is not enough. With success comes generosity. And, you know, right now what I can afford is to think about 1 percent. If we are really successful, and we are more successful, 1 percent may not be the limit. I am actually making a commitment,

and again I'm under oath, and you know, that I will at least provide 1 percent. And I can assure you, Kevin, that there will be no hanky-panky accounting wise. One percent profit will be one percent profit.

And you don't know me, but I can tell you that for me, a lot of what is driving the creation of this venture is to feel that I'm contributing. And that will be -- we will start with 1 percent and then you and I can talk maybe 3 years from now, and you can convince me to give more, and I think it will be -- my arm will be easy to twist.

CHAIRMAN MULLIN: I'll hold you to that. One other question. A lot of concern was on post discharge in the follow up. And there wasn't a lot of questioning on that.

So I just want to -- what assurances can you give us that this isn't a scenario where somebody comes in, they put their money down, they get their 10 days, and then they are kind of left hanging as it goes out in the future. I'm curious what type of post-discharge plans would you have as far as communications with family, providers, et cetera, that makes this work on the long-term.

MR. CATS-BARIL: Yeah. You know, again, this is obvious, but let me just state it

explicitly, is that we are going to live or die by our medical outcomes. You know, we are going to live or die because we are charging a lot of money for a service based on effectiveness of our program. And this discharge planning and placing patients is key, it's a key metric of success for us.

So, you know, to -- we have been asking the questions of how many hours are we going to be spending on post discharge and so forth. I can tell you that it's a critical component of reputation. For us to be able to attract new patients, I cannot make a living attracting a patient, taking their money, and then not succeeding, right? Because that is a community where that kind of reputation gets known very, very quickly, right?

We are going to make the placement, the post discharge part of our treatment, Kevin, it's a critical component of the model that we have. I wish I could, again, give the board and all of you data. I hope we are going to have this conversation in a couple of years, but I expect a hundred percent placement in a program that will actually support what we did in the detox part of the treatment and make us look very good.

A part of what we think we are doing

here, we are preparing patients for greater success at rehab. And the only way that we are going to prove this is by actually placing our patients in environments where they will get the same type of treatment that we are delivering, you know, very effective. So long answer to your question, placement is key for our success. It's going to be a priority for us from the beginning.

CHAIRMAN MULLIN: Thank you. That's all the questions that I had at this time. I'll turn it back to Mike.

MR. BARBER: Thank you, Kevin.

MR. CATS-BARIL: Thank you, Kevin.

MR. BARBER: Thank you. We are running a little late but did want to give board members a quick opportunity to ask any follow-up questions that may have been spurred by other board questions. So if any board member has additional questions, please identify yourselves, and make it quick.

(No response).

MR. BARBER: Okay. I don't hear anything. So I'm going to assume there are no questions, and we will proceed to public comment portion of the hearing. So same deal for public comments. If you wish to make a comment, please

begin by stating your name, if you are here on behalf of an organization, what that organization is. And then provide your comment.

(No response).

MR. BARBER: Okay. I don't hear anyone. So like I said, Dr., if you want to submit that letter of support after the hearing to Donna. And unless there is anything else, I think we will close the hearing. And I'll turn it back over to Kevin for -- to close out the meeting.

CHAIRMAN MULLIN: Thank you, Mike. And thank you, Dr. And for the board, I know that we have a board meeting coming up in less than an hour. So at this point unless someone has anything that needs to be discussed, we will convene this hearing, and I'll talk to all the board members again at 1 o'clock.

Thank you, Mike, for your excellent work as the hearing officer, and thank you, Dr., for your very good presentation and answering a lot of the questions that we have had.

MR. CATS-BARIL: Thank you, Mr. Chairman. Maureen, good seeing you. It has been awhile.

MS. USIFER: Good to see you.

MR. CATS-BARIL: And Donna, I just want to again, please, for all of you, you know what fantastic staff you have, but I cannot tell you how helpful Donna has been throughout the process, and I want to thank her publicly. She's been just terrific. So thank you so much for the opportunity.

CHAIRMAN MULLIN: You're welcome. See everybody at 1. Bye bye.

(Whereupon, the proceeding was adjourned at 12:08 p.m.)

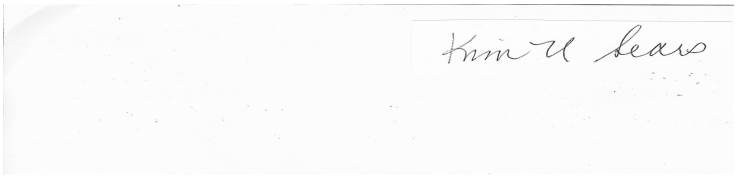
C E R T I F I C A T E

I, Kim U. Sears, do hereby certify that I recorded by stenographic means the hearing re: Silver Pines at Stowe, by Skype, on March 25, 2020, beginning at 9:30 a.m.

I further certify that the foregoing testimony was taken by me stenographically and thereafter reduced to typewriting and the foregoing 98 pages are a transcript of the stenograph notes taken by me of the evidence and the proceedings to the best of my ability.

I further certify that I am not related to any of the parties thereto or their counsel, and I am in no way interested in the outcome of said cause.

Dated at Williston, Vermont, this 30th day of March, 2020.



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