

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

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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

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Public Comment:
None

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

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

11 MR. BARBER: I'll handle that.

12 CHAIRMAN MULLIN: Thank you.

13 (Telephone noise).

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

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

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

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

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

16 CHAIRMAN MULLIN: Everything is fine on
17 my end.

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

20 MS. HOLMES: Yes, I can.

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

23 MS. LUNGE: Yes. Thank you.

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

1 MS. USIFER: Yes, I can.

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

4 MR. PELHAM: I can.

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

9 Dr. Cats-Baril, can you hear okay?

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

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

16 THE COURT REPORTER: I can, thank you.

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

1 organization. So I see Amerin Aborjaily.

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

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

7 Alena Berube?

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

10 MR. BARBER: Abigail Connolly?

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

13 MR. BARBER: Donna Jerry?

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

16 MR. BARBER: Jessica Mendizabal.

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

19 MR. BARBER: Thanks. Janeen Morrison.

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

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

1 8646.

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

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

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

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

19 MR. MOSES: No problem.

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

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

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

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

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

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

7 MR. BARBER: Got it. Thank you.

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

10 MR. BARBER: 9314.

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

13 MR. BARBER: And last four 7000.

14 MR. BELDOCK: Gregg Beldock from
15 Bullrock Corporation also.

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

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

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

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

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

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

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

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

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

5 MR. BARBER: I'm getting there.

6 MS. LUNGE: Okay.

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

9 THE WITNESS: Can you see it?

10 MR. BARBER: I do. Thank you.

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1 WILLIAM CATS-BARIL

2 having been duly sworn, testified

3 as follows:

4 THE WITNESS: I do.

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

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

10 CHAIRMAN MULLIN: We can.

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

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

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

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

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

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

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

25 And one of the reasons that we suggest

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

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

17 The consequences, as you know, in terms
18 of human life is staggering. If we add individuals
19 that die from drug overdoses to the people that die
20 from alcohol-related causes, we are looking at almost
21 160,000 people in this country. And Vermont actually
22 does contribute to that total in terms of number of
23 deaths per hundred thousand inhabitants of Vermont is
24 on the high end of the spectrum. And you can see
25 from this slide I announce like 8, showing the trend

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

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

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

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

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

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

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

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

1 have a systematic tracking of medical outcomes.

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

9 The idea is to have eventually a
10 national reputation. Again, we are going to target
11 the northeast, all the way to the midwest; Chicago
12 being a two-hour direct flight to Burlington,
13 Vermont. And the southern part of Quebec and
14 Ontario. Specifically and intensively within that
15 800-mile circle will be addressing a 300-mile area
16 that contains Montreal, Boston and New York City and
17 Albany. We are going to be focusing on that area,
18 and we are, as part of our program, providing
19 transportation. That is, we are going to provide
20 patients and their families, for us, to go and get
21 the patient back into the clinic if that's what they
22 need.

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

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

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

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

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

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

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

12 I am moving now to slide number 16
13 which shows you the expected admissions. We are
14 expecting a total of 365 admissions in year one. The
15 number in parenthesis, 31 percent, represents the
16 percentage of total capacity. So we are planning to
17 be basically a third full in year 1. And as you can
18 see, year 2 and year 3 our capacity goes from 31
19 percent in year 1 to 79 percent in year 3. And we
20 expect the number of Vermont residents that will be
21 treated at the facility to go from 39 in year one to
22 90.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 is -- I would really suggest -- unacceptable.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 line with the market in Vermont.

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

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

25 We will be connecting, I am convinced,

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

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

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

1 Certificate of Need.

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

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

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

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

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

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

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

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

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

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

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

1 the clinic, or to UVMHC where they may actually need
2 inpatient psychiatric care.

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

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

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

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

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

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

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

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

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

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

3 And in reviewing your patient financial
4 policy form which was page 23 in response to question
5 3, it does look like your plan is for folks to
6 individually ask for reimbursement from their
7 insurance company after paying with whatever
8 documentation you provide. But I also noted in some
9 of your other materials where you were explaining
10 what would be included in the up-front cost versus
11 what would be billed separately, that you had
12 indicated that labs, for example, might be billed to
13 insurance.

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

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

25 MS. LUNGE: Okay. And so could you

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

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

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

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

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

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

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

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

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

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

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

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

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

1 opposed to being open to all payors.

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

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

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

25 MS. LUNGE: Thank you. My next

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

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

18 Does that answer your question?

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

22 MR. CATS-BARIL: Thank you.

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

25 MR. CATS-BARIL: Yeah.

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

3 MR. CATS-BARIL: Yes.

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

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

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

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

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

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

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

1 MS. LUNGE: Okay. Thank you. I'm good
2 for now, Mike. I might have one follow-up question
3 later. But I suspect somebody else will ask it. So
4 --

5 MR. BARBER: Okay. Thank you.

6 MR. CATS-BARIL: Thank you.

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

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

12 MR. CATS-BARIL: Yes. Yes.

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

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

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

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

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

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

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

1 Medicaid, Medicare or commercial?

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

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

20 MR. CATS-BARIL: Yes.

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

1 or --

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

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

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

1 about whether you'll achieve your revenues that
2 you're projecting which is, you know, how many people
3 for a detox 7 to 10-day type facility pay self pay
4 knowing that right now the current model, and I know
5 you're changing the model a little bit, but the
6 current model may be that they would go to that type
7 of facility, you know, at a Betty Ford or something,
8 and then go into, you know, continue on in that
9 facility for another 30, 60, 90 days. And so I'm not
10 sure how many stand-alone detox are not affiliated
11 with something like a Betty Ford or a Hazelton, you
12 know, how many of those exist. Because for many
13 families, this might be the first expense of a much
14 bigger expense if they are doing it, you know, if
15 they are looking at it as a detox and then moving
16 into maybe a 30-day or 60 days which could be another
17 30 or \$45,000 for somebody --

18 MR. CATS-BARIL: Yes.

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

22 MR. CATS-BARIL: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 MS. USIFER: Okay.

25 MR. CATS-BARIL: -- the one that

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

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

5 MR. CATS-BARIL: We are paying. And
6 this is what I think is important; right? That the
7 2.6 million is really -- the proceeds are going to be
8 used all for operations. There is absolutely not a
9 single cent that is going to the partners of this
10 LLC. So the money goes for rent, it goes for
11 salaries to start the operations, and we have, as you
12 saw from our projections, we need around 400 some
13 thousand dollars as a cushion in the first four
14 months of operations.

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

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

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

23 MR. MOSES: I'm here. Yeah.

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

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

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

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

12 MR. BARBER: All right.
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1 GREGG BELDOCK

2 Having been duly sworn, testified
3 as follows:

4 MR. BELDOCK: I do.

5 MR. BARBER: Thank you.

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

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

25 MR. BELDOCK: In addition to the

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

3 MS. USIFER: Pardon?

4 MR. BELDOCK: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 MR. CATS-BARIL: Thank you.

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

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

1 slide 16. You know, where there is the top side
2 numbers of -- in Vermont of 54,000 people older than
3 12 with a substance abuse disorder and only 13
4 percent of them in treatment.

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

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

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

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

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

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

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

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

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

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

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

1 yes. You're absolutely correct.

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

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

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

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

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

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

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

24 MR. PELHAM: Thank you for that.

25 MR. BELDOCK: This is Gregg Beldock.

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

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

12 MR. CATS-BARIL: That's a very good
13 question. I mean again, from my lips to the ears of
14 God, as they say, if we are successful in the way
15 that we want to be successful, we are going to -- 1
16 percent is going to be -- to represent in terms of
17 profitability -- is going to represent around 60 to
18 70 thousand dollars.

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

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

1 will be to everybody's benefit here.

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

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

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

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

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

3 And I just want to make the point that
4 not only were there time amounts on that chart, page
5 5, but dollar amounts. And the dollar amount was
6 \$131 per patient, you know, for the entire year after
7 discharge. And I just -- so it's interesting to look
8 at time, but it's also, you know, what the
9 expenditure is, the benefit is associated with the
10 time.

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

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

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

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

7 So I do want to put the caveat that the
8 dollar amount was really based on an average salary
9 of an aftercare specialist, but it's most likely
10 undercounting the salary, for example, of the
11 clinical and executive directors that may get involved.
12 Maybe the direct care staff and the counselors will
13 get involved.

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

25 I believe that because this is such a

1 high priority for the reputation of Silver Pines, for
2 the success of Silver Pines, for the effectiveness of
3 our treatment, that it's basically a floor. \$130 or
4 5 hours per patient is maybe the minimum amount that
5 we are going to spend, but it's a good estimate.

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

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

13 What is your definition of a Vermonter?

14 MR. CATS-BARIL: Do I even attempt to
15 define a Vermonter? You know, I have been here for
16 37 years. I know that not a lot of people consider
17 me a Vermonter. Might have been with my accent from
18 Charlotte here. So, you know, we consider them
19 residents of Vermont, you know, right? That would be
20 the definition of a Vermonter is someone that
21 actually is a resident of the state.

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

1 his mind.

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

6 MR. BARBER: You're breaking up.

7 MR. PELHAM: Okay. Let me try again.
8 So you reference on slide 36, 424 LADCs in Vermont,
9 and that you in year 1 would be employing three of
10 those, plus or minus; in year 3, six. And so the
11 percentages that you derive are quite low. It's
12 7/10ths of 1 percent and 1.4 percent. But the actual
13 incidents of those hires would probably be -- not be
14 spread evenly across the entire state, and that they
15 might have a much more localized impact on service
16 providers that are in your same field that are, you
17 know, more closely located to Stowe.

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

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

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

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

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

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

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

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

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

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

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

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

7 Thank you.

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

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

13 MR. BARBER: Yes.

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

16 MR. CATS-BARIL: Yes. Thank you.

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

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

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

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

12 MR. CATS-BARIL: Yes.

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

17 MR. CATS-BARIL: Yes.

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

21 MR. CATS-BARIL: Right.

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

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

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

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

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

18 MR. CATS-BARIL: Yes.

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

1 the market share of self pay, up to by year 3 having
2 35 percent of the market share of self pay. And this
3 was just in Vermont. So we are talking about just
4 the Vermont self pay market.

5 MR. CATS-BARIL: Correct.

6 MS. HOLMES: Is that right?

7 MR. CATS-BARIL: That is correct.

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

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

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

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

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

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

21 MS. HOLMES: Right.

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

1 elsewhere to keep them in Vermont.

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

6 MR. CATS-BARIL: Yeah.

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

18 But I think there is a concern about
19 that, and I hear what you say, and I hope that if
20 this CON is approved you can bring in folks from
21 other states. Certainly we need an increase in the
22 work force in the State of Vermont. But there is a
23 concern that you would be taking, you know, your --
24 you have 37 clinical providers; that's 4 providers,
25 12 nurses, and 4 counselors, and that combined group

1 of individuals will be serving 36 to 90 Vermonters.

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

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

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

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

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

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

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

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

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

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

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

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

23 MR. CATS-BARIL: Yes.

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

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

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

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

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

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

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

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

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

9 MR. CATS-BARIL: Yes.

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

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

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

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

10 MS. HOLMES: Okay. Thank you.

11 MR. CATS-BARIL: Thank you so much.

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

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

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

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

23 CHAIRMAN MULLIN: Okay. Can you hear
24 me now?

25 MR. CATS-BARIL: Yes, I can.

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

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

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

19 MR. CATS-BARIL: Triple net.

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

1 assessment.

2 Have you calculated those type of
3 assumptions into your projections?

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

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

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

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

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

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

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

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

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

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

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

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

20 And look, you know, you mentioned that
21 1 percent is not enough. With success comes
22 generosity. And, you know, right now what I can
23 afford is to think about 1 percent. If we are really
24 successful, and we are more successful, 1 percent may
25 not be the limit. I am actually making a commitment,

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

5 And you don't know me, but I can tell
6 you that for me, a lot of what is driving the
7 creation of this venture is to feel that I'm
8 contributing. And that will be -- we will start with
9 1 percent and then you and I can talk maybe 3 years
10 from now, and you can convince me to give more, and I
11 think it will be -- my arm will be easy to twist.

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

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

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

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

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

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

25 A part of what we think we are doing

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

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

12 MR. BARBER: Thank you, Kevin.

13 MR. CATS-BARIL: Thank you, Kevin.

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

20 (No response).

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

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

4 (No response).

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

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

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

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

25 MS. USIFER: Good to see you.

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

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

9 (Whereupon, the proceeding was
10 adjourned at 12:08 p.m.)
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C E R T I F I C A T E

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2
3 I, Kim U. Sears, do hereby certify that I
4 recorded by stenographic means the hearing re: Silver
5 Pines at Stowe, by Skype, on March 25, 2020, beginning at
6 9:30 a.m.

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

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

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

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