CERTIFICATE OF NEED APPLICATION

SILVER PINES

DEVELOPMENT OF A MEDICALLY SUPERVISED WITHDRAWAL TREATMENT CENTER FOR INDIVIDUALS WITH SUBSTANCE USE DISORDER IN STOWE, VT

Docket No: GMCB-016-19con

November 5, 2019

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Acronyms

ACT	Acceptance and Commitment Therapy
ADAP	Alcohol and Drug Abuse Programs
ASAM	American Society of Addiction Medicine
AUD	Alcohol Use Disorder
BCBS	Blue Cross Blue Shield
CARF	Commission on Accreditation of Rehabilitation Facilities
CBT	Cognitive Behavioral Therapy
CDC	Centers for Disease Control and Prevention
DBT	Dialectic Behavioral Therapy
DMH	Vermont Department of Mental Health
DSM	Diagnostic and Statistical Manual of Mental Disorders
ED	Emergency Department
EFT	Emotional Freedom Techniques
EHR	Electronic Health Record
EMDR	Eye Movement Desensitization and Reprocessing
GMCB	Green Mountain Care Board
HRAP	Health Resource Allocation Plan
IHI	Institute of Healthcare Improvement
LADC	Licensed Alcohol and Drug Counselor
MAT	Medication-Assisted Treatment
MBSR	Mindfulness-Based Stress Reduction
MET	Motivational Enhancement Therapy
MMPI	Minnesota Multiphasic Personality Inventory
NAHA	North American Hockey Academy
PTSD	Post-Traumatic Stress Disorder
SAMHSA	Substance Abuse and Mental Health Services Administration
SERAS™	Systematic Expert Risk Assessment for Suicide™
SUD	Substance Use Disorder
TIC	Trauma-Informed Care
WRAP®	Wellness Recovery Action Plan®

Project Overview

Silver Pines will be a medically supervised withdrawal and short-term residential treatment center for individuals with substance use disorders (SUDs). It will offer treatment at American Society of Addiction Medicine (ASAM) Level 3.7 and provide 24-hour medical supervision and care. Our highly trained and experienced team will assist individuals in safely discontinuing the use of substances, preparing for treatment in a community-based setting, and beginning their journey of recovery.

Silver Pines will have a long-term lease on the property, which is be located at 3430 Mountain Road in Stowe, VT.

Objectives

Our vision is for Silver Pines to become one of the premier facilities in the country offering residential medically supervised withdrawal for multiple SUDs by providing innovative, customized, and compassionate care. Our mission is to deliver the most effective, evidence-based, data-informed addiction treatment with dignity and empathy. Our integrated treatment includes counseling, medical care, screening, comprehensive aftercare coordination and outcomes assessment. Our commitment is to continuously improve our clinical practices by analyzing treatment outcomes and optimizing our care delivery based on the evidence.

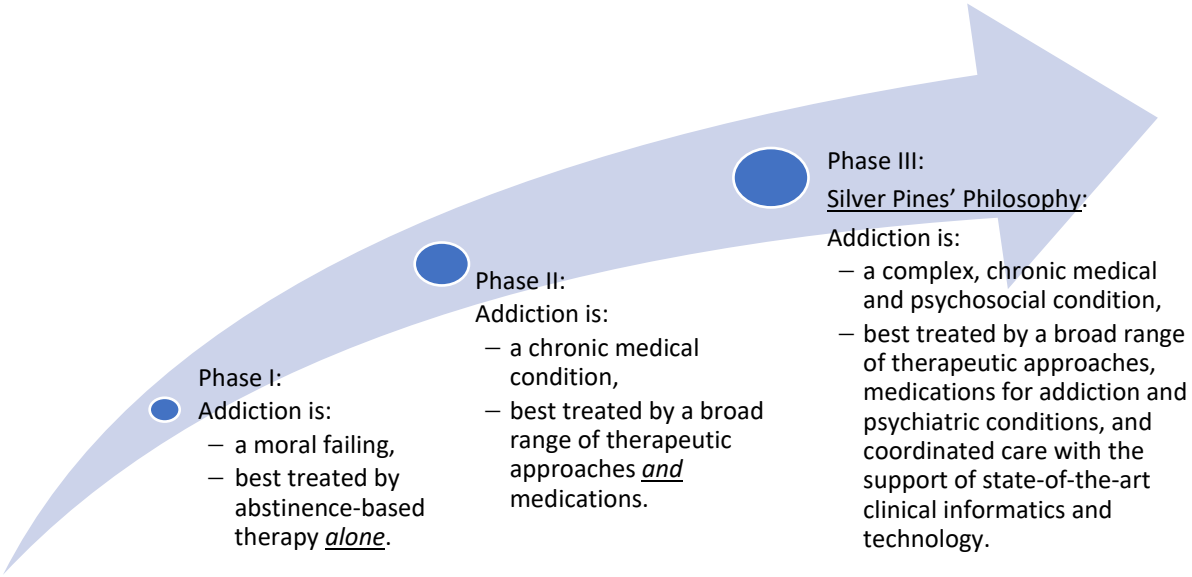
Our treatment includes:

- Comprehensive diagnostic assessment of substance use, co-occurring mental health disorders and appropriate ASAM levels of care;
- Individualized treatment planning based on a proprietary, neural-network algorithm;
- Safe medically supervised withdrawal for individuals with alcohol, opioid, sedative, and other SUDs;
- Evidenced-based treatment with the appropriate psychotropic medication regimen for co-occurring conditions;
- Individual, couples, family, and group therapy;
- Safe and respectful therapeutic environment that is conducive to recovery;
- Comprehensive aftercare coordination; and,
- Proactive, real-time outreach services post discharge through the use of proprietary technologies and processes.

Context

The treatment of addiction has evolved over the past several decades. As illustrated in Figure 1 on the following page, the first phase was comprised of an abstinence-centered model, where the use of prescribed medications was discouraged. This phase was followed by great progress in medication-assisted treatment (MAT) that led to improved efficacy and increased hope for individuals. Despite these advancements, we are currently in the midst of an addiction epidemic with significant rates of morbidity and mortality. One of the contributing factors is that treatment is often delivered in a fragmented, “one-size-fits-all” manner with limited ability to customize it at the highly specific level for individuals on a real-time basis.

Figure 1 - Phases of Substance Use Treatment

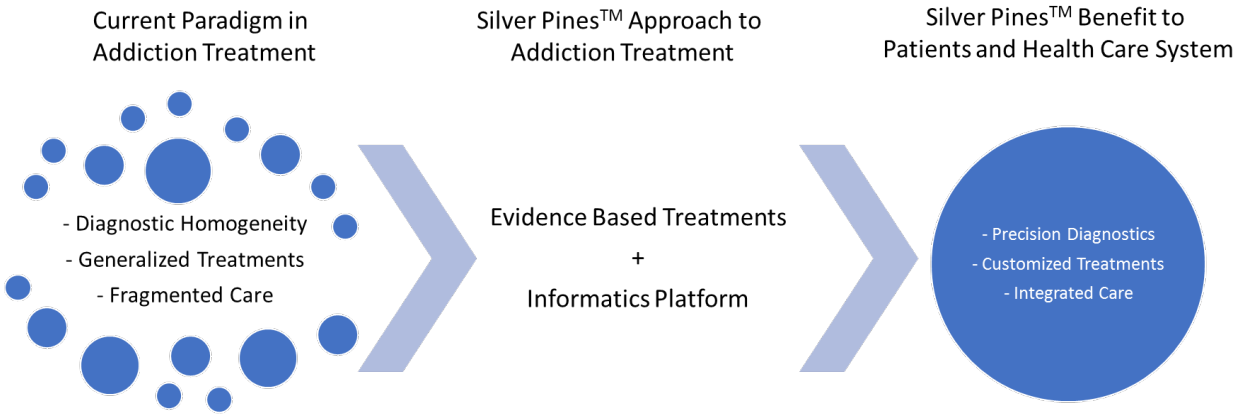


Approach

Silver Pines' innovative, comprehensive, coordinated, and evidence-based approach is the next step in the evolution of treatment for SUDs. We propose to deliver the best quality care, by the best trained professionals, and offer one of the highest clinical staff-to-patient ratios in the country. A fundamental feature of our approach is delivering highly customized treatment. Our proprietary neural network-based algorithms, using machine-learning principles, will assign every individual a score by aggregating clinically relevant data points and, based on that score, match a given individual to the most efficacious treatment. Our team will be comprised of highly experienced addiction professionals and will have world-class expertise in outcomes assessment and program evaluation. We will be analyzing data on a continual basis and will iterate our treatment based on what works best.

The current paradigm in addiction treatment leads to variable results with frequent relapses. Our innovative model, illustrated in Figure 2, involves an integrated and customized approach, which addresses medical stabilization, treatment optimization, and ongoing post-discharge support and follow-up. This care will be delivered by a highly experienced team and lead to better outcomes in terms of increased abstinence and decreased relapse rates. This will, in turn, yield cost savings for the healthcare system at large with decreases in downstream adverse events, potentially fewer emergency department visits, decreased inpatient admissions and improved overall public health. We believe our innovative approach is greatly needed for individuals and their loved ones who suffer deeply, often irreparably, from this pernicious condition.

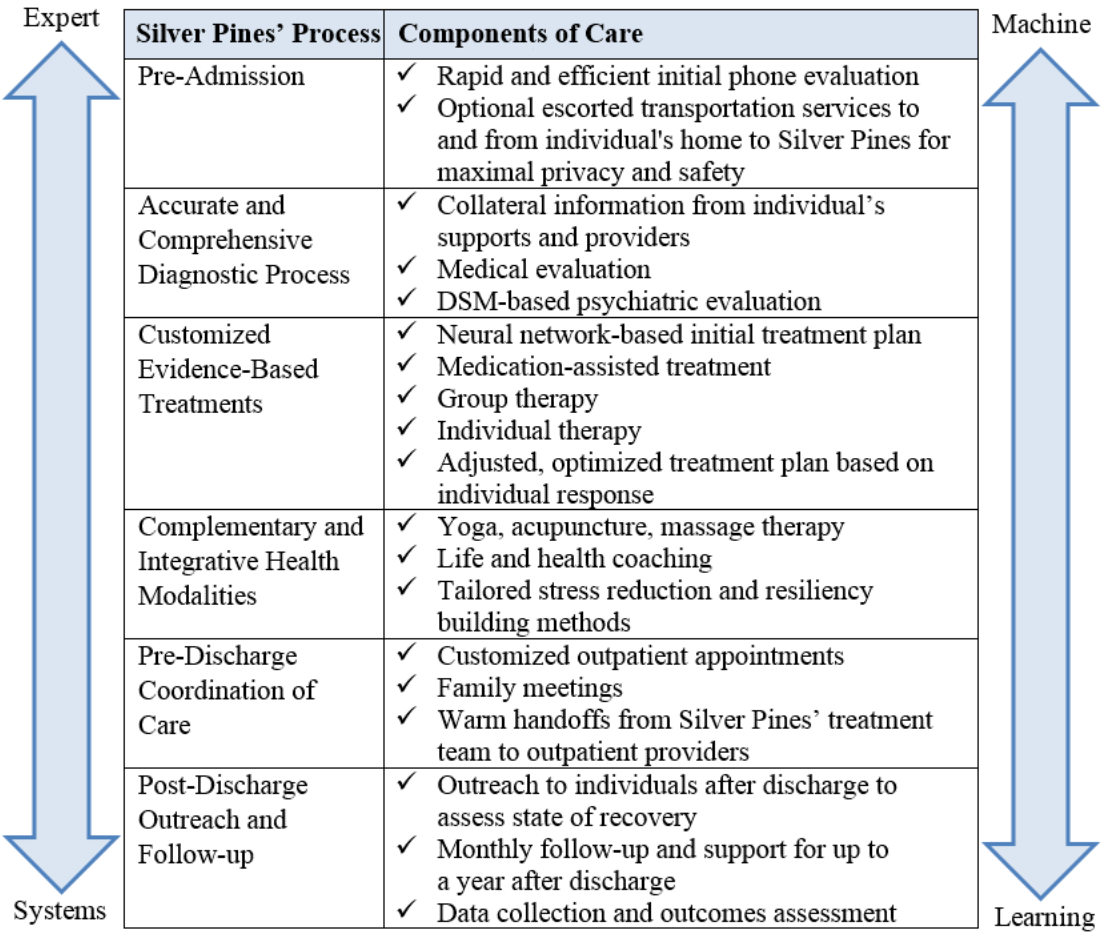
Figure 2 - Silver Pines' Approach and Benefits



As shown in Table 1 on the following page, the first step in our process is a customized phone intake. The intake is then triaged through the clinical and medical teams, who will begin to tailor the treatment approach so that when the individual enters treatment, they can work with the providers to further develop and revise the treatment plan. From that point, the treatment plan will be frequently modified by the clinical and medical team, allowing for the individual to receive the highest quality of care on a daily basis to optimize the treatment outcome for the individual.

In addition, each individual at Silver Pines will sign releases of information for external providers and individuals identified as key members of the psychosocial support group as part of their post-discharge continuing care plan. This will allow the team at Silver Pines to obtain collateral data and outcomes of treatment to augment the individual's self-report; this is important, as it offers an additional data set. This strong emphasis on data and outcomes assessment will allow Silver Pines to continue to adapt to the treatment needs of individuals with SUDs.

Table 1 - Overview of the Silver Pines' Process



Silver Pines' Process	Components of Care
Pre-Admission	✓ Rapid and efficient initial phone evaluation ✓ Optional escorted transportation services to and from individual's home to Silver Pines for maximal privacy and safety
Accurate and Comprehensive Diagnostic Process	✓ Collateral information from individual's supports and providers ✓ Medical evaluation ✓ DSM-based psychiatric evaluation
Customized Evidence-Based Treatments	✓ Neural network-based initial treatment plan ✓ Medication-assisted treatment ✓ Group therapy ✓ Individual therapy ✓ Adjusted, optimized treatment plan based on individual response
Complementary and Integrative Health Modalities	✓ Yoga, acupuncture, massage therapy ✓ Life and health coaching ✓ Tailored stress reduction and resiliency building methods
Pre-Discharge Coordination of Care	✓ Customized outpatient appointments ✓ Family meetings ✓ Warm handoffs from Silver Pines' treatment team to outpatient providers
Post-Discharge Outreach and Follow-up	✓ Outreach to individuals after discharge to assess state of recovery ✓ Monthly follow-up and support for up to a year after discharge ✓ Data collection and outcomes assessment

Case Study

The case study in Table 2 illustrates the key differences between traditional treatment approaches, which are too often fragmented, and the Silver Pines' model.

AB is 55-year-old female attorney who had been missing work frequently. She was diagnosed with alcohol use disorder by her PCP however had continued to drink despite treatment interventions.

Table 2 - Case Study

Dimension	**Silver Pines**	**Previous Treatments**
Brief History	She was referred to Silver Pines after she was discovered to be inebriated at work.	AB was discharged from the ED after being treated at the hospital for acute withdrawals. She attended several residential programs after stepping down from the hospital but relapsed shortly after discharge.
Accurate Diagnosis and Psychosocial Stressors	• Alcohol Use Disorder (AUD), Severe • Post-Traumatic Stress Disorder (PTSD) • MMPI: Diagnosed an introverted personality • Significant credit card debit, which is source of deep shame	• Alcohol Use Disorder (AUD) but no additional DSM specifiers • No diagnostic clarification re: PTSD • No detailed exploration of psychosocial stressors
Comprehensive Coordinated Treatment	• Comprehensive Treatment (medical/ psychiatric/psychological) at one location, rather than the split, fragmented care she received after being discharged from the hospital • Withdrawal severity assessed using Clinical Institute Withdrawal Assessment for Alcohol, revised (CIWA-Ar) • Added FDA-approved medications for AUD, severe. Benzodiazepines were used to control psychomotor agitation and prevent progression to more severe withdrawal. Supportive care, including intravenous (IV) fluids, nutritional supplementation, and frequent clinical reassessment including vital signs • The length of treatment allowed for an assessment of side effects, thus she was switched from acamprosate to naltrexone • Medication trial for depression. Switched SSRI after AB reported side effects. Dose increased to therapeutic level. Started prazosin for PTSD. Was able to articulate that she drank to manage her feelings and numb shame.	• Previous residential treatment was 12-Step oriented; no medications started for AUD • No specialist addiction trained physicians • Did not have medication trials, adjustment or optimization • Did not receive exposure to EMDR • Therapeutic treatment was mostly group-oriented. AB did not engage in these sessions as she was introverted by nature and felt that her trauma would be re-triggered in a group setting

Dimension	Silver Pines	Previous Treatments
	• Insight-oriented therapy: allowed her to establish a therapeutic alliance, received extensive psychoeducation about PTSD • Cognitive behavioral therapy (CBT): offered her practical coping skills to manage anxiety • Amenable to individual trauma-informed care (TIC) and introduction to Eye Movement Desensitization and Reprocessing (EMDR) • Experienced the benefits of complementary and integrative health modalities to augment traditional allopathic medicine • Coaching for managing credit card debt and facilitated call to financial planner	
Coordination of Care	• Family meeting was held and supports were identified • Psychoeducation provided to AB and family • Family attended Al-Anon meeting • Outreach to therapists and intensive outpatient treatment program in area of her residence • Comprehensive Wellness Recovery Action Plan® developed • Follow-up, including self-report, urine drug screens and interview with outpatient providers, after discharge using proprietary technology	• Discharged with brochure for local resources • Minimal family outreach or involvement • Minimal support provided for confirming outpatient appointments • Minimal follow-up efforts

Explanation of Need

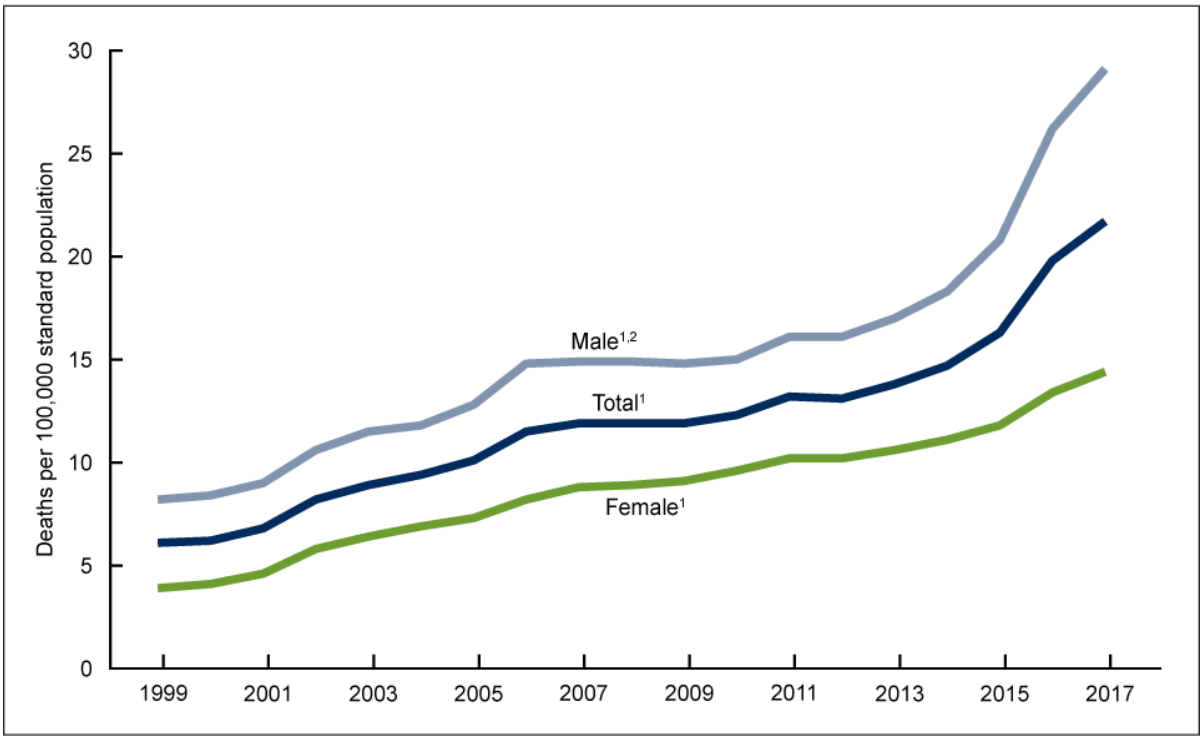
Our nation is in the midst of a record number of deaths due to drug overdoses. In 2017 alone, more than 70,200 Americans died from drug overdoses[1] and an estimated 88,000 people die annually from alcohol-related causes, which makes alcohol the third leading cause of preventable death in the United States.[2] Based on official statistics from the U.S. Centers for Disease Control and Prevention (CDC), there has been a significant increase in overdose rates in the United States in recent years, particularly from opioids. As Figure 3 shows, since the late 1990s, overdose rates have more than tripled.[3]

[1] National Institute on Drug Abuse. (2019, January 29). Overdose Death Rates. Retrieved from https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates.

[2] Centers for Disease Control and Prevention (CDC). (2013) Alcohol and Public Health: Alcohol-Related Disease Impact (ARDI). Average for United States 2006–2010 Alcohol-Attributable Deaths Due to Excessive Alcohol Use. Retrieved from https://nccd.cdc.gov/DPH_ARDI/Default/Report.aspx?T=AAM&P=f6d7eda7-036e-4553-9968-9b17ffad620e&R=d7a9b303-48e9-4440-bf47-070a4827e1fd&M=8E1C5233-5640-4EE8-9247-1ECA7DA325B9&F=&D.

[3] Hedegaard H, Miniño AM, Warner M. Drug overdose deaths in the United States, 1999–2017. NCHS Data Brief, no 329. Hyattsville, MD: National Center for Health Statistics. 2018.

Figure 3 – Age-Adjusted Drug Overdose Death Rates: United States, 1999-2017

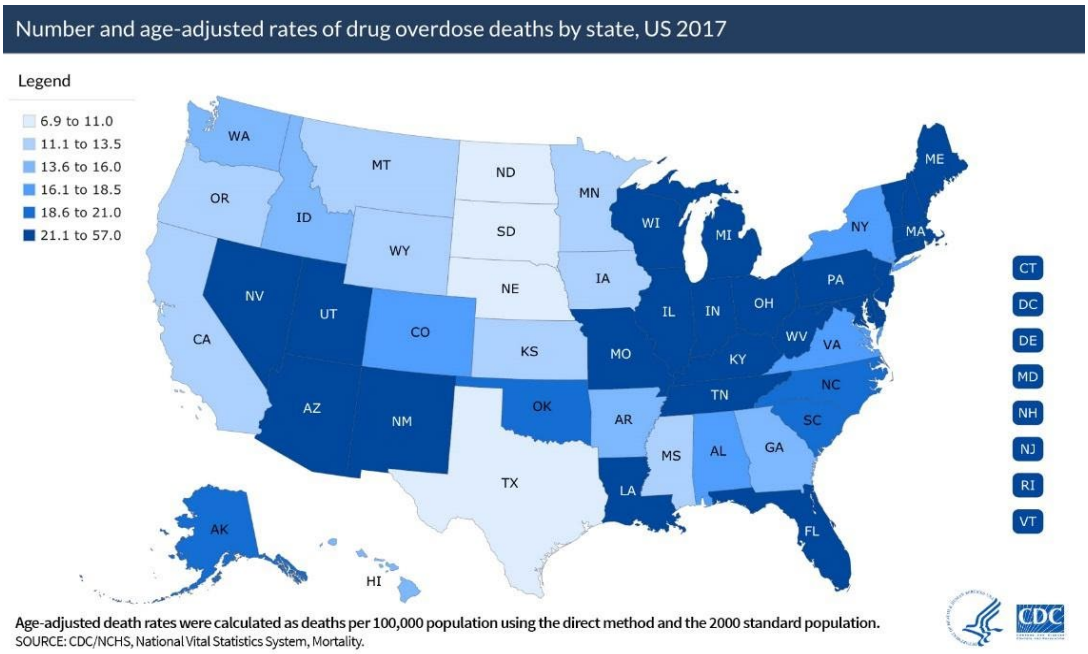


[1]Significant increasing trend from 1999 through 2017 with different rates of change over time, $p < 0.05$.
[2]Male rates were significantly higher than female rates for all years, $p < 0.05$.
NOTES: Deaths are classified using the *International Classification of Diseases, 10th Revision*. Drug-poisoning (overdose) deaths are identified using underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14. The number of drug overdose deaths in 2017 was 70,237. Access data table for Figure 1 at: https://www.cdc.gov/nchs/data/databriefs/db329_tables-508.pdf#1.
SOURCE: NCHS, National Vital Statistics System, Mortality.

As illustrated in Figure 4, New England has some of the highest death rates in the country.[4]

[4] Centers of Disease Control and Prevention. (2019, July 1). 2017 Drug Overdose Death Rates. Retrieved from https://www.cdc.gov/drugoverdose/data/statedeaths/drug-overdose-death-2017.html.

Figure 4 - Overdose Deaths by State



Among Vermonters in 2017, there were 124 drug-related fatalities,[5] and, between 2012 and 2016, an average of 293 alcohol-attributable deaths per year.[6]

According to the latest data, approximately 21.2 million people age 12 and older needed substance use treatment in the United States in 2018. Of those, only 17.4% (3.7 million people) received it and an even smaller percentage (11.3% or 2.4 million) received it in a specialized treatment setting.[7]

The treatment data for Vermont are similar. Among individuals in Vermont aged 12 and older, during 2015-2017, 10% (or 54,000 people) had a SUD in the past year, which is similar to the regional average (9.6%). Of these 54,000 Vermonters, in a single-day count on March 31, 2017, only 7,015 people or 12.9% were enrolled in treatment.[8]

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[5] Vermont Department of Health. (2019, January). Drug-Related Fatalities Among Vermonters. Retrieved from https://www.healthvermont.gov/sites/default/files/documents/pdf/ADAP_Data_Brief_Drug_Related_Fatalities.pdf.

[6] Vermont Department of Health. (2017, December 20). Alcohol-Attributable Deaths in Vermont Data Brief. Retrieved from https://www.healthvermont.gov/sites/default/files/documents/pdf/ADAP_Data_Brief_AlcoholDeath.pdf.

[7] Substance Abuse and Mental Health Services Administration. (2019). Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health (HHS Publication No. PEP19-5068, NSDUH Series H-54). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/.

[8] Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Vermont, Volume 5: Indicators as measured through the 2017 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services. HHS Publication No. SMA-19-Baro-17-VT. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2019. Retrieved from https://www.samhsa.gov/data/sites/default/files/Vermont_BHBarometer_Volume_4.pdf.

The need for timely, individualized, and evidenced-based substance use treatment in Vermont and the United States is clear.

Currently in Vermont, there is only one ASAM 3.7-level facility located in the southern part of the state, and individuals in need of such services outside of that area are using Emergency Departments (EDs) and inpatient hospitalizations at a significant cost. The typical costs of an ED visit and inpatient hospitalization per day are $1,917[9] and $2,244,[10] respectively. Although an ED visit and hospitalization can medically stabilize someone, it does not often address the underlying etiology of the illness of addiction or provide the necessary care coordination to ensure people get continued treatment. According to the Substance Abuse and Mental Health Services Administration (SAMHSA):

> *Each year at least 300,000 patients with substance use disorders or acute intoxication obtain inpatient detoxification in general hospitals, while additional numbers obtain detoxification in other settings. Only 20 percent of people discharged from acute care hospitals receive substance abuse treatment during that hospitalization. Only 15 percent of people who are admitted to a detoxification program through an emergency room and then discharged go on to receive treatment.*[11]

By contrast, Silver Pines will provide accurate diagnoses, medical stabilization, treatment of the underlying SUDs and co-occurring conditions, and support entry into longer-term treatment. Our program is built on the belief that addiction is a chronic, relapsing medical condition and requires acute treatment, coupled with coordinated continued care for optimal results. Our program will achieve higher rates of sobriety, decreased rates of relapse, and fewer medical and psychosocial complications while saving individuals, communities, and insurance companies significant downstream costs by delivering treatment in a comprehensive and coordinated manner with the highest quality care.

It is important to note that a number of Vermonters choose to get treatment out of state due to their preference for a customized approach with a high clinical provider-to-patient ratio. Silver Pines will meet the needs of those Vermonters who have sought this quality and level of care elsewhere. In addition, Silver Pines will be able to provide partners aggregate outcomes on the effectiveness of treatment.

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[9] Health Care Cost Institute. (2018, January). 2016 Health Care Cost and Utilization Report. Retrieved from https://www.healthcostinstitute.org/research/annual-reports/entry/2016-health-care-cost-and-utilization-report/.

[10] Ellison, A. (2019, January 4). Average hospital expenses per inpatient day across 50 states: Below are the adjusted expenses per inpatient day in 2016, organized by hospital ownership type, in all 50 states and the District of Columbia, according to the latest statistics from Kaiser State Health Facts. Retrieved from https://www.beckershospitalreview.com/finance/average-hospital-expenses-per-inpatient-day-across-50-states.html.

[11] Center for Substance Abuse Treatment. Detoxification and Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series No. 45. HHS Publication No. (SMA) 15-413. (2006). Rockville, MD.

About Us

Our Facility

Silver Pines will be located at 3430 Mountain Road, Stowe, Vermont. The facility is the former NAHA building and sits on a private, beautifully landscaped 4.25 acres lot with built-out space, totaling 12,534sqft. Silver Pines will have a multi-year rental contract on the building, which will be retrofitted by the property owners for our specific purposes.

The existing NAHA facility contains 22 rooms, some of which have triple occupancy, and 24 bathrooms. Silver Pines will have only 16 double rooms and 20 bathrooms to serve a maximum capacity of 32 individuals. The footprint and roofline of the existing building will be preserved. We will also preserve the existing landscaping and all perimeter trees.

We aim to establish a national reputation and attract individuals from across the United States and Canada. Our facility is centrally located in Vermont (15 minutes away from Exit 10 on I-89), 35 miles from the Burlington Airport, which is served by direct flights from New York City (50 minutes), Philadelphia (1 hour 5 minutes), Washington DC (1 hour 20 minutes), Charlotte NC (2 hours 15 min), Chicago (2 hours), and Detroit (1 hour 50 minutes). Boston is 3.5 hours by car, and Montreal is 2 hours away.

Ownership

Silver Pines Partners, LLC is a new company, specifically created to meet the need for high-quality, effective substance use treatment. It is a single entity with no other affiliations or facilities in Vermont or nationwide. Below are descriptions of the CEO and Managing Partner, Dr. William Cats-Baril, and general descriptions of the key staff.

CEO and Manager Partner

Dr. William Cats-Baril is as an Associate Professor for Information and Decision Sciences in the Grossman School of Business at the University of Vermont (UVM). He has been a Senior Research Fellow at the London School of Economics and Political Science, and has been a Visiting Professor at several international institutions, including the European Institute Administration at the University of Business Administration in Fontainebleau, France; Reykjavik University; the International Management Centers in Budapest; the Executive Development Centre in Bled (Slovenia), and the China-Europe Management Institute in Beijing. Professor Cats-Baril teaches courses on business strategy, customer-orientation and total quality management, and implementation of change in executive development programs in Asia, Europe, and North and Latin America. He has won several teaching awards, including most recently the Grossman School of Business Teacher of the Year award in 2018.

Dr. Cats-Baril has published over thirty articles and book chapters, and a book in the management literature on business strategy, conflict resolution and negotiation, and implementation of change. This work has appeared in Decision Sciences, Management Information Systems Quarterly, and the Public Administration Review. His book Systems to Support Health Policy Analysis was published by the Hospital Administration Press; a second edition came out last year. The second edition of his book Information Technology and Management (McGraw-Hill/Richard C. Irwin) was translated into Chinese. He has authored

more than 20 teaching cases and was featured on two video-series on increasing the effectiveness of public administrators sponsored by the American Society of Public Administration. His work is referenced often: He is currently ranked in the top 10% of authors on SSRN by all-time downloads. Research Gate ranks him in the top 20% of research influencers.

Dr. Cats-Baril has developed curricula in a variety of settings. For example, he designed, launched and was the Founding Director of the award winning Sustainable Innovation MBA (now ranked #1 by Princeton Review as the best green MBA). He has also designed and participated in many executive programs. For example, he trained most of the Portuguese hospital administrators in management techniques and decision analysis on a three-year grant from the USAID. Through a contract from Institute for Sustainable Communities, Dr. Cats-Baril also trained the staff of 50 of the most influential Ukrainian NGOs in consensus building and implementation of change. He has developed professional continuing education and maintenance of competence programs for medical associations and financial institutions.

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Dr. Cats-Baril is a consultant with an international practice in organizational performance assessment, consensus building, and program evaluation. He has had several major consulting engagements with for-profit and non-profit organizations, government agencies, and political campaigns. His clients have included Airport Council International, AT&T, GE, and Hospital for Special Surgery, IBM, LVMH, Johnson & Johnson, TenetHealthcare, and Wyeth, among others. He directed as a consultant the design and implementation of several outcome programs for multiple medical associations in the US, and is an expert in certification and maintenance of competence programs. Dr. Cats-Baril was a member of the leadership team of the Faculty Practice at Fletcher Allen where he created the Center for Health Care Management. He developed the overall strategy and business plan for the Global Training Hub, the training arm of ACI, the organization representing more than 1,600 airports worldwide; for the Academy for Environmental Health and Safety which is funded by the GE Foundation in Guandong Province, China; and, for the Academy of Medical Educators, at the Hospital for Special Surgery in New York City (NYC).

Dr. Cats-Baril has worked closely with the medical community, in particular, the orthopedic, plastic surgery, and psychiatry communities for the last 35 years. He was a Principal Investigator in the Vermont Rehabilitation Engineering Center (VREC), where he developed a predictive risk model of low back pain disability. His research at the VREC won the Eastern Orthopedic Association Award for Spinal Research. He has worked on numerous projects for the American Academy of Orthopedic Surgeons, American Board of Orthopedic Surgery, the Muller Foundation, the North American Spine Society, the American Academy of Hip and Knee

Surgeons, and the Hospital for Special Surgery in NYC and has been a member of several task forces on outcomes studies.

Dr. Cats-Baril has directed the development of a number of research instruments, including the North American Spine Society's *Lumbar Spine Questionnaire*, and the American Medical Association's *Patient Confidentiality and Medical Ethics Questionnaire* and assisted several medical societies initiate outcomes data collection programs. In particular, he directed, as a consultant, the design and implementation of the American Academy of Orthopedic Surgeons program on outcomes and its program to assess patient satisfaction. He did the same for the American Society of Plastic Surgery and the American Board of Plastic Surgery. He has led the two largest consensus expert panels ever assembled in orthopedic surgery, the International Consensus Meetings (ICM) in 2015 and 2018. By developing over 300 best practices to minimize and treat infections, the ICMs have had a significant worldwide impact. He has published several articles in the orthopedic surgery literature including pieces in Spine, JBJS, and the Journal of Occupational Medicine.

Dr. Cats-Baril is also a successful entrepreneur and has been involved in the development of several businesses. He was the founder of: a company that developed expert systems in the diagnosis and treatment of low back pain; a consulting and data management company that specialized in developing and implementing medical outcomes programs; he founded an internet-based business incubator in the professional continuing education space; he founded a laboratory to create nutraceutical products; he was a partner of a company that sells Graduate Medical Education software. He is the founder and Managing Partner of WISeR Systems, a company that develops expert system-based risk assessment in health care. Their first product, the Systematic Expert System to Assess Risk of Suicide, has won several innovations awards. He is on the Board of Directors of SAP! a maple and birch sap drink company. He is an advisor to Trace, a blockchain technology company. Dr. Cats-Baril was the first inductee in UVM's Entrepreneurship Hall of Fame.

Other Key Staff

Medical Director – Physician with expertise in treating addiction, who is waivered to prescribe buprenorphine, and has significant clinical experience in taking care of a broad spectrum of diverse and complex individuals who have acute and chronic conditions.

Executive Director – Licensed Alcohol and Drug Counselor (LADC) with a Master's Degree and previous experience managing all aspects of residential SUD treatment, including but not limited to operational, clinical, financial, regulatory, and marketing.

Clinical Director – LADC with a Master's Degree, who has significant experience providing direct clinical care in both residential and office-based SUD treatment settings as well as managing and supervising clinical staff.

Staffing

As mentioned above, Silver Pines will have the highest staff-to-patient ratio in the state and will match other premier substance use treatment facilities in the world. In addition to the Medical Director, there will be a physician onsite seven days per week and one on-call during the evening hours. Our staff will be well trained and experienced in providing high-quality, evidence-based addiction care.

Organizational Chart

Figure 5 - Silver Pines' Organizational Chart

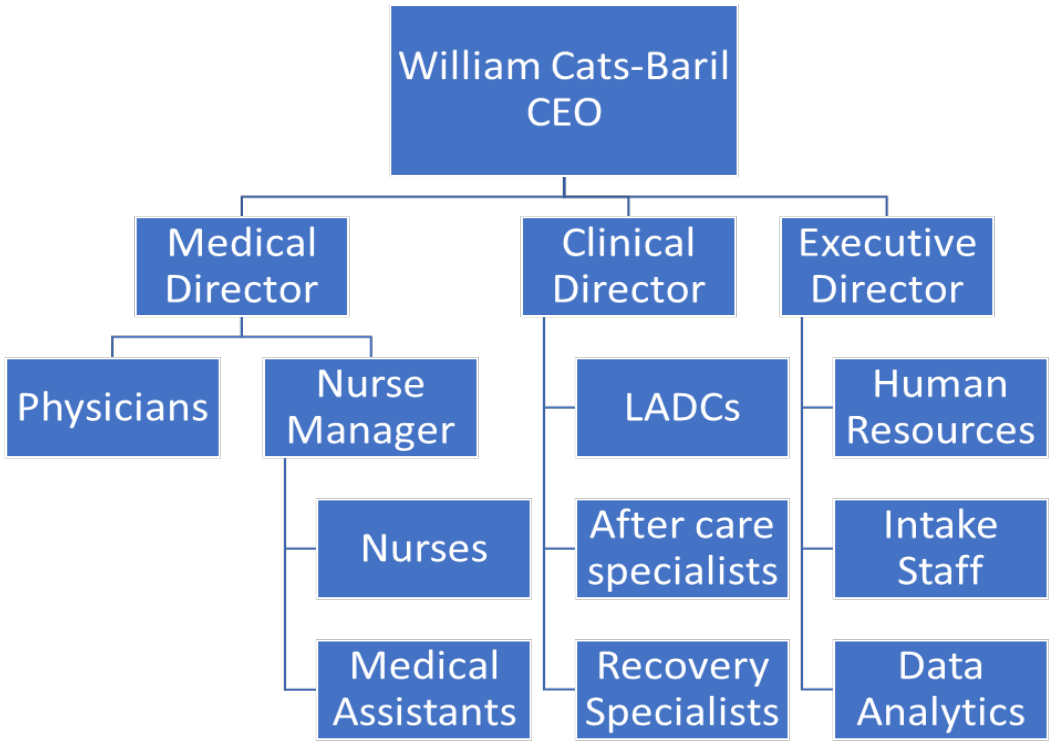


Table 3 - Staff, Full-Time Equivalents (FTEs) at Full Census, Education and Responsibilities

Position	# of FTEs	Education/ License	Responsibilities	Onsite/ Offsite
Management Staff				
Executive Director	1	Master's Degree, LADC	• Oversees strategic planning, operational and financial management, program management and evaluation, compliance, licensure, accreditation, marketing and communication	Onsite
Medical Director	1	Doctor of Medicine	• Supervises all medical staff and provides medical assessments, medication management, consultation, and on-call services.	Both
Clinical Director	1	Master's Degree, LADC	• Provides clinical management and supervision, conducts chart reviews, diagnostic assessment, group and family counseling	Onsite
Clinical Staff				
Physician Mon-Sun	1.5	Doctor of Medicine	• Provides evaluations, diagnosis, medication management, continuous care, psychotherapy support, orders, and health promotion services.	Onsite
Physician On-call Mon-Sun	2	Doctor of Medicine	• Provides consultation, medication management and orders as needed from 17:00 to 8:00.	Both
Nurse Manager	1	Registered Nurse	• Supervises all nurses, manages nursing schedule, provides training and education to the nursing department, conducts chart reviews, facilitates psychoeducation groups	Onsite
Nurse	8.4	Registered Nurse	• Performs history and physicals, observes and reports individuals' symptoms, receives physician orders, transcribes medication, administers medication, facilitates psychoeducation groups	Onsite
Medical Assistant	3	Licensed Nurse Assistant	• Assists with nursing tasks, including medical examinations and medication administration	Onsite
Counselor	4	Master's Degree, LADC	• Performs clinical assessments, diagnosis, treatment planning, group, individual and family counseling	Onsite
Aftercare Specialist	3	Bachelor's Degree	• Coordinates with counselors for essential case management components of post-discharge continued care plan and assists individuals in scheduling outpatient appointments	Onsite
Recovery Support Specialist	10	High School Diploma	• Ensures safe milieu, performs bed checks, interacts daily with individuals, provides transport as needed	Onsite
Administrative Staff				
Receptionist	1	High School Diploma	• Receives all visitors, answering phones	Onsite
Intake Coordinator	8.4	High School Diploma	• Answers admissions calls 24/7 • Provides accurate information on the process of addiction, recovery, and program services to individuals and their families • Completes all intake documents, prepares and develops treatment file at time of admission	Onsite
Database Manager and Analyst	0.5	Master's Degree	• Prepares reports to gain insight into treatment outcomes Identifies service trends through data analysis	Onsite
Human Resources	0.5	Bachelor's Degree	• Develops and administers human resources plans and procedures • Creates and revises job descriptions and conducts new employee orientations • Performs benefits administration	Onsite

Services

Silver Pines will offer medically supervised withdrawal and residential SUD treatment services, which include initial intensive counseling and preparation for treatment in an outpatient setting.

As an *ASAM 3.7-level* facility, we will provide *medically monitored intensive inpatient services withdrawal management* for adults. This level of care provides 24-hour nursing services with a physician's availability. Individuals in this level of care have subacute biomedical and emotional, behavioral, or cognitive problems and require services provided by trained addiction treatment, mental health, and medical personnel. We will also offer *clinically managed high-intensity residential services* for adults, which is 24-hour care with trained counselors to stabilize and prepare for outpatient treatment. Individuals in this level are able to tolerate and use full active milieu or therapeutic communities.[12]

The services offered will include medical, nursing and clinical treatment as described below.

Medical

Table 4 - Medical Services[13] [14]

Components	Details
Review of prior health records (when available)	▪ Collateral information from prior treatments, providers and supports ▪ Review of Prescription Monitoring Programs
Review of prescribed medications	▪ Name; dose; frequency; duration of use; indication of use ▪ Effectiveness; side-effects
Medical and Surgical History	▪ Prior diagnoses ▪ Prior outpatient, inpatient, surgical treatments, and procedures ▪ Treatment response
Psychiatric History	▪ Prior diagnoses ▪ Developmental history and longitudinal course ▪ Prior outpatient; intensive outpatient programs (IOP); partial hospitalization programs (PHP) and inpatient treatments ▪ Treatment response
SUD History	▪ Prior outpatient; peer-support groups; inpatient and residential treatments ▪ Comprehensive review of substance use: - Legal, non-prescribed medications and illicit substances - Age of first use - Patterns of use: frequency, amount, route of use - Longitudinal course of illness - Recent use - Cravings, cues, triggers

[12] American Society of Addiction Medicine. (2018, July 20). What are the ASAM Levels of Care? Retrieved from https://www.asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care/.
[13] American Society of Addiction Medicine. (2014). *The ASAM Standards of Care: For The Addiction Specialist Physician*. Chevy Chase, MD: ASAM.
[14] Center for Substance Abuse Treatment. Medications To Treat Opioid Use Disorder Treatment Improvement Protocol (TIP) Series No. 18. HHS Publication No. (SMA) 18-5063FULLDOC. (2018). Rockville, MD. Retrieved from https://store.samhsa.gov/system/files/sma18-5063fulldoc.pdf.

Components	Details
Social History	▪ Birth and early development; education; employment; relationship history; living situation; legal stressors; financial stressors; other stressors
Family History	▪ Medical; psychiatric; SUDs
Initial Symptom Assessment	▪ Centers of Medicare and Medicaid Services (CMS) recommended review of 14 Systems ▪ Signs of intoxication ▪ Signs of withdrawal: Clinical Opioid Withdrawal Scale (COWS); Clinical Institute Withdrawal Assessment for Alcohol (CIWA) ▪ Psychiatric symptoms (e.g. PHQ-9, GAD-7, DSM-5 Cross-Cutting Symptom Measure)
Risk Assessment	▪ Suicidal Ideation: Systematic Expert Risk Assessment System (SERAS™)
Diagnostic Evaluation	▪ DSM-5 Criteria assessing loss of control, physiologic effects and consequences with descriptors, specifiers and indicators of severity ▪ Diagnosis of co-occurring psychiatric disorders
Physical Exam	▪ Full exam
Laboratory Tests	▪ Urine drug screens ▪ Pregnancy testing (when applicable) ▪ Testing for infectious diseases (e.g. HIV, viral hepatitis) ▪ Additional blood tests where medically indicated (e.g. assessment of liver and kidney function) ▪ ECG where indicated by medications and/or medical conditions
Medication initiation	▪ Evidence-based pharmacotherapy for psychiatric disorders, SUDs, and other medical conditions
Diagnostic Clarification	▪ Refinement of diagnoses based on review of testing, current symptoms and additional collateral information
Ongoing Symptom Monitoring	▪ Clinical assessments ▪ Validated scales to assess treatment response (e.g. PHQ-9 for depression) ▪ COWS; CIWA
Medication adjustment	▪ Effectiveness; side-effects

Nursing

In addition to supporting the medical provider in the above listed tasks, the Silver Pines' nursing staff will facilitate psychoeducation to individuals and groups and administer medications.

Clinical

The clinical staff will offer a variety of evidenced-based therapies in individual and group sessions. These include but are not limited to introductions to: cognitive behavioral therapy (CBT), dialectic behavioral therapy (DBT), acceptance and commitment therapy (ACT), TIC, motivational enhancement therapy (MET), guided mindfulness, validated stress-reduction and resiliency building techniques, emotional freedom techniques (EFT), sleep hygiene, 12-step groups, gender-focused groups, Seeking Safety, and The Wellness Recovery Action Plan® (WRAP®).

Other

Additional services will include neuropsychological testing, acupuncture, massage, yoga, tai chi, exercise and personal training, and a variety of other life skills services. These will be provided by contracting with local providers. Food, housekeeping, and landscaping/lawn care will also be sourced through local businesses.

Table 5 - Services by Provider

	Medical Director	MD	RN	Medical Assistants	LADC	Aftercare	Recovery Support Specialist	External Contractor	Intake	Reception	Data Analyst
Comprehensive Medical & Psychiatric Assessment	X	X	X								
Diagnosis	X	X	X		X						
Medication Management	X	X	X								
Vitals	X	X	X	X							
Acute Needs	X	X	X	X							
Withdrawal Assessment/BAC	X	X	X	X							
Labs, Blood Work, Urine Analysis, STD Panel, HIV/AIDS, Hepatitis B and C, Liver Function	X	X	X	X							
Diagnostic Evaluation					X						
Individual Therapy					X						
Group Therapy					X						
Art Therapist					X						
Family/Couples Therapy					X						
Mindfulness					X		X				
Case Management					X	X					
Continuing Care Planning					X	X					
Psychometric Testing					X						
Crisis Management	X		X	X	X	X	X				
Milieu Management					X	X	X				
Screening and Brief Intervention					X						
Intake									X		
Orientation					X		X	X			
Treatment Planning				X	X	X					
Psychoeducation	X			X	X						
Documentation	X		X	X	X	X		X	X	X	X
Care Coordination				X	X	X					
Post-Discharge Follow-up and Support					X	X		X	X	X	X

	Medical Director	MD	RN	Medical Assistants	LADC	Aftercare	Recovery Support Specialist	External Contractor	Intake	Reception	Data Analyst
Food Service								X			
Laundry								X			
Transportation							X	X			
Housekeeping								X			
Acupuncture								X			
Message								X			
Tai Chi								X			
Qigong								X			
Yoga								X			
Exercise							X	X			
Nordic Activities								X			
Life Coaching								X			
Data Analysis											X
Outcomes Assessment											X
Neural Network Modeling											X

Individuals Served

We will focus our recruiting throughout Vermont, the Northeast and Midwest of the United States, and Quebec, Canada.

We will be in full compliance with the Federal civil rights law, U.S. Department of Federal Civil Rights law, and U.S. Department of Agriculture Civil Rights regulations and policies. We will not discriminate against anyone based on race, color, national origin, religion, sex, gender identity and expression, sexual orientation, disability, age, marital status, family/parental status, and political beliefs.

Length of Stay, Cost, and Payment

Silver Pines anticipates that the average length of stay will be a minimum of 7 days and cost $2,142.00 per day per person. This is comparable with what similar treatment providers cost, including the other ASAM 3.7 facility in Vermont, which charges $1,500-$1,600 per day for medically supervised withdrawal services alone.

Silver Pines will accept private payments, contract with Blue Cross Blue Shield (BCBS) of Vermont, and be eligible for additional third-party insurance reimbursement, but it does not plan to become a participating provider for Medicaid or Medicare reimbursement.

This cost model will enable us to provide the highest quality, customized clinical treatment to individuals in our care. Our high staff-to-patient ratio will be the best in the state, allowing Silver Pines to provide unparalleled safety, compassion and individual attention to people at their most vulnerable time. This cost structure will also support accurate diagnostics and broad exposure to different therapeutic modalities and an array of medical, psychological, addiction, wellness, and

complimentary treatments at a first-rate level. In addition, our resources will allow the team the ability to make rapid adjustments to treatment based on the real-time analysis of data, initial response to treatment modalities, and the latest evidence in the field. This, in turn, will enable us to match individuals with the most effective treatment plans that reflects their level of motivation and commitment.

By being independent of state funding, Silver Pines will have no adverse effects on state budgets or priorities.

Equipment

Silver Pines anticipates the purchase and use of the following equipment:

- Office equipment (computers, fax machines, copiers, telephones, tele-conferencing)
- Electronic Health Record (EHR) program
- BD Pyxis MedStation medication dispensing system
- Diagnostic Electrocardiogram Machine
- Vital signs monitoring devices
- Examination table and basic physical exam equipment
- Automated external defibrillators
- Sample collection (blood, urine, oral swabs) equipment
- Point-of-care urine drug tests

Project Timeline

Table 6 - Project Timeline

Project Task	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Submit Stowe Zoning Board Narrative														
CON Application														
Respond to GMCB CON Questions														
Landscaping*														
Manage HR benefits*														
Select and purchase insurance*														
Acquire permits/certifications*														
Contract with hospitals and primary care providers*														
Contract with pharmacy*														
Contract with vendors (laundry, housekeeping, maintenance, food, transportation, landscaping, lawn care, snowplow, per diem activities, payroll, IT support)*														
Purchase and customization of EHR*														
Branding & Marketing*														
Website development*														
IT infrastructure build*														
Contract with insurance companies*														
Initiate CARF approval*														
Recruitment, hiring and training medical, clinical, administrative, and ancillary staff*														
Purchase equipment*														

** assuming CON approval*

Statutory Criteria 18 V.S.A. § 9437(1)-(5) and (7-9)

1. **Proposed project aligns with statewide health care reform goals and principles because the project:**
   - **A. takes into consideration health care payment and delivery system reform initiatives;**
   - **B. addresses current and future community needs in a manner that balances statewide needs (if applicable); and**
   - **C. is consistent with appropriate allocation of health care resources, including appropriate utilization of services, as identified in the HRAP pursuant to section 9405 of this title.**

A. Silver Pines will offer care that meets the implementation goals of the Health Resource Allocation Plan (HRAP) and takes into account health care payment and delivery system reform in the following ways:

- Per *HRAP Implementation Option 4.1.1- As plans for replacement of the Vermont State Hospital facility and functions move forward, stakeholders could consider ways to leverage expenditures in the community health system to potentially decrease the need for more intensive services,* Silver Pines will provide a cost-effective alternative for individuals that are in need of medically supervised withdrawal services with the goal of decreasing the unnecessary use of more expensive and intensive medical services, such as emergency department visits and inpatient hospital admissions.
- Per *HRAP Implementation Option 4.1.3 - DMH could continue to evaluate costs and outcomes of residential recovery and other programs and replicate successful strategies,* Silver Pines will offer high-quality services to Vermonters and provide data to DMH so that these services can be replicated. Though we recognize we are not contracting with Medicaid or Medicare and are, thereby, limiting the number of Vermont residents who will come to Silver Pines, we strongly believe one of the key benefits of our structure will be the generation of outcomes data associated with our innovative and comprehensive services, and this has the potential to be invaluable to all Vermonters. Research in this area has demonstrated that machine learning algorithms can be used to predict individuals' success in treatment.[15] Machine learning methods can augment traditional statistical approaches to inform improved clinical decision making and thus result in improved outcomes. As the amount of data increases, so does the

Machine Learning

Machine learning, a branch of artificial intelligence, is a computer-based approach of data analysis using programs and algorithms that allow the computer to automatically "learn" without being explicitly programmed. The computer is initially trained to recognize certain patterns in data using a set of known training data (e.g., from known examples or tests). The computer can then apply this information to new data to identify new patterns and make inferences, predictions, or decisions without additional input from programmers. Machine learning allows for the faster and more accurate analysis of massive amounts of data and information than would otherwise be possible, such as those necessary for tasks as diverse as self-driving cars, speech recognition, and analysis of the human genome.

[15] Yip, S.W., Scheinost, D., Potenza, M.N., Carroll, K.M. Connectome-based prediction of cocaine abstinence. *American Journal of Psychiatry* 76(2):156-164, 2019.

system's predictive accuracy. The rigorous analysis of data can be shared with GMCB and other partners to better inform health care resource allocation.

- Per *HRAP Implementation Option 4.1.5 - DMH, VDH, DCF and other stakeholders could implement initiatives to promote family-based mental health and substance abuse care,* Silver Pines will place a strong emphasis on family-based substance use services and encourage participation of the whole family in the care of individuals. Through psychoeducation sessions geared toward loved ones as well as couples and family therapy sessions, Silver Pines will promote a family-systems approach to mental health and substance use care.
- Per *HRAP Implementation Option 4.1.6 - DMH, the community mental health centers, mental health and substance abuse providers, and/or other interested stakeholders could continue to develop additional community-based suicide prevention programs based on the National Strategy for Suicide Prevention and The Vermont Suicide Prevention Platform,* Silver Pines will utilize the SERAS™, which provides rapid, low-cost, high-quality risk assessment for suicide and can be utilized on a community-based level.[16]
- Per *HRAP Implementation Option 4.3.4 - DMH, mental health and substance abuse providers, and patient advocates could collaborate to develop and implement tools to assist individuals and families in informed decision making that explain choices about programs and providers, so that individuals and families may fully participate in planning and evaluating treatment and support services in light of their own preferences,* Silver Pines will have dedicated staff expertise and the necessary time to assist individuals and families in informed decision making about their care. In developing our continuing aftercare plans, our specially trained staff will work closely with individuals and families to explain their treatment options, levels of care, costs, benefits and disadvantages of each option. As addiction is a chronic medical condition, one of our foremost goals is to ensure all individuals receiving treatment at Silver Pines will have a continuing care plan that matches their motivation and commitment and be a plan they can and will actually follow. We understand that empowering individuals and families to actively participate in this process is key to achieving that goal.

B. Currently, the State of Vermont does not have a facility that provides the combination of integrated, neural network-based, comprehensive services that Silver Pines will. Thus, if approved, our facility can offer community members an alternative option that is not available elsewhere in the state. Additionally, Silver Pines will collaborate with and financially contribute to local addiction community resources and supports.

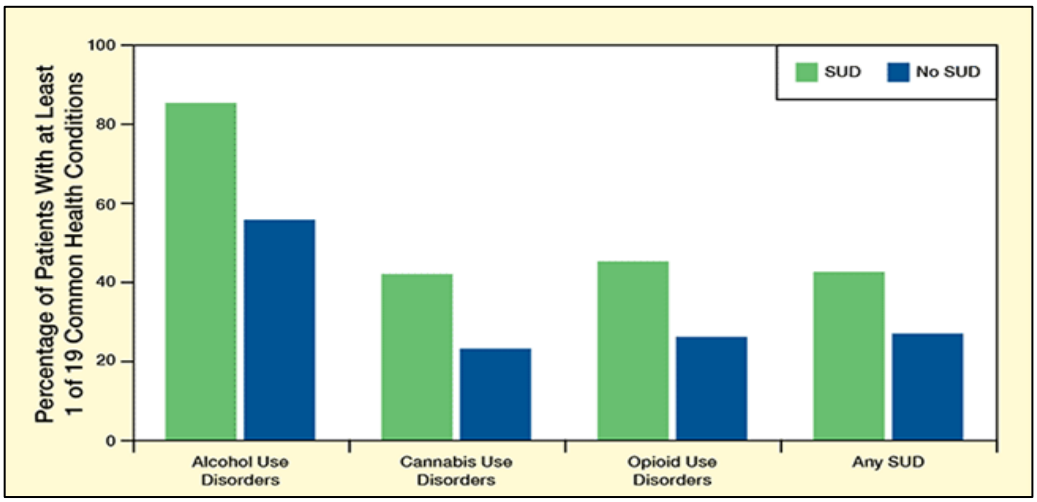
C. Consistent with HRAP and pursuant to section 18 V.S.A. § 9405, Silver Pines' services will protect and promote health and prevent disease through a variety of interventions, including but not limited to medical, therapeutic, nutrition, and wellness activities.

- To protect health and prevent disease transmission and complications, we will test for and treat various medical conditions, including Hepatitis B and C, HIV/AIDS, sexually transmitted infections, abscesses, and cellulitis along with a wide range of other short- and long-term health effects of SUDs. (According to the National Institutes of Drug

[16] Desjardins, I, Cats-Baril, W, Maruti, S, Freeman, K, Althoff, R. Journal of Clinical Psychiatry. 2016 Jul;77(7):e874-82. doi: 10.4088/JCP.15m09881.

Abuse and as shown in Figure 6, SUDs are associated with a variety of medical conditions and can have a wide range of short- and long-term, direct and indirect adverse effects on a variety of organ systems: HIV, Hepatitis, and Other Infectious Diseases, Cancer, Cardiovascular Effects, Respiratory Effects, Gastrointestinal Effects, Musculoskeletal Effects, Kidney Damage, Liver Damage, Neurological Effects, Hormonal Effects, Prenatal Effects, Other Health Effects, and Mental Health Effects. These adverse effects can lead to changes in appetite, wakefulness, heart rate, blood pressure, and mood, heart attack, stroke, psychosis, overdose, heart or lung disease, cancer, mental illness, and even death.[17])

Figure 6 - Patients with Substance Use Disorders (SUDs) Have an Increased Risk of Major Medical Conditions



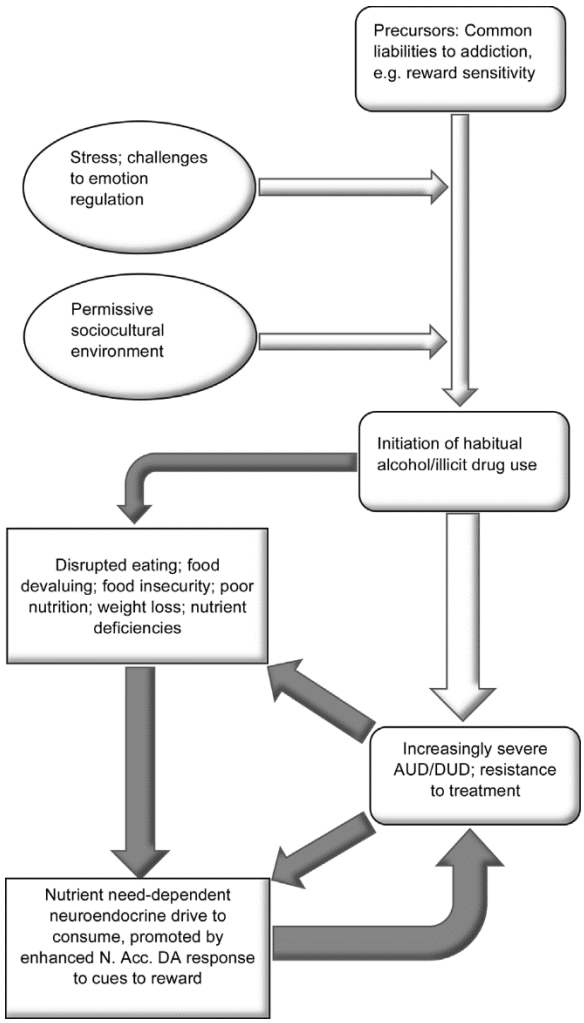
Treating SUDs can, thus, prevent a variety of health conditions and their associated complications. Additionally timely treatment of infectious conditions can prevent their transmission to other community members. Silver Pines will further address health and disease protection by providing psychoeducation groups on the above mentioned health conditions, sleep hygiene, nutrition, exercise and overall wellness. Finally, we will closely coordinate outpatient treatment with individuals' primary care providers (PCPs) to ensure care is delivered in a continuous and cost-effective manner.

- As part of health promotion, Silver Pines understands that exercise can play a significant role in recovery and overall health. The facility will have a full gym, various wellness modalities, and time allotted in the daily schedule to support positive physical health and well-being.

[17] National Institute on Drug Abuse. (2012, December 14). Health Consequences of Drug Misuse. Retrieved October 28, 2019, from https://www.drugabuse.gov/related-topics/health-consequences-drug-misuse.

- Poor nutritional status in SUDs have adverse impacts on individuals' physical and psychological health (see Figure 7). Individuals suffering from SUDs often have impairments in calories, minerals and vitamins. These nutritional deficiencies have been associated with alcoholic myopathy, osteopenia, osteoporosis, and mood disorders, including anxiety and depression.[18] At Silver Pines, we will serve locally sourced farm-to-table meals and individuals will have access to a Registered Dietician who can evaluate their specific needs and create customized dietary plans.

Figure 7 - SUDs and Nutritional Status



2. The cost of project is reasonable because each of the following conditions is met:

A. The applicant's financial condition will sustain any financial burden likely to result from completion of the project;

B. The project will not result in an undue increase in the costs of medical care or an undue impact on the affordability of medical care for consumers. In making a finding, the Board shall consider and weigh relevant factors, including:

(i) The financial implications of the project on hospitals and other clinical settings, including the impact on their services, expenditures and charges; and

(ii) Whether the impact on services, expenditures, and charges is outweighed by the benefit of the project to the public;

C. Less expensive alternatives do not exist, would be unsatisfactory, or are not feasible or appropriate.

D. If applicable, the applicant has incorporated appropriate energy efficiency measures.

A. As demonstrated in the financial tables below, Silver Pines has adequate financial resources through private investment to sustain financial burdens likely to result from the project.

[18] Jeynes, K. D., & Gibson, E. L. (2017, October 1). The importance of nutrition in aiding recovery from substance use disorders: A review. Retrieved October 28, 2019, from https://www.ncbi.nlm.nih.gov/pubmed/28806640.

B. Since we will not participate in Medicaid and Medicare reimbursement, we do not anticipate any significant impact on the cost or affordability of medical care in other clinical settings. While our moderately sized treatment facility may have a slight impact on Vermont hospitals, which currently treat withdrawal, this impact will be a positive one and ultimately result in individuals receiving the appropriate service at the right level of care.
C. As stated, Silver Pines will be one of two ASAM 3.7-level of care facilities in the state. Provided the statistics presented earlier, there is not an adequate amount of treatment services in Vermont to meet the need. The alternative of utilizing an emergency department or hospital bed for medically supervised withdrawal services is not appropriate. In addition, the use of an ASAM 3.5-level or below facility is suboptimal due to the medical needs of and safety risks to individuals experiencing withdrawal.
D. Silver Pines will be renting the facility, therefore, we will implement marginal energy efficiency measures (LED lighting, low-energy appliances and careful monitoring of temperature controls) and be mindful of energy use.

3. There is an identifiable, existing, or reasonably anticipated need for the proposed project that is appropriate for the applicant to provide.

As stated in the above section entitled *Explanation of Need*, substance use-related deaths are not declining. In Vermont alone in 2017, there were 124 drug-related fatalities, and, between 2012 and 2016, an average of 293 alcohol-attributable deaths per year. These data speak directly to the need for additional treatment in Vermont that can reduce the number of substance use-related mortalities as well as increasing access to medically supervised withdrawal at the appropriate level of care. For further identifiable needs for the proposed project, please refer to the section on *Explanation of Need*.

4. The project will improve the quality of health care in the State or provide greater access to health care for Vermont's residents, or both.

Silver Pines will improve the quality of healthcare in Vermont by offering a state-of-the-art approach to treatment. With our high staff-to-patient ratio, broad range of evidenced-based and adjunctive therapies, advanced clinical informatics, emphasis on creating an effective long-term care plan, proactive and extended follow-up, and use of in-house data collection and outcomes measures to continually optimize treatment, our approach is dynamic and unlike any other in Vermont.

As previously stated, there is only one other ASAM 3.7-level of care facility in Vermont, which is in the southern part of the state. Silver Pines will provide greater access to health care for those who live outside of that area.

5. The project will not have an undue adverse impact on any other existing services provided by the applicant.

Silver Pines does not offer any other existing services, thus, this project will not have an undue adverse impact on them.

6. REPEALED

7. The applicant has adequately considered the availability of affordable, accessible transportation services to the facility, if applicable.

Silver Pines has considered the need for transportation and understands the barrier it can often present. Therefore, we will offer the option of transportation to individuals seeking treatment.

8. If the application is for the purchase or lease of new Health Care Information Technology, it conforms with the Health Information Technology Plan established under section 9351 of this title.

Silver Pines will conform to the statutes proposed under section 9351. Our health care information technology will adhere to the privacy standards set by state and federal regulators. We will contract with an electronic health record system that adheres to these same standards and have clear policies and procedures for all employees.

9. The applicant must show the project will support equal access to appropriate mental health care that meets the Institute of Medicine's triple aims. 18 V.S.A. § 9437(9).

Quality – Starting with the first phone call and continuing through to the post-discharge follow-up contacts, Silver Pines will provide every individual with excellent care. Using evidenced-based assessment tools (e.g. Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria, Addiction Severity Index (ASI), Patient Health Questionnaire (PHQ-9), Generalized Anxiety Disorder 7-item (GAD-7) scale, Adult ADHD Self-Report Scale (ASRS), etc.) and treatment modalities previously outlined, the quality of care will be unparalleled. We will have a specific focus on family involvement and psychoeducation as well as a mind and body program, which will include an on-site fitness center, yoga studio, tai chi, smoking cessation services, nutritional services and complementary and integrative medicine approaches.

To provide and ensure the highest standards of care at Silver Pines, we will systematically track outcomes measures, such as treatment initiation, treatment retention, successful completion of program, rates of abstinence and substance use reduction, aftercare follow-up, client satisfaction, and a reduction in ED visits and hospital admissions. Every individual will be assessed and followed up with upon discharge. We will then use these data to inform and continuously improve our programming and protocols.

Access – Silver Pines will contract with Blue Cross Blue Shield (BCBS) of Vermont, expanding the array of high-quality substance use services available to Vermonters. We will be the only ASAM 3.7-level treatment facility in northern Vermont and offer a 24-hour 7-days per week phone triage and intake line to ensure immediate access to care.

Our facility is centrally located in the state, proximal to Exit 10 on Interstate 89 (12 miles) and for out-of-state individuals, the Burlington airport is only 40 miles away. We will establish a relationship with Copley Hospital in Morrisville (13 miles away) and the local Emergency Medical Services (EMS) to ensure individuals can access more acute care if needed.

Affordability – Per data from 2007-2013 gathered by the National Institute on Drug Abuse (NIDA), the misuse of alcohol and substances cost the United States $740 billion annually.[19] The most recent estimates on the opioid epidemic alone show that the total economic burden in the United States from 2015 through 2018 was at least $631 billion. This consists of:

- Nearly one-third ($205 billion) in excess health care spending,
- Forty percent ($253 billion) in mortality,
- Six percent ($39 billion) associated with criminal justice activities, including police protection and legal adjudication activities, lost property due to crime, and correctional facility expenditures,
- Six percent ($39 billion) associated with government-funded child and family assistance and education programs
- Fifteen percent ($96 billion) in lost productivity costs associated with absenteeism, reduced labor force participation, incarceration for opioid-related crimes, and employer costs for disability and workers' compensation benefits to employees with OUD.[20]

According to NIDA, every dollar invested in addiction care yields a downstream return of $12 in reduced drug-related crime, criminal justice costs, theft, and healthcare savings. Additionally, there are significant savings to individuals and society as a whole, which stem from fewer interpersonal conflicts, greater workplace productivity, decreased legal issues and fewer drug-related accidents.[21]

Silver Pines anticipates reducing the overall healthcare costs in Vermont and across the nation by serving people who are currently using ambulatory and emergency services often followed by inpatient hospital admission, which costs $2,244 per day.[22] We will offer the appropriate level of care for individuals with subacute severe biomedical, emotional, behavioral, or cognitive problems at a lower cost than they are currently paying for hospital services.

Additionally, our innovative methods of treatment will lead to lower overall costs as measured by improved engagement and completion of treatment and increased follow-up with aftercare plans. Our innovative approach will avoid unnecessary duplication of services while improving upon the current available level of care. While the highest quality service requires appropriate resources initially, the long-term benefits of decreased spending on continual management of this

[19] National Institute on Drug Abuse. (2017, April 24). Trends & Statistics. Retrieved from https://www.drugabuse.gov/related-topics/trends-statistics#supplemental-references-for-economic-costs.
[20] Davenport, S., Weaver, A., & Caverly, M. (2019). *Economic Impact of Non-Medical Opioid Use in the United States*. *Economic Impact of Non-Medical Opioid Use in the United States*. Society of Actuaries. Retrieved from https://www.soa.org/globalassets/assets/files/resources/research-report/2019/econ-impact-non-medical-opioid-use.pdf.
[21] National Institute on Drug Abuse. (2018, January). Is drug addiction treatment worth its cost? Retrieved from https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/drug-addiction-treatment-worth-its-cost.
[22] Ellison, A. (2019, January 4). Average hospital expenses per inpatient day across 50 states: Below are the adjusted expenses per inpatient day in 2016, organized by hospital ownership type, in all 50 states and the District of Columbia, according to the latest statistics from Kaiser State Health Facts. Retrieved from https://www.beckershospitalreview.com/finance/average-hospital-expenses-per-inpatient-day-across-50-states.html.

chronic condition will ultimately offer increased value for the individual and the overall health care system. We will use evidence-based standards and combine it with integrative clinical informatics to produce improved outcomes and effectiveness.

HRAP CON Standards

CON STANDARD 1.2

CON STANDARD 1.2: Applicants seeking to expand or introduce a specific health care services shall show that such services have been shown to improve health. To the extent such services have been the subject of comparative effectiveness research, an applicant shall show that the results of this research support the proposed project.

Silver Pines will offer a level of service in Vermont that has been extensively researched and documented. Widely accepted evidence indicates medically supervised withdrawal and residential SUD treatment significantly improve an individual's medical and psychological health.

Starting in 1958 when the American Medical Association took the official position that alcoholism is a disease, our understanding of substance use disorders has radically shifted. While stigma still exists and some people continue to view SUDs as a moral failing, society as a whole has shifted to viewing them as a medical condition that requires medical intervention.[23] Today, it is commonly known that abruptly stopping the use of certain substances, particularly alcohol, sedatives, and opioids, can be dangerous and even fatal. According to SAMHSA, detoxification from alcohol, sedative, hypnotics, anxiolytics and opioids in a setting that provides a high level of nursing and medical backup 24 hours a day, 7 days a week is desirable for safety and humanitarian concerns. The course of withdrawal can be variable, and it is not possible to predict who will experience life-threatening complications.[24] From mild symptoms of increased anxiety, insomnia, and nausea to delirium tremens, seizures, and death, medical supervision and pharmacotherapy of withdrawal are necessary to ensure safety and begin a path to lasting recovery.[25]

According to SAMSHA guidelines, studies show that medically supervised withdrawal and its linkage to the appropriate levels of care lead to increased recovery and decreased use of these same services in the future. [26] A systematic review of all relevant studies published between January 2013 and December 2018 in *Drug and Alcohol Dependence* showed evidence for the effectiveness of residential treatment in improving outcomes across a number of substance use

[23] Center for Substance Abuse Treatment. Detoxification and Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series No. 45. HHS Publication No. (SMA) 15-413. (2006). Rockville, MD.
[24] Center for Substance Abuse Treatment. Detoxification and Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series No. 45. HHS Publication No. (SMA) 15-413. (2006). Rockville, MD.
[25] Trevisan, L. A., Boutros, N., Petrakis, I. L., & Krystal, ohn H. (1999). Complications of Alcohol Withdrawal: Pathophysiological Insights. *Alcohol Health & Research World*, *22*(1), 61–66. Retrieved from https://pubs.niaaa.nih.gov/publications/arh22-1/61-66.pdf.
[26] Center for Substance Abuse Treatment. Detoxification and Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series No. 45. HHS Publication No. (SMA) 15-413. (2006). Rockville, MD.

and life domains. These studies also indicated that best practice in residential SUD treatment is to integrate mental health services and provide continuity of care after discharge.[27]

Consistent with the evidence, Silver Pines understands the importance of treating co-occurring mental health disorders and will provide psychiatric assessment and diagnosis, medication management, and intensive group and individual therapy to address these symptoms. We will further make continuity of care a fundamental component of our services. With the understanding that addiction is a chronic medical condition and management of withdrawal is only a starting point, our team will work with each individual to develop a thorough and rigorous continuing care plan. Each person that enters Silver Pines will be assigned an aftercare specialist on day one, and along with the individual and multi-disciplinary care team, will develop and schedule this plan and foster readiness in the individual to follow it. Machine learning-based neural networks will be embedded throughout these services to ensure highly customized and constantly improving care.

By offering an individually tailored, high-quality treatment approach of evidence-based practices, Silver Pines will increase the rate of recovery. Research shows that one third to one half of individuals who adhere to treatment guidelines, demonstrate markedly improved functioning "in terms of reduced criminal activity and drug consumption and improved rates of employment or schooling."[28] Our highly customized approach will support treatment completion, therefore increasing the overall psychosocial well-being of the individual post discharge.

We will offer an array of evidence-based individual and group therapies. These treatments have been shown to assist individuals in building skills and gaining tools that will continue to benefit them over time. One example is CBT group therapy, which has shown efficacy in the treatment of SUDs.[29] According to SAMHSA, "Research studies consistently demonstrate that such techniques improve self-control and social skills and thus help reduce drinking."[30] Additionally, we will be offering trauma-informed care (TIC), which has been demonstrated to be an effective augmentation in the field of addiction treatment.[31] Along with CBT and TIC, the other evidenced-based therapies mentioned in the *Services* section above all have strong evidence bases in the treatment of substance use and mental health disorders.

Another treatment modality Silver Pines will offer is family and couples therapy. As stated in SAMHSA TIP 24, "Several well-designed research studies support the effectiveness of

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[27] Andrade, D. D., Elphinston, R. A., Quinn, C., Allan, J., & Hides, L. (2019). The effectiveness of residential treatment services for individuals with substance use disorders: A systematic review. *Drug and Alcohol Dependence*, *201*, 227–235. doi: 10.1016/j.drugalcdep.2019.03.031.

[28] Center for Substance Abuse Treatment. A Guide to Substance Abuse Services for Primary Care Clinicians Treatment Improvement Protocol (TIP) Series No. 24. DHHS Publication No. (SMA) 08-4075. (2008). Rockville, MD.

[29] McHugh, R. K., Hearon, B. A., & Otto, M. W. (2010). Cognitive behavioral therapy for substance use disorders. Psychiatric Clinics of North America, 33(3), 511–525.

[30] Center for Substance Abuse Treatment. A Guide to Substance Abuse Services for Primary Care Clinicians Treatment Improvement Protocol (TIP) Series No. 24. DHHS Publication No. (SMA) 08-4075. (2008). Rockville, MD.

[31] Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

behavioral relationship therapy in improving the healthy functioning of families and couples and improving treatment outcomes for individuals."[32] A study using both family and nonfamily treatments for SUDs concluded that: 1) when family couples therapy was part of the treatment, results were clearly superior to modalities that do not include families; and (2) family therapy promotes engagement and retention of clients.[33] [34]

CON STANDARD 1.3

CON STANDARD 1.3: To the extent neighboring health care facilities provide the services proposed by a new health care project, an applicant shall demonstrate that a collaborative approach to delivering the service has been taken or is not feasible or appropriate.

In the treatment landscape of Vermont, there is only one other non-hospital facility certified to provide ASAM 3.7 level of care, which Silver Pines is proposing. Brattleboro Retreat, located 9.5 miles north of the Massachusetts border, is an ASAM 3.7-level facility and is a 2.5-hour drive for individuals in the northern part of the state. Valley Vista is another treatment facility in Vermont, however it is certified as an ASAM 3.5 facility and offers a lower level of withdrawal management. Silver Pines will provide a broader and more comprehensive treatment experience and therapeutic milieu than exists in the state. This will include a higher staff-to-patient ratio in conjunction with our neural network-based algorithms, allowing for a more effective and supportive therapeutic environment with personalized interventions. This is in contrast to other facilities, where treatment is often generalized, fragmented and infrequently revised.

CON STANDARD 1.4

CON STANDARD 1.4: If an application proposes services for which a higher volume of such service is positively correlated to better quality, the applicant shall show that it will be able to maintain appropriate volume for the service and that the addition of the service at the facility will not erode volume at any other Vermont facility in such a way that quality at that facility could be compromised.

Silver Pines will have the capacity to treat 32 individuals. We anticipate that our initial census will be low and is expected to grow over time. Research shows effective group-based therapy and peer support can occur with just a small number of individuals. According to studies and experts, groups with between 4 and 8 members are beneficial and even optimal. When groups grow beyond this size, verbal interrelationships (a response that one member directs toward

[32] Center for Substance Abuse Treatment. *A Guide to Substance Abuse Services for Primary Care Clinicians.* Treatment Improvement Protocol (TIP) Series, No. 24. DHHS Publication No. (SMA) 08-4075. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2008
[33] Center for Substance Abuse Treatment. *Substance Abuse Treatment and Family Therapy.* Treatment Improvement Protocol (TIP) Series, No. 39. HHS Publication No. (SMA) 15-4219. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004.
[34] Stanton, M.D., and Shadish, W.R. Outcome, attrition, and family couples treatment for drug abuse: A meta-analysis and review of the controlled, comparative studies. Psychological Bulletin 122(2):170191, 1997.

another member) decrease, affectional ties diminish, and inhibition increases.[35] [36] With our high staff-to-patient ratio, we can easily adapt to a changing census and separate groups into the optimal size to maximize benefit to individuals; when we do meet full capacity, the group size will continue to operate at the above stated range.

We do not anticipate that the introduction of Silver Pines will negatively erode the volume of other Vermont facilities. As we are not seeking state or federal funding, we will have a negligible impact on the two treatment facilities in Vermont that currently provide medically supervised withdrawal services.

CON STANDARD 1.6

CON STANDARD 1.6: Applicants seeking to develop a new health care project shall explain how the applicant will collect and monitor data relating to health care quality and outcomes related to the proposed new health care project. To the extent practicable, such data collection and monitoring shall be aligned with related data collection and monitoring efforts, whether within the applicant's organization, other organizations or the government.

Silver Pines will utilize our state-of-the-art computing platform to collect and analyze aggregate outcomes data to support our population health efforts. We will have clear policies, procedures, and protocols in order to analyze our outcome data. Our staff will be trained in these procedures and protocols.

National data that is collected to determine outcomes for SUDs falls under eight categories/domains:

- Domain 1: Reduced Morbidity - Abstinence from Drug or Alcohol Use;
- Domain 2: Employment/Education;
- Domain 3: Crime and Criminal justice;
- Domain 4: Social Connectedness;
- Domain 5: Access/Capacity;
- Domain 6: Retention;
- Domain 7: Cost Effectiveness; and
- Domain 8: Use of Evidence-based Practices and Strategies.

Of these eight domains, the Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (ADAP) collects data to measure outcomes for Domains 5, 7, and 8.[37] Silver Pines will customize its intake process to begin to collect data around access and capacity that ADAP has been collecting to measure outcomes. In addition, Silver Pines will collect data around the other two data sets that ADAP has deemed to be critical, cost effectiveness and use of

[35] Fuhriman, A., & Burlingame, G. M. (1994). *Handbook of group psychotherapy: an empirical and clinical synthesis*. New York: John Wiley.
[36] Vinogradov, S., & Yalom, I. D. (1989). Concise guide to group psychotherapy. Washington, DC: American Psychiatric Press.
[37] Vermont Department of Health. (2019, October 22). Reporting Forms & Guidance Documents. Retrieved from https://www.healthvermont.gov/alcohol-drug-abuse/grantees-contractors/reporting-forms-and-guidance-documents.

evidence-based practices. Since Silver Pines has a strong emphasis on data outcomes in order to adapt programming based upon the information received, we will also collect data around social connectedness, retention and reduced morbidity. Silver Pines will employ a data analyst to ensure fidelity around outcome measures.

Silver Pines will continually use the data collected to make quality improvements as needed. Our staff at every level will be trained in the process of data collection. We will establish a culture that models continuous excellence from our front-end process to our continuing care coordination. Our proprietary algorithms will also be utilized to collect data post discharge for up to a year.

Additionally, Silver Pines will utilize the following measures:

- Process:
  - Engagement in treatment
  - Successful completion of treatment
  - Abstinence as measured by urine drug screens, self-report, and collateral information
- Outcome:
  - Addiction Severity Index
  - Quality of Life indices
  - Psychiatric symptom scales, such as PHQ-9, MADRS, and SERAS™
  - Morbidity as measured by health complications of ongoing substance use
  - Mortality from overdose, self-injury or other sequelae
  - Health system utilization

CON STANDARD 1.7

CON STANDARD 1.7: Applicants seeking to develop a new health care project shall explain how such project is consistent with evidence-based practice. Such explanation may include a description of how practitioners will be made aware of evidence-based practice guidelines and how such guidelines will be incorporated into ongoing decision making.

As previously stated in CON 1.2, the services and treatment modalities at Silver Pines will consist of evidence-based practices. We are committed to providing ongoing educational opportunities to all staff members through in-house trainings and funding for continuing education. This will allow them to have up-to-date knowledge of continually evolving best practices.

CON STANDARD 4.4

CON STANDARD 4.4: Applications involving substance abuse treatment services shall include an explanation of how such proposed project is consistent with the Department of Health's recommendations concerning effective substance abuse treatment or explain why such consistency should not be required.

Goal 1: Effective and Integrated Public Health

Silver Pines will align with the Department of Health's goal regarding effective and integrated public health by:

- conducting assessments that include but are not limited to screening of sexually transmitted diseases, HIV/AIDS, Hepatitis B and C, liver functions,
- promoting and offering smoking cessation treatments,[38]
- onsite treatment of these conditions, and
- collaboration with the individuals' respective PCPs (or establish primary care).

Silver Pines will also employ aftercare specialists, which will align with our strategy of increasing the percentage of individuals leaving treatment with more support than when they started the program. The aftercare specialists will link each individual with providers in the community, creating a comprehensive continuing care plan. The hallmarks of each plan will be an appointment with a PCP, continued outpatient groups and/or individual counseling (partial hospitalization program, intensive outpatient program), and social supports. The plan will also include social and peer supports, such as recovery coaches, 12-step meetings, and sponsorship.

Goal 2: Communities with the Capacity to Respond to Public Health Need

Silver Pines will employ highly trained physicians, nurses, LADCs, administrative staff that are expertly qualified to assess levels of care using ASAM criteria.

Silver Pines anticipates increasing the number of Vermonters having access to MAT; including buprenorphine (sublingual, subcutaneous extended release injection, subdermal implant), naltrexone (oral and injectable extended release), disulfiram, and acamprosate. In addition, we will collaborate with community providers to transition individuals to the appropriate community level of care after discharge from our program.

Goal 3: Internal Systems that Provide for Consistent and Responsive Support

Silver Pines will utilize a HIPAA (Health Insurance Portability and Accountability Act of 1996), JC (Joint Commission), CARF (Commission on Accreditation of Rehabilitation Facilities) compliant EHR. In addition, our neural-net based system will be able to gather and analyze data in a rapid, consistent and valid manner.

Silver Pines will continually use the data collected to make quality improvements as needed. We will have a culture that models continuous strive for excellence.

[38] Barua, R., & Rigotti,, N. (2018). ACC Expert Consensus Decision Pathway on Tobacco Cessation Treatment. *Journal of American College of Cardiology*, *72*(25), 3333–3365. Retrieved from http://www.onlinejacc.org/content/accj/72/25/3332.full.pdf.

Goal 4: A Competent and Valued Workforce that is Supported in Promoting and Protecting the Public's Health

Pursuant to goal number four, Silver Pines will hire accomplished professionals and will prioritize culturally competent professional development of each staff, regardless of their position at the facility. Silver Pines will also provide funding for continued education for all staff that directly support the recovery efforts of individuals.

Goal 5: A Public Health System that is Understood and Valued by Vermonters

In order to increase the public understanding of substance use services, Silver Pines will provide the public with a list of local resources and direct them towards the appropriate level of care. In addition, our website will incorporate a directory of resources and Vermont substance use providers.

Goal 6: Health Equity for All Vermonters

Silver Pines will align with goal number six by having a customized, culturally sensitive gender equality-oriented program. In addition, we will provide treatment in compliance with the National Standards for Culturally and Linguistically appropriate services. In part of aligning with this standard, Silver Pines will contract with an interpreter on site when indicated. We will incorporate culturally and linguistically appropriate policies and infuse them in our daily operations.

CON STANDARD 4.5

CON STANDARD 4.5: To the extent possible, an applicant seeking to implement a new health care project shall ensure that such project supports further integration of mental health, substance abuse and other health care.

Providing the highest quality of integrated care is a core objective of Silver Pines. As noted by the Institute of Medicine, mental health, substance use and medical health are inherently interconnected, and poor care has serious consequences for the people seeking treatment and for the nation overall.[39] To that end, all treatment modalities offered at Silver Pines will support the integration of the treatment of mental health, SUDs and other medical conditions.

[39] Institute of Medicine, "Improving the Quality of Health Care for Mental Health and Substance-Abuse Conditions: Quality of Chasm Series (Free Executive Summary)," (2006), at https://www.ncbi.nlm.nih.gov/books/NBK19830/ (accessed October 28, 2019).

Silver Pines' approach is to conceptualize the whole person and consider various aspects of their lives to inform and offer the most comprehensive treatment planning and aftercare. As LADCs, many of our clinical staff as well as the executive and clinical directors, have extensive experience and expertise in using ASAM's six dimensions (outlined in Figure 8[40]) to gain a holistic, biopsychosocial understanding of an individual, which informs optimal treatment and post-discharge coordination of care. Our innovative and proactive commitment to follow up with and offer support to individuals for up to one year after discharge will improve the likelihood of them receiving the appropriate level of support for this chronic relapsing condition.

Figure 8 - ASAM's Six Dimensions

CON STANDARD 4.6

CON STANDARD 4.6: Applicants for mental health care, substance abuse treatment or primary care related certificates of need should demonstrate how integration of mental health, substance abuse and primary care will occur, including whether co-location of services is proposed.

We understand that for addiction treatment to be effective, it needs to be integrative and address an individual's underlying mental health symptoms, physical health complications, and psychosocial environment.

To ensure this type of integration, every individual in our care will receive a comprehensive physical exam and psychiatric assessment at the time of intake, which will allow us to detect and address active health issues and underlying mental health conditions. We will also provide access to qualified mental health professionals. This will ensure accurate diagnosis, initiation of appropriate medications, introduction to or continuation of a variety of evidence-based therapies, and preparation for engagement in continuing care upon discharge.

[40] American Society of Addiction Medicine. (2019). What is the ASAM Criteria? Retrieved from https://www.asam.org/resources/the-asam-criteria/about.

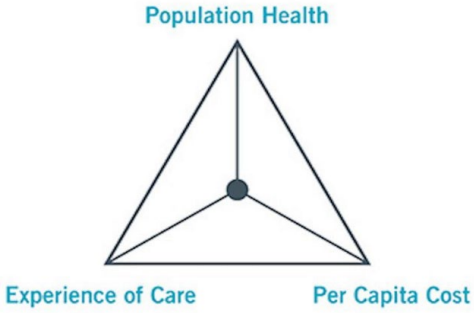
Medical needs that arise during treatment will be addressed by our onsite staff and, if necessary, we will partner with relevant providers for additional care. As a guiding principle, individuals will have an appointment with PCPs upon discharge. We anticipate this improved access to primary care will have a positive impact on individuals' overall risk of developing chronic conditions and their pernicious sequelae.

In addition, our medical and clinical staff will participate in regular multidisciplinary rounds to coordinate individuals' care.

Institute of Healthcare Improvement Triple Aims

Explain how your project is:
(a) Improving the individual experience of care;
(b) Improving health of populations;
(c) Reducing the per capita costs of care for populations.

Figure 9 - The IHI Triple Aim



(a) At Silver Pines, the individual will be assessed and either initiated or continued on psychopharmacology as clinically appropriate. In addition, all of our medical and clinical staff will have regular multidisciplinary clinical rounds to plan and implement individuals' care. Integration of biological, psychological, and social aspects of health is at the core of our model for delivering for the highest quality care. We will have direct access to physicians, nurses, licensed mental health professionals and ancillary professionals. As outlined in Table 7, our treatment will be comprehensive, evidenced-based, personalized, integrated and of the highest quality.

Table 7 - Improved Individual Experience

Comprehensive	▪ All-Inclusive Treatment: - Medical, Psychiatric, Psychometric diagnostics and treatment - Recovery, Wellness and Life Coaching - Family-Based Care - Care Coordination services
Evidence-Based	▪ Nationally Approved Diagnostic and Treatment Guidelines from: - American Academy of Addiction Psychiatry - American College of Physicians - American Society of Addiction Medicine - American Psychiatric Association - American Psychological Association - Substance Abuse and Mental Health Services Administration
Personalized	Culturally informed, gender-equality oriented individualized treatment plan that is customized to each individual. This emphasizes approaches that have previously worked and does not repeat unsuccessful prior treatments.
Integrated Care	Multi-party release of information consents will allow a collaborative process that includes the use of collateral information and active involvement of family, outpatient supports and treatment providers.

Highest Quality	▪ Neural Net-based Expert System that uses a Clinical Informatics platform for accurate and timely clinical decision making ▪ High patient-to-staff ratio to ensure a supportive treatment environment ▪ Safe, comfortable and tranquil facilities that support recovery ▪ Wellness activities, complementary medicine (acupuncture, yoga, massages, relaxation techniques) and healthy nutrition are integrated into the treatment ▪ Proactive, care coordination and real-time outreach services after discharge will allow rapid support for individuals at risk or in the midst of relapse. Supportive services are also offered to friends and family members of the individuals

(b) The pernicious effects of SUDs are devastating to affected individuals, their loved ones, and their communities. Substance use is also a highly social phenomenon with friends or family members often the source of first exposure to addictive substances and major contributors to risk of developing SUDs. Effective individual treatment therefore has potential to produce benefits that carry over to the population by decreasing the spread and perpetuation of substance use within social networks. The emphasis of Silver Pines on education and destigmatization in interactions with individuals, families, medical partners, and the public will also contribute to accessibility and acceptability of treatment for SUDs and assist in decreasing shame, stigma, and stereotypes that currently act as obstacles to availability and utilization of effective treatment.

Silver Pines will also contribute to health at the population level by sharing data with partners to facilitate design, implementation, and evaluation of effective population-level interventions. Our advanced clinical informatics platform will track individuals' characteristics, details of treatment, and outcomes for all individuals using validated instruments to assess SUDs, psychopathology, wellbeing, and functioning. We will obtain data during the admission process, in the course of treatment, and at discharge and post-discharge follow-up via a secure web-based platform and telephone interviews. The ongoing, aggregated data can be shared with GMCB and other partners to inform ongoing assessment of treatment needs, outcomes, and moderators.

(c) SUDs are complex, chronic, remitting and relapsing conditions that often require ongoing treatment and support. At the same time, these are heterogeneous conditions and affected individuals have widely differing experiences, needs, longitudinal courses, and responses to particular therapies. By collecting detailed data on individuals' characteristics, therapeutic interventions, and outcomes at multiple time points Silver Pines will match individuals with the most effective and efficient interventions. Our focus on long-term value for costs utilizing well established measures of comparative clinical effectiveness, incremental cost-effectiveness and situational consideration will support the development of cost-effective, person-centered approaches to the treatment and prevention of SUDs. Individuals with SUDs often have additional unmet medical needs, and attention at Silver Pines to comprehensive aftercare planning including connection with primary care will facilitate preventive care, early intervention, and decreased use of costly emergency services.

Financial Information

Financing

The project will be financed by private investment. Silver Pines will raise $1,000,000 in equity. We will use those funds as working capital to purchase medical equipment, cover the costs associated with the start-up of the business, and cover the operational losses expected in the first few months.

The Bullrock Corporation will assist in managing the facility operations (food, janitorial services, and maintenance). For twelve years the Bullrock Corporation developed, constructed, owned, operated and managed senior living and health care facilities for its own portfolio. Shelburne Bay Senior Living Community, The Lodge at Otter Creek, The Shores at Shelburne Bay, Quarry Hill Senior Living, The Lodges at Old Trail in Crozet are some of the communities Bullrock and its partners have owned and managed. A nation-wide innovator and leader in the memory care arena, Bullrock has remained active in consulting and advising health care operators and senior living developers from concept to implementation.

Profit and Loss Statements

The Profit and Loss Statements spreadsheet exceeds the size limit to be embeded within this document. Please see attached Excel file, *Silver Pines Pro Forma FINAL*.

Revenue Projections – Years 1, 2, and 3

SILVER PINES
Revenues

ASSUMPTIONS: **$10,500 per week (benchmark Brattleboro Retreat)**
Staffing levels adjust to census
Census Year 1: 19% to 44% capacity; i.e., 6 to 14 patients
Census Year 2: 44% to 69% capacity ; i.e., 14 to 22 patients
Census Year 3 and beyond: 69 to 88% capacity; 22 to 28 patients

			Startup & fill up								
			-8	-7	-6	-5	-4	-3	-2	-1	Total
Revenue	**2 months of start-up/fill-up**		Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Pre CO
	Average Daily Census (maximum 32)	1									
	Average Daily Census % Capacity	x/32									
	Monthly Total Patient Days										
	Revenue Per Day per Patient	**$1,500.00**									
	Gross Revenue										
	TOTAL REVENUE		-	-	-	-	-	-	-	-	-

SILVER PINES
Revenues – Year 1

	CO obtained												
	1	2	3	4	5	6	7	8	9	10	11	12	**TOTAL**
Revenue	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	**Year One**
Average Daily Census (maximum 32)	6	6	8	8	10	10	12	12	12	14	14	14	
Average Daily Census % Capacity	19%	19%	25%	25%	31%	31%	38%	38%	38%	44%	44%	44%	
Monthly Total Patient Days	180	186	248	240	310	300	372	372	336	434	420	434	
Revenue Per Day per Patient	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500	
Gross Revenue	$270,000	$279,000	$372,000	$360,000	$465,000	$450,000	$558,000	$558,000	$504,000	$651,000	$630,000	$651,000	
TOTAL REVENUE	$270,000	$279,000	$372,000	$360,000	$465,000	$450,000	$558,000	$558,000	$504,000	$651,000	$630,000	$651,000	**$5,748,000**

SILVER PINES
Revenues – Year 2

	CPI	
	1.05	**rent**
	1.03	**other expenses**

	1	2	3	4	5	6	7	8	9	10	11	12	**TOTAL**
Revenue	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	**Year Two**
Average Daily Census (maximum 32)	16	16	16	18	18	18	20	20	20	22	22	22	
Average Daily Census % Capacity	50%	50%	50%	56%	56%	56%	63%	63%	63%	69%	69%	69%	
Monthly Total Patient Days	480	496	496	540	558	540	620	620	560	682	660	682	
Revenue Per Day per Patient	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500	
Gross Revenue	$720,000	$744,000	$744,000	$810,000	$837,000	$810,000	$930,000	$930,000	$840,000	$1,023,000	$990,000	$1,023,000	
TOTAL REVENUE	$720,000	$744,000	$744,000	$810,000	$837,000	$810,000	$930,000	$930,000	$840,000	$1,023,000	$990,000	$1,023,000	**$10,401,000**

SILVER PINES
Revenues – Year 3

	1	2	3	4	5	6	7	8	9	10	11	12	**TOTAL**
Revenue	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	**Year Three**
Average Daily Census (maximum 32)	24	24	24	26	26	26	28	28	28	28	28	28	
Average Daily Census % Capacity	75%	75%	75%	81%	81%	81%	88%	88%	88%	88%	88%	88%	
Monthly Total Patient Days	720	744	744	780	806	780	868	868	784	868	840	868	
Revenue Per Day per Patient	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500	
Gross Revenue	$1,080,000	$1,116,000	$1,116,000	$1,170,000	$1,209,000	$1,170,000	$1,302,000	$1,302,000	$1,176,000	$1,302,000	$1,260,000	$1,302,000	
TOTAL REVENUE	$1,080,000	$1,116,000	$1,116,000	$1,170,000	$1,209,000	$1,170,000	$1,302,000	$1,302,000	$1,176,000	$1,302,000	$1,260,000	$1,302,000	**$14,505,000**

Balance Sheet

SILVER PINES
BALANCE SHEET
Sources and Uses

SOURCES:	
EQUITY	$1,000,000
FINANCING	$0
	$1,000,000
USES:	
Training, Marketing, I/T, Pre-opening Costs	$529,901
Operating Loss	$312,231
Contingency Op Loss	$63,793
Equipment (see below)	$94,075
	$1,000,000
Equipment):	
BD Pyxis MedStation medication dispensing system	$50,000
Electrocardiogram x 1	$2,850
Vital monitoring equipment x 3	$2,850
Defibrillators x 5	$6,375
Computers/software	$32,000
	$94,075

Cash Flows

The Cash Flows spreadsheet is too large to embed within this document. Please see attached Excel file, *Silver Pines Pro Forma FINAL*.

Operating Costs

The Operating Costs spreadsheet is too large to embed within this document. Please see attached Excel file, *Silver Pines Pro Forma FINAL*.

Staffing Levels and Costs

The Staffing Levels and Costs spreadsheet is too large to embed within this document. Please see attached Excel file, *Silver Pines Pro Forma FINAL*.

Financial Tables

Financial Table 1 - Project Costs

Silver Pines
TABLE 1
PROJECT COSTS

Silver Pines will lease the facility in which it will operate.
The facility will be fully furnished.

Construction Costs				
1.	New Construction			N/A
2.	Renovation			N/A
3.	Site Work			N/A
4.	Fixed Equipment			N/A
5.	Design/Bidding Contingency			N/A
6.	Construction Contingency			N/A
7.	Construction Manager Fee			N/A
8.	Other (please specify)			N/A
		Subtotal		N/A
Related Project Costs				
1.	Major Moveable Equipment			N/A
2.	Furnishings, Fixtures & Other Equip.			N/A
3.	Architectural/Engineering Fees			N/A
4.	Land Acquisition			N/A
5.	Purchase of Buildings			N/A
6.	Administrative Expenses & Permits			N/A
7.	Debt Financing Expenses (see below)			N/A
8.	Debt Service Reserve Fund			N/A
9.	Working Capital			905,925
10.	Other (please specify)			94,075
		Subtotal		$ 1,000,000.00
Total Project Costs				**$ 1,000,000.00**

Debt Financing Expenses				
1.	Capital Interest			N/A
2.	Bond Discount or Placement Fee			N/A
3.	Misc. Financing Fees & Exp. (issuance costs)			N/A
4.	Other			N/A
		Subtotal		N/A
Less Interest Earnings on Funds				
1.	Debt Service Reserve Funds			N/A
2.	Capitalized Interest Account			N/A
3.	Construction Fund			N/A
4.	Other			N/A
		Subtotal		N/A
Total Debt Financing Expenses				**N/A**
feeds to line 7 above				

Financial Table 2 - Financing Arrangement

Silver Pines

TABLE 2

DEBT FINANCING ARRANGEMENT, SOURCES & USES OF FUNDS

Silver Pines will lease the facility in which it will operate.
The facility will be fully furnished.
Silver Pines will only buy medical equipment and computers.
Silver Pines will not raise money through debt.
Silver Pines will raise the necessary funds to start operations through an equity offering to private investors.
The equity offering amount will be $1,000,000.

Sources of Funds

1.	Financing Instrument			
a.	Interest Rate	0.0%		
b.	Loan Period		To:	
c.	Amount Financed			$ -
2.	Equity Contribution			$ 1,000,000.00
3.	Other Sources			
a.	Working Capital			
b.	Fundraising			-
c.	Grants			-
d.	Other			-
Total Required Funds				**$ 1,000,000 .00**

Uses of Funds

Project Costs (feeds from Table 1)			should be zero
1.	New Construction	N/A	$0
2.	Renovation	N/A	$0
3.	Site Work	N/A	$0
4.	Fixed Equipment	N/A	$0
5.	Design/Bidding Contingency	N/A	$0
6.	Construction Contingency	N/A	$0
7.	Construction Manager Fee	N/A	$0
8.	Major Moveable Equipment	N/A	$0
9.	Furnishings, Fixtures & Other Equip.	N/A	$0
10.	Architectural/Engineering Fees	N/A	$0
11.	Land Acquisition	N/A	$0
12.	Purchase of Buildings	N/A	$0
13.	Administrative Expenses & Permits	N/A	$0
14.	Debt Financing Expenses	N/A	$0
15.	Debt Service Reserve Fund	N/A	$0
16.	Working Capital	905,925	$1,000,000
17.	Other (please specify)	94,075	$0
Total Uses of Funds		**$ 1,000,000**	$0

Total sources should equal total uses of funds.

Financial Table 6A - Revenue Source Projections Without Project

Silver Pines

TABLE 6A

REVENUE SOURCE PROJECTIONS

WITHOUT PROJECT

Silver Pines will only exist through this project.

		Latest Actual #REF!	% of Total	Budget #REF!	% of Total	Proposed Year 1 #REF!	% of Total	Proposed Year 2 #REF!	% of Total	Proposed Year 3 #REF!	% of Total
Gross Inpatient Revenue											
	Medicare	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Medicaid	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Commercial	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Self Pay	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Free Care / Bad Debt	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Other	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Gross Outpatient Revenue		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Medicare	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Medicaid	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Commercial	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Self Pay	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Free Care / Bad Debt	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Other	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Gross Other Revenue		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Medicare	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Medicaid	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Commercial	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Self Pay	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Free Care / Bad Debt	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Other	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Silver Pines

TABLE 6A

REVENUE SOURCE PROJECTIONS

WITHOUT PROJECT

Silver Pines will only exist through this project.

		Latest Actual #REF!	% of Total	Budget #REF!	% of Total	Proposed Year 1 #REF!	% of Total	Proposed Year 2 #REF!	% of Total	Proposed Year 3 #REF!	% of Total
Gross Patient Revenue		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Medicare	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Medicaid	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Commercial	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Self Pay	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Free Care / Bad Debt	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Other	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Deductions from Revenue		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Medicare	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Medicaid	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Commercial	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Self Pay	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Free Care / Bad Debt	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Other	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Net Patient Revenue		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Medicare	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Medicaid	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Commercial	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Self Pay	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Free Care / Bad Debt	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Other	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	DSP*	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Latest actual numbers should tie to the hospital budget process. DOES NOT APPLY.

* Disproportionate share payments

Financial Table 6B - Revenue Source Projections Project Only

Silver Pines

TABLE 6B
REVENUE SOURCE PROJECTIONS
PROJECT ONLY

Silver Pines will be a residential/inpatient facility only.
Silver Pines revenues will be Self-Pay (95%) and Commercial (5%)

	Latest Actual #REF!	% of Total	Budget #REF!	% of Total	Proposed Year 1 #REF!	% of Total	Proposed Year 2 #REF!	% of Total	Proposed Year 3 #REF!	% of Total
Gross Inpatient Revenue										
Medicare	N/A	N/A	N/A	N/A	$ -	0.0%	$ -	0.0%	$ -	0.0%
Medicaid	N/A	N/A	N/A	N/A	-	0.0%	-	0.0%	-	0.0%
Commercial	N/A	N/A	N/A	N/A	287,400	5.0%	520,050	5.0%	725, 250	5.0%
Self Pay	N/A	N/A	N/A	N/A	5,460,600	95.0%	9,880,950	95.0%	13,779,750	95.0%
Free Care / Bad Debt	N/A	N/A	N/A	N/A	-	0.0%	-	0.0%	-	0.0%
Other	N/A	N/A	N/A	N/A	-	0.0%	-	0.0%	-	0.0%
	N/A	N/A	N/A	N/A	$ 5,748,000	100.0%	$ 10,401,000	100.0%	$ 14,505,000	100.0%
Gross Outpatient Revenue										
Medicare	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Medicaid	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Commercial	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Self Pay	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Free Care / Bad Debt	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Other	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Gross Other Revenue										

Silver Pines

TABLE 6B

REVENUE SOURCE PROJECTIONS

PROJECT ONLY

Silver Pines will be a residential/inpatient facility only.
Silver Pines revenues will be Self-Pay (95%) and Commercial (5%)

	Latest Actual #REF!	% of Total	Budget #REF!	% of Total	Proposed Year 1 #REF!	% of Total	Proposed Year 2 #REF!	% of Total	Proposed Year 3 #REF!	% of Total
Medicare	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Medicaid	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Commercial	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Self Pay	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Free Care / Bad Debt	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Other	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Gross Patient Revenue										
Medicare	N/A	N/A	N/A	N/A	$ -	0.0%	$ -	0.0%	$ -	0.0%
Medicaid	N/A	N/A	N/A	N/A	-	0.0%	-	0.0%	-	0.0%
Commercial	N/A	N/A	N/A	N/A	287,400	5.0%	520,050	5.0%	725, 250	5.0%
Self Pay	N/A	N/A	N/A	N/A	5,460,600	95.0%	9,880,950	95.0%	13,779,750	95.0%
Free Care / Bad Debt	N/A	N/A	N/A	N/A	-	0.0%	-	0.0%	-	0.0%
Other	N/A	N/A	N/A	N/A	-	0.0%	-	0.0%	-	0.0%
	N/A	N/A	N/A	N/A	$ 5,748,000	100.0%	$ 10,401,000	100.0%	$ 14,505,000	100.0%
Deductions from Revenue										

Silver Pines

TABLE 6B

REVENUE SOURCE PROJECTIONS

PROJECT ONLY

Silver Pines will be a residential/inpatient facility only.
Silver Pines revenues will be Self-Pay (95%) and Commercial (5%)

	Latest Actual #REF!	% of Total	Budget #REF!	% of Total	Proposed Year 1 #REF!	% of Total	Proposed Year 2 #REF!	% of Total	Proposed Year 3 #REF!	% of Total
Medicare	N/A	N/A	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Medicaid	N/A	N/A	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Commercial	N/A	N/A	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Self Pay	N/A	N/A	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Free Care / Bad Debt	N/A	N/A	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other	N/A	N/A	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Net Patient Revenue										
Medicare	N/A	N/A	N/A	N/A	$ -	0.0%	$ -	0.0%	$ -	0.0%
Medicaid	N/A	N/A	N/A	N/A	-	0.0%	-	0.0%	-	0.0%
Commercial	N/A	N/A	N/A	N/A	287,400	5.0%	520,050	5.0%	725, 250	5.0%
Self Pay	N/A	N/A	N/A	N/A	5,460,600	95.0%	9,880,950	95.0%	13,779,750	95.0%
Free Care / Bad Debt	N/A	N/A	N/A	N/A	-	0.0%	-	0.0%	-	0.0%
Other	N/A	N/A	N/A	N/A	-	0.0%	-	0.0%	-	0.0%
DSP*	N/A	N/A	N/A	N/A	**N/A**		**N/A**		**N/A**	
			N/A	N/A	$ 5,748,000	100.0%	$ 10,401,000	100.0%	$ 14,505,000	100.0%

Latest actual numbers should tie to the hospital budget process. DOES NOT APPLY.
* Disproportionate share payments

Financial Table 6C - Revenue Source Projections With Project

Silver Pines
TABLE 6C
REVENUE SOURCE PROJECTIONS
WITH PROJECT

Silver Pines will be a residential/inpatient facility only.
Silver Pines revenues will be Self-Pay (95%) and Commercial (5%)

	Latest Actual #REF!	% of Total	Budget #REF!	% of Total	Proposed Year 1 #REF!	% of Total	Proposed Year 2 #REF!	% of Total	Proposed Year 3 #REF!	% of Total
Gross Inpatient Revenue										
Medicare	N/A	N/A	N/A	N/A	$ -	0.0%	$ -	0.0%	$ -	0.0%
Medicaid	N/A	N/A	N/A	N/A	-	0.0%	-	0.0%	-	0.0%
Commercial	N/A	N/A	N/A	N/A	287,400	5.0%	520,050	5.0%	725, 250	5.0%
Self Pay	N/A	N/A	N/A	N/A	5,460,600	95.0%	9,880,950	95.0%	13,779,750	95.0%
Free Care / Bad Debt	N/A	N/A	N/A	N/A	-	0.0%	-	0.0%	-	0.0%
Other	N/A	N/A	N/A	N/A	-	0.0%	-	0.0%	-	0.0%
	N/A	N/A	N/A	N/A	$ 5,748,000	100.0%	$ 10,401,000	100.0%	$ 14,505,000	100.0%
Gross Outpatient Revenue										
Medicare	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Medicaid	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Commercial	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Self Pay	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Free Care / Bad Debt	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Other	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Silver Pines

TABLE 6C
REVENUE SOURCE PROJECTIONS
WITH PROJECT

Silver Pines will be a residential/inpatient facility only.
Silver Pines revenues will be Self-Pay (95%) and Commercial (5%)

	Latest Actual #REF!	% of Total	Budget #REF!	% of Total	Proposed Year 1 #REF!	% of Total	Proposed Year 2 #REF!	% of Total	Proposed Year 3 #REF!	% of Total
Gross Other Revenue										
Medicare	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Medicaid	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Commercial	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Self Pay	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Free Care / Bad Debt	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Other	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Gross Patient Revenue										
Medicare	N/A	N/A	N/A	N/A	$ -	0.0%	$ -	0.0%	$ -	0.0%
Medicaid	N/A	N/A	N/A	N/A	-	0.0%	-	0.0%	-	0.0%
Commercial	N/A	N/A	N/A	N/A	287,400	5.0%	520,050	5.0%	725, 250	5.0%
Self Pay	N/A	N/A	N/A	N/A	5,460,600	95.0%	9,880,950	95.0%	13,779,750	95.0%
Free Care / Bad Debt	N/A	N/A	N/A	N/A	-	0.0%	-	0.0%	-	0.0%
Other	N/A	N/A	N/A	N/A	-	0.0%	-	0.0%	-	0.0%
	N/A	N/A	N/A	N/A	$ 5,748,000	100.0%	$ 10,401,000	100.0%	$ 14,505,000	100.0%

Silver Pines

TABLE 6C
REVENUE SOURCE PROJECTIONS
WITH PROJECT

Silver Pines will be a residential/inpatient facility only.
Silver Pines revenues will be Self-Pay (95%) and Commercial (5%)

	Latest Actual #REF!	% of Total	Budget #REF!	% of Total	Proposed Year 1 #REF!	% of Total	Proposed Year 2 #REF!	% of Total	Proposed Year 3 #REF!	% of Total
Deductions from Revenue										
Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Commercial	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Self Pay	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Free Care / Bad Debt	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Net Patient Revenue										
Medicare	N/A	N/A	N/A	N/A	$ -	0.0%	$ -	0.0%	$ -	0.0%
Medicaid	N/A	N/A	N/A	N/A	-	0.0%	-	0.0%	-	0.0%
Commercial	N/A	N/A	N/A	N/A	287,400	5.0%	520,050	5.0%	725, 250	5.0%
Self Pay	N/A	N/A	N/A	N/A	5,460,600	95.0%	9,880,950	95.0%	13,779,750	95.0%
Free Care / Bad Debt	N/A	N/A	N/A	N/A	-	0.0%	-	0.0%	-	0.0%
Other	N/A	N/A	N/A	N/A	-	0.0%	-	0.0%	-	0.0%
DSP*	N/A	N/A	N/A	N/A	N/A	0.0%	N/A	0.0%	N/A	0.0%
	N/A	N/A	N/A	N/A	$ 5,748,000	100.0%	$ 10,401,000	100.0%	$ 14,505,000	100.0%

Latest actual numbers should tie to the hospital budget process. **DOES NOT APPLY**

* Disproportionate share payments

Financial Table 7A, 7B, and 7C - Utilization Projections

Silver Pines

TABLE 7

UTILIZATION PROJECTIONS

TOTALS

Recommended length of treatment is 7-14 days.
Expected average length of stay is 10.5 days.

A: WITHOUT PROJECT	**Latest Actual**		**Budget 1**		**Proposed Year 1 2**		**Proposed Year 2 3**		**Proposed Year 3 4**
Inpatient Utilization	N/A		N/A		N/A		N/A		N/A
Staffed Beds	N/A	##	N/A	-	N/A	#	N/A	##	N/A
Admissions	N/A	##	N/A	-	N/A	#	N/A	##	N/A
Patient Days	N/A	##	N/A	-	N/A	#	N/A	##	N/A
Average Length of Stay	N/A	##	N/A	-	N/A	#	N/A	##	N/A
Outpatient Utilization	N/A	##	N/A	-	N/A	#	N/A	##	N/A
All Outpatient Visits	N/A	##	N/A	-	N/A	#	N/A	##	N/A
OR Procedures	N/A	##	N/A	-	N/A	#	N/A	##	N/A
Observation Units	N/A	##	N/A	-	N/A	#	N/A	##	N/A
Physician Office Visits	N/A	##	N/A	-	N/A	#	N/A	##	N/A
Ancillary	N/A	##	N/A	-	N/A	#	N/A	##	N/A
All OR Procedures	N/A	##	N/A	-	N/A	#	N/A	##	N/A
Emergency Room Visits	N/A	##	N/A	-	N/A	#	N/A	##	N/A
Adjusted Statistics	N/A	##	N/A	-	N/A	#	N/A	##	N/A
Adjusted Admissions	N/A	##	N/A	-	N/A	#	N/A	##	N/A
Adjusted Patient Days	N/A	##	N/A	-	N/A	#	N/A	##	N/A

Silver Pines

TABLE 7

UTILIZATION PROJECTIONS

TOTALS

Recommended length of treatment is 7-14 days.
Expected average length of stay is 10.5 days.

B: PROJECT ONLY									
	Latest Actual 0		**Budget 1**		**Proposed Year 1 2**		**Proposed Year 2 3**		**Proposed Year 3 4**
Inpatient Utilization									
Staffed Beds	N/A	#	N/A	#	32	##	32	##	32
Admissions	N/A	#	N/A	#	365	##	660	##	921
Patient Days	N/A	#	N/A	#	3,832	##	6,934	##	9,670
Average Length of Stay	N/A	#	N/A	#	10.50	##	10.50	##	10.50
Outpatient Utilization	N/A	#	N/A	#	N/A	##	N/A	##	N/A
All Outpatient Visits	N/A	#	N/A	#	N/A	##	N/A	##	N/A
OR Procedures	N/A	#	N/A	#	N/A	##	N/A	##	N/A
Observation Units	N/A	#	N/A	#	N/A	##	N/A	##	N/A
Physician Office Visits	N/A	#	N/A	#	N/A	##	N/A	##	N/A
Ancillary	N/A	#	N/A	#	N/A	##	N/A	##	N/A
All OR Procedures	N/A	#	N/A	#	N/A	##	N/A	##	N/A
Emergency Room Visits	N/A	#	N/A	#	N/A	##	N/A	##	N/A
Adjusted Statistics	N/A	#	N/A	#	N/A	##	N/A	##	N/A
Adjusted Admissions	N/A	#	N/A	#	N/A	##	N/A	##	N/A
Adjusted Patient Days	N/A	#	N/A	#	N/A	##	N/A	##	N/A

Silver Pines

TABLE 7

UTILIZATION PROJECTIONS

TOTALS

Recommended length of treatment is 7-14 days.
Expected average length of stay is 10.5 days.

C: WITH PROJECT	Latest Actual 0		Budget 1		Proposed Year 1 2		Proposed Year 2 3		Proposed Year 3 4
Inpatient Utilization		#		#		#		#	
Staffed Beds	N/A	#	N/A	#	32	#	32	#	32
Admissions	N/A	#	N/A	#	365	#	660	#	921
Patient Days	N/A	#	N/A	#	3,832	#	6,934	#	9,670
Average Length of Stay	N/A	#	N/A	#	10.50	#	10.50	#	10.50
Outpatient Utilization	N/A	#	N/A	#	N/A	#	N/A	#	N/A
All Outpatient Visits	N/A	#	N/A	#	N/A	#	N/A	#	N/A
OR Procedures	N/A	#	N/A	#	N/A	#	N/A	#	N/A
Observation Units	N/A	#	N/A	#	N/A	#	N/A	#	N/A
Physician Office Visits	N/A	#	N/A	#	N/A	#	N/A	#	N/A
Ancillary	N/A	#	N/A	#	N/A	#	N/A	#	N/A
All OR Procedures	N/A	#	N/A	#	N/A	#	N/A	#	N/A
Emergency Room Visits	N/A	#	N/A	#	N/A	#	N/A	#	N/A
Adjusted Statistics	N/A	#	N/A	#	N/A	#	N/A	#	N/A
Adjusted Admissions	N/A	#	N/A	#	N/A	#	N/A	#	N/A
Adjusted Patient Days	N/A	#	N/A	#	N/A	#	N/A	#	N/A

Financial Table 9A, 9B, and 9C - Staffing Projections

Silver Pines
TABLE 9
STAFFING PROJECTIONS
TOTALS

Silver Pines will only be an Inpatient Facility.
Staffing levels will adjust to patient census.

A: WITHOUT PROJECT	Latest Actual		Budget 1		Proposed Year 1 2		Proposed Year 2 3		Proposed Year 3 4
Non-MD FTEs									
Total General Services	N/A	#	N/A	#	N/A	#	N/A	#	N/A
Total Inpatient Routine Services	N/A	#	N/A	#	N/A	#	N/A	#	N/A
Total Outpatient Routine Services	N/A	#	N/A	#	N/A	#	N/A	#	N/A
Total Ancillary Services	N/A	#	N/A	#	N/A	#	N/A	#	N/A
Total Other Services	N/A	#	N/A	#	N/A	#	N/A	#	N/A
Total Non-MD FTEs	N/A	#	N/A	#	N/A	#	N/A	#	N/A
		#		#		#		#	
Physician FTEs	**N/A**	#	**N/A**	#	**N/A**	#	**N/A**	#	**N/A**
Direct Service Nurse FTEs	**N/A**	#	**N/A**	#	**N/A**	#	**N/A**	#	**N/A**
		#		#		#		#	

B: PROJECT ONLY	Latest Actual 0	#	Budget 1	#	Proposed Year 1 2	#	Proposed Year 2 3	#	Proposed Year 3 4
Non-MD FTEs		#		#		#		#	
Total General Services	N/A	#	N/A	#	N/A	#	N/A	#	N/A
Total Inpatient Routine Services	N/A	#		#	37.3	#	44.9	#	47.9
Total Outpatient Routine Services	N/A	#	N/A	#	N/A	#	N/A	#	N/A
Total Ancillary Services	N/A	#	N/A	#	N/A	#	N/A	#	N/A
Total Other Services	N/A	#	N/A	#	N/A	#	N/A	#	N/A
Total Non-MD FTEs	**N/A**	#	**N/A**	#	**37.3**	#	**44.9**	#	**47.9**
		#		#		#		#	
Physician Services	**N/A**	#	**N/A**	#	**4.0**	#	**4.3**	#	**4.5**
Direct Service Nurse FTEs	**N/A**	#	**N/A**	#	**5.2**	#	**9.4**	#	**9.4**
		#		#		#		#	

C: WITH PROJECT	Latest Actual 0	Budget 1	Proposed Year 1 2	Proposed Year 2 3	Proposed Year 3 4
Non-MD FTEs					
Total General Services	N/A	N/A	0.0	0.0	0.0
Total Inpatient Routine Services	N/A	N/A	36.3	60.0	63.2
Total Outpatient Routine Services	N/A	N/A	0.0	0.0	0.0
Total Ancillary Services	N/A	N/A	0.0	0.0	0.0
Total Other Services	N/A	N/A	0.0	0.0	0.0
Total Non-MD FTEs	**N/A**	**N/A**	**0.0**	**60.0**	**63.2**
Physician Services	**N/A**	**N/A**	**4.0**	**4.3**	**4.5**
Direct Service Nurse FTEs	**N/A**	**N/A**	**5.2**	**9.4**	**9.4**