Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, D.C. 20554

In the Matter of	)	
	)	
Promoting Telehealth in Rural America	)	WC Docket No. 17-310
	)	

PETITION FOR RECONSIDERATION AND CLARIFICATION

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November 12, 2019

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SUMMARY

Having now reformed the overall Rural Health Care ("RHC") universal service program with more robust protections against potential waste, fraud, and abuse, the Commission should reconsider whether the amount of funding devoted to the RHC program is adequate to meet statutory objectives. Funding demand has continued to grow even as the Commission has provided increased program oversight over a several year period. Indeed, bi-partisan efforts in Congress are underway to find ways to address the continuing crisis in rural health care – but no further act of Congress is needed to authorize the Commission to address this crisis. The Commission has recognized the importance of data-driven decision making, and it should undertake a funding needs analysis – both with respect to the overall RHC funding cap, and the $150 million Healthcare Connect Fund ("HCF") "sub-cap."

In addition, the Commission's Report and Order on Promoting Telehealth in Rural America (*Order*) misconstrues the purpose of the HCF sub-cap which was principally to ensure that HCF fluctuating demand for broadband infrastructure funding did not crowd out funding for broadband services. In concluding that the sub-cap was working as intended and that an increase was not warranted, the *Order* failed to recognize that infrastructure was in fact driving the increase as was originally feared. The Commission previously indicated that an increase in the HCF sub-cap could be warranted if health care providers were shown to be migrating from the Telecom Program to the HCF – and Commission data shows this to be the case. For these reasons, the Commission should increase the size of the HCF sub-cap, and should carry forward unused HCF consortia funding specifically for the HCF sub-cap.

The Commission should also modify the definitions of rural to make them more granular. NCTN and SOHCN offer modest and workable modifications to the current definitions that will ensure health care providers that are objectively rural and which serve primarily rural patient populations are eligible for critical program support.

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Pursuant to Section 1.429 of the Commission's Rules,[1] the North Carolina Telehealth Network Association, on behalf of the North Carolina Telehealth Network ("NCTN"), and Thomas A. Reid, on behalf of the Southern Ohio Health Care Network ("SOHCN"), each of which are consortia in the Rural Health Care ("RHC") program's Healthcare Connect Fund ("HCF"), respectfully petitions the Commission to reconsider or clarify certain aspects of its recent RHC program Report and Order.[2] In support thereof, the following is respectfully submitted:

I. INTRODUCTION

The North Carolina Telehealth Network Association ("NCTNA") is a 501(c)(3) organization that is directed by and for the 325+ health care providers ("HCPs") it serves. The NCTN has served sites across North Carolina since 2010.[3] The SOHCN represents 130+ HCP locations across 34-counties in southern and eastern Ohio. Begun under the FCC Rural Health Care Pilot Program, the SOHCN has transitioned its participants into an HCF-based consortium. SOHCN's board-governed non-profit pools the purchasing power of health care

[1] 47 C.F.R. § 1.429.

[2] *Promoting Telehealth in Rural America*, WC Docket No. 17-310, Report and Order, 34 FCC Rcd 7355 (rel. Aug. 20, 2019) (*Order*); *see also* 84 Fed. Reg. 54952 (Oct. 11, 2019).

[3] *See* http://NCTNA.org.

providers in our rural region to amplify the impact and savings for its members. NCTN and SOHCN seek reconsideration or clarification of the *Order* on behalf of their HCP participants.

II. HAVING TAKEN STEPS TO ADDRESS PROGRAM INTEGRITY, THE COMMISSION SHOULD HAVE REVISITED THE RURAL HEALTH CARE FUNDING CAPS

In 2015, the last year before the cap-driven disruptions the RHC program has faced each year since, the Schools Health & Libraries Broadband ("SHLB") Coalition (of which both NCTN and SOHCN are members) in a Petition for Rulemaking urged the Commission to take notice of the rural hospital closure crisis that was well underway then, and the growing importance of the RHC program to rural America and resulting growing demand for RHC funding.[4] The same rural hospital closure crisis continues unabated today,[5] drawing warranted bipartisan attention from Congress including specific efforts to spur the greater availability of telemedicine as part of the solution. Tennessee Senator Marsha Blackburn has led this charge, announcing in August 2019 three bi-partisan bills to address the issue:[6]

> Tennesseans worry that as rural hospitals close, they will be left without access to health care," said Senator Blackburn. "It is imperative that we find an appropriate substitute for maintaining care in these communities. If the old models of care delivery no longer work in our rural communities, we need new models. These three pieces of legislation, which come

[4] *See* Schools, Health & Libraries Broadband Coalition (SHLB) Petition for Rulemaking, WC Docket No. 02-60, at 30-31 (filed Dec. 7, 2015) (*SHLB Petition for Rulemaking*) ("it is possible the RHC program funding cap will be hit within the next few years. The Commission should therefore act now to establish mechanisms to address the cap on a temporary basis. This will provide a buffer period during which the Commission can consider a cap increase to avoid triggering automatic reductions . . .").

[5] *See* North Carolina Rural Health Research Program, University of North Carolina, 1*60 Rural Hospital Closures: January 2005 – Present (118 since 2010)*, https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/ (last visited Nov. 5, 2019). In 2015, the number of a closures (since 2010) was 59.

[6] *See Blackburn Unveils Rural Health Agenda to Bring Care to Underserved Areas*, Aug. 1, 2019, https://www.blackburn.senate.gov/blackburn-unveils-rural-health-agenda-bring-care-underserved-areas (last visited Nov. 5, 2019).

> directly at the request of small[-]town mayors and community leaders, will fill gaps left by hospital closures. We need to make quality care accessible closer to home for rural America. The [three announced bills] target[] areas that need improvement in order to meet that goal.[7]

But rural communities are not solely dependent on Congress acting anew this year to address this problem. That is because Congress long ago authorized this Commission to provide "sufficient" and "predictable" funding to support basic and advanced telecommunications (*i.e.*, broadband) in rural areas to ensure rural communities have access to the healthcare services their non-rural counterparts enjoy without a second-thought: through the Rural Health Care universal service program.[8] This Commission has specific statutory authority to be at the forefront on the very issue Senator Blackburn and others are championing. And having decisively strengthened controls to protect RHC program integrity, the Commission should not have waited further to act to increase funding.

A. The Current Funding Caps are Based on Outdated or Incomplete Data Regarding the Count of Eligible Entities and Minimum Bandwidth Objectives

NCTN and SOHCN applaud the Commission for taking necessary and definitive steps to strengthen program rules for competitive bidding and implementing other commonsense reforms such as consultant and gift rules that will strengthen program integrity. These reforms increase the rule parity between the RHC and its structurally similar though larger cousin, the E-rate program. However, the Commission should continue to pursue parity between the two programs wherever possible. In particular, the Commission should pursue parity in the type of justifications it uses to set funding caps for the programs. The E-rate cap was originally based on a detailed analysis of the number and type of eligible entities and bandwidth targets established by the

[7] *Id.*

[8] 47 US.C. §§ 254(b)(5), (h)(1)(A), (h)(2)(A).

Commission, updated in 2014.[9] But, the Commission did not perform any type of need assessment when it adjusted the RHC cap.

In December 2017, the Commission adopted a Notice of Proposed Rulemaking for the RHC program that sought comment on, among other things, whether and on what basis to raise the RHC funding cap (then set at $400 million).[10] Among other possibilities, the *NPRM* asked whether to retroactively index the cap using inflation or whether to "consider the universe of potential rural healthcare providers and estimate the average or median support needed?"[11] The Commission acted in 2018, increasing cap from $400 to $571 million based on a retroactive inflation adjustment, and allowing annual inflation-based adjustments going forward.[12] While some commenters had urged a larger increase based on an accurate count of health care providers, others urged no increase until after the Commission acted first to address alarming and credible allegations of waste, fraud, and abuse in the program.[13]

The Commission ultimately took the middle-way, concluding that while a limited cap increase was justified, it was premature to do more until after it had taken further steps address program integrity.[14] The Commission then noted that "[a]s necessary, the Commission will assess

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[9] *See Modernizing the E-rate Program for Schools and Libraries, Connect America Fund*, 29 FCC Rcd 15538, 15569 (2014) (*Second E-rate Modernization Order*) (revising E-rate cap which had been based on demand estimates from a 1996 study by McKinsey, Rothstein, Thesis and the National Commission on Library Information Science); *Federal-State Board on Universal Service*, CC Docket No. 96-45, Report and Order, 12 FCC Rcd 8776, 9054-55, ¶ 529-31 (1997) (*First Report and Order*).

[10] *See Promoting Telehealth in Rural America*, WC Docket No. 17-310, Notice of Proposed Rulemaking and Order, 32 FCC Rcd 10631, 10639-41 (2017) (*NPRM*).

[11] *Id.* at 10640.

[12] See *Promoting Telehealth in Rural America*, WC Docket No. 17-310, Report and Order, 33 FCC Rcd 6574 (2018) (*2018 Report and Order*).

[13] *Id.* at 6580-81, ¶¶ 14-16.

[14] *See id.*

the need for any future increases in the cap to ensure that the RHC Program is sufficiently funded to achieve the Program's goals of increasing access to broadband for health care providers, particularly in rural areas, and fostering the deployment of broadband health care networks."[15] Events since the *2018 Report and Order* suggest the Commission should not wait further.

First, the Commission has been providing heightened oversight in the Telecom Program since at least 2017 regarding urban and rural rates, which has had the apparent effect of significantly reducing Telecom Program demand.[16] Second, funding demand has continued to grow, many parties have argued, for entirely legitimate and important purposes – reflecting the real-world economic, health, and demographic challenges in rural communities, and significant advancements in medical technology and broadband availability. The Commission is obligated to ensure predictability and sufficiency, which includes protecting the RHC program from waste, fraud and abuse, but the Commission frustrates the intent of Congress when it "protects" the RHC program from rural health care providers with legitimate needs – access to telecommunications at urban rates, and to affordable broadband and information services – that are squarely within the RHC program's statutory purposes.[17]

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[15] *Id.* at 6581, ¶ 15.

[16] *See, e.g., WCB Provides Guidance Regarding the Commission's Rules for Determining Rural Rates in the Rural Health Care Telecommunications Program* WC Docket No. 02-60, Public Notice, 34 FCC Rcd 533 (WCB 2019); *Order* ¶ 10 (noting Telecom Program decline between funding years 2016 and 2018); *see also id.* ¶ 7, fig. 1;

[17] And, notwithstanding that this is the *Rural* Health Care program, Section 254(h)(2)(A) clearly authorizes this Commission to further access to "advanced telecommunications [*i.e.*, broadband] and information services [*i.e.*, broadband Internet access] for *all* . . . health care providers." (emphasis supplied). The decision to allow non-rural providers to receive funding when it yields a tangible benefit to rural health care providers is within the statutory purposes of the program. *See also Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, 27 FCC Rcd 16678, 16705 (2012) (*HCF Order*) ("the language in section 254(h)(2)(A) demonstrates Congress's intent to authorize expanding support of 'advanced services,' when possible, for non-rural health providers.") (citing Texas Office of Public Utility Counsel v. FCC, 183 F.3d 393, 446

SHLB in its 2015 *Petition for Rulemaking* and 2018 comments to the *NPRM* considered in detail the data sources the Commission has used over the years to support its estimates of the number of RHC eligible health care providers. SHLB showed how the potentially eligible health care provider counts that the Commission has used over time were not necessarily supportable, providing specific examples where the data was flawed or lacked transparency, and has suggested credible alternative sources.[18] To take just one example, the Commission in 2012 concluded there were around 2,600 potentially eligible Federal Qualified Health Centers (FQHCs), however this figure was not ultimately tied to publicly available data and was contradicted by public data from 2013 suggesting the number could be as high as 10,000.[19] Since that time, Congress, pursuant to statute, has added an unknown number of skilled nursing facilities as potentially eligible entities.

Given these problems in the data assumptions underlying the current RHC cap, it is not tenable to maintain that the RHC program is right-sized for the job Congress intended. Now that the Commission has addressed program integrity, the Commission can and should act boldly to address the rural hospital closure crisis specifically,[20] and the health access challenges facing rural America generally.

(5th Cir. 1999), *aff'g in part, rev'g in part, and remanding in part, Federal State Joint Board on Universal Service*, CC Docket No. 96-45, First Report and Order, 12 FCC Rcd 8776 (1997)).

[18] *SHLB Petition for Rulemaking* at 24-30; *SHLB Comments*, WC Docket 17-310, at 12-14 (filed Feb. 2, 2018).

[19] *SHLB Petition Rulemaking.* at 27-28.

[20] Congress clearly intended the RHC program to provide part of the solution for this crisis and the record shows that majority-rural HCF consortia can be part of the solution for struggling rural hospitals. *See* SHLB *NPRM* Comments, at 26-30 (filed Feb. 2, 2018) ("Many of these small [mostly rural] safety net [health care] providers do not have the administrative resources to participate in the RHC program without being part of a consortium.").

B. The $150 Million Healthcare Connect Fund Sub-Cap Should Be Increased and Rollover Funding Originating from Consortia Should be Dedicated to the Sub-Cap

NCTN and SOHCN agree with the Commission's decision to index to inflation the HCF sub-cap on multi-year funding commitments and upfront payments in the HCF. However, the decision not to increase the $150 million size of the sub-cap[21] is based on an incorrect reading of the purpose of that cap and should be reconsidered. The Commission should then also consider whether to allow unused funding from multi-year and upfront funding commitments to be carried forward specifically for commitments above the HCF sub-cap in a specific year.[22]

The *Order* concludes an increase is not warranted "[a]bsent additional data demonstrating the need to increase the $150 million cap [in the future], providing an economic basis for a particular increase amount, and establishing that an increase would not have a detrimental impact on single year requests."[23] The *Order* further concludes that the $150 million cap performed as intended in funding year 2018 by protecting the overall RHC program from fluctuating funding demand in the HCF.[24] While limiting "major fluctuations in [overall RHC] Fund demand" was a stated purpose of the sub-cap when it was established,[25] the *HCF Order* makes clear the principal concern was potential fluctuations caused by large upfront payments – specifically from potentially large broadband infrastructure projects.[26] The *Order*, however, makes no specific

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[21] *Order* ¶¶ 138-140.

[22] *Cf. 2018 Report and Order*, 33 FCC Rcd 6574, ¶¶ 24-28.

[23] *Order* ¶ 138.

[24] *Id.* (sub-cap intended to prevent multi-year and upfront payment requests from "usurping funding available for single-year requests and recurring services" and safeguarding against large demand flucuations) (citation omitted).

[25] *HCF Order*, 27 FCC Rcd 16764, ¶ 190.

[26] *Id.* (explained within Subsection V.D. of the *HCF Order* entitled "Limitations on Upfront Payments); *see also id.* at 16700, ¶ 47 ("We also impose an annual cap of $150 million that will

finding regarding the degree to which upfront payments are driving sub-cap funding – as opposed to a steady and non-fluctuating demand for broadband services.

Indeed, not only was concern about HCF infrastructure spending the principal reason for the $150 million cap, the Commission recognized that multi-year funding commitments were themselves a way to *limit* unnecessary infrastructure spending. This is because multi-year contracts (among other benefits) "help create incentives for commercial service providers to construct the necessary broadband facilities" thus allowing health care providers "to meet their broadband connectivity needs without having to construct and own their own broadband facilities."[27] Moreover, one reason multi-year funding commitments for broadband services were lumped with upfront infrastructure costs for purposes of the $150 million cap is because the Commission believed they would often go together.[28] To the extent experience shows this has not been the case, the Commission should consider removing multi-year funding commitments from being subject to the $150 million sub-cap. This would make sense given that multi-year funding requests are more efficient for USAC and for health care providers, being cited by the Commission as examples of steps taken to minimize the economic impact of the HCF rules on small entities.[29]

To be clear, NCTN and SOHCN support both broadband infrastructure spending where warranted, and multi-year funding requests for broadband services, but it is worth noting that in

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apply, in part, to the funds available for HCP self-construction, to ensure that ample funding will remain available for HCPs choosing to obtain services.") (footnote omitted).

[27] *Id.* at 16714, ¶ 76 (footnote omitted). If multi-year funding requests for broadband services remain subject to the sub-cap, consortia will likely choose to submit a request every year rather than risk submitting a multi-year request and having it effectively denied if the sub-cap is hit. This is inefficient for Consortia and for USAC, and adds to the uncertainty of the actual price for services to HCPs. This uncertainty deters appropriate consortia participation – especially for small rural sites.

[28] *Id.* at 16802, ¶ 298, n.716.

[29] *Id.* at 16861, ¶ 49.

funding year 2018, the Commission cancelled years two and three of multi-year requests for broadband services while fully funding upfront costs (which consist of upfront construction costs and equipment[30]). NCTN and SOHCN supported that decision, but believe such *ad hoc* decisions are sub-optimal, focused on cost control for its own sake and not enough on statutory purposes and important policy objectives.[31] A better approach would be to reconsider the appropriate size of the $150 million sub-cap in light of its original purpose and data accumulated since 2013 when it was first implemented.

The Commission previously indicated it could consider an upward adjustment to the $150 million cap "if it appears a significant number of [Telecom] Program participants are moving to the [HCF]." While data strongly suggests this is in fact occurring ("Between FY 2013 and FY 2016, the number of healthcare providers in the Telecom Program declined by more than 36 percent. . ."[32]), the *Order* dismisses the idea of a cap increase without even considering this issue. Indeed, not only does the *Order* fail to provide such an analysis, until recently the public was prevented from analyzing the issue itself because USAC, years ago, stopped "periodically inform[ing] the public, through its web site, of the total dollar amounts subject to the $150 million cap that have been (1) requested by HCPs (2) actually committed by USAC for the funding year."[33] Indeed, for funding year 2019 USAC is again withholding information regarding gross funding

[30] 47 C.F.R. § 54.638(a).

[31] *See Qwest Communications Intern., Inc. v. F.C.C,* 398 F.3d 1222, 1224 (10th Cir. 2005) ("the FCC must base its [universal service] policies on the [universal service] principles, . . . any particular principle can be trumped in the appropriate case. . . . [T]he FCC may exercise its discretion to balance the principles against one another when they conflict, but may not depart from them altogether to achieve some other goal.") (internal citation omitted).

[32] *NPRM*, 33 FCC Rcd at 7337, ¶ 10. The HCF was implemented in 2013.

[33] *HCF Order*, 27 FCC Rcd. at 16802, ¶ 298. We recognize that USAC Open Data for the RHC program has recently become available, however, Open Data does not currently include gross demand data (*i.e.,* "dollar amounts . . . requested by HCPs") which is critically important.

demand relative to both RHC funding caps, suggesting 2019 will again face cap shortages of some type – yet another reason the Commission should have acted in the *Order*.

Lastly, a carry-forward process dedicated to the HCF sub-cap is warranted, especially to the extent the amount of carry-forward funding available to the RHC program is coming from HCF consortia themselves. Such a mechanism would provide the Commission with more flexibility in adjusting to yearly demand fluctuations and would be fair insofar as a significant amount of unused funding in recent years has been due to late issuance of funding commitments by USAC, not due to any fault of consortia. Majority rural HCF consortia expend considerable resources applying for funding, and those resources are wasted when approved funding cannot be expended.[34] It would be logical and fair to repurpose such unused funding specifically for the groups and organizations that originally qualified for that funding. Allowing carry-forward of certain funding specifically to the HCF sub-cap would facilitate this.

III. THE COMMISSION SHOULD MODIFY THE DEFINITION OF RURAL

Finally, we respectfully request the Commission consider two modifications to the method of determining rurality of health care provider sites for purposes of rural eligibility and prioritization. First, we suggest the Commission utilize the standard United States Census Bureau (Census) rurality designations. In 2003 the Census defined "Metropolitan Statistical Areas" and "Micropolitan Statistical Areas" as the primary method for distinguishing among Core-Based Statistical Areas.[35]

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[34] This issue is discussed at length in the waiver request filed by New England Telehealth Consortium and Connections Telehealth Consortium in CC Docket 02-60 (filed June 6, 2018); *see also Order* ¶ 187.

[35] https://www.census.gov/topics/housing/housing-patterns/about/core-based-statistical-areas.html

- "Metropolitan Statistical Areas have at least one urbanized area of 50,000 or more population, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties."

- "Micropolitan Statistical Areas have at least one urban cluster of at least 10,000 but less than 50,000 population, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties."

The "metropolitan" and "micropolitan" designations offer a clearer definition of rurality than the current method employed by the Commission, which is not recognized by the Census. The switch will allow applicants and USAC to utilize existing Census designations to pre-qualify sites and to demonstrate rurality assertions and determine the funding priority each site will receive. This would result in the modified tiers of rurality designations later in this section.

Second, we recommend a switch to census blocks instead of census tracts when determining rurality boundaries in the RHC. In an average city or small town, census blocks are rarely larger than six acres. In rural Ohio, for example, census blocks can be as large as 3,500 acres, covering nearly 600 times more space than the average urban census block. There is no maximum size of Census blocks. Using census tracts exacerbates this lack of granularity even further. Switching to census blocks for rurality designations avoids the situation where a large rural geographic area is disqualified from rurality due to a slight overlap with an urban cluster.

These two proposed changes would translate into the recommended wording changes to paragraph 117 of the *Order* are as follows:

> *Extremely rural* – counties entirely outside of both any ~~Core Based Statistical Area~~ Micropolitan Statistical Area or Metropolitan Statistical Area;
>
> *Rural* – census ~~tracts~~ blocks within a ~~Core Based Statistical Area that does not have an urban area or urban cluster with a pollution equal to or greater than 25,000~~ Micropolitan Statistical Area but the census block does not contain any part of an urban area or cluster;
>
> *Less Rural* – census ~~tracts~~ blocks within a ~~Core Based Statistical Area with an urban area or urban cluster with a population equal to or greater than 25,000, but the census track does not contain any part of an urban area or~~

~~cluster with pollution equal to or greater than 25,000~~ Micropolitan Statistical Area, plus census blocks within a Metropolitan Statistical Area but the census block does not contain any part of an urban area or cluster; and

Urban – Census blocks within a Metropolitan Statistical Area that contains a part of an urban cluster

The proposed designations better align with the intent of the program. Consider the two examples of how the proposed change would affect rurality in the RHC.

Below are two specific examples that illustrate the impact of these changes:

1. Example of "Non-Rural" Area that Should Remain "Non-Rural"

    - Upper Arlington, Ohio: Population of 35,000, median income of $102,000.
    - Part of the Census designated Metropolitan Statistical Area of Columbus with a population of 1.4 million.
    - Health care providers in Upper Arlington serve patients primarily from the Columbus metropolitan area.
    - Classification under current rules: "non-rural.
    - Classification under proposed rule modification: "non-rural"

2. Example of "Non-Rural" Area that Should be "Less Rural"

    - Zanesville, Ohio: Population of 26,000, median income of $26,000.
    - Contained in the Census designated Micropolitan Statistical Area of Zanesville
    - 50 miles from closest metropolitan area
    - Healthcare providers in Zanesville serve the surrounding rural expanse, with more than 1,200 square miles in its primary service area.
    - Classification under current rules: "non-rural.
    - Classification under proposed rule modification: "less rural"

Due to the non-standard way in which the FCC defines rurality, many small rural towns across the country are classified as "non-rural." Adoption of the proposed modifications to the rurality definitions will better stratify the rural designations, and serve statutory purposes by classifying as

"less rural" many health care facilities in objectively rural locations serving predominantly rural populations.

IV. CONCLUSION

We respectfully request the Commission grant this petition and reconsider aspects of the recent Report and Order on Promoting Telehealth in Rural America in WC Docket 17-310.

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