

APPENDIX F

FCC Form 466-A Spreadsheet

APPENDIX G

FCC Form 466-A Network Costs Worksheet

Rural Health Care Program
 FCG Form 466-A Network Cost Worksheet

XYZ Health Care Systems (fill in selected participant name here)

Year 1 Network Cost Worksheet								
(Line)	Category	Itemized Components (Description)	Number of Items	Cost per Item	Comments	Eligible Cost? (Y/N)	Explanation of Eligibility	Total Costs (100%)
1	Network Design							
2	Recurring							
3								
4								
5	Recurring Subtotal							
6								
7	Non-recurring							
8								
9								
10	Non-recurring Subtotal							
11	Category Total							
12	Network, Equipment, Including Engineering and Installation							
13								
14	Recurring							
15								
16								
17	Recurring Subtotal							
18								
19	Non-recurring							
20								
21								
22	Non-recurring Subtotal							
23	Category Total							
24								
25	Infrastructure/Outside Plant							
26	Engineering							
27	Recurring							
28								
29								
30	Recurring Subtotal							
31								
32	Non-recurring							
33								
34								
35	Non-recurring Subtotal							
36	Sub-Category Total							
37								
38	Construction							
39	Recurring							
40								
41								
42	Recurring Subtotal							
43								
44	Non-recurring							
45								
46								
47	Non-recurring Subtotal							
48	Sub-Category Total							
49	Category Total							
50								
51	Internet/INL/Internet Connection							
52	Recurring							
53								
54								
55	Recurring Subtotal							
56								
57	Non-recurring							
58								
59								
60	Non-Recurring Subtotal							
61	Category Total							
62								
63	Leased/Tariffed facilities or services							
64	Recurring							
65								
66								
67	Recurring Subtotal							
68								
69	Non-recurring							

Rural Health Care Program
FCC Form 466-A Network Cost Worksheet

XYZ Health Care Systems (fill in selected
participant name here)

(Line)	Category	Total Non-Eligible Costs	Total Eligible Costs	RHC Pilot Program Funding Request (maximum 85% of eligible costs)	Participant Contribution for Eligible Network Costs (minimum 15%)	Source of Participant Funds	Is This an Eligible Source? (Yes/No/ In Part)	Funding Amount Approved in Pilot Program Award Order
1	Network Design							
2	Recurring							
3								
4								
5	Recurring Subtotal							
6								
7	Non-recurring							
8								
9								
10	Non-recurring Subtotal							
11	Category Total							
12								
13	Network Equipment, including Engineering and Installation							
14	Recurring							
15								
16								
17	Recurring Subtotal							
18								
19	Non-recurring							
20								
21								
22	Non-recurring Subtotal							
23	Category Total							
24								
25	Infrastructure/Outside Plant							
26	Engineering							
27	Recurring							
28								
29								
30	Recurring Subtotal							
31								
32	Non-recurring							
33								
34								
35	Non-recurring Subtotal							
36	Sub-Category Total							
37								
38	Construction							
39	Recurring							
40								
41								
42	Recurring Subtotal							
43								
44	Non-recurring							
45								
46								
47	Non-recurring Subtotal							
48	Sub-Category Total							
49	Category Total							
50								
51	Internet/NLR/Internet Connection							
52	Recurring							
53								
54								
55	Recurring Subtotal							
56								
57	Non-recurring							
58								
59								
60	Non-Recurring Subtotal							
61	Category Total							
62								
63	Leased/rented facilities or services							
64	Recurring							
65								
66								
67	Recurring Subtotal							
68								
69	Non-recurring							

Rural Health Care Program
 FCC Form 456-A Network Cost Worksheet

Year 1 Network Cost Worksheet								
(Line)	Category	Itemized Components (Description)	Number of Items	Cost per Item	Comments	Eligible Cost? (Y/N)	Explanation of Eligibility	Total Costs (100%)
70								
71								
72		Non-recurring Subtotal						
73		Category Total						
74								
75		Network Management /Maintenance/ Operations Costs (not captured elsewhere)						
76		Recurring						
77								
78								
79		Recurring Subtotal						
80								
81		Non-recurring						
82								
83		Non-recurring Subtotal						
84		Category Total						
85								
86		Other (specify)						
87		Recurring						
88								
89								
90		Recurring Subtotal						
91								
92		Non-recurring						
93								
94								
95		Non-recurring Subtotal						
96		Category Total						
97								
98								
99		Total Recurring						
100		Total Non-recurring						
101		Total						

(1) Please provide a separate breakout for aerial and buried fiber construction, the budgeted unit cost per mile for each, and the number of miles (to at least the 10th of a mile) to be constructed.

Rural Health Care Program
FCO Form 466-A Network Cost Worksheet

(Line)	Category	Total Non-Eligible Costs	Total Eligible Costs	RHC Pilot Program Funding Request (maximum 85% of eligible costs)	Participant Contribution for Eligible Network Costs (minimum 15%)	Source of Participant Funds	Is This an Eligible Source? (Yes/No/ In Part)	Funding Amount Approved in Pilot Program Award Order
70								
71								
72	Non-recurring Subtotal							
73	Category Total							
74								
75	Network Management /Maintenance/ Operations Costs (not captured elsewhere)							
76	Recurring							
77								
78								
79	Recurring Subtotal							
80								
81	Non-recurring							
82								
83	Non-recurring Subtotal							
84	Category Total							
85								
86	Other (specify)							
87	Recurring							
88								
89								
90	Recurring Subtotal							
91								
92	Non-recurring							
93								
94								
95	Non-recurring Subtotal							
96	Category Total							
97								
98								
99	Total Recurring							
100	Total Non-recurring							
101	Total							

**STATEMENT OF
CHAIRMAN KEVIN J. MARTIN**

Re: In the Matter of Rural Health Care Support Mechanism, WC Docket No. 02-60

I am pleased the Commission adopts today's Order making funding available for the deployment broadband healthcare networks across the country. Through this Order, the Commission dedicates more than 400 million dollars over 3 years to the construction of broadband networks for state-wide and regional healthcare networks reaching over 6,000 facilities in 42 states and 3 U.S. territories, all connected to a national broadband network.

Since becoming Chairman, I have made broadband deployment the Commission's top priority. Broadband technology is a key driver of economic growth. The ability to share increasing amounts of information at greater and greater speeds, increases productivity, facilitates interstate commerce, and helps drive innovation. But perhaps most important, broadband has the potential to affect almost every aspect of our lives – from where and when we work to how we educate our children. In particular, it is increasingly changing the way healthcare is delivered and received.

Broadband infrastructure for healthcare is particularly critical to those living in rural areas where access to medical services can be limited. I can appreciate the tremendous capability of broadband to improve peoples' quality of life and healthcare in rural America. Telemedicine programs around the nation enable patients to receive medical care in a wide variety of areas, including pediatrics, dermatology, psychiatry, cardiology, and radiology, without even leaving their homes or communities. This may not seem like a big deal to those of us who need only drive a couple miles to visit our local doctor or dentist. But, it can mean everything to those patients who don't have that luxury or who don't have access to healthcare at all.

A dedicated national broadband healthcare network will also facilitate the President's goal of implementing electronic medical records nationwide. Electronic medical records will improve the healthcare treatment Americans receive by, among other things: ensuring that appropriate medical information is available; reducing medical errors; reducing health care costs, and; improving the coordination among health care facilities.

In order to receive the benefits of telemedicine, electronic health care records, and other healthcare benefits, health providers must have access to underlying broadband infrastructure. Without this underlying infrastructure, efforts to implement these advances in health care cannot succeed.

It is my vision to see every healthcare facility in the nation connected to each other with broadband. This is especially important in rural areas of the nation that may lack the breadth of medical expertise available in urban areas. To make such connectivity a reality, we need to continue to encourage the deployment of broadband facilities that connect networks of rural and non-rural public and not-for-profit healthcare providers

within a state or region – as well as connect such state-wide or regional healthcare networks to each other across the nation.

As we evaluated the pilot program, it became even more clear to me how well this program aligns with the goals that the Department of Health and Human Services and the health community is working to achieve. That is why it is important that organizations participating in the pilot program use their resources to build networks consistent with the health IT initiatives being promoted by HHS. This includes the implementation of interoperable health IT systems and the use of certified health IT products. Additionally, participants will coordinate with HHS and CDC during public health emergencies, such as pandemics or bioterrorism events.

Through the Commission's Rural Healthcare Pilot Program, I am hoping to establish the basic building blocks of a digitally connected health system – regional and state-wide broadband networks, all connected to a national backbone. I look forward to learning from this pilot program how we can ensure that all Americans, including those in the most remote areas of the country, receive first-rate medical care.

**STATEMENT OF
COMMISSIONER MICHAEL J. COPPS**

Re: *In the Matter of Rural Health Care Support Mechanism*, WC Docket No. 02-60

Since I came to the Commission, I have been pushing for more proactive programs to put our rural health care dollars to work bringing advanced telecommunications to health care facilities in towns and villages across America. I have visited numerous such facilities, and I quickly came to understand both their plight and their potential. Their plight is lack of dollars to develop and deploy rural health communications, lack of partners, lack of sufficient personnel, and lack of a real helping hand from the federal government. Their potential is to improve health care in often less-than-affluent communities and to enhance public safety by connecting health care providers, first responders and rural citizens everywhere.

The Commission is finally tapping into the long underutilized Universal Service system's rural health care support mechanism to tackle these challenges. We today approve the disbursement of more than \$400 million over the next three years to approved health care providers who plan to build a broadband infrastructure that will connect over 6,000 facilities in 42 states and 3 U.S. territories. I am enormously pleased to support this Order, and I want to commend Chairman Martin and all my colleagues for their leadership in developing and bringing this important pilot program to reality.

It is sad but true that rural America lags the rest of the country in access to first-rate health care. That's bad news for so prosperous a nation as ours. This pilot program creatively pushes the envelope in an effort to spur the development of tele-medicine programs to better serve rural America. Having seen first-hand the difference that tele-medicine and tele-health can have on the well-being of our citizens who live hundreds of miles from the nearest hospital and are injured or just need to cure a child's ear infection, tele-medicine can be life-altering, and sometimes even life-saving. We also know that if a health catastrophe visited many of our rural areas today, our rural health care system would not generally be equipped to deal with it. Anyone who believes that terrorists, for example, are only going to focus on urban America is engaged in wrong and potentially fatal reasoning.

So I welcome and enthusiastically support this important initiative, believing it has the very real potential to kick-start badly needed rural-health infrastructure building. Once these pilot programs are under-way, monitoring them becomes critical. I will be doing everything I can to work with the Bureau and my colleagues to make sure we learn the lessons we need to learn and then develop permanent programs to bring these capabilities and services to the many rural communities that are not part of this pilot program. Today we make a good and noble start – but it is a beginning only, and much remains to be done to integrate our rural health care facilities and providers into our nationwide health care system.

**STATEMENT OF
COMMISSIONER JONATHAN S. ADELSTEIN**

Re: In the Matter of Rural Health Care Support Mechanism, WC Docket No. 02-60

Broadband facilities are having a profound effect on the way that we deliver medical care. We are only beginning to envision the potential benefits available from new telecommunications technology. This Order represents an important milestone in the Commission's efforts to explore ways to maximize these benefits.

Through this Order, we are selecting sixty-nine worthy applicants to participate in our Rural Health Care Pilot Program. By expanding the Federal Universal Service Rural Health Care program to fund the construction of broadband infrastructure to connect rural health care providers, we enable local healthcare providers to deliver dramatic benefits for their communities.

Indeed, with advances in broadband and digital imaging, health care providers are increasingly able to send medical records, CAT scans, and other lab results to specialists in distant locations. Connecting our health care providers can also play a critical role in promoting continuing education through distance learning for our health care professionals, and is vital to our efforts to respond to disasters, natural and man-made. As we have seen repeatedly in the past few years, our communications systems are a critical factor in our ability to respond quickly and in a coordinated fashion. For rural residents, telemedicine can bridge distances that might otherwise be unaffordable or physically impractical to cross. They may be the only viable link to vital diagnostic services and specialized care for many patients, and they hold great potential for remote monitoring and home healthcare.

I have repeatedly supported efforts to improve the connectivity of rural health care providers and enhance the Rural Health Care program, which is crucial to the sustainability of many telemedicine programs. Without universal service, the high cost of telemedicine services might put them out of reach of many small communities. I commend Chairman Martin, my colleagues and the Bureau for their efforts to develop this Pilot Program, and I look forward to the continued advancement of the Rural Health Care program and to the results of the projects selected in this Order.

**STATEMENT OF
COMMISSIONER DEBORAH TAYLOR TATE**

Re: In the Matter of Rural Health Care Support Mechanism, WC Docket No. 02-60

At Congress' direction, the Commission implemented a Rural Health Care support mechanism supported within the Universal Service Fund, which provides reduced rates to rural health care providers for their telecommunications and Internet services. Although this rural health care support program has been in place for nearly 10 years, unfortunately, it has been greatly underutilized.

I therefore was extremely supportive when the Chairman proposed that the Commission establish a Rural Health Care Pilot Program (Pilot Program) to examine how Rural Health Care support mechanism funds can be used to enhance public and non-profit health care providers' access to advanced telecommunications and information services. The response was overwhelming. The Commission received 81 applications representing approximately 6,800 health care facilities from 43 states and three United States territories.

I am very pleased by our decision today to select 69 applicants for participation in the Pilot Program. These applicants are selected because their overall qualifications are consistent with the goals of the Pilot Program to stimulate deployment of the broadband infrastructure necessary to support innovative telehealth and, in particular, telemedicine services to those areas of the country where the need for those benefits is most acute.

I am especially proud to see three projects from my home state of Tennessee receive funding- Erlanger Health System, Mountain States Health Alliance, and the Tennessee Telehealth Network. Tennessee continues to be in the forefront on extending telemedicine- and the incredible opportunities that it provides- to all of its citizens.

I am committed to taking whatever steps possible to foster access to a healthcare network that brings 21st century medicine to every corner of the nation. It has been my vision that one day all healthcare facilities in the nation are connected to each other with broadband facilities so that pioneering communities, physicians, and hospitals can show that health care can be transformed by technology no matter where a patient lives. Among other benefits, broadband connectivity among healthcare providers will assist the President's goal of implementing electronic medical records nationwide. Moreover, broadband connectivity and the ability to share information among healthcare providers would also likely assist in addressing a national crisis, whether terrorist, natural or a pandemic flu outbreak.

It has been exciting for me to see first-hand how new medical technologies—when combined with broadband—can enable everything from remote surgery in the mountains of Appalachia to telepsychiatry and teledentistry in remote parts of Alaska. I have witnessed first-hand how the technology at both a research hospital and our most remote communities serves as the bridge not only to improve people's access to

healthcare, but also to narrow the miles between doctor and patient, improve administrative efficiencies, and reduce the cost to the patient and our healthcare systems. These benefits pertain, of course, to people in rural and remote parts of our country who will benefit from the access to specialists and research that, until recently, was often only available in urban or research centers. I look forward to visiting some of these new and innovative projects which literally enable innovations in technology to improve and enhance the lives of real people and especially those who live in rural areas of this great country.

**STATEMENT
COMMISSIONER ROBERT M. McDOWELL**

Re: In the Matter of Rural Health Care Support Mechanism, WC Docket No. 02-60

The response to our call for applications to participate in the Rural Health Care Pilot Program in September 2006 was heartening. The applications demonstrated the need for enhanced access to the most current and advanced health care information and services in rural areas throughout the nation. I am pleased that we are granting 69 of the applications. Our action will speed the development of regional, state and national broadband networks dedicated to health care. We are carrying out the Congressional mandate that the Commission improve the availability of advanced telecommunications and information services for rural health care providers. This program also increases support for rural areas in time of public health emergencies, such as pandemics and bioterrorism attacks. At the same time, we are imposing safeguards to assure that the rural health care funds are used for their intended purposes. I look forward to seeing increased telemedicine and telehealth services in rural areas as a result of our action today.