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January 30, 2009

VIA ELECTRONIC FILING

Ms. Marlene Dortch
Secretary
Federal Communications Commission
445 12th Street, SW
Washington, DC 20554

Re: WC Docket No. 02-60, Quarterly Report & Attachments

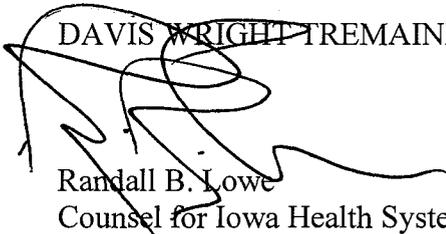
Dear Ms. Dortch:

On behalf of Iowa Health System, Inc., we are filing herewith its Pilot Program Quarterly Report and Attachments in the above-referenced docket.

Please address any correspondence concerning this matter to the undersigned counsel.

Respectfully submitted,

DAVIS WRIGHT TREMAINE LLP



Randall B. Lowe
Counsel for Iowa Health System, Inc.

Enclosures

cc: Antoinette Stevens (by email)

**Pilot Program Quarterly Report of Iowa Health System
Period 10/1/08 – 12/31/08
WC Docket No. 02-60**

1. Project Contact and Coordination Information

a. Identify the project leader(s) and respective business affiliations.

Bill Leaver, President and CEO
Iowa Health System

b. Provide a complete address for postal delivery and the telephone, fax, and e-mail address for the responsible administrative official.

Bill Leaver
President and CEO
Iowa Health System
1200 Pleasant Street
Des Moines, IA 50309
Telephone: 515-241-6347
Fax: 515-241-5712
E-mail: LeaverWB@ihs.org

c. Identify the organization that is legally and financially responsible for the conduct of activities supported by the award.

Iowa Health System
1200 Pleasant Street
Des Moines, IA 50309

d. Explain how project is being coordinated throughout the state or region.

The project is being coordinated by Iowa Health System (“IHS”) leadership in consultation with Fiberutilities Group LLC.

After identifying potential participants and attending RHCPP training, IHS met with potential participants in the region. As a result of that meeting, IHS received letters of agency from 29 initial participants.

A meeting of initial participants was held in Des Moines, Iowa on June 5, 2008 to discuss the project as well as a proposed governance structure that emphasizes participant input into the project’s operations. A second meeting of this group was held September 3, 2008 in Des Moines. This group will play a central role in the governance and operation of the project to ensure that it best meets their needs.

An RFP for 15 year lit capacity IRUs for access to the IHS backbone network was issued on October 6, 2008 with bid closure on November 17, 2008. Bid responses to the RFP were received from 10 vendors. All bid response data was compiled, analyzed and scored resulting in the selection of vendors for final contract negotiation. Contract negotiation is in progress and actual placement of orders with vendors will occur upon final approval and issuance of FCLs by USAC. In the meantime, IHS will continue to identify and meet other potential participants whom IHS anticipates will join the project in future deployment phases.

2. Identify all health care facilities included in the network.

- a. **Provide address (including county), zip code, Rural Urban Commuting Area (RUCA) code (including primary and secondary), six-digit census tract, and phone number for each health care facility participating in the network.**
- b. **For each participating institution, indicate whether it is:**
 - i. **Public or non-public;**
 - ii. **Not-for-profit or for-profit;**
 - iii. **An eligible health care provider or ineligible health care provider with an explanation of why the health care facility is eligible under section 254 of the 1996 Act and the Commission's rules or a description of the type of ineligible health care provider entity.**

See Attachment A. The participating institutions listed in Attachment A are eligible users who have signed a letter of agency with IHS and will be a part of the initial users that will be connected to the IHS-owned backbone network. IHS anticipates that additional users will participate in future phases of the project. (See 1.d. above.)

Note: The eligible health care providers are eligible because they are nonprofit hospitals under 47 U.S.C. Section 254(h)(7)(B).

3. Network Narrative: In the first quarterly report following the completion of the competitive bidding process and the selection of vendors, the selected participant must submit an updated technical description of the communications network that it intends to implement, which takes into account the results of its network design studies and negotiations with its vendors. This technical description should provide, where applicable:

- a. **Brief description of the backbone network of the dedicated health care network, e.g., MPLS network, carrier-provided VPN, a SONET ring;**

The combination of the access connections and the IHS-owned backbone network is a private fiber network equipped with Layer 2 (Ethernet) transport equipment and Layer 3 (packets) core routers. (See Attachment B). The network will be connected to NLR and Internet 2. The network is currently lit to 2Gbps of total capacity and can grow to 10Gbps by inserting small form pluggable (SFP) optics into existing 10 lambda CWDM muxes/demuxes at the appropriate equipment locations in the network.

- b. **Explanation of how health care provider sites will connect to (or access) the network, including the access technologies/services and transmission speeds;**

The access connections to the IHS-owned backbone network will be a fiber-based transparent LAN solution providing symmetrical 100Mbps of Ethernet connectivity using Gigabit Ethernet Passive Optical Network (GEPON) technology to the premise. The Layer 2 Ethernet solution will support VoIP, 802.1 Q VLAN tagging, and video streaming, in addition to data transport.

- c. **Explanation of how and where the network will connect to a national backbone such as NLR or Internet 2;**

The network will connect to NLR and Internet 2 via the Metropolitan Research and Education Network (MREN) located at Northwestern University in Chicago. The

connections will be a 1 gigabit per second interface with MREN's shared lit fiber access to NLR and Internet 2.

d. Number of miles of fiber construction, and whether the fiber is buried or aerial;

The RFP for access to the IHS-owned backbone network requested a 15 year lit capacity IRU for 100 Mbs symmetrical Ethernet. No fiber construction under the RHCPP is anticipated to deliver the access connections to the initial group of eligible users connecting to the network.

e. Special systems or services for network management or maintenance (if applicable) and where such systems reside or are based.

Layer 3 network management will be accomplished by a provider edge router on the user premise located at the end of the provider's connection. It will be managed by IHS. All other management and maintenance of equipment related to the access connection will be provided by the vendor providing the 15 year lit capacity IRU.

4. List of Connected Health Care Providers: Provide information below for all eligible and non-eligible health care provider sites that, as of the close of the most recent reporting period, are connected to the network and operational.

- a. Health care provider site;
- b. Eligible provider (Yes/No);
- c. Type of network connection (e.g., fiber, copper, wireless);
- d. How connection is provided (e.g., carrier-provided service; self-constructed; leased facility);
- e. Service and/or speed of connection (e.g., DS1, DS3, DSL, OC3, Metro Ethernet (10 Mbps));
- f. Gateway to NLR, Internet2, or the Public Internet (Yes/No);
- g. Site Equipment (e.g., router, switch, SONET ADM, WDM) including manufacturer name and model number.
- h. Provide a logical diagram or map of the network.

The access connections related to this network have not been completed at the time of this quarterly report (1/30/09). Accordingly, as of the close of the most recent reporting period, there were no "Connected Health Care Providers" connected to the network and operational. Attachment C is a map of the proposed network. (See also Attachment B for a logical diagram of the access connections.)

5. Identify the following non-recurring and recurring costs,⁴²³ where applicable shown both as budgeted and actually incurred for the applicable quarter and funding year-to-date.

a. Network Design

Network design was funded by IHS, independent of the RHCPP and cost recovery for design costs will not be sought through that program.

⁴²³Non-recurring costs are flat charges incurred only once when acquiring a particular service or facility. Recurring costs are costs that recur, typically on a monthly basis, because they vary with respect to usage or length of service contract.

b. Network Equipment, including engineering and installation

See Attachment D for budgeted costs. Actual costs have not yet been established because IHS has not yet finalized the vendor agreements by which those costs will be incurred.

c. Infrastructure Deployment/Outside Plant

- i. Engineering**
- ii. Construction**

See Attachment D for budgeted costs. Actual costs have not yet been established because IHS has not yet finalized the vendor agreements by which those costs will be incurred.

d. Internet2, NLR, or Public Internet Connection

IHS will connect with Internet2 and NLR via MREN (See Question 3(c)). The budgeted and actual recurring cost for 2009 of interconnecting to Internet2 is \$25,000. The budgeted and actual recurring cost for 2009 of interconnecting to MREN is \$28,800. Both of these costs are budgeted for future years. IHS is currently investigating the non-recurring and recurring costs of NLR. There is no current plan to interconnect with the public Internet.

e. Leased Facilities or Tariffed Services

See Attachment D for budgeted costs. Actual costs have not yet been established because IHS has not yet finalized the vendor agreements by which those costs will be incurred.

f. Network Management, Maintenance, and Operation Costs (not captured elsewhere)

See Attachment D for budgeted costs. Actual costs have not yet been established because IHS has not yet finalized the vendor agreements by which those costs will be incurred.

g. Other Non-Recurring and Recurring Costs

There are no other non-recurring or recurring costs related to the access connections as of this quarterly reporting period.

6. Describe how costs have been apportioned and the sources of the funds to pay them:

a. Explain how costs are identified, allocated among, and apportioned to both eligible and ineligible network participants.

Ineligible participants must fund 100% of their cost to access the backbone network of IHS. Eligible entities connecting in the first phase of deployment will have 15% of their access costs funded by IHS and 85% funded by the RHCPP. (IHS is funding 100% of the capital, maintenance, and operational costs of the backbone network. Thus, no cost allocation is required between eligible and ineligible entities for backbone network costs.)

- b. Describe the source of funds from:**
 - i. Eligible Pilot Program network participants**
 - ii. Ineligible Pilot Program network participants**

See Attachment D.

- c. Show contributions for all other sources (e.g., local, state, and federal sources, and other grants).**
 - i. Identify source of financial support and anticipated revenues that is paying for costs not covered by the fund and by Pilot Program participants.**
 - ii. Identify the respective amounts and remaining time for such assistance.**

See Attachment D.

- d. Explain how the selected participant's minimum 15 percent contribution is helping to achieve both the selected participant's identified goals and objectives and the overarching goals of the Pilot Program.**

The 15% contribution of IHS for initial participants will help it achieve both its goals and objectives by allowing it to complete health care provider access connections to its backbone network which, as stated in its Application before the FCC, "is capable of handling multigigabit data transmissions and the bandwidth intensive applications often associated with advanced imaging and diagnostic services." It will also permit the transmission of continuity of care documents, the creation of a single patient identifier system and access to the nationwide networks of NLR and Internet2 for interaction with health care providers across the nation.

7. Identify any technical or non-technical requirements or procedures necessary for ineligible entities to connect to the participant's network.

There are not technical or non-technical requirements or procedures necessary for ineligible entities to connect to the backbone network of IHS except for the following:

- a) They must be a health care related entity;
- b) They must be a member of the HealthNet connect, LC user group established to administer access to the backbone network;
- c) They must pay the full cost of access connection costs, including the upgrade of their equipment; and
- d) They must meet the Quality of Service (QoS) and security (provider edge router) criteria specified in the RFP.

8. Provide an update on the project management plan, detailing:

- a. The project's current leadership and management structure and any changes to the management structure since the last data report; and**

IHS will provide project leadership using its existing management structure, embodied in its executive management team and its IT Department, which contains more than 200 experienced information technology professionals and currently manages the largest private medical network in the state. Moreover, IHS is the largest integrated nonprofit regional health care system in Iowa, serving a geographically dispersed rural population in the upper Midwest. IHS operates facilities in seven

large communities in Iowa and Illinois supporting a system of rural hospitals in 14 Iowa communities and partnering with 450 physicians and 125 clinics in more than 80 communities in Iowa, Illinois, Nebraska and South Dakota. IHS anticipates the continued utilization of this experience for the leadership, management and execution of this initiative.

The following is the project’s current leadership and management structure:

Project Coordinator - Bill Leaver, Iowa Health System

Assistant Project Coordinator - Stacie Caryl, Iowa Health System

Consultant- Dave Lunemann, Fiberutilities Group LLC
Pat Cram, Fiberutilities Group LLC

Legal Counsel - Denny Drake; Iowa Health System
Joe Clamon; Iowa Health System
Randy Lowe; Davis Wright Tremaine LLP

There have been no changes to the management structure since the last data report.

- b. In the first quarterly report, the selected applicant should provide a detailed project plan and schedule. The schedule must provide a list of key project deliverables or tasks, and their anticipated completion dates. Among the deliverables, participants must indicate the dates when each health care provider site is expected to be connected to the network and operational. Subsequent quarterly reports should identify which project deliverables, scheduled for the previous quarter, were met, and which were not met. In the event a project deliverable is not achieved, or the work and deliverables deviate from the work plan, the selected participant must provide an explanation.**

**HealthNet connect (HNC) Estimated Project Plan Estimated Timelines / Milestones
(Updated from the second quarterly report to reflect changes / progress of the overall project)**

1. 465 / attachments with RFP Bid Package draft complete	5/21/08 Complete
2. Completed bid package sent to USAC for comments / review	5/21/08 Complete
3. Initial healthcare provider (“HCP”) orientation meeting in Des Moines	6/5/08 Complete
4. Preliminary USAC comments returned	7/10/08 Complete
5. USAC / FCC quarterly report due	7/30/08 Complete
6. Second HCP orientation / governance meeting in Des Moines	9/3/08 Complete
7. IHS project team review and revision complete	9/30/08 Complete
8. Final 465/465 attachments/RFP uploaded for USAC administrative review	10/2/08 Complete
9. Final 465/465 attachments/RFP posted to USAC website	10/6/08 Complete

- i. 28 day bid clock starts
 - ii. overall project clock starts
10. First vendor clarification call 10/10/08 Complete
 11. Second vendor clarification call 10/24/08 Complete
 12. Second quarterly report submitted to USAC 10/30/08 Complete
 13. Third vendor clarification call 11/12/08 Complete
 14. Bid closure / all initial HCP group bids received by HNC review team 11/17/08 Complete
 15. Bids analyzed and successful bidders determined 12/19/08 Complete*
 - i. winning bidders notified
 - ii. non winning bidders notified
 16. 466A / network worksheets submitted to USAC 2/11/09*
 17. Contracts signed with vendors 2/9/09*
 18. FCL's issued by USAC to IHS for winning bid 2/25/09*
 19. Access connection installations begin 3/2//09*
 20. Access connections completed 3/2/09 – 5/29/09*
 21. HNC user applications launch 3/18/09*
 22. HNC secondary marketing and sales efforts 1/1/09 – 12/31-09
 23. FCC / USAC award funding years 1 & 2 6/30/09

*These project deliverable dates are different from the previous quarterly report (10/30/08) due to normal and anticipated changes in the project management workflow.

9. Provide detail on whether network is or will become self sustaining. Selected participants should provide an explanation of how network is self sustaining.

See Attachment D.

- 10. Provide detail on how the supported network has advanced telemedicine benefits:**
- a. Explain how the supported network has achieved the goals and objectives outlined in selected participant's Pilot Program application;
 - b. Explain how the supported network has brought the benefits of innovative telehealth and, in particular, telemedicine services to those areas of the country where the need for those benefits is most acute;
 - c. Explain how the supported network has allowed patients access to critically needed medical specialists in a variety of practices without leaving their homes or communities;
 - d. Explain how the supported network has allowed health care providers access to government research institutions, and/or academic, public, and private health care

institutions that are repositories of medical expertise and information;

- e. **Explain how the supported network has allowed health care professional to monitor critically ill patients at multiple locations around the clock, provide access to advanced application in continuing education and research, and/or enhanced the health care community's ability to provide a rapid and coordinated response in the event of a national crisis.**

The access connections related to this network have not been completed at the time of this quarterly report (1/30/09). Accordingly, there are no advanced telemedicine benefits to report at this time.

11. Provide detail on how the supported network has complied with HHS health IT initiatives:

- a. **Explain how the supported network has used health IT systems and products that meet interoperability standards recognized by the HHS Secretary;**
- b. **Explain how the supported network has used health IT products certified by the Certification Commission for Healthcare Information Technology.**
- c. **Explain how the supported network has supported the Nationwide Health Information Network (NHIN) architecture by coordinating activities with organizations performing NHIN trial implementations;**
- d. **Explain how the supported network has used resources available at HHS's Agency for Information Technology;**
- e. **Explain how the selected participant has educated themselves concerning the Pandemic and All Hazards Preparedness Act and coordinated with the HHS Assistant Secretary for Public Response as a resource for telehealth inventory and for the implementation of other preparedness and response initiatives; and**
- f. **Explain how the supported network has used resources available through HHS's Centers for Disease Control and Prevention (CDC) Public Health Information Network (PHIN) to facilitate interoperability with public health and emergency organizations.**

The access connections related to this network have not been completed at the time of this quarterly report (1/30/09). Accordingly, there is no detail to report at this time on how the supported network has complied with HHS health IT initiatives.

12. Explain how the selected participants coordinated in the use of their health care networks with the Department of Health and Human Services (HHS) and, in particular, with its Centers for Disease Control and Prevention (CDC) in instances of national, regional, or local public health emergencies (e.g., pandemics, bioterrorism). In such instances, where feasible, explain how selected participants provided access to their supported networks to HHS, including CDC, and other public health officials.

The access connections related to this network have not been completed at the time of this quarterly report (1/30/09). Accordingly, there is no coordination or access to report at this time.

ATTACHMENT A

**HealthNet connect Initial Users
(Eligible Healthcare Providers)**

HCP	ADDRESS	CITY	STATE	ZIP	COUNTY	RUCA	CENSUS TRACT	PHONE #	PUBLIC OR NON-PUBLIC	FOR-PROFIT OR Nonprofit	ELIGIBLE (Y/N)	REASON FOR ELIGIBILITY
Allen Hospital	1825 Logan Ave	Waterloo	IA	50703	Black Hawk	1	0017.02	319-235-3987	Non-Public	Nonprofit	Y	Nonprofit Hospital
Blank Children's Hospital	1200 Pleasant St	Des Moines	IA	50309	Polk	1	0051.00	515-241-6602	Non-Public	Nonprofit	Y	Nonprofit Hospital
Iowa Methodist Medical Center	1200 Pleasant St	Des Moines	IA	50309	Polk	1	0051.00	515-241-6212	Non-Public	Nonprofit	Y	Nonprofit Hospital
Broadlawn Medical Center	1801 Hickman Rd	Des Moines	IA	50314	Polk	1	0012.00	515-282-2410	Public	Nonprofit	Y	Nonprofit Hospital
Buena Vista Regional Medical Center	1525 W 5th Street	Storm Lake	IA	50588	Buena Vista	7	9605.00	712-213-8600	Public	Nonprofit	Y	Nonprofit Hospital
Cass County Memorial Hospital	1501 E 10th St	Atlantic	IA	50022	Cass	7	9904.00	712-243-3250	Public	Nonprofit	Y	Nonprofit Hospital
Clarke County Hospital	800 S Fillmore St	Osceola	IA	50213	Clarke	7.3	9901.00	641-342-5342	Public	Nonprofit	Y	Nonprofit Hospital
Community Memorial Hospital	909 West First St	Sumner	IA	50674	Bremer	10	0047.00	563-578-3275	Non-Public	Nonprofit	Y	Nonprofit Hospital
Greater Regional Medical Center	1700 W Townline	Creston	IA	50801	Union	7	9904.00	641-782-3503	Public	Nonprofit	Y	Nonprofit Hospital
Greene County Medical Center	1000 W Lincolnway	Jefferson	IA	50129	Greene	7	9803.00	515-386-2114	Public	Nonprofit	Y	Nonprofit Hospital
Grinnell Regional Medical Center	210 4th Ave	Grinnell	IA	50112	Poweshiek	7	9704.00	641-236-2300	Non-Public	Nonprofit	Y	Nonprofit Hospital
Grundy County Memorial Hospital	201 East J Ave	Grundy Center	IA	50638	Grundy	10	9903.00	319-824-5421	Public	Nonprofit	Y	Nonprofit Hospital
* Guthrie County Hospital	710 N 12th St	Guthrie Center	IA	50115	Guthrie	10.4	9503.00	641-332-3821	Public	Nonprofit	Y	Nonprofit Hospital
Guttenberg Municipal Hospital	200 Main St	Guttenberg	IA	52052	Clayton	10.4	9704.00	563-252-5529	Public	Nonprofit	Y	Nonprofit Hospital
Humboldt County Memorial Hospital	1000 N 15th St	Humboldt	IA	50548	Humboldt	7.4	9704.00	515-332-4200	Public	Nonprofit	Y	Nonprofit Hospital
Iowa Lutheran Hospital	700 E University Ave	Des Moines	IA	50316	Polk	1	0048.00	515-241-6212	Non-Public	Nonprofit	Y	Nonprofit Hospital
Jackson County Regional Health Center	700 W Grove St	Maquoketa	IA	52060	Jackson	7	9505.00	563-652-4022	Public	Nonprofit	Y	Nonprofit Hospital
Loring Hospital	211 Highland Ave	Sac City	IA	50583	Sac	10	9804.00	712-662-3823	Non-Public	Nonprofit	Y	Nonprofit Hospital
Mary Greeley Medical Center	1111 Duff Ave	Ames	IA	50010	Story	4	0009.00	515-239-2105	Public	Nonprofit	Y	Nonprofit Hospital
** Mercer County Hospital	409 NW Ninth Avenue	Aledo	IL	61231	Mercer	7.4	0403.00	309-582-5301	Public	Nonprofit	Y	Nonprofit Hospital
Myrtue Memorial Hospital	1213 Garfield Ave	Harlan	IA	51537	Shelby	7	9603.00	712-755-4315	Public	Nonprofit	Y	Nonprofit Hospital
Pocahontas Community Hospital	606 NW 7th St	Pocahontas	IA	50574	Pocahontas	10	9802.00	712-335-5224	Public	Nonprofit	Y	Nonprofit Hospital
St. Luke's Hospital	1026 A Ave NE	Cedar Rapids	IA	52402	Linn	1	0019.00	319-369-7203	Non-Public	Nonprofit	Y	Nonprofit Hospital
St. Luke's Regional Medical Center	2720 Stone Park Blvd	Sioux City	IA	51104	Woodbury	1	0010.00	712-279-3207	Non-Public	Nonprofit	Y	Nonprofit Hospital
The Finley Hospital	350 N Grandview Ave	Dubuque	IA	52001	Dubuque	1	0007.02	563-589-2414	Non-Public	Nonprofit	Y	Nonprofit Hospital
Trinity Medical Center - Terrace Park	4500 Utica Ridge Rd	Bettendorf	IA	52722	Scott	1	0137.03	563-742-5000	Non-Public	Nonprofit	Y	Nonprofit Hospital
Trinity Medical Center - 7th St Campus	500 John Deere Rd	Moline	IL	61265	Rock Island	1	0219.00	309-779-2914	Non-Public	Not-for-profit	Y	Nonprofit Hospital
Trinity Medical Center - West	2701 17th St	Rock Island	IL	61201	Rock Island	1	0232.00	309-779-2204	Non-Public	Not-for-profit	Y	Nonprofit Hospital
Trinity Regional Medical Center	802 Kenyon Rd	Fort Dodge	IA	50501	Webster	4	0009.00	515-574-6600	Non-Public	Nonprofit	Y	Nonprofit Hospital

* No RHCPP funding required for this site at this time.

**No RHCPP funding required for this tie. Will be rebid in a future phase.

ATTACHMENT A

**HealthNet connect Initial Users
(Eligible Healthcare Providers)**

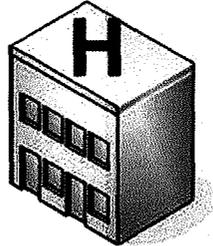
HCP	Type of Network Connection	How Network is Provided	Speed of Connection	Gateway to I2?	Site Equipment
Allen Hospital	Lit Service	Leased Service	100 Mbps	Yes	Provider Edge Router-Juniper 2350 Series
Blank Children's Hospital	Lit Service	Leased Service	100 Mbps	Yes	Provider Edge Router-Juniper 2350 Series
Iowa Methodist Medical Center	Lit Service	Leased Service	100 Mbps	Yes	Provider Edge Router-Juniper 2350 Series
Broadlawns Medical Center	Lit Service	Leased Service	100 Mbps	Yes	Provider Edge Router-Juniper 2350 Series
Buena Vista Regional Medical Center	Lit Service	Leased Service	100 Mbps	Yes	Provider Edge Router-Juniper 2350 Series
Cass County Memorial Hospital	Lit Service	Leased Service	100 Mbps	Yes	Provider Edge Router-Juniper 2350 Series
Clarke County Hospital	Lit Service	Leased Service	100 Mbps	Yes	Provider Edge Router-Juniper 2350 Series
Community Memorial Hospital	Lit Service	Leased Service	100 Mbps	Yes	Provider Edge Router-Juniper 2350 Series
Greater Regional Medical Center	Lit Service	Leased Service	100 Mbps	Yes	Provider Edge Router-Juniper 2350 Series
Greene County Medical Center	Lit Service	Leased Service	100 Mbps	Yes	Provider Edge Router-Juniper 2350 Series
Grinnell Regional Medical Center	Lit Service	Leased Service	100 Mbps	Yes	Provider Edge Router-Juniper 2350 Series
Grundy County Memorial Hospital	Lit Service	Leased Service	100 Mbps	Yes	Provider Edge Router-Juniper 2350 Series
* Guthrie County Hospital	Lit Service	Leased Service	100 Mbps	Yes	Provider Edge Router-Juniper 2350 Series
Guttenberg Municipal Hospital	Lit Service	Leased Service	100 Mbps	Yes	Provider Edge Router-Juniper 2350 Series
Humboldt County Memorial Hospital	Lit Service	Leased Service	100 Mbps	Yes	Provider Edge Router-Juniper 2350 Series
Iowa Lutheran Hospital	Lit Service	Leased Service	100 Mbps	Yes	Provider Edge Router-Juniper 2350 Series
Jackson County Regional Health Center	Lit Service	Leased Service	100 Mbps	Yes	Provider Edge Router-Juniper 2350 Series
Loring Hospital	Lit Service	Leased Service	100 Mbps	Yes	Provider Edge Router-Juniper 2350 Series
Mary Greeley Medical Center	Lit Service	Leased Service	100 Mbps	Yes	Provider Edge Router-Juniper 2350 Series
** Mercer County Hospital	Lit Service	Leased Service	100 Mbps	Yes	Provider Edge Router-Juniper 2350 Series
Myrtue Memorial Hospital	Lit Service	Leased Service	100 Mbps	Yes	Provider Edge Router-Juniper 2350 Series
Pocahontas Community Hospital	Lit Service	Leased Service	100 Mbps	Yes	Provider Edge Router-Juniper 2350 Series
St. Luke's Hospital	Lit Service	Leased Service	100 Mbps	Yes	Provider Edge Router-Juniper 2350 Series
St. Luke's Regional Medical Center	Lit Service	Leased Service	100 Mbps	Yes	Provider Edge Router-Juniper 2350 Series
The Finley Hospital	Lit Service	Leased Service	100 Mbps	Yes	Provider Edge Router-Juniper 2350 Series
Trinity Medical Center - Terrace Park	Lit Service	Leased Service	100 Mbps	Yes	Provider Edge Router-Juniper 2350 Series
Trinity Medical Center - 7th St Campus	Lit Service	Leased Service	100 Mbps	Yes	Provider Edge Router-Juniper 2350 Series
Trinity Medical Center - West	Lit Service	Leased Service	100 Mbps	Yes	Provider Edge Router-Juniper 2350 Series
Trinity Regional Medical Center	Lit Service	Leased Service	100 Mbps	Yes	Provider Edge Router-Juniper 2350 Series

* No RHCPP funding required for this site a

**No RHCPP funding required for this tie.

ATTACHMENT B - HealthNet connect (HnC) Access Connection Specification

Hospital



HealthNet connect Access Connection

LEGEND

First Mile Transport Network

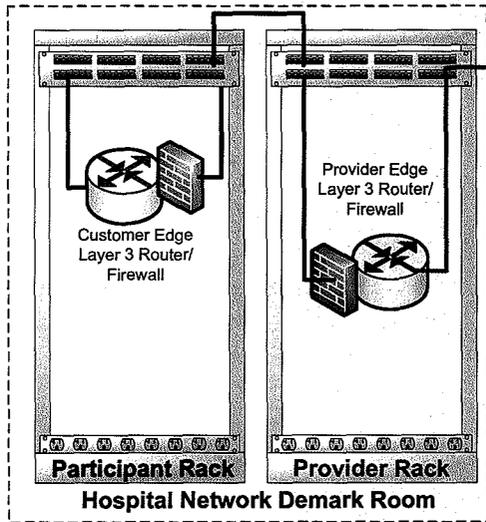
- Gig-E Interface
- Ethernet VLAN tagging (802.1Q)
- 100 / 1000 Mbps CIR / PIR

HealthNet Layer 3

- Firewall / Security
- Access Control
- Routing Policies
- IP Assignment & Management

Minimum 100Mbps
Symmetrical Ethernet Over...
SONET OR Wireless
(Ethernet over TDM) (Licensed Spectrum)
OR Dedicated Fiber
(or WDM Lambdas)

Core Fiber Backbone Network

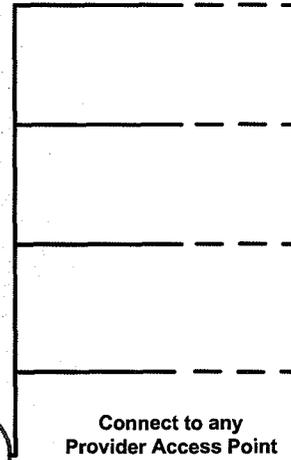


Hospital Supplied:
Space, Power, Rack,
Customer Edge Router

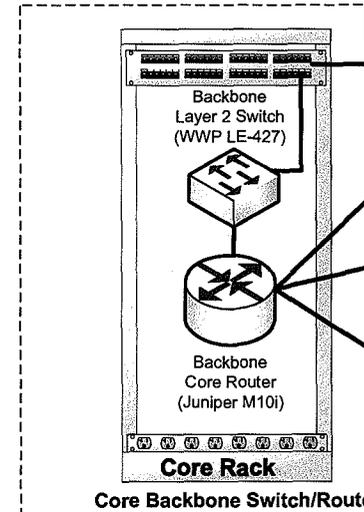
Hospital Supplied:
Space, Power, Rack
Provider Supplied: Provider
Edge Router

All options are delivered "lit"

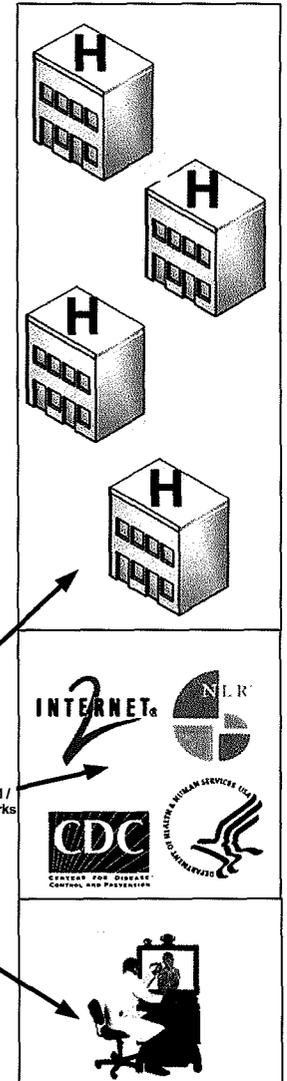
Description	Lease Term	Equipment & Optics	Layer 0/1 Maintenance
Lit Service	15 Year Lit Capacity IRU	Carrier-owned/HnC managed	with or without * * if provided without maintenance HnC must be allowed at will access for maintenance



Connect to any
Provider Access Point



Core Backbone Switch/Router



NOT FCC ELIGIBLE

FCC ELIGIBLE

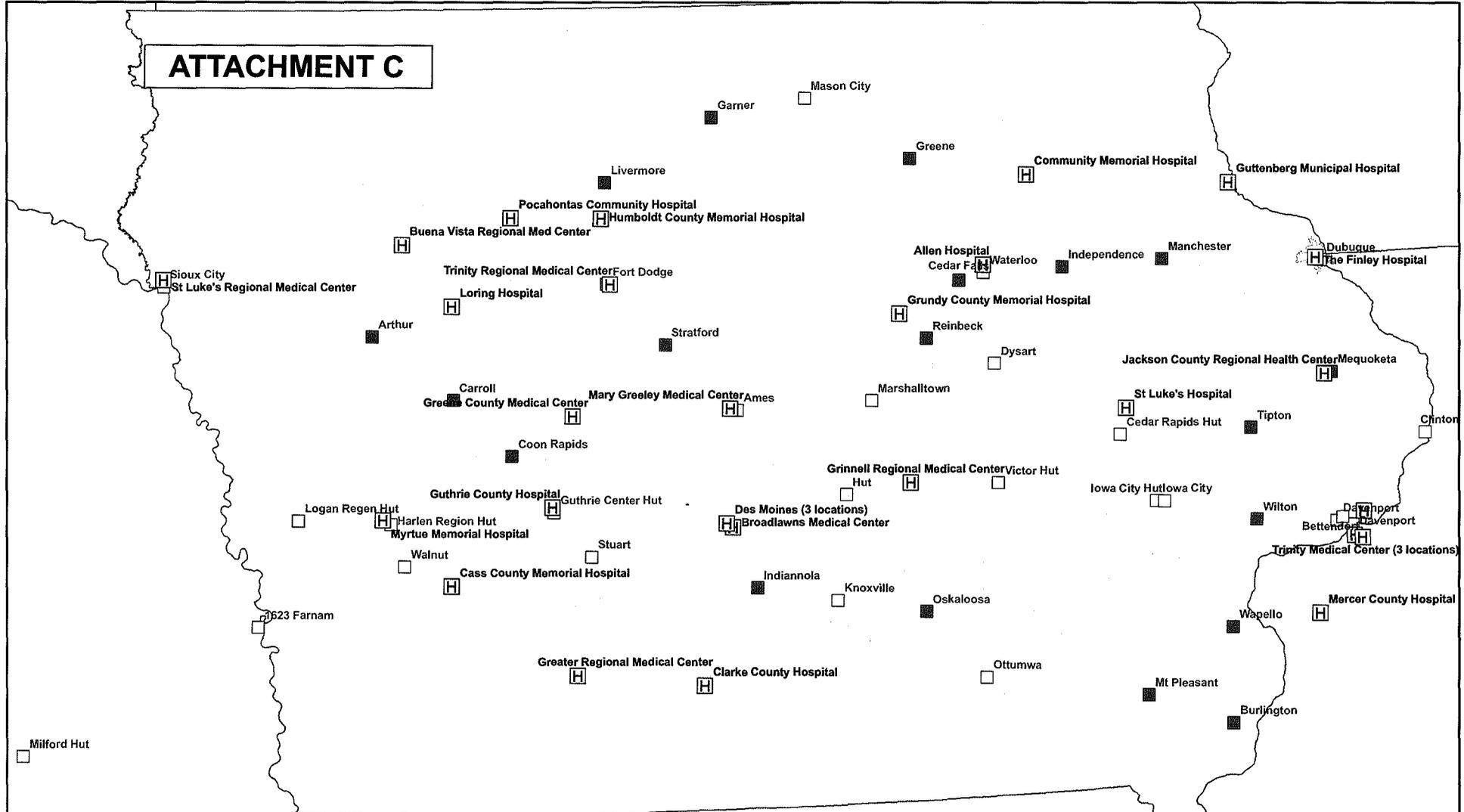
NOT FCC ELIGIBLE

Gerald Horst Sales Engineer	HealthNet First Mile Specifications	Rev #: 4.0 08-13-08
Proprietary & Confidential		

222 3rd Ave, SE
Suite 500
Cedar Rapids, IA 52401
(319) 364-3200
(319) 364-8100 (f)
www.fiberutils.com



ATTACHMENT C



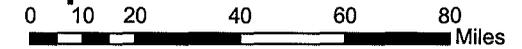
222 3rd Ave SE
 Cedar Rapids, IA 52402
 (319) 364-3200
 (319) 364-8100 (fax)

Legend

- HEALTHNET CONNECT HOSPITAL
- CORE FIBER ACCESS POINT - IHS POP
- CORE FIBER ACCESS POINT - CARRIER COLO



HealthNet connect Hospitals & Access Points





Attachment D

Iowa Health System Sustainability Plan

Prepared by:



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Iowa Health System Sustainability Plan

Overview

The application of Iowa Health System (“IHS”) under the FCC’s Rural Healthcare Pilot Program (“RHCPP”) sought funding for the purpose of constructing access connections to the existing core network of IHS (“Access Connections”). As demonstrated by this sustainability plan, IHS anticipates that it will be able to meet the ongoing operation expenses of the Access Connections from revenues generated by eligible and ineligible users. In fact, IHS expects that the Access Connections will be fully funded and self-sustaining by the fifth year of operation and will remain self-sustaining, including generating sufficient revenues to cover capital costs on an ongoing basis.¹

This Plan shows nominal losses for the Access Connections in the first three years, then positive cash flow for the remainder of the 20 year projection,² including generating sufficient cash to cover electronics replacement for eligible users.³ IHS anticipates sponsoring capital, operational and maintenance costs as well as any cash flow shortfalls.⁴

IHS is Iowa’s first and largest integrated health-care system, serving nearly one of every three patients in Iowa. IHS has hospitals in 14 rural communities and group practices of physicians and clinics in 71 communities. It also has a workforce of nearly 20,000 employees and annual revenues of almost \$2 billion. The core network of IHS which is operational today is a 2,170 route mile, fiber optic-based network used for IHS’ internal traffic as well as data transmissions between and among IHS’ facilities located in seven large Iowa communities plus Rock Island and Moline, Illinois.

In short, IHS has the managerial, technical and financial wherewithal to operate and maintain not only its core network but the Access Connections to that network on a sustainable basis.

Plan Assumptions

The plan reflects the costs to build, maintain, and operate the Access Connections to the IHS core network. IHS estimates that its direct administrative cost of supporting users is

¹ Future capital costs are limited to equipment replacement as the equipment obsolesces.

² IHS used a 20 year projection because it replicates the life of dark fiber IRUs and is within the range of reasonableness for projecting revenues, expenses and cash flow.

³ Exhibit A shows a few years of negative cash flow (2010 through 2011 and 2014 through 2021) but the amounts are small (\$335,905 or 3% of the total project costs).

⁴ The RHCPP Application of IHS shows additional capital costs of approximately \$2.7 million whereas Exhibit A shows those costs as approximately \$2.5 million. The analysis for the Application was done in 2007 whereas Exhibit A was completed in late 2008. During that period of time, IHS had the benefit of reviewing the RFPs of interested providers, the project changed from a complete build to a phased build and the Application is based on dark fiber which is no longer available.

\$82 per user, per month. This amount includes governance, overhead and other miscellaneous support required for users.

The plan tests the financial assumptions for sustainability of the IHS project. The basic approach is to determine whether it will generate sufficient revenues to cover operating costs and provide the funds necessary to periodically refresh electronics. The RHCPP funds (85%) and the funds anticipated to be contributed by IHS (15%) are considered sunk costs.⁵

The plan assumes that it will be supported by both eligible users (not-for-profit hospitals and healthcare providers) and ineligible Users (for-profit healthcare and healthcare-related providers).

1) Eligible Users

The plan limits the total eligible users to 78, as specified in the original FCC application. Eligible users have demonstrated their commitment to the RHCPP by entering into Letters of Agency so that IHS may represent them before USAC. They will also sign the Operating Agreement to become members of HealthNet connect, which will administer the Access Connections on behalf of IHS.

Consistent with that outlined in the RHCPP application of IHS, the plan is based on the goal of insuring that eligible users can participate in basic network applications for a nominal cost. With this in mind, a “basic package” was established at the nominal rate of \$120 per month per eligible user and increases (at an annual rate equivalent to the CPI) to \$187 by the 15th year and \$210 by the 20th year.⁶ For \$120 per month, eligible health care providers will enjoy full usage of healthcare data and applications and Internet2/NLR connectivity over a 100 Mbs connection. This type of connectivity would normally cost between \$2500 and \$3000 per month if purchased directly from the commercial marketplace.

The charge of \$120 per month is not exact nor is it based on an in-depth study of demand. Instead, it takes into consideration the financial resources of rural hospitals that are the target market for the package, the costs of the Access Connections and what appears reasonable under the circumstances. If it turns out that the charge is too high or too low, IHS will need to reconsider it, but in the context of affordability.

⁵ The 15% contribution for the first phase of the project (28 eligible users) will be funded by IHS from internal sources. It is anticipated that the 15% contribution for succeeding phases will also be funded by IHS from internal sources. It should also be noted that Exhibit 3 of the IHS RHCPP Application before the FCC showed that IHS will fund approximately 39% of the total cost of the project (\$4,994,658 of \$12,797,390), which included not only the Access Connections but also the associated backbone and metro costs. The costs of the Access Connections, however, is approximately \$9.2 million, 85% of which, or approximately \$7.8 million, will be funded with RHCPP funds and 15% of which, or approximately \$1.38 million, will be funded by IHS.

⁶ In this instance, the word “nominal” means the estimated, direct costs of governance of the eligible group of users.

Eligible users needing such connections are currently limited to buying various services, such as DSL or T-1's. The typical charge for these connections in rural areas is different than the charge for 100 Mbs connections quoted above and range from \$250 to \$1500 per month. However, the bandwidth of a DSL or T-1 of 1.5 Mbs is relatively narrow in comparison to 100Mbs. As such, it barely supports critical health care functions (*e.g.*, internet, radiology, back office business functions *etc.*). It is reasonable to assume therefore, that eligible healthcare providers will redirect some, if not, all of the dollars otherwise spent on various telecom services to the IHS care network by purchasing the basic package.

The plan generates sufficient revenues to replace eligible user electronics every five years. Electronics have an assumed five-year useful life, with a \$10,000 per user replacement cost, plus spares, setup, installation, warranty and contingency amounts.

2) Ineligible Users

Ineligible users will not be using any portion of the Access Connections funded under the RHCPP. Ineligible users will be required to pay the full cost of connecting to the network and upgrading their electronics.⁷ Once connected, however, they receive the same benefits received by eligible users but at a higher rate of \$250 per month increasing (at an annual rate equivalent to the CPI) to \$389 by the 15th year and \$438 by the 20th year.

Similar to eligible users, it is expected that ineligible users will be able to reduce or eliminate some existing costs by converting existing traffic and routing future traffic over the IHS core network.

This plan reflects the offsetting basic user fees generated by an assumed number of ineligible participants over a 20-year period. This plan estimates the number of ineligible users at 30 in the first year, growing to 74 over the 20 years of the project

Following are additional assumptions underlying the plan:

1) General

- A projected start year of 2009
- Only 6 months of revenue in the first year of operation

⁷ Since the charges paid by eligible users will be nominal (*see supra*, note 6), the charges paid by ineligible users will not only cover the full cost of connecting to the network and upgrading their electronics but it will also include a subsidy of the costs incurred by eligible users. In other words, the costs allocated to ineligible users is determined by calculating the total costs of the project and then subtracting the nominal costs attributable to eligible users.

- Upgrade in edge routers of \$290,000, \$290,000, and \$200,000 in 2014, 2015, and 2016, respectively and again in 2019, 2020, and 2021 as well as 2024, 2025, and 2026
- An annual CPI adjustment of 3%

2) Capital Costs

- Depreciation rates based on standard GAAP/IRS useful lives.
- A capital expenditure contingency of 5% of the total non-fiber capital expenses
- The capital refresh cost is set equal to the initial cost for the same asset. The assumption is that the same dollars will buy then-current capabilities in the electronics. The basis for this assumption is that the price-performance curve for digital technology has been improving for decades. The approach for this Plan, therefore, assumes that the price in dollars for a particular piece of electronics will be the same in 10 years as it is now, but the capabilities will have improved substantially.
- The source of funds for future capital requirements is the net income generated from the operation of the network, primarily ineligible users. Exhibit A shows that sufficient net revenues will be generated to fund replacement electronics.

3) Operating Costs

- Per edge router (*e.g.*, 1 per user) of \$100 per month plus nominal annual charges for licensing, right-of-way, software and miscellaneous costs.

4) Planning (direct G&A)

- Direct general and administrative expense (governance, overhead and other miscellaneous support) of \$82 per customer.

5) Pricing (*see* descriptions above of Eligible Users and Ineligible Users)

6) Take Rates

- Eligible users top out at 78, which is the amount of users set forth in the IHS RHCPP application

- Eligible users increase over time based on the phased build of the RHCPP funded Access Connections to the IHS core network, *e.g.*, design, RFP, approval, construction, turn up.
- Ineligible users ramp up fairly quickly in the first six years. After six years, the ramp up assumption is conservatively set at one ineligible user per year (the actual market of users is limited by geography and cost)

Exhibit A

Summary by Year

FINANCIAL SUMMARY

Date: December 16, 2008

BY: Fiberutilities Group, LLC

Location: Multi-state

Product/Project Title: Iowa Health System (IHS)

Project Description: This plan tests the financial assumptions for sustainability of the IHS Project. The basic approach is to prove sufficient revenues to cover operating costs and provide funds for periodic electronics refresh. The original grant funds and the matching IHS funds are considered sunk costs; this model only considers what is required to sustain operations.

Financial Summary (20 YEAR TOTAL):

Revenues \$ 8,315,854
 Net Income \$ 137,578
 Cash Flow \$ 2,119,378
 Capital Expenditures \$ 2,457,000

SUMMARY BY YEAR	Average % of Revenue																				20 YEAR	
		2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	TOTAL
Operating Revenues	100.00%	\$ 65,880	\$ 225,076	\$ 278,295	\$ 303,035	\$ 329,009	\$ 356,268	\$ 370,538	\$ 385,344	\$ 400,705	\$ 416,640	\$ 433,171	\$ 450,319	\$ 468,106	\$ 486,555	\$ 505,689	\$ 525,534	\$ 546,114	\$ 567,456	\$ 589,587	\$ 612,535	\$ 8,315,854
Non Recurring Revenue	0.00%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TOTAL REVENUE	100.00%	\$ 65,880	\$ 225,076	\$ 278,295	\$ 303,035	\$ 329,009	\$ 356,268	\$ 370,538	\$ 385,344	\$ 400,705	\$ 416,640	\$ 433,171	\$ 450,319	\$ 468,106	\$ 486,555	\$ 505,689	\$ 525,534	\$ 546,114	\$ 567,456	\$ 589,587	\$ 612,535	\$ 8,315,854
Internet2/NLR access	0.00%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
GROSS MARGIN	100.00%	\$ 65,880	\$ 225,076	\$ 278,295	\$ 303,035	\$ 329,009	\$ 356,268	\$ 370,538	\$ 385,344	\$ 400,705	\$ 416,640	\$ 433,171	\$ 450,319	\$ 468,106	\$ 486,555	\$ 505,689	\$ 525,534	\$ 546,114	\$ 567,456	\$ 589,587	\$ 612,535	\$ 8,315,854
Network Operations & Maint	0.08%	\$ 210	\$ 213	\$ 217	\$ 223	\$ 230	\$ 237	\$ 244	\$ 251	\$ 259	\$ 267	\$ 275	\$ 283	\$ 291	\$ 300	\$ 309	\$ 318	\$ 328	\$ 338	\$ 348	\$ 358	\$ 5,497
Sales & Marketing	0.00%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Customer Service	0.00%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
General & Administrative	94.95%	\$ 64,428	\$ 226,188	\$ 281,088	\$ 292,068	\$ 303,048	\$ 314,028	\$ 316,224	\$ 318,420	\$ 320,616	\$ 322,812	\$ 325,008	\$ 327,204	\$ 329,400	\$ 331,596	\$ 333,792	\$ 335,988	\$ 338,184	\$ 340,380	\$ 342,576	\$ 344,772	\$ 6,107,820
Depreciation and Amortization	3.50%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 52,200	\$ 104,400	\$ 140,400	\$ 140,400	\$ 140,400	\$ 140,400	\$ 140,400	\$ 140,400	\$ 140,400	\$ 140,400	\$ 140,400	\$ 140,400	\$ 140,400	\$ 140,400	\$ 140,400	\$ 1,981,800
Bad Debts	1.00%	\$ 659	\$ 2,251	\$ 2,783	\$ 3,030	\$ 3,290	\$ 3,563	\$ 3,705	\$ 3,853	\$ 4,007	\$ 4,166	\$ 4,332	\$ 4,503	\$ 4,681	\$ 4,866	\$ 5,057	\$ 5,255	\$ 5,461	\$ 5,675	\$ 5,896	\$ 6,125	\$ 83,159
TOTAL OP EXPENSES	99.53%	\$ 65,297	\$ 228,652	\$ 284,088	\$ 295,322	\$ 306,568	\$ 370,027	\$ 424,573	\$ 462,925	\$ 465,282	\$ 467,645	\$ 470,014	\$ 472,390	\$ 474,772	\$ 477,162	\$ 479,558	\$ 481,962	\$ 484,373	\$ 486,792	\$ 489,220	\$ 491,656	\$ 8,178,276
Interest Exp (cost of capital)	0.00%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TOTAL EXPENSE	99.53%	\$ 65,297	\$ 228,652	\$ 284,088	\$ 295,322	\$ 306,568	\$ 370,027	\$ 424,573	\$ 462,925	\$ 465,282	\$ 467,645	\$ 470,014	\$ 472,390	\$ 474,772	\$ 477,162	\$ 479,558	\$ 481,962	\$ 484,373	\$ 486,792	\$ 489,220	\$ 491,656	\$ 8,178,276
Interest Income	0.00%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Net income et Income		\$ 583	\$ (3,576)	\$ (5,792)	\$ 7,714	\$ 22,441	\$ (13,759)	\$ (54,035)	\$ (77,561)	\$ (64,577)	\$ (51,005)	\$ (36,843)	\$ (22,071)	\$ (6,686)	\$ 9,393	\$ 26,131	\$ 43,572	\$ 61,741	\$ 80,663	\$ 100,367	\$ 120,879	\$ 137,578
Cash Flow		\$ 583	\$ (3,576)	\$ (5,792)	\$ 7,714	\$ 22,441	\$ 38,441	\$ 50,365	\$ 62,819	\$ 75,823	\$ 89,395	\$ 103,557	\$ 118,329	\$ 133,734	\$ 149,793	\$ 166,531	\$ 183,972	\$ 202,141	\$ 221,063	\$ 240,767	\$ 261,279	\$ 2,119,378
EBITDA percent of gross		0.89%	-1.59%	-2.08%	2.55%	6.82%	10.79%	13.59%	16.30%	18.92%	21.46%	23.91%	26.28%	28.57%	30.79%	32.93%	35.01%	37.01%	38.96%	40.84%	42.66%	25.49%
Fixed Asset Additions (GL Additions)		\$ -	\$ -	\$ -	\$ -	\$ -	\$ 304,500	\$ 304,500	\$ 210,000	\$ -	\$ -	\$ 304,500	\$ 304,500	\$ 210,000	\$ -	\$ -	\$ 304,500	\$ 304,500	\$ 210,000	\$ -	\$ -	\$ 2,457,000
Capital Expenditures (Cash for Assets)		\$ -	\$ -	\$ -	\$ -	\$ -	\$ 304,500	\$ 304,500	\$ 210,000	\$ -	\$ -	\$ 304,500	\$ 304,500	\$ 210,000	\$ -	\$ -	\$ 304,500	\$ 304,500	\$ 210,000	\$ -	\$ -	\$ 2,457,000
Cumulative Capital Expenditures		\$ -	\$ -	\$ -	\$ -	\$ -	\$ 304,500	\$ 609,000	\$ 819,000	\$ 819,000	\$ 819,000	\$ 1,123,500	\$ 1,428,000	\$ 1,638,000	\$ 1,638,000	\$ 1,638,000	\$ 1,942,500	\$ 2,247,000	\$ 2,457,000	\$ 2,457,000	\$ 2,457,000	\$ 2,457,000

Exhibit B

Access Connection Revenues versus Expenses and Cash Flow

