

Rural Health Care Pilot Program Quarterly Data Report
WC Docket No. 02-60
Rural Nebraska Healthcare Network
July– September 2010

1. Project Contact and Coordination Information

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

Todd Sorensen, President, Rural Nebraska Healthcare Network
CEO, Regional West Medical Center

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

Boni Carrell
Executive Director
Rural Nebraska Healthcare Network
4021 Avenue B
Scottsbluff, NE 69361
(308) 630-1703
carrelb@rwmc.net

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

Rural Nebraska Healthcare Network (RNHN)
4021 Avenue B
Scottsbluff, NE 69361

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

The RNHN is a non-profit membership organization of nine non-profit hospitals in the Panhandle of Nebraska. A board of Directors of the Chief Executive Officer for each member hospital governs the RNHN. The RNHN is coordinated by an Executive Director with the President of the RNHN presiding at all meetings and supervising the affairs of the RNHN with the support of a Vice President and Secretary/Treasurer. The RHCPP is a standing agenda item at the monthly RNHN Board meeting. The Project Coordinator (RNHN President) and Associate Project Coordinator (RNHN Executive Director) provide updates and discuss the progress of the project with the Board.

The project is being coordinated through the office of Boni Carrell, Executive Director of the RNHN. Beginning in early December 2007, and with the assistance of Fiberutilities Group, the office has fielded multiple contacts from telecom providers and consultants regarding the project. RNHN has also visited with a number of third parties who may be interested in funding the network. Moreover, in March 2008,

Todd Sorensen, President of the RNHN, advised the Nebraska Public Service Commission of the project. In December of 2008, the RNHN met with Nebraska Lt. Governor Rick Sheehy, Chair of the Nebraska Information Technology Commission (NITC) to discuss the project.

Representatives of the Rural Nebraska Healthcare Network have met with representatives of the Nebraska Statewide Telehealth Network and Network Nebraska to discuss the RHCPP project.

On November 3, 2009, Todd Sorensen and Fiberutilities Group representatives met with Nebraska Lt. Governor Rick Sheehy, Chair of the Nebraska Information Technology Commission, and Brenda Decker, Nebraska Chief Information Officer, to update them on the RNHN project. In addition, Randy Lowe, counsel to RNHN, and Todd Sorensen spoke with the Nebraska Public Service Commission staff and Commissioners Boyle and Vapp about the RNHN project.

On April 20, 2010 Harold Krueger, RNHN Vice President met with Nebraska Governor Dave Heineman to update him on the progress of our project.

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.**

In the following table we have indicated, by strikethrough, the removal of Ash Hollow Rural Health Clinic from the project due to closure because of lack of health care professionals. This is an indication of the tenuousness of rural healthcare and further supports the need for broadband fiber infrastructure to support telemedicine, telehealth, and health information exchange.

Three additional sites are identified within the campus of Regional West Medical Center. Regional West Medical Center, 3700 Ave D, Scottsbluff, NE 69361 was added because Regional West recently moved its data center to this building on the hospital campus which also houses the Regional West Medical Center School of Radiologic Technology and the Community Health Department that provides direct

services to clients. Regional West Physicians Clinic, 3911 Ave B, Scottsbluff, NE 69361 and Regional West Physicians Clinic, 3011 Ave B, Scottsbluff, NE 69361 were added because they were acquired as a result of physician integration at Regional West Health Services for the purpose of facilitating the physicians and the hospital working together for the benefit of the patients in the region.

The Dorwart Cancer Care Center in Sidney Nebraska has been added to the project. Dorwart is a department of Regional West Medical Center and was inadvertently excluded from the original FCC Form 465 submission of RNHN.

There is an additional location for Chadron Community Hospital. A new hospital building is being constructed at 825 Centennial Drive, Chadron, NE 69337. They expect to occupy this location in the summer of 2010. The current hospital location at 821 Morehead Street, Chadron, NE 69337 will become Western Community Health Resources (WCHR) offices and client clinics. Transition of the existing WCHR Chadron locations into the existing building is expected to be completed by December 2010. The existing hospital ER will become the free medical clinic for Chadron State College students. The hospital provides these services through a contract with Chadron State College.

Prairie Pines Clinic was deemed an ineligible entity during the 465 process and has been removed from the funded entities

There are no changes made to participating institutions for the July through September 2010 reporting period.

Rural Nebraska Healthcare Network Member Hospitals and Affiliated Clinics, FCC Rural Health Care Pilot Program	Phone	Census Tract	Prim. RUCA	Sec. RUCA	County	Ownership: public, private, city, county	Not for Profit	Eligible Health Care Facility Section 254 1996 Act
Box Butte General Hospital , 2101 Box Butte Ave, Alliance, NE 69301	(308) 762-6660	9512	7	7.0	Box Butte	County	X	NE Licensed Hospital
Hemingford Clinic, 812 Laramie Ave., Hemingford, NE, 69348		9511	10	10.3	Box Butte	Provider Based RHC	X	CMS Certified RHC
Cow Country Health Clinic, 111 Main St, Hyannis, NE 69350		9563	10	10.0	Grant	Provider Based RHC	X	CMS Certified RHC
Sandhills Family Center, 2107 Box Butte Ave., Alliance, NE 69301		9512	7	7.0	Box Butte	Provider Based RHC	X	Rural Health Clinic
Chadron Community Hospital , 825 Centennial Drive, Chadron, NE 69337	(308) 432-5586	9507	7	7.0	Dawes	Private	X	NE Licensed Hospital
Chadron Community Hospital , 821 Morehead Street, Chadron, NE 69337	(308) 432-5586	9507	7	7.0	Dawes	Private	X	NE Licensed Hospital
Legend Buttes Health Services, 11 Paddock Street, Crawford, NE 69339		9506	10	10.0	Dawes	Provider Based RHC	X	CMS Certified RHC
Hay Springs Medical Clinic, 232 N Main St Hay Springs, NE 69347		9517	10	7.0	Sheridan	Provider Based RHC	X	Title X Federal recipient
Western Community Health Resources, 739 Morehead Street, Chadron, NE 69337		9507	7	7.0	Dawes	Provider Based RHC	X	Title X Federal recipient
Western Community Health Resources, 619 Box Butte Ave. Alliance, NE 69301		9513	7	10.6	Box Butte	Provider Based RHC	X	Title X Federal recipient
Western Community Health Resources, 11 Paddock Street, Crawford, NE 69339		9506	10	10.0	Dawes	Provider Based RHC	X	Title X Federal recipient
Western Community Health Resources, 206 Loofborrow Street, Rushville, NE 69360		9517	10	7.0	Sheridan	Provider Based RHC	X	Title X Federal recipient
Western Community Health Resources, 106 North Main, Gordon, NE 60343		9516	10	7.0	Sheridan	Provider Based RHC	X	Title X Federal recipient
Western Community Health Resources, Native American Ctr. 502 W. 2 nd , Chadron, NE 69337		9507	7	10.6	Dawes	Provider Based RHC	X	Title X Federal recipient
Prairie Pines Clinic, 900 West 7 th St., Chadron, NE 69337	-	9507	7	10.0	Dawes	Provider Based RHC	X	Title X Federal recipient
Family Planning Clinic, 848 Morehead Street, Chadron, NE 69337		9507	7	10.0	Dawes	Provider Based RHC	X	Title X Federal recipient
Garden County Hospital , 1100 West 2 nd , Oshkosh NE 69154	(308) 772-3283	9521	10	7.0	Garden	County	X	NE Licensed Hospital
Garden County Rural Health Clinic, 1100 West 2 nd , Oshkosh, NE 69154		9521	10	7.0	Garden	Rural Health Clinic	X	CMS Certified RHC
Ash Hollow RHC Llewellyn	-	-	10	7.0	Garden	Rural Health Clinic	X	CMS Certified RHC
Gordon Memorial Hospital , 300 E 8 th Street, Gordon, NE 69343	(308) 282-0401	9516	10	10.0	Sheridan	District	X	NE Licensed Hospital
Gordon Clinic, 807 North Ash St., Gordon, NE 69343		9516	10	10.0	Sheridan	Rural Health Clinic	X	CMS Certified RHC
Rushville Clinic, 308 West 3 rd St., Rushville, NE 69360		9517	10	10.0	Sheridan	Rural Health Clinic	X	CMS Certified RHC
Kimball Health Services , 505 S. Burg St., Kimball, NE 69154	(308) 235-1952	9545	7	7.0	Kimball	County	X	NE Licensed Hospital
Kimball Health Services Clinic, 505 S. Burg St., Kimball, NE 69154		9545	7	7.0	Kimball	Provider Based RHC	X	CMS Certified RHC
Memorial Health Center , 645 Osage St., Sidney, NE 69162	(308) 254-5825	9550	7	7.0	Cheyenne	Private	X	NE Licensed Hospital
Sidney Medical Associates, 1625 Dorwart Dr., Sidney, NE, 69162		9550	7	7.0	Cheyenne	Rural Health Clinic	X	CMS Certified RHC
Memorial Health Center Surgical Care and Outpatient Clinic, 645 Osage St., Sidney, NE 69162		9550	7	7.0	Cheyenne	Private	X	Department of Hospital
Chappell Medical Clinic, 562 Vincent Ave., Chappell, NE 69129		9554	10	10.0	Cheyenne	Rural Health Clinic	X	CMS Certified RHC
Morrill County Community Hospital , 1313 S Street, Bridgeport, NE 69336	(308) 262-1616	9525	10	10.5	Morrill	County	X	NE Licensed Hospital
Morrill County Hospital Clinic, 1320 S St., Bridgeport, NE 69336		9525	10	10.0	Morrill	Provider Based RHC	X	CMS Certified RHC
Chimney Rock Medical Center, 320 Main St., Bayard, NE 69334		9525	10	10.0	Morrill	Provider Based RHC	X	CMS Certified RHC
Morrill County Family Resource Center, 1320 S St., Bridgeport, NE 69336		9525	10	10.0	Morrill	Migrant Health	X	Satellite of FQHC
Perkins County Health Services , PO Box 26 Grant, NE 69140	(308) 352-7200	9593	10	10.0	Perkins	District	X	NE Licensed Hospital
Grant Medical Clinic, 912 Central Avenue, Grant, NE 69140		9593	10	10.0	Perkins	Rural Health Clinic	X	CMS Certified RHC
Regional West Medical Center , 4021 Ave B, Scottsbluff, NE 69361	(308) 630-1703	9534	4	4.0	Scotts Bluff	Private	X	NE Licensed Hospital
Regional West Medical Center , 3700 Ave D, Scottsbluff, NE 69361		9534	4	4.0	Scotts Bluff	Private	X	NE Licensed Hospital
Regional West Physicians Clinic, 2 West 42nd Street, Scottsbluff, NE 69361		9534	4	4.0	Scotts Bluff	Private	X	IRS 501c3
Regional West Physicians Clinic, 1456 Center Ave., Mitchell, NE 69357		9530	5	5.0	Scotts Bluff	Rural Health Clinic	X	CMS Certified RHC
Regional West Physicians Clinic, 302 Center Ave., Morrill, NE, 69358		9531	10	10.2	Scotts Bluff	Rural Health Clinic	X	CMS Certified RHC
Regional West Physicians Clinic 1275 Sage Street, Gering, NE, 69341		9538	4	4.0	Scotts Bluff	Private	X	IRS 501c3
Regional West Physicians Clinic, 3911 Ave B, Scottsbluff, NE 69361		9534	4	4.0	Scotts Bluff	Private	X	IRS 501c3
Regional West Physicians Clinic, 3011 Ave B, Scottsbluff, NE 69361		9534	4	4.0	Scotts Bluff	Private	X	IRS 501c3
Dorwart Cancer Care Center, 830 Pine Street, Sidney, NE 69162	(308) 254-9192	9550	7	7.0	Cheyenne	Private	X	IRS 501c3

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 backbone network is a 24-count fiber optic cable that connects all participating facilities utilizing 2 Gigabit optical gear in a multi-ring configuration (for most locations) and a hub-and-spoke configuration for select locations.

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

Each health care provider will have a direct fiber connection to the backbone, with primary care hospitals capable of connecting at 2 Gigabits, and clinic locations connecting at 1 Gigabit.

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

The network will be connected to the Front Range Gigapop facility in Denver, Colorado via redundant circuits in order to access I2. The primary circuit is a 1000 Megabit circuit, and the secondary circuit is 100 Megabits

- d. Number of miles of fiber construction, and whether the fiber is buried or aerial; Special systems or services for network management or maintenance (if applicable) and where such systems reside or are based.**

The estimate for new fiber construction miles is approximately 700 miles of underground cable. Network management will be provided via two redundant, virtual Network Operations Centers located in data centers in Iowa. Outside plant maintenance has been contracted with a local carrier, Zayo Group.

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.

Not applicable at this time because the network is not yet built or operational.

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

- a. Network Design**
- b. Network Equipment, including engineering and installation**
- c. Infrastructure Deployment/Outside Plant**
- d. Engineering**
- e. Construction**
- f. Internet2, NLR, or Public Internet Connection**
- g. Leased Facilities or Tariffed Services**
- h. Network Management, Maintenance, and Operation Costs (not captured elsewhere)**
- i. Other Non-Recurring and Recurring Costs**

Not applicable at this time because the network is not yet designed built or operational.

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.**

All participants are eligible users, and share all costs equally.

b. Describe the source of funds from:

i. Eligible Pilot Program network participants

Eligible program participants are covering 100% of the costs.

ii. Ineligible Pilot Program network participants

Not applicable; all participants are eligible

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.

A 20 year IRU sold to Zayo Group LLC for dark fiber along the network route will cover all eligible user's required 15% match, plus on-going network costs as identified in the Sustainability Plan. See attachment A

ii. Identify the respective amounts and remaining time for such assistance.

See Attachment A

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.

See Attachment A to this Quarterly Report.

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

RNHN has assumed there will not be any ineligible users using any portion of the RNHN network. See Attachment A. If any ineligible users are allowed access to the RNHN network, technical or non-technical requirements or procedures have not yet been developed except that they will be required to pay the full cost of connecting to the network and installing, operating and upgrading their electronics. They will also be required to pay their fair share of network costs attributable to the portion of network capacity used.

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

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

Project leader	Todd Sorensen, President, Rural Nebraska Healthcare Network
Assistant project leader	Boni Carrell, Executive Director, Rural Nebraska Healthcare Network
Counsel	Randy Lowe, Davis Wright Tremaine LLP
Consultants	Fiberutilities Group

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.

The project plan will be determined in partnership with the contracted vendor.*

Activity	Based on RFP posting date	Actual or Anticipated Dates
RFP posted	Day 1	August 28, 2009
RFP question answer session 1	2nd Friday after posting	September 11, 2009
RFP question answer	3 rd Friday after	September 18, 2009

session 2	posting	
Bid response deadline	Posting date + 52 days	October 19, 2009
Award Announcement*	Posting date + 90 days	November 30, 2009
Complete USAC 466 process	Award date + 14 days	To be determined
Contract awarded	Award date + 60 days	October 15, 2010
Construction start		November 1, 2010
Testing and acceptance		Summer/Fall 2011
Healthcare Network 100% operational		Fall 2011

* Although RNHN has completed the competitive bidding process and selected a vendor, the ability to contract with the vendor is dependent on the sale of IRUs for the 15% contribution of RNHN. (See Attachment A to this Quarterly Report.) Until then, RNHN will not award a contract.

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 A to this Quarterly Report.

- 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.**

Not applicable at this time because the network is not yet operational.

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.

Not applicable at this time because the network is not yet operational

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.

Not applicable at this time because the network is not yet operational.

Rural Nebraska Healthcare Network

FCC - Rural Health Care Pilot Program

Sustainability Plan

Updated 6/29/10

Prepared by:



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Rural Nebraska Healthcare Network Sustainability Plan

Overview

The Rural Nebraska Healthcare Network (RNHN) is a not-for-profit corporation whose members are the nine not-for-profit and public hospitals in the Panhandle of Nebraska.¹ A board of directors, which is comprised of the Chief Executive Officer of each member hospital, governs the RNHN.

Since 1996, RNHN members have uniquely collaborated on projects in order to coordinate a unified healthcare response in the face of the geographic isolation of their patients. Thus, RNHN is an integrated healthcare system that serves nearly all patients in the Nebraska Panhandle.²

The RNHN was awarded support of \$19.2M under the FCC's Rural Health Care Pilot Program (RHCPP) to design, construct, operate, and maintain a fiber optic network connecting each of its member hospitals with each other and with other health care facilities (RHCPP Network). The total cost of the RHCPP Network, however, has decreased slightly from \$22,655,226 projected in RNHN's RHCPP Application to \$19,741,865.

As demonstrated by this Sustainability Plan (Plan), RNHN anticipates that it will be able to meet its 15% contribution under the RHCPP, as well as the ongoing capital and operation expenses of the RHCPP Network which will consist of 36 fibers³ (See Exhibits A and B.). It will do so by selling Indefeasible Rights of Use (IRU) in a privately funded, 48 fiber network owned by RNHN that is located in the same trench used for the RHCPP Network (Second Network).⁴ Moreover, this Plan shows positive cash flow beginning with the first year and remaining positive for the next 20 years, including generating sufficient cash to cover electronics replacement and anticipated network capacity upgrades.⁵

¹The member hospitals are: Box Butte General Hospital, Alliance; Chadron Community Hospital, Chadron; Garden County Health Services, Oshkosh; Gordon Memorial Health Services, Gordon; Kimball Health Services, Kimball; Memorial Health Center, Sidney; Morrill County Community Hospital, Bridgeport; Perkins County Health Services, Grant; and Regional West Medical Center, Scottsbluff.

²The Panhandle covers 11 counties spread out over 14,000 square miles with a population density of 6.5 people per square mile.

³ The final design by the contractor (Adesta LLC) required that the fiber count be increased from 24 to 36 fibers in portions of the RHCPP Network in order to meet redundancy requirements. As such, portions of the RHCPP Network will be comprised of 24 fibers, while other portions (primarily the backbone) will have 36 fibers.

⁴ IRU's do not convey legal title, only quiet enjoyment to use of fiber for a specific period of time. Consequently, RNHN, or a wholly-owned subsidiary of RNHN, will be the sole owner of, and hold legal title to the Second Network. The Second Network will contain 48 fibers because it will permit increased revenues to meet the needs of the RHCPP Network. Moreover, and unlike the RHCPP Network, it is expected that certain segments of the Second Network will be used more or less than other segments. In order to accommodate such uneven use, it is necessary to construct more fibers than would otherwise be necessary if all segments were used equally. Nevertheless, if the needs of RHCPP Network users increase beyond 36 fibers, it is expected that the additional fiber of the Second Network will be available to meet those needs.

⁵RNHN 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.

The approach used for this Plan was to determine whether the Second Network will generate sufficient net revenues to cover the 15% contribution and the capital and operating costs of not only the RHCPP Network but also the Second Network. The Plan, therefore, reflects the costs to build, maintain, and operate both the RHCPP and the Second Network and the revenues generated by the Second Network.

Plan Assumptions

1) Second Network

Based on the FCC Order approving the Application, RNHN has revised its original approach to the project as set forth in the Application, and now plans, as noted above, a separately funded second network in the same trench as the RNHN project cable.⁶ The source of the funds for the Second Network will be private, not public. RNHN will place them in an escrow account to assure that sufficient funds will be available to meet the 15% matching requirement when USAC issues the funding commitment letter (FCL) for the RHCPP Network.

RNHN is negotiating a transaction with Zayo Group, a Colorado based telecommunications company, for Zayo to acquire all of the fibers in the Second Network and to provide all outside network maintenance, restoration, repair, relocation and other associated outside plant services for the RHCPP Network for 25 years. This transaction will cover 100% of the incremental cost associated with the Second Network, as well as provide the funding needed for the required RNHN 15% match. Additionally, this revised approach will save approximately \$3M in government funds required to complete the network. RNHN is also negotiating a transaction with Adesta, a Nebraska based company engaged in the design and construction of fiber optic networks, to design and construct the RHCPP Network. The IRU and construction contracts under consideration are arms-length transactions negotiated at fair market value. RNHN estimates that the incremental amount required from private funds to add the Second Network is \$1,428,737 based on the RFP responses.

RNHN estimates that the total (incremental) amount required from private funds to build the Second Network is \$1,430,000. This includes approximately 752 miles of cable with 48 fibers available for IRU's.⁷ The source of funds for future capital requirements is the net income generated from the sale of IRU's and O&M fees received for the Second Network.⁸ For clarity, the \$1.4M used to deploy the Second Network *is funded entirely by RNHN without the use of any governmental funds*. This incremental amount is recaptured by RNHN via the sale of IRU's.

⁶ The RHCPP Application of RNHN before the FCC showed that the project would be funded by Mobius Communications Company, Inc., a Nebraska provider of telecommunications services. *See In the Matter of Rural Health Care Support Mechanism*, 22 FCC Rcd. 20360 (2007), para. 77, n. 245.

⁷The Second Network will not be installed in 190 miles of the 942 mile RHCPP Network that are designated as laterals to reach various eligible health care providers.

⁸ In this context, "net income" means the funds available to RNHN after all expenses of the Second Network are paid. The private-sourced funds received for the Second Network will be used for the sole purpose of funding the Second Network and the RHCPP Network, including the direct expenses incurred to plan, design, build and operate both the RHCPP Network and the Second Network.

The Second Network will be designed and costed as additional fibers placed in the same trench, *i.e.*, the RHCPP Network is a rural build that will be costed as a direct bury with no conduit except where there are road bores. Thus, the \$1,430,000 cost is the cost of adding these incremental fibers. The design, installation, operation and maintenance of the Second Network will not increase the cost of the RHCPP Network.⁹

There is no allocation of costs between the RHCPP Network and the Second Network because there is no shared equipment between them and the Second Network cable is not attached to the RHCPP Network.

2) Eligible Users

The Plan is based on the goal of insuring that eligible users can participate in basic network applications for a nominal fee. This approach for eligible users takes into consideration the very limited financial resources of rural hospitals in the Panhandle.¹⁰ As such, the user fees charged have been developed with the sole purpose of ensuring network sustainability, not necessarily as a profit-generating source. User fees (in conjunction with the IRU fee charged for the Second Network) are projected to generate sufficient cash flow to maintain and operate the RHCPP Network solely as a cost displacement mechanism.

Since these charges are paid by eligible users, the charges paid by ineligible users, if any, will not only cover the full cost of connecting to the network and upgrading their electronics but will, in effect, also include a subsidy of the costs incurred by eligible users.

Costs to eligible users (as well as ineligible users) on the user side of each connection with RNHN will be born by those users; these costs are not part of the costs to be funded by RHCPP funds.

The basic design of the RNHN Network provides a 1 Gb Ethernet connection at the user-designated premise.¹¹ This type of connectivity would, if available, normally cost between \$5,000 and \$10,000 per month if purchased directly from the commercial marketplace. In most cases, such high-speed connections are not currently available at any cost. Instead, eligible users in the Panhandle are generally limited to buying various legacy telecommunications services, such as DSL or T-1's. The typical charge for these connections is very high on a per Mb basis, ranging from \$250 to \$1,500 per month.

⁹RNHN intends to contract with Fiberutilities Group, LLC (FG) for the operation and maintenance of the RHCPP Network and the Second Network at arm's length. The costs of a third party, such as FG, are included in the cost calculations set forth in Exhibit A. No RHCPP funds will be used for FG work performed for RNHN; instead, all of the expenses of operating and maintaining the RHCPP Network are to be covered as consideration for the IRU sale. It will not be necessary, therefore, to bid for these services in accordance with USAC's bidding requirements. Detailed information on FG may be found at www.fiberutilities.com.

¹⁰ RNHN will reconsider this approach in the event of any unforeseen costs.

¹¹Some of the more remote locations may have lower connection speeds (*e.g.*, 100 Mb) based on their locations and the most cost-effective technology available to reach them (wired or wireless, leased or built).

3) Ineligible Users

RNHN has assumed there will not be any ineligible users using any portion of the RHCPP Network.¹²

4) Additional Assumptions

a) General

- A projected start of fall 2011
- Only 6 months of revenue in the first year of operation.
- \$8M (+/-) in IRU revenue (\$5.6M of the IRU is paid in year one) after the following ineligible expenses are paid (rounded):
 - \$1.4M for the incremental cost of deploying the Second Network
 - \$400K non-reimbursable project management and legal costs
 - Leaving \$3.8M (\$3.77M) for payment of 15% Matching requirements, other non-reimbursable expenses and network operations
 - Note: Two additional IRU payments of \$1.2M each in years 6 and 8 cover network operations and equipment upgrades / replacements.
- Upgrade electronics and equipment of \$1,816,368 in 2015, \$2,019,930 in 2020 (includes costs for system electronics refresh plus an anticipated capacity upgrade) and \$1,816,368 in 2025.
 - An annual CPI adjustment of 3%.

b) Capital Costs

- Depreciation rates based on standard GAAP/IRS useful lives with a salvage value set equal to 10% of original cost, *e.g.*, electronics have an assumed five-year useful life, with a \$10,000 per user replacement cost, plus spares, setup, installation, warranty, and contingency amounts.
- The RHCPP and Second Networks will be designed and constructed in a manner that is consistent with industry standards.
- Future capital costs are limited to equipment replacement as the equipment obsolesces.
- A capital expenditure contingency of 7% 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

¹²If any ineligible users are later allowed access to the RHCPP Network, they will be required to pay the full cost of connecting to the Network and installing, operating and upgrading their electronics. They will also be required to pay their fair share of Network costs attributable to the portion of Network capacity used.

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.

c) Operating Costs

Annual operating costs for the RHCPP Network start (in the first full year of operation) at \$1,472,862 in 2011 rising to \$1,528,441 in year 2029. This includes depreciation and amortization for electronics, outside plant O&M, warranty, licensing, software, network management, pole attachment fees, Network O&M, General and Administrative and an operating contingency.

- Operating contingency set at 10% of total operations costs.

The RHCPP Network will interconnect with the NLR network at the FrontRange GigaPOP in Denver. The Plan includes the costs of extending the RHCPP Network to Denver, but no contracts are yet in place for the actual interconnection with NLR.¹³

- The net income available to support the RHCPP Network is \$3,294,464 in the first year of operation (revenue from the sale of the IRU in the Second Network). Additional payments on that sale occur in 2015 and 2017. These payments, plus fees charged to the eligible healthcare entities using the RHCPP Network, make the RHCPP Network cash flow positive for the 20 year life of the project.

d) General & Administrative

- For the Second Network, the direct general and administrative expense is included in the Operating Costs.
- Selling, General & Administrative expense is estimated to be 15% of revenue.

¹³ RNHN does not anticipate NLR interconnection expenses will exceed \$50,000 per year; sufficient revenues from the Second Network are available under this Plan to cover these anticipated costs.

