

**FCC Pilot Program Annual Report
January 1 – September 30, 2013
Erlanger Health System**

1. Project Contract and Coordination Information

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

J. Britton Tabor (Project Coordinator)
Senior Vice President & CFO
Erlanger Health System
975 East Third Street
Chattanooga TN 37403
423-778-7729
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Hale Booth (Associate Project Coordinator)
Executive Vice President
BrightBridge Inc.
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Fax 423-424-4262

c. Responsible organization

Erlanger Health System
975 East Third Street
Chattanooga TN 37403

d. Coordination throughout the state or region.

Erlanger Health System continues periodic discussions with other health care providers across the region regarding the network system as Erlanger has deployed equipment that will be used on the network, to participating hospitals.

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

In order to stay within the budgeted funds a contract has been negotiated with the selected vendor to serve the following hospitals with a direct connection funded by the FCC project. This does not mean that the other hospitals in the proposed network have been eliminated, as Erlanger Health Systems has acquired equipment and dispersed it to these other original locations and they are interacting with Erlanger using non-fiber lower speed access. Erlanger has also negotiated in their vendor contract the right to add additional sites to the network over time. For purposes of this FCC funded project only the locations to be served with high speed fiber funded through the FCC, are listed. All of these facilities have submitted a Letter of Agency on behalf of the Erlanger Health System project and are included in the 465 and 466-A postings.

Erlanger Bledsoe 128 Wheeler Town Road Pikeville, TN 37367 RUCA Code 10 Census Tract 9531 Contact: Ms. Stephanie Boynton, Administrator 423-778-7000	Public non-profit eligible
Erlanger Baroness (including Children's) 975 East Third Street Chattanooga, TN 37403 RUCA Code 1 Census tract 4 Contact: J Britton Tabor, Senior Vice President & CFO 423-778-7729	Public non-profit eligible
Rhea Medical Center 9400 Rhea County Highway Dayton TN 37321 RUCA Code 8 Census tract 9752 Contact; Ken Crooms CEO, 423-775-1121	Public non-profit eligible

3. Network Narrative:

A contract has been executed between Erlanger Health System and EPB for network design and a separate contract has been executed for pre-payment of leased lines and construction of fiber linkages. Funding Commitment Letters have been issued for both the network design and connectivity. EPB has been working with planned rural healthcare network users, sub contractors and other potential network partners to design the network and develop plans for installation of new fiber where needed in the initial construction between Erlanger and the Rhea Medical Center.

Due to cost considerations, it has been necessary to scale back the original proposed network to just two rural locations and the tertiary care main campus of Erlanger Health System, Erlanger Baroness. However these two rural locations that are planned to be served will help establish important fiber backbones which are expected to be expanded in the future.

4. List of connected health care providers.

Not applicable at this time.

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

All costs shown are considered to be non-recurring

	Budgeted	incurred
a. Network design	45,000	45,000.00
b. Network equipment	0	0
c. Infrastructure deployment		
Construction	1,266,600	45,962.62
d. Internet2, NLR	0	0
e. Leased facilities	1,275,000	
f. Network management, maintenance, O&M	0	0
g. other	0	
Total	2,586,600	90,962.62

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.

The network will initially only serve eligible participants which are non-profit health care providers. Generalized expansion plans have been developed and funding applications will continue to be submitted to serve a planned future broader range of rural hospitals and primary health care providers, some of which would be defined as ineligible participants for the FCC funded network. If and when non-FCC funding requests for this health care network expansion are successfully funded and these additional rural health care providers become a part of the system, this issue of apportioning costs will be addressed with the funding agencies. It is anticipated that when the time comes to add ineligible network participants, the rural healthcare network will assess a reasonable one time up front fee to these ineligible participants based upon anticipated bandwidth needs and let the ineligible participants manage their own capital costs for “last mile” access to the network.

Rural Healthcare Network project partners have also successfully applied for additional funding opportunities available through the ARRA “stimulus bill” for use with the telemedicine network. In October 2009, major “stimulus” funding was announced by DOE for one of the public existing service providers in the service area. This development has positively benefited the rural healthcare network by paying for a portion of the needed fiber construction, on which the healthcare network will ride.

- b. Describe the source of funds from:
 - i. Eligible pilot program network participants.

At this time, network participant hospitals are not being asked to contribute to the 15 percent project match as most of these rural partner hospitals have been struggling to simply stay in business and keep their facilities open through the recent severe economic downturn. However due to very recent changes in project matching funding, this option is being re-evaluated.

A number of difficulties have been encountered in developing an acceptable match for the FCC funds. As a result of these previous difficulties in providing an acceptable match, the Board of Directors of BrightBridge Inc. (a regional non-profit economic development corporation assisting EHS with this project) approved the use of Direct Congressional Appropriation funds previously appropriated to BrightBridge Inc. for use in construction activity to complete matching funding of the FCC project. BrightBridge staff have met on several occasions, with HUD officials in Washington who have financial oversight of these matching funds to review the proposed use of these Direct Appropriation funds to match the FCC grant. At these meetings HUD officials agreed this rural telemedicine network is an acceptable

project which meets the guidelines of the grant and requested that staff submit a revised environmental assessment and other forms. That assessment was prepared for construction of the initial line segment needed to connect Erlanger and Rhea Medical Center. Ultimately in late spring of 2013, the revised EA was approved by the appropriate HUD staff.

Erlanger Health System also received \$352,000 in additional project grant funds from USDA Rural Development for non FCC-eligible network equipment that was placed in rural hospitals.

As previously mentioned, one of Erlanger Health System's existing service providers, the non-profit Electric Power Board of Chattanooga (EPB) received notice from DOE in October 2009 that EPB's grant application for SmartGrid funding (which was prepared by BrightBridge Inc. and coordinated with the rural healthcare fiber network plans) was selected for \$111,567,606 in DOE funding to match a local EPB commitment of \$115,139,956. This DOE funding has been used to extend high speed fiber "wall to wall" across the multi-county service area of the Electric Power Board, resulting in the nation's fastest internet service. This additional fiber construction has now been completed and is a major project development for the Rural Health Care Fiber Network. As a result there will not be any FCC funded fiber required to be constructed in the large EPB service area as the healthcare network will lease existing and newly installed fiber.

Project planners have held meetings with other non-profit regional electric distributors and have determined that there is significant fiber available in these adjoining utilities which while not commercially available, will be made available to the rural health care network by the utilities in a prepaid lease arrangement. This reduces the need for new construction to just portions of the fiber corridors where there are gaps in connectivity.

Erlanger and the various project partners are also looking long term toward a non-profit partnership for ownership, operation and maintenance of the network which results in the partners bringing matching cash equity to the project as well as other needed investments. The partnership under development would be Erlanger Health System, BrightBridge Inc. a SBA, HUD, EPA (etc) certified non-profit economic development corporation and some area public power distributors which have the staff, rights-of-way, Pole attachment agreements, fiber and physical capability needed to maintain the fiber network. Preleasing service and the availability of fiber connectivity, will not initially require such a partnership. However, the long term expansion and growth of the network can be better served by this type

of non-profit partnership. A draft consortium agreement has been developed for this partnership and is being circulated to initial partners for review and comment.

ii. Ineligible network participants.

Not applicable (at this time).

c. Show contributions from all other sources

i. Identify source of financial support and anticipated revenues paying for costs not covered by the fund and by pilot program participants.

The FCC grant award for the Rural Healthcare Fiber Network has enabled the project to leverage a sizable investment of federal and local funds to assist with costs not covered by the FCC grant. Major costs and funding have been as follows: a) planning, project administration, and network management equipment; b) operating equipment; c) DOE fiber funding. In addition other funds have been raised for equipment for the Copper Basin Medical Center, but those funds are no longer shown in this report because due to project budget limitations, the Copper Basin Medical Center will be served with existing slower bandwidth (non-FCC project) connectivity.

a) Erlanger Health System continues to incur costs for planning and project administration assistance along with costs for network management equipment. These costs are not covered by the grant and have been paid by Erlanger Health System. Grant eligible costs for design are being incurred at this time as EHS has received a Funding Commitment Letter (FCL) for this portion of the project. Planning and project administration for pre-bid documentation such as Sustainability Plan, LOA's, FCC form 465 submittals, Request for Proposals, 466-A Forms and supplemental documentations have been completed. In addition Erlanger Health System has invested \$228,065 in non-project funds for the purchase of a codian bridge to manage the network.

b) The need for operating equipment to interface with the FCC funded fiber network is an essential component not funded by the FCC grant. To meet this need, Erlanger Health System successfully applied for telemedicine equipment funding from the USDA Rural Development Distance Learning Telemedicine program. This funding request was for non-FCC eligible network equipment to be located in the rural hospitals that will be directly connected as a result of the project. These telemedicine stations have been bid, purchased and deployed in the rural hospitals.

They are initially operating over an existing patchwork system of lower capacity leased copper lines such as T-1's.

- c) As mentioned previously in this report, the US Department of Energy (DOE) awarded major DOE funding to the local non-profit Electric Power Board to complete comprehensive installation of high speed fiber throughout the rural portions of their six county service area. Project administrative staff worked with the Electric Power Board of Chattanooga (EPB) to prepare, write and submit an ARRA SmartGrid Investment Grant Application to the Department of Energy. This grant application to the DOE Office of Electricity Delivery & Energy Reliability, while an electrical system application, included extensive installation of a high speed fiber communications network to all customers and areas of the multi-county EPB service area. The majority of these areas served by the grant are outside of the urban core of Chattanooga and are characterized as very rural. DOE provided \$111,567,606 in grant funding for the project in October 2009 and installation has now been completed. While not a direct part of the FCC funded project, this has significantly leveraged the FCC funding as the DOE funding has paid for construction and development of some of the necessary fiber that had been previously anticipated to be installed as part of the FCC project.
- ii. Identify the respective amounts and remaining time for such assistance.

Some additional unanticipated time is now going to be needed to raise replacement financial assistance to match FCC funds. All RFP's have been posted and the contracts for both 1) network design and 2) prepayment of leases and construction of gaps in service areas have been negotiated and executed. The network design expense has been paid from matching funds and is currently underway. Some construction related costs such as the purchase of fiber have also been incurred and paid. Funding Commitment Letters have been issued on all contracts. Raising eligible matching funds in the current economic environment has been a time consuming task which has continued to delay the project. The total FCC project budget submitted is \$2,586,600. The source of funding is \$2,198,610 from the FCC Pilot grant and \$387,990 in local matching funds which were to be provided from an awarded Direct Congressional Appropriation grant to BrightBridge Inc. however the use of these funds for the project was jeopardized and then lost when ATT refused to allow the rural health project to attach fiber to their poles and alternative measures could not be implemented before these funds were recaptured on October 1st by

the US Treasury. Staff are working with HUD officials to determine the viability of reprogramming the portion of expenses under this matching grant that were used for fiber purchase to be used elsewhere in the project as a portion of the FCC match. Even if this strategy is successful, the project is faced with the sudden loss of \$292,900 in matching funds due to the ATT pole attachment refusal. Erlanger is meeting in the next few days to consider making up this loss of matching funds by the contribution of additional capital to the project and also by applying for additional matching funding through the Appalachian Regional Commission.

- 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.

Erlanger Health System has planned the deployment of the FCC Rural Fiber Network from the inside of their health system out to the rural partners. As part of this systemic process, Erlanger has identified necessary equipment capacity needs for the network that can grow with the network over time. This telemedicine investment along with the FCC Pilot grant supports Erlanger Health System's role as a regional tertiary care provider and a strong partner for the growth of healthcare services in rural communities. It also positions EHS and partners to grow the network into a component of a future national healthcare fiber network.

Project administrators would prefer that the 15 percent matching funds be invested as a pro-rata share with the 85 percent FCC funds to help achieve the goal of building the project. However it was necessary to initially fund all of the network design expense with the matching funds in order to get these funds invested in the project while they were available.

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

At this time, no plans have been developed for ineligible entities to connect directly to the network, so this question is not currently applicable. Meetings with rural electric distributors across the region who will supply fiber linkages have indicated that in the near future it will be possible with very little additional expense to serve several additional eligible dedicated emergency centers of rural for profit hospitals. As the system develops, the rural healthcare fiber network certainly anticipates serving dedicated emergency centers of area private for profit hospitals which survive the economic recession/depression; however these

dedicated emergency departments would be an eligible recipient under current pilot program guidance.

Erlanger Health System is not aware of any issues around ineligible entities i.e. medical practices and doctor groups interfacing through Erlanger's hub/network terminus with data carried on the pilot rural healthcare network. This is important to the long term success of the system as the local public Electric Power Board (EPB) of Chattanooga has now completed the total investment of approximately \$350,000,000 to extend high speed fiber ("last mile-fiber to the home") to all of their 170,000 customers throughout their 600 square mile urban/rural service area which is where the vast majority of the regions tertiary care medical specialists live and work. The ability of these specialists to link from any urban location to the hub or terminus of the health care network at Erlanger through EPB's new fiber network is vital to the long term success of the rural healthcare project and critical to the ability of the network to respond effectively in a natural disaster crisis or large scale medical emergency as envisioned by HHS or the CDC.

We are assuming that if the FCC network terminates at the participating hospitals, then the participating hospitals can send various data to various other local locations or medical service providers utilizing other secure but non-FCC funded networks such as local area networks (LAN's), secure wireless networks, private networks, etc. We have reviewed this strategy with staff of the GAO who were researching the FCC Pilot Program and they did not indicate any programmatic compliance concerns with this assumption. This is a very important assumption for the rural healthcare network that will be critical to the adoption and success of our business model.

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.

The USAC designated point of contact for Project Coordinator has not changed since the last quarterly report. Britt Tabor, Erlanger Senior Vice President and CFO remain the Project Coordinator. Hale Booth, Executive Vice President, BrightBridge Inc. remains as Associate Project Coordinator.

- 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 EHS Rural Healthcare Network has incurred a major problem in the last 30 days prior to this report as pole attachment issues developed which delayed construction of fiber lines through Dayton to the Rhea Medical Center. This delay was initially caused on August 9th by ATT's refusal to allow the rural healthcare fiber project to attach fiber to approximately 140 ATT poles. The remaining 160 poles along this route were owned by the City of Dayton which was agreeable to providing the pole attachment. Facing a September 30, 2013 deadline for the expenditure of these matching funds project planners asked the City of Dayton to assume ownership of the cable sheath and a bundle of 12 fibers so the line could be attached to all of the poles under the City of Dayton's pole attachment agreement. Dayton officials were concerned about potential liability and a potential lawsuit from ATT. BrightBridge staff provided a draft indemnification agreement regarding liability from the fiber, agreed to cover all construction expenses, agreed to be responsible for 15 years of maintenance on the line, and agreed to not provide any retail service directly through the line that would compete with local service providers. Local officials continued to be concerned about ATT possibly filing a lawsuit against the city in the future and tabled the decision to accept ownership of the sheath and one of 8 bundles of fiber. With no pole attachment agreement, the construction line segment which was to be built with project matching funds could not be started and completed by September 30, the date after which the matching grant funds would be recaptured by the US Treasury.

As USAC should realize by now, our pilot project team is tenacious and is regrouping to move forward. This is just the latest in a series of delays in implementing the project schedule due to difficulties that were encountered in raising necessary eligible matching funds and raising necessary equipment funding that was needed by end user hospitals to make effective use of the network. Now a new strategy for the remaining match dollars must be developed quickly and implemented so a revised schedule can be developed for the project. The project schedule will identify the project dates for remaining key milestones. Past critical milestones have been met.

Schedule for connecting each site to the network and operational Now that a vendor is working on completing network design, a more current schedule will be developed for construction and connecting each site to the network and thus making the sites operational.

The current priority for connectivity is no longer the Rhea Medical Center in Dayton and has shifted to Erlanger Bledsoe.

Schedule Changes:

Erlanger Health System met the requirements set by the FCC for having completed the process necessary to secure at least one Funding Commitment Letter (FCL) prior to June 30, 2011. EHS has completed the process for awarding and submitting documents necessary for commitment of all remaining project funds prior to June 30, 2012. Funding Commitment Letters have been received on all aspects of the project. At the time of this report, we are by necessity faced with changing our schedule and are moving aggressively to firm up matching issues.

The project was initially delayed due to match issues, planning needs and regional economic fallout from a national recession/depression. Erlanger Health System had needed more time during the project to raise additional needed matching funds along with raising other funds for non-FCC eligible expenses while also planning how healthcare services will be delivered over the fiber network.

EHS has also invested considerable time in developing a basic strategy for delivery of key medical services over the network which is viewed as critical to the sustainability of the network over time. The strategy for delivery of sustainable services over the network has also demonstrated the importance of scaling the number of “partner” hospitals on the network. This need for more partner primary health care providers in turn lead to additional local investment by Erlanger and additional grant proposal development for funding equipment at these potential sites. This took considerably more time than originally estimated, while also impacting the facility planning process. Complicating this matter further has been a prolonged national economic crisis which has threatened the very survival of some of our partner hospitals and required time of project staff to develop funding strategies aimed at saving some of these potential rural partner hospitals.

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

A sustainability plan has been developed for the project and the most current revision (June 2012) is on file at SharePoint. The network will prepay leased fiber where available and construct new fiber in gaps where needed. The construction of new fiber will create the opportunity for the rural healthcare network to potentially lease excess capacity to generate revenue to help sustain the rural healthcare network. The network presently has 15 miles of fiber in storage for construction of these gaps and is working with HUD to insure that this fiber can be reprogrammed for use in other areas of the network rather than the Dayton route which

encountered pole attachment problems with ATT. The ability to lease excess capacity is highly dependent on broadband demand which may or may not be present in those rural markets. Therefore the network will look to traditional sources of sustainability such as revenue from the existing Rural Health Care Program, grants, state appropriations, in-kind support, downstream revenue from services, membership and/or connectivity fees.

While those traditional sources are critical to sustainability, they are only effective if the network is properly marketed and targeted to meet needs of the participants, provide services and also clearly provide or enhance the opportunity for downstream health care revenue. To be successfully sustained, a regional telemedicine network must meet the clinical, educational and economic needs of all participants. Erlanger Health System views the project as an opportunity to partner with member hospitals, and reach out to physicians and distant communities as well. Erlanger has utilized a collaborative needs assessment to ensure that what is offered and communicated to members is what is needed to extend care access and offer programs not yet available because of sparse or dispersed populations.

Erlanger continues exploring opportunities to partner with target community health and wellness agencies to pursue both State and Federal funds for initiatives that target maternal/fetal health, children's health, and improvement of critical disease states such as diabetes, stroke, obesity, cancer and COPD. Working with the agencies, Erlanger is also developing community-based health initiatives supported by the increased access to specialists and educational opportunities provided by telemedicine.

Sustainability and long term growth will be enhanced by the creation of an ongoing flow of data between network sites which will quickly demonstrate the benefit to physicians, patients and providers. The initial program focus is centered on both stroke and trauma care which are specialty services in which Erlanger is a broadly recognized leader. These are also services that are significant positive revenue generators for Erlanger and which because of their downstream revenue can justify some subsidization of the telemedicine network by EHS if that is necessary in this economic climate.

Erlanger's business model for the initial phase of telemedicine services focuses on development of a regional telestroke network to expand the existing stroke program at Erlanger. The Erlanger Southeast Regional Stroke Center is a recognized national leader in three core areas: clinical care, stroke education and medical research. The telestroke strategy will focus on the FCC project targeted hospitals and will initially use the USDA funded equipment for patient interface. Erlanger recognizes that telemedicine programs are largely mission driven and rely on downstream revenue generated by capture of new market share as well as grants to assist with start up capital expenses. Erlanger has maintained an extensive public information awareness program to build regional public awareness of the stroke therapies which will be the lead initial service of the telemedicine initiative.

The strongest and most effective telemedicine systems typically begin operating in support of key services essential to the health of distant communities. The stroke service is an important business unit for Erlanger Health System due to its high profile in the media as well as its excellent reimbursement, profit, and contribution margin. Erlanger projects a modest but sustainable return in net income which will help sustain costs of the developing telemedicine network and grow with services over time.

The network will pre pay fiber leases for a 15 year period which will significantly reduce start up costs. EHS intends to earn revenue downstream in the patient care cycle by growing market share in profitable areas and through linking rural emergency care to Erlanger's Level 1 Trauma Center capabilities. In addition network staff will seek network revenue through traditional telemedicine funding sources as well as by marketing initial excess network capacity to help underwrite operational and maintenance costs.

Additional Report Questions for Item 9:

1. Which scenario's fit your project?

Erlanger solicited Requests for Proposals (RFP) which predominantly followed Scenario # 9 (Prepaid lease) with some remote linkages that must be built, being Scenario #2 (Participant owns 100% of dedicated network; Excess bandwidth is owned for current or future use). Proposals were received from three separate vendors and the most responsive proposal was selected. The selected proposal was from the Chattanooga Electric Power Board (EPB).

EPB is the predominant fiber network in our service area, through their investments much more rural fiber has become available to pre-lease. Relevant dark or unused fiber is available in significant portions of our rural area through other rural electric power distributors which use the fiber to operate their systems. The rural healthcare network has negotiated a proposal from EPB for 15 year pre payment of-leased segments of their fiber and will pre pay leases/maintenance for additional segments of dark fiber through EPB from other electric cooperatives. However some network links of the project will need to be constructed to access rural Erlanger Bledsoe and the Rhea Medical Center with desired hi-speed fiber.

Nationally demand for telehealth services is growing in such areas as ICU monitoring, mobile applications via handheld devices (countless IPAD/handheld device medical applications now exist), expansion into long term care facilities, home and remote patient monitoring etc. Since we expect the network to continue to grow over time in both connections and content, the network initially solicited proposals to prelease fiber capacity based on scalable demand up to 100 Mb. Where fiber needs to be constructed, the network solicited proposals on a range of fiber strands to rural participating hospital locations on a unit cost per mile.

This number of strands will be more fiber than initially needed, but the system is expected to grow substantially over time as new health care provider locations are served and new health care services (including an anticipated move to HD equipment) are developed which will grow bandwidth demand and network traffic. Also if a fiber connection goes dark, it is less expensive to light a new fiber than to troubleshoot and identify the interruption point. The network is anticipating the possibility of leasing some of the excess fiber on an interim basis to generate revenue and services to exclusively fund the operation and maintenance cost of the rural healthcare fiber network during the early years of operation. Discussions with local non-profit utility systems indicate this is feasible. This is important to helping sustain the network in the early years of operation after the pilot program while network applications and network traffic builds to an expected self sustaining volume. Project staff have reviewed other pilot models and looked at local business models to determine appropriate ways to charge for products and services that are a function of the network.

2. Source of 15% funding.

Erlanger Health System is bringing a non-profit group together to provide long term management and maintenance of the actual fiber network. BrightBridge a non-profit regional economic development organization in this partnership was providing the 15 percent matching funds through a Congressional Direct Appropriation grant. However due to ATT's refusal to provide a pole attachment agreement to the rural health care network in Rhea County TN and the fear of a potential lawsuit from ATT by a local government which had a pole attachment agreement with ATT in Rhea County, most of these matching funds were lost after September 30, 2013. Part of these eligible matching funds were invested in the project prior to the expiration of the matching funds and team members are meeting to determine alternative local matching funds to replace the recaptured grant funds.

3. Commitments from Network Members.

The BrightBridge Inc. Board of Directors had taken board action approving the commitment of necessary matching funds for the FCC grant. To date BrightBridge has paid for network design expenses of \$45,000 and purchased 15 miles of fiber at an additional cost of approximately \$46,000.

Prior to posting the RFP, Letters of Agency were secured and submitted to USAC from all anticipated participating Health Care Providers. There is no plan at this time to put a mandatory time frame on length of participation in the network as the network is planned to be market driven by demand for services with no cost of entry to eligible participants, only cost for pro-rata share of network operation and maintenance that is not covered by pre-leasing or other income and the revenue generated from potential interim leasing of excess fiber. All of our participating hospitals must have internet accessibility to run their business and stay in business. The problem is they don't have reliable service, it is not fiber, so it is slow asynchronous and as a result they are limited on size of data that can be transmitted.

As long as the pilot network can exceed these very low standards at a comparable price, the market driven strategy will succeed and maintain the commitment from network members.

4. Sustainability Period: Will you be able to supply plan/budget of at least 10 years.

An agreement has been executed with EPB which includes construction of missing linkages and pre-payment of fiber leases for 15 years to provide fiber connectivity between the Erlanger Baroness Campus, rural Erlanger Bledsoe and rural Rhea County Medical Center. With a 15 year pre-payment this initial network will be sustainable. The only question is if the total originally proposed network can be developed over time or if fiber connectivity can be established in some additional locations as an alternative to a build out.

Erlanger Health System is planning the rural health care fiber network and telemedicine system to be an integral and permanent part of the on-going health care system and not as a temporary pilot project. We anticipate being able to operate the network sustainably for at least a 15 year period, but once the network is operational it will be necessary to review the cost and benefits periodically to assess if it is performing reasonably.

5. Budget attached to Sustainability: Pro forma financial projections based on the selected response to the RFP and a recommended capital budget which was developed from this, are attached to the updated Sustainability Plan. This plan updated in June 2012 is posted on SharePoint.

6. Use of the Network by non-eligible entities.

We currently do not have any non-eligible entities that will be served by the network. The rural healthcare network is currently planning to link rural eligible non-profit health care providers in the FCC funded rural healthcare fiber network and will assess the needs/opportunities of additional eligible for-profit dedicated emergency centers in the future.

To expand or scale the telemedicine network and reach other rural hospitals in Erlanger's multi-state health catchment area, Erlanger Health System and partners will continue applying for additional funding from various sources (USDA, ARC, foundations, etc.) for both fiber installation and the acquisition of telemedicine equipment to be placed in approximately a dozen additional hospitals beyond the original scope of the project. It is the intent of the project that these additional hospitals will be linked to the FCC funded rural healthcare network over time, at various points, by other existing broadband providers.

Several of these future potential rural health care partner hospitals are private for profit and will require the development of a fair share fee schedule to access the network. The general strategy will be to assess a modest fair share one time initial access fee for joining

the network for non-eligible (for –profit health care provider) entities. This one-time fee would be scaled based upon anticipated bandwidth needs. These entities will also incur their own additional expenses for linkage to the rural healthcare network and will share equally in any network system operation and maintenance costs with other participants.

7. Management of the Network.

Erlanger Health System plans to focus on managing the network content (health care services) and through the pre-leasing arrangement will in effect contract with a qualified public non-profit, EPB to manage and maintain the physical system network. Erlanger will also maintain ownership of telemedicine stations installed at rural hospital locations and will be able to maintain this equipment more cost effectively through vendor service contract(s).

8. Continued RHC Funding.

The healthcare network is anticipating that all eligible rural hospitals will seek appropriate internet access funding assistance in the regular Rural Health Care program. Network staff will offer to assist by preparing necessary annual applications relative to the Pilot Program network for eligible member hospitals.

9. State and Federal Funding:

As noted throughout the report, Erlanger Health System or various network supporters have been actively pursuing state and federal funding to add equipment and fiber to the network. This will continue until the network is fully developed with service to all hospitals, public primary care centers, and public health departments throughout the multi-state service area of Erlanger Health System. Erlanger Health System has already secured additional federal funding needed to equip rural hospitals in the initial FCC funded project with interactive telemedicine stations. Additional grant funds will continue to be requested from appropriate sources to add additional telemedicine equipment to more hospitals.

10. Prepaid Lease Option.

Due to rapid advances in the availability of broadband fiber in rural portions of the rural healthcare service area, a combination of pre-paid leasing and construction of missing linkages were selected for the network contract.

10. Provide detail on how the supported network has advanced telemedicine benefits.

Erlanger Health System has continued work on planning the physical and programmatic structure of the network by hiring staff and committing local dollars to

the effort. Funding of this pilot project and the on-going project planning has catapulted telemedicine to a realistic opportunity in our regional medical community. The FCC grant has generated extensive discussion in the regional medical community on how best to use telemedicine to improve the quality of health care and drive down costs.

Plans have also been developed for providing stroke consultation services from Erlanger's stroke center to primary health care locations across the region and linking the level 1 trauma center specialists at Erlanger's Baroness Hospital in Chattanooga to the rural hospital emergency rooms for real time consultation and determination of treatment options.

Public Health Departments across the service area have also expressed an interest in linking with the rural healthcare network (primarily for training purposes) and have collaborated in seeking additional funding to expand the planned network.

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

Since the network is not yet operational, this is not applicable. However staff involved with the Pilot Project have participated in training sessions presented by HHS staff through USAC sponsored training and are continuing to learn more about these initiatives and the opportunities they present.

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.

Since the network is not yet operational at this time, this is not presently applicable. However, as previously mentioned in Section 7, the Rural Healthcare Fiber Network through the Erlanger main campus hub with the EPB fiber network system will reach every doctor's office and every doctor's home (along with every other address) in the EPB six county service area. This last mile connectivity will provide unparalleled regional opportunities for 24/7 remote rural telemedicine access in instances of national, regional or local public health emergencies such as pandemics, natural disasters, or bioterrorism. Given the increasing local experience with widespread floods, tornadoes, snowstorms, rock slides across key highways, train derailments, toxic chemical fires and other disasters, this capacity may be critical to the ordinary delivery of health care in our region.



Marsha Purcell
Sr. Contract Manager

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BY:-----

August 9, 2013

Mr. Hale Booth
BrightBridge Inc.
535 Chestnut Street
Suite 161
Chattanooga, TN 37402

Re: Request for Attachment of Fiber to AT&T-owned Poles

Dear Mr. Booth:

Thank you for your inquiry dated July 23, 2013, ("Request"), concerning a request to attach fiber to AT&T-owned poles in City of Dayton, TN. For the reasons explained below, AT&T declines the Request to for attachment to AT&T poles in the manner requested.

Consistent with 47 USC 224 and other applicable federal law relating to pole attachments, AT&T only allows certain entities such as a certificated telecommunications carrier to attach equipment and facilities to AT&T-owned poles for the provision of telecommunications services. In doing so, a carrier must confirm that the equipment attached to an AT&T pole will be used for the provision of "telecommunications services," as defined in 47 USC 153. The Request fails to identify a telecommunications carrier and further fails to confirm that the equipment sought to attach will be used for telecommunications services. Therefore the Request must be denied.

Thank you for your inquiry. I can be reached at (850) 914-0593 or mp6326@att.com if you have questions.

Very truly yours,

Marsha Purcell
Sr. Contract Manager