BEFORE THE
REDERAL COMMUNICATION COMMISSION
Washington D.C. 20554

In the Matter of Request for Review by Marshfield Clinic of the Decision of the Universal Service Administration Corporation-Rural Health Care Division (USAC)

Docket No. 02 -60

MARSHFIELD CLINIC REQUEST FOR REVIEW OF FUNDING FROM THE RURAL HEALTH CARE DIVISION

To: Marlene H. Dortch
Federal Communication Commission
Office of the Secretary
445 12th Street, SW
Room TW-A325
Washington, DC 20554

Re: Universal Service Fund Appeal FY 2012
Marshfield Clinic Funding Request Number (FRN) 12234242/12233422

Submitted by: Michael O'Connor USF Consultants

I. Overview

I'm seeking a correction in funding. The Universal Service Administration Corporation was provided an opportunity to correct the funding error which was noted to their attention based on the 29 April 2014 Funding Commitment Letter (FCL). The follow up FCL of 27 May 2014 did not address the funding error, but provided the exact same funding support.

II Information on Request

Marshfield Clinic submitted a funding request for dedicated T-1 point to point service. The service support was requested under the traditional (telecommunications) program. The service unfortunately was quite long as it exceeded the Maximum Allowable Distance (MAD). The total service required two (2) carriers to provide the end to end service. The total MAD for the HCP is 171. Carrier A's portion of the service had a 31 billed miles of service. Based on the HCP MAD and the mileage allocated to Carrier A, the MAD distance for Carrier B was 140 miles.

The service rural cost is $475. The urban rate is $115.70 The $475 is the total cost of the service as the local distribution loop (channel termination) was not specifically allocated a cost and the mileage of the local distribution loop was not provided by the carrier. Based on our calculations $475-$115.70 would result in an initial uncorrected MAD funding of $359.30 The correction of the over mileage would based on the calculation $475 divided into 164 miles with a resulting cost of $2.99 per mile. With 24 billed mileage in excess of the MAD would result in a correction of 24 miles x $2.99 per mile for $71.76. With would result in corrected funding amount of $287.54 per month.

III Conclusion

I am requesting the FCC to reverse the decision of USAC and to fund Marshfield Clinic for Funding Year 2012 for Funding Request Numbers 12234242/12233422 based on the revised calculations noted above.

Dated this 25th Day of July, 2014

Respectfully submitted,

USF Consultants, Inc

By: _____

Michael O'Connor
Corporate Secretary

Contact Information:

Michael O'Connor
PO Box 6641 Monona, WI 53716
(608) 268-2565
Michael@usfnow.com

Beining, Patsy J.

From:	rhcadmin@usac.org
Sent:	Tuesday, April 29, 2014 2:32 PM
To:	Braun, Monica M; Kretschmer, Linda R; Moore, April S; Marshall, Alan L.; Seidel, Jody A; Braun, Monica M; Kretschmer, Linda R; Beining, Patsy J.; Seidel, Jody A
Subject:	Funding Commitment Letter (FCL) for HCP 11933, FRN 12233422

Date: 29-Apr-2014

Funding Year: 2012
Health Care Provider (HCP) Name: Marshfield Clinic - Marshfield Center
HCP Number: 11933
FCC Form 465 Application Number: 43123490
Funding Request Number: 12233422

The Rural Health Care (RHC) division of the Universal Service Administrative Company (USAC) has completed the review of the *Funding Request and Certification Form (FCC Form 466)* submitted on behalf of the Health Care Provider (HCP) named above. Based on the information provided, RHC has determined that the HCP is eligible for the estimated support listed below. Additionally, if the HCP submitted a contract or service agreement with the form, the outcome of the contract review is included in this letter.

HCP Physical Location: 1000 NORTH OAK AVENUE, MARSHFIELD, WI, 54449-5777
Service Type: T1 or DS1
Bandwidth: 1.544 Mbps
Service Provider Name: Windstream Communications, Inc.
Service Provider Identification Number (SPIN): 143030766
Billing Account Number: 4342598-218478

HB ky 47.52 + 2 95.04

Funding Start Date	Funding End Date	Months of Support	Non-Recurring Support Amount	Monthly Recurring Support Amount	Total Support Amount
01-Jul-2012	31-Aug-2012	2.00000	$0.00	$359.30	$718.60

It is the HCP's responsibility to review and verify that all information on this FCL is accurate. All account holders and the service provider listed on the form have received a copy of this FCL. A copy is also saved in the *My Documents* section of *My Portal*.

Contract/Service Agreement Endorsement Determination: Evergreen

Evergreen: For the life of the contract (without any optional or automatic extensions), you do not need to re-compete the service(s) identified above, or post a *Description of Services Requested and Certification Form* (FCC Form 465). The HCP must apply for support of the contracted service by filing the FCC Form 466 and/or the FCC Form 466-A (and the FCC Form 467) to receive funding each year.[1]

HCPs whose contracts have Evergreen status must post an FCC Form 465 and re-compete the service provider selection before the contract ends. An optional contract renewal is considered a new contract and can be selected only after the HCP has gone through the competitive bidding process by posting a Form 465.

Your responsibility:

Beining, Patsy J.

From:	rhcadmin@usac.org
Sent:	Tuesday, May 27, 2014 1:22 PM
To:	Braun, Monica M; Kretschmer, Linda R; Moore, April S; Marshall, Alan L; Seidel, Jody A; Braun, Monica M; Kretschmer, Linda R; Beining, Patsy J.; Seidel, Jody A
Subject:	Funding Commitment Letter (FCL) for HCP 11933, FRN 12233422

Date: 27-May-2014

Funding Year: 2012
Health Care Provider (HCP) Name: Marshfield Clinic - Marshfield Center
HCP Number: 11933
FCC Form 465 Application Number: 43123490
Funding Request Number: 12233422

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Your responsibility:

Beining, Patsy J.

From:	rhcadmin@usac.org
Sent:	Tuesday, May 27, 2014 12:41 PM
To:	Braun, Monica M; Kretschmer, Linda R; Moore, April S; Marshall, Alan L; Seidel, Jody A; Braun, Monica M; Kretschmer, Linda R; Beining, Patsy J.; Seidel, Jody A
Subject:	Funding Commitment Letter (FCL) for HCP 11933, FRN 12234242

Date: 27-May-2014

Funding Year: 2012
Health Care Provider (HCP) Name: Marshfield Clinic - Marshfield Center
HCP Number: 11933
FCC Form 465 Application Number: 43123490
Funding Request Number: 12234242

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Bandwidth: 1.544 Mbps
Service Provider Name: Windstream Communications, Inc.
Service Provider Identification Number (SPIN): 143030766
Billing Account Number: 4342598-218478

Funding Start Date	Funding End Date	Months of Support	Non-Recurring Support Amount	Monthly Recurring Support Amount	Total Support Amount
01-Sep-2012	30-Jun-2013	10.00000	$0.00	$359.30	$3,593.00

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To:	Braun, Monica M; Kretschmer, Linda R; Moore, April S; Marshall, Alan L.; Seidel, Jody A; Braun, Monica M; Kretschmer, Linda R; Beining, Patsy J.; Seidel, Jody A
Subject:	Funding Commitment Letter (FCL) for HCP 11933, FRN 12234242

Date: 29-Apr-2014

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FCC Form 465 Application Number: 43123490
Funding Request Number: 12234242

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Bandwidth: 1.544 Mbps
Service Provider Name: Windstream Communications, Inc.
Service Provider Identification Number (SPIN): 143030766
Billing Account Number: 4342598-218478

Funding Start Date	Funding End Date	Months of Support	Non-Recurring Support Amount	Monthly Recurring Support Amount	Total Support Amount
01-Sep-2012	30-Jun-2013	10.00000	$0.00	$243.60	$2,436.00

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Your responsibility:

Laona

1223342

FCC Form **466**

Health Care Providers Universal Service
Funding Request and Certification Form

Approval by OMB 3060—0804

The Deadline to submit this Form is the June 30th End of the Funding Year.

Estimated time per response: 3 hours

Read instructions thoroughly before completing this form. Failure to comply may cause delayed or denied funding.

Block 1: HCP Information

1 HCP Name Marshfield Clinic - Marshfield Center	2 HCP Number 11933
3 Form 465 Application #43123490	4 Consortium Name (If any) USFNOW

Block 2: Bill Payer Information

5 Billed Entity Name Marshfield Clinic	6 Billed Entity FCC RN 0002719789	
7 Contact Name Patsy Beining		
8 Address Line 1 1000 North Oak Ave		
9 Address Line 2		
10 City Marshfield	11 State WI	12 Zip 54449
13 Contact Phone # (715) 221-5537	14 Fax #	15 E-Mail beining.patsy@marshfieldclinic.org

Block 3: Funding Year Information

16 Funding Year - Check only one box

[ ] Year 2010 (7/1/2010-6/30/2011) [ ] Year 2011 (7/1/2011-6/30/2012) [X] Year 2012 (7/1/2012-6/30/2013)

Block 4: Service Information

17 Type of Service & Circuit Bandwidth (Enclose documentation.) T1 or DS1 1.544 Mbps

18 Total Billed Miles 195 | 19 Maximum Allowable Distance (From Form 465) 171

20 Percentage of HCP's service used for the provision of health care. 100 (If less than 100%, please explain.)

If the HCP indicated it is a part-time eligible entity (on Form 465), describe method of allocating prorated support.

Connection Information	Carrier A	Carrier B	Carrier C	Carrier D
21 Service Provider Name	Charter Fiberlink CCO, LLC	Windstream Communications, Inc.		
22 Service Provider Identification Number (SPIN)	143027625	143030766		
23 Service Provider Contact Person Name	Christy Ipock	Cindy Brenning		
24 Service Provider Contact Person's Phone #	(314) 288-3085	(402) 436-4466		
25 Service Provider Contact Person Email	christy.ipock-messmer@chartercom.co	e-rate@windstream.com		
26 Circuit Start Location	[illegible]	Meet Point [illegible]		
27 Circuit Termination Location	[illegible]	[illegible]		
28 Billing Account Number	[illegible]	[illegible]		
29 Tariff, Contract or other document reference number	Contract [illegible]	Tariff Term Discount 3 years		
30 Date Contract Signed or Date HCP Selected Carrier	07-May-2007	14-Feb-2011		
31 Contract Expiration Date (mm/dd/yyyy or NA if MTM)	31-Aug-2012	28-Feb-2014 - N/A		
32 Service Installation Date	21-Jul-2007	01-Mar-2011		
33 Actual Rural Rate per Month (Enclose Documentation)	250.00	475.00		

34 If you are a consortium member OR have multiple carriers, please attach a Circuit Diagram to show how the sites interconnect and which carrier(s) provides each circuit segment. Circuit Diagram included: [ ] Yes [X] No

35 Are you a mobile rural health care provider? [ ] Yes [X] No If yes, see instructions and attach a list of all sites to be served.

IF YOU ARE REQUESTING SUPPORT FOR MILEAGE-BASED CHARGES, COMPLETE BLOCK 5 ONLY AND SKIP BLOCK 6. (PLEASE SEE INSTRUCTIONS). IF YOU ARE REQUESTING SUPPORT BASED ON URBAN/RURAL RATE COMPARISON, SKIP BLOCK 5 AND COMPLETE ONLY BLOCK 6. YOUR APPLICATION CANNOT BE PROCESSED IF BOTH BLOCKS ARE COMPLETED.

Block 5: Mileage-based Charge Discount Request

Complete this block if you are seeking support for mileage (distance-based) charges only. Do not enter any other charges in this block. You may need to ask your service provider representative to provide this information

36 Billed Circuit Miles				
37 Monthly Mileage Charges (Exclude Channel Termination chgs, etc.)				
38 Cost per Mile per Month				

If Line 33 equals Line 37, please ensure that ONLY mileage-related charges are included in Line 37. (See instructions.)

Block 6: Comprehensive Rate Comparison Request

Complete Block 6 if you have not completed Block 5 and are requesting support for all elements of your telecommunications service necessary for the provision of health care. The information in this block will establish the difference between the urban and rural rates for your requested service. Please call RHCD at 1-800-229-5476 if you need assistance.

39 One-time Urban Rate Charge (in selected large city)	0			
40 One-time Rural Rate Charge (in city where HCP is located)	0	0		
41 Monthly Urban Rate (in selected large city). From RHCD web site: ☐ or Other rate documentation attached: ■	115.70			

If your circuit includes charges for mileage over the Maximum Allowable Dist., (Line 19), please complete Lines 42 to 44. Otherwise, skip to Block 7.

42 Billed Circuit Miles	31	164		
43 Monthly Mileage Based Charges	0.00	325.00		
44 Cost per Mile per Month	0.00	1.98		

Block 7: Bid Documentation

45 Did you receive any bids in response to the Form 465 Request for Services posted on the RHCD website? ☐ Yes [X] No
If you checked yes, copies of the bids MUST be mailed to RHCD.

Block 8: Certification

46 [X] I certify that the above named entity has considered all bids received and selected the most cost-effective method of providing the requested service or services. The "most cost-effective service" is defined in the Universal Service Order as the service available at the lowest cost after consideration of the features, quality of transmission, reliability, and other factors that the health care provider deems necessary for the service to adequately transmit the health care services required by the health care provider.

47 [X] Pursuant to 47 C.F.R. Secs. 54.601 and 54.603, I certify that the HCP or consortium that I am representing satisfies all of the requirements herein and will abide by all of the relevant requirements, including all applicable FCC rules, with respect to universal service benefits provided under 47 U.S.C. Sec. 254. I understand that any letter from RHCD that erroneously states that funds will be made available for the benefit of the applicant may be subject to rescission.

48 [X] I hereby certify that the billed entity will maintain complete billing records for the service for five years.

49 [X] I certify that I am authorized to submit this request on behalf of the above-named Billed Entity and HCP, and that I have examined this form and attachments and that to the best of my knowledge, information, and belief, all statements of fact contained herein are true.

50 Signature Electronically signed	51 Date 20-May-2013
52 Printed name of authorized person Patsy Beining	53 Title or position of authorized person Accounting Assistan
54 Employer of authorized person Marshfield Clinic	55 Employer's FCC RN 0002719789

Luma(a) 1223424

FCC Form **466**

Health Care Providers Universal Service
Funding Request and Certification Form

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24 Service Provider Contact Person's Phone #	(314) 288-3085	(402) 436-4466		
25 Service Provider Contact Person Email	christy.ipock-messmer@chartercom.co	e-rate@windstream.com		
26 Circuit Start Location	1000 N Oak [illegible]	[illegible] Stevens Point, WI 54481		
27 Circuit Termination Location	[illegible]	[illegible]		
28 Billing Account Number	8245 11 211 0000183 [illegible]	4342598 216178 [illegible]		
29 Tariff, Contract or other document reference number	[illegible]	Tariff-Term Discount [illegible] years		
30 Date Contract Signed or Date HCP Selected Carrier	N/A	14-Feb-2011		
31 Contract Expiration Date (mm/dd/yyyy or NA if MTM)	30-Jun-2013 - N/A	28-Feb-2014 - N/A		
32 Service Installation Date	01-Sep-2012	01-Mar-2011		
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71.76

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52 Printed name of authorized person Patsy Beining	53 Title or position of authorized person Accounting Assistan
54 Employer of authorized person Marshfield Clinic	55 Employer's FCC RN 0002719789

475
- 115.70
359.30
- 71.76
287.54