and that granting the requested waiver would be in the public interest. To satisfy this standard, the waiver request must be substantiated through documentary evidence as stated in the following. A waiver request will not be entertained if it does not also set forth a rural rate that the service provider demonstrates will permit it to obtain no more than the current Commission prescribed rate of return authorized for incumbent rate of return local exchange carriers.

(1) For purposes of paragraph (c), petitions seeking a waiver must include all financial data and other information to verify the service provider's assertions, including, at a minimum, the following information:

(i) Company-wide and rural health care service gross investment, accumulated depreciation, deferred state and federal income taxes, and net investment; capital costs by category expressed as annual figures (*e.g.*, depreciation expense, state and federal income tax expense, return on net investment); operating expenses by category (*e.g.*, maintenance expense, administrative and other overhead expenses, and tax expense other than income tax expense); the applicable state and federal income tax rates; fixed charges (*e.g.*, interest expense); and any income tax adjustments;

(ii) An explanation and a set of detailed spreadsheets showing the direct assignment of costs to the rural health care service and how company-wide common costs are allocated among the company's services, including the rural health care service, and the result of these direct assignments and allocations as necessary to develop a rate for the rural health care service;

(iii) The company-wide and rural health care service costs for the most recent calendar year for which full-time actual, historical cost data are available;

(iv) Projections of the company-wide and rural health care service costs for the funding year in question and an explanation of those projections;

(v) Actual monthly demand data for the rural health care service for the most recent three calendar years (if applicable);

(vi) Projections of the monthly demand for the rural health care service for the funding year in question, and the data and details on the methodology used to make those projections;

(vii) The annual revenue requirement (capital costs and operating expenses expressed as an annual number plus a return on net investment) and the rate for the funded service (annual revenue requirement divided by annual demand divided by twelve equals the monthly rate for the service), assuming one rate element for the service), based on the projected rural health care service costs and demands;

(viii) Audited financial statements and notes to the financial statements, if available, and otherwise unaudited financial statements for the most recent three fiscal years, specifically, the cash flow statement, income statement, and balance sheets. Such statements shall include information regarding costs and revenues associated with, or used as a starting point to develop, the rural health care service rate; and

(ix) Density characteristics of the rural area or other relevant geographical areas including square miles, road miles, mountains, bodies of water, lack of roads, remoteness, challenges and costs associated with transporting fuel, satellite and backhaul availability, extreme weather conditions, challenging topography, short construction season or any other characteristics that contribute to the high cost of servicing the health care providers.

§ 54.606 Calculating support.

(a) The amount of universal service support provided for an eligible service to be funded from the Telecommunications program shall be the difference, if any, between the urban rate and the rural rate charged for the services, as defined in this section. In addition, all reasonable charges that are incurred by taking such services, such as state and federal taxes, shall be eligible for universal service support. Charges for termination liability, penalty surcharges, and other charges not included in the cost of taking such service shall not be covered by the universal service support mechanisms.

(b) The universal service support mechanisms shall provide support for intrastate telecommunications services, as set forth in § 54.101(a), provided to rural health care providers as well as interstate telecommunications services.

(c) *Mobile rural health care providers*—(1) *Calculation of support.* The support amount allowed under the Telecommunications Program for satellite services provided to mobile rural health care providers is calculated by comparing the rate for the satellite service to the rate for an urban wireline service with a similar bandwidth. Support for satellite services shall not be capped at an amount of a functionally similar wireline alternative. Where the mobile rural health care provider provides service in more than one state, the calculation shall be based on the urban areas in each state, proportional to the number of locations served in each state.

(2) *Documentation of support.* (i) Mobile rural health care providers shall provide to the Administrator documentation of the price of bandwidth equivalent wireline services in the urban area in the state or states where the service is provided. Mobile rural health care providers shall provide to the Administrator the number of sites the mobile health care provider will serve during the funding year.

(ii) Where a mobile rural health care provider serves less than eight different sites per year, the mobile rural health care provider shall provide to the Administrator documentation of the price of bandwidth equivalent wireline services. In such case, the Administrator shall determine on a case-by-case basis whether the telecommunications service selected by the mobile rural health care provider is the most cost-effective option. Where a mobile rural health care provider seeks a more expensive satellite-based service when a less expensive wireline alternative is most cost-effective, the mobile rural health care provider shall be responsible for the additional cost.

HEALTHCARE CONNECT FUND PROGRAM

§ 54.607 Eligible recipients.

(a) *Rural health care provider site—individual and consortium.* Under the Healthcare Connect Fund Program, an eligible rural health care provider may receive universal service support by applying individually or through a consortium. For purposes of the Healthcare Connect Fund Program, a ''consortium'' is a group of two or more health care provider sites that request support through a single application. Consortia may include health care providers who are not eligible for support under the Healthcare Connect Fund Program, but such health care providers cannot receive support for their expenses and must participate pursuant to the cost allocation guidelines in § 54.617(d).

(b) *Limitation on participation of non-rural health care provider sites in a consortium.* An eligible non-rural health care provider site may receive universal service support only as part of a consortium that includes more than 50 percent eligible rural health care provider sites. The majority-rural consortia percentage requirement will increase by 5 percent for the following funding year (up to a maximum of 75 percent) if the Commission must prioritize funding for a given year because Rural Health Care Program demand exceeds the funding cap.

(c) *Limitation on large non-rural hospitals.* Each eligible non-rural public or non-profit hospital site with 400 or more licensed patient beds may receive no more than $30,000 per year in Healthcare Connect Fund Program support for eligible recurring charges and no more than $70,000 in Healthcare Connect Fund Program support every five years for eligible nonrecurring charges, exclusive in both cases of costs shared by the network.

§ 54.608 Eligible service providers.

For purposes of the Healthcare Connect Fund Program, eligible service providers shall include any provider of equipment, facilities, or services that is eligible for support under the Healthcare Connect Fund Program.