

Form 641 – Parts A, B & C

ASHNHA Quarterly Project Budget Summary
& Performance Analysis Reporting Form

For All Remaining 2009 Denali Commission Approved Projects:
Projects No. 1150 – A1 through 1150 – A4; 1150 – C; or 1150 – G

Project Name: CT Scanner

Name of Hospital / Grant Sub-Recipient: Wrangell Medical Center

Reporting Period: October 1, 2010 – December 31, 2010

Sub-Recipient Grant No.: 1150 – G

Part 641 – A. Project Budget Summary (provide the following information requested; use additional pages as necessary):

1. Original Project Budget Information:

- a. The *original total* approved project budget:
 - i. Amount of Denali Commission Grant Award: \$366,676.00
 - ii. Amount of Facility Cost Share Match (CSM): \$366,676.00
 - iii. Original Total Project Cost [line 1(a)(i) plus line 1(a)(ii)]: \$733,353.00

2. Actual Project Costs Recorded During the Current Reporting Period:

- a. Amount of the Facility's own Project CSM Expended (non-reimbursed expenditures) during the current reporting period: **\$0**
- b. Amount of Facility funds expended during the current reporting period for which Denali Commission grant funds are being requested this period on Form 642 (Part B) to reimburse your hospital for its project expenditures: **\$210,350.00**
- c. Total amount of project costs recorded during the reporting period, whether expended facility CSM or reimbursement for facility expenditures is being sought (add lines 2a & 2b):
\$210,350.00

3. Total Denali Commission Grant Funds Received to Date:

Please report the **total** amount of Denali Commission grant funds **received** (whether received as an advance or as reimbursement for expenses) as of the end of the current reporting period (i.e., the total grant funds received to-date): **\$14, 893.00**

4. Total Facility Cost Share Match Funds Expended to Date:

Please report the **total** amount of hospital funds **expended** (i.e., the hospital's share of the cost of the project *for which reimbursement was not and cannot be sought* from the Denali Commission) as of the end of the current reporting period (i.e., the total hospital matching funds expended to-date for which you did not seek reimbursement): **\$0**

5. Project Schedule:

Please state the anticipated start and end dates of this funded 2009 Denali Commission Primary Care Improvements in Hospitals project, and provide a list of appropriate milestone dates for the major phases or activities of your project.

Start date: August 15, 2010

End date: September 30, 2011

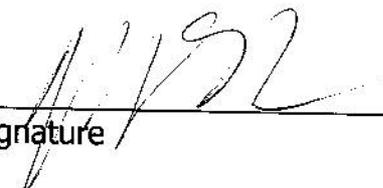
<u>Description of Milestone Or Activity</u>	<u>Anticipated Completion Date</u>
1. Conceptual design and engineering/architecture	August 30, 2010
2. Design	September 15, 2010
3. Construction (if required)	October 31, 2010
4. Contract and deposit of CT Scanner	December 14, 2010
5. Completed Purchase and Delivery of CT Scanner	April 18, 2011
6. Installation and testing	June 20, 2011

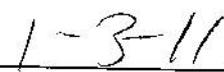
Part 641 – B. Project Performance Analysis (add line items to the chart as appropriate):

2009 Project Budget Line Items:	Approved Budget:	Actual Cost:	Scheduled Completion Date:	Actual Work Performed:
Feasibility and Conceptual Design		\$14,893.34	08/31/09	Conducted feasibility study for CT Scanner placement and developed conceptual drawings for project.
Deposit for CT Scanner from Medical Imaging Resources		\$210,350.00	12/14/2010	Signed contract with Medical Imaging Resources for a CT Scanner and paid a deposit down on the Scanner.
Totals:		\$225,243.34		

Part 641 – C. Facility Certification:

The preparer of this report, by signing below, certifies on behalf of his or her employer that the information contained herein is accurate and complete to the best of his or her knowledge.





Noel D. Selle-Rea, CEO Wrangell Medical Center

 Printed Name and Official Title

(Last Revised 12.15.2010)

Form 642 – Parts A & B

ASHNHA's Quarterly Project Reporting Form

Covering 2009 Denali Commission Projects
Numbered 1150 – A1 through 1150 – A4; 1150 – C; or 1150 – G

Please Use this Form to File the Quarterly Narrative Progress Report And / Or Make a Fund Disbursement Request

Project Name: CT Scanner

Name of Hospital / Grant Sub-Recipient: Wrangell Medical Center

Reporting Period: October 1, 2010 – December 31, 2010

Denali Commission Grant No.: 1150 - G

Part 642 – A. Project Narrative (use additional pages as necessary):

1. **What is the status of your D/C 2009 "Primary Care Improvements in Hospitals" project as of December 31, 2010?** (Please list all project phases completed or milestones achieved during the report period.)

We have contracted Medical Imaging Resources (MIR) to provide the new CT scanner for our hospital. As of 12/14/10 we have paid a deposit for the CT scanner in the amount of \$210,350.00 to MIR.

2. **Is your 2009 project on schedule? If not, what kind of problem(s) does the delay present? How will this be dealt with? Will the delay potentially extend the project beyond 9/30/2011?**

Yes, our project is on schedule and will be completed by 9/30/2011.

3. **Is the 2009 project on budget, or over or under budget? If over budget, how will this be dealt with? What funds is your facility using to cover the additional project costs?**

Our project is on budget and we do not foresee any additional project costs.

4. **Other comments, problems and solutions:**

Part 642 – B. Project Fund Disbursement Request (Advance or Reimbursement)

We are requesting ASHNHA to release \$ 210,350.00 in Denali Commission Grant Funds for our project at this time. *This funding request is:*

1. a request for an *Advance* against our Project Grant Award Funds; **or**
2. a request for *Reimbursement* from Project Grant Award Funds in order to cover project expenses incurred by our hospital during the reporting period.

(Copies of all invoices submitted and checks written in payment must accompany any request for reimbursement; copies of purchase orders or other commitment documents must accompany any request for an advance).

Wire Transfer Services

Outgoing Wire Transfer Request



A customer or team member, with the customer present, completes this form when requesting to send a wire. Outgoing wires can only be sent for Wells Fargo customers. Retain the original copy in the bank and provide a copy to the customer ensuring you give the customer the Agreement for Outgoing Wire Transfer Request (page 2 when form is accessed on-line & preprinted on the back of printed forms). **Required information is noted with an asterisk.** Note: Wells Fargo Wire Transfer Services will route wires based on correspondent banking relationships. See back (page 2) for explanations of the Mexican CLABE account, the SWIFT BIC, the International Routing Code (IRC) and the International Bank Account Number (IBAN).

*Today's Date 12/13/2010 *Send Date (If next day submit wire after 4:30 CT. Store must hold if other than today or next day date.) 12/14/2010

1. Originator's Information

*Customer's Name Wrangell Medical Center *Phone Number (907) 874-7000

*Customer's Address, City, State, Zip Code 310 BENNETT ST WRANGELL, AK 9992

*Transfer from Wells Fargo Bank Account No. (Must be checking, savings, market rate or wholesale checking account) 12950076 *U.S. Dollar Wire Amount 210,350.00

International Wire only: When sending in foreign currency, please ensure the beneficiary's account accepts the designated currency.
 Funds to be sent in foreign currency Yes No Foreign Currency Type/Name (SVT/SVP will default to FX unless specified otherwise) _____ *Currency Code (if known) _____ *Foreign Currency Amount _____

2. Beneficiary/Recipient Information (This is the ultimate recipient of the wire transfer funds.)

*Beneficiary/Recipient Name Medical Imaging Resources

*Beneficiary Account Number, Mexican CLABE # or the International Bank Account Number (IBAN) where applicable: 1851150571

Beneficiary Address, City, State, Zip Code (A physical address is required for foreign wires.) _____

Information for the Beneficiary (invoice number, Purchase order number, etc.) _____ Beneficiary Phone Number _____

3. Beneficiary Bank Information (This is the financial institution where the beneficiary maintains their account.)

*Beneficiary Bank RTN or SWIFT Bank Identifier Code (SWIFT BIC) 072000096 *International Routing Code (IRC) _____

*Beneficiary Bank Name Comerica Bank

Beneficiary Bank Address, City, State, Zip, Country (optional information) _____

Information for Beneficiary Bank (wires to Mexican banks require the CLABE account number in the Beneficiary instructions to ensure correct payment.) _____

4. Intermediary Bank Information (This is a financial institution that the wire must pass through before reaching the final beneficiary bank.) This section is optional and not required for all wires. Please note that routing may be altered depending on Wells Fargo Bank's correspondent relationships.

Optional: *Intermediary Beneficiary Bank RTN or SWIFT BIC _____ International Routing Code (IRC) _____

*Intermediary Bank Name _____ *Intermediary Bank Account No. _____

Intermediary Bank Address City, State, Zip, Country (optional information) _____

Information for Intermediary Bank _____

5. Wire Fee & Customer Signature (Additional fees from intermediary and beneficiary banks may be charged to international transactions – see Fees Section on page 2 of this form.)

Wire Fee Amount (the Transfer From account will be charged the fee.) The region that houses the account being debited determines the fee amount. Use the fee information available through Teamworks and/or the Banker's Guide. Do not use SVT/SVP for fee when account is not in your region. Additional fees may apply (see page 2 of this form). *AU where the Originator's account is located 01743 *Fee Amount \$ 20.00

My signature here indicates agreement to all of the information on this Outgoing Wire Transfer Request and to the terms and conditions on the second page of this request. Wells Fargo Bank is authorized to rely on the information on this Request in making the requested funds transfer. *Date 12/13/2010
 *X

6. Bank Use Only – Bank Approval – Following MUST be completed for All outgoing wires

International Wire Foreign Currency Information Rate _____ Contract # (required when \$15,000 or more U.S. \$) _____ FX Trader Contact _____

*Wire Transaction/FAS Number _____ *Name on ID used by customer Olinda White Method used to verify business acct. transaction authority HOGAN

*1st ID type, number, issued by State/Country & Expiration Date _____ *2nd ID type, issued by State/Country & Expiration Date _____

known by _____ *Initiated by and AU # X 01743 *First Approval X Second Approval, if applicable X