

Hi Jeannie,

Just to clarify on the attached forms:

The Hospital has received all the equipment and it is installed and in use. I have received invoices totaling \$253,266 for the project. We do not have funds to pay for the project then be reimbursed by the Denali Commission so I am hercin requesting the \$100,000 from the Denali Commission. I have requested the \$140,000 from the City of Sitka (they own us and appropriated these funds for us) and as soon as I receive these funds the Hospital will pay for the project utilizing Hospital funds for the additional \$13,266.

If you or the Denali Commission have any questions please let me know.

Thanks,

Lee

A handwritten signature in black ink, appearing to be the name 'Lee' written in a cursive style.

Form 641 – Parts A, B & C

ASHNHA Quarterly Project Budget Summary
& Performance Analysis Reporting Form

**For All 2010 Denali Commission Approved Projects –
Projects No. 1265 – A through 1265 – L**

Project Name: Replacement of Surgical Equipment

Name of Hospital / Grant Sub-Recipient: Sitka Community Hospital

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

Sub-Recipient Grant No.: 1265 – K

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: \$100,000.00

ii. Amount of Facility Cost Share Match (CSM): \$140,000.00

iii. Original Total Project Cost [line 1(a)(i) plus line 1(a)(ii)]: \$240,000.00

2. Actual Project Costs Recorded During the Current 3 Month Reporting Period:

a. Amount of the Facility's own Project CSM Expended (non-reimbursed expenditures) during the current reporting period:

\$153,266

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: \$100,000

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):
\$253,266

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):

\$100,000

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):

\$153,266

5. Project Schedule:

Please state the anticipated start and end dates of this funded 2010 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: July 1, 2010

End date: December 31, 2010

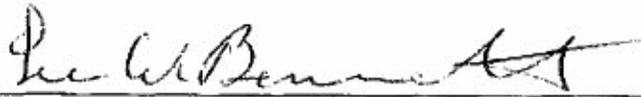
<u>Description of Milestone Or Activity</u>	<u>Anticipated Completion Date</u>
1. Trial various pieces of equipment from different vendors.	8/31/2110
2. Pick vendor/vendors and negotiate prices.	9/15/2010
3. Order equipment.	9/30/2010
4. Receive equipment – install/accept equipment – pay for equipment.	12/30/2010

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

2010 Project Budget Line Items:	Approved Budget:	Actual Cost:	Scheduled Completion Date:	Actual Work Performed:
Surgical Equipment	\$240,000	\$253,266	12/31/2010	All equipment for project has been received , installed, and is now in use.
Totals:	\$240,000	\$253,266		

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.



Signature

12/9/2010

Date

Lee W. Bennett, CFO

Printed Name and Official Title

(Last Revised 8.31.2010)

Form 642 – Parts A & B

ASHNHA's Quarterly Project Reporting Form

Covering All 2010 Denali Commission Approved Projects Projects No. 1265 – A through 1265 – L

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

Project Name: Replacement of Surgical Equipment

Name of Hospital / Grant Sub-Recipient: Sitka Community Hospital

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

Sub-Recipient Grant No.: 1265 - K

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

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

All equipment for the project has been received, installed and is in use.

2. **Is your 2010 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 9/30/2012?**

Yes and is completed.

3. **Is the 2010 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?**

It came in \$13,266 over budget. The Hospital will use reserves for difference.

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

None at this time. Except to say Sitka community Hospital has greatly appreciated the efforts of the Denali Commission and our Hospital has benefited greatly from the grants it has received. We are extremely sorry to see the availability of this type of funding coming to an end.

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

We are requesting ASHNHA to release \$ 100,000.00 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).



Invoice

NUMBER
12066227 RI

MAIL ALL CORRESPONDENCE TO:

OLYMPUS
 3500 CORPORATE PARKWAY
 P.O. BOX 610
 CENTER VALLEY, PA 18034-0610
 TEL (484) 896-5000

YOUR CREDIT REPRESENTATIVE IS:
Petal Wilson 484-896-5708 484-896-7924 fax petal.wilson@olympus.com

MAIL REMITTANCE TO:

OLYMPUS
 Dept 0600
 P.O. Box 120600
 Dallas, TX 75312-0600

SOLD TO: 113154
 SITKA COMMUNITY HOSPITAL
 209 MOLLER AVENUE
 SITKA AK 99835

SHIP TO: 77858
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 209 MOLLER AVENUE
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 jconway@sitkahospital.org
 SITKA AK 99835

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Tax ID: Tax Cert: PAGE: 1

CUSTOMER AC NUMBER	TERMS	REG DATE	DELIVERY INSTRUCTIONS	BRANCH PLANT	ORDER NO	INVOICE DATE
12686	Net 30 Days	09/30/10		600	9621733 S9	10/27/10

ITEM NUMBER	QTY SHIP	DESCRIPTION	UNIT PRICE	AMOUNT
WM-DP1	1	Double-Wide Endoscopy	4,918.03	
		Net Price	4,918.03	4,918.03
THANK YOU FOR YOUR ORDER				

Tax Rate	Sales Tax	Net Due Date	INVOICE TOTAL
	.00	11/26/10	PAY THIS AMOUNT USD 4,918.03

Trade-in Credit will be issued under a separate document after Olympus receives the trade-in equipment. The trade-in credit may reflect a discount, reduction in price or participation in a Discount Program. Any such discount or reduction in price is fully and accurately reported herein in accordance with Sec. 1128B(b) (3) of the Social Security Act, 42 U.S.C. Sec. 1320a-7b(b) (3) and applicable regulations (42 C.F.R. Sec 1002.952 (h)). Further, you may be obligated to properly disclose the discount or other reduction in price in costs claimed by you to the Medicare or state healthcare program.

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YOUR CREDIT REPRESENTATIVE IS:
 Petal Wilson
 484-896-6708
 484-896-7924 fax
 petal.wilson@olympus.com

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 Dept 0600
 P.O. Box 120600
 Dallas, TX 75312-0600

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CUSTOMER P.O. NUMBER	TERMS	REQ. DATE	DELIVERY INSTRUCTIONS	BRANCH PLANT	ORDER NO.	INVOICE DATE
12686	Net 30 Days	09/30/10		600	9621733 S9	10/08/10

ITEM NUMBER	QTY SHIP	DESCRIPTION	UNIT PRICE	AMOUNT
0EV-261H	1	OLYMPUS 26" FULL HD LCD MONITO	6,981.00	6,981.00
		Serial numbers		
		THANK YOU FOR YOUR ORDER		

Tax Rate	Sales Tax	Net Due Date	PAY THIS AMOUNT	INVOICE TOTAL
	.00	11/07/10	USD	6,981.00

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YOUR CREDIT REPRESENTATIVE IS:
 Petal Wilson
 484-896-5708
 484-896-7924 fax
 petal.wilson@olympus.com

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 Dept 0600
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CUSTOMER P.O. NUMBER	TERMS	REQ. DATE	DELIVERY INSTRUCTIONS	BRANCH PLANT	ORDER NO.	INVOICE DATE
12686	Net 30 Days	09/30/10		600	9621733 59	10/22/10

ITEM NUMBER	QTY SHIP	DESCRIPTION	UNIT PRICE	AMOUNT
A70940A	2	A70940A TELESCOPE 4MM 0 DEGREE Serial numbers 607169 607172 THANK YOU FOR YOUR ORDER	4,160.00	8,320.00

Tax Rate	Sales Tax	Net Due Date	INVOICE TOTAL	
	.00	11/21/10	PAY THIS AMOUNT USD	8,320.00

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12000649 RI

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OLYMPUS
 3500 CORPORATE PARKWAY
 P.O. BOX 610
 CENTER VALLEY, PA 18034-0610
 TEL (484) 896-5000

YOUR CREDIT REPRESENTATIVE IS:
 Samantha Capasso
 484-896-5504
 484-896-7925 fax
 Samantha.Capasso@Olympus.com

MAIL
 REMITTANCE
 TO:

OLYMPUS
 Dept 0600
 P.O. Box 120600
 Dallas, TX 75312-0600

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CUSTOMER P.O. NUMBER	TERMS	REQ DATE	DELIVERY INSTRUCTIONS	BRANCH PLANT	ORDER NO	INVOICE DATE
12686	Net 30 Days	09/30/10		600	9621733 S9	09/30/10

ITEM NUMBER	QTY SHIP	DESCRIPTION	UNIT PRICE	AMOUNT
MAJ-188	1	CYLINDER HOLDER CO2 STANDARD	183.48	183.48
K10008283	1	LCD ROLL STAND TALL FIXED HEIGHT	1,096.38	1,096.38
IS50017	1	E857247 15" 1528L Medical Grade LCD Monitor, Accutouch.	868.15	868.15
IS40260	1	nStream G3 SD Dual Channel Image Capture System w/DICOM	15,210.52	15,210.52
A70950A	2	A70950A SHEATH HIGH FLOW, 4MM 1 STOPCOCK ROTATABLE	800.00	1,600.00
A70955A	2	A70955A TROCAR SPIKE, 4MM BLUN T FOR A70950A, A70951A	140.00	280.00

THANK YOU FOR YOUR ORDER

Tax Rate	Sales Tax	Net Due Date	INVOICE TOTAL	
	.00	10/30/10	PAY THIS AMOUNT	USD 19,238.53

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 TEL (484) 896-5000

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 P.O. Box 120600
 Dallas, TX 75312-0600

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12686		09/30/10		600	9621733 S9	09/30/10

ITEM NUMBER	QTY SHIP	DESCRIPTION	UNIT PRICE	AMOUNT
✓MAJ-199	1	ADDITIONAL SHELF (WM-WP1) Net Price	219.28 219.28	219.28
✓UHI-3	1	UHI-3 HIGH FLOW INSUFFLATOR 35 ^L Net Price Serial numbers 7012914	5,994.00 5,994.00	5,994.00
✓OTV-S7PROH-HD-12Q	3	OTV-S7ProH-HD-12Q 1.2x. Net Price Serial numbers 7917672 7917674 7917678	14,700.00 14,700.00	44,100.00
✓WA03210A	3	LIGHT GUIDE 7MM X 3M AUTOCLAVE Net Price W/O CONDENSER, CF COMPATIBLE	429.60 429.60	1,288.80
✓WA50372B	1	WA50372B TELESCOPE 0 DEGREE 5M Net Price Serial numbers	3,410.00 3,410.00	3,410.00

Tax Rate	Sales Tax	Net Due Date	INVOICE TOTAL
			PAY THIS AMOUNT USD

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12686		09/30/10		600	9621733 S9	09/30/10

ITEM NUMBER	QTY SHIP	DESCRIPTION	UNIT PRICE	AMOUNT
WA53000A	1	584660 QUICK LOCK TELESCOPE, 10MM 0 DEGREE HD	3,465.00	3,465.00
		Net Price	3,465.00	3,465.00
		Serial numbers 606118		
WA05970A	3	HIGH STERILIZATION TRAY W/ LID	524.00	1,572.00
		Net Price	524.00	1,572.00
		WA05970A, WITH SILICONE MAT		
WA05971A	3	TRAY INSERT FOR UPPER PART OF	372.00	1,116.00
		Net Price	372.00	1,116.00
FREIGHT-HCS	1	Freight	560.56	560.56

The freight charge is set forth on this invoice, such charge amounts to the total freight charges attributable to the shipment of all of the products ordered under your purchase order. Some of these products may be shipped separately from the items shipped under this invoice, and the invoices for such products will not include the freight. In the event that Olympus permits the cancellation or termination of part or all of the purchase order prior to the shipment of all of the products under the purchase order, a pro-rata amount of the freight charge shall be refunded. Notwithstanding the foregoing, nothing herein shall be construed to authorize the cancellation or termination of a purchase order without the express approval of Olympus which may be accepted or

Tax Rate	Sales Tax	Net Due Date	PAY THIS AMOUNT	INVOICE TOTAL
				USD

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OLYMPUS
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 TEL (484) 896-5000

YOUR CREDIT REPRESENTATIVE IS:
 Samantha Capasso
 484-896-5504
 484-896-7925 fax
 Samantha.Capasso@Olympus.com

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 P.O. Box 120600
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CUSTOMER P.O. NUMBER	TERMS	REQ. DATE	DELIVERY INSTRUCTIONS	BRANCH PLANT	ORDER NO	INVOICE DATE
12686	Net 30 Days	09/30/10		600	9621733 S9	09/30/10

ITEM NUMBER	QTY SHIP	DESCRIPTION	UNIT PRICE	AMOUNT
		withheld in its sole and absolute discretion. THANK YOU FOR YOUR ORDER		

Tax Rate	Sales Tax	Net Due Date	INVOICE TOTAL	
	.00	10/30/10	PAY THIS AMOUNT	USD 61,725.64

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