

Please fill out the tables below (please provide additional sheets, if needed) or the electronic Microsoft Excel version. All invoices and proof of payments must be submitted with this completion report. Invoice dates must fall within the contract period of **July 1, 2016 – June 30, 2017**.

Expense Category (please provide a brief description)*	Invoice Number	Invoice Date	Vendor Name	Total Cost
<i>Equipment</i>				
a.				
b.				
c.				
d.				
e.				
f.				
<i>Contract for Non-Medical Services</i>				
a.				
b.				
c.				
d.				
e.				
f.				
<i>Patient Transportation</i>				
a.				
b.				
c.				
d.				
e.				
f.				

Construction				
a.				
b.				
c.				
d.				
e.				
f.				
TOTAL DIRECT COST				\$

Project Cost, Funds Requested & Matched		
Total Direct Cost	CIP Funds Requested	Hospital Match
<u>How to calculate the amounts:</u>		
Total Direct Cost: The same as the "Total Direct Cost" in the first table.		
CIP Funds Requested: Divide "Total Direct Cost" by 1.25; cannot be more than \$75,000.		
Hospital Match: Multiply "CIP Funds Requested" by 0.25; if "CIP Funds Requested" equal \$75,000, then "Hospital Match" is <i>at least</i> \$18,750.		

***Definition of Expense Categories:**

- Equipment is defined by TDA as non-expendable personal property with a unit cost of more than \$5,000 and a useful life of more than one year.
- Contracts for non-medical services includes, but is not limited to, contracts for designing, engineering, supervising, surveying, and other expenses incidental to the acquisition, construction or improvements of new hospitals.
- Patient transportation includes, but is not limited to, contracts for patient transportation projects such as the purchase of ambulances.
- Construction includes, but is not limited to, contracts for any construction of building on the hospital or outbuildings, remodel projects, additions, etc.

C. Describe any significant differences between budgeted amount in the original application and the actual amount noted above (*significant changes must receive written prior approvals from the SORH*).

D. What was the initial purpose of your project?

E. Did the purpose of your project change during the implementation? If so, please explain? (*changes must receive written prior approvals from the SORH*).

F. What were the outcomes of your project? How did it impact your community/hospital? Provide 1-3 photos of your project.

G. Recommendations for CIP

Please use this section to document any comments, concerns or questions that your facility has in regards to the CIP program.

Administrator/CEO Signature: _____ Date: _____