

(Follow instructions on the back)

1. Federal Agency and Organizational Element to Which Report is Submitted Denali Commission		2. Federal Grant or Other Identifying Number Assigned By Federal Agency 0103-DC-2003-116		OMB Approval No. 0348-0038	Page of 1 / 1 pages		
3. Recipient Organization (Name and complete address, including ZIP code) Morton Sound Health Care P P.O. Box 966 NOME, AK 99762							
4. Employer Identification Number 920041488		5. Recipient Account Number or Identifying Number		6. Final Report <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
7. Basis <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual							
8. Funding/Grant Period (See instructions) From: (Month, Day, Year) 11/1/1995 9/30/03		To: (Month, Day, Year) 10/1/2009 9/30/05		9. Period Covered by this Report From: (Month, Day, Year) 1/1/2008			
				To: (Month, Day, Year) 3/31/2006			
10. Transactions:							
				I Previously Reported	II This Period	III Cumulative	
a. Total outlays				1,469,661.00	1,153,673.39	2,623,334.39 0.00	
b. Recipient share of outlays				120,000	0	120,000 -0.00	
c. Federal share of outlays				1,349,661	1,153,673.39	2,503,334.39 0.00	
d. Total unliquidated obligations						2,676,665.61	
e. Recipient share of unliquidated obligations						0.00	
f. Federal share of unliquidated obligations						2,676,665.61	
g. Total Federal share (Sum of lines c and f)						5,180,000 -0.00	
h. Total Federal funds authorized for this funding period						2,503,334.39	
i. Unobligated balance of Federal funds (Line h minus line g)						2,676,665.61 0.00	
11. Indirect Expense							
a. Type of Rate (Place "X" in appropriate box) <input type="checkbox"/> Provisional <input type="checkbox"/> Predetermined <input type="checkbox"/> Final <input type="checkbox"/> Fixed							
b. Rate		c. Base		d. Total Amount		e. Federal Share	
12. Remarks: Attach any explanations deemed necessary or information required by Federal sponsoring agency in compliance with governing legislation. PREVIOUS REPORT NOT ACCURATE DUE TO ROUNDING. WILL DISCONTINUE PRACTICE							
13. Certification: I certify to the best of my knowledge and belief that this report is correct and complete and that all outlays and unliquidated obligations are for the purposes set forth in the award documents.							
Typed or Printed Name and Title Haven Harris ASST. VICE President Hospital Services				Telephone (Area code, number and extension) 907-443-3255			
Signature of Authorized Certifying Official Haven Harris				Date Report Submitted 5/17/06			

NSN 7540-01-218-4387

269-202

Standard Form 269A (Rev. 7-97)

Prescribed by OMB Circulars A-102 and A-111

ACCEPTED