

FINANCIAL STATUS REPORT
(Short Form)

(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 pages
3. Recipient Organization (Name and complete address, including ZIP code) Norton Sound Health Corporation 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) 1/1/2003		To: (Month, Day, Year) 10/1/2007		9. Period Covered by this Report From: (Month, Day, Year) 4/1/2006	
				To: (Month, Day, Year) 6/30/2006	
10. Transactions:					
		I Previously Reported	II This Period	III Cumulative	
a. Total outlays		\$2,623,334.39	\$311,417.65	\$2,934,752.04	0.00
b. Recipient share of outlays		\$120,000	—	\$120,000	0.00
c. Federal share of outlays		\$2,503,334.39	\$311,417.65	\$2,814,752.04	0.00
d. Total unliquidated obligations				\$2,365,247.96	
e. Recipient share of unliquidated obligations					
f. Federal share of unliquidated obligations				\$2,365,247.96	
g. Total Federal share (Sum of lines c and f)				\$5,180,000.00	0.00
h. Total Federal funds authorized for this funding period				\$2,814,752.04	
i. Unobligated balance of Federal funds (Line h minus line g)				\$2,365,247.96	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.					
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 Hosp. Services				Telephone (Area code, number and extension) 907-443-3255	
Signature of Authorized Certifying Official <i>Haven Harris</i>				Date Report Submitted 7/29/06 7/31/06	

NSN 7540-01-218-4387

269-202

Standard Form 269A (Rev. 7-97)
Prescribed by OMB Circulars A-102 and A-111

ACCEPTED

