**Rural Health Facility Capital improvement Program (CIP)**

**PROJECT COMPLETION REPORT**

**June 1, 2019 – May 31, 2020**

The Project Completion Report is due **when the project is completed** and must be submitted/emailed no later than ***June*** ***15, 2020.*** Please email RuralHealth@TexasAgriculture.gov  or Shari.Wyatt@TexasAgriculture.gov  with any questions.

**A. Grantee Information:**

**Hospital Name:**

**Project Number:**

**Tax ID number:**

**Address:**

**City:**       **State:**       **Zip:**       **County:**

**Phone:**

**Administrator/CEO Name:**       **E-mail:**

**CIP Project Director Name:**       **E-Mail:**

(Individual responsible for managing CIP-funded project for the hospital)

**B. June 1, 2019 – May 31, 2020 Grant Program Expenditures**

Amount Awarded:

Amount Matched:

Is the project complete? □ Yes □ No

If yes, completion date:

If no, what activities still need to be performed (please provide additional sheet if needed)? When will project be complete?

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Please fill out the tables below (please provide additional sheets, if needed). All invoices and proof of payments must be submitted with this completion report.Invoice dates must fall within the contract period of **June 1, 2019 – May 31, 2020.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Expense Category (please provide a brief description)\*** | **Invoice Number** | **Invoice Date** | **Vendor Name** | **Total Cost** |
| ***Equipment*** |  |  |  |  |
| **a.** |  |  |  |  |
| **b.**  |  |  |  |  |
| **c.** |  |  |  |  |
| **d.** |  |  |  |  |
| **e.** |  |  |  |  |
| **f.** |  |  |  |  |
| ***Contract for Non-Medical Services*** |  |  |  |  |
| **a.** |  |  |  |  |
| **b.**  |  |  |  |  |
| **c.** |  |  |  |  |
| **d.** |  |  |  |  |
| **e.** |  |  |  |  |
| **f.** |  |  |  |  |
| ***Patient Transportation*** |  |  |  |  |
| **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** |
|  |  |  |
|  |  |  |
| ***How to calculate the amounts:*** |
| **If Total Direct Cost < $93,750, calculate by:** **Total Direct Cost divided by 1.25 = CIP grant amount, remaining is matching funds.****Example:****Total Project Cost = $65,000****$65,000/1.25 = $52,000 (CIP Grant Amount)****$65,000 - $52,000 = $13,000 (Matching Funds)****(Note: 25% of $52,000 (CIP grant amount) = $13,000 (matching funds)** |

**\*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).***

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**D. What was the initial purpose of your project?**

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

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**F. What were the outcomes of your project? How did it impact your community/hospital? Provide 1-3 photos of your project in separate .pdf or jpeg files.**

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**G. Recommendations for CIP**

**Please use this section to document any comments or recommendations that your facility has in regard to the CIP program.**

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**Administrator/CEO Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**