DSS-1571 III
Rev July-16

# North Carolina Department of Health and Human Services
## Division of Social Services

### DSS-1571 III (Administrative Costs Report )
**Month Ending: July-16**

Contract ID No: **12345**
NC Grants # **12345**
Provider Name: **Adoption Agency**

Address **123 Main Street**
**Somewhere, NC 12345**

| Section I (1) Object of Expenditure | (2) Current Expenses | (3) YTD Expenses | (4) Approved Budget | (5) DSS-6844S Budget, Amendments | *Am *R | (6) Unexpended Balance |
|---|---|---|---|---|---|---|
| A. Salaries | 0.00 | 0.00 | 0.00 | 0.00 | | 0.00 |
| B. Fringe Benefits | 0.00 | 0.00 | 0.00 | 0.00 | | 0.00 |
| C. Staff Development | 0.00 | 0.00 | 0.00 | 0.00 | | 0.00 |
| D. Travel | 0.00 | 0.00 | 0.00 | 0.00 | | 0.00 |
| E. Equipment Purch. - Tangible Prop. | 0.00 | 0.00 | 0.00 | 0.00 | | 0.00 |
| F. Transportation - Recipient | 0.00 | 0.00 | 0.00 | 0.00 | | 0.00 |
| G. Medical Supplies | 0.00 | 0.00 | 0.00 | 0.00 | | 0.00 |
| H. Cost of Space | 0.00 | 0.00 | 0.00 | 0.00 | | 0.00 |
| I. Room and Board-Residential Treatment | 0.00 | 0.00 | 0.00 | 0.00 | | 0.00 |
| J. Service Payments | 0.00 | 0.00 | 0.00 | 0.00 | | 0.00 |
| K. Other Expenses (list individual items) | | | | | | |
| Adoption Promotion Payment | 7,200.00 | 7,200.00 | 100,000.00 | 100,000.00 | | 92,800.00 |
| | | 0.00 | 0.00 | 0.00 | | 0.00 |
| | | 0.00 | 0.00 | 0.00 | | 0.00 |
| | | 0.00 | 0.00 | 0.00 | | 0.00 |
| | | 0.00 | 0.00 | 0.00 | | 0.00 |
| | | 0.00 | 0.00 | 0.00 | | 0.00 |
| | | 0.00 | 0.00 | 0.00 | | 0.00 |
| | | 0.00 | 0.00 | 0.00 | | 0.00 |
| | | 0.00 | 0.00 | 0.00 | | 0.00 |
| | | 0.00 | 0.00 | 0.00 | | 0.00 |
| | | 0.00 | 0.00 | 0.00 | | 0.00 |
| | | 0.00 | 0.00 | 0.00 | | 0.00 |
| | | 0.00 | 0.00 | 0.00 | | 0.00 |
| | | 0.00 | 0.00 | 0.00 | | 0.00 |
| | | 0.00 | 0.00 | 0.00 | | 0.00 |
| L. Indirect Cost | 0.00 | 0.00 | 0.00 | 0.00 | | 0.00 |
| Total Expenditures | 7,200.00 | 7,200.00 | 100,000.00 | 100,000.00 | | 92,800.00 |
| Less: Provider Match: **0.00%** Act. 432996 | 0.00 | 0.00 | 0.00 | 0.00 | | 0.00 |
| **NET REIMBURSABLE AMOUNT** | 7,200.00 | 7,200.00 | 100,000.00 | 100,000.00 | | 92,800.00 |

*Am = Amendments
*R = Realignments

**Section II - Certification**

As chief executive officer of the contracting organization, I hereby certify that the cost or units billed on this form were incurred and delivered according were incurred and delivered according to the provisions of the contract. I further certify that any required expenditures have been incurred, and that to the best of my knowledge and belief we have complied with all laws, regulations and contractual provisions that are conditions of payment under this contract.

Mary Jones — 7/10/2016
Authorized Provider Official Signature — Date

EIN / Group No

John Smith — 7/10/2016
Person Responsible for Completion of Report — Telephone #(Area Code) — 100%

NCAS -PO No.:

Acct / Center

Contract Administrator: Michelle Reines — 0% — Acct / Center

Telephone Number: 919-527-6437 — 0% — Acct / Center

Date: — 0% — Match Acct #