DSS-1571 III

Rev June-17

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

DSS-1571 III (Administrative Costs Report)

Month Ending: Jul-17

Contract ID No: **12345** Contract Period **7/1/17-6/30/18** Address **123 Main Street**

NC Grants # **55555** **Somewhere, NC 12345**

Provider Name: **Adoption Agency**

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 Payments	14,400.00	14,400.00	100,000.00	100,000.00		85,600.00
		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
Administrative Cost (If applicable)		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	14,400.00	14,400.00	100,000.00	100,000.00		85,600.00
Less: Provider Match: 0.000000%	0.00	0.00	0.00	0.00		0.00
Act. 432996						
NET REIMBURSABLE AMOUNT	14,400.00	14,400.00	100,000.00	100,000.00		85,600.00
	0.00	0.00				
	0.00	0.00				
	0.00	0.00				

** 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 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.

John Smith 8/1/17

Authorized Provider Official Signature Date

EIN / Group No

NCAS -PO No.:

Amy Jones 8/1/17

Person Responsible for Completion of Report Telephone #(Area Code) 100.000000% Acct / Center

Contract Administrator: Kimberly Best 0.000000% Acct / Center

Telephone Number: 919-527-6354 0.000000% Acct / Center

Date: 0.000000% Match Acct #