



FINANCIAL STATUS REPORT (FSR) FORM PREPARATION INSTRUCTIONS

The Financial Status Report (FSR) is used to provide a standardized format for reporting the financial status of individual programs. All expenditures - including fees, local, state, federal, and others – for the particular program are reported on the FSR. The FSR is prepared shortly after the end of the month and must be submitted to the Detroit Wayne Integrated Health Network (DWIHN) by the fifth (5th) business day following the close of the calendar month. The FSR is to be prepared reporting expenditures and submitted with original signature(s) to the attention of Mrs. Keisha Burnett, SUD Finance Manager and Ms. Patti Garbacz, Accounts Payable Specialist. The FSR may be submitted electronically or by U.S. mail or in person to:

**DWIHN Finance Department
707 W. Milwaukee
Detroit, MI 48202**

FORM PREPARATION

- A. This space should include the invoice number.
- B. Local Agency Name – Enter the name of the local agency.
- C. Street Address – Enter the street address of the local agency.
- D. City, State, ZIP Code – Enter the City, State, and ZIP Code of the local agency.
- E. Contract Number – Enter either the contract number or purchase order number for the current agreement period.
- F. Program – Enter the title of the program.
- G. Revision – Indicate with a checkmark whether this Financial Status Report is a revision of an originally submitted FSR.
- H. Report Period – Enter the inclusive dates covered by the report (report month).
- I. Date Prepared – Enter the date on which the report is prepared.
- J. Agreement Period – Enter the inclusive dates of the agreement (fiscal year).
- K. F.E. ID Number – Enter the Federal Employer Identification Number of the local agency.
- L. Expenditures Current Period Column – Enter the current period expenditures for the following items. Expenditures must include only those authorized under the terms of agreement, as specified in the approved program budget summary and cost detail. Report all expenditures related to the contract, regardless of funding source (the current period must represent the report period).
 - 1. **Salaries and Wages** – This category includes the compensation paid to all permanent and part-time employees on the payroll of the agency and assigned directly to the program. This does not include contractual services, professional fees, or personnel hired on a private contract basis. It is necessary to maintain sufficient documentation to support the allocation of staff working less than 100% of their time on one program.
 - 2. **Fringe Benefits** – This category is to include the employer’s contributions for insurance, retirement, FICA, and other similar benefits for all permanent and part-time employees assigned to the program.
 - 3. **Travel** – Use only for travel costs of permanent and part-time employees assigned to the program. This includes costs for mileage, per diem, lodging, registration fees, and approved seminars or conferences, as well as other

approved travel costs incurred by the employees for the conduct of the program. Travel of consultants is included under Other Expenses – Consultant Services.

4. **Supplies and Materials** – Use for all consumable and short-term items and equipment items costing less than five thousand dollars (\$5,000.00). This includes office, printing, janitorial, postage, and education supplies, medical supplies, contraceptives and vaccines, tape and gauze, educational films, etc. according to the requirements of each applicable program.
5. **Contractual (Subcontractors)** – Use for written contracts or agreements with secondary recipient organizations such as affiliates, cooperating institutions, or delegate agencies. Payments to individuals such as stipends, allowances for trainees, and consulting fees are to be identified in the Other Expenses category.
6. **Equipment** – This category includes stationary and movable equipment to be used in carrying out the objectives of the program. The cost of a single unit or piece of equipment includes the necessary accessories, installation costs, and any taxes. Equipment items costing less than five thousand dollars (\$5,000.00) each are to be included in the Supplies and Materials category. All expenditures for equipment must relate to the budgeted equipment items. Equipment is defined to be an article of non-expendable tangible personal property having a useful life of more than one (1) year and acquisition cost of \$5,000.00 or more per unit.
7. **Other Expenses** – This category includes other allowable costs incurred for the benefit of the program. Identify on the available lines the same items identified in the approved Program Budget. Some of the more significant groups or sub-categories of costs follows:
 - a. **Consultant Services** – These are costs for consultation services related to the planning and operations of the program, or for some special aspect of the project. This does not include consultant services for patient care, which is covered under item 7.b. Travel and other costs of these consultants are also to be included in this category.
 - b. **Patient Care** – Services as required such as medical, social, and educational services to patients relating to prevention, diagnosis and treatment. This category also includes medical fees, laboratory, pharmacy, or other health inpatient care, home care services, treatments, professional and consultation fees and related travel costs, transportation of patients including accompanying parents or guardians (or other escort), and for sundry related support, such as meals and housing. This does not include personnel costs which are included under Salaries and Wages.

- c. **Rentals and Leases** – Costs of building space, rental of equipment, instruments, etc. necessary for the operation of the program.
 - d. **Communication Costs** – Cost of telephone, telegraph, data lines, etc. when directly related directly to the operation of the program.
 - e. **Other** – All other items purchased exclusively for the operation of the program and not previously included. These items must be listed.
8. **Total Direct** – The total of the direct expenditures (lines 1 through 7).
9. **Indirect Costs** – Enter the indirect rate and the amount of the indirect costs for the current period. Indirect costs can only be applied if an approved indirect cost rate has been established and is accepted by the Detroit Wayne Integrated Health Network (DWIHN).

NOTE: TOTAL INDIRECT COSTS CANNOT EXCEED 10% OF TOTAL DIRECT COSTS

10. **Other Cost Distributions** – Not applicable.
11. **Total Expenditures** – Enter the total of expenditures being reported for the program. This is the total of lines 8 and 9.
- 12-15. **Source of Funds** – The various source of funds utilized to provide program support.
16. **Fees and Collections** – Fees and collections received during the current report period. Fees and collections represent funds, which the program earns through its operation and retains for operational purposes. This would include fees for services, payments by third parties (insurance, patient collections, Medicaid, etc.), and any other collections.
17. **Total Funding** – The total funding (lines 12-16) must be equal to the total Expenditures (line 11).

Enter only amounts for the current agreement period in this column. The local agency should assure that no items or unallowable category deviations are reported until approval is requested and received from the Detroit Wayne Integrated Health Network (DWIHN).

- M. **Expenditures Agreement YTD Column** – Add the “Current Period” amounts from this period’s report and the “Agreement YTD” amounts from the previously submitted periods’ reports for each item (lines 1-17) in the Agreement YTD column.
- N. **Agreement Budget Column** – This column needs to reflect the program agreement budgeted amount. Enter the “Agreement Budget” amounts for each item (lines 1-

17). DO NOT CHANGE BUDGET AMOUNTS UNLESS A SIGNED AGREEMENT HAS BEEN RECEIVED. You may change line item budget amounts by submitting a request in writing to the Detroit Wayne Integrated Health Network (DWIHN) as long as the total budget does not change.

- O. Agreement Balance Column – These balances are computed by subtracting the “Agreement YTD” expenditure amounts from the “Agreement Budget” amounts for each item. DO NOT SHOW ANY NEGATIVE AMOUNTS.
- P. Authorized Signature and Date Signed – This section **must** be signed by an authorized official, certifying that documentation and records are available and easily accessible in support of all the data contained in the report. The individual signing on behalf of the local agency certifies by his/her signature that he/she is authorized to sign on behalf of the agency. Any item found as a result of audits to be improper or undocumented will be subject to an audit citation and generally will require a payment adjustment.
- Q. Title – Enter the title of the person signing as authorized signee.
- R. Contact Person – Enter the person’s name to which questions should be directed concerning this report.
- S. Telephone Number – Enter the telephone number of the person to which questions should be directed concerning this report.

For questions or concerns regarding completion and/or submission of the Financial Status Reports, please contact one of the following persons:

Ms. Patti Garbacz at either (313) 344-9099, ext 3292 or pgarbacz1@dwihn.com , or

Mrs. Keisha Burnett at either (313) 344-9099, ext. 3277 or kburnett@dwihn.com



FSR SUPPORT SCHEDULE FORM PREPARATION INSTRUCTIONS

The FSR Support Schedule is used to provide a detailed summary of monthly expenditures for individual programs. The FSR Support Schedule is typically prepared as backup documentation to the monthly Financial Status Report (FSR) and must be submitted with the Financial Status Report (FSR) to the Detroit Wayne Integrated Health Network (DMIHN) by the 5th day following the close of the calendar month.

FORM PREPARATION:

- A. Agency Name – Enter the name of the local agency.
- B. Month Ending – Enter the ending date for the report month.
- C. Salaries – Enter the position title and current month’s compensation paid to all permanent and part-time employees on the payroll of the local agency and assigned directly to the program. Do not include contractual services, professional fees, or personnel hired on a private contract basis. **Carry over the subtotal amount to Line 1 in the “Current Period” column on the FSR.**
- D. Fringe Benefits – Enter the current month’s employer’s contributions for insurance, retirement, FICA, and other similar benefits for all permanent and part-time employees assigned to the program. **Carry over the subtotal amount to Line 2 in the “Current Period” column on the FSR.**
- E. Travel – Enter the current month’s travel costs of permanent and part-time employees assigned to the program. Include costs for mileage, per diem, lodging, registration fees, and approved seminars or conferences, and all other approved travel costs incurred by the employees for the conduct of the program. **Carry over the subtotal to Line 3 in the “Current Period” column on the FSR.**
- F. Supplies and Materials – Enter the current month’s expenditures for all consumable and short-term items and equipment costing less than five thousand dollars (\$5,000.00). This includes office, printing, janitorial, postage, and educational supplies, medical supplies, contraceptives and vaccines, tape and gauze, educational films, etc. **Carry over the subtotal to Line 4 in the “Current Period” column on the FSR.**

- G.** Contractual (sub-contracts) – Enter the subcontractor name and current month’s expenditures for written contracts or agreements with secondary recipient organizations such as affiliates, cooperating institutions, or delegate agencies. **Carry over the subtotal to Line 5 in the “Current Period” column on the FSR.**
- H.** Equipment – Enter the current month’s expenditures for stationary and movable equipment costing \$5,000.00 or more to be used in carrying out the objectives of the program. **Carry over the subtotal to Line 6 in the “Current Period” column on the FSR.**
- I.** Other Expenses – Enter the current month’s expenditures for other allowable costs incurred for the benefit of the program. Identify on the available lines the same items identified on the approved Program Budget, such as consultant services, patient care, rentals and leasing, communication costs, and all other items purchased for the operation of the program. **Carry over the subtotal to Line 7 in the “Current Period” column on the FSR.**
- J.** Total – Enter the total of the expenditures (lines A-I), then **carry over this total to Line 8 in the “Current Period” column on the FSR.**

FINANCIAL STATUS REPORT
DETROIT WAYNE INTEGRATED HEALTH NETWORK

| Invoice Number | | Purchase Order Number | | Page | Of |
|--|----------------|-----------------------|------------------|---------------|----|
| Local Agency Name | | Program | | Code | |
| Street Address | | Report Period | | Date Prepared | |
| City, State, ZIP Code | | Agreement Period | | FE ID Number | |
| Category | Expenditures | | Agreement | | |
| | Current Period | Agreement YTD | Budget | Balance | |
| 1. Salaries & Wages | | | | \$ | - |
| 2. Fringe Benefits | | | | \$ | - |
| 3. Travel | | | | \$ | - |
| 4. Supplies & Materials | | | | \$ | - |
| 5. Contractual (Sub-contracts) | | | | \$ | - |
| 6. Equipment | | | | \$ | - |
| 7. Other Expenses | | | | \$ | - |
| | | | | | |
| 8. TOTAL DIRECT | \$ - | \$ - | \$ - | \$ | - |
| 9. Indirect Costs: Rate % | | | | \$ | - |
| | | | | | |
| 11. TOTAL EXPENDITURES | \$ - | \$ - | \$ - | \$ | - |
| | | | | | |
| SOURCE OF FUNDS: | | | | | |
| 12. State Agreement | \$ - | \$ - | \$ - | \$ | - |
| 13. Local | | | | | |
| 14. Federal | | | | | |
| 15. Other | | | | | |
| 16. Fees & Collections | | | | | |
| 17. TOTAL FUNDING | \$ - | \$ - | \$ - | \$ | - |
| NOTE: | | | | | |
| CERTIFICATION: I certify that I am authorized to sign on behalf of the local agency and that this is an accurate statement of expenditures and collections for the report period. Appropriate documentation is available and will be maintained for the required period to support costs and receipts reported. | | | | | |
| Authorized Signature Date | | | Title | | |
| | | | | | |
| Contact Person Name | | | Telephone Number | | |
| | | | | | |

FSR Support Schedule

1

Agency Name:

2

Month Ending:

**Current
Month**

3

Salaries: Position Titles

Sub Total \$ -

4

Fringe Benefits:

Health Insurance
Life, Disability, Dental
Retirement
FICA
Workers Compensation
Unemployment Insurance

Sub Total \$ -

5

Travel

Mileage

Sub Total _____

6

Supplies & Materials:

Office Supplies
Program Supplies
Postage

Sub Total \$ -

7

Contractual (sub-contracts):

Sub Total \$ -

8

Equipment:

Sub Total \$ -

9

Other:

Sub Total \$ -

10

Total \$ -

**DETROIT WAYNE INTEGRATED HEALTH NETWORK
INSTRUCTIONS FOR PREPARATION OF BUDGET FORMS**

I. INTRODUCTION

The budget should reflect all expenditures and funding sources associated with the program, including fees and collections and local, state and federal funding sources. When developing a budget it is important to note that total expenditures for a program must equal total funds.

The Program Budget Summary is utilized to provide a standard format for the presentation of the financial requirements (both expenditure and funding) for each applicable program. Detail information supporting the Program Budget Summary is contained in the Program Budget-Cost Detail Schedule. General instruction for the completion of these forms follows in Sections II-III. Budgets must be submitted on Detroit Wayne Integrated Health Network approved forms.

II. PROGRAM BUDGET SUMMARY FORM PREPARATION

Use the **Program Budget Summary** supplied by the Detroit Wayne Integrated Health Network. An example of this form is attached (**see Attachment B.1**) for reference. **The Program Budget Cost Detail Schedule should be completed prior to completing the Program Budget Summary form.**

- A. Program - Enter the title of the program.
- B. Date Prepared - Enter the date prepared.
- C. Page ___ of ___ - Enter the page number of this page and the total number of pages comprising the complete budget package.
- D. Grantee Name - Enter the name of the Grantee.
- E. Budget Period - Enter the inclusive dates of the budget period.
- F. Mailing Address - Enter the complete address of the Grantee.
- G. Budget Agreement: Original or Amended - Check whether this is an original budget or an amended budget. The budget attached to the agreement at the time it is signed is considered the original budget although it may have been revised in the negotiation process. If the budget pertains to an amendment, enter the amendment number to which the budget is attached.
- H. Federal Identification Number – Enter the Employer Identification Number (EIN), also known as a Federal Tax Identification Number.

PROGRAM BUDGET SUMMARY () FORM PREPARATION (continued)

- I. Expenditure Category – All expenditure amounts for the form should be obtained from the total amounts computed on the Program Budget Cost Detail Schedule. (See Section III for explanation of expenditure categories.)

Expenditures:

1. Salaries and Wages
 2. Fringe Benefits
 3. Travel
 4. Supplies and Materials
 5. Contractual (Subcontracts/Sub-recipients)
 6. Equipment
 7. Other Expenses
 8. Total Direct Expenditures
 9. Indirect Costs
 10. Total Expenditures
- J. Source of Funds – Refers to the various funding sources that are used to support the program. Funds used to support the program should be recorded in this section according to the following categories:
11. Fees and Collections - Enter the total fees and collections estimated. The total fees and collections represent funds that the program earns through its operation and retains for operation purposes. This includes:
 - a. 1st party funds projected to be received from private payers, including patients, source users and any member of the general population receiving services,
 - b. 2nd Party funds projected to be received from organizations, private or public, who might reimburse services for a group or under a special plan.
 - c. 3rd Party funds projected to be received from private insurances, Medicaid, Medicare or other applicable titles of the Social Security Act directly related to the cost of providing patient care or other services, and
 - d. any other collections.

PROGRAM BUDGET SUMMARY FORM PREPARATION

(continued)

12. State Agreement - Enter the amount of DWIHN funding allocated for support of this program. This amount includes all state and federal funds received by the Department that are to be awarded to the Grantee through the agreement.
 13. Local - Enter the amount of Grantee funds utilized for support of this program. In-kind and donated services from other agencies/sources should not be included on this line.
 14. Federal - Enter the amount of any Federal grants received directly by the Grantee in support of this program and identify the type of grant received in the space provided.
 15. Other(s) - Enter and identify the amount of any other funding received. Other funding could consist of foundation grants, United Way grants, private donations, fund-raising, charitable contributions, etc. In-kind and donated services should not be included unless specifically requested by DWIHN.
 16. Total Funding - The total funding amount is entered on line 16. This amount is determined by adding lines 11 through 15. The total funding amount must be equal to line 10 - Total Expenditures.
- K. Total Budget Column - The Program Budget Summary is designed for use in presenting a budget for a specific program agreement funded in part by or through DWIHN or some other non-local funding source. Total Budget column represents the program budget amount. **The “K” Total Budget column must be completed while the remaining columns are not required unless additional detail is required by the Department.**

III. PROGRAM BUDGET-COST DETAIL SCHEDULE FORM P R E P A R A T I O N

Use the **Program Budget-Cost Detail Schedule** supplied by the Detroit Wayne Integrated Health Network. An example of this form is attached (**see Attachment B.2**) for reference. Use additional pages if needed.

- A. Page ___ of ___ - Enter the page number of this page and the total number of pages comprising the complete budget package.
- B. Program - Enter the title of the program.
- C. Budget Period - Enter the inclusive dates of the budget period.
- D. Date Prepared - Enter the date prepared.
- E. Grantee Name - Enter the name of the Grantee.

PROGRAM BUDGET-COST DETAIL SCHEDULE () FORM
PREPARATION (continued)

- F. Budget Agreement: Original or Amended - Check whether this is an original budget or an amended budget. If an amended budget, enter the amendment number to which the budget is attached.

Expenditure Categories:

- G. Salaries and Wages - Position Description - List all position titles or job descriptions required to staff the program. This category includes compensation paid to all permanent and part-time employees on the payroll of the Grantee and assigned directly to the program. This category does not include contractual services, professional fees or personnel hired on a private contract basis. Consulting services, professional fees or personnel hired on a private contracting basis should be included in Other Expenses. Contracts with sub-recipient organizations such as cooperating service delivery institutions or delegate agencies should be included in Contractual (Subcontracts/Sub-recipients) Expenses.
- H. Comments - Enter information to clarify the position description or the calculation of the positions salary and wages or fringe benefits, (i.e., if the employee is limited term and/or does not receive fringe benefits).
- I. Positions Required - Enter the number of positions required for the program corresponding to the specific position title or description. This entry could be expressed as a decimal (e.g., Full-time equivalent – FTE) when necessary. If other than a full-time position is budgeted, it is necessary to have a basis in terms of a time study or time reports to support time charged to the program.
- J. Total Salary - Compute and enter the total salary cost by multiplying the number of positions required by the annual salary.
- K. Salaries and Wages Total - Enter a total in the Positions Required column and the Total Salaries and Wages column. The total salaries and wages amount is transferred to the Program Budget Summary - Salaries and Wages expenditure category. If more than one page is required, attach an additional DCH 0386.
- L. Fringe Benefits – Check applicable fringe benefits for employees assigned to this program. This category includes the employer's contributions for insurance, retirement, FICA, and other similar benefits for all permanent and part-time employees. Enter composite fringe benefit rate and total amount of fringe benefit. (The composite rate is calculated by dividing the fringe benefit amount by the Salaries and Wages amount.) Tuition remissions should to be listed separately for agencies using the 10% de minimis rate.
- M. Travel - Enter cost of employee travel (mileage, lodging, registration fees). **Use only for travel costs of permanent and part-time employees assigned to the program.** This includes cost for mileage, per diem, lodging, lease vehicles, registration fees and approved seminars or conferences and other approved travel costs incurred by the employees (as listed under the Salary and Wages category) for conducting the program. **Specific detail**

should be stated in the space provided on the Cost Detail Schedule if the Travel category (line 3) exceeds 10% of the Total

**PROGRAM BUDGET-COST DETAIL SCHEDULE FORM
PREPARATION (continued)**

Expenditures (line 10). Travel of consultants is reported under Other Expenses - as part of the Consultant Services.

- N. **Supplies & Materials** - Enter cost of supplies & materials. This category is used for all consumable and short-term items and equipment items costing less than five thousand dollars (\$5,000). This includes office supplies, computers, office furniture, printers, printing, janitorial, postage, educational supplies, medical supplies, contraceptives and vaccines, tape and gauze, education films, etc., according to the requirements of each applicable program. **Specific detail should be stated in the space provided on the Cost Detail Schedule if the Supplies and Materials category (line 4) exceeds 10% of the Total Expenditures (line 10).**
- O. **Contractual (Subcontracts/Sub-recipients)** – **Specify the subcontractor(s) working on this program in the space provided under line 5.** Specific details **must** include:
- 1) subcontractor(s) and/or sub-recipient(s) name and address,
 - 2) amount for each subcontractor and/or sub-recipient,
 - 3) the total amount for all subcontractor(s) and/or sub-recipient(s).
- Multiple small subcontracts can be grouped (e.g., various worksite subcontracts). Use this category for written contracts or agreements with sub-recipient organizations such as **affiliates, cooperating institutions or delegate Grantees when compliance with federal grant requirements is delegated (passed-through) to the sub-recipient Grantee.** Contractor payments such as stipends and allowances for trainees, fee-for-service or fixed-unit rate patient care, consulting fees, etc., are to be identified in the Other Expense category.
- P. **Equipment** - Enter a description of the equipment being purchased, including number of units and the unit value, the total by type of equipment and total of all equipment. This category includes stationary and movable equipment to be used in carrying out the objectives of the program. The cost of a single unit or piece of equipment includes the necessary accessories, installation costs and any taxes. Equipment is defined to be an article of non-expendable tangible personal property having a useful life of more than one (1) year and an acquisition cost of \$5,000 or more per unit. **Equipment items costing less than five thousand dollars (\$5,000) each are to be included in the Supplies and Materials category. All equipment items summarized on this line must include: item description, quantity and budgeted amount and should be individually identified in the space provided (line 6). Upon completing equipment purchase, equipment must be tagged and listed on the Equipment Inventory Schedule (see Attachment B.3) and submitted to the agreement's contract manager.**

ATTACHMENT B

- Q. Other Expenses - This category includes other allowable cost incurred for the benefit of the program. The most significant items should be specified. Minor items may be identified by general type of cost and summarized as a single item on the Cost Detail Schedule to arrive at a total Other Expenses category. Significant groups or subcategories of costs are described as follows and should be individually identified in the space provided (line 7). **Specific detail should be stated in the space provided on the Cost Detail Schedule if the Other Expenses category (line 7) exceeds 10% of the Total Expenditures (line 10).**
1. Communication Costs - Costs of telephone, telegraph, data lines, Internet access, websites, fax, email, etc., when related directly to the operation of the program.
 2. Space/Rental Costs - Costs of building space, rental and maintenance of equipment, instruments, etc., necessary for the operation of the program. If space is publicly owned, the cost may not exceed the rental of comparable space in privately owned facilities in the same general locality. Department funds may not be used to purchase a building or land.
 3. Participant Support Costs – Cost for items such as stipends or subsistence allowance, travel allowance, registration fees paid to or on behalf of participants or trainees (but not employees) in connection with conferences, or training projects.
 4. Scholarships and Fellowships – Cost for students allowable only when the purpose of the award is to provide training to selected participants and the charge is approved by the Department.
 5. Patient Care – Cost for services rendered by members of the health professions for the benefit of a patient.
 6. Consultant or Contractor Services - These are costs for consultation services, professional fees and personnel hired on a private contracting basis related to the planning and operations of the program, or for some special aspect of the project. Travel and other costs of these consultants are to be included in this category.
 7. Other - All other items purchased exclusively for the operation of the program and not previously included, such as patient care, fee for service, auto and building insurance, automobile and building maintenance, membership dues, fees, etc.
- R. Total Direct Expenditures – Enter the sum of items 1 – 7 on line 8.

PROGRAM BUDGET-COST DETAIL SCHEDULE FORM PREPARATION

(continued)

S. Indirect Costs Calculations - **Enter the allowable indirect costs for the budget.** Enter the rate description, base amount, percentage and indirect costs. Indirect costs can be applied using one of the two methods detailed below:

- 1) If an approved indirect costs rate has been established or an actual rate has been approved by a State of Michigan department (i.e., Michigan Department of Education) or the applicable federal cognizant agency and is accepted by the Department or
- 2) If a non-Federal entity has never received a negotiated indirect cost rate, a 10% de minimis rate of modified total direct costs (MTDC) may be charged. Complete the Indirect Cost Rate: 10% De Minimis Calculation form and attach it to the budget

MTDC includes all direct salaries and wages, fringe benefits, supplies and materials, travel, services, and contractual expenses up to the first \$25,000 of each contract. MTDC excludes all equipment, capital expenditures, charges for patient care, rental costs, tuition remission, scholarships and fellowships, participant support costs, and portions each subcontractual and/or subward expenses in excess of \$25,000 per contract.

Attach a current copy of the letter stating the applicable indirect costs rate or calculation information justifying the de minimis rate calculation. **Detail on how the indirect costs was calculated must be shown on the Cost Detail Schedule ().**

GOVERNMENTAL GRANTEES: *The following are additional guidance for Governmental Grantees in accordance with Title 2 CFR Part 200 Appendix V and Appendix VII:*

- a. Governmental Grantees receiving more than \$35 million in direct Federal awards are required to have an approved indirect cost rate from a Federal Cognizant Agency. If your agency has received an approved indirect rate from a Federal Cognizant agency, attach the Federal approval letter to your MI E-Grants Grantee Profile.
- b. Governmental Grantees receiving \$35 million or less in direct Federal awards are required to prepare indirect cost rate proposals in accordance with Title 2 CFR and maintain the documentation on file subject to review.
- c. Governmental Grantees that received approved indirect cost rates from another State of Michigan Department should attach their State approval letter to their MI E-Grants Grantee Profile.
- d. Governmental Grantees with cost allocation plans should reflect these allocations in the indirect budget category.
- e. As a Sub-recipient of federal funds from DWIHN, a Governmental Grantee that has never received a negotiated indirect cost rate, may elect to charge a de minimis rate of 10% of modified total direct costs based on Title 2 CFR part 200 requirements. Complete the Indirect Cost Rate: De Minimis Calculation spreadsheet and attach it to the budget.

T. Total Expenditures – Enter the sum of items 8 and 9 on line 10.

PROGRAM BUDGET SUMMARY
DETROIT WAYNE INTEGRATED HEALTH NETWORK

| | | | | | | |
|---|--------------------|--------------------------|--|--|---------------|-------------------------|
| PROGRAM (A) Budget and Contracts | | | DATE PREPARED (B) 7/01/xx | | Page (C) 1 | Of 2 |
| GRANTEE NAME (D) Michigan Agency | | | BUDGET PERIOD (E) From: 10/01/xx To: 9/30/xx | | | |
| MAILING ADDRESS (Number and Street) (F) 123 ABC Drive | | | (G) BUDGET AGREEMENT ORIGINAL AMENDMENT ► | | | AMENDMENT # 1 |
| CITY Acme | STATE MI | ZIP CODE 44444 | FEDERAL ID NUMBER (H) 38-1234567 | | | |

| (I) EXPENDITURE CATEGORY | | | | (K) TOTAL BUDGET (Use Whole Dollars) |
|---|----------------|--|--|---|
| 1. SALARY & WAGES | 43,000 | | | 43,000 |
| 2. FRINGE BENEFITS | 11,180 | | | 11,180 |
| 3. TRAVEL | 1,400 | | | 1,400 |
| 4. SUPPLIES & MATERIALS | 37,000 | | | 37,000 |
| 5. CONTRACTUAL (Subcontracts/Subrecipients) | 3,500 | | | 3,500 |
| 6. EQUIPMENT | 5,000 | | | 5,000 |
| 7. OTHER EXPENSES | | | | |
| | 8,000 | | | 8,000 |
| EXAMPLE | | | | |
| 8. TOTAL DIRECT EXPENDITURES (Sum of Lines 1-7) | 110,090 | | | 110,090 |
| 9. INDIRECT COSTS: Rate #1 % | | | | |
| INDIRECT COSTS: Rate #2 % | | | | |
| 10. TOTAL EXPENDITURES | 110,090 | | | 110,090 |

| (J) SOURCE OF FUNDS | | | | |
|--------------------------|----------------|--|--|----------------|
| 11. FEES & COLLECTIONS | 10,000 | | | 10,000 |
| 12. STATE AGREEMENT | 90,000 | | | 90,000 |
| 13. LOCAL | 9,090 | | | 9,090 |
| 14. FEDERAL | | | | |
| 15. OTHER(S) | | | | |
| 16. TOTAL FUNDING | 110,090 | | | 110,090 |

| | |
|--|---|
| AUTHORITY: P.A. 368 of 1978 | The Department of Community employer, services and program |
| COMPLETION: Is Voluntary, but is required as a condition of funding | |

PROGRAM BUDGET – COST DETAIL SCHEDULE

DETROIT WAYNE INTEGRATED HEALTH NETWORK

View at 100% or Larger

Use **WHOLE DOLLARS ONLY**

| (B) PROGRAM | (C) BUDGET PERIOD | | (D) DATE PREPARED |
|---|---|---------------------------|-------------------|
| Budget and Contracts | From: 10/01/xx | To: 9/30/xx | 7/01/xx |
| (E) GRANTEE NAME | (F) BUDGET AGREEMENT | | AMENDMENT # |
| Michigan Agency | ORIGINAL AMENDMENT | | |
| (G) 1. SALARY & WAGES POSITION DESCRIPTION | (H) COMMENTS | (I) POSITIONS REQUIRED | (J) TOTAL SALARY |
| Nurse | 9 month position | 1 | 25,000 |
| Project Director | | .5 | 18,000 |
| | | | |
| | | | |
| (K) 1. TOTAL SALARY & WAGES: | | 1.5 | \$ 43,000 |
| (L) 2. FRINGE BENEFITS (Specify) | | | |
| FICA | LIFE INS. | DENTAL INS | COMPOSITE RATE |
| UNEMPLOY INS. | VISION INS. | WORK COMP | AMOUNT 26% |
| RETIREMENT | HEARING INS. | | |
| HOSPITAL INS. | OTHER (specify) _____ | | |
| 2. TOTAL FRINGE BENEFITS: | | | \$ 11,180 |
| (M) 3. TRAVEL (Specify if category exceeds 10% of Total Expenditures) | | | |
| Conference registration | \$350 | | |
| Airfare | \$600 | | |
| Hotel accommodations and per diem for 4 days | \$450 | | |
| 3. TOTAL TRAVEL: | | | \$ 1,400 |
| (N) 4. SUPPLIES & MATERIALS (Specify if category exceeds 10% of Total Expenditures) | | | |
| Office Supplies | 2,000 | | |
| Medical supplies | 35,000 | | |
| 4. TOTAL SUPPLIES & MATERIALS: | | | \$ 37,000 |
| (O) 5. CONTRACTUAL (Specify Subcontracts/Subrecipients) | | | |
| Subcontractor Name | Address | Amount | |
| ACME Evaluation Services | 555 Walnut, Lansing, MI 48933 | \$ 2,000 | |
| Subrecipient Name | | | |
| Health Care Partners | 333 Kalamazoo, Lansing, MI 48933 | \$ 1,500 | |
| 5. TOTAL CONTRACTUAL: | | | \$ 3,500 |
| (P) 6. EQUIPMENT (Specify items) | | | |
| Microscope | \$5,000 | | |
| 6. TOTAL EQUIPMENT: | | | \$ 5,000 |
| (Q) 7. OTHER EXPENSES (Specify if category exceeds 10% of Total Expenditures) | | | |
| Communication Costs | \$2,400 | | |
| Space Costs | \$3,600 | | |
| Consultant or Vendor: John Doe, Evaluator, 100 Main, E. Lansing | \$2,000 | | |
| 7. TOTAL OTHER: | | | \$ 8,000 |
| (R) 8. TOTAL DIRECT EXPENDITURES (Sum of Totals 1-7) | 8. TOTAL DIRECT EXPENDITURES: | | \$ 110,090 |
| (S) 9. INDIRECT COSTS CALCULATIONS | Rate #1: Base \$0 X Rate 0.0000 % Total | | \$ 0 |
| | Rate #2: Base \$0 X Rate 0.0000 % Total | | \$ 0 |
| 9. TOTAL INDIRECT EXPENDITURES: | | | \$ 0 |
| (T) 10. TOTAL EXPENDITURES (Sum of lines 8-9) | | | \$ 110,090 |
| AUTHORITY: P.A. 368 of 1978 | The Detroit Wayne Integrated Health Network is an equal opportunity | | |
| COMPLETION: Is Voluntary, but is required as a condition of funding | employer, services and programs provider. | | |

ATTACHMENT B. 3

**DETROIT WAYNE INTEGRATED HEALTH NETWORK
CONTRACT MANAGEMENT SECTION**

EQUIPMENT INVENTORY SCHEDULE

Please list equipment items that were purchased during the grant agreement period as specified in the grant agreement budget, Attachment B.2. Provide as much information about each piece as possible, including quantity, item name, item specifications: *make, model*, etc. Equipment is defined to be an article of non-expendable tangible personal property having a useful life of more than one (1) year and an acquisition cost of \$5,000 or more per unit. Please complete and forward this form to the DWIHN contract manager with the final progress report.

Grantee Name: Michigan Agency Contract #: 201xxxxx Date: 10/31/20xx

| Quantity | Item Name | Item Specification | Tag Number | Purchase Price |
|--------------|---------------------------|---|---------------|----------------|
| 1 | LW Scientific M5 Labscope | <ul style="list-style-type: none"> • Binocular • Trinocular with C-mount or eye tube • 35mm and digital camera adapters available • Diopter adjustment • Inclined 30 degrees (45 degrees available), rotates 360 degrees • 10X/20 high point eyepieces • Interpupillary distance range 50-75mm | N1038438EW109 | \$ 5,000 |
| | | | | \$ |
| | | | | \$ |
| | | | | \$ |
| | | | | \$ |
| | | | | \$ |
| | | | | \$ |
| Total | | | | \$ 5,000 |

Grantee's Signature: _

Date: _