

**PROGRAM BUDGET – COST DETAIL SCHEDULE**

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

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Use **WHOLE DOLLARS** Only

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|   |  |  |                                |               |
|---|--|--|--------------------------------|---------------|
| PROGRAM   |  | BUDGET PERIOD  |                                | DATE PREPARED |
|   |  | From:  | To:                            |               |
| CONTRACTOR NAME   |  | BUDGET AGREEMENT<br><input type="checkbox"/> ORIGINAL <input type="checkbox"/> AMENDMENT             |                                | AMENDMENT #   |
| 1. SALARY & WAGES<br>POSITION DESCRIPTION   | COMMENTS                                       | POSITIONS<br>REQUIRED  | TOTAL SALARY                   |               |
|   |  |  | \$0                            |               |
|   |  |  | \$0                            |               |
|   |  |  | \$0                            |               |
|   |  |  | \$0                            |               |
|   |  |  | \$0                            |               |
|   |  |  | \$0                            |               |
| 1. TOTAL SALARIES & WAGES:  |  | 0  | \$ 0                           |               |
| 2. FRINGE BENEFITS (Specify)  |  |  |                                |               |
| <input type="checkbox"/> FICA   | <input type="checkbox"/> LIFE INS.             | <input type="checkbox"/> DENTAL INS.   | COMPOSITE RATE                 |               |
| <input type="checkbox"/> UNEMPLOY INS.  | <input type="checkbox"/> VISION INS.           | <input type="checkbox"/> WORK COMP.  | AMOUNT 0.00%                   |               |
| <input type="checkbox"/> RETIREMENT   | <input type="checkbox"/> HEARING INS.          |  |                                |               |
| <input type="checkbox"/> HOSPITAL INS.  | <input type="checkbox"/> OTHER (specify) _____ |  | 2. TOTAL FRINGE BENEFITS:      | \$0           |
| 3. TRAVEL (Specify if category exceeds 10% of Total Expenditures)                       |  |  |                                |               |
|   |  |  | 3 TOTAL TRAVEL:                | \$0           |
| 4. SUPPLIES & MATERIALS (Specify if category exceeds 10% of Total Expenditures)         |  |  |                                |               |
|   |  |  | 4. TOTAL SUPPLIES & MATERIALS: | \$0           |
| 5. CONTRACTUAL (Specify Subcontracts/Subrecipients)                                     |  |  |                                |               |
| <u>Name</u>   | <u>Address</u>                                 | <u>Amount</u>  |                                |               |
|   |  |  | 5. TOTAL CONTRACTUAL:          | \$0           |
| 6. EQUIPMENT (Specify items)  |  |  |                                |               |
|   |  |  | 6. TOTAL EQUIPMENT:            | \$0           |
| 7. OTHER EXPENSES (Specify if category exceeds 10% of Total Expenditures)               |  |  |                                |               |
|   |  |  | 7. TOTAL OTHER:                | \$0           |
| 8. TOTAL DIRECT EXPENDITURES (Sum of Totals 1-7)  |  | 8. TOTAL DIRECT EXPENDITURES:  |                                | \$ 0          |
| 9. INDIRECT COST 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                           |               |
| 10. TOTAL EXPENDITURES (Sum of lines 8-9)   |  |  |                                | \$ 0          |
| AUTHORITY: P.A. 368 of 1978   |  | The Department of Community Health is an equal opportunity employer, services and programs provider. |                                |               |
| COMPLETION: Is Voluntary, but is required as a condition of funding                     |  |  |                                |               |
| DCH-0386 (E) (Rev 04/11) (W) Previous Edition Obsolete. Use Additional Sheets as Needed |  |  |                                |               |