

FINANCIAL STATUS REPORT

Lakeshore Regional Entity/Michigan Department of Health and Human Services

Program Budget/Department Number	SUD Treatment License Number	Page	Of
		1	1
Agency Name	Project/Program Service	Code	
Street Address	Report Period 10/1/2022 Thru <input type="checkbox"/> Final	Date Prepared	
City, State, ZIP Code	Agreement Period 10/1/2022 Thru 9/30/2023	FE ID Number	

Category	Expenditures		Agreement	
	Current Period	Agreement YTD	Budget	Balance
1. Salaries and Wages	\$ -	\$ -		\$ -
2. Fringe Benefits	\$ -	\$ -		\$ -
3. Travel	\$ -	\$ -		\$ -
4. Supplies and Materials	\$ -	\$ -		\$ -
5. Contractual (Sub-Contracts)	\$ -	\$ -		\$ -
6. Equipment	\$ -	\$ -		\$ -
7. Other Expenses	\$ -	\$ -		\$ -
8. Law Enforcement	\$ -	\$ -		\$ -
				\$ -
				\$ -
9. TOTAL DIRECT	\$ -	\$ -	\$ -	\$ -
10. Indirect Costs: Rate %	\$ -	\$ -		\$ -
11. Other Cost Distributions	\$ -	\$ -		\$ -
				\$ -
				\$ -
12. TOTAL EXPENDITURES	\$ -	\$ -	\$ -	\$ -
SOURCE OF FUNDS:				
13. LRE Grant Agreement	\$ -	\$ -	\$ -	\$ -
14. Federal	\$ -	\$ -		\$ -
15. Other:	\$ -	\$ -		\$ -
16. Local/PA2	\$ -	\$ -		\$ -
17. Fees & Collections	\$ -	\$ -		\$ -
18. TOTAL FUNDING	\$ -	\$ -	\$ -	\$ -

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	

Message:

Authority: P.A. 368 of 1978
Completion: is a condition of Reimbursement

The Department of Community Health is an equal opportunity, employer, services, and programs provider.