New Jersey Department of Health  
REPORT OF GRANT EXPENDITURES  

Reporting Agency | Grant Number | Reporting Period FROM: | TO: | Report Number  
--- | --- | --- | --- | ---  
Address | Grantee Account/Fund Number | Budget Period FROM: | TO: | Revision Report No.  
City | NJDOH Account Number(s) | Basis of Report | |  
   | | | | FINAL  
Grant Title  

BUDGET CATEGORIES  

| BUDGET CATEGORIES | APPROPRIATED BUDGET | PERIOD EXPENDITURES | CUMULATIVE EXPENDITURES |  
|--- | --- | --- | --- | ---  
| Grant Funds | Other Funds | Grant Funds | Other Funds | Grant Funds | Other Funds |  
 A. PERSONNEL COST  
   Salaries/Wages  
   Fringe Benefits  
   Total  
 B. CONSULTANT/PROFESSIONAL SERVICES COST  
   Total  
 C. OTHER COST CATEGORIES  
   Office Expense and Related Cost  
   Program Expense and Related Cost  
   Staff Training and Education Cost  
   Travel, Conferences and Meetings  
   Equipment and Other Capital Expenditures  
   Facility Cost  
   Sub-Grants  
   Total  
   Total Direct Cost  
   Indirect Cost  
   Total Cost  
   Less Program Income  
   NET TOTAL COST  
 I certify this report is true and correct and all expenditures reported herein have been made in accordance with the terms and conditions of this grant and are properly reflected in the grantee’s accounting records.  

Name of Chief Financial Officer  

Title  

Accepted By:  

Grants Management Officer  

Yes  

No  

Status of Funds:  

Cash received to date  

$  

Less:  

Cash disbursements as of  

(Date)  

$  

Cash Balance as of  

(Date)  

$  

Signature  

Date  

FS-20a  
AUG 12