**EXPENDITURE BASED BUDGET**

RFP 2019-13 PREA Employee Refresher Training

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| --- | --- |
| PROJECT NAME: |  |
| CONTRACTOR SFS PAYEE NAME: |  |

**SUMMARY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Category of Expense | A) Budget | B) Indirect Costs \* | C) Sub-Total | D) Third Party Funds | E) Total Budget  (A+B=C-D=E) |
| 1. Personal Services |  |  |  |  |  |
| a) Salary |  |  |  |  |  |
| b) Fringe |  |  |  |  |  |
| Subtotal |  |  |  |  |  |
| 2. Non Personal Services |  |  |  |  |  |
| a) Contractual Services |  |  |  |  |  |
| b) Equipment |  |  |  |  |  |
| c) Space/Property & Utilities |  |  |  |  |  |
| d) Operating Expenses |  |  |  |  |  |
| e) Other |  |  |  |  |  |
| Subtotal |  |  |  |  |  |
| Total |  |  |  |  |  |

**\*Indirect Cost Percentage is \_\_\_\_\_\_\_\_\_\_\_%**

*Indirect Costs - It is important that we know what is factored into the Indirect Cost figures. If the salary items from # 1 are included in those indirect costs, they can only be listed once. Please explain what costs are included and the calculation to arrive at the figure that was submitted. Any additional information you can provide for this section is greatly appreciated.*

**PERSONAL SERVICES DETAIL**

*In the Salary section only include staff positions related to the implementation and administration of the program. If Salary is not applicable leave this section blank. List only one position on each line.*

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Position Title | Annualized Salary Per Position | Standard Work Week | Percent of Effort | Number of Months | Funds | Indirect Costs | Third Party Funds | Total Budget |
| 1. |  |  |  |  |  |  |  |  |
| 2. |  |  |  |  |  |  |  |  |
| 3. |  |  |  |  |  |  |  |  |
| 4. |  |  |  |  |  |  |  |  |
| 5. |  |  |  |  |  |  |  |  |
| 6. |  |  |  |  |  |  |  |  |
| TOTAL | | | | |  |  |  |  |

**SALARY JUSTIFICATION AND NARRATIVE**

*1**. Name, Title, Official Workstation Location, Work Hours,*

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| --- |
|  |

*1.* *Enter Justification Below*

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|  |

*2. Name, Title, Official Workstation Location, Work Hours*

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|  |

*2. Enter Justification Below*

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|  |

*3. Name, Title, Official Workstation Location, Work Hours*

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|  |

*3. Enter Justification Below*

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|  |

*4. Name, Title, Official Workstation Location, Work Hours*

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|  |

*4. Enter Justification Below*

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|  |

*5. Name, Title, Official Workstation Location, Work Hours*

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|  |

*5. Enter Justification Below*

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|  |

*6. Type/Description of Salary, Enter Justification Below, Work Hours*

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|  |

*6. Enter Justification Below*

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***NOTE: If more positions are needed, please add them using the same format above.***

**FRINGE BENEFIT DETAIL**

*Fringe Benefits should be budgeted in line with your organization's Standard Fringe Benefit Policy and/or Negotiated Bargaining Agreements and should not Exceed the current NYS rate. Provide a brief explanation of the percentage and composition of the fringe benefit structure. If fringe is not applicable, leave this section blank.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Fringe – Type/Description | Funds | Indirect Costs | Third Party Funds | Total Budget |
| Full Time Fringe Percent \_\_\_\_% |  |  |  |  |
| Part Time Fringe Percent \_\_\_\_% |  |  |  |  |
| TOTAL |  |  |  |  |

*1. Type Description of Fringe: Full Time Fringe, Enter Justification Below:*

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*2. Type Description of Fringe: Part Time Fringe, Enter Justification Below:*

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*Fringe Benefits should be budgeted in line with your organization’s Standard Fringe Benefit Police and/or Negotiated Bargaining Agreements and should not exceed the current NYS rate. Provide a brief explanation of the percentage and composition of the budgeted fringe benefit structure. If the budgeted fringe benefits represent an exception to the current NYS rate, please explain the difference.*

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**CONTRACTUAL SERVICES**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Contractual Services/Description  NOTE: Not-for-Profit Organizations will not be reimbursed sales tax since they are exempt  NOTE: Insurances are the responsibility of the vendor and should not be included as a budgeted line item | Funds | Indirect Costs | Third Party Funds | Total Budget |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| TOTAL |  |  |  |  |

**CONTRACTUAL SERVICES JUSTIFICATION**

*Provide a justification of each description of contractual services in the budget*

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**CONTRACTUAL SERVICES NARRATIVE**

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**EQUIPMENT**

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| Equipment Type/Description  NOTE: Not-for-Profit Organizations will not be reimbursed sales tax since they are exempt | Funds | Indirect Costs | Third Party Funds | Total Budget |
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|  |  |  |  |  |
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| TOTAL |  |  |  |  |

**EQUIPMENT EXPENSES JUSTIFICATION**

*Enter justification for each equipment expense listed in the budget*

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**EQUIPMENT EXPENSES NARRATIVE**

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**SPACE/PROPERTY & UTILITIES**

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| --- | --- | --- | --- | --- |
| Space/Property & Utilities Type/Description  NOTE: Not-for-Profit Organizations will not be reimbursed sales tax since they are exempt  NOTE: Insurances are the responsibility of the vendor and should not be included as a budgeted line item | Funds | Indirect Costs | Third Party Funds | Total Budget |
| Rent/Lease Expenses |  |  |  |  |
| Electric |  |  |  |  |
| Gas |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| TOTAL |  |  |  |  |

**SPACE/PROPERTY & UTILITIES EXPENSES JUSTIFICATION**

*Enter justification for each space/property and utilities expense listed in the budget*

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**SPACE/PROPERTY & UTILITIES EXPENSES NARRATIVE**

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**OPERATING EXPENSES DETAIL**

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| --- | --- | --- | --- | --- |
| Operating Expenses Type/Description  NOTE: Not-for-Profit Organizations will not be reimbursed sales tax since they are exempt  NOTE: Insurances are the responsibility of the vendor and should not be included as a budgeted line item | Funds | Indirect Costs | Third Party Funds | Total Budget |
| Telephone (land-lines) |  |  |  |  |
| Telephone (cell phones) *must be registered to Organization – personal phones will not be reimbursed – in justification, indicate each position assigned a cell phone.* |  |  |  |  |
| Photo Copier |  |  |  |  |
| Office Supplies |  |  |  |  |
| Postage |  |  |  |  |
| Other: |  |  |  |  |
| Other: |  |  |  |  |
| Other: |  |  |  |  |
| Other: |  |  |  |  |
| TOTAL |  |  |  |  |

**OPERATING EXPENSES JUSTIFICATION**

*Enter justification for each operating expense listed in the budget*

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**OPERATING EXPENSES NARRATIVE**

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**OTHER EXPENSES DETAIL**

*If Other Expenses is not applicable, leave this section blank.*

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| --- | --- | --- | --- | --- |
| Other Expenses Type/Description  NOTE: Not-for-Profit Organizations will not be reimbursed sales tax since they are exempt.  NOTE: Insurances are the responsibility of the vendor and should not be included as a budgeted line item | Funds | Indirect Costs | Third Party Funds | Total Budget |
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|  |  |  |  |  |
| TOTAL |  |  |  |  |

**OTHER EXPENSES JUSTIFICATION**

*Enter justification for each other expense listed in the budget*

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**OTHER EXPENSES NARRATIVE**

*If applicable, please provide an explanation of any extraordinary costs or significant changes to the original contract. For example, a program may have a dollar threshold whereby the other expenses of a certain amount must be justified.*

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