QUARTERLY REQUEST FOR OPERATING REIMBURSEMENT

North Dakota Department of Transportation, Local Government
SFN 58544 (Rev. 04-2009)

☐ **SECTION 5311 RURAL**
☐ **SECTION 5316 JARC**
☐ **SECTION 5317 NEW FREEDOM**

Reimbursed at 50%

Name of Transit Project		Calendar Quarter or Other	
Mailing Address	City	State	Zip Code
Contact Person		Phone Number	

BELOW, LIST ALL COSTS/EXPENDITURES FOR YOUR PROGRAM

1. SALARIES & BENEFITS COSTS	**$ Total Cost**	**% for Rural Transit**	**$ Amount**
Project Director			
Secretary			
Bookkeeper			
Driver(s)			
Dispatcher(s)			
Fringe Benefits / Taxes			
Other (define each on an attached sheet)			
TOTAL SALARIES & BENEFITS			

2. GENERAL COSTS	**$ Total Cost**	**% for Rural Transit**	**$ Amount**
General Liability Insurance			
Other Insurance			
Office Rent			
Building Leases			
Building Maintenance			
Utilities			
Phone			
Office Supplies			
Computer / Copier Maintenance			
Marketing / Advertising			
Costs to Administer Drug & Alcohol Testing			
Driver(s) Physicals			
Personal Travel/Training **(define)**			
Other (define each on an attached sheet)			
TOTAL GENERAL COSTS			

3. VEHICLE COSTS	**$ Total Cost**	**% for Rural Transit**	**$ Amount**
Regular Maintenance			
Vehicle Insurance			
Vehicle Registration Fees			
Repairs			
Fuel			
Other (define each on an attached sheet)			
TOTAL VEHICLE COSTS			

4. CAPITAL COSTS @ 50% Capital **not** reimbursed under other federal program dollars such as Sections 5309 / 5310
Define capital and attach invoice(s)

	$ Total Cost	% for Rural Transit	$ Amount
TOTAL CAPITAL COSTS			

5. SUMMARY TOTAL (total blocks 1, 2, 3 & 4)	$ Total Cost	$ Amount
-Minus Fare Income Collected		**$**
NET COST		**$**

6. SECTION 5311 Reimbursement @ 50% **$**

TOTAL SECTION 5311 OPERATING FUNDS GRANTED THIS YEA	$
OPERATING FUNDS REMAINING AFTER THIS CLAIM	$

7. LOCAL REVENUE (for reporting purposes only)
List ALL sources of revenue and the entire amount. Do **Not** Just List Your Match Amount!

Contract Revenue	$	State Aid	$
Mill Levy	$	Fundraising	$
Other (specify)	$	Medicaid Rides	$
Other Federal Programs	$	**TOTAL LOCAL REVENUE**	**$**

8. DATA REPORT	Sponsored Rides	Unsponsored Rides	Total
A. Ridership (one-way trips)	Elderly & Disabled	General Public	Total
B. Vehicle Miles/Vehicle Hours		Total Miles	*Total Vehicle Hours

C. Safety (attach incident form for each occurrence listed below)

Fatalities
Major Incidents
Major Injuries

D. List any expenditures made with Disadvantaged Business Enterprises (DBE)

DBE Company & Address	Item or Service Purchased	$ Amount	Date of Purchase

Form Completed by (signature)	Title	Date

Please note, all transportation costs / expenditures shown above must be documented in your records and are subject to periodic audit. Records pertaining to vehicles must be maintained for the period of federal interest plus 3 years.

Send this form to: LOCAL GOVERNMENT DIVISION/TRANSIT SECTION
ND DEPARTMENT OF TRANSPORTATION
608 E BOULEVARD AVE
BISMARCK ND 58505-0700

* See new requirements for vehicle hours - time of pull out to go into revenue service, to the time pulling in from revenue service.