



**DIVISION OF BLIND SERVICES**  
 Florida Department of Education | [dbs.fldoe.org](http://dbs.fldoe.org)

Note: use the Tab key to navigate this form.

**FACILITY VENDOR'S  
 MONTHLY BUSINESS REPORT**

**PART I**

<b>1. Facility Number (3 digit number)</b>	<b>2. Report Month -Year</b>	<b>3. Date</b>
<b>4. Printed Vendor's Name</b>	<b>5. Business Name</b>	
<b>6. Federal Employer ID Number</b>	<b>7. Vendor's Address</b>	
I declare that I have examined this report, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct and complete.	<b>8. Vendor's Signature</b> _____	
<b>9. Printed Preparer's Name</b>	<b>10. Preparer's Signature</b> _____	

**THIS REPORT IS TO BE RECEIVED NO LATER THAN  
 THE LAST CALENDAR DAY OF THE FOLLOWING MONTH.  
 Copies are acceptable but must have original signature.**

**Mail To:** Department of Education  
 Division of Blind Services  
 Bureau of Business Enterprise  
 Turlington Bldg., Suite 1114  
 325 West Gaines Street  
 Tallahassee, FL 32399-0400

## Part II

### Computation of Net Income for Set Aside Levy

1. Vending Drink Sales (less sales tax)		
2. Vending Snack Sales (less sales tax)		
3. Over the Counter Sales (less sales tax)		
<b>4. Total Sales</b> (Line 1 + 2 + 3)	\$ -	\$ -
5. Sales Tax Collected		
6. Cost of Goods Sold:		
a. Beginning Merchandise Inventory Value		
b. Purchase of Merchandise		
c. Ending Merchandise Inventory Value		
<b>7. TOTAL COST OF GOODS SOLD</b> (Line 6a + 6b - 6c)	-	-
<b>8. GROSS PROFIT FROM SALES</b> (Line 4 minus 7)	-	-
9. Employee Gross wages (do not include vendor)		
10. Employee Payroll Taxes (employer's half only)		
<b>11. TOTAL LABOR COST</b> (Line 9 + 10)	-	-
12. Approved Business Expenses:		
a. General Liability Insurance		
b. Workers Compensation Insurance		
c. Commercial Vehicle Insurance		
d. Business Licenses (Federal, State, County, Muni.)		
e. Commission/Rent Paid to the Facility		
f. Utility Fees		
g. Equipment Fees		
h. Storage Space Rental		
i. Pest Control		
j. Other Approved Business Expenses		

<b>13. TOTAL BUSINESS EXPENSES</b> (add 12a through 12j)	-	-
<b>14. NET PROFIT FROM FACILITY</b> (Line 8 minus 11 & 13)	-	-
15. Total of Full Service Vending or Other Income		
<b>16. NET PROFIT</b> (Line 14 +15)	\$ -	\$ -
<b>17. SET-ASIDE LEVY</b> (Line 16 x current set-aside %)	\$ -	\$ -

\* **NOTE:** If Line 16 is greater than \$0, please prepare a business check, cashier's check, or money order for that amount made payable to the **DIVISION OF BLIND SERVICES**. The check must be attached to the monthly report.