

**COUNTY INDIGENT HEALTH CARE PROGRAM
MONTHLY FINANCIAL REPORT**

County Name **TOM GREEN**

Report for Month/Year **03/2009**

OR

Amendment of the Report for Month/Year _____

I. REIMBURSABLE EXPENDITURES during This Report Month

Physician Services	1.	\$22,447.49	
Prescription Drugs	2.	\$14,196.70	
Hospital, Inpatient Services	3.	\$114,901.20	
Hospital, Outpatient Services	4.	\$19,610.71	
Laboratory/X-Ray Services	5.	\$3,942.19	
Skilled Nursing Facility Services	6.	\$0.00	
Family Planning Services	7.	\$0.00	
Rural Health Clinic Services	8.	\$0.00	
State Hospital Contracts	9.	\$0.00	
Optional Health Care Services	10.	\$11,041.92	
Total Expenditures (Add #1 through #10)	11.	\$186,140.21	
Reimbursements Received (Do not include State Assistance.)	12.	(\$791.12)	
6% Eligibility System Review Findings (\$ in error)	13.	(\$0.00)	
Total to be deducted (Add #12 + #13)	14.	(\$791.12)	
Applied to State Assistance Eligibility/Reimbursement (#11 minus #14)	15.	\$185,349.09	

II. EXPENDITURE TRACKING for State Assistance Funds Eligibility/Reimbursement

TOTAL EXPENDITURE TRACKING for Current State Fiscal Year (9/1-8/31) \$ 803,627.83

GRTL \$ 25,489,726.00

6% of GRTL \$ 1,529,383.56

8% of GRTL \$ 2,039,178.08



04/03/2009

Signature of person Submitting Form 105

Date