

FORM 105

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

County Name **TOM GREEN**Report for Month/Year **03/2011**

or

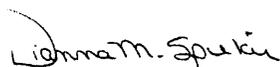
Amendment of the Report for Month/Year _____

I. REIMBURSABLE EXPENDITURES during This Report Month

Physician Services	1.	\$6,455.41		
Prescription Drugs	2.	\$0.00		
Hospital, Inpatient Services	3.	\$3,068.18		
Hospital, Outpatient Services	4.	\$1,219.54		
Laboratory/X-Ray Services	5.	\$798.29		
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.	\$5,369.66		
Total Expenditures (Add #1 through #10)			11.	\$16,911.08
Reimbursements Received (Do not include State Assistance.)	12.	(\$1,407.78)		
6% Eligibility System Review Findings (\$ in error)	13.	(\$0.00)		
Total to be deducted (Add #12 + #13)			14.	(\$1,407.78)
Applied to State Assistance Eligibility/Reimbursement (#11 minus #14)			15.	\$15,503.30

II. EXPENDITURE TRACKING for State Assistance Funds Eligibility/Reimbursement

TOTAL EXPENDITURE TRACKING for Current State Fiscal Year (9/1-8/31)	\$ 128,013.86
GRTL \$ 26,076,193.00	
6% of GRTL	\$ 1,564,571.58
8% of GRTL	\$ 2,086,095.44



04/04/2011

Signature of person Submitting Form 105

Date

 CIHCP 05-5
 September 2005