

FORM 105

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

County Name **TOM GREEN**Report for Month/Year **04/2011**

or

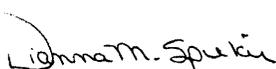
Amendment of the Report for Month/Year \_\_\_\_\_

**I. REIMBURSABLE EXPENDITURES during This Report Month**

Physician Services	1.	\$10,442.57		
Prescription Drugs	2.	\$0.00		
Hospital, Inpatient Services	3.	\$14,042.36		
Hospital, Outpatient Services	4.	\$0.00		
Laboratory/X-Ray Services	5.	\$273.81		
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.	\$13,935.96		
<b>Total Expenditures</b> (Add #1 through #10)			11.	<b>\$38,694.70</b>
<b>Reimbursements Received</b> (Do not include State Assistance.)	12.	<b>(\$252.00)</b>		
<b>6% Eligibility System Review Findings</b> (\$ in error)	13.	<b>(\$0.00)</b>		
<b>Total to be deducted</b> (Add #12 + #13)			14.	<b>(\$252.00)</b>
<b>Applied to State Assistance Eligibility/Reimbursement</b> (#11 minus #14)			15.	<b>\$38,442.70</b>

**II. EXPENDITURE TRACKING for State Assistance Funds Eligibility/Reimbursement**

<b>TOTAL EXPENDITURE TRACKING for Current State Fiscal Year (9/1-8/31)</b>	<b>\$ 166,456.56</b>
<b>GRTL \$ 26,076,193.00</b>	
<b>6% of GRTL</b>	<b>\$ 1,564,571.58</b>
<b>8% of GRTL</b>	<b>\$ 2,086,095.44</b>



05/05/2011

Signature of person Submitting Form 105

Date

 CIHCP 05-5  
 September 2005

