

FORM 105

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

County Name **TOM GREEN**

Report for Month/Year **05/2011**

or

Amendment of the Report for Month/Year _____

I. REIMBURSABLE EXPENDITURES during This Report Month

Physician Services	1.	\$9,477.92		
Prescription Drugs	2.	\$0.00		
Hospital, Inpatient Services	3.	\$45,274.71		
Hospital, Outpatient Services	4.	\$0.00		
Laboratory/X-Ray Services	5.	\$522.23		
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.	\$10,609.40		
Total Expenditures (Add #1 through #10)			11.	\$65,884.26
Reimbursements Received (Do not include State Assistance.)	12.	(\$50.00)		
6% Eligibility System Review Findings (\$ in error)	13.	(\$0.00)		
Total to be deducted (Add #12 + #13)			14.	(\$50.00)
Applied to State Assistance Eligibility/Reimbursement (#11 minus #14)			15.	\$65,834.26

II. EXPENDITURE TRACKING for State Assistance Funds Eligibility/Reimbursement

TOTAL EXPENDITURE TRACKING for Current State Fiscal Year (9/1-8/31)	\$ 232,290.82
GRTL	\$ 26,076,193.00
6% of GRTL	\$ 1,564,571.58
8% of GRTL	\$ 2,086,095.44

Lionna M. Spuki

06/01/2011

Signature of person Submitting Form 105

Date

CIHCP 05-5
September 2005