

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

County Name **TOM GREEN**

Report for Month/Year 08/2011

Amendment of the Report for Month/Year _____
or _____

I. REIMBURSABLE EXPENDITURES during This Report Month

Physician Services	1.	\$4,040.70	
Prescription Drugs	2.	\$0.00	
Hospital, Inpatient Services	3.	\$0.00	
Hospital, Outpatient Services	4.	\$379.51	
Laboratory/X-Ray Services	5.	\$10,774.76	
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.	\$14,028.48	
Total Expenditures (Add #1 through #10)	11.	\$29,223.45	
Reimbursements Received (Do not include State Assistance.)	12.	(\$19,907.81)	
6% Eligibility System Review Findings (\$ in error)	13.	(\$0.00)	
Total to be deducted (Add #12 + #13)	14.	(\$19,907.81)	
Applied to State Assistance Eligibility/Reimbursement (#11 minus #14)	15.	\$9,315.64	

II. EXPENDITURE TRACKING for State Assistance Funds Eligibility/Reimbursement

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

09/01/2011

Ligman Spaker

Signature of person Submitting Form 105

Date

