

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

County Name _____ Report for (Month/Year) _____
 or
 Amendment of the Report for (Month/Year) _____

I. REIMBURSABLE EXPENDITURES during This Report Month

Physician Services	1.	
Prescription Drugs	2.	
Hospital, Inpatient Services	3.	
Hospital, Outpatient Services	4.	
Laboratory/X-Ray Services	5.	
Skilled Nursing Facility Services	6.	
Family Planning Services	7.	
Rural Health Clinic Services	8.	
State Hospital Contracts	9.	
Optional Health Care Services	10.	
Amount of Intergovernmental Transfer	11.	
Total Expenditures (Add #1 through #11.)		12.
Reimbursements Received (Do not include State Assistance.)	13. ()	
6% Eligibility System Review Findings (\$ in error)	14. ()	
Total to be Deducted (Add #13 + #14.)		15. ()
Applied to State Assistance Eligibility/Reimbursement (#12 minus #15)		16.

II. EXPENDITURE TRACKING for State Assistance Funds Eligibility/Reimbursement

TOTAL EXPENDITURES for Current State Fiscal Year (9/1 – 8/31) \$ _____
GRTL \$ _____
4% of GRTL \$ _____
6% of GRTL \$ _____
8% of GRTL \$ _____

----- Signature of Person Submitting Form 105 ----- Date -----