

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

 County Name TOM GREEN

 Report for (Month/Year) 10/2013

or

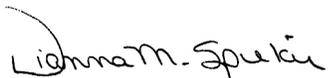
Amendment of the Report for (Month/Year)

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

Physician Services	1.	\$7,733.25	
Prescription Drugs	2.	\$0.00	
Hospital, Inpatient Services	3.	\$0.00	
Hospital, Outpatient Services	4.	\$47.83	
Laboratory/X-Ray Services	5.	\$16,848.07	
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.	\$16,481.55	
<b>Total Expenditures</b> (Add #1 through #10.)			<b>11.</b> \$41,110.70
<b>Reimbursements Received</b> (Do not include State Assistance.)	<b>12.</b>	( \$0.00 )	
<b>6% Eligibility System Review Findings</b> (\$ in error)	<b>13.</b>	( \$0.00 )	
<b>Total to be Deducted</b> (Add #12 + #13.)			<b>14.</b> ( \$0.00 )
<b>Applied to State Assistance Eligibility/Reimbursement</b> (#11 minus #14)			<b>15.</b> \$41,110.70

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

<b>TOTAL EXPENDITURES for Current State Fiscal Year (9/1 - 8/31) \$</b>	<u>58,118.96</u>
<b>GRTL \$</b> <u>2,493,543.44</u>	
<b>6% of GRTL \$</b>	<u>149,612.61</u>
<b>8% of GRTL \$</b>	<u>199,483.48</u>



Signature of Person Submitting Form 105

11/01/2013

Date