

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

 County Name TOM GREEN

Report for (Month/Year)

01/2016

or

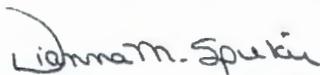
Amendment of the Report for (Month/Year)

I. REIMBURSABLE EXPENDITURES during This Report Month

Physician Services	1.	\$395.81	
Prescription Drugs	2.	\$0.00	
Hospital, Inpatient Services	3.	\$0.00	
Hospital, Outpatient Services	4.	\$0.00	
Laboratory/X-Ray Services	5.	\$0.00	
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.	\$4,272.32	
Amount of Intergovernmental Transfer	11.	\$0.00	
Total Expenditures (Add #1 through #11.)			12. \$4,668.13
Reimbursements Received (Do not include State Assistance.)	13. (\$0.00)	
6% Eligibility System Review Findings (\$ in error)	14. (\$0.00)	
Total to be Deducted (Add #13 + #14.)			15. (\$0.00)
Applied to State Assistance Eligibility/Reimbursement (#12 minus #15)			16. \$4,668.13

II. EXPENDITURE TRACKING for State Assistance Funds Eligibility/Reimbursement

TOTAL EXPENDITURES for Current State Fiscal Year (9/1 - 8/31) \$	<u>81,942.37</u>
GRTL \$ <u>37,602,713.00</u>	
4% of GRTL \$	<u>1,504,108.52</u>
6% of GRTL \$	<u>2,256,162.78</u>
8% of GRTL \$	<u>3,008,217.04</u>



Signature of Person Submitting Form 105

02/09/2016

Date