

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

 County Name TOM GREEN

 Report for (Month/Year) 04/2016

or

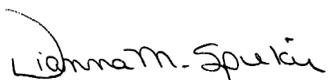
Amendment of the Report for (Month/Year)

I. REIMBURSABLE EXPENDITURES during This Report Month

Physician Services	1.	\$46.73	
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.	\$5,529.39	
Amount of Intergovernmental Transfer	11.	\$0.00	
Total Expenditures (Add #1 through #11.)			12. \$5,576.12
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. \$5,576.12

II. EXPENDITURE TRACKING for State Assistance Funds Eligibility/Reimbursement

TOTAL EXPENDITURES for Current State Fiscal Year (9/1 - 8/31) \$		<u>112,371.16</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

05/09/2016

Date