

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

County Name **ARANSAS**

Report for Month/Year **04/2011**

OR

Amendment of the Report for Month/Year _____

I. REIMBURSABLE EXPENDITURES during This Report Month

Physician Services	1.	\$13,140.10		
Prescription Drugs	2.	\$13,752.59		
Hospital, Inpatient Services	3.	\$13,046.79		
Hospital, Outpatient Services	4.	\$16,215.49		
Laboratory/X-Ray Services	5.	\$8,365.52		
Skilled Nursing Facility Services	6.	\$0.00		
Family Planning Services	7.	\$0.00		
Rural Health Clinic Services	8.	\$1,590.85		
State Hospital Contracts	9.	\$0.00		
Optional Health Care Services	10.	\$5,935.35		
Total Expenditures (Add #1 through #10)			11.	\$72,046.69
Reimbursements Received (Do not include State Assistance.)	12.	(\$4,535.98)		
6% Eligibility System Review Findings (\$ in error)	13.	(\$0.00)		
Total to be deducted (Add #12 + #13)			14.	(\$4,535.98)
Applied to State Assistance Eligibility/Reimbursement (#11 minus #14)			15.	\$67,510.71

II. EXPENDITURE TRACKING for State Assistance Funds Eligibility/Reimbursement

TOTAL EXPENDITURE TRACKING for Current State Fiscal Year (9/1-8/31)	\$ 324,838.35
GRTL	\$ 8,935,648.00
	6% of GRTL \$ 536,138.88
	8% of GRTL \$ 714,851.84

04/29/2011

Signature of person Submitting Form 105

Date