

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

County Name **ARANSAS**

Report for Month/Year **08/2011**

or

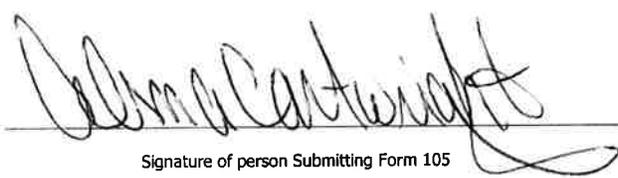
Amendment of the Report for Month/Year _____

I. REIMBURSABLE EXPENDITURES during This Report Month

Physician Services	1.	\$8,426.74		
Prescription Drugs	2.	\$9,296.73		
Hospital, Inpatient Services	3.	\$20,993.59		
Hospital, Outpatient Services	4.	\$7,443.93		
Laboratory/X-Ray Services	5.	\$6,424.95		
Skilled Nursing Facility Services	6.	\$0.00		
Family Planning Services	7.	\$0.00		
Rural Health Clinic Services	8.	\$1,595.85		
State Hospital Contracts	9.	\$0.00		
Optional Health Care Services	10.	\$4,636.02		
Total Expenditures (Add #1 through #10)			11.	\$58,817.81
Reimbursements Received (Do not include State Assistance.)	12.	(\$9,239.99)		
6% Eligibility System Review Findings (\$ in error)	13.	(\$0.00)		
Total to be deducted (Add #12 + #13)			14.	(\$9,239.99)
Applied to State Assistance Eligibility/Reimbursement (#11 minus #14)			15.	\$49,577.82

II. EXPENDITURE TRACKING for State Assistance Funds Eligibility/Reimbursement

TOTAL EXPENDITURE TRACKING for Current State Fiscal Year (9/1-8/31)		\$ 533,811.09
GRTL	\$ 8,935,648.00	
	6% of GRTL	\$ 536,138.88
	8% of GRTL	\$ 714,851.84



Signature of person Submitting Form 105

09/01/2011

Date