

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

County Name **ARANSAS**

Report for Month/Year **09/2011**

or

Amendment of the Report for Month/Year \_\_\_\_\_

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

Physician Services	1.	\$0.00		
Prescription Drugs	2.	\$10,312.92		
Hospital, Inpatient Services	3.	\$0.00		
Hospital, Outpatient Services	4.	\$0.00		
Laboratory/X-Ray Services	5.	\$59.76		
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.	\$0.00		
<b>Total Expenditures</b> (Add #1 through #10)			11.	\$10,372.68
<b>Reimbursements Received</b> (Do not include State Assistance.)	12.	(\$16,673.49)		
<b>6% Eligibility System Review Findings</b> (\$ in error)	13.	(\$0.00)		
<b>Total to be deducted</b> (Add #12 + #13)			14.	(\$16,673.49)
<b>Applied to State Assistance Eligibility/Reimbursement</b> (#11 minus #14)			15.	\$-6,300.81

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

**TOTAL EXPENDITURE TRACKING for Current State Fiscal Year (9/1-8/31)    \$ -6,300.81**

**GRTL                    \$ 7,649,419.00**

**6% of GRTL    \$ 458,965.14**

**8% of GRTL    \$ 611,953.52**



Signature of person Submitting Form 105

10/06/2011

Date