03-10		Form C	CMS 222-92		299	0 (Cont.)
This report is requ	ired by law (42 USC. 1395g: CFR 413.2	0(b)). Failure to report can r	esult		FORM APPROVED	
in all payments ma	ade during the reporting period being dee	emed overpayments (42 USC	1395g).		OMB NO: 0938-0107	
INDEPENDENT I	RURAL HEALTH CLINIC/FREESTAN	DING	PROVIDER NO:	PERIOD:	WORKSHEET	
FEDERALLY QU	ALIFIED HEALTH CENTER WORKS	HEET		FROM:	S	
STATISTICAL D	ATA AND CERTIFICATION STATEM	ENT		TO:	PART I	
Intermediary Use	Only:					
[Date Received		[] Initial	[] Re-opened	
[] Desk Reviewed	Intermediary No.		[] Final		
PART I - STATIS	TICAL DATA	[] Projected Cost R		[] Actual/Final Cost	Report	
Check		[] Electronic filed cos		Date:		
applicable box		[] Manually submittee	l cost report	Time:		
1 Name:						1
1.01 Street:				P.O. Box:		1.01
1.02 City:						1.02
1.03 County:						1.03
2 Provider						2
3 Designat						3
4 Reporting	g Period: From	То				4
				1		
	Type of Control		Type of Provider			
	(see instructions)		(see instructions)	Dai	te Certified	
1	2		3		4	
5						5
			1 -		İ	1
	Source of Federal Funds			Award Number		
	(see instructions)		(see	instructions)	Date	
1	2			3	4	-
6						6
		YY 1.1 YE 11. YY 1 A				
	f Physicians Furnishing Services At The					7
(As Desc	ribed in Instructions) and Medicare Billi	ng Numbers (Include all Par	t B Billing Numbers)		Dilli M. I	
	Name				Billing Number	
	1				2	= 0.1
7.01						7.01
7.02						7.02
7.03						7.03
7.04						7.04
7.05						7.05
0	Cupowigor Di					0
8	Supervisory Physicians			**	-f.C	8
	N				of Supervision	
	Name			For Re	porting Period	
0.01	1				2	0.01
8.01						8.01
8.02						8.02
8.03						8.03
8.04						8.04

FORM CMS-222-92 (1-2005) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 2903 and 2903.1)

8.05

8.05

INDEPENDENT RURAL HEALTH CLINIC/ PROVIDER NO: PERIOD: WORKSHEET S FEDERALLY QUALIFIED HEALTH CENTER WORKSHEET From: PART I (Cont.) & STATISTICAL DATA AND CERTIFICATION STATEMENT To: PART I (CONTINUED)-STATISTICAL DATA 9 Does the facility operate as other than a RHC or FQHC? Enter "Y" for yes or "N" for no. 9 1011 Identify days and hours by listing the time the facility operates as a RHC or FQHC next to the applicable day 10 11.01 Sunday 10.01 11.02 11.02 Monday 11.03 11.03 11.03 Tuesday 11.03 11.03 11.04 Wednesday 11.05 11.06 11.05 Thursday 11.06 11.06 11.06 Friday 11.05 11.02 11.06 Friday 11.02 11.02 11.06 Friday 11.06 11.02 11.04 Wednesday 11.01 11.06 11.05 Sturday 11.07 11.02 11.06 Friday 11.01 11.02 11.06 Friday 11.02 11.05 11.06 Fri	2990	(Cont.) For	rm CMS 222-92			03-10
STATISTICAL DATA AND CERTIFICATION STATEMENT To: PART II PART II (CONTINUED)-STATISTICAL DATA 9 9 9 Does the facility operate as other than a RHC or FQHC? Enter "Y" for yes or "N" for no. 9 9 10 If yes, specify what type of operation. (i.e., physicians office, independent laboratory, etc.) 10 10 11 Identify days and hours by listing the time the facility operates as a RHC or FQHC next to the applicable day 11 Days Hours of Operation 11.01 11.02 Monday 11.02 11.02 11.03 Tuesday 11.02 11.02 11.04 Wednesday 11.03 11.03 11.05 Thursday 11.04 11.05 11.06 Friday 11.06 11.06 11.07 Saturday 11.02 11.04 12.01 Sunday 11.04 11.07 12.02 Monday 11.04 11.07 12.03 Tuesday 12.01 12.02 12.04 Wednesday 12.03 12.03 12.03 Tuesday 12.04 12.03 12.04 Wednesday	INDEPE	NDENT RURAL HEALTH CLINIC/	PROVIDER NO:	PERIOD:	WORKSHEI	ET S
PART I (CONTINUED)-STATISTICAL DATA 9 9 Does the facility operate as other than a RHC or FQHC? Enter "Y" for yes or "N" for no. 9 10 [f yes, specify what type of operation. (i.e., physicians office, independent laboratory, etc.) 10 11 Identify days and hours by listing the time the facility operates as a RHC or FQHC next to the applicable day 11 Days Hours of Operation 11.01 Sunday 11.01 11.02 Monday 11.03 11.03 Tuesday 11.03 11.04 Wednesday 11.04 11.05 Thursday 11.05 11.06 Friday 11.06 11.06 Friday 11.06 11.05 Saturday 11.05 11.06 Friday 11.06 11.07 Saturday 11.06 11.08 Unday 11.06 11.09 Saturday 11.07 12 Identify days and hours by listing the time the facility operates as other than a RHC or FQHC next to the applicable day. 12.01 12.01 Sunday 12.01 12.02 Monday 12.02 12.03 Tuesday </td <td>FEDERA</td> <td>ALLY QUALIFIED HEALTH CENTER WORKSHEET</td> <td></td> <td>From:</td> <td>PART I (Con</td> <td>t.) &</td>	FEDERA	ALLY QUALIFIED HEALTH CENTER WORKSHEET		From:	PART I (Con	t.) &
9 Does the facility operate as other than a RHC or FQHC? Enter "Y" for yes or "N" for no. 9 10 If yes, specify what type of operation. (i.e., physicians office, independent laboratory, etc.) 10 11 Identify days and hours by listing the time the facility operates as a RHC or FQHC next to the applicable day 11 Days Hours of Operation 11.01 11.01 Sunday 11.02 11.02 Monday 11.03 11.03 Tuesday 11.03 11.04 Wednesday 11.03 11.05 Thursday 11.04 11.06 Friday 11.05 11.07 Saturday 11.07 11.02 Monday 11.07 11.03 Tuesday 11.03 11.04 Wednesday 11.04 11.05 Thursday 11.05 11.06 Friday 11.07 12 Identify days and hours by listing the time the facility operates as other than a RHC or FQHC next to the applicable day. 12.01 12.01 Sunday 12.01 12.02 12.02 Monday 12.01 12.03 Tuesday 12.02 12.04 Wednesday 12.03 12.05 Thursday 12.05 12.06 <td>STATIS</td> <td>FICAL DATA AND CERTIFICATION STATEMENT</td> <td></td> <td>To:</td> <td>PART II</td> <td></td>	STATIS	FICAL DATA AND CERTIFICATION STATEMENT		To:	PART II	
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11.05Thursday11.0511.06Friday11.0611.07Saturday11.0712Identify days and hours by listing the time the facility operates as other than a RHC or FQHC next to the applicable day.12DaysHours of Operation12.01Sunday12.0112.02Monday12.0212.03Tuesday12.0312.04Wednesday12.0412.05Thursday12.0512.06Friday12.0612.07Saturday12.0713If this is a low or no Medicare Utilization cost report, enter "L" for low or "N" for No Medicare Utilization.1314Is this facility filing a consolidated cost report under CMS Pub. 100-4, chapter 9, section14	11.03	Tuesday				11.03
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From To 12.01 Sunday 12.01 12.02 Monday 12.02 12.03 Tuesday 12.03 12.04 Wednesday 12.04 12.05 Thursday 12.05 12.06 Friday 12.06 12.07 Saturday 12.07 13 If this is a low or no Medicare Utilization cost report, enter "L" for low or "N" for No Medicare Utilization. 13 14 Is this facility filing a consolidated cost report under CMS Pub. 100-4, chapter 9, section 14	12	Identify days and hours by listing the time the facility operates as other th	an a RHC or FQHC next to th	e applicable day.		12
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12.04Wednesday12.0412.05Thursday12.0512.06Friday12.0612.07Saturday12.0713If this is a low or no Medicare Utilization cost report, enter "L" for low or "N" for No Medicare Utilization.1314Is this facility filing a consolidated cost report under CMS Pub. 100-4, chapter 9, section14	12.02	Monday				12.02
12.05Thursday12.0512.06Friday12.0612.07Saturday12.0713If this is a low or no Medicare Utilization cost report, enter "L" for low or "N" for No Medicare Utilization.1314Is this facility filing a consolidated cost report under CMS Pub. 100-4, chapter 9, section14	12.03	Tuesday				12.03
12.06Friday12.0612.07Saturday12.0713 If this is a low or no Medicare Utilization cost report, enter "L" for low or "N" for No Medicare Utilization.1314 Is this facility filing a consolidated cost report under CMS Pub. 100-4, chapter 9, section14	12.04	Wednesday				12.04
12.07Saturday12.0713 If this is a low or no Medicare Utilization cost report, enter "L" for low or "N" for No Medicare Utilization.1314 Is this facility filing a consolidated cost report under CMS Pub. 100-4, chapter 9, section14	12.05	Thursday				12.05
13 If this is a low or no Medicare Utilization cost report, enter "L" for low or "N" for No Medicare Utilization. 13 14 Is this facility filing a consolidated cost report under CMS Pub. 100-4, chapter 9, section 14	-	Friday				
14 Is this facility filing a consolidated cost report under CMS Pub. 100-4, chapter 9, section 14	12.07	Saturday				12.07
5 0 1		*		ion.		13
	14	5 0 1	apter 9, section			14
30.8? Enter "Y" for yes or "N" for no. If yes, see instructions.		30.8? Enter "Y" for yes or "N" for no. If yes, see instructions.				

PART II - CERTIFICATION BY OFFICER OR ADMINISTRATOR

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR

and ending ______ and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the Provider in accordance with the laws and regulations regarding the Provider in accordance with the laws and regulations regarding the provision of health care services and that the services identified in this cost report were provided in compliance with such laws and regulations.

 (Signed)

 Officer or Administrator of Facility
 Title

 Date

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0107. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Centers for Medicare & Medicaid Services, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

FORM CMS-222-92 (3-2010) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 2903 and 2903.2)

01-05		Form CMS 222-92		299	0 (Cont.
INDEPEN	IDENT RURAL HEALTH CLINIC/FREESTANDING	PROVIDER NO.:	PERIOD:	WORKSHEET	
FEDERAL	LLY QUALIFIED HEALTH CENTER WORKSHEET		FROM:	S	
STATISTI	ICAL DATA AND CERTIFICATION STATEMENT	CLINIC NO.:	TO:	PART III	
			1		
	- STATISTICAL DATA FOR CLINICS FILING UNDER CON	NSOLIDATED COST REPORTIN	NG		
1 Na 2 Str			P.O. Box:		1
2 Su 3 Cit			Zip Code:		
	ounty:		Zip Gode.		
	ovider Number:				
	esignation:	Date Certified:			(
	0				
	ames of Physicians Furnishing Services At The Health Facility As Described in Instructions) and Medicare Billing Numbers (Ir	-			
(Name			Billing Number	
	1			2	
7.01					7.0
7.02					7.02
7.03					7.03
7.04					7.04
7.05					7.05
8	Supervisory Physicians				8
	× • • •		Hou	irs of Supervision	
	Name		For	Reporting Period	
	1			2	
8.01					8.01
8.02					8.02
8.03					8.03
8.04					8.04
8.05					8.05
9 Do	oes the facility operate as other than a RHC or FQHC? Enter "Y	Y" for yes or "N" for no.			
10 If y	yes, specify what type of operation. (i.e., physicians office, ind	ependent laboratory, etc.)			1
11 Ide	entify days and hours by listing the time the facility operates as	a RHC or FQHC next to the appl	icable day		1
	Days		Но	urs of Operation	
			From	То	_
11.01	Sunday				11.0
11.02	Monday				11.0
11.03	Tuesday				11.0
11.04	Wednesday				11.0
11.05 11.06	Thursday Friday				11.0
11.00	Saturday				11.0
	entify days and hours by listing the time the facility operates as	s other than a RHC or FOHC next	to the applicable day.	1	11.0
	Days			urs of Operation	
	- 5 -		From	То	-
12.01	Sunday				12.0
12.02	Monday				12.0
12.03	Tuesday				12.0
12.04	Wednesday				12.0
12.05	Thursday				12.0
12.06	Friday				12.0
12.07	Saturday				12.0

FORM CMS-222-92 (1-2005) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 2903.2)

RECLASSIFIC			Form CMS 222-9	92				2990	(Cont.)
BALANCE OF	CATION AND ADJUSTMENT OF TRIAL TEXPENSES		Facility No.		Reporting Perio From To	d	WORKSHEET A Page 1		
	COST CENTER		Other	Total (Col. 1 + 2)	Reclassi- fications	Reclassified Trial Balance (Col. 3 +/- 4)	Adjustments Increases (Decreases)	Net Expenses (Col. 5 +/- 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
	Physician								1
	Physician Assistant								2
	Nurse Practitioner								3
	Visiting Nurse								4
	Other Nurse								5
6 0600	Clinical Psychologist								6
	Clinical Social Worker								7
8 0800	Laboratory Technician								8
9 0900	Other (Specify)								9
10 1000									10
11 1100									11
12 5	Subtotal-Facility Health Care Staff Costs								12
(COSTS UNDER AGREEMENT								
13 1300	Physician Services Under Agreement								13
14 1400	Physician Supervision Under Agreement								14
15 1500									15
16 5	Subtotal Under Agreement (Lines 13-15)								16
	OTHER HEALTH CARE COSTS								
17 1700	Medical Supplies								17
18 1800	Transportation (Health Care Staff)								18
19 1900	Depreciation-Medical Equipment								19
20 2000	Professional Liability Insurance								20
21 2100	Other (Specify)								21
22 2200									22
23 2300									23
24 S	Subtotal-Other Health Care Costs (Lines 17-23)								24
25 T	Total Cost of Services (Other Than								25
	Overhead And Other RHC/FQHC Services)								
S	Sum of Lines 12, 16, And 24								
'F	FACILITY OVERHEAD-FACILITY COST								
	Rent								26
	Insurance								27
	Interest On Mortgage Or Loans								28
	Utilities					1			29

FORM CMS-222-92 (1-2005) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2904)

2990 (Form CMS 222	-92				
	LASSIFICATION AND ADJUSTMENT OF TRIAL ANCE OF EXPENSES		Facility No.		Reporting Per From To	iod	WORKSHEET A Page 2	
	COST CENTER	Compen- sation	Other	Total (Col. 1 + 2)	Reclassi- fications	Reclassified Trial Balance (Col. 3 +/- 4)	Adjustments Increases (Decreases)	Net Expenses (Col. 5 +/- 6)
		1	2	3	4	5	6	7
30	3000 Depreciation-Buildings And Fixtures							
31	3100 Depreciation-Equipment							
32	3200 Housekeeping And Maintenance							
33	3300 Property Tax							
34	3400 Other(Specify)							
35	3500							
36	3600							
37	Subtotal-Facility Costs (Lines 26-36)							
	FACILITY OVERHEAD-ADMINISTRATIVE COSTS							
38	3800 Office Salaries							
39	3900 Depreciation-Office Equipment							
40	4000 Office Supplies							
41	4100 Legal							
42	4200 Accounting							
43	4300 Insurance							
44	4400 Telephone							
45	4500 Fringe Benefits And Payroll Taxes							
46	4600 Other (Specify)							
47	4700							
48	4800							
49	Subtotal-Administrative Cost (Lines 38-48)							
50	Total Overhead (Lines 37 And 49)							
	COST OTHER THAN RHC/FQHC SERVICES							
51	5100 Pharmacy							
52	5200 Dental							
53	5300 Optometry							
54	5400 Other (Specify)							
55	5500							
56	5600							
57	Subtotal-Cost Other Than RHC/FQHC (Lines 51-56)							
	NON-REIMBURSABLE COSTS (Specify)							
58	5800							
59	5900						1	
60	6000							
61	Subtotal Non-Reimbursable Costs (Lines 58-60)			1			1	
62	TOTAL COSTS (Sum Of Lines 25, 50, 57, And 61)				-0-			

FORM CMS-222-92 (3-2010) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2904)

03-10

03-02	Form CMS 222-92					2990 (Cont.			
RECLASSIFICATIONS	Facility N	10.	Reporting Period From To	g Period WORKSHEET A-1					
	CODE	DDE INCREASE				DECREASE			
		COST	LINE		COST	LINE			
EXPLANATION OF ENTRY	(1)	CENTER	NO.	AMOUNT (2)	CENTER	NO.	AMOUNT (2)		
	1	2	3	4	5	6	7	_	
1		۷			5	- 0	1	1	
2								2	
3								3	
4								4	
5								5	
6								6	
7								7	
8								8	
9								9	
10								10	
11								11	
12								12	
13								13	
14								14	
15								15	
16								16	
17								17	
18								18	
19 20								19	
20 21						_		20 21	
22						_		21	
23								22 23	
23								23	
24 25				+				25	
26								26	
27								27	
28								28	
29								29	
30								30	
31								31	
32								32	
33 34				1		1		33	
34								34	
35								35	
36 TOTAL RECLASSIFICATIONS (Sum of Column 4								36	
must equal sum of Column 7)									

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
(2) Transfer to Worksheet A, Col 4, line as appropriate.
FORM CMS-222-92 (3/93) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2905)

ADJUSTMENTS TO EXPENSES	Facility No.		Reporting Period	WORKSHEET A-2		
			From			
			То			
	Basis for		Expense Classification on Worksheet A			
	Adjust-		from which amount is to be o			
Description (1)	ment		or to which the amount is to			
	(2)	Amount	Cost Center	Line No		
	1	2	3	4		
1 Investment income on commingled						
restricted and unrestricted funds						
(chapter 2)						
2 Trade, quantity and time discounts						
on purchases (chapter 8)	В					
3 Rebates and refunds of	D					
expenses (chapter 8)	В					
4 Rental of building or office	D					
space to others 5 Home office costs						
(chapter 21)						
6 Adjustment resulting from transactions	From					
with related organizations	Supp. Wkst.					
(chapter 10)	A-2-1					
7 Vending machines						
8 Practitioner Assigned by National Health Service Corps						
9 Depreciation - Buildings and Fixtures			Depreciation			
10 Depreciation - Equipment			Depreciation	n 31		
11 Other (Specify)						
12 Total				62		

(1) Description - all line references in this column pertain to CMS Pub. PRM 15-I.

(2) Basis for adjustment (SEE INSTRUCTIONS)

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

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2990 (Cont.)		Form CMS 222	2-92			01-10		
STATEMENT OF COSTS OI	F SERVICES	Facility No.	Repor	ting Period	SUPPLEMENT	AL		
FROM RELATED ORGANIZ	ZATIONS		From		WORKSHEET	A-2-1		
			То		PARTS I-III			
Part I. Introduction. Are th	ere any costs inclu	ded on Worksheet A which resulted	l from transactions wit	h related organizations	s as			
defined in the Provid	er Reimbursement	Manual, Part I, Chapter 10?						
[] Yes [] No (If "Yes", complete Parts II and III)								
Part II. Costs incurred and adjust	ments required (as res	ult of transactions with related organization	ons):		_			
				AMOUNT	NET			
LOCATION AND AMOUNT IN	CLUDED ON WORK	SHEET A, COLUMN 6		ALLOWABLE	ADJUSTMENT			
				IN COST	(COL.4 MINUS			
Line No. Cost	Center	Expense Items	AMOUNT		COL. 5)			
1	2	3	4	5	6			
1						1		
2						2		

5 TOTALS (sum of lines 1-4) Transfer col. 6, line 1-4 to Wkst. A,col.6 as appropriate) (Transfer col.6, line 5 to Wkst. A-2, col.2, line 6, Adjustment to Expenses)

Part III. Interrelationship of facility to related organization (s):

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires the provider to furnish the information requested on Part III of this worksheet.

This information is used by the Centers for Medicare & Medicaid Services and its intermediaries in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control, represent reasonable costs as determined under section 1861 of the Social Security Act. If the provider does not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

						RELATED ORGANIZ	ATION (S)	
			Percentage			Percentage		
	SYMBOL		of			of	Type of	
	(1)	Name	Ownership	Name		Ownership	Business	
	1	2	3		4	5	6	
1								1
2								2
3								3
4								4

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in the provider;

B. Corporation, partnership, or other organization has financial interest in the provider;

C. Provider has financial interest in corporation, partnership, or other organization(s);

D. Director, officer, administrator, or key person of the provider or relative of such person has financial interest in related organization;

E. Individual is director, officer, administrator, or key person of the provider and related organization;

F. Director, officer, administrator, or key person of related organization or relative of such person has

financial interest in the provider;

G. Other (financial or non-financial) specify _____

FORM CMS-222-92 (3/93) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, Section 2909)

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3

01-05	Form CM	S 222-92			2990 (Cont.)
VISITS AND OVERHEAD COST FOR RHC/FQHC SERVICES	Facility No.		Reporting Perio From To	od	WORKSHEET B PARTS I & II
PART I - VISITS AND PRODUCTIVITY		Part A - Visi	ts And Productivi	ity	
	1	2	3	4	5
Positions	Number of FTE Personnel	Total Visits	Productivity Standard	Minimum Visits (Col. 1 x Col. 3)	Greater of Col. 2 or Col. 4
1. Physicians			4200		
2. Physician Assistants			2100		
3. Nurse Practitioners			2100		
4. Subtotal (Sum of lines 1-3)					
5. Visiting Nurse					
6. Clinical Psychologist					
7. Clinical Social Worker					L
8. Total Staff					
9. Physician Services Under Agreement					
PART II - DETERMINATION OF TOTAL ALLOW	ABLE COST AP	PLICABLE 7	TO RHC/FQHC S	SERVICES	
					Amount
10. Cost of RHC/FQHC Services - excluding overhea	$d (M/S \land Col 7$	7 Lino 25)			
11. Cost of Other Than RHC/FQHC Services - Exclue			Sum of		
Lines 57 and 61)					
12. Cost of All Services - excluding overhead - (Sum	of Lines 10 and 1	.1)			
13. Ratio of RHC/FQHC Services (Line 10 Divided b	y Line 12)				
14. Total Overhead - (W/S A, Col. 7, Line 50)					
15. Overhead Applicable to RHC/FQHC Services (Li	ne 13 x Line 14)				
16. Total Allowable Cost of RHC/FQHC Services (St	um of Lines 10 an	ıd 15)			

2990 (0	Cont.)	Form CMS 22	2-92			01-05
DETE	RMINATION OF MEDICARE	Facility No.	Reporting Per	od	WORKSHEET C	
PAYN	1ENT		From		PART 1	
			То			
PART	I- DETERMINATION OF RATE FOR RHC/FQHC SERVIC	ES	•		AMOUNT	
1	Total Allowable Costs(Worksheet B, Part II, Line 16)					1
2	Cost of Pneumococcal and Influenza Vaccine and Its (Their) Administratic	n			2
	(From Supplemental Worksheet B-1, Line 15)					
3	Total Allowable Cost Excluding Pneumococcal and Influenz	za Vaccine				3
	(Line 1 - Line 2)					
4	Greater of Minimum Visits or Actual Visits by Health Care			4		
	(Worksheet B, Part 1, Column 5, Line 8					
5	Physicians Visits Under Agreements					5
	(Worksheet B, Part 1, Column 5, Line 9)					
6	Total Adjusted Visits					6
	(Line 4 + Line 5)					
7	Adjusted Cost Per Visit					7
	(Line 3 divided by Line 6)					
		1	2	2.01	3	
_		Rate Period 1	Rate Period 2	Rate Period 3	-	_
8	Maximum Rate Per Visit (See Instructions)					8
9	Rate For Medicare Covered Visits					9
	(Lessor of Line 7 or Line 8)					

PAYMI	MINATION OF MEDICARE ENT	Facility No.	Reporting Period	1	WORKSHEET	
PARTI			From To	r	PART II	I C
	I - DETERMINATION OF TOTAL PAYMENT	1	2	2.01	3	
		Rate period 1	Rate Period 2	Rate Period 3		
10	Data for Madigara Coverad Visita (Dart I. Ling 0)				-	10
	Rate for Medicare Covered Visits (Part I, Line 9) Medicare Covered Visits Excluding Mental Health					10
11	Services (From Intermediary Records)					11
12	Medicare Cost Excluding Costs for Mental Health					12
12	Services (Line 10 multiplied by Line 11)					12
13	Medicare Covered Visits for Mental Health					13
	Services (From Intermediary Records)					
14	Medicare Covered Cost for Mental Health					14
	Services (Line 10 multiplied by Line 13)					
15	Limit Adjustment					15
	(Line 14 times the applicable percentage) (see instructions)					
16	Total Medicare Cost					16
	(Line 12 plus line 15)					
17	Less: Beneficiary Deductible					17
	(From Intermediary Records)					
18	Net Medicare Cost Excluding Pneumococcal					18
	and Influenza Vaccine and Its (Their) Administration					
	(Line 16 minus line 17)					
19	Reimbursable Cost of RHC/FQHC Services, Other Than Pneumococc	al				19
	and Influenza Vaccine (80% multiplied by line 18, Column 3)					
20	Medicare Cost of Pneumococcal and Influenza Vaccine and					20
	Its (Their) Administration (From Supp. Worksheet B-1, Line 16)					
21	Total Reimbursable Medicare Cost (Line 19 plus Line 20)					21
22	Less Payments to RHC/FQHC During Reporting Period					22
23	Balance Due To/From The Medicare Program					23
20	Exclusive of Bad Debts (Line 21 less Line 22)					20
24	Total Reimbursable Bad Debts, Net of Bad Debt					
	Recoveries (From Provider Records)					24
24.01	Total Gross Reimbursable Bad Debts for Dual Eligible Beneficiaries					24.01
	(From Provider Records)					2
						-
25	Total Amount Due To/From The Medicare Program (Line 23 plus Lin	e 24)				25

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA Facility No. Reporting Period From VACCINE COST 1 2 2.01 PART 1 - CALCULATION OF COST PNEUMOCOCCAL INFLUENZA H1N1 1 Health Care Staff Cost INFLUENZA H1N1 2 Ratio of Pneumococcal and Influenza Vaccine SEASONAL H1N1 3 Pneumococcal and Influenza Vaccine Health Care Staff Cost (Line 1 x Line 2) Health Care Staff Cost (Line 1 x Line 2) 4 Medical Supplies Cost - Pneumococcal and Influenza Vaccine (From Your Records) Vaccine (From Your Records) 5 Direct Cost of Pneumococcal and Influenza Vaccine (Sum of Lines 3 & 4) Hind Staff Cost (Line 1 x Line 2) 6 Total Direct Cost of the Facility (Worksheet A, Column 7, Line 25) Health Care Staff Cost (Line 1 x Line 2) 7 Total Facility Overhead Hind Staff	01-1)	Form CMS 222-92		
VACCINE COST To 1 2 2.01 PART 1 - CALCULATION OF COST PNEUMOCOCCAL INFLUENZA 1 Health Care Staff Cost INFLUENZA H1N1 1 Health Care Staff Cost INFLUENZA H1N1 2 Ratio of Pneumococcal and Influenza Vaccine Staff Time to Total Health Care Staff Time Implement 3 Pneumococcal and Influenza Vaccine Health Care Staff Cost (Line 1 x Line 2) Implement Implement 4 Medical Supplies Cost - Pneumococcal and Influenza Vaccine (From Your Records) Vaccine (From Your Records) Implement 5 Direct Cost of the Pacility Implement Implement Implement 6 Total Direct Cost of the Facility Implement Implement Implement 7 Total Facility Overhead Implement Implement Implement 8 Ratio of Pneumococcal and Influenza Implement Implement Implement 9 Overhead Cost - Pneumococcal and Influenza Implement Implement Implement 9 Overhead Cost - Pneumococcal and Influenza Implement Implement Implement	COMPUTATION OF			Facility No.	Reporting Period
1 2 2.01 PART 1 - CALCULATION OF COST PNEUMOCOCCAL INFLUENZA 1 Health Care Staff Cost INFLUENZA H1N1 2 Ratio of Pneumococcal and Influenza Vaccine Staff Time to Total Health Care Staff Time Staff Time to Total Health Care Staff Time 3 Pneumococcal and Influenza Vaccine Health Care Staff Cost (Line 1 x Line 2) Health Care Staff Cost (Line 1 x Line 2) 4 Medical Supplies Cost - Pneumococcal and Influenza Vaccine (From Your Records) Vaccine (Sum of Lines 3 & 4) 5 Direct Cost of Pneumococcal and Influenza Vaccine (Sum of Lines 3 & 4) Vaccine (Sum of Lines 3 & 4) 6 Total Direct Cost of the Facility (Worksheet A, Column 7, Line 25) Total Facility Overhead 7 Total Facility Overhead (Worksheet A, Column 7, Line 50) B 8 Ratio of Pneumococcal and Influenza Vaccine 9 Overhead Cost - Pneumococcal and Influenza Vaccine (Line 7 x Line 8) 10 Total Pneumococcal and Influenza Vaccine (Line 7 x Line 8) 10 Total Pneumococcal and Influenza Vaccine Cost and Influenza 10 Total Number of Pneumococcal and Influenza Influenza 10 Total Pneumococcal and Influenza Influenza 10 Total Number of Pneumococcal and Influenza	PNEUMOCOCCAL AND INFLUENZA				From
PART 1 - CALCULATION OF COST PNEUMOCOCCAL SEASONAL INFLUENZA 1 Health Care Staff Cost (Worksheet A, Column 7, Line 12) H1N1 2 Ratio of Pneumococcal and Influenza Vaccine Staff Time to Total Health Care Staff Time 3 Pneumococcal and Influenza Vaccine Health Care Staff Cost (Line 1 x Line 2) 4 Medical Supplies Cost - Pneumococcal and Influenza Vaccine (From Your Records) 5 Direct Cost of Pneumococcal and Influenza Vaccine (Sum of Lines 3 & 4) 6 Total Direct Cost of the Facility (Worksheet A, Column 7, Line 25) 7 Total Facility Overhead (Worksheet A, Column 7, Line 50) 8 Ratio of Pneumococcal and Influenza Vaccine (Line 7 x Line 8) 9 Overhead Cost - Pneumococcal and Influenza Vaccine (Line 7 x Line 8) 10 Total Pneumococcal and Influenza Vaccine (Line 7 x Line 5 5 & 9)	VACCINE COST				То
PART 1 - CALCULATION OF COSTPNEUMOCOCCALINFLUENZAH1N11Health Care Staff Cost (Worksheet A, Column 7, Line 12)			1	2	2.01
PART 1 - CALCULATION OF COSTPNEUMOCOCCALINFLUENZAH1N11Health Care Staff Cost (Worksheet A, Column 7, Line 12)					
1 Health Care Staff Cost (Worksheet A, Column 7, Line 12) 2 Ratio of Pneumococcal and Influenza Vaccine Staff Time to Total Health Care Staff Time 3 Pneumococcal and Influenza Vaccine Health Care Staff Cost (Line 1 x Line 2) 4 Medical Supplies Cost - Pneumococcal and Influenza Vaccine (From Your Records) 5 Direct Cost of Pneumococcal and Influenza Vaccine (Sum of Lines 3 & 4) 6 Total Direct Cost of the Facility (Worksheet A, Column 7, Line 25) 7 Total Facility Overhead (Worksheet A, Column 7, Line 50) 8 Ratio of Pneumococcal and Influenza Vaccine (Sum of Lines 3 & 4) 6 Total Facility Overhead (Worksheet A, Column 7, Line 50) 8 Ratio of Pneumococcal and Influenza Vaccine (Line 7 x Line 8) 9 Overhead Cost - Pneumococcal and Influenza Vaccine (Line 7 x Line 8) 10 Total Pneumococcal and Influenza Vaccine (Line 7 x Line 8) 10 Total Number of Pneumococcal and Influenza				SEASONAL	
(Worksheet A, Column 7, Line 12) 2 Ratio of Pneumococcal and Influenza Vaccine Staff Time to Total Health Care Staff Time 3 Pneumococcal and Influenza Vaccine Health Care Staff Cost (Line 1 x Line 2) 4 Medical Supplies Cost - Pneumococcal and Influenza Vaccine (From Your Records) 5 Direct Cost of Pneumococcal and Influenza Vaccine (Sum of Lines 3 & 4) 6 Total Direct Cost of the Facility (Worksheet A, Column 7, Line 25) 7 Total Facility Overhead (Worksheet A, Column 7, Line 25) 8 Ratio of Pneumococcal and Influenza Vaccine (Line 7 Line 50) 8 Ratio of Pneumococcal and Influenza Vaccine (Line 7 Line 50) 9 Overhead Cost - Pneumococcal and Influenza Vaccine (Line 7 x Line 8) 10 Total Pneumococcal and Influenza Vaccine (Line 7 x Line 8) 11 Total Number of Pneumococcal and Influenza		PART 1 - CALCULATION OF COST	PNEUMOCOCCAL	INFLUENZA	H1N1
2 Ratio of Pneumococcal and Influenza Vaccine 3 Pneumococcal and Influenza Vaccine Health Care Staff Cost (Line 1 x Line 2) 4 Medical Supplies Cost - Pneumococcal and Influenza Vaccine (From Your Records) 5 Direct Cost of Pneumococcal and Influenza Vaccine (Sum of Lines 3 & 4) 6 Total Direct Cost of the Facility (Worksheet A, Column 7, Line 25) 7 Total Facility Overhead (Worksheet A, Column 7, Line 50) 8 Ratio of Pneumococcal and Influenza Vaccine Direct Cost to Total Direct Cost (Line 5 divided by Line 6) 9 Overhead Cost - Pneumococcal and Influenza Vaccine (Line 7 x Line 8) 10 Total Pneumococcal and Influenza 11 Total Number of Pneumococcal and Influenza	1	Health Care Staff Cost			
Staff Time to Total Health Care Staff Time		(Worksheet A, Column 7, Line 12)			
3 Pneumococcal and Influenza Vaccine Health Care Staff Cost (Line 1 x Line 2) 4 Medical Supplies Cost - Pneumococcal and Influenza Vaccine (From Your Records) 5 Direct Cost of Pneumococcal and Influenza Vaccine (Sum of Lines 3 & 4) 6 Total Direct Cost of the Facility (Worksheet A, Column 7, Line 25) 7 Total Facility Overhead (Worksheet A, Column 7, Line 50) 8 Ratio of Pneumococcal and Influenza Vaccine (Line 7 x Line 8) 10 Total Pneumococcal and Influenza Vaccine (Line 7 x Line 8) 11 Total Number of Pneumococcal and Influenza	2	Ratio of Pneumococcal and Influenza Vaccine			
Health Care Staff Cost (Line 1 x Line 2) Health Care Staff Cost (Line 1 x Line 2) 4 Medical Supplies Cost - Pneumococcal and Influenza Vaccine (From Your Records) Vaccine (Sum of Lines 3 & 4) 5 Direct Cost of Pneumococcal and Influenza Vaccine (Sum of Lines 3 & 4) Vaccine (Sum of Lines 3 & 4) 6 Total Direct Cost of the Facility (Worksheet A, Column 7, Line 25) (Worksheet A, Column 7, Line 50) 7 Total Facility Overhead (Worksheet A, Column 7, Line 50) (Worksheet A, Column 7, Line 50) 8 Ratio of Pneumococcal and Influenza Vaccine Direct Cost to Total Direct Cost (Line 5 divided by Line 6) Direct Cost to Total Direct Cost (Line 5 divided by Line 6) 9 Overhead Cost - Pneumococcal and Influenza Vaccine (Line 7 x Line 8) 10 Total Pneumococcal and Influenza Vaccine Cost and Its (Their) Administration (Sum of Lines 5 & 9) Its (Their) Administration (Sum of Lines 5 & 9) 11 Total Number of Pneumococcal and Influenza Its (Their) Administration (Sum of Lines 5 & 9)		Staff Time to Total Health Care Staff Time			
4 Medical Supplies Cost - Pneumococcal and Influenza Vaccine (From Your Records)	3	Pneumococcal and Influenza Vaccine			
Vaccine (From Your Records) Image: Construction of Construction		Health Care Staff Cost (Line 1 x Line 2)			
5 Direct Cost of Pneumococcal and Influenza Vaccine (Sum of Lines 3 & 4)	4	Medical Supplies Cost - Pneumococcal and Influenza			
Vaccine (Sum of Lines 3 & 4) Image: Sector of the Sect		Vaccine (From Your Records)			
6 Total Direct Cost of the Facility (Worksheet A, Column 7, Line 25) 7 Total Facility Overhead (Worksheet A, Column 7, Line 50) 8 Ratio of Pneumococcal and Influenza Vaccine Direct Cost to Total Direct Cost (Line 5 divided by Line 6) 9 Overhead Cost - Pneumococcal and Influenza Vaccine (Line 7 x Line 8) 10 Total Pneumococcal and Influenza Vaccine Cost and Its (Their) Administration (Sum of Lines 5 & 9) 11 Total Number of Pneumococcal and Influenza	5	Direct Cost of Pneumococcal and Influenza			
(Worksheet A, Column 7, Line 25) Image: Column 7, Line 25) 7 Total Facility Overhead (Worksheet A, Column 7, Line 50) Image: Column 7, Line 50) 8 Ratio of Pneumococcal and Influenza Vaccine Direct Cost to Total Direct Cost (Line 5 divided by Line 6) Image: Column 7, Line 50) 9 Overhead Cost - Pneumococcal and Influenza Vaccine (Line 7 x Line 8) Image: Column 7, Line 50) 10 Total Pneumococcal and Influenza Vaccine Cost and Its (Their) Administration (Sum of Lines 5 & 9) Image: Column 7, Line 50) 11 Total Number of Pneumococcal and Influenza Image: Column 7, Line 50)		Vaccine (Sum of Lines 3 & 4)			
7 Total Facility Overhead (Worksheet A, Column 7, Line 50) 8 Ratio of Pneumococcal and Influenza Vaccine Direct Cost to Total Direct Cost (Line 5 divided by Line 6) 9 Overhead Cost - Pneumococcal and Influenza Vaccine (Line 7 x Line 8) 10 Total Pneumococcal and Influenza Vaccine Cost and Its (Their) Administration (Sum of Lines 5 & 9) 11 Total Number of Pneumococcal and Influenza	6	Total Direct Cost of the Facility			
(Worksheet A, Column 7, Line 50) Image: Constant of Cons		(Worksheet A, Column 7, Line 25)			
8 Ratio of Pneumococcal and Influenza Vaccine Direct Cost to Total Direct Cost (Line 5 divided by Line 6) 9 Overhead Cost - Pneumococcal and Influenza Vaccine (Line 7 x Line 8) 10 Total Pneumococcal and Influenza Vaccine Cost and Its (Their) Administration (Sum of Lines 5 & 9) 11 Total Number of Pneumococcal and Influenza	7	Total Facility Overhead			
Direct Cost to Total Direct Cost (Line 5 divided by Line 6)		(Worksheet A, Column 7, Line 50)			
9 Overhead Cost - Pneumococcal and Influenza Vaccine (Line 7 x Line 8) 10 Total Pneumococcal and Influenza Vaccine Cost and Its (Their) Administration (Sum of Lines 5 & 9) 11 Total Number of Pneumococcal and Influenza	8	Ratio of Pneumococcal and Influenza Vaccine			
Vaccine (Line 7 x Line 8) Image: Constant of the state of the stat		Direct Cost to Total Direct Cost (Line 5 divided by Line 6)			
10 Total Pneumococcal and Influenza Vaccine Cost and Its (Their) Administration (Sum of Lines 5 & 9) 11 Total Number of Pneumococcal and Influenza	9	Overhead Cost - Pneumococcal and Influenza			
Its (Their) Administration (Sum of Lines 5 & 9) 11 Total Number of Pneumococcal and Influenza		Vaccine (Line 7 x Line 8)			
11 Total Number of Pneumococcal and Influenza	10	Total Pneumococcal and Influenza Vaccine Cost and			
		Its (Their) Administration (Sum of Lines 5 & 9)			
Vaccine Injections (From Provider Records)	11	Total Number of Pneumococcal and Influenza			
		Vaccine Injections (From Provider Records)			
12 Cost Per Pneumococcal and Influenza	12	Cost Per Pneumococcal and Influenza			
Vaccine Injection (Line 10 divided by Line 11)		Vaccine Injection (Line 10 divided by Line 11)			
13 Number of Pneumococcal and Influenza Vaccine	13	Number of Pneumococcal and Influenza Vaccine			
Injections Administered to Medicare Beneficiaries		Injections Administered to Medicare Beneficiaries			
14 Medicare Cost of Pneumococcal and Influenza Vaccine	14	Medicare Cost of Pneumococcal and Influenza Vaccine			
and Its (Their) Administration (Line 12 Multiplied by Line 13)		and Its (Their) Administration (Line 12 Multiplied by Line 13)			
15 Total Cost of Pneumococcal and Influenza Vaccine and Its (Their) Administration	15	Total Cost of Pneumococcal and Influenza Vaccine and Its (Their) Administration			
(Sum of Line 10, Columns 1, 2, 2.01, and 2.02) Transfer to Wkst. C, Part I, Line 2		(Sum of Line 10, Columns 1, 2, 2.01, and 2.02) Transfer to Wkst. C, Part I, Line 2			
16 Total Medicare Cost of Pneumococcal and Influenza Vaccine and Its (Their) Administration	16 Total Medicare Cost of Pneumococcal and Influenza Vaccine and Its (Their) Administration				
(Sum of Line 14, Columns 1, 2, 2.01, and 2.02) Transfer to Wkst. C, Part II, Line 20		(Sum of Line 14, Columns 1, 2, 2.01, and 2.02) Transfer to Wkst. C, Part II, Line 20			

Rev. 8

2990 SUPPLEMENTAL	(Cont.)
WORKSHEET B-1	
2.02	
INFLUENZA	
& H1N1	
(See instructions)	
	1
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