This report is required by law (42 USC. 1395g: CFR 413.20(b)). Failure to report can result in all payments made during the reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO: 0938-0107

INDEPENDENT RURAL HEALTH CLINIC/FREESTANDING FEDERALLY QUALIFIED HEALTH CENTER WORKSHEET STATISTICAL DATA AND CERTIFICATION STATEMENT	PROVIDER CCN:	PERIOD: FROM: TO:	WORKSHEET S PART I

Intermediary Use Only:

[ ] Audited [ ] Desk Reviewed Date Received _____ Contractor No. _____ [ ] Initial [ ] Final [ ] Re-opened

PART I - STATISTICAL DATA [ ] Projected Cost Report [ ] Actual/Final Cost Report

Check applicable box [ ] Electronic filed cost report [ ] Manually submitted cost report Date: Time:

1	Name:		1
1.01	Street:	P.O. Box:	1.01
1.02	City: State:	Zip Code:	1.02
1.03	County:		1.03
2	CCN:		2
3	Designation:		3
4	Reporting Period: From To		4

		Type of Control (see instructions)	Type of Provider (see instructions)	Date Certified	
	1	2	3	4	
5					5

		Source of Federal Funds (see instructions)	Grant Award Number (see instructions)	Date	
	1	2	3	4	
6					6

	Names of Physicians Furnishing Services At The Health Facility or Under Agreement (As Described in Instructions) and Medicare Billing Numbers (Include all Part B Billing Numbers)		
	Name	Billing Number	
	1	2	
7.01			7.01
7.02			7.02
7.03			7.03
7.04			7.04
7.05			7.05

	Supervisory Physicians		
	Name	Hours of Supervision 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

		Y/N	XVIII	TOTAL	
8.50	Are you claiming allowable GME costs as a result of "substantial payment" for interns and residents? If yes, enter the number of Medicare visits performed by interns and residents in col. 2 and total visits in col. 3 performed by interns and residents and complete Worksheet A, lines 20.50 and 53.50 as applicable.	1	2	3	8.50
8.51	Have you received an approval for an exception to the productivity standard?				8.51

INDEPENDENT RURAL HEALTH CLINIC/ FEDERALLY QUALIFIED HEALTH CENTER WORKSHEET STATISTICAL DATA AND CERTIFICATION STATEMENT	PROVIDER CCN:	PERIOD: FROM: TO:	WORKSHEET S PART I (Cont.) & PART II

PART I (CONT.)-STATISTICAL DATA

9	Does the facility operate as other than a RHC or FQHC? Enter "Y" for yes or "N" for no.				9
10	If line 9 is "Y", specify 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 From	Hours of Operation To		
11.01	Sunday				11.01
11.02	Monday				11.02
11.03	Tuesday				11.03
11.04	Wednesday				11.04
11.05	Thursday				11.05
11.06	Friday				11.06
11.07	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
	Days	Hours of Operation From	Hours of Operation 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 30.8? Enter "Y" for yes or "N" for no. If yes, see instructions.				14

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 WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by _____ (Provider Name and Number) for the cost report period beginning _____ and ending _____ and that to the best of my knowledge and belief, this report and statement are true, correct, complete, and prepared from the books and records of the Provider in accordance with applicable instructions,except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in the cost report were provided in compliance with such laws and regulations.

(Signed)

Officer or Administrator of Facility Title Date

INDEPENDENT RURAL HEALTH CLINIC/FREESTANDING	PROVIDER CCN:	PERIOD:	WORKSHEET S
FEDERALLY QUALIFIED HEALTH CENTER WORKSHEET		FROM:	PART III
STATISTICAL DATA AND CERTIFICATION STATEMENT	CLINIC CCN:	TO:	

PART III - STATISTICAL DATA FOR CLINICS FILING UNDER CONSOLIDATED COST REPORTING

1	Name:		1
2	Street:	P.O. Box:	2
3	City: State:	Zip Code:	3
4	County:		4
5	Provider Number:		5
6	Designation:	Date Certified:	6

7	Names of physicians furnishing services at the health facility or under agreement (as described in instructions) and Medicare billing numbers (include all Part B billing numbers)		7
	Name	Billing Number	
	1	2	
7.01			7.01
7.02			7.02
7.03			7.03
7.04			7.04
7.05			7.05

8	Supervisory Physicians		8
	Name	Hours of Supervision 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	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		
		From	To	
11.01	Sunday			11.01
11.02	Monday			11.02
11.03	Tuesday			11.03
11.04	Wednesday			11.04
11.05	Thursday			11.05
11.06	Friday			11.06
11.07	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
	Days	Hours of Operation		
		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

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES	PROVIDER CCN:	PERIOD: FROM: TO:	WORKSHEET A Page 1

		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	
		FACILITY HEALTH CARE STAFF COSTS								
1	0100	Physician								1
2	0200	Physician Assistant								2
3	0300	Nurse Practitioner								3
4	0400	Visiting Nurse								4
5	0500	Other Nurse								5
6	0600	Clinical Psychologist								6
7	0700	Clinical Social Worker								7
8	0800	Laboratory Technician								8
9	0900	Other (Specify)								9
10	1000									10
11	1100									11
12		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		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
20.50	2050	Allowable GME Pass Through Costs								20.50
21	2100	Other (Specify)								21
22	2200									22
23	2300									23
24		Subtotal-Other Health Care Costs (Lines 17-23)								24
25		Total Cost of Services (Other Than Overhead And Other RHC/FQHC Services) Sum of Lines 12, 16, And 24								25
		FACILITY OVERHEAD-FACILITY COST								
26	2600	Rent								26
27	2700	Insurance								27
28	2800	Interest On Mortgage Or Loans								28
29	2900	Utilities								29

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES			PROVIDER CCN:			PERIOD: FROM: TO:		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								30
31	3100	Depreciation-Equipment								31
32	3200	Housekeeping And Maintenance								32
33	3300	Property Tax								33
34	3400	Other(Specify)								34
35	3500									35
36	3600									36
37		Subtotal-Facility Costs (Lines 26-36)								37
		FACILITY OVERHEAD-ADMINISTRATIVE COSTS								
38	3800	Office Salaries								38
39	3900	Depreciation-Office Equipment								39
40	4000	Office Supplies								40
41	4100	Legal								41
42	4200	Accounting								42
43	4300	Insurance								43
44	4400	Telephone								44
45	4500	Fringe Benefits And Payroll Taxes								45
46	4600	Other (Specify)								46
47	4700									47
48	4800									48
49		Subtotal-Administrative Cost (Lines 38-48)								49
50		Total Overhead (Lines 37 And 49)								50
		COST OTHER THAN RHC/FQHC SERVICES								
51	5100	Pharmacy								51
52	5200	Dental								52
53	5300	Optometry								53
53.50	5350	Non-allowable GME Pass Through Costs								53.50
54	5400	Other (Specify)								54
55	5500									55
56	5600									56
57		Subtotal-Cost Other Than RHC/FQHC (Lines 51-56)								57
		NON-REIMBURSABLE COSTS (Specify)								
58	5800									58
59	5900									59
60	6000									60
61		Subtotal Non-Reimbursable Costs (Lines 58-60)								61
62		TOTAL COSTS (Sum Of Lines 25, 50, 57, And 61)				-0-				62

RECLASSIFICATIONS	PROVIDER CCN:	PERIOD: FROM: TO:	WORKSHEET A-1

	EXPLANATION OF ENTRY	CODE	INCREASE			DECREASE			
		(1)	COST CENTER	LINE NO.	AMOUNT (2)	COST CENTER	LINE NO.	AMOUNT (2)	
		1	2	3	4	5	6	7	
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									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34
35									35
36	TOTAL RECLASSIFICATIONS (Sum of Column 4 must equal sum of Column 7)								36

(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 (03-1993) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 2905)

ADJUSTMENTS TO EXPENSES	PROVIDER CCN:	PERIOD: FROM: TO:	WORKSHEET A-2

Description (1)	Basis for Adjust-ment (2)	Amount	Expense Classification on Worksheet A from which amount is to be deducted or to which the amount is to be added	
			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)	B			
3 Rebates and refunds of expenses (chapter 8)	B			
4 Rental of building or office space to others				
5 Home office costs (chapter 21)				
6 Adjustment resulting from transactions with related organizations (chapter 10)	From Supp. Wkst. A-2-1			
7 Vending machines				
8 Practitioner Assigned by National Health Service Corps				
9 Depreciation - Buildings and Fixtures			Depreciation	30
10 Depreciation - Equipment			Depreciation	31
11 Other (Specify)				
12 Total				62

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

(2) Basis for adjustment (SEE INSTRUCTIONS)

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

B. Amount Received - if cost cannot be determined.

FORM CMS-222-92 (03-1993) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 2906)

VISITS AND OVERHEAD COST FOR RHC/FQHC SERVICES	PROVIDER CCN:	PERIOD: FROM: TO:	WORKSHEET B PARTS I & II

PART I - VISITS AND PRODUCTIVITY

	Part A - Visits And Productivity				
	1	2	3	4	5
Positions	Number of FTE Personnel	Total Visits	Productivity Standard (1)	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					
7.01. Medical Nutrition Therapist (FQHC only)					
7.02. Diabetes Self Management Training (FQHC only)					
8. Total Staff					
9. Physician Services Under Agreement					

(1) Productivity standards established by CMS are: 4200 visits for each physician and 2100 visits for each nonphysician practitioner. If an exception to the productivity standard has been granted (Wkst. S, *Part I*, line 8.51 equals "Y"), input in col. 3, lines 1 through 3, the productivity standards derived by the contractor.

PART II - DETERMINATION OF TOTAL ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

	Amount
10. Cost of RHC/FQHC Services - excluding overhead - (Wkst. A, col. 7, line 25 minus *W*kst. A, col. 7, line *20.50*)	
11. Cost of Other Than RHC/FQHC Services - Excluding overhead (W/S A, *c*ol. 7, *s*um of *l*ines 57 and 61)	
12. Cost of All Services - excluding overhead - (*s*um of *l*ines 10 and 11)	
13. Ratio of RHC/FQHC Services (*l*ine 10 *d*ivided by *l*ine 12)	
14. Total Overhead - (Wkst. A, col. 7, line 50)	
14.01. Allowable GME Overhead (*s*ee instructions)	
14.02. Net Facility Overhead Costs	
15. Overhead Applicable to RHC/FQHC Services (*s*ee instructions)	
16. Total Allowable Cost of RHC/FQHC Services (sum of lines 10 and 15)	

DETERMINATION OF MEDICARE PAYMENT	PROVIDER CCN:	PERIOD: FROM: TO:	WORKSHEET C PART I

	PART I- DETERMINATION OF RATE FOR RHC/FQHC SERVICES	AMOUNT	
1	Total Allowable Costs (Worksheet B, Part II, *l*ine 16)		1
2	Cost of Pneumococcal and Influenza Vaccine and Its (Their) Administration (*f*rom Supplemental Worksheet B-1, *l*ine 15)		2
3	Total Allowable Cost Excluding Pneumococcal and Influenza Vaccine (*l*ine 1 - *l*ine 2)		3
4	Greater of Minimum Visits or Actual Visits by Health Care Staff (Worksheet B, Part 1, *c*olumn 5, *l*ine 8*)*		4
5	Physicians Visits Under Agreements (Worksheet B, Part 1, *c*olumn 5, *l*ine 9)		5
6	Total Adjusted Visits (*l*ine 4 + *l*ine 5)		6
7	Adjusted Cost Per Visit (*l*ine 3 divided by *l*ine 6)		7

		1	2	2.01	3	
		Rate Period 1	Rate Period 2	Rate Period 3		
8	Maximum Rate Per Visit (*s*ee *i*nstructions)					8
9	Rate For Medicare Covered Visits (*l*essor of *l*ine 7 or *l*ine 8)					9

DETERMINATION OF MEDICARE PAYMENT		PROVIDER CCN:	PERIOD: FROM: TO:		WORKSHEET C PART II	
PART II - DETERMINATION OF TOTAL PAYMENT		1	2	2.01	3	
		Rate period 1	Rate Period 2	Rate Period 3		
10	Rate for Medicare Covered Visits (*from Worksheet C,* Part I, *l*ine 9)					10
11	Medicare Covered Visits Excluding Mental Health Services (*f*rom *contractor* records)					11
12	Medicare Cost Excluding Costs for Mental Health Services (*l*ine 10 multiplied by *l*ine 11)					12
13	Medicare Covered Visits for Mental Health Services (*f*rom *contractor r*ecords)					13
14	Medicare Covered Cost for Mental Health Services (*l*ine 10 multiplied by *l*ine 13)					14
15	Limit Adjustment (*l*ine 14 times the applicable percentage) (see instructions)					15
15.10	Graduate Medical Education Pass Through Cost (see instructions)					15.10
16	Total Medicare Cost (*l*ine 12 plus *l*ine 15 plus line 15.10)					16
17	Less: Beneficiary Deductible for RHC only (see instructions) (*f*rom contractor records)					17
18	Net Medicare Cost Excluding Pneumococcal and Influenza Vaccine and Its (Their) Administration (see instructions)					18
18.01	Total Medicare charges (see instructions)(from contractor's records (PS&R Report))					18.01
18.02	Total Medicare preventive charges (see instructions)(from provider's records)					18.02
18.03	Total Medicare preventive costs ((line 18.02/line 18.01) times line 16)					18.03
18.04	Total Medicare non-preventive costs ((line 18 minus line 18.03) times 80%)					18.04
18.05	Net Medicare cost (see instructions)					18.05
18.06	*Beneficiary coinsurance for RHC/FQHC services* (see instructions) (from contractor records)					18.06
19	Reimbursable Cost of RHC/FQHC Services, Other Than Pneumococcal and Influenza Vaccine (see instructions)					19
20	Medicare Cost of Pneumococcal and Influenza Vaccine and Its (Their) Administration (*f*rom *S*upp. Worksheet B-1, line 16)					20
20.50	Other adjustments (specify)					20.50
21	Total Reimbursable Medicare Cost (see instructions)					21
22	Less Payments to RHC/FQHC During Reporting Period					22
23	Balance Due To/From The Medicare Program Exclusive of Bad Debts (line 21 less line 22)					23
24	Total Reimbursable Bad Debts, Net of Bad Debt Recoveries (*f*rom *p*rovider *r*ecords)					24
24.01	Total Gross Reimbursable Bad Debts for Dual Eligible Beneficiaries (*f*rom *p*rovider *r*ecords)					24.01
24.02	Tentative settlement (for contractor use only)					24.02
24.10	Adjusted reimbursable bad debts (see instructions)					24.10
24.11	Sequestration adjustment (see instructions)					24.11
25	Total Amount Due To/From The Medicare Program (see instructions)					25

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS	PROVIDER CCN:	PERIOD: FROM: TO:	SUPPLEMENTAL WORKSHEET A-2-1 PARTS I - III

Part I. Introduction. Are there any costs included on Worksheet A which resulted from transactions with related organizations as defined in the Provider Reimbursement Manual, Part I, Chapter 10?

[ ] Yes [ ] No (If "Yes", complete Parts II and III)

Part II. Costs incurred and adjustments required (as result of transactions with related organizations):

LOCATION AND AMOUNT INCLUDED ON WORKSHEET A, COLUMN 6				AMOUNT ALLOWABLE IN COST	NET ADJUSTMENT (COL.4 MINUS COL. 5)	
Line No.	Cost Center	Expense Items	AMOUNT			
1	2	3	4	5	6	
1						1
2						2
3						3
4						4
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)					5

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.

	SYMBOL (1)	Name	Percentage of Ownership	RELATED ORGANIZATION (S) Name	Percentage of Ownership	Type of 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 _____

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	PROVIDER CCN:	PERIOD: FROM: TO:	SUPPLEMENTAL WORKSHEET B-1

	PART 1 - CALCULATION OF COST	1 PNEUMOCOCCAL	2 SEASONAL INFLUENZA	
1	Health Care Staff Cost (Worksheet A, *c* olumn 7, *l* ine 12)			1
2	Ratio of Pneumococcal and Influenza Vaccine Staff Time to Total Health Care Staff Time			2
3	Pneumococcal and Influenza Vaccine Health Care Staff Cost (*l* ine 1 x *l* ine 2)			3
4	Medical Supplies Cost - Pneumococcal and Influenza Vaccine (*f* rom *y* our *r* ecords)			4
5	Direct Cost of Pneumococcal and Influenza Vaccine (*s* um of *l* ines 3 & 4)			5
6	Total Direct Cost of the Facility (Worksheet A, *c* olumn 7, *l* ine 25)			6
7	Total Facility Overhead (Worksheet A, *c* olumn 7, *l* ine 50)			7
8	Ratio of Pneumococcal and Influenza Vaccine Direct Cost to Total Direct Cost (*l* ine 5 divided by *l* ine 6)			8
9	Overhead Cost - Pneumococcal and Influenza Vaccine (*l* ine 7 x *l* ine 8)			9
10	Total Pneumococcal and Influenza Vaccine Cost and Its (Their) Administration (Sum of *l* ines 5 & 9)			10
11	Total Number of Pneumococcal and Influenza Vaccine Injections (*f* rom *p* rovider *r* ecords)			11
12	Cost Per Pneumococcal and Influenza Vaccine Injection (*l* ine 10 divided by *l* ine 11)			12
13	Number of Pneumococcal and Influenza Vaccine Injections Administered to Medicare Beneficiaries			13
14	Medicare Cost of Pneumococcal and Influenza Vaccine and Its (Their) Administration (line 12 *m* ultiplied by *l* ine 13)			14
15	Total Cost of Pneumococcal and Influenza Vaccine and Its (Their) Administration (*s* um of *l* ine 10, *c* olumns 1 and *2*) Transfer to Wkst. C, Part I, *l* ine 2			15
16	Total Medicare Cost of Pneumococcal and Influenza Vaccine and Its (Their) Administration (*s* um of *l* ine 14, *c* olumns 1 and *2*) Transfer to Wkst. C, Part II, *l* ine 20			16