of the cost reporting year in which the liability was incurred. Contributions to the deferred compensation plan must be reduced to reflect estimated forfeitures. Actual forfeitures above or below estimated forfeitures must be used to adjust annual contributions to the fund.

(B) If the sick leave plan grants employees the nonforfeitable right to demand cash payment for unused sick leave at the end of each year, sick pay is includable in allowable costs, without funding, in the cost reporting period in which it is earned.

(C) Sick pay paid on any basis other than that specified in paragraphs (c)(2)(iii) (A) or (B) of this section can be claimed for Medicare payment only on a cash basis for the year in which the benefits are paid.

(iv) *Compensation of owners.* Accrued liability related to compensation of owners other than sole proprietors and partners must be liquidated within 75 days after the close of the cost reporting period in which the liability occurs.

(v) *Nonpaid workers.* Obligations incurred under a legally-enforceable agreement to remunerate an organization of nonpaid workers must be discharged no later than the end of the provider's cost reporting period following the period in which the services were furnished.

(vi) *FICA and other payroll taxes.* The provider's share of FICA and other payroll taxes that the provider becomes obligated to remit to governmental agencies is included in allowable costs only during the cost reporting period in which payment (upon which the tax is based) is actually made to the employee. For example, no legal obligation exists for a provider-employer to pay FICA taxes until the employee is paid and the specific amount of liability known.

(vii) *Deferred compensation.*

(A) Reasonable provider payments made under unfunded deferred compensation plans are included in allowable costs only during the cost reporting period in which actual payment is made to the participating employee.

(B) Accrued liability related to contributions to a funded deferred compensation plan must be liquidated within 1 year after the end of the cost reporting period in which the liability is incurred. An extension, not to exceed 3 years beyond the end of the cost reporting year in which the liability was incurred, may be granted by the intermediary for good cause if the provider, within the 1-year time limit, furnishes to the intermediary sufficient written justification for non-payment of the liability.

(C) Postretirement benefit plans (including those addressed in Statement of Financial Accounting Standards No. 106 (December 1990)) are deferred compensation arrangements and thus are subject to the provisions of this section regarding deferred compensation and to applicable program instructions for determining Medicare payment for deferred compensation.

(viii) *Self-insurance.* Accrued liability related to contributions to a self-insurance program that are systematically made to a funding agency and that cover malpractice and comprehensive general liability, unemployment compensation, workers' compensation insurance losses, or employee health benefits, must be liquidated within 75 days after the close of the cost reporting period.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance)

Dated: April 20, 1995.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

[FR Doc. 95–15341 Filed 6–26–95; 8:45 am]

BILLING CODE 4120–01–P

42 CFR Part 413

[BPD–794–F]

RIN 0938–AG55

Medicare Program; Date for Filing Medicare Cost Reports

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule.

SUMMARY: This final rule extends the time frame providers have to file cost reports from no later than 3 months after the close of the period covered by the report to no later than 5 months after the close of that period. This change is necessary to ensure that providers have an adequate amount of time to file complete and accurate cost reports. We are also defining what HCFA considers to be an ''acceptable'' cost report submission.

EFFECTIVE DATE: These regulations are effective June 27, 1995. Thus, for cost reporting periods ending before June 27, 1995, cost reports continue to be due no later than 3 months following the close of the cost reporting period. For cost reporting periods ending on or after June 27, 1995, cost reports are due no later than 5 months following the close of the cost reporting period.

FOR FURTHER INFORMATION CONTACT: Katie Walker (410) 966–7278.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1815(a) of the Social Security Act (the Act) requires that each provider participating in the Medicare program submit information (as requested by the Secretary) in order to determine the amount of payment due to the provider for services furnished under the Medicare program. Implementing regulations at 42 CFR 413.24(f) require that participating providers submit cost reports that generally cover a consecutive 12-month period of the provider's operations. Section 102 of the Provider Reimbursement Manual, Part II (PRM-II), states that a provider may select any annual period for Medicare cost reporting purposes regardless of the reporting period it uses for other purposes. Once a provider has informed the Health Care Financing Administration (HCFA) of its selection, HCFA requires it to report annually thereafter for periods ending on the same date unless that provider's intermediary approves a change in the provider's reporting period. The intermediary makes interim payments to the provider during the provider's cost reporting year. Based on the annual cost report, a retroactive adjustment is made after the end of the provider's cost reporting year to bring the interim payments made during the period into agreement with the reimbursable amount payable to the provider. Section 413.24(f)(2)(i) specifies that cost reports are due on or before the last day of the third month following the close of the period covered by the report. Section 413.24(f)(2)(ii) states that the intermediary may grant a 30-day extension of the due date, for good cause, after first obtaining the approval of HCFA. Section 104.A.2 of the PRM requires that in order to obtain an extension, the provider must submit a written request and obtain written approval from its intermediary before the cost report due date.

A provider that voluntarily or involuntarily terminates its participation in the Medicare program, or experiences a change of ownership, must file a cost report no later than 45 days following the effective date of the termination of the provider agreement or the change of ownership, as required by § 413.24(f)(2)(iii). HCFA will not grant an extension of the cost report due date in either of these situations.

To ensure timely receipt of the cost reports, section 2231.1 of the Medicare Intermediary Manual, Part 2, requires that the intermediary send a ''reminder'' letter to the provider at the end of the second month following the end of the

cost reporting period. The letter advises the provider of the due date for filing the cost report and informs the provider that its interim payments will be reduced or suspended if the cost report is not received on or before the last day of the third month following the close of the period covered by the report. However, under § 413.24(f)(2)(ii), the provider may, for good cause, request that the intermediary grant a 30-day extension of the due date of the cost report. If the intermediary does not receive the cost report by the required due date (including an extension if approved), the intermediary sends the first of three ''demand'' letters to the provider requesting the submission of the provider's cost report and informing the provider of the percentage by which its interim payment rate will be reduced. The letter also states that further delay in filing the cost report will result in an additional reduction in the interim rate and, ultimately, a suspension of interim payments.

HCFA regulations at 42 CFR 405.376 set forth specific rules for the payment of interest on Medicare overpayments and underpayments. Interest is assessed unless the intermediary recoups the overpayment or the intermediary pays the provider an amount equal to the underpayment within 30 days of a ''final determination.'' When a provider does not file its cost report timely, all interim payments advanced for the period are considered overpayments, and a final determination is deemed to occur on the day after the date the cost report was due. Interest accrues on the deemed overpayment until the provider files the cost report, after which the usual audit rules and procedures regarding overpayment determinations apply.

HCFA has established a Provider Statistical and Reimbursement System (PS&R) to assist intermediaries in reconciling provider cost reports. This system provides a number of reports to be used in developing and auditing provider cost reports. HCFA prepares the reports for each participating provider. These reports contain Medicare charge and reimbursement information compiled by the provider's fiscal year. One of these reports, the Provider Summary Report, is sent to providers by their intermediaries in order to assist the providers in preparing their cost reports. The Provider Summary Report contains information about charges, Medicare patient days, coinsurance, etc. HCFA requires the intermediaries to furnish the Provider Summary Report to each provider within 60 days following the end of the provider's fiscal year. The provider then has 30 days to submit its completed cost report to its intermediary (60 days if an extension has been granted.)

Another system that provides useful cost report data is the Hospital Cost Report Information System (HCRIS). For purposes of maintaining the HCRIS data base, Medicare intermediaries currently must submit an extract of provider cost report data to HCFA within either 180 days of the end of the hospital cost reporting period or 60 days of receipt of the cost report from the provider, whichever is later.

II. Summary of Provisions of the Proposed Regulation

On May 25, 1994, we published a proposed rule in the **Federal Register** (59 FR 26998) to extend the due date for filing Medicare cost reports from 3 months following the close of a provider's cost reporting period to 5 months following the close of a provider's cost reporting period. The proposed rule also defined what HCFA considers to be an ''acceptable'' cost report submission. Presented below is a detailed explanation of these proposals and several related issues that were discussed in the proposed rule.

A. Due Dates for Filing Cost Report

In response to objections from providers that believe the current 3-month time frame for filing cost reports creates an undue burden on their financial departments, we proposed to increase the amount of time a provider has to file its cost report. Presently, under § 413.24(f)(2)(i), a provider must file its cost report on or before the last day of the third month following the close of the period covered by the report. We proposed that a provider would be required to file an acceptable cost report, as defined at new § 413.24(f)(5), on or before the last day of the fifth month following the close of the period covered by the report. For cost reporting periods ending on a day other than the last day of a month, cost reports would be due 150 days after the last day of the cost reporting period. (In accordance with § 405.376(e)(3), interest would not begin to accrue until the day following the due date of the report.)

We also proposed to change the regulations at § 413.24(f)(2)(ii) that allow an intermediary to grant, for good cause, a 30-day extension of the due date after first obtaining the approval of HCFA. Instead, we proposed that extensions may be granted by the intermediary only when a provider's operations are significantly adversely affected due to extraordinary circumstances over which the provider has no control. An example of such extraordinary circumstances might be a flood or a fire that forced a provider to cease operations and transfer its patients temporarily to other providers outside of the impacted area. The intermediary would still be required to obtain HCFA approval.

In conjunction with these changes, we proposed to delete § 413.24(f)(2)(iii), which now states that the cost report from a provider that voluntarily or involuntarily ceases to participate in the Medicare program or experiences a change of ownership is due no later than 45 days following the effective date of the termination of the provider agreement or change of ownership. Instead, providers in these circumstances would be permitted the same amount of time to file a cost report as other providers.

B. Acceptable Cost Report Submissions

We proposed to define at § 413.24(f)(5) what HCFA considers to be an acceptable cost report submission. Provisions of the proposed definition are as follows:

- All providers: The provider must complete and submit the required cost reporting forms, including all necessary signatures, and also must submit all supporting documentation required by the intermediary (for example, the HCFA Form 339, Provider Cost Report Reimbursement Questionnaire, and copies of audited financial statements).
- Providers that are required to file electronic cost reports: In addition to completing and submitting the required cost reporting forms, the provider also must submit its cost report in an electronic cost report format in conformance with the requirements contained in section 130 of the Electronic Cost Report (ECR) Specifications Manual (unless the provider has received an exemption from HCFA.) These requirements include the electronic file passing all of the level-1 edits contained in the ECR Specifications Manual. An acceptable cost report submission also must include all of the appropriate signatures. (Additional instructions concerning electronic submission of cost reports can be found at § 413.24(f)(4), as set forth in our May 25, 1994 final rule with comment period (59 FR 26960).)

In addition, we proposed that the intermediary is to make a determination of acceptability within 30 days of receipt of the cost report. If the intermediary considers the cost report unacceptable, the intermediary returns it to the provider with a letter explaining the reasons for the rejection (for example, the cost report failed a

level-1 edit or included incomplete documentation). When the cost report is rejected, it is deemed an unacceptable submission and treated as if a report had never been filed. The intermediary would also inform the provider of the consequences of filing a late cost report, that is, interest would be assessed on all overpayments. Furthermore, if a provider does not file its cost report timely, all interim payments advanced for the period are considered overpayments, and the provider's interim payments would be suspended. Given the additional filing time, we believe providers should have sufficient time to complete and submit an acceptable cost report. Thus, we proposed to suspend all payments if the cost report is not filed within the 5-month timeframe. The provider should make the necessary corrections to the cost report and resubmit the cost report to the intermediary as quickly as possible.

C. Related Issues

As a result of the proposed regulation changes, the timing of provider reminder letters, PS&R Summary Reports and the submission of HCRIS data would also be affected. Therefore, we stated our intention to revise the Medicare Intermediary Manual and the PRM as necessary to account for these changes.

- Reminder Letters. Because we proposed to lengthen the amount of time a provider has to file its cost report, we also indicated that we would change the deadline for the intermediaries to send reminder letters to providers to notify them that cost reports are due. The revised deadline would be by the end of the fourth month after the close of the cost reporting period. The reminder letter may be sent at the same time an intermediary sends the PS&R Summary Report to the providers, but an intermediary may not send the reminder letter before sending the PS&R Summary Report. The reminder letter will inform the provider that if the cost report is not received by the end of the fifth month following the close of the cost reporting period (or 150 days, whichever is applicable), the provider's interim payments will be suspended in their entirety the following day, rather than just reduced (as the Medicare Intermediary Manual now provides).
- PS&R Summary Report. In conjunction with the change in the cost report due dates, we also stated our intention to revise our Manual instructions to extend the time that HCFA allows the intermediaries to furnish the PS&R Summary Report to providers. Intermediaries would be required to furnish the PS&R Summary Report by the last day of the fourth month following the end of the provider's cost reporting period, instead of 60 days following the end of the provider's cost reporting period, as is currently the practice. For cost reporting periods ending on a day other than the last day of a month, intermediaries would be required to furnish the PS&R Summary Report by the 120th day following the end of a provider's cost reporting period. If the provider receives the PS&R Summary Report later than the last day of the fourth month (or the 120th day, if applicable) following the end of its cost reporting period, the provider would have 30 days from receipt to file its cost report. Thus, under the proposed policy, a provider still would have 30 days after receipt of the PS&R Summary Report to complete and submit the cost report to the intermediary.
- HCRIS Data. Presently, the intermediary must submit HCRIS data to HCFA within either 180 days of the end of the hospital cost reporting period or 60 days of receipt of the cost report from the provider, whichever is later. In conjunction with the proposed extension of the deadline for filing a cost report, we indicated that we would revise the Medicare Intermediary Manual to instruct intermediaries to submit HCRIS data to HCFA within 210 days of the last day of the hospital cost reporting period.

In addition, we stated our intention to revise our Manual instructions to specify that if the intermediary is late in sending the PS&R Summary Report to the providers, the amount of time for the intermediary to submit the HCRIS data would be reduced by the same number of days the PS&R Summary Report was late. For example, if the intermediary sends the PS&R Summary Report to the provider 10 days late, the provider would still have 30 days from receipt of the PS&R Summary Report to file its cost report. However, the time remaining for the intermediary to submit the HCRIS data would be reduced by a corresponding 10 days (that is, from 60 to 50 days following receipt of the cost report.) In such cases, the intermediary still would have a total of 210 days from the end of the hospital cost reporting period to submit HCRIS data to HCFA.

As noted above, the overall effect of the proposal to extend the time frame for providers to file cost reports would be that HCFA would not have access to updated HCRIS data until 210 days after the end of a given cost reporting period. This change would not delay significantly the availability of the analytical files (which are updated quarterly) in HCRIS, and it should improve the accuracy of initial cost report data.

III. Discussion of Public Comments

We received 43 timely comments on the May 25, 1994 proposed rule (59 FR 26998) from providers, intermediaries, certified public accounting firms, and others. In general, commenters expressed strong support for our proposals. Specific questions raised by commenters are addressed below.

Comment: Many commenters asked when the new deadline for filing cost reports would take effect.

Response: This final rule is effective June 27, 1995. How the new 5-month deadline affects individual providers will depend on when a provider's cost reporting period ends. That is, a provider with a cost reporting period that ends before the effective date of this final rule must file its report on or before the last day of the third month following the close of the period covered by the report. A provider with a cost reporting period that ends on or after the effective date of this final rule must file its cost report on or before the last day of the fifth month following the close of the period covered by the report (or, if applicable, within 150 days of the last day of the cost reporting period).

Comment: One commenter asked that we clarify when a cost report is considered to be filed, for purposes of meeting the filing deadline. The commenter believes that the timeliness of a cost report should be determined based on when a provider sends the report rather than when the intermediary receives it. The commenter also requested clarification on when the 30-day period begins for an intermediary to determine the acceptability of a cost report.

Response: In accordance with section 2219.4C of the Medicare Intermediary Manual, a cost report must be postmarked by its due date to be considered timely filed. This requirement applies regardless of whether the provider furnishes a hard copy of its cost report or a diskette version. If a cost report is due on a Saturday, Sunday, or Federal holiday, the cost report is considered timely filed if postmarked by the following work day.

The 30 days for an intermediary to determine the acceptability of a cost report begins on the date that the intermediary receives the cost report, rather than the date the provider files it. (We generally allow up to a 7-day grace period between the postmarked date and the date the cost report is received

by the intermediary.) If a provider files a cost report early and receives a notice of rejection before the end of the fifth month, the provider would have the remaining days in that 5-month period to file a corrected cost report. If the corrected cost report is filed by the end of the fifth month, it would be considered timely. If a provider files a cost report that is rejected by the intermediary, and the provider subsequently is unable to file a corrected report before the 5-month period has elapsed, the cost report is considered late. The intermediary then initiates the suspension of interim payments and assessment of interest against payments made to the provider for the fiscal period.

Comment: One commenter suggested that we eliminate the instructions in Section 2413.A.3 of the PRM-I that permit an additional 30 days for filing a certified cost report.

Response: Under the new due date policy set forth in this rule, all cost reports are due no later than 5 months following the close of a provider's cost reporting period. In view of this change, we believe that the additional 30 days for filing a certified cost report is no longer necessary. Thus, as the commenter suggested, we intend to revise the manual accordingly.

Comment: Several commenters pointed out that providers may be required to file cost reports sooner than 5 months after the close of a cost reporting period. For example, one commenter cited a New York State requirement that providers file cost reports within 4 months of the close of their cost reporting periods, rather than within the Federal deadline of 5 months. Thus, the commenter believes that affected providers would need the PS&R Summary Reports no later than 3 months following the end of their cost reporting periods instead of the 4 months reflected in our revised policy.

Another commenter believes that providers that are reimbursed on a cost basis may choose to file their cost reports sooner than 5 months after the close of their cost reporting periods in order to avoid possible delays in lump sum adjustments and interim rate adjustments.

Response: We recognize that there may be State requirements, or other requirements, that a provider file its cost report sooner than 5 months from the last day of its cost reporting period. In these situations, a provider should contact the intermediary and request that the intermediary furnish the PS&R Summary Report to the provider 30 days before the due date of the cost report. We emphasize that it is the provider's responsibility to ascertain from the intermediary the amount of time needed for the intermediary to submit the PS&R Summary Report. The provider should make any such request early enough (as determined by the intermediary) to give the intermediary sufficient time to provide the PS&R Summary Report to the provider in time for the provider to meet its filing due date. Once again, each intermediary determines the amount of time it needs to submit the PS&R to the provider.

Thus, our general policy in situations where providers need their PS&R Summary Reports before they would normally receive them is that each provider should contact its intermediary to obtain the PS&R on an expedited basis. However, this policy could prove cumbersome in situations where most or all of an intermediary's providers face a similar State-imposed deadline, possibly resulting in a large volume of individual requests for expedited PS&Rs. In such a situation, we would strongly encourage the State to work with affected intermediaries and providers to develop a more efficient means of addressing a widespread need for PS&Rs before the reports are required under Medicare.

As a commenter suggested, some providers may wish to file their cost reports earlier than the 5-month deadline of their own accord. These providers too should contact their intermediaries with their requests that the PS&R Summary Reports be furnished earlier than the usual timeframe of 4 months after the close of a provider's cost reporting period. The providers should request the PS&R in time to allow the fiscal intermediary no less than 30 days to prepare the PS&R.

We note that an intermediary is required to provide only one PS&R Summary Report to each provider. If a provider that requests its PS&R Summary Report early subsequently requests a later PS&R, the subsequent version of the PS&R will be furnished by the intermediary at the provider's expense.

Comment: Several commenters believe that we should include situations that reasonably impact the provider's ability to file its cost report timely, such as changes in key provider personnel, among the acceptable ''circumstances beyond the provider's control'' for granting an extension to a provider for filing its cost report. Other commenters are concerned that an intermediary's operations (such as audits, desk reviews, and settlements) could impact on a provider's ability to timely file cost reports.

Response: Under revised § 413.24(f)(2)(ii), an extension of the due date for filing a cost report may be granted by the intermediary only when a provider's operations are significantly adversely affected due to extraordinary circumstances over which the provider has no control, such as flood or fire. Although this policy constitutes a more stringent standard for a filing extension than the ''good cause'' criterion that has been in effect, we believe that this change is reasonable and necessary in conjunction with the change to a 5-month deadline for filing the cost report. Even for providers that routinely have obtained 30-day ''good cause'' filing extensions beyond the previous 3-month deadline, the new 5-month deadline allows approximately 30 additional days to file a cost report.

We recognize that personnel changes create workload problems for the provider. In general, however, we consider personnel changes and varying workload demands to be acknowledged parts of any provider's business operations rather than ''circumstance over which a provider has no control.''

With regard to the commenters' concern that an intermediary's operations may impact on a provider's ability to file cost reports on a timely basis, we note that in any case where an intermediary is late in furnishing a PS&R Summary Report, a provider would always be allowed 30 days after receipt of the PS&R Summary Report to complete and submit its cost report to the intermediary.

As always, intermediaries and HCFA will consider requests for extensions on a case-by-case basis. As the regulations reflect, however, in view of the additional time now permitted for filing a cost report, we believe the standard for requesting an extension should be stringent.

Comment: Two commenters objected to our proposal that the deadline for a provider that is changing ownership or terminating to file its cost report be extended from 45 days to 5 months following change of ownership or termination. The commenters believe that this change may result in the intermediary finding it difficult to collect overpayments made to the provider.

Response: Our experience is that the current 45-day timeframe for a provider that is changing ownership or terminating often is not sufficient for an intermediary to supply the provider with its PS&R Summary Report and then for the provider to submit an accurate cost report to its intermediary. We believe that extending the due date for these providers' cost reports to 5

months following the date of termination or change of ownership, consistent with the requirement for other providers, will allow these providers sufficient time to gather and reconcile their data and submit complete and accurate cost reports. Although we recognize that the extension in the filing timeframe may result in difficulties in collecting overpayments, on balance, we believe that these potential problems are outweighed by the advantages of a consistent policy and more accurate reporting. Intermediaries should be aware of the potential for overpayment and, in the event of an overpayment, should begin collection of any overpayment at the earliest possible time.

Comment: Many commenters addressed our proposal that an intermediary submit the PS&R Summary Report to a provider within 4 months (or 120 days) of the close of the provider's cost reporting period. Several commenters requested that the due date for the PS&R Summary Report continue to be 60 days following the close of a provider's cost reporting period; others requested that the due date be extended to 90 days rather than the proposed 120 days. These commenters believe that extending the due date for the PS&R Summary Report from 60 days to 120 days offers obvious benefits to the intermediary. However, the commenters stated that it is not equitable to give the intermediary an additional 2 months to provide the PS&R Summary Report to the provider, while the provider must continue to file its cost report within 30 days of receipt of the PS&R Summary Report.

Response: The purpose of the PS&R Summary Report is to assist the providers in reconciling their data so that they can prepare and file an accurate and timely cost report. We realize that providers would like to receive the PS&R Summary Reports as early as possible. We note, however, that the providers should be maintaining ongoing records to be used for cost reporting purposes and the PS&R Summary Report should be used as a tool in reconciling these ongoing records. In our opinion, 30 days is ample time for this reconciliation.

We believe that providing an additional 60 days for intermediaries to submit PS&R Summary Reports to providers ensures that intermediaries can furnish more accurate and complete PS&R data to providers, which in turn results in providers requiring less time to reconcile the PS&R data with their records. In addition, under the new timeframes, providers will have 2 more months to prepare their books and records, complete the necessary audits, and develop the financial statements and reports that are needed before they can complete the cost reporting forms.

Of course, if the PS&R is received later than 120 days after the end of the cost reporting period, a provider still would have 30 days from the date of receipt to file its cost report.

Comment: One commenter requested that manual instructions be updated to assist intermediaries in completing the PS&R Summary Report.

Response: The Medicare Intermediary Manual, Part 2, is being revised to provide updated instructions for completing the PS&R Summary Report.

Comment: Several commenters believe that 210 days is insufficient time for an intermediary to submit HCRIS data to HCFA.

Response: Presently, the intermediary must submit HCRIS data to HCFA within either 180 days of the end of the hospital cost reporting period or 60 days of receipt of the cost report from the provider, whichever is later. The current 180-day deadline for an intermediary to submit HCRIS data to HCFA is based on the following: (1) 90 days for a provider to file its cost report, (2) 30 days for an extension of time to file (available to providers with good cause), and (3) an additional 60 days for the intermediary to submit HCRIS data to HCFA. In conjunction with the extension of the deadline for filing a cost report, we are revising the Intermediary Manual to instruct intermediaries to submit HCRIS data to HCFA within 210 days of the last day of the hospital cost reporting period. The revised deadline is based on the following: (1) 150 days for filing a cost report; and (2) 60 days for submission of HCRIS data to HCFA.

Thus, both the current process, and the new process being implemented through this final rule, give intermediaries 60 days after cost reports are filed to submit HCRIS data to HCFA. The change from an overall time frame for the submission of HCRIS data of 180 days after the close of a cost reporting period to 210 days after the close of a cost reporting period is a logical end product of the 2-month increase in the timeframe for a provider to file its cost report combined with the elimination of the routine 30-day filing extension.

These changes in no way increase the burden or time constraints on intermediaries. Rather, we believe that these changes will ease the burden on intermediaries by allowing them additional time to prepare PS&R Summary Reports, resulting in more accurate and complete PS&R data to the providers, in turn producing more accurate cost reports back to the intermediaries. We note that the continuing growth in the proportion of cost reports being filed electronically should also produce more accurate cost reporting. With these increases in accuracy, intermediaries should have to expend fewer resources in determining the acceptability of cost reports, and intermediary requests to providers for additional data to meet HCRIS requirements should be minimized. Therefore, we believe the overall 210-day timeframe for reporting HCRIS data is sufficient.

Comment: Several intermediaries are concerned about workload demands that result from a large percentage of providers having cost reporting periods that end at the same time. The commenters are concerned that, with a large percentage of their providers having common year ending dates, the time allotted for the intermediary to determine the acceptability of these cost reports is insufficient.

One commenter is concerned that its current workload patterns will be disrupted by our revised policy of allowing providers an additional 2 months to submit their cost reports.

Response: We recognize that some intermediaries have many providers with common year-ending dates, resulting in cyclical increases in an intermediary's workload. The change in the cost reporting deadline will have an impact on when these cyclical periods of increased workload occur, but not on the amount of work involved. In fact, as discussed above, the extended time frames for cost report submission should result in increased accuracy and, consequently, fewer resources being expended by the intermediary in determining the acceptability of the provider's cost report. The requirement that hospitals file their cost reports electronically (see our May 25, 1994 final rule (59 FR 26960)), combined with the continued growth in electronic filing among other providers, will also contribute to reducing the workload associated with determining the acceptability of cost reports. Thus, we believe that intermediaries should be able to determine the acceptability of cost reports within 30 days of receiving them, even when the intermediary receives many reports concurrently.

We recognize that the current workload patterns of intermediaries will undergo a one-time disruption as a result of the new cost reporting deadline. In the short-term, this change may inconvenience some intermediaries, while benefiting others, depending to some extent on when cost reporting years end for each

intermediary's various providers. In the long run, however, we believe that extending the cost reporting deadline and the accompanying increases in the accuracy of cost reports, should prove advantageous to both intermediaries and providers.

Comment: A commenter is concerned that electronically-filed cost reports may not be compatible with intermediary software, possibly making it difficult for an intermediary to produce a hard copy of the cost report. The commenter also requested further clarification regarding rejection of the cost report for failure to pass level-1 edits as well as for failure to furnish the supporting documentation that a provider must submit with the cost report.

Response: As discussed in section II.B of this preamble, a provider that files an electronic cost report must submit its cost report in an electronic format in conformance with the requirements contained in section 130 of the Electronic Cost Report (ECR) Specifications Manual (unless the provider has received an exemption from HCFA.) These requirements include the electronic file passing all of the fatal (level-1) edits contained in the ECR Specifications Manual.

The criteria for an acceptable electronic cost report also are addressed in chapter 1 of the PRM–II, which discusses the required format for electronic filing and the procedures for specialized providers, such as providers with all-inclusive rate structures and low-Medicare utilization providers. (See Chapter 28 of the PRM–II for the specified level-1 edits.) All Automated Data Reporting (ADR) vendors and commercial vendors must adhere to these edits when developing the software used by the provider to create the electronic cost report file. In view of the requirement that vendor, provider and intermediary software be compatible, and the requirement that an acceptable cost report must pass all level-1 edits, we do not anticipate that intermediaries will have difficulty in producing a hard copy of the cost reports.

The requirements for supporting documentation that each provider type must submit with its cost report are set forth in various chapters of the PRM–II. In the May 25, 1994 proposed rule (59 FR 27002), we specified under proposed § 413.24(f)(5)(i) that in order for a cost report submission to be considered acceptable, a provider must submit the required cost reporting forms and all supporting documentation required by program instructions. Under proposed 413.24(f)(5)(iii), any cost report not considered acceptable would be rejected and thus treated as if it had never been filed.

As we considered the public comments and developed this final rule, we realized that it was not necessary or efficient for an intermediary to reject a cost report summarily based solely on the initial absence of complete supporting documentation. Therefore, we have revised proposed § 413.24 by deleting the provision that a cost report must include all required supporting documentation to be considered acceptable and thus avoid rejection. We believe that this change will benefit both intermediaries and providers by permitting the intermediary's review process to continue in cases where a provider inadvertently fails to submit complete supporting documentation.

We emphasize that, despite this change, providers remain responsible for submitting all supporting documentation required under applicable program instructions. However, we are instructing intermediaries that a cost report is to be rejected for lack of supporting documentation only if it does not include the Provider Cost Reimbursement Questionnaire (HCFA Form 339). Additionally, cost reports for teaching hospitals will be rejected for lack of supporting documentation if the cost report does not include a copy of the Intern and Resident Information System (IRIS) diskette. These requirements now are specified in the Uniform Desk Review Program published in Part 4 of the Medicare Intermediary Manual, and we are now setting them forth under § 413.24(f)(5) as well. Otherwise, if a cost report does not include required supporting documentation, the intermediary contacts the provider in writing and requests the missing supporting documentation. If the documentation is not received from the provider within 15 days from the date of receipt of the intermediary request (allowing 7 days for mailing), the intermediary may begin suspending payments until the supporting documentation is received. We are revising the Medicare Intermediary Manual and chapter 1 of the PRM–II to reflect this policy.

Comment: One commenter stated that the requirement that a provider submit supporting documentation may be in conflict with the American Institute of Certified Public Accountant (AICPA) recommendations concerning proper disclosure. The commenter believes that the required supporting documentation could be considered confidential.

Response: To carry out the settlement process, an intermediary must request sufficient documentation to assure the accuracy and allowability of costs reported on the cost report. We do not believe that this information is necessarily confidential in nature. Nevertheless, the intermediary will retain the data and maintain its confidentiality. Generally, the release of provider information is limited to that information contained in the provider's cost report. Supporting documentation, or documentation obtained through audit, is not considered releasable to the public under the Freedom of Information Act.

IV. Provisions of the Final Regulations

This rule adopts the provisions of the proposed rule as final with the exception of one change at § 413.24(f)(5)(i) concerning our proposed definition of an acceptable cost report submission. As discussed above in section III, we have eliminated the proposed requirement that a cost report must include all supporting documentation in order to be considered an acceptable submission.

V. Impact Statement

We generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612) unless we certify that a final rule will not have a significant economic impact on a substantial number of small entities. This final rule extends from 3 months to 5 months after the close of a cost reporting period the time frame for providers to file their cost reports. It also defines what HCFA considers to be an ''acceptable'' cost report submission. Neither of these changes will have a significant economic impact on providers. Therefore, we have determined, and we certify, that this rule would not have a significant effect on a substantial number of small entities. Thus, we are not preparing a regulatory flexibility analysis.

Section 1102(b) of the Act requires us to prepare a regulatory impact statement if a final rule may have a significant economic impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 50 beds.

We are not preparing a regulatory impact statement since we have determined, and we certify, that this final rule would not have a significant economic impact on the operations of a

substantial number of small rural hospitals.

In accordance with the provisions of Executive Order 12866, this regulation was not reviewed by the Office of Management and Budget.

VI. Other Required Information

A. Waiver of 30–Day Delay in Effective Date

We normally provide a delay in the effective date of 30 days after publication for final rules. However, we may waive the delay in the effective date if we find good cause that a delay in the effective date is impracticable, unnecessary, or contrary to the public interest.

As explained above, this final rule extends the time frame for providers to file cost reports from 3 months after the close of a cost reporting period to 5 months after the close of a cost reporting period. We believe this change will be beneficial to providers and that a delay in implementing this change would serve no purpose. Thus, we have concluded that in this instance it would be unnecessary and contrary to the public interest to provide for a 30-day delay in the effective date of this final rule. Therefore, we find good cause to waive the usual 30-day delay in effective date.

B. Paperwork Reduction Act

Section 413.24 contains information collection and recordkeeping requirements concerning provider cost reports that are subject to review by the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1980 (44 U.S.C. 3501 et seq.). The burdens associated with filing cost reports have been approved by OMB. This final rule merely changes the date on which cost reports are due and thus has no effect on the information collection and recordkeeping burden. However, the information collection and recordkeeping requirements contained in § 413.24 are not effective until they have been approved by OMB. We will publish a notice in the **Federal Register** when OMB approval has been obtained. Organizations and individuals desiring to submit comments on the information collection and recordkeeping requirements set forth in § 413.24 should direct them to the Office of Management and Budget, Human Resources and Housing Branch, Room 10235, New Executive Office Building, Washington, D.C., 20503, Attention: Allison Eydt (desk officer for HCFA).

List of Subjects in 42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Chapter IV, part 413, is amended as follows:

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES

1. The authority citation for part 413 continues to read as follows:

Authority: Secs. 1102, 1122, 1814(b), 1815, 1833 (a), (i), and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1320a–1, 1395f(b), 1395g, 13951 (a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww).

Subpart B—Accounting Records and Reports

2. In § 413.24, paragraph (f)(2) is revised, and a new paragraph (f)(5) is added to read as follows:

§ 413.24 Adequate cost data and cost finding

* * * * *

(f) * * *

(2) *Due dates for cost reports.* (i) Cost reports are due on or before the last day of the fifth month following the close of the period covered by the report. For cost reports ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost reporting period.

(ii) Extensions of the due date for filing a cost report may be granted by the intermediary only when a provider's operations are significantly adversely affected due to extraordinary circumstances over which the provider has no control, such as flood or fire.

* * * * *

(5) An acceptable cost report submission is defined as follows:

(i) All providers—The provider, must complete and submit the required cost reporting forms, including all necessary signatures. A cost report is rejected for lack of supporting documentation only if it does not include the Provider Cost Reimbursement Questionnaire. Additionally, a cost report for a teaching hospital is rejected for lack of supporting documentation if the cost report does not include a copy of the Intern and Resident Information System diskette.

(ii) For providers that are required to file electronic cost reports—In addition to the requirements of paragraphs (f)(4) and (f)(5)(i) of this section, the provider must submit its cost reports in an electronic cost report format in conformance with the requirements contained in the Electronic Cost Report (ECR) Specifications Manual (unless the provider has received an exemption from HCFA).

(iii) The intermediary makes a determination of acceptability within 30 days of receipt of the provider's cost report. If the cost report is considered unacceptable, the intermediary returns the cost report with a letter explaining the reasons for the rejection. When the cost report is rejected, it is deemed an unacceptable submission and treated as if a report had never been filed.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: May 30, 1995.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

[FR Doc. 95–15340 Filed 6–26–95; 8:45 am]

BILLING CODE 4120–01–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 73

[MM Docket No. 95–24; RM–8583]

Radio Broadcasting Services; Clarendon, TX

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: The Commission, at the request of ROHO Broadcasting, allots Channel 257C2 to Clarendon, Texas, as the community's first local aural transmission service. *See* 60 FR 10534, February 27, 1995. Channel 257C2 can be allotted to Clarendon, Texas, in compliance with the Commission's minimum distance separation requirements without the imposition of a site restriction. The coordinates for Channel 257C2 at Clarendon are 34–56–16 and 100–53–16. With this action, this proceeding is terminated.

DATES: Effective August 7, 1995. The window period for filing applications will open on August 7, 1995, and close on September 7, 1995.

FOR FURTHER INFORMATION CONTACT: Pam Blumenthal, Mass Media Bureau, (202) 418–2180.

SUPPLEMENTARY INFORMATION: This is a synopsis of the Commission's *Report and Order,* MM Docket No. 95–24, adopted June 13, 1995, and released June 22, 1995. The full text of this