cost limits for freestanding and hospital-based SNFs in urban and rural areas. If an SNF believes that it will not receive adequate payment under this optional system, it is not required to elect this payment system. Instead, it could continue to be reimbursed for its reasonable costs up to its cost limit with the possibility of obtaining an exception under the provisions of § 413.30 for its costs in excess of the limit.

Comment: Several commenters responded to our request for comments on alternative methodologies for determining payment amounts for ancillary services. One commenter stated that the best method for computing an ancillary payment rate system would be by developing reasonable charge payment screens, or, as an alternative, using an average per diem rate weighted on the basis of ancillary services provided. Another commenter urged the Secretary not to adopt a system of reasonable charges for the purpose of paying for ancillary services because such a system could not serve to reasonably cover the cost of providing services. Two commenters urged the Secretary to continue payment for ancillary services on a cost basis, until such time as another method could be developed.

Response: While we agree that the reasonable charge payment screen method would meet the statutory requirement for determining payment rates on the basis of reasonable charges, the data to establish such payment screens are unavailable. At the same time, we do not believe that using an average per diem rate weighted on the basis of ancillary services provided complies with the statutory requirement for determining a rate for ancillary services based on reasonable charges. We do not intend to adopt a reasonable charge system unless it can provide an equitable level of reimbursement. To date, we have not been able to develop a methodology that meets this requirement. Until we develop an equitable system based on reasonable charges, payment for ancillary services will continue on a cost basis. We have gathered data for certain ancillary therapies and are in the process of evaluating this information to determine if it would be appropriate for establishing a rate for ancillary services based on reasonable charges.

IV. Provisions of the Final Regulations

After careful consideration of public comments, no substantive changes have been made to the regulations. Thus, this final rule basically adopts the provisions of the proposed rule, with several minor clarifications that are discussed below.

In § 413.304(a), (b), and (c), we have changed ''may'' receive to ''is eligible to'' receive, in order to more clearly differentiate between the eligibility criteria and the rules governing election to be paid a prospectively determined payment rate under § 413.308.

We have amended § 413.308(b) by adding ''and the timely election requirements under 413.308(a)'' to clarify that the SNF must meet election, as well as eligibility, requirements. We have also changed ''determination'' to ''initial and final determinations'' for clarification.

We have amended § 413.308(c) by prohibiting an SNF from revoking its request once the intermediary has given initial determination of eligibility (as opposed to final determination, as stated in the proposed rule (59 FR 29578)). The time needed to make a final determination of the number of Medicare covered days in a cost reporting period can extend for many months due to various factors. Thus, we believe allowing an SNF to revoke its election until it receives a final approval would not conform with the intent of the statute.

We have added § 413.308(d), which clarifies the intermediary's authority to revoke the prospectively determined payment rate option if the intermediary determines that the SNF did not meet the eligibility criteria.

We have amended § 413.310(b) by adding the term ''for routine capital costs'' for clarification.

We have amended § 413.314 by adding the term ''and qualifies for such payment'' to clarify that in order to be paid a prospectively determined rate, an SNF must not only elect to be paid prospectively, but must qualify to do so.

V. Impact Statement

Unless we certify that a final rule will not have a significant economic impact on a substantial number of small entities, we generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612). For purposes of the RFA, we consider SNFs as small entities.

In our analysis of the impact of the June 8, 1994 proposed rule, we noted that Medicare payments to SNFs comprise only about 5.3 percent of total SNF revenues and this rule will only have a small impact on those revenues. Moreover, the purpose of this rule is to ease the compliance burden for small entities, and we believe the rule will have a positive impact on small entities. We received no comments on these issues.

Also, section 1102(b) of the Act requires the Administrator to prepare a regulatory impact statement if a final rule has 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 603 of the RFA. With the exception of hospitals located in certain rural counties adjacent to urban areas, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 50 beds.

We have determined, and the Administrator certified, that this final rule will not have a significant effect on the operations of a substantial number of small entities or on small rural hospitals. Therefore, we have not prepared a regulatory flexibility analysis or an analysis of the effects of this rule on 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. Collection of Information Requirements

Sections 413.308 and 413.321 of this document contain information collection and recordkeeping requirements 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.). When OMB approves these provisions, we will publish a notice to that effect. The information collection requirements in § 413.321 concern the collection of financial data of skilled nursing facilities needed to prepare the applicable Medicare cost reports. The respondents who will provide the information include an estimated 1,250 SNFs. Public reporting burden for this collection of information is estimated to be 123,750 hours during the first 12-month period that the rule will be in effect.

The information collection requirements in § 413.308 concern notification of election of prospectively determined payment rates by each SNF to its intermediary for each cost reporting period and review by the SNF of the intermediary's determination. The respondents who will provide the information include the electing SNFs and their intermediaries. Public reporting burden for these requirements is estimated to be one half hour total for each request and review. The total for 1,250 SNFs and their intermediaries would be approximately 625 hours.