''§ 17.250 through § 17.266'' is added in place thereof.

§ 17.254 [Amended]

99. In redesignated § 17.254 introductory text, ''Chief Medical Director'' is removed both times it appears and ''Under Secretary for Health'' is added in place thereof both times it appears.

§ 17.255 [Amended]

100. In redesignated § 17.255, ''§ 17.266'' is removed and ''§ 17.254'' is added in place thereof.

§ 17.257 [Amended]

101. In redesignated § 17.257 introductory text, ''Chief Medical Director'' is removed and ''Under Secretary for Health'' is added in place thereof.

102. In redesignated § 17.257(b), ''§ 17.271'' is removed and ''§ 17.258'' is added in place thereof.

103. In redesignated § 17.257(c), ''§§ 17.266 through 17.268'' is removed and ''§§ 17.254 through 17.256'' is added in place thereof.

§ 17.258 [Amended]

104. In redesignated § 17.258(b), ''§§ 17.266 through 17.267'' is removed and ''§§ 17.254 through 17.256'' is added in place thereof.

105. In redesignated § 17.258(c), ''§§ 17.275 through 17.277'' is removed and ''§§ 17.259 through 17.261'' is added in place thereof.

§ 17.262 [Amended]

106. In redesignated § 17.262, ''Chief Medical Director'' is removed and ''Under Secretary for Health'' is added in place thereof.

§ 17.350 [Amended]

107. In § 17.350, ''§§ 17.37 through 17.42'' is removed and ''38 U.S.C. 1724 and § 1732, and 38 CFR 17.36 through 17.40'' is added in place thereof.

§ 17.355 [Amended]

108. In § 17.355, ''Chief Medical Director'' is removed and ''Under Secretary for Health'' is added in place thereof.

§ 17.364 [Amended]

109. In § 17.364(a), ''§§ 17.37 through 17.39'' is removed and ''38 U.S.C. 1724 and 1732, and 38 CFR 17.36 through 17.37'' is added in place thereof.

§ 17.367 [Amended]

110. In § 17.367, ''§§ 17.37 through 17.42'' is removed and ''38 U.S.C. 1724 and 1732, and 38 CFR 17.36 through 17.40'' is added in place thereof.

* * * * *

111. In § 17.601 paragraph (f) is revised to read as follows:

§ 17.601 Definitions.

(f) Under Secretary for Health means the Under Secretary for Health for Veterans Health Administration or designee.

* * * * *

§ 17.603, 17.608, 17.609 [Amended]

112. In §§ 17.603, 17.608(c) introductory text, and 17.609, ''Chief Medical Director'' is removed and ''Under Secretary for Health'' is added in each place thereof.

[FR Doc. 96–11637 Filed 5–10–96; 8:45 am]
BILLING CODE 8320–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 412

[BPD–856–FC]

Medicare and Medicaid Program; Criteria for a Rural Hospital To Be Designated as an Essential Access Community Hospital (EACH)

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

ACTION: Final rule with comment period.

SUMMARY: This final rule revises the criteria that a rural hospital must meet to be designated as an Essential Access Community Hospital (EACH). The revised criteria permit HCFA to designate a hospital as an EACH if the hospital cannot be designated as an EACH by the State only because it has fewer than 75 beds and is located 35 miles or less from another hospital. Hospitals in rural areas that are designated as EACHs by HCFA are treated, for payment purposes, as sole community hospitals.

The revised criteria are designed to facilitate development of network affiliations between rural EACHs and small rural facilities, known as Rural Primary Care Hospitals (RPCHs). The revisions would affect only hospitals located in rural areas of the States of California, Colorado, Kansas, South Dakota, New York, West Virginia, and North Carolina, or in an adjacent State.

DATES: Effective Date: This regulation is effective May 13, 1996.

Comment Period: Comments will be considered if received at the appropriate address, as provided below, no later than 5 p.m. on July 12, 1996.

ADDRESSES: Mail written comments (one original and three copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: BPD–856–FC, P.O. Box 7517, Baltimore, MD 21207–0517.

If you prefer, you may deliver your written comments (one original and three copies) to one of the following addresses:

Room 309–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201, or
Room C5–09–26, Central Building, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code BPD–856–FC. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 309–G of the Department's offices at 200 Independence Avenue SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 690–7890).

For comments that relate to information collection requirements, mail a copy of comments to: Health Care Financing Administration, Office of Financial and Human Resources, Management Planning and Analysis Staff, Room C2–26–17, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Copies: To order copies of the Federal Register containing this document, send your request to: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250–7954. Specify the date of the issue requested and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 512–1800 or by faxing to (202) 512–2250. The cost for each copy is $8.00. As an alternative, you can view and photocopy the Federal Register document at most libraries designated as Federal Depository Libraries and at many other public and academic libraries throughout the country that receive the Federal Register.

FOR FURTHER INFORMATION CONTACT: George Morey, (410) 786–4653.

SUPPLEMENTARY INFORMATION:

I. Background

On May 26, 1993, we published in the Federal Register (58 FR 30630) a final rule to implement the Essential Access Community Hospital (EACH) Program. That program, which is authorized by

section 1820 of the Social Security Act (the Act), is intended to promote regionalization of health services in rural areas, improve access to hospital and other health services for rural residents, and enhance the provision of emergency and other transportation services related to health care. The program is not national in scope, but is limited to the States (not to exceed seven) that have been given Federal grants for their activities in support of it. The States that have received such grants are California, Colorado, Kansas, South Dakota, New York, West Virginia, and North Carolina.

An important component of the EACH program is the rural health network, which is an organization made up of at least one Rural Primary Care Hospital (RPCH), and at least one EACH, regional referral center, or hospital located in an urban area that meets the criteria for classification as a regional referral center. An RPCH is a small, limited-service facility that is located in a rural area and furnishes outpatient and short-term inpatient care needed to stabilize a patient before discharge or transfer to another facility for further care. An EACH is a larger, full-service hospital that has agreed to provide emergency and medical backup services to the RPCH (or RPCHs) participating in its network. Network membership is optional for RPCHs, but a hospital cannot be designated as an EACH unless it has a network agreement. EACHs in rural areas are treated for Medicare payment purposes as sole community hospitals, which typically entitles the facilities to a higher level of payment for their inpatient services than they would otherwise receive.

As is the case with any other relationships between providers or between providers and other persons or entities, any arrangements are subject to the provisions of the Medicare and Medicaid anti-kickback statute (section 1128B(b) of the Social Security Act, 42 U.S.C. 1320a–7b(b)). That statute prohibits knowingly and willfully offering, paying, soliciting or receiving remuneration in order to induce business reimbursed under the Medicare, Medicaid or other State health care programs. Prohibited conduct includes the transferring of anything of value intended to induce referrals of patients, as well as *soliciting or receiving remuneration in return for* the purchasing, leasing, ordering or arranging for any good, facility, service or item paid for by Medicare, Medicaid, or other State health care program.

II. Criteria for Designation of EACHs

Under section 1820(I)(1)(A) of the Act, HCFA can designate a hospital as an EACH only if it meets specific requirements and is first designated as such by the grant State. The criteria for State designation are set forth in section 1820(e). Under these criteria, a State may designate a rural facility as an EACH only if the hospital—

• Is located in a rural area, as defined in section 1886(d)(2)(D);

• Is located more than 35 miles from any hospital that—

+ Has been designated as an essential access community hospital;

+ Is classified by the Secretary as a rural referral center under section 1886(d)(5)(C); or

+ Meets such other criteria relating to geographic location as the State may impose with the approval of the Secretary;

• Has at least 75 inpatient beds or is located more than 35 miles from any other hospital;

• Has in effect an agreement to provide emergency and medical backup services to rural primary care hospitals participating in the rural health network of which it is a member and throughout its service area;

• Has in effect an agreement, with each rural primary care hospital participating in the rural health network of which it is a member, to accept patients transferred from such primary care hospital, to receive data from and transmit data to such primary care hospital, and to provide staff privileges to physicians providing care at such primary care hospital; and

• Meets any other requirements imposed by the State with the approval of the Secretary.

Section 1820 also contains a provision that allows the Secretary some flexibility in designating hospitals as EACHs even though they do not meet the general bed size and geographic location criteria. Section 1820(i)(1)(B) of the Act allows the Secretary to designate a hospital as an EACH if it is not eligible for designation by the State only because it does not have 75 or more beds, or is not located more than 35 miles from another hospital. While we were preparing the final rule published May 26, 1993 (58 FR 30629), we received comments suggesting that we use this authority to designate facilities as EACHs, even though they do not meet the bed size and geographic criteria specified in section 1820(e)(2). We considered these comments carefully but decided to exercise the authority only with respect to hospitals that have fewer than 75 beds and are located within 35 miles of another hospital, but are not located within 35 miles of any hospital having 75 or more beds. Where such hospitals meet other applicable criteria and are recommended by the State as the EACH member of a proposed network, HCFA will designate them as EACHs. Regulations permitting such designations are set forth at 42 CFR 412.109(c)(2) (ii) and (iii).

Based on our further experience in administering the EACH program, we now believe that in order to increase access to hospital services in rural areas, there may be other circumstances in which it would be appropriate to exercise our section 1820(i)(1)(B) authority for rural hospitals. For example, a full-service hospital that meets other requirements to be the EACH member of a network may be located within 35 miles of another hospital that has 75 or more beds. In this situation the hospital could not, under existing regulations, be designated as an EACH, even if it is the only hospital that is willing and able to furnish the rural health network emergency and medical backup services available from EACHs that might be needed to permit a third facility to operate successfully as an RPCH, thus preserving access to care in its area. Under these circumstances, section 1820(i)(1)(B) authority may appropriately be exercised to permit designation of an EACH, thus allowing the small facility to be converted successfully to an RPCH and to continue providing services to its patients.

To allow for designation of facilities as EACHs in these circumstances while not defeating the purpose of the basic statutory requirements for EACH designations, we are revising § 412.109(c) of our regulations to specify additional criteria under which designations by HCFA will be made. As revised, the regulations allow a hospital located 35 miles or less from another hospital to be designated as an EACH only if—

• The hospital is not eligible for State designation as an EACH solely because it has fewer than 75 beds and is located 35 miles or less from any other hospital; and

• The hospital is located more than 35 miles from the nearest hospital having 75 or more beds, and is recommended by the State for designation as the EACH member of a proposed network; or

• The following criteria are met—

—The hospital seeking EACH designation has entered into a network agreement under 42 CFR

485.603 with a facility that the State has designated as an RPCH, and the hospital designated as an RPCH by the State does not have a network agreement with any existing EACH;

—The facility that the State has designated as an RPCH, and that has entered into the network agreement described above, is located more than 35 miles from any other hospital having 75 or more inpatient beds;

—The distance between the facility that the State has designated as an RPCH and the hospital seeking designation as an EACH is less than the distance between the facility that the State has designated as an RPCH and the nearest hospital that has 75 or more inpatient beds or is designated as an EACH; and

—The State certifies to HCFA that—

+ The rural health network emergency and medical backup services actually being provided by the hospital seeking EACH designation are essential to the continued existence of the facility as an RPCH; and

+ The existence of the facility as an RPCH is needed to ensure access to health care services in the area of the State served by the facility that the State has designated as an RPCH.

The criteria described above are designed to ensure that the section 1820(i)(1)(B) authority is exercised only in appropriate cases. First, there must be a network agreement in effect between the hospital seeking EACH designation and a particular facility that the State has designated an RPCH, and the RPCH must not have entered into any network agreement with any other hospital that is currently an EACH. This criterion is needed to ensure that there is a valid network agreement linking the two facilities, and that only one hospital is able to achieve EACH designation based on its agreement with a particular RPCH. In addition, a prospective EACH will not be able to qualify if the RPCH with which it has entered into a network agreement is within 35 miles of any other hospital having 75 or more inpatient beds or is designated as an EACH. We also are requiring that the hospital seeking designation as an EACH under these criteria be closer to the RPCH than the nearest hospital that has 75 or more beds or is designated as an EACH. We are including these provisions because we do not wish to encourage EACH designations that are inappropriate in terms of the location of the EACH or RPCH relative to other facilities.

In applying these criteria, we will consider only a hospital's location relative to other facilities that participate in Medicare as general hospitals (that is, under the criteria in 42 CFR 482.1 through 482.57). We will not take into account the location of nonparticipating hospitals or of those that participate in Medicare as psychiatric hospitals, since those hospitals would not be appropriate referral sites for most Medicare patients following care at an RPCH.

In addition, we require that the State make certain certifications to HCFA. These are—

- That the rural health network and emergency medical backup services actually being provided by the hospital seeking EACH designation are essential to the continued existence of the facility as an RPCH; and
- That the RPCH is needed to ensure access to health care services in its service area.

We have decided not to prescribe specific criteria for the State to follow in determining what constitutes a desirable level of patient access to care in rural areas, or whether the assistance of the EACH is needed to help ensure that a certain level of access is maintained. We believe each State should develop its own criteria and procedures for making these determinations, based on local and Statewide characteristics such as population density, travel conditions, existing referral patterns, availability of health care professionals, and other factors that affect access.

We are including a requirement under which EACH designation made under our revised regulation will remain in effect only as long as the criteria in § 412.109(c)(2)(D)(ii) continue to be met. Thus, for EACH designation to continue, the EACH must continue to carry out its network responsibilities with respect to the RPCH, and the continued existence of the facility as an RPCH must remain necessary to ensure patient access to care in the facility's service area. If we determine that these criteria are no longer met (because, for example, another source of care becomes available to patients in the area of the RPCH), or if a false certification was made, we will terminate the EACH status of the hospital prospectively, effective with discharges occurring on or after 30 days after the date of the determination. We are redesignating § 412.109(f) as new paragraph (g), and adding a new paragraph (f) that specifies this requirement.

Although we expect that States will notify us promptly of any changes in hospitals' activities and will not make false or inaccurate certifications, we reserve the right to review any information that calls the accuracy of a certification into question, and to terminate a hospital's EACH designation if we find factual information sufficient to convince us that the designation is no longer appropriate. The hospital's Medicare participation would not be affected by this change but, as of the effective date of the change, it would no longer be paid by Medicare as a sole community hospital. As in the case of any other determination that the hospital does not meet the criteria for EACH designation or that a hospital's EACH designation should be terminated, the determination would be subject to review under the provider appeals regulations at 42 CFR Part 405, Subpart R.

We note that a separate provision of the law and regulations allows a hospital to be designated as an EACH only if it has in effect an agreement for acceptance of patients and sharing of patient data with each RPCH in the network of which it is a member (section 1820(e)(4) of the Act and the implementing regulations at 42 CFR 412.109(d)(3)). Since an agreement of this kind can be made only with a facility participating in Medicare as an RPCH, the effect of this requirement is to allow EACH status for any hospital to be effective no earlier than the first date of participation of an affiliated RPCH. This provision is not subject to waiver under section 1820(I)(1)(B), and thus is not affected by this final rule.

III. Other Required Information

A. Paperwork Reduction Act

Under the Paperwork Reduction Act of 1995, agencies are required to provide 60 days' notice in the Federal Register to solicit public comments before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3504(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment in the following issues:

- Whether the information collection is necessary and useful to carry out the proper functions of the agency;
- The accuracy of the agency's estimate of the information collection burden;
- The quality, utility, and clarity of the information to be collected; and
- Recommendation to minimize the information collection burden on the affected public, including automated collection technique.

Following is a discussion of these requirements:

Under § 412.109(c), a hospital can be considered for HCFA designation as an

EACH, even though it does not meet the requirements for State designation as set forth in § 412.109(d), if the State makes certain certifications to HCFA. These include the importance of the EACH to the continued existence of the facility as an RPCH, by providing emergency and medical backup services with respect to the RPCH under its network agreement, and the importance of RPCH ongoing operation to access to care for residents of its service area. While the regulations do not require direct reporting of information to HCFA, we expect that as a practical matter the prospective EACH will be required to furnish the State with some information in order to support the second item of the certification, and that the prospective RPCH will need to supply the State with information in support of the other items.

Public reporting burden for this collection of information is estimated to be 2 hours for the hospital's first year of operation as an EACH and one hour for each subsequent year of operation as an EACH. Existing regulations require EACHs to furnish HCFA with information regarding their agreements with RPCHs, and we believe very little additional time will be required to supply the State with similar information.

Public reporting burden for the RPCH for this collection of information is estimated to be 6 hours for the hospital's first year of operation as an RPCH and 2 hours for each subsequent year of operation as an RPCH. These information collection and record keeping requirements are not effective until they have been approved by OMB. A notice will be published in the Federal Register when approval is obtained. Organizations and individuals desiring to submit comments on these information collection and record keeping requirements should direct them to the Health Care Financing Administration, Office of Financial and Human Resources, Management Planning and Analysis Staff, Room C2–26–17, 7500 Security Boulevard, Baltimore, MD 21244–1850.

B. Regulatory Flexibility Analysis

We generally prepare an initial regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA)(5 U.S.C. 601 through 612) unless the we certify that the final rule will not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, we consider all hospitals to be small entities. Individuals and States are not included in the definition of a small entity.

Also, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any final rule that may have a significant impact on a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 603 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 a Metropolitan Statistical Area and has fewer than 50 beds.

We have determined, and certify, that these regulations will not have a significant impact on a substantial number of small rural hospitals. As noted earlier, EACH designation is available only in seven States and in the States adjacent to those seven States. Moreover, only a few prospective EACHs would be so located relative to other hospitals that they would be affected by the changes in this rule. Therefore, we have not prepared a regulatory flexibility analysis or an analysis of the effect 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.

Under the provisions of Public Law 104–121, we have determined that the rule is not a major rule.

C. Waiver of Notice of Proposed Rulemaking and 30-Day Delay in the Effective Date

We ordinarily publish a notice of proposed rulemaking for a rule to provide a period for public comment. However, we may waive that procedure if we find good cause that prior notice and comment are impractical, unnecessary, or contrary to public interest. We find good cause to implement this rule as a final rule because the delay involved in prior notice and comment procedures for the new provisions of this rule would be contrary to the public interest.

This rule does not impose an additional burden or obligation on any hospital or community; on the contrary, it relaxes a restriction on the designation of certain rural hospitals as EACHs. We expect that the resulting assistance will enable the small facilities to avoid closure and to continue to provide needed services to their communities. In view of the precarious financial status of many small rural hospitals, and in consideration of the likelihood that Medicare beneficiaries and other patients served by these facilities would be left without access to care if they closed, we believe it is necessary to implement this change as soon as possible. Thus, we find that the delay involved in prior notice and comment would be contrary to the public interest. We have concluded that it is appropriate to implement the revisions to § 412.109 as final in this instance.

We also normally provide a delay of 30 days in the effective date of a regulation. However, if adherence to this procedure would be impractical, unnecessary, or contrary to public interest, we may waive the delay in the effective date. We may also waive the delay in the case of a rule that grants an exemption or relieves a restriction. We find good cause to waive the usual 30-day delay in this instance. As explained above, it is in the public interest for the transition from hospital to RPCH to be made by many small facilities as soon as possible, so as to avert insolvency and complete closure. A 30-day delay in the effective date would only postpone unnecessarily the start of the transition for many facilities, and place them at greater risk. Therefore, we believe that a 30-day delay in the effective date for this provision would be contrary to the public interest, and we find good cause to waive the usual 30-day delay in the effective date.

List of Subjects in 42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and record keeping requirements.

42 CFR part 412 is amended as set forth below:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

1. The authority citation for part 412 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart G—Special Treatment of Certain Facilities Under the Prospective Payment System for Inpatient Operating Costs

2. In § 412.109, paragraph (c) is revised, paragraph (f) is redesignated as paragraph (g), and a new paragraph (f) is added to read as follows:

§ 412.109 Special treatment: Essential access community hospitals (EACHs).

* * * * *

(c) *Criteria for HCFA designation.*

(1) HCFA designates a hospital as an EACH if the hospital is located in a State that has received a grant under section 1820(a)(1) of the Act or in an adjacent State and is designated as an

EACH by the State that has received the grant.

(2) HCFA designates a hospital as an EACH if—

(i) The hospital—

(A) Is not eligible for State designation as an EACH solely because the hospital has fewer than 75 inpatient beds and is located 35 miles or less from any other hospital; and

(B) Is located more than 35 miles from the nearest hospital having 75 or more inpatient beds, and is recommended by the State for designation as the EACH member of a proposed network; or

(ii) The following criteria are met—

(A) The hospital seeking EACH designation has entered into a network agreement under § 485.603 of this chapter with a facility that the State has designated as an RPCH, and the hospital designated as an RPCH by the State does not have a network agreement with any existing EACH;

(B) The facility that the State has designated as an RPCH, and that has entered into the network agreement described in paragraph (c)(2)(ii)(A) of this section, is located more than 35 miles from any other hospital having 75 or more inpatient beds;

(C) The distance between the facility that the State has designated as an RPCH and the hospital seeking designation as an EACH is less than the distance between the facility that the State has designated as an RPCH and the nearest hospital that has 75 or more inpatient beds or is designated as an EACH;

(D) The State certifies to HCFA that—

(*1*) The rural health network emergency and medical backup services actually being provided by the hospital seeking EACH designation are essential to the continued existence of the facility as a RPCH; and

(*2*) The existence of the facility as an RPCH is needed to ensure access to health care services in the area of the State served by the RPCH.

For purposes of this paragraph (c)(2)(ii), the location of a hospital will not be considered unless the hospital participates in Medicare under §§ 482.1 through 482.57 of this chapter.

* * * * *

(f) *Termination of EACH designation under paragraph (c)(2)(ii)(D).* If HCFA determines that the criteria in paragraph (c)(2)(ii)(D) of this section are no longer met with respect to a hospital HCFA has designated as an EACH under that paragraph, HCFA will terminate the EACH designation of the hospital, effective with discharges occurring on or after 30 days after the date of the determination.

* * * * *

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

Dated: May 6, 1996.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

Dated: May 8, 1996.

Donna E. Shalala,

Secretary.

[FR Doc. 96–11990 Filed 5–9–96; 10:26 am]

BILLING CODE 4120–01–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 73

[MM Docket No. 94–156; RM–8564]

Radio Broadcasting Services; Hawesville, KY and Tell City, IN

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: The Commission, at the request of WLME, Inc, substitutes Channel 246A for Channel 289A at Hawesville, Kentucky, and modifies Station WKCM-FM's license accordingly. To accommodate the allotment, we also substitute Channel 289A for vacant Channel 245A at Tell City, Indiana. *See* 60 FR 90, January 3, 1995. Channel 246A can be substituted for Channel 289A at Hawesville in compliance with the Commission's minimum distance separation requirements with a site restriction of 3.7 kilometers (2.3 miles) northeast at petitioner's presently licensed site. The reference coordinates for Channel 246A at Hawesville are North Latitude 37–55–33 and West Longitude 86–43–19. *See* Supplementary Information, *infra.*

EFFECTIVE DATE: June 17, 1996.

FOR FURTHER INFORMATION CONTACT: Sharon P. McDonald, Mass Media Bureau, (202) 418–2180.

SUPPLEMENTARY INFORMATION: This is a synopsis of the Commission's *Report and Order,* MM Docket No. 94–156, adopted April 24, 1996, and released May 3, 1996. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Reference Center (Room 239), 1919 M Street, NW., Washington, DC. The complete text of this decision may also be purchased from the Commission's copy contractors, International Transcription Service, Inc., (202) 857–3800, 2100 M Street, NW., Suite 140, Washington, DC 20037.

Additionally, Channel 289A can be substituted for vacant Channel 245A at Tell City, Indiana, in compliance with the Commission's minimum distance separation requirements with a site restriction of 12.6 kilometers (7.8 miles) south in order to avoid short-spacings to the licensed sites of Station WASE(FM), Channel 288A, Fort Knox, Kentucky, and Station WUZR(FM), Channel 289A, Bicknell, Indiana. The modified reference coordinates for Channel 289A at Tell City are North Latitude 37–50–49 and West Longitude 86–43–27. With this action, this proceeding is terminated.

List of Subjects in 47 CFR Part 73

Radio broadcasting.

Part 73 of title 47 of the Code of Federal Regulations is amended as follows:

PART 73—[AMENDED]

1. The authority citation for part 73 continues to read as follows:

Authority: Sections 303, 48 Stat., as amended, 1082; 47 U.S.C. 154, as amended.

§ 73.202 [Amended]

2. Section 73.202(b), the Table of FM Allotments under Kentucky, is amended by removing Channel 289A and adding Channel 246A at Hawesville.

3. Section 73.202(b), the Table of FM Allotments under Indiana, is amended by removing Channel 245A and adding Channel 289A at Tell City.

Federal Communications Commission.

Andrew J. Rhodes,

Acting Chief, Allocations Branch, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 96–11815 Filed 5–10–96; 8:45 am]

BILLING CODE 6712–01–F

DEPARTMENT OF DEFENSE

48 CFR Part 231

[DFARS Case 96–D303]

Defense Federal Acquisition Regulation Supplement; Cost Reimbursement Rules for Indirect Costs—Private Sector

AGENCY: Department of Defense (DoD).

ACTION: Interim rule with request for comments.

SUMMARY: The Director of Defense Procurement has issued an interim rule amending the Defense Federal Acquisition Regulation Supplement to permit the DoD to enter into a defense