This rule does not use technical standards. Therefore, we did not consider the use of voluntary consensus standards.

**Environment**

We have analyzed this rule under Commandant Instruction M16475.lD, which guides the Coast Guard in complying with the National Environmental Policy Act of 1969 (NEPA) (42 U.S.C. 4321–4370f), and have concluded that there are no factors in this case that would limit the use of a categorical exclusion under section 2.B.2 of the Instruction. Therefore, this rule is categorically excluded, under figure 2–1, paragraph (34)(g), of the Instruction, from further environmental documentation because we are proposing to establish a safety zone.

A final ''Environmental Analysis Check List'' and a final ''Categorical Exclusion Determination'' are available in the docket where indicated under **ADDRESSES.**

**List of Subjects in 33 CFR Part 165**

Harbors, Marine safety, Navigation (water), Reporting and recordkeeping requirements, Security measures, Waterways.

■ For the reasons discussed in the preamble, the Coast Guard amends 33 CFR part 165 as follows:

## PART 165—REGULATED NAVIGATION AREAS AND LIMITED ACCESS AREAS

■ 1. The authority citation for part 165 continues to read as follows:

**Authority:** 33 U.S.C. 1226, 1231; 46 U.S.C. Chapter 701; 50 U.S.C. 191, 195; 33 CFR 1.05–1(g), 6.04–1, 6.04–6, and 160.5; Pub. L. 107–295, 116 Stat. 2064; Department of Homeland Security Delegation No. 0170.1.

■ 2. Add § 165.1156 to read as follows:

**§ 165.1156 Safety Zone; Offshore Marine Terminal, El Segundo, CA.**

(a) *Location.* The following area is a safety zone: All waters of Santa Monica Bay, from surface to bottom, enclosed by a line beginning at latitude 33°54′59″ N, longitude 118°26′50″ W; then to latitude 33°54′59″ N, longitude 118°27′34″ W; then to latitude 33°54′00″ N, longitude 118°27′34″ W; then to latitude 33°54′00″ N, longitude 118°26′50″ W; then to the point of beginning (NAD 1983).

(b) *Regulations.* (1) In accordance with the general regulations in § 165.23 of this part, entry into or movement within this zone is prohibited except for:

(i) Commercial vessels authorized to use the offshore marine terminal for loading or unloading;

(ii) Commercial tugs, lighters, barges, launches, or other vessels authorized to engage in servicing the offshore marine terminal or vessels therein;

(iii) Public vessels of the United States.

(2) Persons desiring to transit the area of the safety zone may contact the Captain of the Port at telephone number 1–800–221–8724 or on VHF–FM channel 16 (156.8 MHz). If permission is granted, all persons and vessels must comply with the instructions of the Captain of the Port or his or her designated representative.

(3) Nothing in this section shall be construed as relieving the owner or person in charge of any vessel from complying with the Navigation Rules as defined in 33 CFR chapter I, subchapters D and E and safe navigation practice.

Dated: May 13, 2005.

**Peter V. Neffenger,**

*Captain, U.S. Coast Guard, Captain of the Port, Los Angeles–Long Beach.*

[FR Doc. 05–10594 Filed 5–26–05; 8:45 am]

**BILLING CODE 4910–15–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare & Medicaid Services

### 42 CFR Part 413

**[CMS–1199–IFC]**

**RIN 0938–AN87**

## Medicare Program; Electronic Submission of Cost Reports: Revision to Effective Date of Cost Reporting Period

**AGENCY:** Centers for Medicare & Medicaid Services (CMS), HHS.

**ACTION:** Interim final rule with comment period.

**SUMMARY:** This interim final rule with comment period revises the existing effective date by which all organ procurement organizations (OPOs), rural health clinics (RHCs), Federally qualified health centers (FQHCs), and community mental health centers (CMHCs) are required to submit their Medicare cost reports in a standardized electronic format from cost reporting periods ending on or after December 31, 2004 to cost reporting periods ending on or after March 31, 2005.

This interim final rule with comment does not affect the current cost reporting requirement for hospices and end-stage renal disease (ESRD) facilities. Hospices and ESRD facilities are required to continue to submit cost reports under the Medicare regulations in a standardized electronic format for cost reporting periods ending on or after December 31, 2004.

**DATES:** *Effective date:* These regulations are effective on June 27, 2005.

*Comment date:* To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on July 26, 2005.

**ADDRESSES:** In commenting, please refer to file code CMS–1199–IFC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of three ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments on specific issues in this regulation to *http://www.cms.hhs.gov/regulations/ecomments.* (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By mail.* You may mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1199–IFC, P.O. Box 8018, Baltimore, MD 21244–8018.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–7197 in advance to schedule your arrival with one of our staff members. Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244–1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and could be considered late. All comments received before the close of the comment period are available for viewing by the public, including any

personally identifiable or confidential business information that is included in a comment. After the close of the comment period, CMS posts all electronic comments received before the close of the comment period on its public Web site.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

**FOR FURTHER INFORMATION CONTACT:** Darryl E. Simms, (410) 786–4524.

**SUPPLEMENTARY INFORMATION:**

*Submitting Comments:* We welcome comments from the public on all issues set forth in this rule to assist us in fully considering issues and developing policies. You can assist us by referencing the file code CMS–1199-IFC and the specific ''issue identifier'' that precedes the section on which you choose to comment.

*Inspection of Public Comments:* All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all electronic comments received before the close of the comment period on its public Web site as soon as possible after they are received. Hard copy comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

## I. Background

On August 23, 2003, we published in the **Federal Register** (68 FR 50717), a final regulation that requires that all hospices, organ procurement organizations (OPOs), rural health clinics (RHCs), Federally qualified health centers (FQHCs), community mental health centers (CMHCs), and end-stage renal disease (ESRD) facilities submit Medicare cost reports in a standardized electronic format. This requirement is effective for cost reporting periods ending on or after December 31, 2004.

The provider's electronic program must be capable of producing the CMS standardized output file in a form that can be read by the fiscal intermediary's automated system. This electronic file, which must contain the input data required to complete the cost report and to pass specified edits, must be forwarded to the fiscal intermediary for processing through its system.

These facilities are generally paid under the Medicare program for the reasonable costs of the covered items and services they furnish to Medicare beneficiaries. Sections 1815(a) and 1833(e) of the Social Security Act (the Act) provided that no payments will be made to a provider unless it has furnished the information, requested by the Secretary of the Department of Health and Human Services (Secretary), needed to determine the amount of payments due the provider.

In general, providers submit this information through cost reports that cover a 12-month period. Regulations governing the submission of cost reports are set forth in § 413.20 and § 413.24. Section 413.20(a) specifies that all providers participating in the Medicare program are required to maintain sufficient financial records and statistical data for proper determination of costs payable under the Medicare program. In addition, providers must use standardized definitions and follow accounting, statistical, and reporting practices that are widely accepted in the health care industry and related fields. In § 413.20(b) and § 413.24(f), providers are required to submit cost reports annually, with the reporting period based on the provider's accounting year. Section 412.52 specifies that all hospitals participating in the prospective payment system must meet cost reporting requirements set forth at § 413.20 and § 413.24.

Section 1886(f)(1)(B)(i) of the Act requires the Secretary to establish a standardized electronic cost reporting system for all hospitals participating in the Medicare program. This provision was effective for hospital cost reporting periods beginning on or after October 1, 1989. On January 2, 1997, we published a final rule in the **Federal Register** (62 FR 26) that revised § 413.24(f)(4)(ii) to extend the electronic cost reporting requirements to skilled nursing facilities (SNFs) and home health agencies (HHAs).

The required cost reports must be electronically transmitted to the intermediary in American Standard Code for Information Interchange (ASCII) format. In addition to the electronic file, hospitals, SNFs, and HHAs were initially required to submit a hard copy of the full cost report. The January 2, 1997 final rule revised § 413.24(f)(4)(iv) to state that providers were required to submit, instead, a hard copy of a one-page settlement summary, a statement of certain worksheet totals found in the electronic file, and a statement signed by the provider's administrator or chief financial officer certifying the accuracy of the electronic file. To preserve the integrity of the electronic file, in the January 2, 1997 final rule we specified procedures regarding the processing of electronic cost reports once they are submitted to the intermediary.

## II. Provisions of the Interim Final Rule

This interim final rule revises the existing effective date for submission of electronic cost reports for OPOs, RHCs, FQHCs, and CMHCs from cost reporting periods ending on or after December 31, 2004 to cost reporting periods ending on or after March 31, 2005. As a result of the delays in the availability of the CMS free cost reporting software and commercially available cost reporting software, OPOs, RHCs, FQHCs, and CMHCs will now be required to file their cost reports in a standardized electronic format effective for cost reporting periods ending on or after March 31, 2005. This is a change from the August 23, 2003 final rule that established the electronic filing requirement for cost reporting periods ending on or after December 31, 2004.

Hospices and ESRD facilities will continue to be subject to the electronic filing requirements as referenced in the August 23, 2003 final rule as software for these provider types is available. Therefore, all hospices and ESRD facilities are still required to submit standardized electronic cost reports for cost reporting periods ending on or after December 31, 2004. Standardized electronic cost reports have been in place since October 1989. Since that time, the accuracy of cost reporting has increased. Under this interim final rule, the only change is to the effective date for submission of electronic cost reporting for OPOs, RHCs, FQHCs, and CMHCs. These providers will still be given a transition period (described in the August 23, 2003 final rule (68 FR 50717)) beginning with the new effective date and are still required to provide a hard copy of the settlement summary, statement of certain worksheet totals, and a statement signed by the administrator or chief financial officer certifying the accuracy of the electronic file or the manually prepared cost report under the new effective date.

## III. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of

this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

**IV. Waiver of Proposed Rulemaking**

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule. The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substances of the proposed rule or a description of the subjects and issues involved. This procedure can be waived, however, if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued.

Because of the delay in the availability of the requisite cost reporting software (CMS-provided and commercially available) needed to comply with the effective date provisions of the August 23, 2003 final rule, OPOs, RHCs, FQHCs, and CMHCs are not able to submit cost reports in a standardized electronic format for cost reporting periods ending December 31, 2004. These cost reports are due to their respective fiscal intermediaries (FIs) 150 days or 5 months following the close of the cost reporting period which is May 31, 2005. Revising the reporting requirement to be effective for cost reporting periods ending on or after March 31, 2005, provides the time for the contractors to develop the requisite cost reporting software. The new electronic filing requirement for cost reporting periods ending on or after March 31, 2005 requires OPOs, RHCs, FQHCs, and CMHCs, with a March 31, 2005 cost reporting ending date to submit cost reporting data to FIs by August 31, 2005. We find the notice-and-comment procedure impracticable since it is not feasible for these providers to meet the current effective date as the technology to meet the reporting requirement is not available. Also, this interim final rule with comment does not impose any additional requirements, but merely extends the effective date of the existing reporting requirement until the software is available. Therefore, we find good cause to waive notice-and-comment procedures and to issue this final rule on an interim basis. However, we are providing a 60-day public comment period.

**V. Collection of Information Requirements**

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. However, the requirements referenced and discussed below are currently approved by OMB.

*Section 413.24 Adequate Cost Data and Cost Finding*

Currently § 413.24 requires hospitals, to submit cost reports in a standardized electronic format for cost reporting periods beginning on or after October 1, 1989. SNFs, and HHAs must submit cost reports in a standardized electronic format for cost reporting periods ending on or after December 31, 1996. Hospices, ESRD facilities, OPOS, RHCs, FQHCs and CMHCs must submit cost reports in a standardized electronic format for cost reporting periods ending on or after December 31, 2004. These reporting requirements are currently approved as described below.

This interim final rule revises the dates by which OPOs, RHCs, FQHCs, and CMHCs must submit cost reports in a standardized electronic format. Under the revised requirements OPOs, RHCs, FQHCs, and CMHCs must now submit cost reports in a standardized electronic format for cost reporting periods ending on or after March 31, 2005, rather than December 31, 2004. This change does not impose any new burden.

As noted above, while all the above reporting requirements are subject to the PRA, they are currently approved under OMB approval numbers 0938–0050, ''Hospital/Healthcare Complex Cost Report,'' with a current expiration date of November 30, 2005, 0938–0463; ''Skilled Nursing Facility Cost Report,'' with a current expiration date of April 30, 2007; 0938–0022, ''Home Health Agency Cost Report,'' with a current expiration date of April 30, 2007; 0938–0758, ''Hospice Cost Report,'' with a current expiration date of January 31, 2008; 0938–0102, ''Organ Procurement Agency/Laboratory Statement of Reimbursable Costs,'' with a current expiration date of August 31, 2006; 0938–0107, ''Independent Rural Health Clinic/Freestanding Federally Qualified Health Center Cost Report,'' with a current expiration date of October 31, 2005; 0938–0236, ''Medicare Independent Renal Dialysis Facility Cost Report,'' with a current expiration date of June 30, 2007; and 0938–0657, ''End Stage Renal Disease Network Cost Report,'' with a current expiration date of September 30, 2006.

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following:

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Regulations Development Group, Attn: Jim Wickliffe, CMS–1199–IFC, Room C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850; and

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Christopher Martin, CMS Desk Officer, CMS–1199–IFC, *Christopher_Martin@omb.eop.gov,* Fax (202) 395–6974.

**VI. Regulatory Impact Statement**

We have examined the impact of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act (the Act), the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). This rule does not reach the economic threshold and thus is not considered a major rule.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any 1 year. Individuals and States are not included in the definition of a small entity. We are not preparing an analysis for the RFA because we have determined that this rule will not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a

significant impact on the operations of a substantial number of small rural hospitals. This 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 100 beds. We are not preparing an analysis for section 1102(b) of the Act because we have determined that this rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This rule will have no consequential effect on the governments mentioned or on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it publishes a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. Since this regulation does not impose any costs on State or local governments, the requirements of E.O. 13132 are not applicable.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

**List of Subjects in 42 CFR Part 413**

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

■ For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV, as set forth below:

## PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

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

**Authority:** Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1871, 1881, 1883 and 1886 of the Social Security Act (42 U.S.C. 1302, 1395dd(d), 1395f(b), 1395g, 1395l(a), (i) and (n), 1395hh, 1395rr, 1395tt, and 1395ww).

### Subpart B—Accounting Records and Reports

■ 2. Section 413.24 is amended by—
■ A. Revising paragraph (f)(4)(ii).
■ B. Revising paragraph (f)(4)(iv).
The revisions read as follows:

**§ 413.24 Adequate cost data and cost finding.**

* * * * *

(f) * * *

(4) * * *

(i) * * *

(ii) Effective for cost reporting periods beginning on or after October 1, 1989 for hospitals, cost reporting periods ending on or after December 31, 1996 for skilled nursing facilities and home health agencies, cost reporting periods ending on or after December 31, 2004 for hospices, and end-stage renal disease facilities, and cost reporting periods ending on or after March 31, 2005 for organ procurement organizations, rural health clinics, Federally qualified health centers, and community mental health centers, a provider is required to submit cost reports in a standardized electronic format. The provider's electronic program must be capable of producing the CMS standardized output file in a form that can be read by the fiscal intermediary's automated system. This electronic file, which must contain the input data required to complete the cost report and to pass specified edits, must be forwarded to the fiscal intermediary for processing through its system.

* * * * *

(iv) Effective for cost reporting periods ending on or after September 30, 1994 for hospitals, cost reporting periods ending on or after December 31, 1996 for skilled nursing facilities and home health agencies, cost reporting periods ending on or after December 31, 2004 for hospices and end-stage renal disease facilities, and cost reporting periods ending on or after March 31, 2005 for organ procurement organizations, rural health clinics, Federally qualified health centers, community mental health centers) providers must submit a hard copy of a settlement summary, a statement of certain worksheet totals found within the electronic file, and a statement signed by its administrator or chief financial officer certifying the accuracy of the electronic file or the manually prepared cost report. During a transition period (first two cost-reporting periods on or after December 31, 2004 for hospices and end-stage renal disease facilities, and the first two cost-reporting periods on or after March 31, 2005 for organ procurement organizations, rural health clinics, Federally qualified health centers, community mental health centers) providers must submit a hard copy of the completed cost report forms in addition to the electronic file. The following statement must immediately precede the dated signature of the provider's administrator or chief financial officer:

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 Statement of Revenue and Expenses prepared by _____ (Provider Name(s) and Number(s)) for the cost reporting 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 this cost report were provided in compliance with such laws and regulations.

* * * * *

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

Dated: April 14, 2005.

**Mark B. McClellan,**

*Administrator, Centers for Medicare & Medicaid Services.*

Approved: May 3, 2005.

**Michael O. Leavitt,**

*Secretary.*

[FR Doc. 05–10570 Filed 5–26–05; 8:45 am]

BILLING CODE 4120–01–P

## DEPARTMENT OF HOMELAND SECURITY

### Federal Emergency Management Agency

### 44 CFR Part 65

**[Docket No. FEMA–D–7569]**

### Changes in Flood Elevation Determinations

**AGENCY:** Federal Emergency Management Agency (FEMA), Emergency Preparedness and Response Directorate, Department of Homeland Security.

**ACTION:** Interim rule.

**SUMMARY:** This interim rule lists communities where modification of the Base (1% annual chance) Flood Elevations (BFEs) is appropriate because of new scientific or technical data. New flood insurance premium rates will be