Due dates falling on a Saturday, Sunday, or national holiday will become effective the first following working day.

2. Revise § 298.61 to read as follows:

§ 298.61 Filing of flight schedules—current schedules and subsequent modifications.

Each commuter air carrier shall file with the Director, Office of Facilities and Operations, Civil Aeronautics Board, Washington, D.C. 20428, to be received within thirty (30) days after commencing operations, a copy of its most recent published flight schedules, along with a statement of rates and fares charged for transportation on scheduled flights. Thereafter, if any modification in such schedules or statement of rates or fares is made, a copy of such modifications shall be filed, to be received by the Board not later than ten (10) days after the modification becomes effective.

3. Revise § 298.62 to read as follows:

§ 298.62 Extension of filing time.

If circumstances prevent the filing of a report on or before the prescribed due date, consideration will be given to the granting of an extension upon receipt of a written request therefor. To provide ample time for consideration and communication to the air carrier of the action taken, such a request must be delivered to the Board in writing at least three (3) days in advance of the due date, setting forth good and sufficient reason to justify the granting of the extension and the date when the report can be filed. Except in cases of emergency, no such request will be entertained which is not in writing and received by the Civil Aeronautics Board at least three (3) days before the prescribed due date. If the request is denied, the air carrier remains subject to the filing requirements to the same extent as if no request for extension of time had been made.

4. Revise § 298.63 to read as follows:

§ 298.63 Certification.

The certificate of the officer in charge of the carrier's accounts, executed in triplicate, shall be filed quarterly with the Board. This certificate is the cover sheet of Form 298–C and applies to all schedules and documents filed therewith.

(Secs. 204 and 416, Federal Aviation Act of 1958, as amended, 72 Stat. 743, 771 (49 U.S.C. 1324, 1386))

Effective: June 30, 1974.

Adopted: April 16, 1974.

By the Civil Aeronautics Board:

[SEAL] PHYLLIS T. KAYLOR,
Acting Secretary.

[FR Doc.74–10721 Filed 5–9–74;8:45 am]

Title 20—Employees' Benefits

CHAPTER III—SOCIAL SECURITY ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

[Regs. 5, further amended]

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

Subpart D—Principles of Reimbursement for Provider Costs and for Services by Hospital-Based Physicians

AMOUNT OF PAYMENTS WHERE CUSTOMARY CHARGES FOR SERVICES FURNISHED ARE LESS THAN REASONABLE COST

On September 13, 1973, there was published in the FEDERAL REGISTER (38 FR 25448) a notice of proposed rulemaking with proposed amendments to Subpart D of Regulations No. 5 (20 CFR Part 405), regarding implementation of section 233 of Pub. L. 92–603 entitled "Amount of Payments Where Customary Charges for Services Furnished are Less Than Reasonable Cost." Interested persons were given until October 15, 1973, to submit written comments or suggestions thereon. Comments and suggestions received with regard to this notice of proposed rulemaking, responses thereto, and changes in the proposed regulations are summarized below.

1. Many comments urged that the proposed regulations be revised so that the provider's health insurance reimbursable costs and health insurance charges be compared to each other on an aggregate basis—without regard to whether the related services were rendered under Part A or Part B of title XVIII of the Social Security Act. Upon reconsideration, the Department believes that it was the intent of Congress that providers be able to rationally establish charges consistent with overall provider objectives and without regard to whether Medicare reimbursement for these services resulted from Part A or Part B. This suggestion is adopted and the regulations have been revised to indicate that the comparison will be between total health insurance charges and total health insurance costs without regard to whether the services were rendered under Part A or Part B of title XVIII.

2. Comments were received indicating that providers were inhibited in taking action to raise charges by uncertainty as to their ability to do so under economic stabilization rules. Other providers indicated that they were unable to gauge the effect of these provisions on their operations due to the uncertainty as to how such terms as "customary charges," "nominal charges," and "public providers" would be defined. The law has been amended to change the effective date of these provisions to apply to cost reporting periods beginning on or after January 1, 1974, to assure that providers will not suffer undue hardship and may reasonably comply with the new rules.

3. The statute authorizes reimbursement to public providers on the basis of fair compensation if such public provider furnishes services free of charge or for a nominal charge. Section 405.455(e), as published in the notice of proposed rulemaking, defined fair compensation to be the same as reasonable cost. No comments on this point have been received and the same definition of fair compensation is now proposed. However, many comments were received about the definition of "public provider" and "nominal charges."

(a) Some commenters indicated that the definition of "public provider" should be revised to include providers, not operated by a governmental agency, which receive public support either through charitable contributions or as a subsidy from a governmental agency. The Department believes that it was the intent of Congress to utilize the ordinary meaning ascribed to "public" i.e., only those providers actually operated by a governmental agency. Therefore, this suggestion has not been adopted.

(b) Public providers whose charges are more than 50 percent of cost, but who actually collect less than 50 percent of the cost of delivering services, requested that revenues rather than charges be compared to cost to determine whether they should be exempt from the effect of section 233 of Pub. L. 92–603. As the statute is specific in extending the exception to public providers whose charges, and not revenue collections, are nominal, we are unable to adopt this suggestion.

4. Some commenters indicated they were unsure of our interpretation or application of the term "customary charges." As the proposed regulations indicate by specific reference to existing regulations, the term "customary charges" simply means the same consistent charges that providers have been recording on Medicare bills since the start of the program.

5. Other commenters indicated they were unsure of the interpretation of the term "reasonable effort to collect such charges." This term envisions that the same effort be used to collect the charges as is required for recognition of health insurance program bad debts under § 405.420(e)(2) of the regulations.

6. Various editorial changes have also been made in the interest of clarity.

The regulations are issued under the authority contained in sections 1102, 1814(b), 1833(a), 1871, 49 Stat. 647, as amended, 79 Stat. 294, as amended, 79 Stat. 302, as amended, 79 Stat. 321; 42 U.S.C. 1302, 1395f(b), 1395l(a), 1395hh.

Effective date. These amendments shall be effective for cost accounting periods beginning on or after January 1, 1974.

(Catalog of Federal Domestic Assistance Program No. 13.800, Health Insurance for the Aged—Hospital Insurance, and 13.801, Health

Insurance for the Aged—Supplementary Medical Insurance)

Dated: January 10, 1974.

J. B. CALDWELL,
Commissioner of Social Security.

Approved: May 2, 1974.

CASPAR W. WEINBERGER,
Secretary of Health, Education, and Welfare.

Part 405 of Chapter III of Title 20 of the Code of Federal Regulations is amended as follows:

1. Paragraph (a) of § 405.401 is revised to read as follows:

§ 405.401 Introduction.

(a) Under the health insurance program for the aged, the amount paid to any provider of services for the covered services furnished to beneficiaries is required by section 1814(b) and section 1833(a)(2) of the Social Security Act to be the reasonable cost of such services. However, with respect to cost reporting periods beginning after December 31, 1973, payments to providers of services are based on the lesser of the reasonable cost of services or the customary charges to the general public for such services.

* * * * *

2. Paragraph (a) of § 405.402 is revised to read as follows:

§ 405.402 Cost reimbursement; general.

(a) In formulating methods for making fair and equitable reimbursement for services rendered beneficiaries of the program, payment is to be made on the basis of current costs of the individual provider, rather than costs of a past period or a fixed negotiated rate. All necessary and proper expenses of an institution in the production of services, including normal standby costs, are recognized. Furthermore, the share of the total institutional cost that is borne by the program is related to the care furnished beneficiaries so that no part of their cost would need to be borne by other patients. Conversely, costs attributable to other patients of the institution are not to be borne by the program. Thus, the application of this approach, with appropriate accounting support, will result in meeting actual costs of services to beneficiaries as such costs vary from institution to institution. However, with respect to cost reporting periods beginning after December 31, 1973, payments to providers of services for services rendered health insurance program beneficiaries are based on the lesser of the reasonable cost of services or the customary charges to the general public for such services.

* * * * *

3. Paragraph (a) of § 405.451 is revised to read as follows:

§ 405.451 Cost related to patient care.

(a) *Principle.* All payments to providers of services must be based on the reasonable cost of services covered under title XVIII of the Act and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in rendering the services, subject to principles relating to specific items of revenue and cost. However, for cost reporting periods beginning after December 31, 1973, payments to providers of services are based on the lesser of the reasonable cost of services covered under title XVIII of the Act and furnished to program beneficiaries or the customary charges to the general public for such services, as provided for in § 405.455.

* * * * *

4. The following new section is added to read as follows:

§ 405.455 Amount of payments where customary charges for services furnished are less than reasonable cost.

(a) *Principle.* Providers of services will be paid the lesser of the reasonable cost of services furnished to beneficiaries or the customary charges made by the provider for the same services. Public providers of service rendering services free of charge or at a nominal charge will be paid fair compensation for services furnished to beneficiaries. This principle is applicable to services rendered by providers in cost reporting periods beginning after December 31, 1973.

(b) *Definitions.*—(1) *Customary charges.* Customary charges for services rendered to beneficiaries are the charges as defined in § 405.452(d)(4). Such charges must be recorded on all bills submitted for program reimbursement. Where the provider does not actually impose such charges in the case of most patients liable for payment for its services on a charge basis or fails to make reasonable efforts to collect such charges from patients liable for payment for its services on a charge basis, customary charges for services rendered to beneficiaries shall be the charges as defined in § 405.452(d)(4) and recorded on the bills submitted for program reimbursement reduced in proportion to the ratio of the aggregate amount actually collected from patients liable for payment for services on a charge basis to the amounts that would be realized had charges consistent with the charges as defined in § 405.452(d)(4) and recorded on the bills submitted for program reimbursement been paid by or on behalf of all patients liable for payment on a charge basis.

(2) *Reasonable cost.* For purposes of comparison with customary charges, the reasonable cost of services furnished to beneficiaries shall exclude (i) payments made to a provider as reimbursement for bad debts arising from noncollection of Medicare deductible and coinsurance amounts, (ii) amounts which represent the recovery of excess depreciation resulting from termination, or a decrease in Medicare utilization (§ 405.415(d)(3)) applicable to prior cost periods, (iii) amounts applicable to prior cost periods resulting from disposition of depreciable assets (§ 405.415(f)), and (iv) payments to funds for the donated services of teaching physicians.

(3) *Public provider.* A public provider means any provider operated by a Federal, State, county, city, or other local Government agency or instrumentality.

(4) *Nominal charges.* A public provider's charges are considered nominal where the aggregate charges are less than one-half of the reasonable cost of services or items represented by such charges.

(5) *New provider.* A new provider is an institution that has operated as the type of facility for which it is certified in the program (or the equivalent thereof) under present and previous ownership for less than 3 full years.

(c) *Aggregation of charges.* It is appropriate that, on an aggregate basis, payments to a provider for covered services rendered beneficiaries under title XVIII should not exceed the customary charges made by the provider to the general public for the same services. In comparing charges and costs, customary charges for items and services, and the reasonable cost of such items and services will be aggregated, without regard to whether the related services were reimbursable under Part A or Part B of title XVIII. The principle established is to be applied after the provider's charges and costs have been adjusted in accordance with the requirements set forth in paragraph (b)(2) of this section and in §§ 405.480–405.488, to exclude any amounts attributable to physicians' services not reimbursable to the provider on a reasonable cost basis and to exclude costs and charges with respect to noncovered provider services.

Example. The reasonable cost of covered services furnished to program beneficiaries by a provider for a cost reporting period is $125,000. The customary charges to these beneficiaries for these services totaled $110,000. The amount to be reimbursed this provider will be $110,000 less deductible and coinsurance amounts to be borne by program beneficiaries.

(d) *Accumulation of unreimbursed costs and carryover to subsequent periods.*—(1) *General.* Any provider of services whose charges are lower than costs in any cost reporting period beginning after December 31, 1973, may carry forward costs attributable to program beneficiaries which are unreimbursed under the provisions of this section for the two succeeding reporting periods. Where beneficiary charges exceed reasonable cost in such subsequent periods, such previously unreimbursed amounts carried forward shall be reimbursed to the provider to the extent that such previously unreimbursed amounts carried forward, together with costs applicable to program beneficiaries in such subsequent periods, do not exceed customary charges with respect to services to program beneficiaries in such subsequent periods. If such two succeeding cost reporting periods combined include fewer than 24 full calendar months, the provider may carry forward costs unreimbursed under this section for one additional reporting period.

Example. In the reporting period ending December 31, 1974, the provider's reimbursable costs attributable to covered services

furnished program beneficiaries were $100,000. The provider's customary charges for these services were $90,000. The provider will, therefore, be reimbursed $90,000 less any deductible and coinsurance amounts but will be permitted to carry the unreimbursed $10,000 forward for the next two succeeding reporting periods. If, in the reporting period ending December 31, 1975, the charges to beneficiaries for covered services exceeded the reimbursable reasonable costs of such services by $10,000 or more, the provider could recover the entire $10,000 previously not reimbursed. If, however, beneficiary charges exceeded costs by $8,000, this amount would be added to the provider's reimbursable costs for this period. The balance of the unreimbursed amount or $2,000 would be carried over to the next reporting period.

(2) *New provider.* A new provider of services may carry forward for five succeeding cost reporting periods costs attributable to program beneficiaries which are unreimbursed under the provisions of this section during a base period, which includes any cost reporting period which begins after December 31, 1973, and ends on or before the last day of its third year of operation. Where beneficiary charges exceed reasonable cost in the five succeeding reporting periods, such previously unreimbursed amounts carried forward shall be reimbursed to the provider to the extent that such previously unreimbursed amounts carried forward, together with costs applicable to program beneficiaries in such subsequent periods, do not exceed customary charges with respect to services to program beneficiaries in such subsequent periods. If such five succeeding cost reporting periods combined include fewer than 60 full calendar months, the provider may carry forward costs unreimbursed under this section for one additional reporting period.

Example. A provider begins its operations on March 5, 1972. However, it begins to participate in the Medicare program as of January 1, 1973, and reports on a calendar year basis. Since it would be subject to the application of the provision for its cost reporting period beginning with January 1, 1974, it would be permitted to accumulate any unreimbursed costs (excess of costs over its charges) incurred during this reporting period. Since this cost reporting period ends before the end of the third year of operation, its carryover period will be the succeeding five cost reporting periods ending with December 31, 1979. (Had this provider begun its operations on July 1, 1973, and become a participating provider as of the same date (with a fiscal year ending June 30), it would have been able to accumulate any unreimbursed costs for the two cost reporting periods ending June 30, 1975, and June 30, 1976. Its carryover period would then be the five cost reporting periods ending no later than June 30, 1981, in the case of costs unreimbursed in either of the reporting periods ending June 30, 1975, and June 30, 1976.

(e) *Public providers.*—Fair compensation to public providers rendering services free of charge or at nominal charges, as defined in paragraph (b)(4) of this section, for the services they furnish will be the reasonable costs of covered services, as defined in this subpart.

[FR Doc.74-10740 Filed 5-9-74;8:45 am]

Title 21—Food and Drugs

CHAPTER I—FOOD AND DRUG ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

SUBCHAPTER A—GENERAL

PART 8—COLOR ADDITIVES

Listing of Color Additives for Cosmetic Use Exempt From Certification; Disodium EDTA-Copper

The Commissioner of Food and Drugs, on the basis of a petition (CAP No. 800069), submitted by Revlon Research Center, Inc., Bronx, NY 10473, and other relevant information, finds that disodium EDTA-copper is suitable and safe for use in the coloring of cosmetics under the conditions prescribed by this order and that certification is not necessary for the protection of the public health.

Disodium EDTA-copper is currently provisionally listed in § 8.501(g) (21 CFR 8.501(g)) for use in cosmetics under the name copper versenate. There are no other color additive petitions nor progress reports, as required by the color additive regulations (21 CFR Part 8), for the use of disodium EDTA-copper (copper versenate) in cosmetics. Accordingly, copper versenate will be deleted from § 8.501(g) when this order becomes effective.

Therefore, pursuant to provisions of the Federal Food, Drug, and Cosmetic Act (sec. 706 (b), (c) and (d), 74 Stat. 399–403 (21 U.S.C. 376 (b), (c) and (d))) and under the authority delegated to the Commissioner (21 CFR 2.120), Part 8 is amended in Subpart H by adding a new § 8.8006 to read as follows:

§ 8.8006 Disodium EDTA-copper.

(a) *Identity.* The color additive disodium EDTA-copper is disodium [[*N,N'*-1,2 - ethanediylbis[*N* - (carboxymethyl) glycinato]](4-) - $N,N',O,O',O^{N},O^{N'}$]cuprate(2-).

(b) *Specifications.* Disodium EDTA-copper shall conform to the following specifications and shall be free from impurities other than those named to the extent that such impurities may be avoided by good manufacturing practice:

Total copper, not less than 13.5 percent.
Total (ethylene-dinitrilo)tetraacetic acid, not less than 62.5 percent.
Free copper, not more than 100 parts per million.
Free disodium salt of (ethylene-dinitrilo) tetraacetic acid, not more than 1.0 percent.
Moisture, not more than 15 percent.
Water insoluble matter, not more than 0.2 percent.
Lead (as Pb), not more than 20 parts per million.
Arsenic (as AS), not more than 3 parts per million.

(c) *Uses and restrictions.* Disodium EDTA-copper may be safely used in amounts consistent with good manufacturing practices in the coloring of shampoos which are cosmetics.

(d) *Labeling requirements.* The labeling of the color additive shall conform to the requirements of § 8.32.

(e) *Exemption from certification.* Certification of this color additive is not necessary for the protection of the public health and therefore batches thereof are exempt from the requirements of section 706(c) of the act.

Any person who will be adversely affected by the foregoing order may at any time on or before June 10, 1974, file with the Hearing Clerk, Food and Drug Administration, Rm. 6–86, 5600 Fishers Lane, Rockville, MD 20852, written objections thereto. Objections shall show wherein the person filing will be adversely affected by the order, specify with particularity the provisions of the order deemed objectionable, and state the grounds for the objections. If a hearing is requested, the objections shall state the issues for the hearing, shall be supported by grounds factually and legally sufficient to justify the relief sought, and shall include a detailed description and analysis of the factual information intended to be presented in support of the objections in the event that a hearing is held. Objections may be accompanied by a memorandum or brief in support thereof. Six copies of all documents shall be filed. Received objections may be seen in the above office during working hours, Monday through Friday.

Effective date. This order shall become effective July 9, 1974, except as to any provisions that may be stayed by the filing of proper objections. Notice of the filing of objections or lack thereof will be announced in the FEDERAL REGISTER.

(Sec. 706 (b), (c), and (d), 74 Stat. 399–403 (21 U.S.C. 376 (b), (c), and (d)))

Dated: May 6, 1974.

SAM D. FINE,
Associate Commissioner for Compliance.

[FR Doc.74-10823 Filed 5-9-74;8:45 am]

SUBCHAPTER B—FOOD AND FOOD PRODUCTS

PART 121—FOOD ADDITIVES

Antioxidants and/or Stabilizers for Polymers

The Commissioner of Food and Drugs, having evaluated the data in a petition (FAP 3B2899) filed by Ciba-Geigy Corp., Ardsley, NY 10502, and other relevant material, concludes that the food additive regulations should be amended, as set forth below, to provide for safe use of octadecyl 3,5-di-*tert*-butyl-4-hydroxyhydrocinnamate as an antioxidant and/or stabilizer in acrylonitrile-butadiene-styrene copolymers used in the manufacture of articles or components of articles that contact food.

Therefore, pursuant to provisions of the Federal Food, Drug, and Cosmetic Act (sec. 409(c)(1), 72 Stat. 1786 (21 U.S.C. 348(c)(1))) and under authority delegated to the Commissioner (21 CFR 2.120), § 121.2566(b) is amended by adding to the item "Octadecyl 3,5-di-*tert*-butyl-4-hydroxyhydrocinnamate" a new limitation to read as follows:

§ 121.2566 Antioxidants and/or stabilizers for polymers.

* * * * *

(b) List of substances:

	Limitations
* * *	* * *
	For use only:
Octadecyl 3,5-di-tert-butyl-4-hydroxyhydrocinnamate.	* * *
	4. At levels not to exceed 0.5 percent by weight of acrylonitrile-butadiene-styrene copolymers used in accordance with prior sanction or regulations in this Subpart F.
* * *	* * *

Any person who will be adversely affected by the foregoing order may at any time on or before June 10, 1974, file with the Hearing Clerk, Food and Drug Administration, Rm. 6–86, 5600 Fishers Lane, Rockville, MD 20852, written objections thereto. Objections shall show wherein the person filing will be adversely affected by the order, specify with particularity the provisions of the order deemed objectionable, and state the grounds for the objections. If a hearing is requested, the objections shall state the issues for the hearing, shall be supported by grounds factually and legally sufficient to justify the relief sought, and shall include a detailed description and analysis of the factual information intended to be presented in support of the objections in the event that a hearing is held. Objections may be accompanied by a memorandum or brief in support thereof. Six copies of all documents shall be filed. Received objections may be seen in the above office during working hours, Monday through Friday.

Effective date. This order shall become effective May 10, 1974.

(Sec. 409(c)(1), 72 Stat. 1786 (21 U.S.C. 348(c)(1))

Dated: May 6, 1974.

SAM D. FINE,
Associate Commissioner for Compliance.

[FR Doc.74–10824 Filed 5–9–74;8:45 am]

PART 121—FOOD ADDITIVES

Republication; Correction

In FR Doc. 65–13706 appearing at page 15845 in the issue of Thursday, December 23, 1965, the item "Diethylene glycol monoethyl ether" was inadvertently omitted from the list of substances in § 121.2520(c)(5) on page 15946. As corrected, § 121.2520(c)(5) is amended by alphabetically inserting the omitted item to read as follows:

§ 121.2520 Adhesives.

* * * * *

(c) * * *
(5) * * *

COMPONENTS OF ADHESIVES

Substances	Limitations
* * *	* * *
Diethylene glycol monoethyl ether	
* * *	* * *

Dated: May 6, 1974.

SAM D. FINE,
Associate Commissioner for Compliance.

[FR Doc.74–10825 Filed 5–9–74;8:45 am]

Title 37—Patents, Trademarks, and Copyrights

CHAPTER I—PATENT OFFICE, DEPARTMENT OF COMMERCE

PART 2—RULES OF PRACTICE IN TRADEMARK CASES

PART 6—CLASSIFICATION OF GOODS AND SERVICES UNDER THE TRADEMARK ACT

International Trademark Classification; Correction

In FR Doc. 73–10996 appearing at page 14681 in the issue of Monday, June 4, 1973 (38 FR 14681), the language in the tenth line of the sixth paragraph of the preamble reading "mark was registered" should read "application was filed", and the language in the sixth line of revised § 2.85(b) reading "registration was granted" should read "application was filed."

Dated: April 26, 1974.

C. MARSHALL DANN,
Commissioner of Patents.

Approved: May 3, 1974.

BETSY ANCKER-JOHNSON,
Assistant Secretary for Science and Technology.

[FR Doc.74–10822 Filed 5–9–74;8:45 am]

Title 41—Public Contracts and Property Management

CHAPTER 5A—FEDERAL SUPPLY SERVICE, GENERAL SERVICES ADMINISTRATION

PART 5A–1—GENERAL

PART 5A–7—CONTRACT CLAUSES

Option To Extend the Term of Contract

This change to the General Services Administration Procurement Regulations (GSPR) provides standard procedures for the extension of contracts and a clause for use in requirements type contracts when extending such contracts.

Section 5A–1.376–2 is amended as follows:

§ 5A–1.376–2 Exercise of options.

* * * * *

(d) An "Option to Extend the Term of Contract" clause for use in requirements type contracts is provided in § 5A–7.103–92.

The table of contents for Part 5A–7 is amended to add the following:

5A–7.103–92 Option to extend the term of contract.

Section 5A–7.103–92 is added as follows:

§ 5A–7.103–92 Option to extend the term of contract.

Where it is to the Government's advantage to extend existing contracts, the contractual clause specified below is authorized for use. Contracting officers are cautioned that such action must be predicated on a decision that an extension is in the best interest of the Government.

OPTION TO EXTEND THE TERM OF CONTRACT

The term of this contract may be extended by mutual consent of the parties, provided:

(a) A written notice of intent to extend is given to the Contractor 60 days before expiration of the current contract (this notice shall not be deemed to commit the Government to an extension).

(b) The extension of the contract shall be signed by both parties using Standard Form 30, Amendment of Solicitation/Modification of Contract.

(c) The extension shall be for a period of no more than 60 days.

(d) The prices of the current contract shall remain unchanged during the period of the extension.

(Sec. 205(c), 63 Stat. 390 (40 U.S.C. 486(c)))

Effective date. These regulations are effective April 30, 1974.

Dated: April 30, 1974.

M. J. TIMBERS,
Commissioner, FSS.

[FR Doc.74–10831 Filed 5–9–74;8:45 am]

PART 5A–72—REGULAR PURCHASE PROGRAMS OTHER THAN FEDERAL SUPPLY SCHEDULE

Monthly Supply Potential and Method of Award Clauses

The following prescribes revised monthly supply potential and related method of award clauses and revised guidelines to be used when they are utilized.

Section 5A–72.105–16 is amended as follows:

§ 5A–72.105–16 Monthly Supply Potential (MSP) and Method of Award clauses.

* * * * *

(c) *Guidelines for use of the MSP and Method of Award clauses.* (1) Items or groups of items will not be subdivided for award purposes. It should be noted that subdivision for partial quantities may be made only as progressive awards (see § 5A–72.105–15).

(2) The MSP clause provides space for bidders to insert their MSP's for individual items, or to furnish a combined MSP for all items or groups of items. This space shall not be rearranged or relocated in the item listing as it is designed to encourage bidders to furnish a combined MSP for as many items or groups of items as possible.

(3) Estimated requirements for the contract period and estimated peak monthly requirements (EPMR) shall be shown for each item whether the award is to be made on individual items or in the aggregate.

(4) The contracting officer shall use the estimated quantities and EPMR's