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HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents - Chapter 23	23-1 - 23-1.1 (2 pp.)	23-1 - 23-1.1 (2 pp.)
2328 (Cont.) - 2337.6 (Cont.)	23-12.7 - 23-13.9 (12 pp.)	23-12.7 - 23-13.9 (10 pp.)

NEW/REVISED MATERIAL--EFFECTIVE DATE: ***June 1, 2000***

Section 2337, Effective Date of Change in Bed Size and/or Bed Designation(s) of Participating Skilled Nursing Facility and/or Nursing Facility, title of section changed and material previously found in this section is moved to §§2337.2 and 2337.3. This section now includes new material on HCFA's authority to regulate bed size changes.

Section 2337.1, Requirements for Distinct Part Certification, title of section changed and material previously found in this section is moved to §§2337.2 and 2337.3. This section now includes previously published information found in Skilled Nursing Facility and State Operations Manuals regarding the definition of a distinct part.

Section 2337.2, Changes in Bed Size of Participating SNF and/or NF, title of section changed and material previously found in this section is moved to §2337.3. This section now includes previously published information on how often a SNF can change its beds size and under what circumstances, as well as, when such a change is effective, as revised.

Section 2337.3, General Request Filing Requirements, title of section changed and material previously found in this section is moved to §2337.4. This section now includes previously published information on filing a general request for a change in bed size, as revised.

Section 2337.4, Exceptions, title of section changed and material previously found in this section is moved to §2337.6. This section now includes previously published information on exceptions and new material allowing for an exception based on the elimination of a distinct part.

Section 2337.5, Change in Designated Bed Location(s), is added to incorporate previously published information on the definition of what constitutes a change in a designated bed location(s) and information on how to request a change in designated bed location(s) as found in the State Operations Manual.

Section 2337.6, Cost Report Requirement After Change in Bed Size and/or Change in Designated Bed Location(s), replaces what was formerly §2337.4.

CLARIFICATION--EFFECTIVE DATE: NOT APPLICABLE

Section 2336, Separate Cost Entities in an Institutional Complex, title of section changed and subsection B **deleted**.

Section 2336.1, Patient Service Criteria for Establishing Cost Entities in an Institutional Complex, title of section changed.

Section 2336.2, Accounting Criteria for Establishing Cost Entities in an Institutional Complex, title of section changed.

Section 2336.3, Cost Report Requirements of an Institutional Complex, replaces what was formerly §2336.4, retitled.

Section 2337.1, Requirements for Distinct Part Certification clarifies previously published information found in skilled nursing facility and state operations manuals regarding the definition of a distinct part and provides examples by way of a floor plan of a nursing facility.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

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D. Gift, Flower and Coffee Shops.--Where cost centers are maintained for these functions (see §§2105.2 and 2145 concerning coffee shops), the cost should be carried forward for cost finding and receive an allocable share of general service costs. After the allocation is made, the total cost of these functions must be excluded in determining reimbursable costs. In this case, income will not be used to reduce costs. Where the costs (direct and allowable share of general service costs) attributable to any nonallowable cost area are so insignificant as to not warrant establishment of a nonreimbursable cost center, these costs may be adjusted on the Adjustments to Expenses worksheet of the cost reporting forms. However, where cost centers are not maintained for these functions, the income derived from them must be used to reduce total hospital costs. For expediency, the cost in the "Operation of Plant" account can be reduced.

E. Amount Applicable to Part B for Hospital-Based Physicians.--Since this amount is generally based upon the direct salary and fringe benefits of the physicians, no general service costs would normally apply and the adjustment would be made on the Adjustments to Expenses worksheet. If, however, the contractual agreement with hospital-based physicians requires the physicians to reimburse the hospital for costs incurred by the hospital related to physician services, these costs should bear an appropriate portion of general service costs.

F. Services Furnished as Payment-In-Kind Under Reserved Bed Agreements.--Under the terms of a reserved bed agreement, a provider may agree to compensate another facility for reserving beds by offering free or discounted services rather than by making cash payment. (See §2105.3.) When this occurs, the provider making payment must make an adjustment to remove the cost of furnishing the free or discounted services from its allowable costs. This is accomplished by (1) "grossing-up" the appropriate department charges as described in §2314 B., if the services are billable or (2) if the services are not billable, by either establishing a nonallowable cost center, as described above, or making appropriate adjustments on the Adjustments to Expenses worksheet to remove direct as well as indirect costs associated with the cost of the services provided.

G. Home-Delivered Meals.--The acquisition cost of meals in a home-delivered meals program may be excluded from the statistical basis used to allocate A&G cost. In the case of meals prepared by the provider, the cost of raw food is excluded. In the case of the purchase of prepared meals, the cost of the meals is excluded. The amount of cost excluded must be based on auditable records of actual cost. Neither estimates nor statistics are acceptable. All other direct costs (salaries, fringe benefits, transportation and contract services) will receive overhead cost through the required step-down process. This treatment of direct cost is limited to the costs of home-delivered meals programs only.

H. Home Health Agency-Based Hospice.--The cost of inpatient care provided under contract for an HHA-based hospice may be excluded from the statistical basis used to allocate A&G cost. The amount of cost excluded must be based on auditable records of the actual cost to the HHA for care provided to

hospice patients under an arms-length contract with a non-related provider of inpatient care. All other hospice costs will receive overhead cost from the parent HHA through the required step-down process.

This treatment of direct cost is limited to the determination of the costs of HHA-based hospice programs only.

The next page is 23-13

2336. SEPARATE COST ENTITIES IN AN INSTITUTIONAL COMPLEX

A. General.--There are a number of institutions which, although operating as a single administrative entity, offer several clearly different types of service; e.g., short-term acute, long-term medical, rehabilitation, skilled nursing, home health, hospice, long-term psychiatric or long-term tuberculosis.

Where the cost of services rendered for each type of service differs or where there are significant differences in the operating costs of the various facilities, to treat the institution as one entity for cost reimbursement purposes would mean an underpayment or overpayment for services rendered to beneficiaries. The average cost of a patient day in one part of the complex may differ from another part, but treatment of the complex as one unit for cost reimbursement purposes will result in averaging the costs of the various components. Under these circumstances, a high utilization by Medicare patients in the more costly area would result in an underpayment to the institution, while a high utilization in the lower cost areas would result in an overpayment.

In order to insure equitable treatment for those institutions furnishing different types of services separate entities for cost reimbursement must be established in, and subprovider identification numbers issued to, those institutions that meet the criteria described in §§ 2336.l and 2336.2. These separate entities must, if they seek to be considered a part of the main provider for purposes of Medicare certification and reimbursement, meet the applicable criteria.

2336.l Patient Service Criteria for Establishing Cost Entities in an Institutional Complex.--The following criteria pertaining to patient services will be evaluated by the State agency.

A. Types of Service.--Separate cost entities can only be established for components providing clearly different services; e.g., short-term acute, long-term medical, long-term psychiatric, or long-term tuberculosis. Those services generally provided by short-term acute hospitals (intensive care, self care, and similar services) may not be established as separate cost facilities, nor may the customary separate clinical departments of a short-term hospital (pediatrics, obstetrics, etc.) be set up as separate cost entities.

The definition of long-term and short-term entities will be in conformity with the definition in the AHA Guide Issue (August l, l969): "Long term--over 50 percent of all patients admitted have a stay of 30 days or more. Short term--over 50 percent of all patients have a stay of less than 30 days."

B. Admission and Discharge Procedures.--Separate admission and discharge records must be maintained for each unit. When a patient is moved from one cost entity to another cost entity, the patient's record must be closed and sent to medical records, and a new medical chart prepared upon admission to the receiving cost entity.

C. Physical Arrangement.--The components to be separately costed must be in separate buildings; or, if not separated, the physical arrangement must be equivalent to separate buildings in the location of the nursing stations, the call system hook-ups, and the arrangement of equipment, walks, doors, etc.

Each unit must have enough beds to permit economical and effective operation as a separate unit and all beds comprising a unit must be contiguous (not scattered through various floors, wings, or buildings), except swing beds.

D. Nursing Staff Organization.--The nursing or patient care staffs assigned to a separate cost entity must service exclusively in that cost entity during a shift. Also, there must be a charge nurse or other supervisor of patient care to supervise each shift for each separate cost entity exclusively.

E. Licensure and Accreditation.--If State law provides for separate licensing of facilities of the kind represented by a unit to be separately costed, the unit must be so licensed

F. Utilization Review Plan.--The institution's utilization review plan must reflect the proper standards for each type of care offered.

2336.2 Accounting Criteria for Establishing Cost Entities in an Institutional Complex.--The following criteria pertaining to the cost-finding capability of each institutional complex will be evaluated by the fiscal intermediary.

A. The process of cost finding in an institutional complex is one of allocating the cost of the entire institution to the different entities. In effect, each entity will be treated as a cost center.

B. The accounting system must provide for the proper allocation to the various cost entities those revenues and costs that are attributable to facilities or services that are shared by them including those entities providing noncovered care. Adequate statistical data must be developed and maintained currently to corroborate the basis of allocation. One of the required statistics must be the number of square feet used by each component both before and after the effective date of the change to an institutional complex.

2336.3 Cost Report Requirements of an Institutional Complex.-- The following cost reporting requirements apply:

A. The institution will be required to file one cost report covering the period from the beginning of its reporting period to its regular year-end reporting time. Where the effective date of the change does not coincide with the beginning of the cost reporting year, the provider will use the weighted average method to determine the total square feet used by each component during the year. The number of square feet used by each component, as determined by the use of this method, will be used as a basis to allocate those expenses that are required to be allocated on the basis of square feet. This method will be used only for a year in which a change in certification occurs.

EXAMPLE:

Facts:

Total square feet in hospital	100,000 sq. ft.
Certified as short-term acute care hospital	9 months
Certified as short-term acute care hospital and long-term care unit	3 months

Acute care unit - 75,000 sq. ft.
Long-term care unit - 25,000 sq. ft.

Computation of total square feet used by each unit:

Acute care unit - 9 months x 100,000 sq. ft. =	900,000	
Acute care unit - 3 months x 75,000 sq. ft. =	225,000	
	1,125,000 =	93.75%
Long-term care - 3 months x 25, 000 sq. ft. unit	75,000 -	6.25%
	1,200,000	100.00%

Acute care unit - 93.75% x 100,000 sq. ft. =	93,750 sq. ft.
Long-term care - 6.25 x 100,000 sq. ft. = unit	6,250 sq. ft.
	100,000 sq. ft.

B. The cost report must include each entity as a separate cost center (see § 2336.2A).

C. Worksheet A, trial balance of expenses, and Worksheet B, cost-finding schedule, of the cost report must show total cost for the entire institutional complex. Separate cost centers must be listed on Worksheet B for each subprovider number and any noncovered area. Worksheet B-l, statistical basis for cost-finding, must show the statistical apportionment basis for each area listed on Worksheet B. Separate calculations of reimbursement settlement and statistics must be submitted by each cost entity.

D. The cost report and supplemental schedules for all components within an institutional complex must be submitted simultaneously and must cover the same cost reporting period.

E. All components included in the cost report must use the same method of cost apportionment and must establish the same charges for like services (see §2203).

F. All components within an institutional complex must be serviced by the same fiscal intermediary for purposes of audit and settlement.

G. Each component within an institutional complex that offers patient care services that are covered under the program should be considered, within the limitations imposed by this section, to be a provider for reimbursement purposes. Such reimbursement functions as the establishment of interim rates, limitation of reasonable costs, application of lower of costs or charges, and similar matters will be governed by regulations and policies that apply to all hospital cost reports.

H. An institutional complex must file the profit and loss and the balance sheet section of the cost report to reflect the entire hospital.

The next page is 23-13.4

2337. EFFECTIVE DATE OF CHANGE IN BED SIZE AND/OR BED DESIGNATION(S) OF PARTICIPATING SKILLED NURSING FACILITY AND/OR NURSING FACILITY

Under §1866 of the Social Security Act (the Act), the Secretary has the authority to enter into an agreement with an institution or an institutional complex to provide covered services to our beneficiaries. The provider agreement requires compliance with the requirements the Secretary deems necessary for participation in the Medicare or Medicaid program. See §1866(b)(2) and §1902 (a)(27) of the Act. On the effective date of the provider agreement, the institution or institutional complex is deemed to have met the requirements for participation based upon a survey of the institution or institutional complex as it was configured (i.e., bed size/bed location configuration) on the date(s) of the survey. HCFA's authority to regulate bed size changes in a SNF or a NF is based on the authority to ensure compliance with the provider agreement under §1866 of the Act and to further ensure that the configuration that has been approved for the institution or institutional complex does not so drastically change from that of the original certified configuration so as to endanger resident health and safety or otherwise change in a material fashion the identity of the entity that HCFA originally certified for program participation.

An institution or institutional complex may choose to participate in the Medicare and/or Medicaid programs either in its entirety, or a portion thereof, but not both. If only a portion of an institution or institutional complex actually participates in either program it is classified as a distinct part and must meet the criteria found in §2337.1. For example, an institution has 4 wings that consist of 25 beds each. Three contiguous wings that contain 75 beds are dually participating (i.e., participating in Medicare and Medicaid) . The fourth wing is only certified to participate in Medicare. It consists of 25 beds. Therefore, in this instance the institution is fully participating for purposes of Medicare (i.e., 100 beds) and is participating as a distinct part (i.e., 75 beds) for purposes of Medicaid. The policies on bed size changes and changes in designated bed locations that are included in this section apply, regardless of whether an institution is fully participating (i.e., all beds within the institution or institutional complex are certified to participate in the Medicare and/or Medicaid program) or participating as or with a distinct part.

A SNF may be:

- o An entire institution for skilled nursing or rehabilitative care, such as a nursing home; or

- o A distinct part of an institution such as, a hospital, personal care home, assisted living facility, board and care home, domiciliary care facility, rest home, continuing care retirement community or nursing home.

An institution that is primarily for the care and treatment of mental diseases cannot be a SNF.

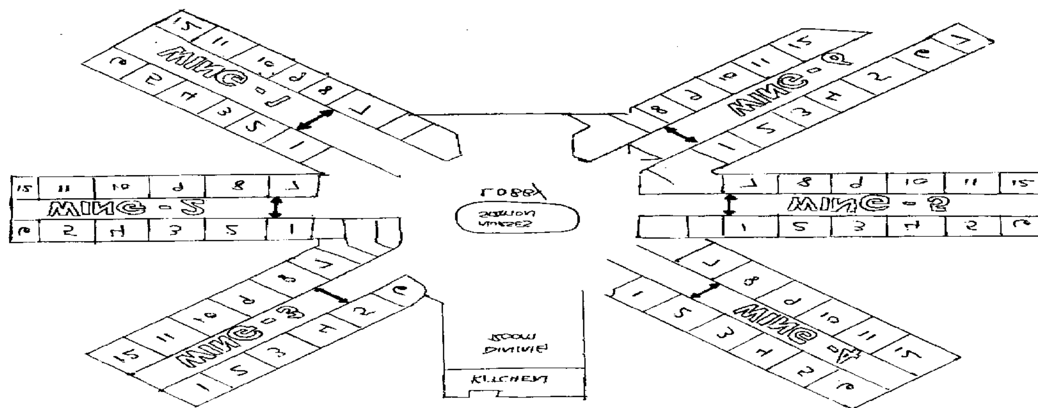

EXHIBIT I
FLOOR PLAN OF A NURSING FACILITY

2337.1 Requirements for Distinct Part Certification.--If the institution or institutional complex is participating as a distinct part SNF and/or NF, for a change to be approved the requested change in bed size must conform with the requirements to be classified as a distinct part. The term “distinct part” refers to a portion of an institution or institutional complex (e.g., a nursing home or a hospital) that is certified to provide SNF and/or NF services. A distinct part must be physically distinguishable from the larger institution and fiscally separate for cost reporting purposes. An institution or institutional complex can only be certified with one distinct part SNF and/or one distinct part NF. A hospital-based SNF is by definition a distinct part. Multiple certifications within the same institution or institutional complex are strictly prohibited. The distinct part must consist of all beds within the designated area. The beds in the certified distinct part area must be physically separate from (that is, not commingled with) the beds of the institution or institutional complex in which it is located. However, the distinct part need not be confined to a single location within the institution or institutional complex’s physical plant. It may, for example, consist of several floors or wards in a single building or floors or wards which are located throughout several different buildings within the institutional complex. In each case, however, all residents of the distinct part would have to be located in units that are physically separate from those units housing other patients of the institution or institutional complex. Where an institution or institutional complex owns and operates a SNF and/or a NF distinct part, that SNF and/or NF distinct part is a single distinct part even if it is operated at various locations throughout the institution or institutional complex. The aggregate of the SNF and/or NF locations represents a single distinct part subprovider, not multiple subproviders, and must be assigned a single provider number. Exhibit I, above, is an illustration of a floor plan of a nursing facility followed below by example which meet the requirements for a distinct part, as well as examples that do not meet the requirements for a distinct part.

1. Meet Distinct Part Certification.--An institution or institutional complex can any **one** of the following examples discussed in the context of Exhibit I above, that meets the requirements for distinct part certification.

o All rooms numbered 1 through 12 in wing 1 and all rooms numbered 1 through 12 in wing 2 constitute a distinct part. This option is approvable because it constitutes all beds in each wing.

o All rooms numbered 1 through 12 in wing 5. This option is approvable because it includes all beds in the wing.

o Room numbers 1 through 6 in wing 4 constitute a distinct part. This option is approvable because it includes all beds that constitute a single side of the corridor.

o Room numbers 7 through 12 in wing 2 and all rooms 1 through 12 in wing 1 constitute a distinct part. This option is approvable because it includes all beds in wing 1 and all beds that constitute a single side of the corridor in wing 2.

2. Do Not Meet Distinct Part Certification.--Neither of the options discussed below, in the context of Exhibit I above, meet the requirements for distinct part certification.

o Room numbers 1 through 12 in wing 1 and rooms 3,4, and 5 in wing 6 do not constitute a distinct part. This option is not approvable because of the inclusion of the three rooms in wing six.

o Room number 2 in wing 1, room numbers 5 and 7 in wing 6, and room numbers 4,5,6, 10, 11, and 12 in wing 4. This option is not approvable because the distinct part area must be physically separate from (that is, not commingled with) the beds of the institution or institutional complex in which it is located.

2337.2 Changes in Bed Size of Participating SNF and/or NF.--When an institution or institutional complex not previously certified as or with a SNF or NF establishes a SNF or NF, it must be initially certified and periodically recertified. If an institution or institutional complex has an existing SNF or NF agreement, it may elect to change the number of beds that are certified to participate in the Medicare or Medicaid program *up to two times* per cost reporting year in accordance with the requirements set out below. Where a change in the size of a SNF also impacts the size of a NF, or vice versa this represents one change for the SNF and one change for the NF. An institution or institutional complex may only change the bed size of its SNF and/or its NF once on the first day of the beginning of its cost reporting year and again on the first day of a single cost reporting quarter within that same cost reporting year in order to effect one of the following combinations:

o An increase in its bed size on the first day of the beginning of its cost reporting year and an increase in its bed size on the first day of a single cost reporting quarter that falls within the same cost reporting year, or;

o An increase in its bed size on the first day of the beginning of its cost reporting year and a decrease in its bed size on the first day of a single cost reporting quarter that falls within the same cost reporting year, or;

o A decrease in its bed size on the first day of the beginning of its cost reporting year and an increase in its bed size on the first day of a single cost reporting quarter that falls within the same cost reporting year.

At no time can the RO or the SA approve two decreases in the bed size of an institution within the same cost reporting year.

The institution or institutional complex may submit only ONE change in bed size at a time. Furthermore, an institution cannot request a change in its bed size just because it undergoes a change of ownership (CHOW) or because it has been approved to change its cost reporting year. In either of these circumstances, it is still bound by the filing requirements found in §2337.3.

A request for a change in the number of certified beds cannot be approved on a retroactive basis. All changes are made on a prospective basis only in accordance with the effective date indicated above. The institution requesting a change in bed size must submit a written request to the RO or SA (as appropriate) in conformance with the requirements found in §2337.3. An institution or institutional complex can not self-designate the effective date of a change in bed size.

2337.3 General Request Filing Requirements.--An institution or institutional complex seeking a change in the number of Medicare or Medicaid certified beds must:

1. Submit a written request to the RO or SA (as appropriate) for the change 45 days before

o The first day of its cost reporting year to effect a change on the first day of its cost reporting year or;

o The first day of a single cost reporting quarter within the same cost reporting year at which time it seeks to change its bed size to effect a change on the first day of the designated cost reporting quarter.

2. Submit floor plans identifying all areas of the institution or institutional complex with the current certified bed configuration and the proposed certified bed configuration in order for the RO or SA to determine that the proposed change is in fact, in conformance with the rules for full participation or distinct part certification, whichever applies.

3. Include a reference to the cost reporting year of the institution or institutional complex. If there has been a change in the cost reporting year originally selected by the institution or institutional complex, submit a copy of the letter submitted to the fiscal intermediary (for Medicare) and the fiscal intermediary's response to the request. Absent such a change, the institution or institutional complex must adhere to the cost reporting year selected at its initial certification.

The RO or the SA will review the request and notify the institution in writing of its determination regarding the request, including the effective date of the change in bed size and the bed locations, prior to the start of the cost reporting year or the cost reporting quarter, whichever applies.

2337.4 Exceptions--There are certain situations (described below) which we believe warrant an exception to the above policy. Therefore, even if the institution or institutional complex has been approved for a change in bed size in accordance with the policies articulated above, the institution or institutional complex may be granted a change in bed size on the basis of one of these situations. To request a change in bed size based on one of these situations, the institution or institutional complex must file a written request with the RO or the SA (as appropriate) 45 days before the first day of its next cost reporting quarter, at which time the request will be effective if approved, along with floor plans identifying all areas of the institution or institutional complex with the current certified bed configuration and the proposed certified bed configuration. An exception may be granted based only on one of the following situations:

A. Life Safety Code (LSC) Requirements.--An exception may be granted if the request is to reduce the size of the SNF or NF to avoid being out of compliance with LSC requirements (e.g., sprinkler installation). The proposed bed configuration must be separated from the rest of the institution or institutional complex by a 2-hour fire wall, so that there is no danger of the fire spreading there from other parts not meeting safety requirements. In this case, the proposed reduction in the size of the SNF or NF may be established with an effective date that is requested by the institution or institutional complex, but not earlier than the date that the separation can be documented. A full survey by the fire authority must be performed if the reason for the request is to limit noncompliance with LSC requirements.

B. Elimination of Distinct Part.--An exception may be granted if an institution or institutional complex concludes that it wants to become fully participating (i.e., all beds within the institution or institutional complex are certified to participate in the Medicare and/or Medicaid program). If the institution or institutional complex decides to become fully certified to participate in the Medicare and/or Medicaid program, **it cannot return** to distinct part certification until, at the earliest, the beginning of its next cost reporting year.

C. Enlargement Through Construction, Purchase or Lease of Additional Space.--An exception may be granted if the institution or institutional complex requests to increase the size of its SNF or NF to include space acquired through new construction, purchase or lease (e.g., constructing a new wing, purchasing an adjacent building or leasing a floor in a hospital).

2337.5 Change in Designated Bed Location(s).--An institution or institutional complex may request to change its designated bed locations, as long as there is no change in the number of beds certified to participate in the Medicare and/or Medicaid program, by submitting a written request to the SA or the RO 30 days in advance of such a change. In addition, the institution or institutional complex must submit floor plans identifying all areas of the institution or institutional complex with the current certified bed configuration and the proposed certified bed configuration in order for the RO or SA to determine that the proposed change is in fact, in conformance with the rules for full certification or distinct part certification, whichever applies. The institution or institutional complex must adhere to the notification requirements found in 42 CFR 483.10(b)(11)(ii)(A) and the residents rights requirements found in 42 CFR 483.10(o). The request must be approved by the RO or SA before the institution or institutional complex makes the change. No changes are made on a retroactive basis.

2337.6 Cost Report Requirement After Change in Bed Size and/or Change in Designated Bed Location(s).--Where an institution or institutional complex receives approval for a change in bed size and/or a change in its designated bed locations, it will be required to file one cost report covering the period from the beginning of its reporting period to its regular year-end reporting time. Where an institution or institutional complex changes its bed size or its designated bed location(s) during its cost reporting year, adequate statistical data must be maintained to corroborate the basis for allocation of costs. One of the required statistics must be the number of square feet used by the certified area and nonparticipating area both before and after the effective date of the change in bed size and/or the effective date of the change in designated bed location(s). The SNF will use the weighted average method to determine the total square feet used by the certified area and the nonparticipating area during the year. The number of square feet used by the certified area and the nonparticipating area, as determined by this method, will be used as a basis to allocate those expenses that are required to be allocated on the basis of square feet. This method will be used only for a year in which a change in bed size and/or a change in designated bed location(s) occurs.

EXAMPLES:

A. Facts:

Total square feet in facility	100,000 sq. ft.
Wholly certified SNF	6 months
Distinct-part SNF	6 months
Certified area - 50,000 sq. ft.	
Nonparticipating area - 50,000 sq. ft.	

Computation of total square feet used by each area:

Certified area - 6 months x 100,000 sq. ft.	=	600,000	
Certified area - 6 months x 50,000 sq. ft.	=	300,000	
		900,000	= 75%
Nonparticipating-6 months x 50,000 sq. ft. area	=	300,000	= 25%
		1,200,000	100%

Certified area - 75% x 100,000 sq. ft.	=	75,000 sq. ft.
Nonparticipating - 25% x 100,000 sq. ft. area	=	25,000 sq. ft.
		100,000 sq. ft.

B. Facts:

Total Square feet in facility	100,000 sq. ft.
Distinct-part SNF	9 months
Certified area - 50,000 sq. ft.	
Nonparticipating area - 50,000 sq. ft.	
Distinct-part SNF	
Certified area - 25,000 sq. ft.	
Nonparticipating area - 75,000 sq. ft.	

Computation of total square feet used by each area:

Certified area - 9 months x 50,000 sq. ft.	=	450,000	
Certified area - 3 months x 25,000 sq. ft.	=	75,000	
		525,000	= 43.75%
Nonparticipating area - 9 months x 50,000 sq. ft.	=	450,000	
Nonparticipating area - 3 months x 75,000 sq. ft.	=	225,000	
		675,000	= 56.25%
		1,200,000	100.00%

Certified area - 43.75% x 100,000 sq. ft.	=	43,750 sq. ft.
Nonparticipating area - 56.25% x 100,000 sq. ft.	=	56,250 sq. ft.
		100,000 sq. ft.