indicated. The application also will be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the standards enumerated in the BHC Act (12 U.S.C. 1842(c)). If the proposal also involves the acquisition of a nonbanking company, the review also includes whether the acquisition of the nonbanking company complies with the standards in section 4 of the BHC Act (12 U.S.C. 1843). Unless otherwise noted, nonbanking activities will be conducted throughout the United States. Additional information on all bank holding companies may be obtained from the National Information Center website at *www.ffiec.gov/nic/*.

Unless otherwise noted, comments regarding each of these applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than November 3, 2006.

A. Federal Reserve Bank of Chicago (Patrick M. Wilder, Assistant Vice President) 230 South LaSalle Street, Chicago, Illinois 60690-1414:

1. Bancorp Financial, Inc., Evergreen Park, Illinois; to become a bank holding company by acquiring 100 percent of the voting shares of Evergreen Interim Bank, Evergreen Park, Illinois (in organization).

Board of Governors of the Federal Reserve System, October 3, 2006.

Jennifer J. Johnson,

Secretary of the Board.

[FR Doc. E6–16561 Filed 10–5–06; 8:45 am]

BILLING CODE 6210–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–06–0502]

Proposed Data Collections Submitted for Public Comment and Recommendations

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 for opportunity for public comment on proposed data collection projects, the Centers for Disease Control and Prevention (CDC) will publish periodic summaries of proposed projects. To request more information on the proposed projects or to obtain a copy of the data collection plans and instruments, call 404–639–5960 and send comments to Seleda Perryman, CDC Assistant Reports Clearance Officer, 1600 Clifton Road, MS-D74, Atlanta, GA 30333 or send an e-mail to *omb@cdc.gov.*

Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Written comments should be received within 60 days of this notice.

Proposed Project

Racial and Ethnic Approaches to Community Health (REACH) 2010 Evaluation (0920–0502)—Revision—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

REACH 2010 is a part of the Department of Health and Human Services' response to the President's Race Initiative and to the Healthy People 2010 goal to eliminate health disparities in the health status of racial and ethnic minorities.

After initial review of the national data, a study approach was adopted on the statistical techniques of ''excess deaths'' to define the difference in minority health in relation to non-minority health. The analysis of excess deaths revealed that six specific health areas accounted for more than 80 percent of the higher annual proportion of minority deaths. Because of these sobering statistics, and the overarching goals of Healthy People 2010 to eliminate disparities in health, this program was launched in 1999 and is currently ongoing. This is a proposed revision to the currently approved project. REACH 2010 will help to continue assessing the prevalence of self-reported risk behaviors associated with cardiovascular disease, health disparities in infant mortality; deficits in breast and cervical cancer screening and management; diabetes; HIV/AIDS; and deficits in childhood and adult immunizations.

This jointly developed program was designed to be lead by the communities in which it serves, and to demonstrate that adequately funded community-based programs can be instrumental in reducing health disparities in their communities. REACH 2010 serves communities with: African American, American Indian, Hispanic American, Asian American, and Pacific Islander citizens. As part of the program evaluation, CDC has collected uniform surveys annually in 27 communities since 2001. The survey which contains questions that are standard public health performance measures for each health priority areas are administered by telephone or in-person interview. REACH 2010 will be changed so that these surveys will be conducted in only 20 communities (900 individuals each) after October 2007. However, the questionnaire used will remain the same.

There are no costs to respondents except their time to participate in the survey.

ESTIMATED ANNUALIZED BURDEN HOURS

Respondents	No. of respondents	No. of responses per respondent	Average burden per response (in hrs.)	Total burden hours)
Adult ages 18 and older who live in communities participating in the REACH 2010 Program	18,000	1	15/60	4,500
Total				4,500

Dated: October 2, 2006.

Joan F. Karr,

Acting Reports Clearance Officer, Centers for Disease Control and Prevention.

[FR Doc. E6–16501 Filed 10–5–06; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–684A–I]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Centers for Medicare & Medicaid Services.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Centers for Medicare & Medicaid Services (CMS) is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

1. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* End-Stage Renal Disease (ESRD) Network Business Proposal Forms and Supporting Regulations in 42 CFR 405.2110 and 42 CFR 405.2112; *Use:* Section 1881(c) of the Social Security Act establishes ESRD Network contracts. The regulations designated at 42 CFR 405.2110 and 405.2112 designated 18 End Stage Renal Disease (ESRD) Networks which are funded by renewable contracts. These contracts are on 3-year cycles. To better administer the program, CMS requires the contractors to submit a standardized business proposal package of forms so that cost proposing and pricing among the ESRD Networks will be uniform and easily tracked by CMS. *Form Number:* CMS–684A–I (OMB#: 0938–0658); *Frequency:* Reporting—Other, every three years; *Affected Public:* Not-for-profit institutions; *Number of Respondents:* 18; *Total Annual Responses:* 36; *Total Annual Hours:* 1,080.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS' Web Site address at *http://www.cms.hhs.gov/PaperworkReductionActof1995*, or e-mail your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov*, or call the Reports Clearance Office on (410) 786–1326.

To be assured consideration, comments and recommendations for the proposed information collections must be received at the address below, no later than 5 p.m. on *December 5, 2006.*

CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development—C, Attention: Bonnie L Harkless, Room C4–26–05, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: September 29, 2006.

Michelle Shortt,

Director, Regulations Development Group, Office of Strategic Operations and Regulatory Affairs.

[FR Doc. E6–16598 Filed 10–5–06; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)

Centers for Medicare & Medicaid Services

Notice of Hearing: Reconsideration of Disapproval of Oregon State Plan Amendment 05–003

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

ACTION: Notice of hearing.

SUMMARY: This notice announces an administrative hearing to be held on December 8, 2006, at 2201 6th Street, Suite 1101, Seattle, Washington 98121, to reconsider CMS' decision to disapprove Oregon State plan amendment 05–003.

Closing Date: Requests to participate in the hearing as a party must be received by the presiding officer by October 23, 2006.

FOR FURTHER INFORMATION CONTACT: Kathleen Scully-Hayes, Presiding Officer, CMS, Lord Baltimore Drive, Mail Stop LB–23–20, Baltimore, Maryland 21244, *Telephone:* (410) 786–2055.

SUPPLEMENTARY INFORMATION: This notice announces an administrative hearing to reconsider CMS' decision to disapprove Oregon State plan amendment (SPA) 05–003 which was resubmitted on April 11, 2006. This SPA was disapproved on July 10, 2006. Under SPA 05–003, Oregon proposed to modify the State's methodology for calculating supplemental payments that are tied to the regulatory upper payment limit (UPL) for inpatient hospital services.

This amendment was disapproved because it did not comport with the general requirements of section 1902(a) and the specific requirements of 1902(a)(30)(A) of the Social Security Act (the Act).

At issue in this reconsideration is whether the State has demonstrated that the proposed supplemental payments, in conjunction with regular payments, would result in rates that are consistent with the regulatory UPL established at 42 CFR 447.272 under the authority of section 1902(a)(30)(A) of the Act, which requires that provider payment rates be ''consistent with efficiency, economy, and quality of care.'' Under that regulatory UPL, rates must be based on a reasonable estimate of what would be paid under Medicare payment principles for the same services. Also at issue is whether, in the absence of such a showing, the State plan can be a sound basis for Federal financial participation (FFP).

In a formal request for additional information and several subsequent discussions, CMS requested that the State demonstrate that its calculation of the UPL for inpatient hospital services would be a reasonable estimate of what would be paid under Medicare payment principles for the same services, which is the standard set forth in the Federal regulations at 42 CFR 447.272(b)(1). Oregon currently uses a case-mix index model to determine the UPL as specified in the approved Medicaid State plan, but proposed in SPA 05–003 to change to a length of stay (LOS) model. Case mix acuity appears to be a more accurate adjuster for Medicaid acuity than the LOS model because it reflects increases in services furnished, as opposed to just being based on the amount of time that patients spend in the hospital. Applying a case-mix index model to services furnished by the Oregon Health and Science University to adjust for Medicaid acuity reduced the UPL for inpatient hospital services for all non-State governmentally owned or operated hospitals by about 25 percent compared to the LOS model. (The difference between the two adjustments is an indication that, while Medicaid patients may have longer lengths of stay, the length of stay does