A. Federal Reserve Bank of Boston (Richard Walker, Community Affairs Officer) P.O. Box 55882, Boston, Massachusetts 02106-2204:

1. Marlborough Bancshares, Inc. and Marlborough Bancshares MHC; to become bank holding companies by acquiring 100 percent of the voting shares of Marlborough Savings Bank, all of Marlborough, Massachusetts.

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

1. PrivateBancorp, Inc., Chicago, Illinois; to merge with Piedmont Bancshares, Inc. Atlanta, Georgia, and thereby indirectly acquire Piedmont Bank of Georgia, Atlanta, Georgia.

Board of Governors of the Federal Reserve System, September 12, 2006.

Robert deV. Frierson,

Deputy Secretary of the Board.

[FR Doc. E6–15371 Filed 9–15–06; 8:45 am]

BILLING CODE 6210–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–06–05BW]

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

Survey of Primary Care Physicians' Practices regarding Prostate Cancer Screening—New—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Prostate cancer is the most common cancer in men and is the second leading cause of cancer deaths, behind lung cancer. The American Cancer Society estimates that there will be about 234,460 new cases of prostate cancer and about 27,350 deaths in 2006. Although prostate cancer deaths have declined over the past several years, it ranks fifth among deaths from all causes. The digital rectal examination (DRE) and prostate specific antigen (PSA) test are used to screen for prostate cancer. Screening is controversial and many are not in agreement as to whether the potential benefits of screening outweigh the risks, that is, if prostate specific antigen (PSA) based screening, early detection, and later treatment increases longevity. Although major medical organizations are divided on whether men should be routinely screened for this disease, it appears that all of the major organizations recommend discussion with patients about the benefits and risks of screening.

The purpose of this project is to develop and administer a national survey to a sample of American primary care physicians to examine whether or not they: Screen for prostate cancer using (PSA and/or DRE), recommend testing and under what conditions, discuss the tests and the risks and benefits of screening with patients, and if their screening practices vary by factors such as age, ethnicity, and family history. This study will examine demographic, social, and behavioral characteristics of physicians as they relate to screening and related issues, including knowledge and awareness, beliefs regarding efficacy of screening and treatment, frequency of screening, awareness of the screening controversy, influence of guidelines from medical practices and other organizations, and participation and/or willingness to participate in shared decision-making. There will be no cost to respondents other than their time to participate in the survey.

ESTIMATED ANNUALIZED BURDEN HOURS

Respondents	Number of respondents	Number of responses per respondents	Average burden per response (in hours)	Total burden (in hours)
Primary Care Physicians	2,000	1	30/60	1,000

Dated: September 11, 2006.

Joan F. Karr,

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

[FR Doc. E6–15435 Filed 9–15–06; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–06–06BR]

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–74, 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

Brownfield/Land Re-use Public Health Involvement Triage Tool—New—Agency for Toxic Substances and Disease Registry (ATSDR), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

ATSDR has developed a Triage Tool that rapidly screens sites to assess the need for public health agency involvement. Users of this tool are likely to include: Health departments, redevelopers, financial institutions, licensed environmental professionals, environmental regulatory agencies, and economic development agencies. Any Brownfield or land re-use site that is being considered for redevelopment is a candidate for processing through this rapid assessment tool.

Brownfield sites and land re-use sites may contain conditions that represent potential health hazards. Some brownfield sites contain significant physical or chemical health hazards. For example, some physical hazards include open holes, unstable structures, and sharp objects. Past industrial activities often leave behind chemical contamination or drums of chemical wastes. These types of sites usually do not have adequate security to prevent people from being exposed to site hazards. Abandoned sites generally lack any restriction to site access. When people enter these properties there is a chance that they may be injured or exposed to toxic chemicals. While most adults may show little interest in entering these properties, children and adolescents often view brownfields as playgrounds and places to explore, thereby increasing their risk of exposure.

Public health agencies are an important resource to communities who are either concerned about the health impacts of current conditions at these types of sites or are considering redevelopment of these properties for expanded re-use. Public health agencies can assist the community in assessing potential health impacts, addressing health concerns of conditions at brownfield sites, communicating risks, and supporting appropriate actions to protect the health of the community.

The Triage Tool consists of an interactive checklist that is used to collect information related to the site, including the suspected contamination, site access, type of site, proposed re-use, community concerns, and site surroundings. After the checklist is completed, the responses are analyzed by the internal logic of the Tool. The Triage Tool uses a hierarchical decision matrix, which assesses site characteristics, community concerns, and the need for public health involvement. A separate system within the Tool allows users to view subject-specific information (contaminants, community concerns, etc.) via an interactive web tool. A Tour Guide has been developed to provide a visual walk-through of the Tool and all of its components.

While ATSDR can only estimate the annual number of users of the Triage Tool, we hope that the tool will be widely available as a resource for site assessment. To protect user privacy, ATSDR does not intend to maintain information entered by users into the Triage Tool checklist function. ATSDR also provides disclaimers in the Triage Tool for purposes of Agency liability. Users are advised within the Tool to avoid entering personal information (e.g., social security numbers, medical information). Any identifying information, such as the site contact, entered into the Triage Tool is provided for the use by the Tool user and will not be maintained by ATSDR. ATSDR does plan to invite feedback regarding the Triage Tool from users through a voluntary process. Users may send a separate e-mail or access a Web site maintained by ATSDR. This separate e-mail or Web site will also exist to enable users to contact ATSDR should they require more assistance or other information regarding brownfields/land re-use sites.

Each respondent may use the Triage Tool more than one time. A high-end, conservative estimate of five uses per year is provided here (i.e., assessment of five sites), with each use requiring about 30 minutes of time. There are no costs to respondents except their time to participate in the survey.

ESTIMATED ANNUALIZED BURDEN HOURS

Respondents	Number of respondents	Number of responses per respondent (average)	Average burden per response (in hours)	Total burden (hours)
Local Health Agency Workers	1,000	5	30/60	2,500
State Employees (e.g., EPA, DNR, DEM)	1,000	5	30/60	2,500
Developers	500	5	30/60	1,250
Financial institution personnel	500	5	30/60	1,250
Environmental or economic professionals	500	5	30/60	1,250
Total				8,750

Dated: September 11, 2006.

Joan F. Karr,

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

[FR Doc. E6–15451 Filed 9–15–06; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8028–N]

RIN 0938–AO18

Medicare Program; Part A Premium for Calendar Year 2007 for the Uninsured Aged and for Certain Disabled Individuals Who Have Exhausted Other Entitlement

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

ACTION: Notice.

SUMMARY: This annual notice announces Medicare's Hospital Insurance (Part A) premium for uninsured enrollees in calendar year (CY) 2007. This premium is to be paid by enrollees age 65 and over who are not otherwise eligible (hereafter known as the ''uninsured aged'') and for certain disabled individuals who have exhausted other entitlement. The monthly Part A premium for the 12 months beginning January 1, 2007 for these individuals will be $410. The reduced premium for certain other individuals as described in this notice will be $226. Section 1818(d) of the Social Security Act specifies the method to be used to determine these amounts.

DATES: *Effective Date:* This notice is effective on January 1, 2007.

FOR FURTHER INFORMATION CONTACT: Clare McFarland, (410) 786–6390.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1818 of the Social Security Act (the Act) provides for voluntary enrollment in the Medicare Hospital Insurance program (Medicare Part A), subject to payment of a monthly premium, of certain persons aged 65 and older who are uninsured under the Old-Age, Survivors and Disability Insurance (OASDI) program or the Railroad Retirement Act and do not otherwise meet the requirements for entitlement to Medicare Part A. (Persons insured under the OASDI program or the Railroad Retirement Act and certain others do not have to pay premiums for hospital insurance.)

Section 1818A of the Act provides for voluntary enrollment in Medicare Part A, subject to payment of a monthly premium, of certain disabled individuals who have exhausted other entitlement. These are individuals who are not currently entitled to Part A coverage, but who were entitled to coverage due to a disabling impairment under section 226(b) of the Act, and who would still be entitled to Part A coverage if their earnings had not exceeded the statutorily defined substantial gainful activity amount (section 223(d)(4) of the Act).

Section 1818A(d)(2) of the Act specifies that the provisions relating to premiums under section 1818(d) through section 1818(f) of the Act for the aged will also apply to certain disabled individuals as described above.

Section 1818(d) of the Act requires us to estimate, on an average per capita basis, the amount to be paid from the Federal Hospital Insurance Trust Fund for services incurred in the following calendar year (including the associated administrative costs) on behalf of individuals aged 65 and over who will be entitled to benefits under Medicare Part A. We must then determine, during September of each year, the monthly actuarial rate for the following year (the per capita amount estimated above divided by 12) and publish the dollar amount for the monthly premium in the succeeding CY. If the premium is not a multiple of $1, the premium is rounded to the nearest multiple of $1 (or, if it is a multiple of 50 cents but not of $1, it is rounded to the next highest $1).

Section 13508 of the Omnibus Budget Reconciliation Act of 1993 (Pub. L. 103–66) amended section 1818(d) of the Act to provide for a reduction in the premium amount for certain voluntary enrollees (section 1818 and section 1818A). The reduction applies to an individual who is eligible to buy into the Medicare Part A program and who, as of the last day of the previous month—

- Had at least 30 quarters of coverage under title II of the Act;
- Was married, and had been married for the previous 1-year period, to a person who had at least 30 quarters of coverage;
- Had been married to a person for at least 1 year at the time of the person's death if, at the time of death, the person had at least 30 quarters of coverage; or
- Is divorced from a person and had been married to the person for at least 10 years at the time of the divorce if, at the time of the divorce, the person had at least 30 quarters of coverage.
- Section 1818(d)(4)(A) of the Act specifies that the premium that these individuals will pay for CY 2007 will be equal to the premium for uninsured aged enrollees reduced by 45 percent.

II. Monthly Premium Amount for CY 2007

The monthly premium for the uninsured aged and certain disabled individuals who have exhausted other entitlement for the 12 months beginning January 1, 2007, is $410.

The monthly premium for those individuals subject to the 45 percent reduction in the monthly premium is $226.

III. Monthly Premium Rate Calculation

As discussed in section I of this notice, the monthly Medicare Part A premium is equal to the estimated monthly actuarial rate for CY 2007 rounded to the nearest multiple of $1 and equals one-twelfth of the average per capita amount, which is determined by projecting the number of Part A enrollees aged 65 years and over as well as the benefits and administrative costs that will be incurred on their behalf.

The steps involved in projecting these future costs to the Federal Hospital Insurance Trust Fund are:

- Establishing the present cost of services furnished to beneficiaries, by type of service, to serve as a projection base;
- Projecting increases in payment amounts for each of the service types; and
- Projecting increases in administrative costs.

We base our projections for CY 2007 on: (a) Current historical data, and (b) projection assumptions derived from current law and the Mid-Session Review of the President's Fiscal Year 2007 Budget.

We estimate that in CY 2007, 35.808 million people aged 65 years and over will be entitled to benefits (without premium payment) and that they will incur $176.264 billion of benefits and related administrative costs. Thus, the estimated monthly average per capita amount is $410.21 and the monthly premium is $410. The full monthly premium reduced by 45 percent is $226.

IV. Costs to Beneficiaries

The CY 2007 premium of $410 is about 4 percent higher than the CY 2006 premium of $393.

We estimate that approximately 556,000 enrollees will voluntarily enroll in Medicare Part A by paying the full premium. We estimate an additional 1,000 enrollees will pay the reduced premium. We estimate that the aggregate cost to enrollees paying these premiums will be about $114 million in CY 2007