or the offices of the Board of Governors not later than March 25, 2014.

A. Federal Reserve Bank of Dallas (E. Ann Worthy, Vice President) 2200 North Pearl Street, Dallas, Texas 75201–2272:

1. *First Bells Bankshares, Inc.,* Bells, Texas; to acquire 100 percent of the voting shares of Cendera Funding, Inc., Fort Worth, Texas, and thereby engage in extending credit and servicing loans, pursuant to section 225.28(b)(1).

Board of Governors of the Federal Reserve System, March 5, 2014.

**Michael J. Lewandowski,**

*Associate Secretary of the Board.*

[FR Doc. 2014–05088 Filed 3–7–14; 8:45 am]

**BILLING CODE 6210–01–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Disease Control and Prevention

**[30Day–14–0636]**

### Agency Forms Undergoing Paperwork Reduction Act Review

The Centers for Disease Control and Prevention (CDC) publishes a list of information collection requests under review by the Office of Management and Budget (OMB) in compliance with the Paperwork Reduction Act (44 U.S.C. Chapter 35). To request a copy of these requests, call (404) 639–7570 or send an email to *omb@cdc.gov.* Send written comments to CDC Desk Officer, Office of Management and Budget, Washington, DC 20503 or by fax to (202) 395–5806. Written comments should be received within 30 days of this notice.

**Proposed Project**

Centers for Disease Control and Prevention (CDC) Secure Public Health Emergency Response Communications Network (Epi-X) (OMB Control No. 0920–0636, exp. 5/31/2014)—Revision—Office of Public Health Preparedness and Response (OPHPR), Centers for Disease Control and Prevention (CDC).

*Background and Brief Description*

The effectiveness and efficiency of CDC's response to any public health incident depends on information at the agency's disposal to characterize and monitor the incident, make timely decisions, and take appropriate actions to prevent or reduce the impact of the incident.

Available information in anticipation of, during and following public health incident responses is often incomplete, is not easily validated by state and local health authorities, and is sometimes conflicting. This lack of reliable information often creates a high level of uncertainty with potential negative impacts on public health response operations. Secure communications with CDC's state, local, territorial, and tribal public health partners is essential to resolve conflicting information, validate incident status, and establish and maintain situational awareness. Reliable, secure communications are essential for the agency to gain and maintain accurate situational awareness, make informed decisions, and to respond in the most appropriate manner possible in order to minimize the impact of an incident on the public health of the United States.

This generic Information Collection Request (ICR) is being revised to: (1) Remove verbiage limiting data collection to activation of the Incident Management Structure, (2) broaden categories under which data may be collected to increase its utilization, and (3) provide clarity regarding the data elements.

*(Epi-X) is* CDC's Web-based communication system for securely communicating in immediate anticipation of, during and following public health emergencies that have multi-jurisdictional impacts and implications. The incidents of September 11, 2001 illustrated the need for an encrypted and secure communications system that would permit CDC to communicate urgently with partners at the state and local levels, and to notify them ''24 hours a day, 7 days a week'', when necessary. Similarly, *Epi-X* was specifically designed to provide public health decision-makers at the state and local levels a secure, reliable tool for communicating sensitive, unusual, or urgent public health incidents to neighboring jurisdictions as well as to CDC.

CDC has recognized a need to expand the use of *Epi-X* to collect specific response related information in anticipation of, during and following public health emergencies. Proposed data collection instruments under this generic ICR will be designed to ensure ready access to public health and disease epidemiology information.

Authorized officials from state and local health departments affected by the public health incident will be informed of this data collection first through an *Epi-X* Facilitator, who will work closely with *Epi-X* program staff and the *Epi-X* Information Collection Request Liaison to ensure that *Epi-X* incident specific information collections are understood. The survey instruments will contain specific questions relevant to the current and ongoing public health incident and response activities.

Respondents will receive the survey instrument(s) as an official CDC email, which is clearly labeled, ''*Epi-X* Emergency Public Health Incident Information Request.'' The email message will be accompanied by a link to an *Epi-X Forum* discussion Web page. Respondents can provide their answers to the survey questions by posting information within the discussion.

The estimated annual burden to respondents is 24,400 hours. The total estimated burden for the generic information collection is 73,200 hours for three years.

There are no costs to respondents except their time.

ESTIMATED ANNUALIZED BURDEN HOURS

| Type of respondent | Form name | Number of respondents | Number responses per respondent | Average burden per response (in hours) |
|---|---|---|---|---|
| State Epidemiologists | *Epi-X* Emergency Public Health Incident Information Request. | 50 | 104 | 1 |
| County Health Officials | *Epi-X* Emergency Public Health Incident Information Request. | 1,600 | 12 | 1 |

**Leroy Richardson,**

*Chief, Information Collection Review Office, Office of Scientific Integrity, Office of the Associate Director for Science, Office of the Director, Centers for Disease Control and Prevention.*

[FR Doc. 2014–05077 Filed 3–7–14; 8:45 am]

**BILLING CODE 4163–18–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare & Medicaid Services

**[Document Identifiers: CMS–10225, CMS–10502, CMS–10503, CMS–10504 and CMS–10506]**

### Agency Information Collection Activities: Submission for OMB Review; Comment Request

**ACTION:** Notice.

**SUMMARY:** The Centers for Medicare & Medicaid Services (CMS) is announcing an opportunity for the public to comment on CMS' intention to collect information from the public. Under the Paperwork Reduction Act of 1995 (PRA), federal agencies are required to publish notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension or reinstatement of an existing collection of information, and to allow a second opportunity for public comment on the notice. Interested persons are invited to send comments regarding the 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.

**DATES:** Comments on the collection(s) of information must be received by the OMB desk officer by April 9, 2014.

**ADDRESSES:** When commenting on the proposed information collections, please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be received by the OMB desk officer via one of the following transmissions: OMB, Office of Information and Regulatory Affairs, Attention: CMS Desk Officer, Fax Number: (202) 395–5806, *OR* Email: *OIRA_submission@omb.eop.gov*.

To obtain copies of a supporting statement and any related forms for the proposed collection(s) summarized in this notice, you may make your request using one of the following:

1. Access CMS' Web site address at *http://www.cms.hhs.gov/PaperworkReductionActof1995*.

2. Email your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov*.

3. Call the Reports Clearance Office at (410) 786–1326.

**FOR FURTHER INFORMATION CONTACT:** Reports Clearance Office at (410) 786–1326.

**SUPPLEMENTARY INFORMATION:** Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501–3520), federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. The term ''collection of information'' is defined in 44 U.S.C. 3502(3) and 5 CFR 1320.3© and includes agency requests or requirements that members of the public submit reports, keep records, or provide information to a third party. Section 3506(c)(2)(A) of the PRA (44 U.S.C. 3506(c)(2)(A)) requires federal agencies to publish a 30-day notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension or reinstatement of an existing collection of information, before submitting the collection to OMB for approval. To comply with this requirement, CMS is publishing this notice that summarizes the following proposed collection(s) of information for public comment:

1. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Disclosures Required of Certain Hospitals and Critical Access Hospitals Regarding Physician Ownership; *Use:* There is no Medicare prohibition against physician investment in a hospital or critical access hospitals (CAH). Likewise, there is no Medicare requirement that a hospital or CAH have a physician on-site at all times; although, there is a requirement that they be able to provide basic elements of emergency care to their patients. Medicare quality and safety standards are designed to provide a national framework that is sufficiently flexible to apply simultaneously to hospitals of varying sizes, offering varying ranges of services in differing settings across the nation. At the same time, however, patients might consider an ownership interest by their referring physician, the presence of a physician on-site or both to be important factors in their decisions about where to seek hospital care. A well-educated consumer is essential to improving the quality and efficiency of the healthcare system. Accordingly, patients should be made aware of the physician ownership of a hospital, whether or not a physician is present in the hospital at all times, and the hospital's plans to address patients' emergency medical conditions when a physician is not present. The intent of the disclosures is to increase the transparency of the hospital's ownership and operations to patients as they make decisions about receiving care at the hospital. Please note that the associated information collection request has been revised subsequent to the publication of the 60-day **Federal Register** notice (78 FR 75925, December 13, 2013.). *Form Number:* CMS–10225 (OCN: 0938–1034); *Frequency:* Occasionally; *Affected Public:* Private sector—Business or other for-profits and Not-for-profit institutions; *Number of Respondents:* 2,597; *Total Annual Responses:* 30,654,968; *Total Annual Hours:* 261,447. (For policy questions regarding this collection contact Teresa Walden at 410–786–3755).

2. *Type of Information Collection Request:* New collection (Request for a new OMB control number); *Title of Information Collection:* Long Term Care Hospital Quality Reporting Program: Program Evaluation; *Use:* Section 3004(a) of the Affordable Care Act (ACA) mandated that we establish a quality reporting program for Long Term Care Hospitals (LTCHs). Specifically, section 3004(a) added section 1886(m)(5) to the Social Security Act (the Act) to establish a quality reporting program for LTCHs. This program requires that quality data be submitted by LTCH providers in a time, form and manner specified by the Secretary.

We are interested in exploring how LTCH providers are responding to the new quality reporting program (QRP) and its measures. We believe that it is important to understand early trends in outcomes, to make adjustments as needed to enhance the effectiveness of the program, and to seek opportunities to minimize provider burden, and ensure the QRP is useful and meaningful to providers. The methodology employed in the evaluation is the utilization of qualitative interviews (as opposed to quantitative statistical methods). In consultation with research experts, we have decided that at this juncture it would be meaningful to use a rich, contextual approach to evaluation the process and success of the QRP initiative.