PRA Disclosure Statement This information collection request is required by states to obtain benefits. It provides for the collection of hospital specific DSH payment information as required by section 1923(j)(1) of the Social Security Act (the Act). Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0746. The time required to complete this information collection is estimated to average 42 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Hospital Name	Estimate of Hospital-Specific DSH Limit	Medicaid I/P Utilization Rate	Low-Income Utilization Rate	State-Defined DSH Qualitification Criteria	IP/OP Medicaid FFS Rate Payments	IP/OP Medicaid MCO Payments	Supplemental / Enhanced Medicaid IP/OP Payments	Total Medicaid IP/OP Payments	Total Cost of Care - Medicaid IP/OP Services	Total Medicaid Uncompensated Care Costs	Total Uninsured IP/OP Revenue	Total Applicable Section 1011 Payments	Total Cost of IP/OP Care for Uninsured	Total Uninsured IP/OP Uncompensated Care Costs	Total Annual Uncompensated Care Costs	Disproportionate Share Hospital Payments	Medicaid Provider Number	Medicare Provider Number	Total Hospital Cost
Institute for Mental Disease																			
Out of State DSH Hospitals																			

OMB Approved # 0938-0746 Expires TBD

Field Name	Field format	Field format description	In-state field Designation	Institute for Mental Disease field Designation	Out of State field Designation
Hospital Name	Alphanumeric	Text/Alphanumeric	Required	Required	Required
Estimate of Hospital Specific DSH limit	Numeric	Amount	Required	Required	Required
Medicaid Inpatient Utilization Rate	Percentage	Proportion/Amount	Required	Required	Required
Low Income Utilization Rate	Percentage	Proportion/Amount	Required	Required	Required
State Defined DSH Qualification Criteria	Alphanumeric	Text/Alphanumeric	Required	Required	Required
IP/OP Medicaid FFS Basic Rate Payments	Numeric	Amount	Required	Required	Required
IP/OP Medicaid MCO Payments	Numeric	Amount	Required	Required	Optional
Supplemental/Enhanced Medicaid IP/OP Payments	Numeric	Amount	Required	Required	Required
Total Medicaid IP/OP Payments	Numeric	Amount	Required	Required	Required
Total Cost of Care for Medicaid IP/OP Services	Numeric	Amount	Required	Required	Optional
Total Medicaid Uncompensated Care	Numeric	Amount	Required	Required	Optional
Uninsured IP/OP Revenue	Numeric	Amount	Required	Required	Optional
Total Applicable Section 1011 Payments	Numeric	Amount	Required	Required	Optional
Total Cost of IP/OP Care for the Uninsured	Numeric	Amount	Required	Required	Optional
Total Uninsured IP/OP Uncompensated Care Costs	Numeric	Amount	Required	Required	Optional
Total Annual Uncompensated Care Costs	Numeric	Amount	Required	Required	Optional
Disproportionate Share Hospital Payments	Numeric	Amount	Required	Required	Required
Medicaid Provider Number	Alphanumeric	Alphanumeric	Required	Required	Required
Medicare Provider Number	Alphanumeric	Alphanumeric	Required	Required	Required
Total Hospital Cost	Numeric	Amount	Required	Required	Optional
Financial Impact of Audit Findings	Numeric	Amount	Required	Required	Optional