

**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.



| <b>Field Name</b>                              | <b>Field format</b> | <b>Field format description</b> | <b>In-state field Designation</b> | <b>Institute for Mental Disease field Designation</b> | <b>Out of State field Designation</b> |
|--|---------------------|---------------------------------|-----------------------------------|---|---------------------------------------|
| 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                              |