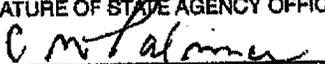
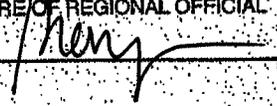


|  |  |   |          |
|--|--|---|----------|
| <b>TRANSMITTAL AND NOTICE OF APPROVAL OF<br/>STATE PLAN MATERIAL<br/>FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>   |  | 1. TRANSMITTAL NUMBER   | 2. STATE |
|  |  | 1 2 — 0 2 0   | IOWA     |
| TO: REGIONAL ADMINISTRATOR<br>CENTERS FOR MEDICARE & MEDICAID SERVICES<br>DEPARTMENT OF HEALTH AND HUMAN SERVICES  |  | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)  |          |
|  |  | 4. PROPOSED EFFECTIVE DATE<br><p style="text-align: right;">July 1, 2012</p>  |          |
| 5. TYPE OF PLAN MATERIAL (Check One)   |  |   |          |
| <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT  |  |   |          |
| COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate transmittal for each amendment)  |  |   |          |
| 6. FEDERAL STATUTE/REGULATION CITATION   |  | 7. FEDERAL BUDGET IMPACT  |          |
|  |  | a. FFY '12 <u>\$ 299,380.26</u>   |          |
|  |  | b. FFY '13 <u>\$ 299,380.26</u>   |          |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT   |  | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)   |          |
| Attachment 4.19-A, Page <del>25</del> 26i  |  | Attachment 4.19-A, Page <del>25</del> 26i   |          |
| 10. SUBJECT OF AMENDMENT   |  |   |          |
| HF 2388 established a DSH fund for rural prospective payment hospitals that are not designated as critical access hospitals. If a hospital chooses to participate, the nonfederal share will be provided through IGT using city or county tax levy collections. <span style="float: right;">■</span> |  |   |          |
| 11. GOVERNOR'S REVIEW (Check One)  |  |   |          |
| <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED<br><input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED<br><input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL                                  |  |   |          |
| 12. SIGNATURE OF STATE AGENCY OFFICIAL   |  | 16. RETURN TO   |          |
|   |  | CHARLES M. PALMER<br>DIRECTOR<br>DEPARTMENT OF HUMAN SERVICES<br>1305 EAST WALNUT 5TH FLOOR<br>DES MOINES IA 50319-0114 |          |
| 13. TYPED NAME   |  |   |          |
| CHARLES M. PALMER  |  |   |          |
| 14. TITLE  |  |   |          |
| DIRECTOR   |  | 15. DATE SUBMITTED  |          |
| 9-26-12  |  | FOR REGIONAL OFFICE USE ONLY  |          |
| 17. DATE RECEIVED  |  | 18. DATE APPROVED   |          |
| September 26, 2012   |  | MAY 29 2013   |          |
| PLAN APPROVED - ONE COPY ATTACHED  |  |   |          |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL  |  | 20. SIGNATURE OF REGIONAL OFFICIAL  |          |
|  |  |                                     |          |
| 21. TYPED NAME   |  | 22. TITLE   |          |
|  |  |   |          |
| 23. REMARKS  |  |   |          |
|  |  |   |          |