

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>	1. TRANSMITTAL NUMBER: 12-15	2. STATE Minnesota
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
<b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>	4. PROPOSED EFFECTIVE DATE June 5, 2012	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		

5. TYPE OF PLAN MATERIAL (Check One):

NEW STATE PLAN       AMENDMENT TO BE CONSIDERED AS NEW PLAN       AMENDMENT

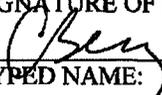
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR §447.252	7. FEDERAL BUDGET IMPACT (in thousands) a. FFY '12: \$4,500 b. FFY '13: \$4,500
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Att. 4.19-D (Non-State Government-Owned or Operated NF), pp.1-186	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Att. 4.19-D, pp. 1-186

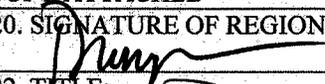
10. SUBJECT OF AMENDMENT:  
Methods and Standards for Determining Payment Rates for Services Provided by Nursing Facilities

11. GOVERNOR'S REVIEW (Check One):

GOVERNOR'S OFFICE REPORTED NO COMMENT       OTHER, AS SPECIFIED:  
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: Ann Berg Minnesota Department of Human Services Federal Relations Unit PO Box 64983 St. Paul, MN 55164-0983
13. TYPED NAME: Ann Berg	
14. TITLE: Deputy Medicaid Director	
15. DATE SUBMITTED: June 29, 2012	

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:	18. DATE APPROVED: <b>SEP 26 2012</b>
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>JUN -5 2012</b>	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: <b>Penny Thompson</b>	22. TITLE: <b>Deputy Director, CMCS</b>
23. REMARKS:	