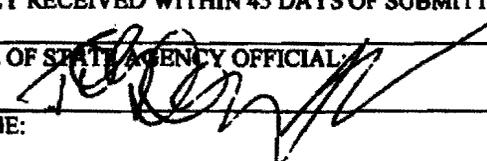
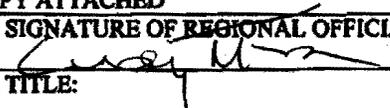


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 10-015	2. STATE CA
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE August 1, 2010	
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: 42 CFR 447 Subpart B Subpart C		7. FEDERAL BUDGET IMPACT:	
		a. FFY 2010 -\$12,625,950 \$16,306,978	
		b. FFY 2011 -\$75,370,300 \$85,094,504	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 4 to Attachment 4.19-D, pages 1, 1.1, 6, 8, 9, 10, 11, 14, 15, 16, 17, 18, 19		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Supplement 4 to Attachment 4.19-D, pages 1, 6, 8, 9, 10, 11, 14, 15, 16, 17	
10. SUBJECT OF AMENDMENT: Freestanding Skilled Nursing Facilities Reimbursement Rates			
11. GOVERNOR'S REVIEW (Check One):			
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL		<input checked="" type="checkbox"/> OTHER, AS SPECIFIED: The Governor's Office does not wish to review the State Plan Amendment.	
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO:	
13. TYPED NAME: Toby Douglas		Department of Health Care Services Attn: State Plan Coordinator 1501 Capitol Avenue, Suite 71.3.26 P.O. Box 997417 Sacramento, CA 95899-7417	
14. TITLE: Chief Deputy Director			
15. DATE SUBMITTED:			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED:	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 2 7 2011		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME:		22. TITLE:	
23. REMARKS:			

Pen-and-ink change made to Boxes 6, 7, and 8 by Regional Office with State concurrence.

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: 09-020	2. STATE CA
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE August 1, 2009	

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 Subpart B Subpart C	7. FEDERAL BUDGET IMPACT: a. FFY 2009 \$19,400,000 \$(20,698,811) b. FFY 2010 \$117,400,000 \$(145,926,616)
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 4 to Attachment 4.19-D page 16	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Supplement 4 to Attachment 4.19-D page 16

10. SUBJECT OF AMENDMENT:
Freestanding Skilled Nursing Facilities Reimbursement Rate (AB 1629)

11. GOVERNOR'S REVIEW (Check One):

- GOVERNOR'S OFFICE REPORTED NO COMMENT
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
- OTHER, AS SPECIFIED:
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME:
Toby Douglas

14. TITLE:
Chief Deputy Director

15. DATE SUBMITTED:

16. RETURN TO:

Department of Health Care Services
Attn: State Plan Coordinator
1501 Capitol Avenue, Suite 71.3.26
P.O. Box 997417
Sacramento, CA 95899-7417

FOR REGIONAL OFFICE USE ONLY

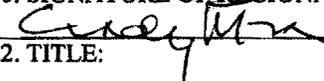
17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT 27 2011

20. SIGNATURE OF REGIONAL OFFICIAL:

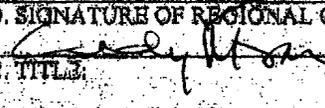


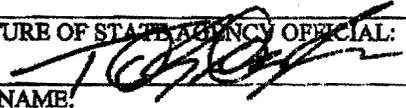
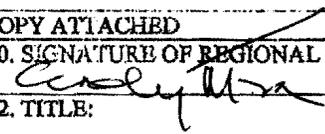
21. TYPED NAME:

22. TITLE:

23. REMARKS:

Pen-and-ink change made to Boxes 6 and 7 by Regional Office with State concurrence.

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 11-010	2. STATE California
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE June 1, 2011	
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: AB 97 42 CFR 447 Subpart C		7. FEDERAL BUDGET IMPACT: a. FFY 2010-2011 \$-16,029,075 b. FFY 2011-2012 \$-105,055,000 c. FFY 2012-2013 \$-127,816,000	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-D Page 15.4 and 15.4a		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-D Page 15.4 and 15.4a	
10. SUBJECT OF AMENDMENT: Reduced payment rates as mandated by Assembly Bill 97			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED The Governor's Office does not wish to review State Plan Amendments <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Department of Health Care Services Attn: State Plan Coordinator 1501 Capitol Avenue, Suite 71.4001 P.O. Box 997417 Sacramento, CA 95899-7417	
13. TYPED NAME: Toby Douglas			
14. TITLE: Director			
15. DATE SUBMITTED: 10/4/11			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED:	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 7 2011		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME:		22. TITLE:	
23. REMARKS: Pen-and-ink changes made to Boxes 6 and 7 by Regional Office with State concurrence.			

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 11-011	2. STATE CA
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE June 1, 2010	
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: 42 CFR 447 Subpart B & 42 CFR 447 Subpart C		7. FEDERAL BUDGET IMPACT:	
		a. FFY 2010 \$0.00	
		b. FFY 2011 \$8,900,000.00	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 4 to Attachment 4.19-D, pages 1, 16, & 17		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Supplement 4 to Attachment 4.19-D, pages 1, 16, & 17	
10. SUBJECT OF AMENDMENT: Freestanding Skilled Nursing Facilities Reimbursement Rates			
11. GOVERNOR'S REVIEW (Check One):			
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT		<input checked="" type="checkbox"/> OTHER, AS SPECIFIED:	
<input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED		The Governor's Office does not wish to review the State Plan Amendment.	
<input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO:	
13. TYPED NAME: Toby Douglas		Department of Health Care Services Attn: State Plan Coordinator 1501 Capitol Avenue, Suite 713.26 P.O. Box 997417 Sacramento, CA 95899-7417	
14. TITLE: Director			
15. DATE SUBMITTED: 10/14/11			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED:	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT 27 2011		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME:		22. TITLE:	
23. REMARKS: Pen-and-ink change made to Box 7 by Regional Office with State concurrence.			