

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: <b>10 - 006</b>	2. STATE <b>OHIO</b>
<b>FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES</b>		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE July 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"/> <b>AMENDMENT</b>			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR part 441 – Subpart C; 42 CFR Part 441 – Subpart D; 42 CFR part 447 – Subpart C		7. FEDERAL BUDGET IMPACT: a. FFY 2009      \$ 0 b. FFY 2010      \$ 0	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: 4.19-A Rule 5101:3-2-23 Cost Reports and Appendix		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): 4.19-A Rule 5101:3-2-23 Cost Reports and Appendix	
10. SUBJECT OF AMENDMENT: Cost Reports			
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: Governor has delegated signature authority to ODJFS Director. Director has delegated signature authority to Medicaid Director	
12. SIGNATURE OF STATE AGENCY OFFICIAL: <i>Tracy Plouck / me</i>		16. RETURN TO:	
13. TYPED NAME: TRACY J. PLOUCK		Becky Jackson OHP/Bureau of Health Plan Policy Ohio Department of Job and Family Services P.O. BOX 182709 Columbus, Ohio 43218	
14. TITLE: STATE MEDICAID DIRECTOR			
15. DATE SUBMITTED: 8-31-10			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED:		18. DATE APPROVED: 04-29-2010	
<b>PLAN APPROVED – ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL - 1 2010		20. SIGNATURE OF REGIONAL OFFICIAL: <i>William Lasowski RCL</i>	
21. TYPED NAME: William Lasowski		22. TITLE: Deputy Director CMCS	
23. REMARKS:			

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