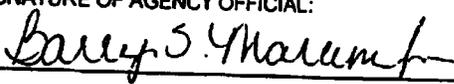
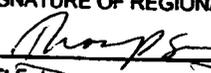


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTER FOR MEDICARE AND MEDICAID SERVICES	1. TRANSMITTAL NUMBER 09-08	2. STATE: ILLINOIS
	3. PROGRAM IDENTIFICATION: Title XIX of the Social Security Act (Medicaid)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE: October 1, 2009	
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: Section 1902(a) Social Security Act	7. FEDERAL BUDGET IMPACT a. FFY 2010 \$7.2 million b. FFY 2011 \$8.4 million	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-D Pages 3, 4, 17, 21, 77, 78, 109, 109(A), 109(B), 109(C)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-D Pages 3, 4, 17, 21, 77, 78, 109	
10. SUBJECT OF AMENDMENT: METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - Reimbursement to Long Term Care Facilities		
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: Not submitted for review by prior approval.		
12. SIGNATURE OF AGENCY OFFICIAL: 	16. RETURN TO: Illinois Department of Healthcare and Family Services Bureau of Program and Reimbursement Analysis Attn: Frank Kopel, Chief 201 South Grand Avenue East Springfield, IL 62763-0001	
13. TYPED NAME: Barry S. Maram		
14. TITLE: Director of Healthcare and Family Services		
15. DATE SUBMITTED 11-24-09		
FOR REGIONAL OFFICE USE ONLY		
17. DATE RECEIVED:	18. DATE APPROVED: DEC - 2 2011	
PLAN APPROVED—ONE COPY ATTACHED		
19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT - 1 2009	20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Penny Thompson	22. TITLE: Deputy Director, CMCS	
23. REMARKS:		