DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTER FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

# 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)*

[ ] NEW STATE PLAN [ ] AMENDMENT TO BE CONSIDERED AS NEW PLAN [X] 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 ~~$10.4~~ 7.2 million
b. FFY 2011 $ ~~8.4~~ 6.7 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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: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)*
[ ] GOVERNOR'S OFFICE REPORTED NO COMMENT
[ ] COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
[ ] NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
[X] OTHER, AS SPECIFIED: Not submitted for review by prior approval.

12. SIGNATURE OF AGENCY OFFICIAL:
Barry S. Maram

13. TYPED NAME: Barry S. Maram

14. TITLE: Director of Healthcare and Family Services

15. DATE SUBMITTED
11-24-09

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

**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:
Thompson

21. TYPED NAME: Penny Thompson

22. TITLE: Deputy Director, CMCS

23. REMARKS:

FORM CMS-179 (07/92)

*Instructions on Back*