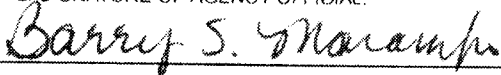
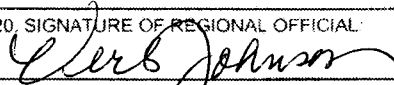


<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTER FOR MEDICARE AND MEDICAID SERVICES</b>		1. TRANSMITTAL NUMBER <b>09-10</b>	2. STATE: <b>ILLINOIS</b>
		3. PROGRAM IDENTIFICATION: <b>Title XIX of the Social Security Act (Medicaid)</b>	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE: <b>December 10, 2009</b>	
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: <b>Section 1902 of the Social Security Act</b>		7. FEDERAL BUDGET IMPACT a. FFY <b>2010</b> <b>\$ 19.9 million</b> b. FFY <b>2011</b> <b>\$ 2.1 million</b>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: <b>Attachment 4.19-B pages 51, 52, 54, 57</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): <b>Attachment 4.19B pages 51, 52, 54</b>	
10. SUBJECT OF AMENDMENT: <b>Hospital outpatient payment adjustments</b>			
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: <b>Department of Healthcare and Family Services Bureau of Program and Reimbursement Analysis Attn: Greg Wilson, Chief 201 South Grand Avenue East Springfield, IL 62763-0001</b>	
13. TYPED NAME: <b>Barry S. Maram</b>			
14. TITLE: <b>Director of Healthcare and Family Services</b>			
15. DATE SUBMITTED <b>December 31, 2009</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: <b>12-31-09</b>		18. DATE APPROVED: <b>NOV 01 2010</b>	
PLAN APPROVED—ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>12-10-09</b>		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME <b>Verlon Johnson</b>		22. TITLE: <b>Associate Regional Administrator</b>	
23. REMARKS:			