

<b>TRANSMITTAL AND NOTICE OF APPROVAL                  OF STATE PLAN MATERIAL</b> FOR: CENTER FOR MEDICARE AND MEDICAID SERVICES	1. TRANSMITTAL NUMBER 10-07	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, 2010	

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)

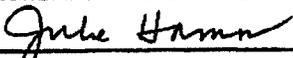
6. FEDERAL STATUTE/REGULATION CITATION: Section 1902 of the Social Security Act	7. FEDERAL BUDGET IMPACT a. FFY 2011 \$ 30.3 b. FFY 2012 \$ 26.6
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-A Pages 41, 52, 56 & 155 52A, 155A	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): 52A, Attachment 4.19-A Pages 41, 52, 56 & 155, 155A

10. SUBJECT OF AMENDMENT:

Inpatient Hospital Specific Inflator for Large Government Hospitals and Obstetric Services Definition

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: Not submitted for review by prior approval.

12. SIGNATURE OF AGENCY OFFICIAL: 	16. RETURN TO: 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
13. TYPED NAME: Julie Hamos	
14. TITLE: Director of Healthcare and Family Services	
15. DATE SUBMITTED	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: APR - 3 2012
PLAN APPROVED—ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT - 1 2010	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: Penny Thompson	22. TITLE: Deputy Director, CMCS
23. REMARKS: Pen ink change made to blocks 899	