

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: CENTER FOR MEDICARE AND MEDICAID SERVICES

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

1. TRANSMITTAL NUMBER
12-021

2. STATE:
ILLINOIS

3. PROGRAM IDENTIFICATION:
Title XIX of the Social Security Act (Medicaid)

4. PROPOSED EFFECTIVE DATE:
July 1, 2012

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 **2012** (\$ **1.8 million**)

b. FFY **2013** (\$ **7.3 million**)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

**State Plan, Page 59
Attachment 4.19-C, Pages 1 and 2**

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

**State Plan, Page 59
Attachment 4.19-C, Pages 1 and 2**

10. SUBJECT OF AMENDMENT:

Bed Reserves

11. GOVERNOR'S REVIEW (Check One)

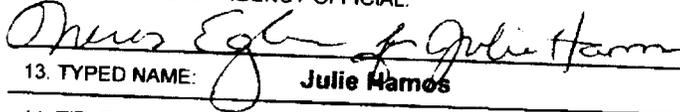
GOVERNOR'S OFFICE REPORTED NO COMMENT

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:



13. TYPED NAME: **Julie Hamos**

14. TITLE: **Director of Healthcare and
Family Services**

15. DATE SUBMITTED **8-24-12**

16. RETURN TO:

**Department of Healthcare and Family Services
Bureau of Program and Reimbursement Analysis
Attn: Theresa Eagleson**

**201 South Grand Avenue East
Springfield, IL 62763-0001**

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

08-24-2012

18. DATE APPROVED: **11-20-2012**

PLAN APPROVED—ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

07--01-2012

20. SIGNATURE OF REGIONAL OFFICIAL:



21. TYPED NAME **Verlon Johnson**

22. TITLE: **Associate Regional Administrator**

23. REMARKS: