

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTER FOR MEDICARE AND MEDICAID SERVICES	1. TRANSMITTAL NUMBER 07-08	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: July 1, 2007	

5. TYPE OF PLAN MATERIAL (Check One)
 NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

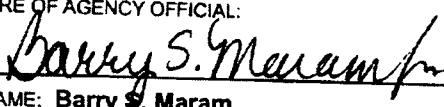
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION: Section 1902(a)(13) and Section 1905(a)(2)(C) of the Social Security Act	7. FEDERAL BUDGET IMPACT a. FFY 2007—\$0 b. FFY 2008—\$0
--	--

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-A, page 122, 123,124, 125, 131.	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-A, page 122, 123,124, 125, 131.
---	---

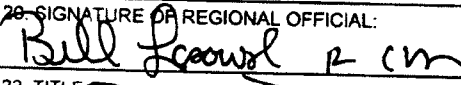
10. SUBJECT OF AMENDMENT:
CHAP Trauma Center Qualifications

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: 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	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: 7-12-10
PLAN APPROVED—ONE COPY ATTACHED	

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL - 1 2007	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: William Lasowski	22. TITLE: Deputy Director, CMCS
23. REMARKS:	