IDAHO DEPARTMENT OF HEALTH & WELFARE

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March 20, 2008

MEDICAID INFORMATION RELEASE 2008-07

To: All Nursing Home and ICF/MR Administrators

From: Leslie M. Clement, Administrator

Subject: Information Request Related To PCS Wage Determination

Each year, the Department of Health and Welfare (DHW) gathers information from all Nursing Facilities (including hospital-based facilities) and Intermediate Care Facilities for the Mentally Retarded, to determine wage data for select employees in the nursing home industry.* DHW requires you to respond according to the attached instructions and complete the attached certification.

If your facility was certified for participation in the Medicaid program before March 15, 2008, **you must respond by April 16, 2008.** Otherwise, you are not required to participate this year. Please return the required information as soon as possible to:

Myers and Stauffer LC
8555 West Hackamore Drive, Suite 100
Boise, ID 83709-1693

If you have questions, please contact the Division of Medicaid at: (208) 364-1817, or Myers and Stauffer at: (800) 336-7721. Thank you for your participation in Idaho Medicaid.

LMC/rs

Attachments

* According to *Idaho Code, Section 39-5606*, and *IDAPA 16.03.10.281.02*

IR 2008-07 INFORMATION REQUEST INSTRUCTIONS
(Please read carefully as strict adherence to these standards is required)

As of March 15, 2008 (*Idaho Code, Section 39-5606*), we are requesting the following information regarding select staff at all nursing facilities (including hospital-based facilities) and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR).

You **must** submit the following information to Myers and Stauffer **no later than** April 16, 2008 (*IDAPA 16. 03.10.281.02*). Early submissions are greatly appreciated.

1) Employee Name: Include only the name or identifier for each employee (e.g., I.D. number). Do **not** include employee social security numbers.

2) Employment Class: Include and assign **only** the staff that fall into the categories shown below. Do **not** send information for staff who are not involved in the routine direct care of LTC residents (e.g., physical therapy, occupational therapy, speech therapy, restorative aides, staff development, social service, activities, health information, admin or ward clerks, etc.).

   * Registered Nurses (indicate Director of Nursing, MDS staff, Care Manager, etc.)
   * Licensed Practical Nurses
   * Qualified Mental Retardation Professional (ICFs/MR only)
   * Certified Nurse Aides
   * Nurse Aides
   * Therapy Technicians (ICFs/MR only)

3) Hourly Wage: Include only the hourly wage in this category. If the individual is paid a salary, please convert it to an hourly wage (full time = 2,080 hours/year).

4) Weekly Hours: Include the number of hours that the individual works in an average work week and round figures to the nearest hour. Include PRN staff **only** if a weekly average can be determined.

5) Time Frame: The wage data must be the rate paid as of March 15, 2008. Do **not** include personnel hired after this date.

6) Format: Electronic files **must** be in a standard spreadsheet format. A printout of the file **must** be attached to the signed certification page (see #7). In addition to mailing the hard copy, electronic files should be emailed directly to: **valc@mslc.com** or submitted on other electronic media. A sample printout is included for your reference. Design your printed report according to the following layout:

Employee Name	Employment Class	Hourly Wage	Avg. Weekly Hours
(Example) John Doe	Certified Nurse Aide	$8.95	32

No subtotals or summarizations are necessary.

Please note, a payroll schedule will not satisfy the requirements of this request.

7) Certification: Included with this request is a cover sheet/certification page. This page **must** be completed, signed, and attached to the information requested above.

STATE OF IDAHO
DEPARTMENT OF HEALTH AND WELFARE
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* * *
PERSONNEL LISTING WITH WAGE DATA
* * *
REQUESTED TO COMPLY WITH
IDAHO CODE, SECTION 39-5606
(Medicaid Information Release 2008-07)
* * *
* * * * * * * * * * * * * * * * * * *
AS OF MARCH 15, 2008

_____
(Name of Facility)

_____
(Address)

_____
(City, State, Zip)

_____
(Medicaid Provider Number)

I certify that, to the best of my knowledge, the information reflected herein is an accurate representation of the facts.

_____
Administrator Signature

_____
Print or Type Name

_____
Date

_____
Phone Number