



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

C.L. "BUTCH" OTTER – Governor  
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator  
DIVISION OF MEDICAID  
Post Office Box 83720  
Boise, Idaho 83720-0036  
PHONE: (208) 334-5747  
FAX: (208) 364-1811

March 17, 2010

**MEDICAID INFORMATION RELEASE 2010-05**

**To:**  All Nursing Facility and ICF/MR Administrators  
**From:**  Leslie M. Clement, Administrator  
**Subject:** Information Request Related To Personal Care Service Wage Determination

Each year, the Idaho Department of Health and Welfare gathers information from all nursing facilities (including hospital-based facilities) and intermediate care facilities for the mentally retarded (ICF/MR) to determine wage data for select employees in the nursing home industry.\* You must respond according to the attached instructions and complete the attached certification.

If you were a Medicaid provider on or before March 15, 2010, **you must respond by April 14, 2010.**

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

LMC/rs

Attachments

\* According to *Idaho Code, Section 39-5606, IDAPA 16.03.10.281.02, and IDAPA 16.03.10.603.02*

**IR 2010-05 INFORMATION REQUEST INSTRUCTIONS**

(Please read carefully as strict adherence to these standards is required)

As of March 15, 2010 (*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 14, 2010 (*IDAPA 16. 03.10.281.02 and IDAPA 16.03.10.603.02*). 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 long term care (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, Mini Data Set (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 Pro Re Na (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, 2010. 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:

<u>Employee Name</u>	<u>Employment Class</u>	<u>Hourly Wage</u>	<u>Avg. Weekly Hours</u>
<i>(Example)</i> John Doe	Certified Nurse Aide	\$9.37	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

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REQUESTED TO COMPLY WITH  
IDAHO CODE, SECTION 39-5606  
(Medicaid Information Release 2010-05)

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AS OF MARCH 15, 2010

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(Name of Facility)

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(Address)

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(City, State, Zip)

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(Medicaid Provider Number)

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

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Administrator Signature

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Print or Type Name

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Date

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Phone Number

