

**STATE OF MISSISSIPPI  
Division of Medicaid  
LONG TERM CARE FACILITIES**

**2009 MINIMUM WAGE INCREASE SURVEY**

Name of Facility \_\_\_\_\_ Provider Number \_\_\_\_\_

The Division of Medicaid is collecting information that may be used for calculating your **2010** rate. Please complete the following and return it to the Bureau of Reimbursement no later than **August 31, 2009**. Forms may be returned by e-mail, fax or postal mail using the following contact information.

**E-Mail:** [rbftb@medicaid.state.ms.us](mailto:rbftb@medicaid.state.ms.us)  
**Fax:** (601) 359-4193  
**Mail:** Division of Medicaid  
 Bureau of Reimbursement  
 550 High Street  
 Jackson, MS 39201

Should you have any questions regarding this form, please e-mail them to [rbftb@medicaid.state.ms.us](mailto:rbftb@medicaid.state.ms.us) or call the Bureau of Reimbursement at (601) 359-6046.

Please check (✓) the box if your facility was not legally required to increase the wage of any employee as a result of the minimum wage increase to \$7.25 effective July 24, 2009. If you check this box, then skip 1. and 2. and sign the form.

1. Enter the number of employees and full-time equivalents making less than \$7.25 per hour, and the average hourly wage of the employees making under \$7.25 per hour for each position prior to the change.

Type of Position	Number of Employees	Number of Full Time Equivalents	Average Hourly Wage
Nursing Assistants			
Dietary			
Housekeeping			
Laundry			
Maintenance			

2. Enter the total number of employees, the full-time equivalents, and the average hourly wage of all employees by type of position prior to the change. Please report information for all position types that are included above.

Type of Position	Number of Employees	Number of Full Time Equivalents	Average Hourly Wage
Nursing Assistants			
Dietary			
Housekeeping			
Laundry			
Maintenance			

I certify that the information provided above is true and correct.

\_\_\_\_\_  
 Signature Title Date  
 Phone Number: \_\_\_\_\_