



# 2010 Millage Form

Please print clearly and note any changes to information (if provided).

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Member Facility Name

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Address

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City / State / Zip Code

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Prime Contact Name

Title

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Prime Contact E-mail Address

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Phone

Fax

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Corporate/Parent Organization Name (\*see below if applicable)

\*Parent organizations are those organizations that have more than one member as part of their overall operations.

**Services Offered (check all that apply):**

*(If any of the services you offer are done under a separate nonprofit corporate structure, please fill out a separate sheet for them.)*

- CCRC
- Nursing (not part of CCRC)
- Assisted living(not part of a CCRC)
- Senior housing site (not part of a CCRC)
- Home and communited based service
- Managed Care Organization

**Type of Sponsorship (check applicable box):**

- Religious
- Union
- Government
- Fraternal
- Hospital
- Community
- Private Foundation
- Other

## Program Service Revenue

Program services are those activities your organization was created to conduct, plus programs and activities later added, that form the basis of your current federal tax exemption. Program service revenue includes, but is not limited to, revenue from nursing care, assisted living, independent living, adult day care services, home health care, transportation, outpatient services, hospice, meals and other community-based services.

Program service revenue would exclude your interest on savings and temporary cash investments, realized and unrealized gains or losses, special events and activities, charitable contributions, and any other services unrelated to AAHSA's mission.

The program service revenue should come from IRS Form 990, Part I, line 9 of the most recently completed fiscal year.

1. If your organization does not file Form 990 with the IRS, provide program service revenue from one of the following documents using the IRS definition (see above) for program service revenue:

- The organization's audited financial statement
- Medicaid Cost Report
- Profit and loss statement

2. Please report your program service revenue and fiscal year it represents:

\_\_\_\_\_

Program Revenue

\_\_\_\_\_

Fiscal Year

3. Certification Status (check if applicable):  Medicaid  Medicare

## Supportive Services

So that AAHSA can better understand those services offered by our member organizations, please check all services that you have included in program service revenue above.

- |   |   |
|---|---|
| <input type="checkbox"/> Adult Day            | <input type="checkbox"/> Physical Therapy           |
| <input type="checkbox"/> Adult Day Healthcare | <input type="checkbox"/> Social/Activities Programs |
| <input type="checkbox"/> Alzheimer's Unit     | <input type="checkbox"/> Rehabilitation             |
| <input type="checkbox"/> Home Health Care     | <input type="checkbox"/> Respite Care               |
| <input type="checkbox"/> Home Health Agency   | <input type="checkbox"/> Senior Center              |
| <input type="checkbox"/> Hospice              | <input type="checkbox"/> Sub Acute Care             |
| <input type="checkbox"/> Congregate Meals     | <input type="checkbox"/> Service Coordination       |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Personal Care              |
| <input type="checkbox"/> Meals on Wheels      | <input type="checkbox"/> Transportation             |

## Facility Information

1. On the last day of your reporting fiscal year, how many residents/clients were you serving? \_\_\_\_\_
2. On the last day of your reporting fiscal year, how many fulltime employees did you have? \_\_\_\_\_
3. How many individuals are currently on your active volunteer roster? \_\_\_\_\_
4. How many nursing care beds do you have? \_\_\_\_\_
5. How many assisted living units do you have? \_\_\_\_\_
6. How many independent living units do you have?
  - a. Federally Subsidized Senior Housing \_\_\_\_\_
  - b. Tax Credit/Income Restricted Senior Housing \_\_\_\_\_
  - c. Market Rate Senior Housing \_\_\_\_\_
  - d. Other \_\_\_\_\_