MONTANA DEPARTMENT OF REVENUE

# Intermediate Care Facility Utilization Fee

ICFUF
V3 1/2022

Clear Form

Quarter ending date _____ Federal ID # _____

Name and address of intermediate care facility

_____

_____

_____

1. Total facility expenditures for quarter ..... $ _____
2. Line 1 times 6% (.06) ..... $ _____
3. Total number of resident bed days for quarter ..... _____
4. Utilization fee per resident bed day
   (line 2 divided by line 3) ..... $ _____
5. Total utilization fee due (line 3 times line 4) ..... $ _____
6. Penalty and interest ..... $ _____
7. Total paid with return ..... $ _____

| _____ | _____ | _____ |
|---|---|---|
| Signature of preparer | Date | Phone |

Retain a copy for your records. Statement and remittance for any tax due must be received on or before the last day of the month following the end of each calendar quarter.

**Questions?** Call us at (406) 444-6900, or Montana Relay at 711 for the hearing impaired. You may also write to us at the below address:

Montana Department of Revenue
PO Box 5835
Helena, MT 59604-5835