Montana Department of REVENUE

MONTANA
Form ICFUF
Rev. 4-05

Intermediate Care Facility Utilization Fee

Quarter ending _____/_____/_____ 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. If you have an questions, please call or write to:

Montana Department of Revenue
PO Box 5835
Helena, MT 59604-5835
(406) 444-6900