



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
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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