



Intermediate Care Facility Utilization Fee

ICFUF
V3 1/2022

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