

## MONTANA HUF

Rev. 01-09

## **Hospital Facility Utilization Fee**

15-66-101, MCA Return and Instructions

- Line 7: Enter total number of inpatient bed days for the period indicated on line 3.
- Line 8: Enter hospital facility utilization fee due. Multiply line 7 by the rate of \$43.00.
- Line 9: Enter amount of interest and penalty if applicable. The late payment penalty accrues at 1.2% a month, not to exceed 12% of the tax due. In addition, a late filing penalty of \$50 or the amount of the tax due, whichever is less, also applies if the return is filed late. If payment is delinquent interest will apply at 12% per year, calculated daily, from the original due date of this report until paid.
- Line 10: Enter total amount due (sum of lines 8 and 9).
- Line 11: Enter amount paid with this return. This is the amount on line 10.

If you have questions, please call us toll free at (866) 859-2254 (in Helena, 444-6900). Make check payable to the Department of Revenue. Mail this return and payment to:

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

------ Cut on this line------

Montana Department of Revenue Hospital Facility Utilization Fee (HUF)								
1.	FEIN 2. A	ccount ID						
3.	Period: 01/01/2008 through 12/31/2008  Due: 02-Feb-2009	4. If this is an amended return, check here. □		Above space is for department us	se only			
5.	you are no longer in business and want your account cancelled, nter the final date.			Total number of inpatient bed days for the year.				
6.	If your mailing address has changed, check the box and print your new address below: $\Box$		8	. Hospital utilization fee (line 7 x \$43.00)	\$			
			9	. Penalty and interest	\$			
			10	. Total amount due with return (sum of lines 8 and 9)	\$	I		
Si	gnature							
Tit	le							
Phone Date								
Na	ame		]			cents		
Address			111					
Address			''	11. Enter amount paid with this return.				
City, State Zip				,				



## Hospital Facility Utilization Fee (HUF)

## **Payment Instructions**

Attention: Montana Department of Revenue Cashier

Complete the payment voucher below to ensure proper credit of your payment. If you are paying fees for multiple periods, submit a separate check or money order and a separate voucher for each period. On the memo line of your check, please note your FEIN or account ID and the reporting period for which the payment applies.

Boxes 1 and 2 – Box 3 – Box 4 – Box 5 –	Print an "X" in one box only for the type of paymed Check box 1, if your payment is for an original re Check box 2, if your payment is for an amended Enter the reporting period for which this payment Enter your federal employer identification number Enter the amount you are remitting. (This amount your return).	turn for any period. return. t applies. r (FEIN).	nount as repo	orted on lii	ne 11 of					
Name										
Address										
City, State, Zip C	ode									
Phone										
Mail this form w	ith your payment and return (if applicable) to:									
Department of Ro PO Box 5835 Helena, MT 5960										
If you have ques	tions, please call us toll free at (866) 859-2254 (in	Helena, 444-6900).								
Make check or m	oney order payable to the Department of Revenu	e.								
Hospital Facility Utilization Fee Payment Form										
			month	day	year					
1. Original re	turn	3. Period ending	/	/						
2. Amended	return	Federal employer identification number (FEIN)								

5. Amount paid