Montana Department of REVENUE

MONTANA
NFBT
Rev. 2-07

Nursing Facility Bed Tax

15-60-101, MCA
Return and Instructions
Rate Effective July 1, 2006 to June 30, 2007

Name _____

Address _____

Address _____

City, ST, ZIP _____

1. FEIN	4. If this is an amended return, check here ☐
2. Account ID	5. If you are no longer in business and want your account cancelled, enter the final date _____
3. Quarter Ending: Due:	6. If your mailing address has changed, check the box and print new address below: ☐ _____ _____

	a. Bed Days Available	b. Bed Days Occupied	c. Bed Days Medicaid	d. Bed Days Medicare	e. Bed Days Other	f. Bed Days Private Pay
7. First Month.....						
8. Second Month.....						
9. Third Month.....						
10. Quarter Total.....						

11. Total bed days subject to tax (Total of line 10 columnb b)
Column b must equal totals of columns c, d, e and f ..... _____

12. Total tax due (line 11 times tax rate of $8.30)..... _____

13. Penalty..... _____

14. Interest..... _____

15. Total tax due (lines 12, 13, and 14) ..... _____

Signature _____

Title _____

Phone _____ Date _____

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Nursing Facility Bed Tax

Lines 7-9:	Enter monthly bed day information.
Line 10:	Enter quarter totals (sum of lines 7, 8 and 9).
Line 11:	Total bed days subject to tax (line 10, column b).
Line 12:	Mulitply line 11 times rate.
Lines 13 & 14:	If your return/payment is delinquent, you are subject to penalty and interest. Interest on late tax payments must bear interst until paid at a arate of 12% per year, computed from the original due date of the return. A penalty of 1.5% a month on unpaid taxes, not to exceed 18% of the tax due is assessed on late payments. A penalty of $50 or the amount of the tax due whichever is less, is assessed on late filed returns.
Line 15:	Enter total amount due (sum of lines 12, 13 and 14).

Nursing Facility Bed Tax
(NFBT)
Payment Instructions
Attention: Montana Department of Revenue Cashier

Complete the payment coupon below to ensure proper credit of your payment. If you are paying taxes for multiple periods, submit a separate check or money order and a separate coupon 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 – Print an "X" in **one** box only for the type of payment you are remitting:
Check box 1, if your payment is for an original return for any period.
Check box 2, if your payment is for an amended return.
Box 3 – Enter the reporting period for which this payment applies.
Box 4 – Enter your federal employer identification number (FEIN).
Box 5 – Enter the amount you are remitting. (This amount should be the same amount as reported on line 15 of your return).

Name _____

Address _____

_____

City, State, Zip Code _____

Phone _____

Mail this entire form with your check or money order and return to:
Department of Revenue
PO Box 5835
Helena, MT 59604-5835

Questions? Call (406) 444-6900.

Make check or money order payable to the Department of Revenue.

Montana Nursing Facility Bed Tax
Payment Form

☐ 1. Original return

☐ 2. Amended return

	month day year
3. Period ending	/ /
4. Federal employer identification number (FEIN)	-
5. Amount paid	