

HEALTH CARE PROVIDER TAX RETURN



NAME AND ADDRESS

AMENDED

Period Beginning:

Period Ending:


Return Due:

Account No.:

FOR OFFICIAL USE ONLY

Example: Write numbers like this.

1	2	3	4	5	6	7	8	9	0
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See reverse for Class Definitions

Class	Gross Revenues (whole dollars)	Tax Rate	Amount of Tax
1. 01	<input type="text"/>	X	<input type="text"/>
2. 12	<input type="text"/>	2.0%	<input type="text"/>
3. 14	<input type="text"/>	5.5%	<input type="text"/>
4. 30	<input type="text"/>	0.0%	<input type="text"/>
5. 31	<input type="text"/>	0.0%	<input type="text"/>
6. 32	<input type="text"/>	5.5%	<input type="text"/>
7. 33	<input type="text"/>	5.5%	<input type="text"/>

See reverse for Class Definitions

Nursing Facility Services

Class	Non-Medicare Patient Bed Days	Amount of Tax
8. 15	<input type="text"/>	X \$5.63
9. 77	<input type="text"/>	X \$2.82
10. 88	<input type="text"/>	X \$6.38
11. 99	<input type="text"/>	X \$19.89

12. Tax Due. Add amounts on lines 1 through 11

13. Less: Preauthorized credits / /
 MM DD YY

14. Net Tax Due

15. Penalties (see instructions)

16. Interest (see instructions) (DAILY INTEREST RATE: 0.000247)

17. Total Amount Due. Add amounts on lines 14, 15 and 16

(Please do not staple check to return.)

IMPORTANT: Return must be postmarked by the 20th of the month following the taxable month to avoid the assessment of penalty and interest. Remit total amount due. Make check payable to: Kentucky State Treasurer. Mail to: Department of Revenue, Frankfort, Kentucky 40619.

FOR OFFICIAL USE ONLY

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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I declare, under penalty of perjury, that this return has been examined by me and to the best of my knowledge and belief is a true, correct and complete return.

Signature of President or Other Principal Officer, Partner or Proprietor _____ Date _____ Signature of Tax Return Preparer and Title _____ Date _____

DO NOT WRITE BELOW THIS LINE

Class Code Definitions

- 01** - Hospitals
- 12** - Home Health Agency Services
- 14** - ICF-MR Services
- 33** - Supports for Community Living Services

Classes Taxable for Periods Beginning July 1, 2005

- 30** - Regional Community Mental Health & Mental Retardation Services
- 31** - Psychiatric Residential Treatment Facility Services
- 32** - Medicaid Managed Care Organization Services

Nursing Facility Services Class Definitions

- 15** - Hospital Based Nursing Facilities
- 77** - Non-Hospital Based Nursing Facility with 60 or fewer beds and a designation as an intermediate care or nursing home facility.
OR
Non-Hospital Based Nursing Facility with 40 or fewer beds.
- 88** - Non-Hospital Based Nursing Facility with Total Patient Days greater than 60,000
- 99** - Non-Hospital Based Nursing Facility with Total Patient Days less than or equal to 60,000

If you are filing an amended return, mark the box in the top center of the form and attach supporting documentation.