



**Oregon Department of Human Services  
FY2008 Quarterly Nursing Facility Provider Tax**

**Quarterly Tax Assessment Form**

Quarter ending	Nursing Facility (include Corporate owners' names where applicable)		
Address			
City	State	Zip Code	Telephone
Medicaid Provider No. (where applicable)		Federal Tax ID No.	
<b>Calculate Tax Owed:</b>			
Enter Total Patient Bed Days		Total _____	
Multiply by Long Term Care Facility Assessment (\$rate Per Patient Bed Day)		X \$13.75	
<b>Total Assessment Due</b> (Payment = total occupied bed days X \$13.75)		\$ _____	
<b>Facility's Quarterly Revenue \$ _____</b>			
<p>Please report revenue paid for patient care, room, board, and services less contractual adjustments for the quarter. Does not include revenue derived from other than long term care facility operations, donations, interest, guest meals, or any revenue not attributable to patient care and does not include hospital revenue derived from hospital operations.</p>			
<p>I certify that the information provided on this form is true, accurate and complete to the best of my knowledge, as of the date indicated below. Information provided herein is not deliberately false, fraudulent or misleading. Information that changes will be reflected in subsequent reporting.</p>			
Print Name _____		Date _____	
Signature _____			
Send payment and this form to: Oregon Department of Human Services Receipting & Trust Unit PO Box 14006 Salem, OR 97301  If submitting payment electronically, fax this form to 503-378-2806		<b>NOTE: To avoid a \$500/day penalty, this form and associated payment must be submitted to the address noted by the last day of the month following the end of the quarter for which the information is being reported. Submission may be electronic or by mail. For example, when the quarter ends September 30, the due date is October 31<sup>st</sup>.</b>	
<b>FOR DHS USE ONLY</b>	Check #:	Check Postmark Date:	
Deposit #:	Check Amount:	Report Postmark Date:	
PCA #	Index #	Agency Object #	
Date Received:			