

STATE OF ALABAMA  
NURSING FACILITY TAX RETURN

Prepare/file/pay this return online:  
www.revenue.alabama.gov/salestax/efiling.html

ACCOUNT NUMBER \_\_\_\_\_

PERIOD COVERED
DUE DATE

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DO NOT USE THIS SPACE		
BALANCE OF TAX		
INTEREST		
PENALTY		
TOTAL		

CHECK THIS BOX IF PAYMENT MADE  
THROUGH ELECTRONIC FUNDS TRANSFER (EFT)   
TOTAL AMOUNT REMITTED

\$ \_\_\_\_\_

fold

**TAX ON NURSING FACILITIES**

- No. of patient days utilized for the month..... \_\_\_\_\_
- No. of patient days available for the month..... \_\_\_\_\_
- Percent of occupancy (Item 1 divided by Item 2)..... \_\_\_\_\_
- No. of licensed beds, if any, added since July 1, 1991 provided the monthly occupancy rate has not equaled or exceeded 85% since such beds were added..... \_\_\_\_\_
- No. of licensed beds as of last day of the month covered by this return excluding those beds, if any, shown in Item 4..... \_\_\_\_\_
- Total no. of licensed beds (Item 4 + Item 5)..... \_\_\_\_\_
- Tax due (If Item 4 is zero, tax equals Item 6 x \$100.00; if Item 4 is greater than zero, tax equals Item 3 x \$100.00 x Item 6).....
- Penalty (see instructions).....
- Interest due for late payment (see instructions).....
- LESS: Credit claimed.....
- TOTAL AMOUNT DUE (Line 7 plus Line 8 plus Line 9 minus Line 10).....

\$		
\$		
\$		
\$		
\$		

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

fold

**DO NOT CUT OR STAPLE.**

Please be sure to put the proper name, account number, and period covered on the return before submitting it.