

**SELF EMPLOYED
IN HOME HEALTHCARE & THERAPY PROVIDERS**

DATE _____	TAX YEAR _____
NAME _____	ADDRESS _____
OCCUPATION _____	_____

INCOME:

TOTAL INCOME \$ _____

(To figure total income add all 1099's and put total on line above. If there are no 1099's reported or if you earn more income then reported on the 1099's you need to add up the total of all deposits.)

EXPENSES:

ACCOUNTING FEES \$ _____

AUTO EXPENSE:

TOTAL MILES _____

WORK MILES _____

1. GAS/FUEL \$ _____

4. PARKING \$ _____

2. REPAIRS & MAINT \$ _____

5. INSURANCE \$ _____

3. TOLLS \$ _____

6. LEASE PMTS \$ _____

EDUCATION & TRAINING \$ _____

INSURANCE (NO HEALTH) \$ _____

INTERNET FEES \$ _____

MEALS & ENTERTAIN \$ _____

LICENSES & DUES \$ _____

OFFICE & COMP EQUIP \$ _____

(List each piece of equipment with a description, date of purchase, and amount of purchase)

PATIENT SUPPLIES \$ _____

(Including gloves and any other misc patient expenses you may incur)

TELEPHONE \$ _____

TRAVEL & SEMINARS \$ _____

UNIFORMS \$ _____

HOME OFFICE EXPENSES: (If you pay a mortgage please only report the mortgage interest which is reported on form 1098 not the full amount of your monthly pmt)

MORTGAGE INTEREST \$ _____

PROPERTY TAX \$ _____

RENT \$ _____

ELECTRIC/GAS \$ _____

INSURANCE \$ _____

WATER \$ _____

REPAIRS & MAINT \$ _____

CLEANING SUPPLIES \$ _____

SECURITY \$ _____

TOTAL SQ FEET ROOM USED AS OFFICE _____

TOTAL SQ FEET OF HOUSE/APT _____