

HCP

Maine Revenue Services Health Care Provider Tax Reconciliation Return



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1114500

Registration No.

Fiscal Year

Due Date

1. Entity Information		
2. <input type="checkbox"/> OUT OF BUSINESS? Date closed: _____ 3. <input type="checkbox"/> OWNERSHIP OR NAME CHANGE? Date _____ Explanation _____ 4. <input type="checkbox"/> SOLD? Date _____		
ADDRESS CHANGE? Make corrections above and check here <input type="checkbox"/>		

1. Revenue for above fiscal year

1. _____, _____, _____ . _____

Nursing homes – use operating revenues

Residential Treatment Facilities – use gross patient serv. revenues

3. Health Care Provider Tax (Line 1 x 6%)

3. _____, _____, _____ . _____

4. Less: Monthly estimated payments made

4. _____, _____, _____ . _____

5. Additional Amount Due

5. _____, _____, _____ . _____

(Line 3 less line 4. Use line 6 if this is a credit amount.)

6. Credit Due

6. _____, _____, _____ . _____

(If line 3 minus line 4 is a credit amount, enter the amount to the right.)

If you wish a refund rather than a carry forward to the next period, check here



Mail To:
Maine Revenue Service
P.O. Box 1065
Augusta, ME 04332-1065

Signature and Title

Print Name

Date

Phone #