

HCP

Maine Revenue Services
Health Care Provider Tax
Reconciliation Return



2514500

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Registration No.

Fiscal Year

Due Date

1. Entity Information

2. ☐ **OUT OF BUSINESS?** Date closed:

3. ☐ **OWNERSHIP OR NAME CHANGE?** Date

Explanation

4. ☐ **SOLD?** Date

5. ☐ *Check here if this is an AMENDED return.*

ADDRESS CHANGE? Check here and make corrections above

☐

1. Revenue for above fiscal year

1.

Nursing homes – use operating revenues

Residential Treatment Facilities – use gross patient serv. revenues

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

2.

3. Less: Monthly estimated payments made

3.

4. Less credit from prior period

4.

5. Additional Amount Due

5.

(Line 2 less line 3. Use line 5 if this is a credit amount.)

6. Credit Due

6.

(If line 2 minus line 3 is a credit amount, enter the amount to the right.)

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

☐

Make check or money order payable to the **STATE TREASURER** and send your remittance with your return postmarked by the due date printed on the front of the return to: **MAINE REVENUE SERVICES, P.O. BOX 1065, AUGUSTA ME 04332-1065.**

Please record your registration number on your check. Failure to file a return on or before the due date will result in interest and penalty charges. Billings will be issued shortly after the processing of your return.

DECLARATION(S) UNDER THE PENALTIES OF PERJURY. I declare that I have examined this return/report/document and (if applicable) accompanying schedules and statements and to the best of my knowledge and belief they are true, correct, and complete.

Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Signature and Title

Print Name

Date

Phone #