

# HCP

## Maine Revenue Services Health Care Provider Tax Reconciliation Return



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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

**Nursing homes** – use operating revenues

**Residential Treatment Facilities** – use gross patient serv. revenues

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

### 3. Less: Monthly estimated payments made

### 4. Additional Amount Due

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

### 5. Credit Due

(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, check 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.

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Signature and Title

Print Name

Date

Phone #