

# HCP

## Maine Revenue Services Health Care Provider Tax Reconciliation Return



00

\*0914500\*

Due Date

Registration No.

Fiscal Year

--	--	--

1. Entity Information

***Use this area only to report changes in your business***

2. **OUT OF BUSINESS?** Check here , return permit to Bureau and complete information at right. Date closed: \_\_\_\_\_

3. **OWNERSHIP CHANGE?** If you have changed ownership, indicate the date when this occurred here \_\_\_\_\_ and check the type of change below.

- Incorporated  Partner added or dropped
- Other (explain on reverse)
- Sold to \_\_\_\_\_

4. **NAME CHANGE?** Attach explanation to this return.

ADDRESS CHANGE? If your address above is incorrect, please make the appropriate changes to the preprinted address.

- 1. Annual revenue for fiscal year identified above 1. \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ . \_\_\_\_\_
- 2. Health Care Provider Tax (Line 1 multiplied by 5.5%) 2. \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ . \_\_\_\_\_
- 3. Less: Monthly estimated payments made 3. \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ . \_\_\_\_\_
- 4. Additional Amount Due (Line 2 less line 3. Use line 5 if this is a credit amount.) 4. \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ . \_\_\_\_\_
- 5. Credit Due (If line 2 minus line 3 is a credit amount, enter the amount to the right.) 5. \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ . \_\_\_\_\_

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

**Instructions:**

**Line 1.** For nursing homes, enter your annual net operating revenue for the fiscal year identified above. For residential treatment facilities, enter your annual gross patient services revenue for the fiscal year identified above.

**Line 3.** Enter the total of all estimated payments made for the fiscal year period identified above.



Mail To:  
Maine Revenue Service  
P.O. Box 9119  
Augusta, ME 04332-1064

Signature and Title

Print Name

Date

Phone #

_____
-------