HCP-4

HOSPITAL LICENSING FEE

State of Rhode Island and Providence Plantations
Department of Revenue - Division of Taxation

HOSPITAL LICENSING FEE REPORT
Due on June 18, 2012

NAME		
ADDRESS		
CITY	STATE	ZIP CODE
CONTACT PERSON	TITLE	PHONE NUMBER
FEDERAL IDENTIFICATION NUMBER		
RETURN FOR THE PERIOD OF: **OCTOBER 1, 2009 THROUGH SEPTEMBER 30, 2010**	EMAIL ADDRESS	

Calculation of Amount Due:

1. Gross Patient Services Revenue (See instructions)	1.			
2. Amount of Charity Care, Bad Debts Expense and Contract Allowances	2.			
3. Net Patient Services Revenue - Line 1 minus Line 2			3.	
4. Net Licensing Fee Due - Line 3 times 5.43% (0.0543)			4.	
5. Interest - (1.5% per month) See instructions			5.	
6. Penalty - (10%) See instructions			6.	
7. TOTAL AMOUNT DUE (Add lines 4, 5 and 6)			7.	

INSTRUCTIONS

NOTE: AS OUTLINED IN R.I.G.L. 23-17-38.1, THIS RETURN IS DUE BY JUNE 18, 2012 EVEN THOUGH THE REMITTANCE IS NOT DUE UNTIL JULY 16, 2012.

Line 1: **Gross Patient Services Revenue** - Enter the amount reported on Line 1 of Worksheet G3, Medicare Hospital and Hospital Health Care Complex Cost Report for the Hospital Fiscal Year ending September 30, 2010.

Line 2: **Deductions** - Enter the amount of Charity Care, Bad Debts Expense and Contract Allowances.

Line 3: **Net Patient Services Revenue** - Line 1 minus Line 2.

Line 4: **Net Licensing Fee Due** - Multiply Line 3 times 5.43% (0.0543).

Line 5: **Interest** - If remitting after July 16, 2012, multiply Line 4 times 1.5% (0.015) times the number of months late. Interest is calculated from July 16, 2012 to the date of remittance at a rate of 18% per annum.

Line 6: **Penalty** - If remitting after July 16, 2012, multiply Line 4 times 10% (0.10). Penalty is calculated at 10% of the net licensing fee due.

Line 7: **Total Amount Due** - Add line 4, 5 and 6.

PAYMENTS MUST BE MADE BY ELECTRONIC FUNDS TRANSFER (EFT).
QUESTIONS REGARDING EFT TRANSFERS MAY BE DIRECTED TO (401)574-8484.

Under penalties of perjury, I hereby certify that I have personal knowledge of the statements and other information constituting this return, that the same are true, correct and complete to the best of my knowledge and belief.

Date _____ Signature of authorized officer _____ Title _____

Date _____ Signature of preparer _____ Address of preparer _____

MAY THE DIVISION CONTACT YOUR PREPARER ABOUT THIS RETURN? YES ☐ NO ☐ Phone number _____

MAILING ADDRESS: RHODE ISLAND DIVISION OF TAXATION, ONE CAPITOL HILL, PROVIDENCE, RI 02908-5811

revised 06/21/2011