State of Rhode Island and Providence Plantations

Form HCP-64

13112499990101

Outpatient Health Care Facility Surcharge Return

Name			Federal employer identification number
Address			**For the month ending:**
			MM/DD/YYYY
Address 2			
City, town or post office	**State**	**ZIP code**	**E-mail address**

Calculation of Amount Due:

1	Net patient services revenue received				1		
2	Outpatient health care facility surcharge. Multiply line 1 times 2% (0.02)				2		
3	Interest calculated at 1.5% per month. See instructions	3					
4	Penalty calculated at 10%. See instructions	4					
5	Total interest and penalty amount. Add lines 3 and 4				5		
6	TOTAL AMOUNT DUE. Add lines 2 and 5				6		

INSTRUCTIONS

Line 1: **Net Patient Services Revenue Received** - Enter the amount of all monies and other consideration received for patient care services for the month being reported on this return.

Line 2: **Outpatient Health Care Facility Surcharge** - Multiply line 1 times 2.0% (0.02)

Line 3: **Interest** - If remitting after the due date, multiply line 2 times 1.5% (0.015) times the number of months late. Interest is calculated from the due date of the return to the date of remittance at a rate of 18% per annum.

Line 4: **Penalty** - If remitting after the due date, multiply line 2 time 10% (0.10). Penalty is calculated at 10% of the surcharge due.

Line 5: **Total Interest and Penalty Amount** - Add lines 3 and 4.

Line 6: **Total Amount Due** - Add lines 2 and 5.

PAYMENTS MUST BE MADE BY ELECTRONIC FUNDS TRANSFER (EFT).
For more information, visit www.tax.ri.gov/contact/ .

Under penalties of perjury, I declare that I have examined this return and accompanying schedules and statements, and to the best of my knowledge and belief, it is true, accurate and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Authorized officer signature	Print name		Date	Telephone number
Paid preparer signature	**Print name**		**Date**	**Telephone number**
Paid preparer address	**City, town or post office**	**State**	**ZIP code**	**PTIN**

May the Division of Taxation contact your preparer? YES ☐

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