HCP-2

NURSING FACILITIES RETURN

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

HEALTH CARE PROVIDER TAX RETURN
Due on or before the 25th day of the following month

NAME		
ADDRESS		
CITY	STATE	ZIP CODE
PHONE NUMBER		
FEDERAL IDENTIFICATION NUMBER:		
LICENSE NUMBER:		
RETURN FOR THE PERIOD OF: MONTH		YEAR

	Services Provided Prior to 01/01/2008	Services 01/01/2008 and Thereafter	Total Due
Line 1: Gross Patient Revenue			
Line 2: Rate:	6.00%	5.50%	
Line 3: Provider Assessment Due (Line 1 times Line 2)			
Line 4: Interest			
Line 5: Penalty			
Line 6: Total Due (Add Lines 3, 4 and 5)			

INSTRUCTIONS

Line 1: **Gross Patient Revenue** - Enter the gross amount received on a cash basis by the provider from all patient care services provided on June 1, 1992 and thereafter. Charitable contributions, donated goods and services, fund raising proceeds, endowment support, income from meals on wheels, income from investments and such other nonpatient revenues defined by the Tax Administrator upon the recommendation of the Department of Human Services shall not be considered "gross patient revenue".

Line 2: **Rate** - The applicable rate for a Nursing Facility is 6.00% for services provided prior to 1/1/2008 and 5.50% for services provided 1/1/2008 and thereafter.

Line 3: **Provider Assessment Due** - Multiple Line 1 times Line 2.

Line 4: **Interest** - Interest is calculated from the due date of the return to the date of remittance at a rate of 18% per annum. If remitting after the due date, multiply Line 3 times 1.5% (0.015) times the number of months late.

Line 5: **Penalty** - If remitting after the due date, multiply Line 3 times 10% (0.10). Penalty is calculated at 10% of the provider assessment due.

Line 6: **Total Amount Due** - Add lines 3, 4 and 5.

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