

**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 14, 2010**

NAME		
ADDRESS		
CITY	STATE	ZIP CODE
CONTACT PERSON	TITLE	PHONE NUMBER
FEDERAL IDENTIFICATION NUMBER		
RETURN FOR THE PERIOD OF: <b>OCTOBER 1, 2007 THROUGH SEPTEMBER 30, 2008</b>		

**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 5.314% (0.05314) .....	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 14, 2010 EVEN THOUGH THE REMITTANCE IS NOT DUE UNTIL JULY 12, 2010.**

Line 4: **Net Licensing Fee Due** - Multiply Line 3 times 5.314% (0.05314).

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, 2008.

Line 5: **Interest** - If remitting after July 12, 2010, multiply Line 4 times 1.5% (0.015) times the number of months late. Interest is calculated from July 12, 2010 to the date of remittance at a rate of 18% per annum.

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

Line 6: **Penalty** - If remitting after July 12, 2010, multiply Line 4 times 10% (0.10). Penalty is calculated at 10% of the net licensing fee due.

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

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)574-8732.**

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**