

**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 20, 2011**

NAME		
ADDRESS		
CITY	STATE	ZIP CODE
CONTACT PERSON	TITLE	PHONE NUMBER
FEDERAL IDENTIFICATION NUMBER		
RETURN FOR THE PERIOD OF: OCTOBER 1, 2008 THROUGH SEPTEMBER 30, 2009		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 5.465% (0.05465)	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 20, 2011 EVEN THOUGH THE REMITTANCE IS NOT DUE UNTIL JULY 18, 2011.

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, 2009.

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 5.465% (0.05465).

Line 5: **Interest** - If remitting after July 18, 2011, multiply Line 4 times 1.5% (0.015) times the number of months late. Interest is calculated from July 18, 2011 to the date of remittance at a rate of 18% per annum.

Line 6: **Penalty** - If remitting after July 18, 2011, 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