CITY OF LITTLE FALLS
RESTAURANT TAX RETURN
Phone 320-616-5500

Name of Restaurant/Deli/Organization _____

_____

Address: _____

_____

State Sales Tax Account Number: _____

Period Covered (To-From): _____

Date Due: _____

I declare and certify under penalty of law that I have examined this statement and that to the best of my knowledge and belief it is true and complete.

Signature _____

Title _____ Date _____

1. Gross Monthly Food/ Non-Alcoholic Beverage Receipts	$ _____
2. Less Exceptions and Exemptions	_____
3. Less Bad Debts	_____
4. Plus Collected Bad Debts	_____
5. Subtotal	_____
6. Tax Percentage .005	_____ x .005
7. Tax Due	_____
8. Penalty and Interest (If Due)	_____
9. Total Amount Due	_____

Make Checks Payable to: **City of Little Falls**

Send To: City of Little Falls
P.O. Box 244
Little Falls, MN 56345

WHITE COPY- City **YELLOW COPY-** Keep For Your Files

Spectrum Marketing Services - Rev. 5/05