DO NOT STAPLE New Hampshire Department of Revenue Administration	DP-153										
MEDICAID ENHANCEMENT TAX RETURN											
MMDDYYYY Tax Period Begin Date	Tax Peri	od End Date	MMDDYYYY								
STEP 1 - PRINT OR TYPE Name of Hospital			Taxpayer Identification Number								
Number & Street Address			Hospital Fiscal Year End Date								
Address (continued)											
City / Town	S	tate	Zip Code + 4 (or Canadian Postal Code)								
STEP 2 - Type of Return (check if applicable) Initial Return (1st filing)	Final Return	Last Day of E	Business								
5TEP 3 - Calculate Your Balance Due or Over 1. Gross Charges: (a) Inpatient Hospital Services	payment _{R(}	ound to the i	nearest whole dollar								
(b) Outpatient Hospital Services	1(b)										
Total Gross Charges (Sum of Lines 1(a) and 1(b))		1									
2. Net Excluded Charges for Outpatient Hospital Services f	from Form DP-153-SCH, Li	ne 21 2									
3. Subtotal (Line 1 minus Line 2)		3									
4. Deductions: (a) Bad Debts	4(a)										
(b) Charity Care	4(b)										
(c) Payor Discounts	4(c)										
Total Deductions (Sum of Lines 4(a), 4(b), and 4(c))		4									
5. Net Patient Services Revenue (Line 3 minus Line 4)		5									
6. New Hampshire Medicaid Enhancement Tax (Line 5 mu	ltiplied by applicable tax r	ate) 6									
7. Credits: (a) Credit Carryover from prior tax period	7(a)										
(b) Payment made with original return (Amended ret	turns only) 7(b)										
Total Credits (Sum of Lines 7(a) and 7(b))		7									
8. Balance of Tax Due (Line 6 less Line 7)		8									

Department of Revenue Administration

New Hampshire

MEDICAID ENHANCEMENT TAX RETURN

STEP 3 - Calculate Your Balance Due or Overpayment - continued

9. Additions: (a) Interest	9(a)							
(b) Failure to Pay Penalty	9(b)							
(c) Failure to File Penalty	9(c)							
Total Additions (Enter the sum of Lines 9(a), 9(b), and 9(c))			9					
10. Balance Due (Line 8 plus Line 9)			10					
11. Overpayment: Enter balance due if less than zero			11					
12. Apply overpayment to: (a) Credit - Next Year's Tax Liability	12(a)							
(b) Refund	12(b)							

STEP 4 - Signatures

Under penalties of perjury, I declare that I have examined this return and to the best of my belief it is true, correct and complete. If prepared by a person other than the person owning or operating the utility, this declaration is based on all information of which the preparer has knowledge.

Signature of Officer (in ink)		MMDDYYYY
Print Signatory Name & Title		Phone Number
Signature of Preparer		MMDDYYYY
Printed Name of Preparer		Preparer's Tax Identification Number
Preparer's Address		Phone Number
Address (continued)		
City / Town	State	Zip Code + 4 (or Canadian Postal Code)

FILE ONLINE AT GRANITE TAX CONNECT

www.revenue.nh.gov/gtc

Or mail to: NH DRA PO BOX 637 CONCORD NH 03302-0637