



New Hampshire
Department of
Revenue Administration

**DP-153
Medicaid
Enhancement Tax
Return**

FOR DRA USE ONLY

For the TAXABLE period beginning July 1, 2015 and ending June 30, 2016, prepared in accordance with RSA 84-A:4

STEP 1	NAME OF HOSPITAL	TAXPAYER IDENTIFICATION NUMBER
	NUMBER & STREET ADDRESS	
	ADDRESS (continued)	
	CITY/TOWN, STATE & ZIP CODE+4	HOSPITAL FISCAL YEAR END DATE
Check the type of return: <input type="checkbox"/> INITIAL RETURN <input type="checkbox"/> AMENDED RETURN <input type="checkbox"/> FINAL RETURN		

STEP 2 Calculate your Tax	Round to the nearest whole dollar		
	1	Gross Charges: (a) Inpatient Hospital Services 1(a)	<input style="width: 100%;" type="text"/>
		(b) Outpatient Hospital Services 1(b)	<input style="width: 100%;" type="text"/>
		TOTAL GROSS CHARGES (Sum of Lines 1a and 1b) 1	<input style="width: 100%;" type="text"/>
	2	Net Excluded Charges For Outpatient Hospital Services from attached 2	<input style="width: 100%;" type="text"/>
		schedule Line 21	
	3	Subtotal (Line 1 minus Line 2) 3	<input style="width: 100%;" type="text"/>
4	Deductions: (a) Bad Debts 4(a)	<input style="width: 100%;" type="text"/>	
	(b) Charity Care 4(b)	<input style="width: 100%;" type="text"/>	
	(c) Payor Discounts 4(c)	<input style="width: 100%;" type="text"/>	
	TOTAL DEDUCTIONS (Sum of Lines 4a, 4b, and 4c) 4	<input style="width: 100%;" type="text"/>	
5	Net Patient Services Revenue (Line 3 minus Line 4) 5	<input style="width: 100%;" type="text"/>	
6	New Hampshire Medicaid Enhancement Tax (Line 5 multiplied by 5.45%)6	<input style="width: 100%;" type="text"/>	

STEP 3 Credits Interest and Penalties	7	Credits: (a) Credit carried over from prior tax period7(a)	<input style="width: 100%;" type="text"/>
		(b) Payment made with original return (Amended returns only)...7(b)	<input style="width: 100%;" type="text"/>
		TOTAL 7	<input style="width: 100%;" type="text"/>
	8	BALANCE OF TAX DUE (Line 6 less Line 7) 8	<input style="width: 100%;" type="text"/>
	9	Additions to Tax	
		(a) Interest 9(a)	<input style="width: 100%;" type="text"/>
		(b) Failure to Pay 9(b)	<input style="width: 100%;" type="text"/>
	(c) Failure to File 9(c)	<input style="width: 100%;" type="text"/>	
	TOTAL 9	<input style="width: 100%;" type="text"/>	

STEP 4 Balance Due or Overpay- ment	10	BALANCE DUE (Line 8 plus Line 9) 10	<input style="width: 100%;" type="text"/>
	11	Overpayment: Enter balance due if less than zero 11	<input style="width: 100%;" type="text"/>
	12	Apply Overpayment to:	
	(a) Credit 12(a)	<input style="width: 100%;" type="text"/>	
	(b) Refund 12(b)	<input style="width: 100%;" type="text"/>	

STEP 5 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
Signatures prepared by a person other than the taxpayer, this declaration is based on all information of which the preparer has knowledge.)

FOR DRA USE ONLY	Signature of Officer (in ink)	Date	Signature (in ink) of Paid Preparer Other Than Taxpayer	Date
	Print Signatory Name & Title		Print Preparer's Name & Tax Identification Number	
	Officer's Telephone Number		Preparer's Address	
	MAIL NH DRA TO: ADMINISTRATION UNIT PO BOX 457 CONCORD NH 03302-0457		City/Town, State & Zip Code+4	
			Preparer's Telephone Number	



INSTRUCTIONS

WHO MUST FILE

The Medicaid Enhancement Tax Return must be filed by every hospital required to be licensed under RSA 151 that provide inpatient and outpatient hospital services.

WHEN TO FILE

Every hospital shall file a Medicaid Enhancement Tax Return including applicable supporting schedules on or before the fifteenth day of April in the taxable period to the Department of Revenue Administration.

WHERE TO FILE

MAIL TO:
NH DRA
ADMINISTRATION UNIT
PO BOX 457
CONCORD NH 03302-0457

NEED FORMS?

To obtain additional forms, you may visit our website at www.revenue.nh.gov/ or call the Forms Line at (603) 230-5001.

NEED HELP?

Questions not covered here may be answered in our Frequently Asked Questions (FAQ) available on our website at www.revenue.nh.gov/ or by calling Central Tax Services at (603) 230-5920, Monday through Friday, 8:00 am to 4:30 pm. All written correspondence to the Department should include the taxpayer name, taxpayer identification number, the name of a contact person and a daytime telephone number. Individuals who need auxiliary aids for effective communications in programs and services of the New Hampshire Department of Revenue Administration are invited to make their needs and preferences known. Individuals with hearing or speech impairments may call TDD Access: Relay NH 1-800-735- 2964.

LINE BY LINE INSTRUCTIONS

STEP 1

Enter the name of hospital, taxpayer identification number [Federal Employer Identification Number (FEIN)], address and hospital's fiscal year end date.

Check the appropriate box as applicable to indicate whether this is the "initial" or first return, an "amended" return, or the "final" return being filed.

STEP 2

Line 1(a): Enter the gross charges for inpatient hospital services.

Line 1(b): Enter the gross charges for outpatient hospital services.

Line 1: Enter the sum of Lines 1(a) and 1(b).

Line 2: Enter the net excluded charges for outpatient services from the Net Excluded Charges Calculation Schedule, Line 21.

Line 3: Enter the subtotal. Line 1 minus Line 2.

Line 4(a): Enter the amount of bad debts to be deducted.

Line 4(b): Enter the amount of charity care to be deducted.

Line 4(c): Enter the amount of payor discounts to be deducted.

Line 4: Enter the sum of Lines 4(a) through 4(c).

Line 5: Enter the balance of Line 3 minus Line 4 for the total of Net Patient Services Revenue.

Line 6: Enter the product of Line 5 multiplied by 5.45% (0.0545).



INSTRUCTIONS - continued

STEP 3

Line 7(a): Enter the credit carried over from the prior tax period, if any.

Line 7(b): Enter the payment made with the original return (only if this is an amended return).

Line 7: Enter the sum of Lines 7(a) and 7(b).

Line 8: Calculate the balance of tax due. Line 6 minus Line 7 and enter the result on Line 8.

Line 9(a): Enter the Interest, if applicable. Interest is calculated on the balance of tax due from the original due date to the date paid at the applicable rate of 5% (.000137).

$$\frac{\text{Tax Due}}{\text{Number of Days}} \times \frac{\text{Daily Decimal Rate Equivalent}}{\text{Daily Decimal Rate Equivalent}} = \text{Interest due} \quad [\text{Enter on Line 9(a)}]$$

Line 9(b): Enter the Penalty for Failure to Pay, if applicable. A penalty equal to 10% of any nonpayment or underpayment of taxes shall be imposed if the taxpayer fails to pay the tax when due. If the failure to pay is due to fraud, the penalty shall be 50% of the amount of the nonpayment or underpayment.

Line 9(c): Enter the Penalty for Failure to File, if applicable. A taxpayer failing to timely file a complete return may be subject to a penalty equal to 5% of the tax due for each month or part thereof that return remains unfiled or incomplete. The total amount of this penalty shall not exceed 25% of the balance of tax due. Calculate this penalty starting from the original due date of the return until the date a complete return is filed.

NOTE: Taxpayers who substantially understate their tax may be assessed a penalty by the Department in the amount of 25% of any underpayment of the tax resulting from such understatement. There is a substantial understatement of tax if the amount of the understatement exceeds the greater of 10% of the tax required to be shown on the return or \$5,000.

Line 9: Calculate the sum of Lines 9(a) through 9(c) and enter the result on Line 9.

STEP 4

Line 10: Enter the Balance Due by calculating Line 8 plus Line 9 and entering the result on Line 10. The amount indicated as Balance Due will be debited from your designated financial institution's account by the NH Department of Treasury on the date specified (see Form DP-153-ACH).

Line 11: Enter balance due from Line 10 if less than zero.

Line 12(a): Enter the overpayment amount from Line 11 to be credited to the next payment due.

Line 12(b): Enter the overpayment amount from Line 11 to be refunded.

STEP 5 SIGNATURES

Form DP-153 must be dated and signed by a hospital officer or authorized agent. If the return was completed by a paid preparer, then the preparer must also sign and date the return. Preparers must also enter their Federal Preparer Identification Number (PTIN), their complete address and telephone number.