FORM
DP-156
811

NEW HAMPSHIRE DEPARTMENT OF REVENUE ADMINISTRATION

NURSING FACILITY QUALITY ASSESSMENT RETURN

FOR DRA USE ONLY

Assessment Period Beginning _____ and ending _____ prepared in accordance with RSA 84-C:4

For Assessment Period: Check One ☐ January 1 - March 31 ☐ April 1 - June 30 ☐ July 1 - September 30 ☐ October 1 - December 31 ☐ 2007

STEP 1

NURSING FACILITY NAME

FEDERAL EMPLOYER IDENTIFICATION NUMBER

NUMBER AND STREET ADDRESS

ADDRESS (continued)

CITY/TOWN STATE & ZIP CODE

STEP 2 Return Type

Check the type of return

☐ INITIAL RETURN ☐ AMENDED RETURN ☐ FINAL RETURN LAST DAY OF BUSINESS _____ MO DAY YEAR

STEP 3 Figure Your Assessment

1 Net Patient Services Revenue 1

2 New Hampshire Nursing Facility Quality Assessment 2
[Line 1 x 6% (.06)]

STEP 4 Credits Interest and Penalties

3 Credits: (a) Payment made with extension ..... 3(a)

(b) Credit carried over from prior period ..... 3(b)

(c) Original Return Payment ..... 3(c)
(Amended returns only)

TOTAL [Sum of Line 3(a) through Line 3 (c)] 3

4 BALANCE OF ASSESSMENT DUE (Line 2 less Line 3) 4

5 Additions

(a) Interest ..... 5(a)

(b) Failure to Pay Penalty ..... 5(b)

(c) Failure to File Penalty ..... 5(c)

5 TOTAL (Sum of Line 5(a) through Line 5(c) 5

STEP 5 Balance Due

6 Balance Due (Line 4 plus Line 5) 6

STEP 6 For Amended Returns or Overpayment ONLY

NOTE: Do Not complete Step 6, Lines 7-10, unless you are filing an amended return.

7 Payments Made by Electronic Transfer 7

8 Adjusted BALANCE DUE [Line 6 minus Line 7]. Do not pay if less than $1.00 8
If a negative amount, enter zero and go to Line 9.

9 Overpayment 9
(Line 2 minus Line 3 plus Line 5, minus Line 7 if applicable)

10 Apply Overpayment to Credit on subsequent return payment 10

STEP 7 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 authorized Nursing Facility Representative, 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 Nursing Facility Representative

Preparer's Tax Identification Number Date

Preparer's Address

City/Town, State & Zip Code

MAIL TO:	NH DEPT OF REVENUE ADMINISTRATION DOCUMENT PROCESSING DIVISION PO BOX 1004 CONCORD NH 03302-1004
and a COPY TO:	NH DEPT OF HEALTH & HUMAN SERVICES BUREAU OF ELDERLY & ADULT SERVICES RATE SETTING & AUDIT UNIT 129 PLEASANT STREET CONCORD NH 03301-3857

FORM

DP-156

INSTRUCTIONS

NEW HAMPSHIRE DEPARTMENT OF REVENUE ADMINISTRATION

NURSING FACILITY QUALITY ASSESSMENT RETURN

GENERAL INSTRUCTIONS

WHAT IS IT	Pursuant to RSA 84-C:2, there's an assessment of 6% of net patient service revenues on all nursing facilities on the basis of patient days in each nursing facility.
WHO PAYS IT	All nursing facilities in New Hampshire. Nursing facility means all nursing facilities licensed by the New Hampshire Department of Health and Human Services as defined by RSA 151-E:2,V.
WHEN IS THE RETURN DUE	Quarterly returns are due the 10th day of the month following the close of the assessment period, unless you have received an extension to file or payment plan approval from the Commissioner of Revenue Administration. Period: January 1 - March 31 Due April 10 Period: April 1 - June 30 Due July 10 Period: July 1 - September 30 Due October 10 Period: October 1 - December 31 Due January 10
WHERE TO FILE THE RETURN	Completed returns shall be filed with: NH Department of Revenue Administration Document Processing Division PO Box 1004 Concord, NH 03302-1004 And a copy shall be sent to: NH Department of Health & Human Services Bureau of Elderly & Adult Services Rate Setting & Audit Unit 129 Pleasant Street Concord, NH 03301-3857
WHEN TO MAKE PAYMENTS	Pursuant to RSA 84-C:3, payments shall be made electronically no later than the fifteenth day of the month following the assessment period. No penalty or interest will be assessed if payment is made on or before the last day of the month it is due. A completed Form DP-156-ACH must be submitted 30 days prior to the first return to facilitate the initiation of ACH Debit payments.
STEP 1 NAME & ID	Enter the Nursing Facility name, address, and federal employer identification number in the spaces provided.
STEP 2 RETURN TYPE	Please check whether this is an:- **Initial return** - First return ever filed by the facility; **Final return** - Last return to be filed by the facility; or **Amended return** - Used to report audit adjustments. Adjustments as a result of late notice of qualified beds should be reported as Prior Quarter Adjustments (P.P.A.) using worksheet.
STEP 3 ASSESSMENT	Line 1 Enter the net patient services revenue for the assessment period as defined by RSA 151, E:2,V. Line 2 Enter your New Hampshire Nursing Facility Quality Assessment by multiplying Line 1 by .06.
STEP 4 CREDITS INTEREST PENALTIES	Line 3(a) Enter payments made with extension. Line 3(b) Enter credit carried over from prior return, if applicable. Line 3(c) If this is an amended return, enter the original return payments. Line 3 Enter the sum of Lines 3(a), 3(b) and 3(c) on Line 3. Line 4 Calculate the balance of Assessment Due - Line 2 less Line 3. Line 5(a)-(c) Additions to assessment. Enter on Lines 5(a) through 5(c) any applicable interest and penalties for late payment or late filing. Calculate your interest and penalties, if any, as follows, and enter them on Lines 5(a) through 5(d). Line 5(a) Interest: Interest is calculated on the balance of assessment due from the original due date to the date paid at the applicable rate listed below. Assessment due x number of days from due date to date tax was paid x daily rate decimal equivalent. _____ X _____ X ___._____ = _____ Enter on Line 5(a). Assessment Due Number of Days Daily Decimal Rate Equivalent Interest Due PERIOD RATE DAILY RATE DECIMAL EQUIVALENT 1/1/2007 - 12/31/2007 10% .000274 1/1/2006 - 12/31/2006 8% .000219 1/1/2005 - 12/31/2005 6% .000164 1/1/2004 - 12/31/2004 7% .000191 Line 5(b) FAILURE TO PAY: A penalty equal to 10% of any nonpayment or underpayment of assessment 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 5(c) FAILURE TO FILE: A taxpayer failing to timely file a complete return may be subject to a penalty equal to 5% of the assessment due for each month or part thereof that the return remains unfiled or incomplete. The total amount of this penalty shall not exceed 25% of the balance of assessment due. Calculate this penalty starting from the original due date of the return until the date a complete return is filed. Line 5 Enter the sum of Lines 5(a) through 5(c) on Line 5. If zero, enter 0.
STEP 5 BALANCE DUE	Line 6 Enter the balance of Line 4 plus Line 5. This represents the amount to be debited to your bank account 2 days prior to the last business day of the month, but not later than the last day of the month.
STEP 6 AMENDED RETURNS OR OVER PAYMENTS	**NOTE: Do Not complete Step 6, Lines 7-10, unless you are filing an amended return.** Line 7 Enter payments made by electronic transfer. Line 8 Enter the balance of Line 6 minus Line 7. If a negative amount, enter zero and go to Line 9. (File the return but do not pay if less than $1.00.) Line 9 Overpayment - Line 2, minus Line 3, plus Line 5, minus Line 7 if applicable. Line 10 Enter on Line 10 any overpayment you want credited to your next return, if applicable.
STEP 7 SIGNATURES	**Original signatures (in ink)** of Officer or authorized agent are required on all returns.