**New Hampshire Department of Revenue Administration**

**DP-156 Nursing Facility Quality Assessment Return**

**For Assessment Period: Check One**

- January 1 - March 31
- April 1 - June 30
- July 1 - September 30
- October 1 - December 31

**2019** [ ] **2020** [ ]

**STEP 1**

**NURSING FACILITY NAME**

**TAXPAYER IDENTIFICATION NUMBER**

**NUMBER AND STREET ADDRESS**

**ADDRESS (continued)**

**CITY/TOWN/STATE & ZIP CODE**

**STEP 2**

**Return Type**

- INITIAL RETURN [ ]
- AMENDED RETURN [ ]
- FINAL RETURN [ ]
- LAST DAY OF BUSINESS

**MO** [ ] **DAY** [ ] **YEAR** [ ]

**STEP 3**

**Calculate Your Assessment**

1. Net Patient Services Revenues ........................................ 1
2. New Hampshire Nursing Facility Quality Assessment ........................................ 2
   [Line 1 x 5.5% (.055)]

**STEP 4**

**Credits: Interest and Penalties**

3. (a) Payment made with extension .......................... 3(a)
   (b) Credit carried over from prior period ........... 3(b)
   (c) Original Return Payment ................................. 3(c)

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

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

**STEP 5**

**Balance Due**

5. Balance Due (Line 4 plus Line 5) ........................................ 5

**STEP 6**

**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:**

**Print Signatory Name & Title:**

**Preparer's Tax Identification Number:**

**Date:**

**Preparer's Address:**

**City/Town, State & Zip Code:**

**MAIL TO:**

NH DRA
TAXPAYER SERVICES
PO BOX 3306
CONCORD NH 03302-3306

**COPY TO:**

NH DHHS
FINANCE-RATE SETTING UNIT
129 PLEASANT STREET
CONCORD NH 03301-3857

**DP-156**

Rev 1.2/1.9
WHAT IS IT
Pursuant to RSA 84-C:2, there is an assessment of 5.5% of net patient services 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, and facilities licensed as a specialty hospital and certified to receive federal reimbursement as a nursing facility.

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.

WHERE TO FILE THE RETURN
Completed returns shall be filed with:

NH DRA
Taxpayer Services
PO Box 3306
Concord, NH 03302-3306

And a copy shall be sent to:

NH DHHS
Finance-Rate Setting 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.

GENERAL INSTRUCTIONS

STEP 1: NAME ADDRESS & TAXPAYER IDENTIFICATION NUMBER
Enter the Nursing Facility name, address, and Taxpayer 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 and indicate last day of business; or Amended return - Used to report audit adjustments. Adjustments as a result of late notice of qualified beds should be reported as Prior Period Adjustments (P.P.A.) using NFQA Calculation worksheet.

STEP 3: CALCULATE YOUR ASSESSMENT
Line 1
Enter the net patient services revenue for the assessment period as defined by RSA 84-C:1.

Line 2
Enter your New Hampshire Nursing Facility Quality Assessment by multiplying Line 1 by .055.

STEP 4: CREDITS INTEREST AND PENALTIES
Line 3(a)
Enter payments made with extension.

Line 3(b)
Enter credit carried over from prior return, if applicable.
INSTRUCTIONS -continued

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.

Lines 5(a) through 5(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(c).

Line 5(a)
INTEREST: Enter in the amount of any interest due. 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 multiplied by number of days from due date to date tax was paid multiplied by daily rate decimal equivalent.

\[
\text{Interest due} = \frac{\text{Assessment Due} \times \text{Number of Days}}{\text{Daily Decimal Rate Equivalent}}
\]

**NOTE:** The interest rate is recomputed each year under the provisions of RSA 21-J:28, II. Applicable rates are as follows:

<table>
<thead>
<tr>
<th>PERIOD</th>
<th>RATE</th>
<th>DAILY RATE DECIMAL EQUIVALENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/1/2019 - 12/31/2019</td>
<td>7%</td>
<td>0.000192</td>
</tr>
<tr>
<td>1/1/2017 - 12/31/2018</td>
<td>6%</td>
<td>0.000164</td>
</tr>
<tr>
<td>1/1/2013 - 12/31/2016</td>
<td>5%</td>
<td>0.000137</td>
</tr>
<tr>
<td>1/1/2010 - 12/31/2012</td>
<td>6%</td>
<td>0.000164</td>
</tr>
</tbody>
</table>

Contact the Department for applicable rates for any other tax periods.

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.