New Hampshire
Department of
Revenue Administration

DP-153
Medicaid Enhancement Tax Return

FOR DRA USE ONLY

For the TAXABLE period beginning July 1, 2018 and ending June 30, 2019, 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: ☐ INITIAL RETURN ☐ FINAL RETURN ☐ AMENDED RETURN For Taxable Period ending: _____

STEP 2 Calculate your Tax

Round to the nearest whole dollar

1	Gross Charges: (a) Inpatient Hospital Services ..... 1(a)	
	(b) Outpatient Hospital Services ..... 1(b)	
	TOTAL GROSS CHARGES (Sum of Lines 1a and 1b) 1	
2	Net Excluded Charges For Outpatient Hospital Services from attached schedule Line 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 4a, 4b, and 4c) 4	
5	Net Patient Services Revenue (Line 3 minus Line 4) 5	
6	New Hampshire Medicaid Enhancement Tax (Line 5 x applicable tax rate) 6	

STEP 3 Credits Interest and Penalties

7	Credits: (a) Credit Carryover from prior tax period .....7(a)	
	(b) Payment made with original return (Amended returns only)...7(b)	
	TOTAL CREDITS (Sum of Lines 7a and 7b).....7	
8	BALANCE OF TAX DUE (Line 6 less Line 7) 8	
9	Additions to Tax	
	(a) Interest ..... 9(a)	
	(b) Failure to Pay ..... 9(b)	
	(c) Failure to File ..... 9(c)	
	TOTAL ADDITIONS TO TAX (Sum Lines 9(a), 9(b), and 9(c).....9	

STEP 4 Balance Due or Overpay-ment

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 ..... 12(a)	
	(b) Refund ..... 12(b)	

STEP 5 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 taxpayer, this declaration is based on all information of which the preparer has knowledge.

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Signature of Officer (in ink) Date

Print Signatory Name & Title

Officer's Telephone Number

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

Signature (in ink) of Paid Preparer Other Than Taxpayer Date

Print Preparer's Name & Tax Identification Number

Preparer's Address

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 Taxpayer 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 the applicable tax rate in the chart below.

INSTRUCTIONS - continued

Line 6 continued: Medicaid Enhancement Tax Rates

TAXABLE PERIOD	RATE
7/1/2016 - Present	5.4%
7/1/2015 - 6/30/2016	5.45%
Ending on or before June 30, 2015	5.5%

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 below.

_____ x _____ x __•_____ = **Interest due**

Tax Due | Number of Days | Daily Decimal Rate Equivalent | [Enter on Line 9(a)]

PERIOD	RATE	DAILY RATE DECIMAL EQUIVALENT
1/1/2019 - 12/31/2019	7%	.000192
1/1/2017 - 12/31/2018	6%	.000164
1/1/2013 - 12/31/2016	5%	.000137
Contact the Department for applicable rates for any other tax periods.		

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: Enter the sum of Lines 9(a) through 9(c) 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.