New Hampshire
Department of
Revenue Administration

DP-153

MEDICAID ENHANCEMENT TAX RETURN
GENERAL INSTRUCTIONS

WHO MUST FILE
The Medicaid Enhancement Tax Return must be filed by every hospital required to be licensed under RSA 151 that provides 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. Taxable period, as defined in RSA 84-A:1, V, means a 12-month period beginning July 1 and ending June 30.

NOTE: If the fifteenth falls on a Saturday, Sunday, or legal holiday, the return is due on the next business day.

WHERE TO FILE
Medicaid Enhancement tax returns may be submitted electronically through the DRA's online portal, Granite Tax Connect (GTC), at www.revenue.nh.gov/gtc or mailed to: NH DRA, PO Box 637, Concord, NH 03302-0637. Tax payments are required to be made electronically on GTC or by wire transfer to the NH State Treasurer.

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?
Call the Department of Revenue Administration, Taxpayer Services at (603) 230-5920. Individuals with hearing or speech impairments may call TDD Access: Relay NH 1-800-735-2964.

LINE-BY-LINE INSTRUCTIONS
Continue onto page 2 for line-by-line instructions.

Enter the tax period begin and end dates.

STEP 1 - PRINT OR TYPE

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

STEP 2 - TYPE OF RETURN

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 3 - CALCULATE YOUR BALANCE DUE OR OVERPAYMENT

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 (Form DP-153-SCH), 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), 4(b), and 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.

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%

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
Total Credits; enter the sum of Lines 7(a) and 7(b).

LINE 8
Calculate the balance of tax due. Line 6 minus Line 7.

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.

TAX DUE	x	NUMBER OF DAYS	x	• DAILY DECIMAL RATE EQUIVALENT	=	**INTEREST DUE** [ENTER ON LINE 9(a)]

PERIOD	RATE	DAILY RATE DECIMAL EQUIVALENT
1/1/2024 - 12/31/2024	9%	.000247
1/1/2023 - 12/31/2023	7%	.000192
1/1/2021 - 12/31/2022	5%	.000137
1/1/2019 - 12/31/2020	7%	.000192
1/1/2017 - 12/31/2018	6%	.000164
1/1/2013 - 12/31/2016	5%	.000137
1/1/2010 - 12/31/2012	6%	.000164

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 assessment or $10, whichever is greater, for the tax 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 tax due or $50, whichever is greater. 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.

LINE 10
Enter the Balance Due by calculating Line 8 plus Line 9. This is the amount to be paid online at www.revenue.nh.gov/gtc or by wire transfer to the NH State Treasurer by April 15th. If the result is less than zero, enter amount on Line 11.

LINE 11
If total tax (Line 6) plus interest and penalties (Line 9) is less than credits (Line 7), you have an overpayment. Enter the amount of overpayment on Line 11.

LINE 12(a)
Enter the overpayment amount from Line 11 to be credited to the next year's tax liability.

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

STEP 4 - 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.