DO NOT STAPLE

New Hampshire
Department of
Revenue Administration

DP-153

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0DP1532411862

MEDICAID ENHANCEMENT TAX RETURN

Tax Period Begin Date (MMDDYYYY): 01012024

Tax Period End Date (MMDDYYYY): 12312024

STEP 1 - PRINT OR TYPE

Name of Hospital: GENERAL HOSPITAL

Taxpayer Identification Number: 123456789

Number & Street Address: 123 ABCDEFG DR

Hospital Fiscal Year End Date: 06302024

Address (continued): UNIT 3

City / Town: LEBANON

State: NH

Zip Code + 4 (or Canadian Postal Code): 03215

STEP 2 - Type of Return (check if applicable)

☐ Initial Return (1st filing) ☐ Amended Return ☒ Final Return Last Day of Business: 12312024

STEP 3 - Calculate Your Balance Due or Overpayment

Round to the nearest whole dollar

1. Gross Charges: (a) Inpatient Hospital Services	1(a)	250750
(b) Outpatient Hospital Services	1(b)	150450
Total Gross Charges (Sum of Lines 1(a) and 1(b))	1	401200
2. Net Excluded Charges for Outpatient Hospital Services from Form DP-153-SCH, Line 21	2	26450
3. Subtotal (Line 1 minus Line 2)	3	374750
4. Deductions: (a) Bad Debts	4(a)	35500
(b) Charity Care	4(b)	1500
(c) Payor Discounts	4(c)	7550
Total Deductions (Sum of Lines 4(a), 4(b), and 4(c))	4	44550
5. Net Patient Services Revenue (Line 3 minus Line 4)	5	330200
6. New Hampshire Medicaid Enhancement Tax (Line 5 multiplied by applicable tax rate)	6	17831
7. Credits: (a) Credit Carryover from prior tax period	7(a)	10000
(b) Payment made with original return (Amended returns only)	7(b)	5000
Total Credits (Sum of Lines 7(a) and 7(b))	7	15000
8. Balance of Tax Due (Line 6 less Line 7)	8	2831

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STEP 3 - Calculate Your Balance Due or Overpayment - continued

9. Additions: (a) Interest	9(a)	1750
(b) Failure to Pay Penalty	9(b)	
(c) Failure to File Penalty	9(c)	550
Total Additions (Enter the sum of Lines 9(a), 9(b), and 9(c))	9	2300
10. Balance Due (Line 8 plus Line 9)	10	5131
11. Overpayment: Enter balance due if less than zero	11	
12. Apply overpayment to: (a) Credit - Next Year's Tax Liability	12(a)	
(b) Refund	12(b)	

STEP 4 - 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 person owning or operating the utility, this declaration is based on all information of which the preparer has knowledge.

Signature of Officer (in ink)

MMDDYYYY: 12152024

Print Signatory Name & Title: ADAM RYKARD/MANAGER

Phone Number: 6031234567

Signature of Preparer

MMDDYYYY: 12152024

Printed Name of Preparer: SAMANTHA MUGGLE

Preparer's Tax Identification Number: 123456789

Preparer's Address: 789 CENTRAL ST

Phone Number: 6031234567

Address (continued): APT 7

City / Town: MANCHESTER

State: NH

Zip Code + 4 (or Canadian Postal Code): 03103

FILE ONLINE AT GRANITE TAX CONNECT
gtc.revenue.nh.gov/TAP/_/

Or mail to: NH DRA
PO BOX 637
CONCORD NH 03302-0637