

FORM 207 HCC

HEALTH CARE CENTER TAX RETURN

(Rev. 12/99)

SEE INSTRUCTIONS ON REVERSE BEFORE COMPLETING THIS FORM

1. Due Date: This return must be filed on or before March 1 following the close of the calendar year. If the due date falls on a Saturday, Sunday or a legal holiday, the next business day will be the due date.
2. A copy of Schedule N and the Statement of Revenue, Expenses and Net Worth from the Annual Statement filed with the Insurance Department must accompany this return.
3. If this is an amended return enter the calendar year of the return which you are amending: _____.

▶	Connecticut Tax Registration Number
▶	For Calendar Year
▶	Date Received (For Department Use Only)
▶	Federal Employer Identification Number

1. Total net direct subscriber charges (less returned charges, including cancellations). Please see instructions on reverse	▶	1		
2. Health care center tax: <i>Multiply Line 1 by 1.75% (.0175)</i>	▶	2		
3. Total Connecticut business tax credits (<i>attach Form CT-1120K</i>)	▶	3		
4. Net tax (<i>Subtract Line 3 from Line 2. If result is negative, enter 0</i>)	▶	4		
5. Overpayment from prior year.	▶	5		
6. Payments made with estimated tax payment coupons (Forms 207 HCC ESA, ESB, ESC and ESD)	▶	6		
7. Payments made with extension request (Form 207 HCC EXT)	▶	7		
8. Total prior payments (<i>Add Lines 5, 6 and 7</i>)	▶	8		
9. Balance of tax due/overpaid (<i>Subtract Line 8 from Line 4</i>)	▶	9		
10. Penalty (See instructions) (10a) ▶ \$ _____ plus Interest (10b) ▶ \$ _____ =	▶	10		
11. Interest on underpayment of estimated tax (Form 207 I)	▶	11		
12. Total penalty and interest (<i>Add Line 10 and Line 11</i>)	▶	12		
13. Amount to be credited to an estimated return (13a) ▶ \$ _____ amount of refund (13b) ▶ \$ _____ =	▶	13		
14. Balance due with this return (<i>Add Line 9 and Line 12</i>) (<i>Make check payable to: Commissioner of Revenue Services</i>)	▶	14		

DECLARATION: I declare under the penalties of false statement that I have examined this return, **FORM 207 HCC**, *Health Care Center Tax Return*, and to the best of my knowledge and belief it is true, complete, and correct. (The penalty for false statement is imprisonment not to exceed one year or a fine not to exceed two thousand dollars, or both.) Declaration of preparer (other than the taxpayer) is based on all information of which preparer has any knowledge.

Sign Here Keep a copy of this return for your records	Signature of Principal Officer	Title	Date	Telephone Number ()
	Print Name of Principal Officer			
	Paid Preparer's Signature		Date	
	Firm Name and Address			▶ Federal Employer Identification Number

INSTRUCTIONS

Health care centers providing contracts or policies to direct subscribers must file **Form 207 HCC**, *Health Care Center Tax Return*, or **Form 207 HCC EXT**, *Extension to File Health Care Center Tax Return*, by March 1 following the close of the calendar year. Any balance due with this return must be paid with **Form 207 HCC** or **Form 207 HCC EXT** to be considered timely.

Line 1: Enter the total net direct subscriber charges received on any new or renewal contract for the calendar year. Note that the following net direct subscriber charges are not subject to the tax and should not be included on Line 1:

1. Any new or renewal contract or policy entered into with the state on or after July 1, 1997, to provide health care coverage to state employees, retirees and their dependents.
2. Any subscriber charges received from the federal government to provide coverage for Medicare patients.
3. Any subscriber charges attributable to a period on or after January 1, 1998, which are received under a contract or policy entered into with the State to provide health care coverage to Medicaid recipients under the Medicaid managed care program established under Conn. Gen. Stat. §17b-28, which charges are attributable to a period on or after January 1, 1998.
4. Any new or renewal contract or policy entered into with the State on or after April 1, 1998, to provide health care coverage to eligible beneficiaries under the Husky Plan, or the Husky Plus Programs, as defined in Conn. Gen. Stat. §17b-290, or to provide health care coverage to recipients of state administered general assistance under Conn. Gen. Stat. §17b-257.

Line 2: Multiply Line 1 by 1.75% (.0175).

Line 3: Enter the total tax credits that may be claimed against the Health Care Center Tax.

If you claim a Neighborhood Assistance Act credit: Documentation from the Department of Revenue Services approving the proposal and stating the maximum credit allowable with this return must accompany this return.

If you claim an Employer-Assisted Housing credit: Documentation from the Connecticut Housing Finance Authority (CHFA) approving the credit must accompany this return.

If you claim a Housing Program Contribution credit: A copy of the tax credit voucher issued by CHFA must accompany this return.

If you have a Child Day Care credit carryforward: Proof of the approved credit by the Commissioner of Social Services must accompany this return.

If you claim an Electronic Data Processing Equipment Property Tax credit: A copy of **Form CT-1120K**, **Form CT-1120 EDP**, **Form M-15** and the applicable property tax bill must accompany this return.

Note: The allowable Electronic Data Processing Equipment Property Tax Credit must first be applied

against Connecticut Corporation Business Tax. The remaining credit may be applied to this tax.

If you claim a Connecticut Insurance Reinvestment Fund Credit: A copy of documentation from the Department of Economic and Community Development, a copy of **Form CT-1120K** and **Form CT-IRF** must accompany this return.

Line 4: Subtract Line 3 from Line 2. If the result is negative, enter zero.

Line 5: Enter any overpayments from prior year applied to current year.

Line 6: Enter any estimated payments made with **Forms 207 HCC ESA, ESB, ESC, and ESD**.

Line 7: Enter payments made with **Form 207 HCC EXT**

Line 8: Add Lines 5, 6, and 7.

Line 9: Subtract Line 8 from Line 4.

Line 10: Complete Line 10a and Line 10b if you reported tax due on Line 9 that was not paid by the due date.

Line 10a: Late Payment Penalty: Multiply Line 9 by 10% (.10). If tax is due, enter the result or \$50, whichever is greater.

Late Filing Penalty: According to Conn. Gen. Stat. §12-30, the Commissioner of Revenue Service may impose a \$50 penalty for failure to file any tax return that is required by law to be filed.

Line 10b: Multiply Line 9 by 1% (.01) per month or fraction of a month from the original due date of the return to the date of payment.

Line 11: If estimated tax was underpaid, complete and attach **Form 207 I** and enter the total interest due from **Form 207 I**.

Line 12: Add Line 10 and Line 11.

Line 13a: Enter amount of overpayment on Line 9 to be credited to estimated tax.

Line 13b: Enter the amount of overpayment on Line 9 to be refunded.

Line 14: If Line 9 is greater than or equal to zero, add Line 9 and Line 12.

Make check payable to:

COMMISSIONER OF REVENUE SERVICES

Mail to: Department of Revenue Services
PO Box 2990
Hartford CT 06104-2990