Illinois Department of Revenue

PTAX-300-H Application for Hospital Property Tax Exemption — County Board of Review Statement of Facts

Complaint no.: _____ (County use only) Volume no.: _____ IDOR docket number: _____ (IDOR use only)

Step 1: Identify the property

1 _____
Name of hospital or affiliate applying for exemption

2 _____
Street address of hospital or affiliate

_____ IL _____
City ZIP

3 _____
County in which hospital or affiliate is located

4 Dimensions or acreage of this property_____
Attach a plot plan of each building's location on the property

5 Date of ownership __ __/__ __/__ __ __ __
Attach a copy of proof of ownership (deed, contract for deed, title insurance policy, condemnation order, and proof of payment, etc.)

6 Check the relevant hospital entity:
___ hospital owner - write the license number: _____
___ hospital affiliate - explain relationship: _____
___ hospital system - explain relationship: _____

Step 2: Provide information about exemptions or applications

7 For what year is this exemption being sought? _____

8 If the applicant has an Illinois sales tax exemption number, write it here. E— ___ ___ ___ ___ — ___ ___ ___ ___

Step 3: Provide the following about the services and activities for the relevant hospital entity

9 Check what the value of services and activities below reflect: ____ hospital year ____average of 3 fiscal years ending with hospital year

10 What is your fiscal year? _____

11 Write the amount of charity care provided. ***Attach most recently filed Form AG-CBP-I.*** **11** _____

12 Write the amount of unreimbursed costs for health services provided to low-income and underserved individuals. ***Attach a list of identifying activities or services provided.*** **12** _____

13 If the hospital gives a subsidy to a state or local government, write the total amount. ***Attach a list identifying each entity and the amount.*** **13** _____

14 If the hospital gives support for Illinois health care programs to low-income individuals, write the amount. ***Attach the most recently filed federal Form 990, Schedule H.*** **14** _____

15 If the hospital provides a dual-eligible subsidy by treating Medicare/Medicaid patients, multiply
1) the hospital's ratio of dual-eligible patients to the total number of Medicare patients by
2) the total of unreimbursed costs of Medicare.

_____ / _____ X $ _____ =
1) ratio 2) unreimbursed Medicare **15** _____

16 If the hospital provided relief for the government as it relates to health care services for low income individuals, write the total low-income portion of unreimbursed costs. ***Attach Schedule A and a copy of the CMS 2552-10, Worksheet C, Part 1.*** **16** _____

17 Other. See instructions and identify: _____ **17** _____

Step 4: Calculate and determine the exemption

18 Add Lines 11 through 17 and enter the total amount of services or activities provided. **18** _____

19 Has the property been assessed?

☐ Yes. Write the amount of the actual property tax from your property tax bill or the estimated property tax from Schedule E, Line 18, whichever is less. ***Attach the tax bill.***

☐ No. Write the estimated property tax amount from Schedule E, Line 18. ***Attach Schedule E.*** **19** _____

If Line 19 is equal to or less than Line 18, you qualify for this exemption.
If Line 19 is greater than Line 18, you do not qualify for this exemption.

20 Is any part of this property leased? **20** ☐ Yes ☐ No
If "yes", attach a copy of any contracts or leases.

21 If the assessed or estimated assessed value is $100,000 or more, has the municipality, school district, community college district, and fire protection district in which the property is located been notified that this application has been filed? **21** ☐ Yes ☐ No
Attach a copy of the notices and postal return receipts.

Step 5: Identify the person to contact regarding this application

22 _____
Name of applicant's representative

_____
Mailing address

_____
City State ZIP

( ) —
_____
Phone number

23 _____
Owner's name (if the applicant is not the owner)

_____
Mailing address

_____
City State ZIP

( ) —
_____
Phone number

Step 6: Signature and notarization

State of Illinois) SS.
County of _____)

I, _____, _____, being duly sworn upon oath, say that I have read
Name Position
the foregoing application and that all of the information is true and correct to the best of my knowledge and belief.

_____
Affiant's signature

Subscribed and sworn to before me this _____ day of _____, 2_____.

_____
Notary Public

County official use only. Do not write below this line.

Step 7: County board of review statement of facts

1 Current assessment $_____ For assessment year 2_____

2 Is this exemption application for a leasehold interest assessed to the applicant? ☐ Yes ☐ No
If "Yes", write the Illinois Department of Revenue docket number for the exempt fee interest to the owner, if known. ___ ___ — ___ ___ ___ — ___ ___ ___ ___

3 State all of the facts considered by the county board of review in recommending approval or denial of this exemption application.

_____
_____
_____

4 County board of review recommendation
___ Full year exemption
___ Partial year exemption from ___ ___ / ___ ___ / ___ ___ ___ ___ to ___ ___ / ___ ___ / ___ ___ ___ ___
___ Partial exemption for the following described portion of the property: _____
_____
___ Deny exemption

5 Date of board's action ___ ___ / ___ ___ / ___ ___ ___ ___

Step 8: County board of review certification

I certify this to be a correct statement of all facts arising in connection with proceedings on this exemption application.

_____
Signature of clerk of county board of review

Mail to: OFFICE OF LOCAL GOVERNMENT SERVICES MC 3-520
ILLINOIS DEPARTMENT OF REVENUE
101 WEST JEFFERSON STREET
SPRINGFIELD IL 62702

This application must be completed in its entirety and all supporting documentation must be attached. All incomplete applications will be returned.

Step 1: Identify the property

Line 4 — Write the dimensions (square footage) or acreage of this property. **Attach a plot plan of each building's location and use of the property.**

Line 5 — Write the date on which ownership began. **Attach a copy of proof of ownership (deed, contract for deed, or title insurance policy, *etc.*).**

Line 6 — Check the relevant hospital entity—hospital owner, hospital affiliate, or hospital system. If you check "hospital affiliate" or "hospital system", describe the type of entity (*e.g.*, corporation, partnership, limited liability company) and the relationship with one or more hospital owners.

Definitions

Hospital - Any institution, place, building, buildings on a campus, or other health care facility located in Illinois that is licensed under the Hospital Licensing Act and has a hospital owner.

Hospital owner - A not-for-profit corporation that is the title holder of a hospital, or the owner of the beneficial interest in an Illinois land trust that is the titleholder of a hospital.

Hospital affiliate - Any corporation, partnership, limited partnership, joint venture, limited liability company, association or other organization, other than a hospital owner, that directly or indirectly controls, is controlled by, or is under common control with one or more hospital owners and that supports, is supported by, or acts in furtherance of the exempt health care purposes of at least one of those hospital owners' hospitals.

Hospital system - A hospital and one or more other hospitals or hospital affiliates related by common control or ownership.

Step 2: Provide information about exemptions or applications

Follow the instructions on the form.

Step 3: Provide the following about the services and activities for the relevant hospital entity

Line 9 — Check whether the figures for services and activities you will enter on Lines 11 through 17 are for the hospital year or the average of the previous three fiscal years ending with the hospital year.

Hospital year - The fiscal year of the relevant hospital entity, or the fiscal year of one of the hospital owners in the hospital system if the relevant hospital entity is a hospital system with members with different fiscal years, that ends in the year for which the exemption is sought.

Line 11 — ***Charity care*** — Free or discounted services provided pursuant to the Relevant Hospital Entity's financial assistance policy, measured at cost, including discounts provided under the Hospital Uninsured Patient Act. **Attach Form AG-CBP-I.**

Line 12 — ***Health services to low-income and underserved individuals*** — Unreimbursed costs of the Relevant Hospital Entity for providing without charge, paying for, or subsidizing goods, activities, or services for the purpose of addressing the health of low-income or underserved individuals. Those activities or services may include, but are not limited to, financial or in-kind support to affiliated or unaffiliated hospitals, hospital affiliates, community clinics, or programs that treat low-income or underserved individuals; providing or subsidizing outreach or educational services to low-income or underserved individuals for disease management and prevention; free or subsidized goods, supplies, or services needed by low-income or underserved individuals because of their medical condition; and prenatal or childbirth outreach to low-income or underserved persons. **Attach a list of identifying activities or services provided.**

Line 13 — ***Subsidy of state or local governments*** — Direct or indirect financial or in-kind subsidies of state or local governments by the Relevant Hospital Entity that pay for or subsidize activities or programs related to health care for low-income or underserved individuals.

Line 14 — ***Support for state health care programs for low-income individuals*** — At the election of the Hospital Applicant for each applicable year, either

- 10 percent of payments to the Relevant Hospital Entity and any Hospital Affiliate designated by the relevant Hospital Entity (provided that such hospital affiliate's operations provide financial or operational support for or receive financial or operational support from the Relevant Hospital Entity) under Medicaid or other means-tested programs, including, but not limited to, General Assistance, the Covering ALL KIDS Health Insurance Act, and the State Children's Health Insurance Program; or
- the amount of subsidy provided by the Relevant Hospital Entity and any hospital affiliate designated by the Relevant Hospital Entity (provided that such hospital affiliate's operations provide financial or operational support for or receive financial or operational support from the Relevant Hospital Entity) to state or local government in treating Medicaid recipients and recipients of means-tested programs, including but not limited to General Assistance, the Covering ALL KIDS Health Insurance Act, and the State Children's Health Insurance Program.

The amount of subsidy for purposes of the item is calculated in the same manner as unreimbursed costs are calculated for Medicaid and other means-tested government programs on federal Form 990, Schedule H. Unreimbursed costs shall be net of fee-for-services payments, payments pursuant to an assessment, quarterly payments, and all other payments included on the Schedule H.

Line 15 — ***Dual-eligible subsidy*** — This is the amount of subsidy provided to the government by treating dual-eligible Medicare/Medicaid patients. The amount of subsidy is calculated by multiplying the Relevant Hospital Entity's ratio of dual-eligible patients to total Medicare patients by the Relevant Hospital Entity's unreimbursed costs for Medicare (calculated in the same manner as federal Form 990, Schedule H).

Line 16 — ***Relief of the burden of government related to health care of low-income individuals*** — **Complete Schedule A and attach it and a copy of the CMS 2552-10 Worksheet C, Part 1**.

Line 17 — Enter any other activity by the hospital that the department determines relieves the burden of government or addresses the health of low-income or underserved individuals. Clearly specify the service or activity. **Attach all supporting documentation.**

Step 4: Calculate and determine the exemption

Follow the instructions on the form. All lines must be completed.

Step 5: Identify the person to contact regarding this application

Follow the instructions on the form.

Step 6: Signature and notarization

The application must be signed under oath, verifying that all of the information is true and correct to the best of the applicant's knowledge and belief. **This application must be notarized** before sending to the county board of review.