Illinois Department of Revenue

PTAX-300-HA Affidavit for Hospital Property Tax Exemption — (35 ILCS 200/15-10e)

Step 1: Identify the property

1 _____
Name of hospital or affiliate filing the affidavit

2 _____
Street address of hospital or affiliate

_____ IL _____
City ZIP

3 _____
County in which property is located

4 Provide the Department of Revenue Docket number for which this affidavit is being filed. _____

5 Write the assessment year for which this affidavit is being filed. _____

6 What is your fiscal year? _____

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

8 Property index numbers (PIN) included in this affidavit.
_____
_____
(Continue on back page.)

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

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

Step 2: Provide the following about the services and activities for the relevant hospital entity

11 Write the amount of charity care provided. **11** _____

12 Write the amount of unreimbursed costs for health services provided to low-income and underserved individuals. **12** _____

13 If the hospital gives a subsidy to a state or local government, write the total amount. **13** _____

14 If the hospital gives a subsidy for Illinois health care programs to low-income individuals, write the total amount. **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. **16** _____

17 The value of any other service or activity not reported above. **17** _____
Clearly specify the service or activity: _____

18 Total-Add Lines 11 through 17. **18** _____

19 What is the total amount of property taxes, actual or estimated, for all the exempt property the owner, affiliate, or system, identified on Line 7, owns for the tax year for which this affidavit is being submitted? **19** _____

20 Has the ownership or use of this property identified on Line 8 changed from the prior year? **20** ☐ Yes ☐ No

21 Have there been any changes from the prior year with respect to the leasing of any of the properties identified on Line 8? If yes, please explain and provide a copy of the rental agreement/lease. **21** ☐ Yes ☐ No

_____

Step 3: Signature and notarization

Under penalties of perjury, I state that, to the best of my knowledge, the information contained in this affidavit is true, correct, and complete.

_____ ____/____/_____
Signature Date

Contact phone number _____

Email address _____

Subscribed and sworn to before me this
_____day of _____, 20 ___.

_____
Notary public

Complete and submit this affidavit to the Chief County Assessment Officer.

--For county use only--

_____ _____/_____/_____
Authorized Signature of Chief County Assessment Officer Date

Instructions

Step 1: Identify the property

Lines 1-7 — Follow the instructions on the form.
Line 8 — List the property index numbers (PIN) included in this affidavit. If you need additional room to list multiple PINs, continue below.
Line 9 — Follow the instructions on the form.
Line 10 — Check whether the figures for services and activities you will enter on Lines 11 through 21 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.*

Step 2: Provide information about the services and activities for the relevant hospital entity

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.
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.
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*** — **From Schedule A**.
Line 17 — Enter the value of 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.
Line 18 — Add Lines 11-17 and enter the total here.
Line 19 — Write the amount of the actual property tax from the property tax bill or the estimated property tax from Schedule E, Line 18, whichever is less, for **all** of the exempt property the owner, affiliate, or system owns for the year for which this affidavit is being submitted. ***From Schedule E.***
Line 20 — Check yes or no if this property's ownership or use has changed.
Line 21 — Check yes or no if there have been any changes from the prior year with respect to the leasing of any of the properties identified on Line 8. If yes, enter a brief explanation and attach a copy of the rental agreement or lease.

Step 3: Signature and notarization

The affidavit 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 affidavit must be notarized** before sending to the Chief County Assessment Officer.

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8 **Additional** Property index numbers (PIN) included in this affidavit.