Illinois Department of Revenue

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

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

7 Property index numbers (PIN) included in your application for exemption.
_____
_____
Attach a separate sheet if needed. Attach a copy of the legal description if the property is a division.

Step 2: Provide information about exemptions or applications

8 For what year is this exemption being sought? _____

9 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

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

11 What is your fiscal year? _____

12 Write the amount of charity care provided. ***Attach most recently filed Form AG-CBP-I.*** **12** _____

13 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.*** **13** _____

14 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.*** **14** _____

15 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.*** **15** _____

16 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 **16** _____

17 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.*** **17** _____

18 Other. See instructions and identify: _____ **18** _____

Step 4: Calculate and determine the exemption

19 Add Lines 12 through 18 and enter the total amount of services or activities provided. **19** _____

20 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.*** **20** _____

If Line 20 is equal to or less than Line 19, you qualify for this exemption.
If Line 20 is greater than Line 19, you do not qualify for this exemption.

21 Is any part of this property leased? **21** ☐ Yes ☐ No
If "yes", attach a copy of any contracts or leases.

22 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? **22** ☐ Yes ☐ No
Attach a copy of the notices and postal return receipts.

Step 5: Identify the person to contact regarding this application

23 _____
Name of applicant's representative

_____
Mailing address

_____
City State ZIP

( ) —
_____
Phone number

24 _____
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.

Line 7 — List the property index numbers (PIN) included in your application for exemption. If you need additional room to list multiple PINs, attach a separate statement. **Attach a copy of the legal description if the property is a division.**

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 10 — Check whether the figures for services and activities you will enter on Lines 12 through 18 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 12 — ***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 13 — ***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 14 — ***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 15 — ***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 16 — ***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 17 — ***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 18 — 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.

Schedule A Calculation of Low-Income Portion of Unreimbursed Costs

Attach to Form PTAX-300-H

Step 1: Write the total of unreimbursed costs

1	Emergency	$_____	
2	Trauma	$_____	
3	Burn	$_____	
4	Neonatal	$_____	
5	Psychiatric	$_____	
6	Rehabilitation	$_____	
7	Medical education	$_____	
8	Research	$_____	
9	Other (describe)	$_____	
10	Other (describe)	$_____	
11	Total. Add Lines 1 through 10.		$_____

Step 2: Calculate the low-income ratio

12	Charity	$_____	
13	Medicaid	$_____	
14	Other means-tested programs	$_____	
15	Disabled Medicare for people less than 65 years of age	$_____	
16	Dual-eligible	$_____	
17	Add gross charges for Lines 12 through 16. This is your numerator.		$_____
18	Total gross charges. This is your denominator.		$_____
19	Multiply Line 17 by cost to charge ratio _____	=	$_____
20	Multiply Line 18 by cost to charge ratio _____	=	$_____
21	Divide Line 19 by Line 20. This is the low-income ratio.		_____

Step 3: Determine the low-income portion of unreimbursed costs

22	Multiply Line 11 by Line 21. Write this amount on Form PTAX- 300-H, Line 17.	$_____

General Instructions

The portion of unreimbursed costs of the Relevant Hospital Entity attributable to providing, paying for, or subsidizing goods, activities, or services that relieve the burden of government related to health care for low-income individuals. Examples of these activities or services are

- providing emergency, trauma, burn, neonatal, psychiatric, rehabilitation, or other special services;
- providing medical education; and
- conducting medical research or training of health care professionals.

The portion of those unreimbursed costs attributable to benefiting low-income individuals shall be determined using the ratio calculated by adding the Relevant Hospital Entity's costs attributable to charity care, Medicaid, other means-tested government programs, disabled Medicare patients under age 65, and dual-eligible Medicare/Medicaid patients and dividing that total by the Relevant Hospital Entity's total costs. Costs for the numerator and denominator shall be determined by multiplying gross charges by the cost to charge ratio taken from the most recently filed Medicare cost report (CMS 2552-10 Worksheet C, Part 1). In the case of emergency services, the ratio shall be calculated using costs (gross charges by the cost to charge ratio taken from the most recently filed Medicare cost report (CMS 2552-10 Worksheet C, Part 1)) of patients treated in the Relevant Hospital Entity's emergency department.

Schedule E Calculation of Estimated Property Tax for Relevant Hospital Entity

Attach to Form PTAX-300-H

Step 1: Describe the property

1 Use of property							
2 Address							
3 Property index numbers							

Step 2: Provide the estimated land value

4 Total assessed land value							

Step 3: Figure the estimated buildings value

5 Square footage of building							
6 Marshall & Swift Cost Manual	x	x	x	x	x	x	x
7 Total replacement cost	=	=	=	=	=	=	=
8 Actual age							
9 **Adjusted** remaining life							
10 Percentage of remaining life	x . ___ ___	x . ___ ___	x . ___ ___	x . ___ ___	x . ___ ___	x . ___ ___	x . ___ ___
11 Assessment factor	x	x	x	x	x	x	x
12 Assessed buildings value	=	=	=	=	=	=	=

Step 4: Figure the total estimated assessed value

13 Land value (Line 4)							
14 Buildings value (Line 12)	+	+	+	+	+	+	+
15 Total estimated value	=	=	=	=	=	=	=

Step 5: Figure the total estimated property tax

16 Add all Line 15 totals together. **16** _____

17 Multiply Line 16 by the state equalization rate: _____ **17** _____

18 Multiply Line 17 by the applicable tax rate: _____ Write this amount on PTAX-300-H, Line 20. **18** _____

Instructions for Schedule E

Step 2: Provide the estimated assessed land value

Line 4 – Total assessed land value - Determine a square foot average of assessed values of three parcels of land (not including farm land, and excluding the assessed value of the improvements thereon) that are reasonably comparable to the property. Multiply this average by the square foot of land for which the exemption is sought.

Step 3: Figure the estimated buildings value

Line 5 – Square footage of building – Calculate the square footage of the building for which the exemption is sought.

Line 6 – Marshall & Swift Cost Manual – Calculate the replacement cost per square foot for Class A Average building found in the most recent edition of the Marshall & Swift Valuation Services Manual, adjusted by any appropriate current cost and local multipliers.

Line 7 – Total replacement Cost – Multiply Line 5 by Line 6 to obtain an estimated replacement cost of building.

Line 8 – Actual Age – Write the actual age of the building.

Line 9 – Adjusted Remaining Life – The useful life of a building is a weighted mean life based on original construction. Hospitals are assumed to have a 40-year life and other types of buildings will use the applicable life from the American Hospital Association publication “Estimated Useful Lives of Depreciable Hospital Assets”. Hospital buildings older than 35 years will have an assumed remaining life of 5 years and hospital buildings newer than 8 years will assume to have a remaining life of 32 years. Apply the same parameter ratios of remaining life to non-hospital buildings.

Line 10 – Percentage of remaining life – The adjusted remaining life is divided by the useful life. For example, a hospital with a remaining life of 28 years is divided by a 40 year useful life to obtain a percentage of 70%.

Line 11 – Assessment factor – Write the assessment factor for the county.

Line 12 – Estimated assessed buildings value – Multiply Line 7 by Line 10 by Line 11.

Step 4: Figure the total estimated assessed value

Follow the instructions on the form.

Step 5: Figure the total estimated property tax

Follow the instructions on the form.

Lake County Board of Review

Pete Fleming, C.I.A.O.
Chairman

Wendy M. Kotulla, M.B.A.
Raymond M. Hibnick, C.I.A.O.
Members

Martin P. Paulson, M.B.A., M.S.
Clerk

18 North County Street – 7th Floor
Waukegan, IL 60085-4335
Phone (847) 377-2100

CERTIFICATION

I, _____, do hereby certify that copies of
Owner, Attorney, Agent

this Application for Tax Exemption to the Lake County Board of Review by

_____
Applicant

have been mailed to the municipality, school district and community college district in which the property is situated on _____.
Date

Signed:_____

Dated:_____

THIS FORM IS TO BE SUBMITTED IN DUPLICATE TO:

LAKE COUNTY BOARD OF REVIEW
18 N COUNTY ST – 7TH FLOOR
WAUKEGAN, IL 60085

This form is authorized by the Lake County Board of Review pursuant to Chapter 35 (ILCS) 200/16-70. Any Application for Tax Exemption filed with the Board requesting the removal of $100,000 or more in assessed valuation will not be processed until receipt of this completed form. The Board reserves the right to deny a hearing to any person(s) not in compliance with the aforementioned statute, as provided in the Rules Governing Hearings Before the Board of Review of Lake County, Rule VII.