



# Illinois Department of Revenue

## STAX-300-H Application for Hospital Sales Tax Exemption

E \_\_\_\_\_ - \_\_\_\_\_  
IDOR use only

### Step 1: Identify the entity

- 1 \_\_\_\_\_  
Name of hospital or affiliate applying for exemption
- 2 \_\_\_\_\_  
Street address of hospital or affiliate
- \_\_\_\_\_ IL \_\_\_\_\_  
City ZIP
- 3 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

- 4 Is this a new application or a renewal? (choose one)  new application  renewal  
 • If this is a renewal, write your Illinois Department of Revenue Exemption Number.  
 E \_\_\_\_\_ - \_\_\_\_\_
- 5 If the applicant has an Illinois property tax exemption, please provide your Illinois Department of Revenue docket number(s) below.  
 Docket # \_\_\_\_\_

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

- 6 Check what the value of services and activities below reflect: a. hospital year **6a**   
 b. average of 3 fiscal years ending with hospital year **6b**
- 7 What is your fiscal year? **7** \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- 8 Write the amount of charity care provided. **Attach most recently filed Form AG-CBP-I.** **8** \_\_\_\_\_
- 9 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.** **9** \_\_\_\_\_
- 10 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.** **10** \_\_\_\_\_
- 11 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.** **11** \_\_\_\_\_
- 12 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 \$ \_\_\_\_\_ = **12** \_\_\_\_\_
- 13 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.** **13** \_\_\_\_\_
- 14 Other. See instructions and identify: \_\_\_\_\_ **14** \_\_\_\_\_

### Step 4: Calculate and determine the exemption

- 15 Add Lines 8 through 14 and enter the total amount of services or activities provided. **15** \_\_\_\_\_
- 16 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.** **16** \_\_\_\_\_

If Line 16 is equal to or less than Line 15, you qualify for this exemption.  
 If Line 16 is greater than Line 15, you do not qualify for this exemption.

Continue to next page ==>

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**Step 5:****Identify the person to contact regarding this application****17** \_\_\_\_\_  
Name of applicant's representative**18** \_\_\_\_\_  
Owner's name (if the applicant is not the owner)\_\_\_\_\_  
Mailing address\_\_\_\_\_  
Mailing address\_\_\_\_\_  
City State ZIP\_\_\_\_\_  
City State ZIP( ) —  
Phone number( ) —  
Phone number

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**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

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**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.**

# Instructions for STAX-300-H

## Step 1: Identify the entity

**Lines 1-2** — Follow the instructions on the form.

**Line 3** — 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

**Line 4-5** — Follow the instructions on the form. If this is a renewal, enter your Illinois Department of Revenue Exemption number.

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

**Line 6** — Check whether the figures for services and activities you will enter on Lines 8 through 14 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 7** — Write your fiscal year.

**Line 8 — 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 9 — 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 10 — 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 11 — 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 12 — 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 13 — 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 14** — 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 Illinois Department of Revenue.