



**Step 1: Identify the entity**

**1** \_\_\_\_\_  
Name of hospital or affiliate filing the certification

\_\_\_\_\_

**2** \_\_\_\_\_  
Street address of hospital or affiliate

\_\_\_\_\_ IL \_\_\_\_\_  
City ZIP

**3** What is your fiscal year? \_\_\_\_\_

**Certification for: E -** \_\_\_\_\_ - \_\_\_\_\_

**4** Check the relevant hospital entity:  
 \_\_\_ hospital owner - enter the license number: \_\_\_\_\_  
 \_\_\_ hospital affiliate - explain relationship: \_\_\_\_\_  
 \_\_\_ hospital system - explain relationship: \_\_\_\_\_

**5** 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**

**6** Enter the amount of charity care provided. **6** \_\_\_\_\_

**7** Enter the amount of unreimbursed costs for health services provided to low-income and underserved individuals. **7** \_\_\_\_\_

**8** If the hospital gives a subsidy to a state or local government, enter the total amount. **8** \_\_\_\_\_

**9** If the hospital gives a subsidy for Illinois health care programs to low-income individuals, enter the total amount. **9** \_\_\_\_\_

**10** 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 **10** \_\_\_\_\_

**11** If the hospital provided relief for the government as it relates to health care services for low income individuals, enter the total low-income portion of unreimbursed costs. **11** \_\_\_\_\_

**12** The value of any other service or activity not reported above. **12** \_\_\_\_\_  
 Clearly specify the service or activity: \_\_\_\_\_

**13 Total-Add Lines 6 through 12.** **13** \_\_\_\_\_

**14** What is the total amount of property taxes, actual or estimated, for all the exempt property of the owner, affiliate, or system, identified on Line 1? **14** \_\_\_\_\_

**Step 3: Signature and notarization**

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

Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Contact Name (Please print) \_\_\_\_\_

Contact phone number \_\_\_\_\_

Mailing address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Email address \_\_\_\_\_

Subscribed and sworn to before me this  
 \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_.

\_\_\_\_\_  
 Notary public

**Complete and submit this certification to:**

**ILLINOIS DEPARTMENT OF REVENUE  
 TAXPAYER SERVICES - EXEMPTIONS SECTION MC 3-520  
 101 WEST JEFFERSON STREET  
 SPRINGFIELD IL 62702**

*IDOR use only*

CERTIFICATION APPROVED  CERTIFICATION DENIED \_\_\_\_\_/\_\_\_\_/\_\_\_\_  
 STAX-300-HC front (N-05/17) Date

# Instructions

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## Step 1: Identify the property

Enter the exemption number in the blank at the top of the form for which you are requesting a certification.

**Lines 1-4** — Follow the instructions on the form.

**Line 5** — Check whether the figures for services and activities you will enter on Lines 6 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.*

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

**Line 6 — 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 7 — 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 8 — 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 9 — 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 10 — 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 11 — Relief of the burden of government related to health care of low-income individuals — From Schedule A.**

**Line 12** — 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 13** — Add Lines 6 - 12 and enter the total here.

**Line 14** — 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 certification is being submitted.

## Step 3: Signature and notarization

The certification

- **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.
- **must be notarized** before sending to the Illinois Department of Revenue.
- must include the **contact name and information** so that if we have any questions, we will easily know who to contact.
- **must be legible.**

## When completed, send this certification to:

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ILLINOIS DEPARTMENT OF REVENUE  
TAXPAYER SERVICES - EXEMPTIONS SECTION MC 3-520  
101 WEST JEFFERSON STREET  
SPRINGFIELD IL 62702