PROCEDURE #: M-1 **SUBJECT:** **Financial Assistance for Those in Need**

EFFECTIVE DATE: **July 01, 2004**
DATES REVISED: **April 23, 2007**
June 9, 2010
March 3, 2016
April 26, 2016
May 27, 2016

Chief Operating Officer, Ascension Health

REFERENCE TO ASCENSION HEALTH POLICIES AND PROCEDURES:

Policy No. 16	Financial Assistance for Those in Need and Billing and Collection Practices
Policy No. 9	Community Benefit Goal Setting, Planning and Reporting
Procedure No. M-2	Billing and Collection Practices
Procedure No. M-3	Community Benefit Goal Setting, Planning and Reporting

Subject

In light of its identity and Mission, Ascension Health is committed to the principles of Catholic Social Teaching. This procedure is informed by the principle of human dignity which acknowledges the intrinsic worth of each person by virtue of his or her existence as a human being. The principle of the common good is also foundational to this procedure, which promotes *collaboration* in the goods we hold in common so that each person may flourish. Lastly, the principle of solidarity with those in poverty strives to identify with those affected by poverty, serve their needs and advocate on their behalf. This procedure sets forth the requirement that each Ascension Health ministry have an effective financial assistance policy. Each of our health ministry's financial assistance practices will reflect our commitment to and reverence for individual human dignity and the common good, our special concern for and solidarity with persons who live in poverty and other vulnerable persons, and our commitment to distributive justice and stewardship. Each health ministry must ensure that its employees and agents behave in a manner that reflects the policies and values of a Catholic-sponsored facility, including treating patients and their families with dignity, respect and compassion.

Financial Assistance Policy

Ascension and Ascension Health intend for themselves and for each Ascension Health ministry that provides medical care ("Health Ministry," for purposes of this procedure) to comply with Section 501(r) of the Internal Revenue Code and the regulations promulgated thereunder (collectively, "501(r)"), as applicable. This procedure, together with Exhibits A, B and C, shall be interpreted and applied in accordance with 501(r), except where specifically indicated. Ascension and Ascension Health further intend that the following organizations (or billing arrangements) that provide emergency and other medically necessary health care services within each Health Ministry

will likewise comply with 501(r):

- State-licensed hospital facilities;
- Organizations operating an emergency department on behalf of a hospital facility;
- Employed physician practices;
- Physician practices controlled by a Health Ministry;
- Joint venture operations where Ascension Health or any of its direct or indirect subsidiaries is the controlling member;
- Billing-under-arrangement bills; and
- Substantially related entities, meaning
  - any partnership (for tax purposes) in which Ascension Health or any of its direct or indirect subsidiaries owns a capital or profits interest that provides emergency or medically necessary care in a hospital facility, or
  - a disregarded entity of which Ascension Health or any of its direct or indirect subsidiaries is the sole member that provides emergency or medically necessary care in a hospital facility,

  but excluding (even if such entity also meets the criteria above), subject to written approval for exclusion by the Ascension Health Chief Financial Officer and Ascension's Tax Department,
  - any entity that Ascension Health treats as providing such care as an unrelated trade or business, or
  - an organization that is operated primarily for educational or scientific purposes.

In furtherance of this objective, the general objectives of this procedure and the objectives of Ascension Health Policies 9 and 16, the Board of Directors of each Health Ministry will adopt a Financial Assistance Policy ("FAP"), the form of which is attached to this procedure as Exhibit A. Health Ministries shall have authority to customize certain limited aspects of the FAP (e.g., to comply with applicable state law), subject to this procedure. Once customization has been completed, the italicized prompts or footnotes providing direction to the Health Ministry should be deleted from the version of the FAP that will be widely publicized. It is expected, however, that all hospital facilities and other organizations that are subject to a particular Health Ministry's authority will adopt an identical FAP. When it approves the FAP, the Health Ministry also is to direct that the FAP be ratified (and thus adopted) by each hospital facility and other applicable organization under the authority of that Health Ministry. For each hospital facility, the FAP will have an effective date no later than July 1, 2016 which also will be the target effective date for other applicable organizations.

Each Health Ministry also will ensure that each of its hospital facilities maintains, and makes available upon request, (1) a list of all service providers delivering care in the hospital facility and specifying which are covered by the FAP and which are not covered by the FAP, the form of which is attached to this procedure as Exhibit B, and (2) a description of the calculation of the amount generally billed ("AGB") applicable to that hospital facility, the form of which is attached as Exhibit C. Each Health Ministry will develop and maintain its own FAP application form (the "FAP Application") and instructions for its FAP Application (the "FAP Application Instructions), to be publicized and disseminated as described below.

Elements of Financial Assistance Policy

Minimum Standards

1. Patients with income less than or equal to 250% of the Federal Poverty Level ("FPL"), will be eligible for 100% charity care write off on that portion of the charges for services for which the patient is responsible following payment by an insurer, if any. 100% charity care is intended to be subject to 501(r), including, but not limited to, the application of the AGB limitation described below.

2. At a minimum, patients with incomes above 250% of the FPL, but not exceeding 400% of the FPL, will receive a sliding scale discount on that portion of the charges for services provided for which the Patient is responsible following payment by an insurer, if any. A patient eligible for the sliding scale discount will not be charged more than the calculated AGB charges. The sliding scale will be determined by each Health Ministry in accordance with principles established in Ascension Health Policies 9 and 16. This financial assistance is intended to be subject to 501(r), including, but not limited to, the application of the AGB limitation described below.

3. Eligibility for financial assistance may be determined at any point in the revenue cycle and may include the use of presumptive scoring to determine eligibility notwithstanding an applicant's failure to complete a financial assistance application ("FAP Application"). Presumptive eligibility may be based on a prior FAP-eligibility determination for such Patient or based on information provided by the Patient. In the event that a determination is made that the Patient is eligible for less than 100% charity care, then the Health Ministry must notify the Patient of the basis for the determination and inform the Patient as to how to apply for more generous financial assistance. In making determinations about presumptive eligibility, Health Ministries should utilize the following guidelines:

a. For the purpose of helping patients that need financial assistance, a Health Ministry may utilize a third-party to review patient's information to assess financial need. This review utilizes a healthcare industry recognized, predictive model that is based on public record databases. The model incorporates public record data to calculate a socio-economic and financial capacity score that includes estimates for income, assets and liquidity. The model's rule set is designed to assess each patient to the same standards and is calibrated against historical financial assistance approvals for the Health Ministry. The predictive model enables the Health Ministry to assess whether a patient is characteristic of other patients who have historically qualified for financial assistance under the FAP Application.
b. After efforts to confirm coverage availability, the predictive model provides a systematic method to grant presumptive financial assistance to patients with appropriate financial needs. When predictive modeling is the basis for presumptive eligibility, an appropriate discount based upon the score will be granted for eligible services for retrospective dates of service only. For those patients not awarded 100% charity care, a letter should be generated notifying the patient of the level of financial assistance awarded and giving instructions on how to appeal the decision.
c. In the event a patient does not qualify under the presumptive eligibility rule set, the patient may still be considered for financial assistance pursuant to a FAP Application.
d. In addition to the use of the predictive model outlined above, presumptive financial

assistance should also be provided at the 100% charity care level in the following situations:

i. Deceased patients where the Health Ministry has verified there is no estate and no surviving spouse.
ii. Patients who are eligible for Medicaid from another state in which the Health Ministry is not a participating provider and does not intend to become a participating provider.
iii. Patients who qualify for other government assistance programs, such as food stamps, subsidized housing, and Women's Infants and Children's Program (WIC).

4. Eligibility for 100% charity care must be determined for any balance for which the patient with financial need is responsible.

5. Each Health Ministry shall develop and include within its FAP a "Means Test" by which a hospital facility or other organization may assess whether a patient with income greater than 400% of the FPL has demonstrated financial needs and therefore should be eligible for some discount of their charges for services. The Means Test shall involve a determination based on eligible assets and income, including, but not be limited to, income, medical bill obligations, mortgage payments, utility payments, number of family members and disability considerations. Eligibility under the Means Test may be determined at any point in the revenue cycle and must be determined for any balance for which the patient is responsible. This financial assistance is intended to be subject to 501(r), including, but not limited to, the application of the AGB limitation described below.

6. Uninsured patients who are not eligible for the financial assistance described under Paragraphs 1, 2 or 5 above will be provided a discount based on the discount provided to the highest-paying payor for that Health Ministry. The highest paying payor must account for at least 3% of the Health Ministry's population as measured by volume or gross patient revenues. If a single payor does not account for this minimum level of volume, more than one payor contract should be averaged such that the payment terms that are used for averaging account for at least 3% of the volume of the Health Ministry's business for that given year. This discount for uninsured patients is not intended to be subject to 501(r) (and therefore not subject to, among other things, the application of the AGB limitation described below) for a patient that is not eligible for financial assistance under Paragraphs 1, 2 and 5 above.

7. Uninsured patients who are not eligible for the financial assistance described under Paragraphs 1, 2, or 5 above may be provided a prompt pay discount. A Health Ministry may also extend a similar prompt pay discount to insured patients who are not eligible for the financial assistance described under Paragraphs 1, 2, or 5 above only after the Health Ministry's Managed Care leader has determined that such discounts can be offered pursuant to all applicable managed care contracts. The prompt pay discount may be offered in addition to the uninsured discount described in Paragraph 6 above, but the prompt pay discount provided should not, together with the uninsured discount described in Paragraph 6 above, exceed the discounts provided to a patient that would qualify for financial assistance under Paragraphs 1, 2 or 5 above. The prompt pay discount is not intended to be subject to 501(r) (and therefore not subject to, among other things, the application of the AGB limitation described below) for a patient that is not eligible for financial assistance under items 1, 2 and 5 above.

8. Each Health Ministry must establish a process for patients and families to appeal an organization's decision regarding eligibility for financial assistance consistent with the following:

a. Patients and families, as applicable, can appeal the decision regarding eligibility for 100% charity care or financial assistance by submitting a written appeal and should be encouraged to provide additional information to evaluate their case.
b. Appeals should be initially received by Patient Financial Services for review and follow up questions, if applicable.
c. A committee shall then meet on a monthly basis to review all appeals. The committee membership should include representation from Patient Financial Services, Mission Integration, Case Management/Social Services and Finance/CFO. Appeals shall be distributed to the committee members prior to the monthly committee meeting for review.
d. A Patient Financial Services representative should be present at the committee meeting to discuss each case and provide additional input that the patient may have provided.
e. The committee will review the applicant's FAP Application with special attention to additional information and points made by the applicant in the appeal process.
f. The committee may approve, disapprove or table the appeal. The committee may table an appeal if additional information is required based on questions asked during the appeal discussion.
g. Patient Financial Services will communicate in writing the outcome of the appeal to the Patient or family members.

Other Requirements and Exceptions

1. Health Ministries may require the uninsured to work with a financial counselor and apply for Medicaid or other public assistance programs to qualify for 100% charity care. If a Health Ministry chooses to apply this requirement, it should be reflected as a requirement in the applicable FAP Application or FAP Application Instructions.

2. Other programs that allow for "packaging" payment programs are acceptable. For example, many Health Ministries package prenatal care and delivery charges into a "package" price for the uninsured.

3. A nominal amount may be charged to patients qualifying for 100% charity care. The participation of individuals in the financial obligation of their health care is recommended by those who work with persons living in poverty since it respects their dignity as well as their sense of responsibility. If a Health Ministry chooses to apply this requirement, it should be reflected in the applicable FAP.

4. Large deductible or coinsurance balances will be considered when determining qualification for 100% charity care, financial assistance or applicable discount, regardless of patient's insured status.

5. Ascension Health intends that each hospital facility will cause its FAP to apply to emergency room operations, even if such operations are outsourced to a third party.

6. Health Ministries may, but are not required to, establish geographic boundaries by defining the community served and limiting financial assistance to those that live in the community. If a Health Ministry chooses to impose such a limitation, then the community must be defined to include at least the same area reflected in the Health Ministry's Community Health Needs Assessment's definition of the community.

FAP Summary

In order to comply with 501(r), a hospital facility must prepare a plain language summary of its FAP (the "FAP Summary"), which must be widely publicized (as described below) and must be provided to patients as part of the hospital facility's billing and collection processes, as may be required by Ascension Health Procedure M-2. To satisfy 501(r), this FAP Summary must notify individuals that the hospital facility offers financial assistance under a FAP and must provide the following additional information:

- A brief description of the eligibility requirements and assistance offered under the FAP;
- A brief summary of how to apply for assistance under the FAP;
- The direct Web site address and physical locations where the individual can obtain copies of the FAP and the FAP Application;
- Instructions on how the individual can obtain a free copy of the FAP and FAP Application form by mail;
- Contact information (including telephone number and physical location) of the Hospital Facility office that can provide information about the FAP and of either (A) the Hospital Facility office or department that can provide assistance with the FAP Application process; or (B) if the Hospital Facility does not provide assistance with the FAP Application process, at least one nonprofit organization or government agency that the hospital facility has identified as an available source of assistance with FAP Applications;
- A statement that translations of FAP, FAP Application, and plain language summary are available in other languages; and
- A statement that an individual eligible for financial assistance may not be charged more than AGB for emergency or other medically necessary care.

The FAP Summary must present all of this information in language that is clear, concise and easy to understand.

Widely Publicizing the FAP

Under 501(r), each hospital facility must "widely publicize" its FAP and certain related documents. Each Health Ministry must ensure that each hospital facility under its authority takes the following steps:

- Makes its FAP (and, if separate, the List of Providers Covered by the Financial Assistance Policy and the Amount Generally Billed Calculation), "FAP Application," and "FAP Summary" widely available on the hospital facility's website;
- Makes paper copies of the FAP, FAP Application, and FAP Summary available upon

request and without charge, both by mail and in public areas in the hospital facility (including, at a minimum, in the emergency room, if any, and admissions areas);

- Notifies and informs members of the community it serves about the FAP in manner reasonably calculated to reach those most likely to need financial assistance; and
- Notifies and informs its patients of the FAP by: (1) offering paper copies of the FAP Summary to patients as part of intake or discharge; (2) including conspicuous notice on billing statement about availability of financial assistance, including phone number and web address where more information may be found; and (3) setting up conspicuous public displays or other measures reasonably calculated to attract attention of patients, including at a minimum the emergency room and admissions areas.

Additionally, each hospital facility must make these notifications and documents available not only in English but also for certain limited English proficiency ("LEP") populations – meaning a group with a LEP population exceeding the lesser of 1,000 individuals or 5% of the community the hospital facility serves. The hospital facility may determine the percentage or number of LEP individuals in the hospital facility's community or likely to be affected or encountered by the hospital facility using any reasonable method, but in any event, not inconsistent with any similar determination made by the hospital facility in connection with its applicable Community Health Needs Assessment.

Emergency Medical Care Policy

Under 501(r), a hospital facility also must have a written policy that requires it to provide care for emergency medical conditions to individuals, without discrimination, regardless of whether they are eligible under the FAP. A hospital's EMTALA policy typically will satisfy this requirement. Additionally, the emergency care policy must prohibit the hospital from engaging in activities that discourage individuals from seeking emergency care, such as demanding payment from patients before providing emergency care. Each Health Ministry should ensure that any hospital facility under its authority has adopted an appropriate emergency care policy.

Calculation of AGB

Patients that are eligible for financial assistance that is subject to 501(r), as described in Paragraphs 1, 2 and 5 (but not Paragraphs 6 and 7) under *Elements of Financial Assistance Policy* above, will not be charged more than AGB for emergency and other medically necessary care. The amount "charged" to the patient means the amount the patient is personally responsible for paying, after all deductions, discounts (including discounts available under the FAP), and insurance reimbursements are applied. AGB will be determined by multiplying the gross charges for the care by the applicable AGB percentage, which is calculated as described below.

Each hospital facility will calculate its AGB percentage (or multiple AGB percentages) in accordance with the "look-back" method. A hospital facility shall either (i) calculate two AGB percentages, one for inpatient services and one for outpatient services, or (ii) one aggregate AGB percentage. The AGB calculation(s) must be updated at least annually, and the hospital facility must begin applying the AGB percentage(s) by the 120th day after the end of the 12-month period the hospital facility used in calculating its most recent AGB percentage(s).

The AGB percentage(s) will be calculated by dividing the sum of the amounts of all of the hospital facility's claims for emergency and other medically necessary care that have been allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility (either separately for inpatient and outpatient services or in the aggregate, depending on the AGB methodology being utilized) by the sum of the associated gross charges for those claims. The only claims that should be utilized for purposes of determining the AGB percentage(s) should be those that were allowed by a health insurer during the 12 month period prior to the AGB percentage calculation (rather than those claims that relate to care provided during the prior 12 months). If the hospital facility is covered under the same Medicare provider agreement as other hospitals facilities, the hospital facility may use the same AGB percentage(s) based on the claims and gross charges for all such hospital facilities and implement the AGB percentage across all hospitals. In addition, if multiple hospital facilities in the same Ministry Market that do not share the same Medicare provider agreement want to use the same AGB percentage(s) for those hospitals (which AGB percentage(s) may either be in the aggregate or separated by inpatient and outpatient services), they must use the lowest AGB percentage(s) calculated for all of the hospitals that intend to use the same AGB percentage(s). If multiple hospitals choose to use the same AGB percentage(s), then the AGB calculation description at Exhibit C should include a statement noting that the AGB percentage(s) that will be applied are the lower than the actual AGB percentage(s) calculated and including the AGB percentage(s) that will actually be applied to calculate patient charges.

State Law Compliance

In addition to the requirements of 501(r), certain states in which hospital facilities are located may impose additional requirements on hospital facilities related to the financial assistance provided to patients. To the extent 501(r) and other aspects of this policy conflict with or are inconsistent with state law requirements, the hospital facility must fulfill the greater level of obligation imposed by 501(r) or state law so long as that will also fulfill the hospital facility's obligations under the lesser standard. To the extent state law requirements are additive to the requirements of this policy and 501(r), hospital facilities must fulfill both sets of obligations. Each Health Ministry should ensure that the FAP or an accompanying procedure includes language that addresses any additional applicable state requirements.

Exhibit A

ST. JOHN HEALTH SYSTEM

FINANCIAL ASSISTANCE POLICY

July 1, 2016

POLICY/PRINCIPLES

It is the policy of St. John Health System (the "Organization") to ensure a socially just practice for providing emergency or other medically necessary care at the Organization's facilities. This policy is specifically designed to address the financial assistance eligibility for patients who are in need of financial assistance and receive care from the Organization.

1. All financial assistance will reflect our commitment to and reverence for individual human dignity and the common good, our special concern for and solidarity with persons living in poverty and other vulnerable persons, and our commitment to distributive justice and stewardship.

2. This policy applies to all emergency and other medically necessary services provided by the Organization, including employed physician services and behavioral health. This policy does not apply to payment arrangements for elective procedures or other care that is not emergency care or otherwise medically necessary.

3. The List of Providers Covered by the Financial Assistance Policy provides a list of any providers delivering care within the Organization's facilities that specifies which are covered by the financial assistance policy and which are not.

4. Financial Assistance provided by St. John Health System to patients is only to assist in covering required patient payment for services provided at a facility owned or operating by a wholly-owned subsidiary of St. John Health System or provided by a physician who is an employee of St. John Clinic. Financial assistance awarded by St. John does not apply to services provided by independent physicians or at facilities that are not owned or operated by St. John Health System.

DEFINITIONS

For the purposes of this Policy, the following definitions apply:

- "**501(r)**" means Section 501(r) of the Internal Revenue Code and the regulations promulgated thereunder.
- "**Amount Generally Billed**" or "**AGB**" means, with respect to emergency or other medically necessary care, the amount generally billed to individuals who have insurance covering such care.
- "**Community**" means St. John Health System is comprised of six main hospitals in Northeastern Oklahoma with each facility serving their surrounding communities.
  St. John Medical Center (Tulsa)

St. John Owasso
St. John Broken Arrow
St. John Sapulpa
Jane Phillips Medical Center (Bartlesville)
Jane Phillips Nowata

St. John Medical Center is a regional tertiary referral and trauma center serving the entire northeastern Oklahoma region, as well as parts Kansas, Arkansas and Missouri. The primary service area is Tulsa County and the surrounding counties. St. John Owasso is a not-for-profit healthcare facility serving Owasso, Oklahoma, and surrounding communities. St. John Broken Arrow is a not-for-profit healthcare facility serving Broken Arrow, Oklahoma, and surrounding communities. St. John Sapulpa is a not-for-profit hospital serving Sapulpa, Oklahoma, and surrounding communities. Jane Phillips Medical Center primarily serves Washington County and its surrounding counties including all of Nowata and Osage. Jane Phillips Nowata Inc. serves as an important provider of healthcare services to northeastern Oklahoma, particularly in the Nowata County area.

- "**Emergency Care**" means care to treat a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention may result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or placing the health of the individual in serious jeopardy.
- "**Medically Necessary Care**" means care that is determined to be medically necessary following a determination of clinical merit by a licensed physician in consultation with the admitting physician.
- "**Organization**" means St. John Health System.
- "**Patient**" means those persons who receive emergency or medically necessary care at the Organization and the person who is financially responsible for the care of the patient.

Financial Assistance Provided

Financial assistance described in this section is limited to Patients that live in the Community:

1. Patients with income less than or equal to 400% of the Federal Poverty Level ("FPL"), will be eligible for 100% charity care write off on that portion of the charges for services for which the Patient is responsible following payment by an insurer, if any.
2. Patients with demonstrated financial needs with income greater than 400% of the FPL may be eligible for consideration under a "Means Test" for some discount of their charges for services from the Organization based on a substantive assessment of their ability to pay. The Financial Counseling Review Committee will use a Debt-to-Income (DTI) ratio to determine if financial assistance will be approved for patients with income(s) greater than 400% of the Federal Poverty Level. A Patient eligible for the "Means Test" discount will not be charged more than the calculated AGB charges.
3. Eligibility for financial assistance must be determined for any balance for which the patient with financial need is responsible.
4. The process for Patients and families to appeal an Organization's decisions regarding eligibility for financial assistance is as follows:
    a. Patients receiving a denial on their application are encouraged to file an appeal within fourteen (14) days of receiving the notice of determination if there is extenuating

circumstances or additional information regarding their financial situation is presented.

b. All appeals will be considered by St. John Health System's 100% charity care and financial assistance appeals committee, and decisions of the committee will be sent in writing to the Patient or family that filed the appeal within forty-five (45) days of receipt of the request for an appeal.

Other Assistance for Patients Not Eligible for Financial Assistance

Patients who are not eligible for financial assistance, as described above, still may qualify for other types of assistance offered by the Organization. In the interest of completeness, these other types of assistance are listed here, although they are not need-based and are not intended to be subject to 501(r) but are included here for the convenience of the community served by St. John Health System.

1. Uninsured Patients who are not eligible for financial assistance will be provided a 50% discount of the total billed charges and will be applied toward the balance of the account at the time the final bill is produced.
2. Uninsured and insured Patients who are not eligible for financial assistance may receive a prompt pay discount of 10% if the balance due is fully paid prior to 30 days after the date of the first billing statement. Insured Patients who are not eligible for financial assistance will receive a prompt pay discount of 10% if such balance due is fully paid prior to 30 days after the date of the first billing statement. The prompt pay discount may be offered in addition to the uninsured discount described in the immediately preceding paragraph.

Limitations on Charges for Patients Eligible for Financial Assistance

Patients eligible for Financial Assistance will not be charged individually more than AGB for emergency and other medically necessary care and not more than gross charges for all other medical care. The Organization calculates one or more AGB percentages using the "look-back" method and including Medicare fee-for-service and all private health insurers that pay claims to the Organization, all in accordance with 501(r). A free copy of the AGB calculation description and percentage(s) may be obtained by contacting St. John Health System's Financial Counseling Department.

Applying for Financial Assistance and Other Assistance

A Patient may qualify for financial assistance by applying for financial assistance by submitting a completed FAP Application. The FAP Application and FAP Application Instructions are available in the following areas.

1. Patient Access Departments in all SJHS facilities
2. Financial Counseling
3. Central Business Office
4. Other departments performing admission functions
5. External agencies or business partners

6. St. John Health System Website
   http://www.stjohnhealthsystem.com/media/file/1826/Financial_Assistance_Form.pdf

Billing and Collections

The actions that the Organization may take in the event of nonpayment are described in a separate billing and collections policy. A free copy of the billing and collections policy may be obtained by contacting St. John Health System's Central Business Office:

SJHS Business Office
4848 S 129th E Ave
Tulsa, OK 74134
(918)744-2900

Interpretation

This policy is intended to comply with 501(r), except where specifically indicated. This policy, together with all applicable procedures, shall be interpreted and applied in accordance with 501(r) except where specifically indicated.

Exhibit B

ST. JOHN HEALTH SYSTEM

LIST OF PROVIDERS COVERED BY THE FINANCIAL ASSISTANCE POLICY

July 1, 2016

Per Reg. Sec. 1.504(r)-4(b)(1)(iii)(F) and Notice 2015-46, this list specifies which providers of emergency and medically necessary care delivered in the hospital facility are covered by the Financial Assistance Policy (FAP). Only the facilities, physicians and other medical providers listed in the column entitled "providers covered by FAP" are covered by the financial assistance policy. All other physicians and other providers providing services in St. John wholly-owned facilities or in other non-St. John facilities are not covered by the Financial Assistance Policy. The list of Providers not covered by FAP is intended to be representative, but not necessarily all inclusive of providers not covered by the Financial Assistance Policy.

Providers covered by FAP	Providers not covered by FAP
St. John Medical Center - facility charges	EMSA and all ground and air ambulance and medical transport services
St. John Owasso - facility charges	Tulsa Radiology Associates
St. John Sapulpa - facility charges	Oklahoma Cancer Specialists and Research Institute
St. John Broken Arrow - facility charges	Surgery Inc.
Jane Phillips Medical Center -facility charges	Tulsa Bone and Joint, including Union Pines Surgery Center and TBJ Ortho Urgent Care
Jane Phillips Nowata - facility charges	Urology Associates
All physicians and Providers doing business as "St. John Clinic", including:	All Saints Durable Medical Equipment
OMNI Medical Group	Memorial Surgery Center
Family Medical Care Associates	St. John Rehabilitation Hospital, affiliated with HealthSouth
St. John Physicians - Emergency Care and Specialists	Fresenius Medical Care of Tulsa
St. John Anesthesia	Prairie House Assisted Living Center
St. John Urgent Care Tulsa	Corner Stone Long Term Acute Care Hospital
St. John Urgent Care Sand Springs	All active and courtesy staff members of St. John – wholly owned hospitals and medical facilities that are not employees of the organizations doing business as "St. John Clinic"
St. John Urgent Care Broken Arrow	
St. John Urgent Care Claremore	
St. John Clinic Bartlesville After Hours	
Bluestem Cardiology	
Regional Medical Lab	

Exhibit C

ST. JOHN HEALTH SYSTEM

AMOUNT GENERALLY BILLED CALCULATION

July 1, 2016

St. John Health System calculates one AGB percentage using the "look-back" method and including Medicare fee-for-service and all private health insurers that pay claims to the Organization, all in accordance with IRS Reg. Sec. 1.501(r)-5(b)(3), 1.501(r)-5(b)(3)(ii)(B) and 1.501(r)-5(b)(3)(iii). The details of that calculation and AGB percentage is described below.

The AGB percentages for St. John Health System is as follows:

AGB:

Tulsa - AGB Calculated 4/1/2015 - 3/31/2016, Inpatient ZBA Threshold: $10,000, Outpatient ZBA Threshold $5,000				
Facility Name	Inpatient AGB %	Outpatient AGB %	Inpatient AGB Formula	Outpatient AGB Formula
Jane Phillips Medical Center	39.8%	36.7%	1 - (43,094,057 / 71,540,794) = 39.8%	1 - (87,456,620 / 138,208,575) = 36.7%
Saint John Broken Arrow	30.0%	37.6%	1 - (52,518,593 / 74,964,280) = 30.%	1 - (44,947,841 / 71,992,881) = 37.6%
Saint John Medical Center	33.3%	38.1%	1 - (433,459,991 / 650,182,210) = 33.3%	1 - (262,855,316 / 424,675,825) = 38.1%
Saint John Owasso Hospital	42.1%	39.1%	1 - (11,440,323 / 19,747,848) = 42.1%	1 - (33,530,286 / 55,053,189) = 39.1%
Saint John Sapulpa	67.8%	40.0%	1 - (1,832,942 / 5,689,300) = 67.8%	1 - (16,210,877 / 27,033,373) = 40.%

This AGB percentage is calculated by dividing the sum of the amounts of all of the hospital facility's claims for emergency and other medically necessary care that have been allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility by the sum of the associated gross charges for those claims. The only claims that are utilized for purposes of determining the AGB are those that were allowed by a health insurer during the 12 month period prior to the AGB calculation (rather than those claims that relate to care provided during the prior 12 months).