Exhibit A

ST. JOHN HEALTH SYSTEM

FINANCIAL ASSISTANCE POLICY
July 1, 2019

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 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.
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 discount is as follows:
   0% - 250% FPL Base = 100% write off
   251% - 300% FPL Base = 80% write off
   301% - 399% FPL Base = 70% write off
3. 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.

4. Eligibility for financial assistance must be determined for any balance for which the patient with financial need is responsible.
5. 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").
6. For the purposes of helping patients that need financial assistance, St. John Health System 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 St. John Health System to assess whether a patient is characteristic of other patients who have historically qualified for financial assistance under the FAP Application.
7. 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 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.
8. 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.
9. 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:
    a. Deceased patients where St. John Health System has verified there is no estate and no surviving spouse.
    b. 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.
    c. Patients who qualify for other government assistance programs, such as food stamps, subsidized housing, and Women's Infants and Children's Program (WIC).
    d. Uninsured patients treated at the Transitional Care Clinic within forty-five (45) days of their prior admission.
10. 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 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.

11. Patients approved for charity will be charged the following copay amounts.
    a. Emergency and/or Inpatient Services - $100.00 per date of service
    b. Outpatient and Reoccurring Services - $25.00 per visit
    c. St. John Clinic and Urgent Care Services - $25.00 per visit
    d. Presumptive Charity - $100.00 per date of service

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 55% 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 Patients may receive a prompt pay discount of 10% if the balance due is fully paid at the time of service. The prompt pay discount may be offered in addition to the uninsured discount.

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. A Patient may be denied financial assistance if the Patient provides false information on a FAP Application or in connection with the presumptive scoring eligibility process. 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

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 at (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, 2019

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). Elective procedures and other care that is not emergency care or otherwise medically necessary are not covered by the FAP for any providers. 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	
Bluestem Emergency Management	
Regional Medical Lab	

Exhibit C

ST. JOHN HEALTH SYSTEM

AMOUNT GENERALLY BILLED CALCULATION

July 1, 2019

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:

Jane Phillips Medical Center	32.2%
JPN Acute	80.0%
St. John Broken Arrow	29.2%
St. John Medical Center	32.6%
St. John Owasso Hospital	34.1%
St. John Sapulpa	37.1%

Physician Providers DBA St. John Clinic 45.0%

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).

Notwithstanding the foregoing AGB calculation, St. John Health System has chosen to apply a lower AGB percentage (for all their hospitals and medical group) as follows:

AGB: 29.2%