
POLICY/PRINCIPLES

It is the policy of the organizations listed below this paragraph (each one being the “Organization”) to ensure a socially just practice for providing emergency and 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. This policy applies to each of the following Organizations within Ascension Via Christi Health:

Ascension Via Christi St. Francis
Ascension Via Christi St. Joseph
Ascension Via Christi St. Teresa
Ascension Via Christi Rehabilitation Hospital
Ascension Via Christi Hospital in Pittsburg
Ascension Via Christi Hospital in Manhattan
Ascension Via Christi Emergency Department in Wellington
Wamego Health Center
Ascension Via Christi Emergency Department in Fort Scott
Ascension Medical Group
Kansas Surgery and Recovery Center
Anatomi Imaging

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 care provided by the Organization, including employed physician services and behavioral health. This policy does not apply to charges for care that is not emergency and other medically necessary care.
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.

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.



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- **“Amount Generally Billed”** or **“AGB”** means, with respect to emergency and other medically necessary care, the amount generally billed to individuals who have insurance covering such care.
 - **“Community”** means that Sedgwick County is part of the Wichita, Kansas, Metropolitan Statistical Area (MSA), as defined by the United States Office of Management and Budget. The MSA is an area consisting of five counties in south central Kansas, anchored by the city of Wichita. The five counties include Butler, Harvey, Sedgwick, Sumner and Kingman. Ascension Via Christi Hospital Manhattan and Wamego Health Center community is defined as Riley, Pottawatomie and Geary counties. Ascension Via Christi Hospital Pittsburg community is defined as Crawford, Bourbon, Cherokee and Linn counties.
 - **“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 (1) appropriate and consistent with and essential for the prevention, diagnosis, or treatment of a Patient’s condition; (2) the most appropriate supply or level of service for the Patient’s condition that can be provided safely; (3) not provided primarily for the convenience of the Patient, the Patient’s family, physician or caretaker; and (4) more likely to result in a benefit to the Patient rather than harm. For future scheduled care to be “medically necessary care,” the care and the timing of care must be approved by the Organization’s Chief Medical Officer (or designee). The determination of medically necessary care must be made by a licensed provider that is providing medical care to the Patient and, at the Organization’s discretion, by the admitting physician, referring physician, and/or Chief Medical Officer or other reviewing physician (depending on the type of care being recommended). In the event that care requested by a Patient covered by this policy is determined not to be medically necessary by a reviewing physician, that determination also must be confirmed by the admitting or referring physician.
 - **“Organization”** means Ascension Via Christi Health.
 - **“Patient”** means those persons who receive emergency and other medically necessary care at the Organization and the person who is financially responsible for the care of the patient.
 - **“Catchment”** - defines those communities who fall within the Community Health Needs Assessment (CHNA) and therefore are eligible for financial assistance, if meeting the qualifications of the application process and policy guidelines.

Financial Assistance Provided

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

1. Subject to the other provisions of this Financial Assistance Policy, Patients with income less than or equal to 250¹% of the Federal Poverty Level income (“FPL”), will be eligible for 100% charity care on that portion of the charges for services for which the Patient is responsible following payment by an insurer, if any, if such Patient determined to be eligible pursuant to presumptive scoring (described in Paragraph 5 below) or submits a financial assistance application (an “Application”) on or prior to the 240th day after the Patient’s first discharge bill and the Application is approved by the Organization. Patient will be eligible for up to 100% financial assistance if Patient submits the Application after the 240th day after the Patient’s first discharge bill, but then the amount of financial assistance available to a Patient in this category is limited to Patient’s unpaid balance after taking into account any payments made on Patient’s account. A Patient eligible for this category of financial assistance will not be charged more than the calculated AGB charges.

2. Subject to the other provisions of this Financial Assistance Policy, Patients with incomes above 250²% of the FPL but not exceeding 400³% 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, if such Patient submits an Application on or prior to the 240th day after the Patient’s first discharge bill and the Application is approved by the Organization. Patient will be eligible for the sliding scale discount financial assistance if Patient submits the Application after the 240th day after the Patient’s first discharge bill, but then the amount of financial assistance available to a Patient in this category is limited to Patient’s unpaid balance after taking into account any payments made on Patient’s account. A Patient eligible for this category of financial assistance will not be charged more than the calculated AGB charges. The sliding scale discount is as follows:

251% - 300% FPL Base = 85% write off
301% - 350% FPL Base = 80% write off
351% - 399% FPL Base = 75% write off

3. Subject to the other provisions of this Financial Assistance Policy, a Patient with income greater than 400⁴% of the FPL may be eligible for financial assistance under a “Means Test” for some discount of Patient’s charges for services from the Organization based on a Patient’s total medical debt. A Patient will be eligible for financial assistance pursuant

¹ Health Ministries may adjust the 250% threshold higher, but not lower. (Any adjustments should be uniform across an entire Health Ministry, as opposed to being made at the hospital facility level.)

² As adjusted at the Health Ministry for any adjustment made pursuant to footnote 5.

³ Health Ministries may adjust the 400% threshold higher or lower for cost of living utilizing the local wage index compared to national wage index.

⁴ As adjusted at the Health Ministry for any adjustment made pursuant to footnote 9.

to the Means Test if the Patient has excessive total medical debt, which includes medical debt to Ascension and any other health care provider, for emergency and other medically necessary care, that is equal to or greater than such Patient's household's gross income. The level of financial assistance provided pursuant to the Means Test is the same as is granted to a patient with income at 400¹⁰% of the FPL under Paragraph 2 above, if such Patient submits an Application on or prior to the 240th day after the Patient's first discharge bill and the Application is approved by the Organization. Patient will be eligible for the means test discount financial assistance if such Patient submits the Application after the 240th day after the Patient's first discharge bill, but then the amount of financial assistance available to a Patient in this category is limited to Patient's unpaid balance after taking into account any payments made on Patient's account. A Patient eligible for this category of financial assistance will not be charged more than the calculated AGB charges.

4. A Patient may not be eligible for the financial assistance described in Paragraphs 1 through 3 above if such Patient is deemed to have sufficient assets to pay pursuant to an "Asset Test." The Asset Test involves a substantive assessment of a Patient's ability to pay based on the categories of assets measured in the FAP Application. A Patient with such assets that exceed that exceed 250% of such Patient's FPL amount may not be eligible for financial assistance.
5. Eligibility for financial assistance may be determined at any point in the revenue cycle and may include the use of presumptive scoring for a Patient with a sufficient unpaid balance within the first 240 days after the Patient's first discharge bill to determine eligibility for 100% charity care notwithstanding Patient's failure to complete a financial assistance application ("FAP Application"). If Patient is granted 100% charity care without submitting a completed FAP Application and via presumptive scoring only, the amount of financial assistance for which Patient is eligible is limited to Patient's unpaid balance after taking into account any payments made on Patient's account. A determination of eligibility based on presumptive scoring only applies to the episode of care for which the presumptive scoring is conducted.
6. For a Patient that participates in certain insurance plans that deem the Organization to be "out-of-network," the Organization may reduce or deny the financial assistance that would otherwise be available to Patient based upon a review of Patient's insurance information and other pertinent facts and circumstances.
7. Patients that are eligible for financial assistance may be charged a nominal flat fee for services. The nominal flat fee will not exceed the AGB charge for services.⁵

⁵ To be included if the Organization charges such a flat fee and revised to reflect the Organization's practices.

Financial Assistance copays are required per visit per encounter.

Standard Financial Assistance Copay Amounts:

- ED: \$100/visit
- Hospital Based Outpatient visit: \$25/visit
- Observation Stay: \$100/visit
- Inpatient Stay: \$100/visit

NOTE: Inpatient co-pay is inclusive of all visits the patient has while an inpatient.

- Outpatient Rehab Visit: \$25/visit.

NOTE: Accounts set up for recurring rehabilitation visits will have appropriate facility copay applied with a cap of \$250 dollars.

8. If a patient lives outside of the defined catchment area where they are seeking services, they are not eligible to apply for financial assistance and other means of payment should be established if the patient chooses to have treatment at an Ascension Via Christi facility. In addition, the patients' location to other facilities in their home community, who provide the same services will be explored.
 - a. If a patient is treated through the Emergency Department for an emergent service, is admitted to the hospital from the Emergency Department or is Direct Admit, the catchment area will be waived for that date of service only.
 - b. If a patient who lives outside the defined catchment area is referred to an Ascension Via Christi facility and has an order from the referring physician for a service not available within their home community and the service is medically necessary. Ascension Via Christi will review those services that qualify for financial assistance with a complete application and supporting documents. The patient must fully comply with the application process and policy guidelines.

9. The Patient may appeal any denial of eligibility for Financial Assistance by providing additional information to the Organization within fourteen (14) calendar days of receipt of notification of denial. All appeals will be reviewed by the Organization for a final determination. If the final determination affirms the previous denial of Financial Assistance, written notification will be sent to Patient. The process for Patients and families to appeal the Organization's decisions regarding eligibility for financial assistance is as follows:
 - a. By providing a written request of appeal to the financial counseling department. The reason for the appeal should be documented in the request. All request should be mailed to: Financial Counseling/Appeals at P.O. Box 3870, Wichita, KS 67201. Additional documentation may be requesting during the appeal process.
 - b. All appeals will be considered by the Organization's financial assistance appeals committee, and decisions of the committee will be sent in writing to the Patient or family that filed the 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 the Organization.

1. Uninsured Patients who are not eligible for financial assistance will be provided a discount based on the discount provided to the highest-paying payor for that Organization. The highest paying payor must account for at least 3% of the Organization'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 Organization's business for that given year.
2. Uninsured and insured Patients who are not eligible for financial assistance may receive a prompt pay discount. 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 on the Organization's website or by contacting the Financial Assistance Department at 888-244-2266, option #2.

Applying for Financial Assistance and Other Assistance

A Patient may qualify for financial assistance through presumptive scoring eligibility or by applying for financial assistance by submitting a completed FAP Application. The FAP Application and FAP Application Instructions are available on the Organization's website or by contacting the Financial Assistance Department at 888-244-2266, option #2. The Organization will require the uninsured to work with a financial counselor to apply for Medicaid or other



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public assistance programs for which the patient is deemed to be potentially eligible in order to qualify for financial assistance (except where eligible and approved via presumptive scoring). 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, if the patient refuses to assign insurance proceeds or the right to be paid directly by an insurance company that may be obligated to pay for the care provided, or if the patient refuses to work with a financial counselor to apply for Medicaid or other public assistance programs for which the patient is deemed to be potentially eligible in order to qualify for financial assistance (except where eligible and approved via presumptive scoring). The Organization may consider a FAP Application completed less than six months prior to any eligibility determination date in making a determination about eligibility for a current episode of care. The Organization will not consider a FAP Application completed more than six months prior to any eligibility determination date.

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 on the Organization's website or by contacting the Financial Assistance Department at 888-2442266, option #2.

Interpretation

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

Exhibit B

Kansas Surgery & Recovery Center LLC

LIST OF PROVIDERS COVERED BY THE FINANCIAL ASSISTANCE POLICY

3/15/2026

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):

Kansas Surgery & Recovery Center LLC

Physicians covered by the FAP:

None

Exhibit C

Kansas Surgery & Recovery Center LLC

AMOUNT GENERALLY BILLED CALCULATION

3/15/2026

Kansas Surgery & Recovery Center calculates the AGB percentage for hospital facility charges 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 those calculations and AGB percentages are described below.

The AGB percentage for Kansas Surgery & Recovery Center hospital facility charges: 35.00%

These AGB percentages are 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 (separately for facility charges and professional services) 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).