SALEM COUNTY HOSPITAL CORP.
DBA SALEM MEDICAL CENTER
Patient Financial Services Department

FINANCIAL ASSISTANCE POLICY

Effective Date: January 1, 2019
Revised: August 10, 2022

ARTICLE I. PURPOSE:

1.1 This Financial Assistance Policy (FAP) is intended to ensure that all patients receive essential emergency and other medically necessary health care services provided by Salem County Hospital Corp. dba Salem Medical Center (the "Hospital"), regardless of their ability to pay.

1.2 The Hospital is committed to maintaining this FAP consistent with its mission and values and takes into account an individual's ability to pay for medically necessary health care services. This policy constitutes the official Financial Assistance Policy (within the meaning of Section 1.501(r) of the Internal Revenue Service's regulations promulgated thereunder and the New Jersey Hospital Services Manual, Chapter 52, Subchapter 11 (N.J.A.C. § 10:52-11.1 et seq.).

ARTICLE II. POLICY:

2.1 It is the Hospital's policy to ensure patients receive essential "Covered Services" (*i.e.*, emergency and other medically necessary health care services, as each of those terms is defined below) regardless of a patient's ability to pay. Financial assistance is available through a variety of programs as described in Section IV below to those low-income, uninsured and underinsured patients who do not otherwise have the ability to pay all or part of their hospital bill.

2.2 Financial assistance and discounts are available only for "Covered Services". Certain other services are excluded from this policy, as is discussed below.

2.3 Not all services provided within the Hospital are provided by Hospital employees and therefore may not be covered under this FAP. Please refer to Appendix A which indicates providers that are covered under this FAP and those who are not. The provider listing will be reviewed quarterly and updated, if necessary.

ARTICLE III. DEFINITIONS:

A. Amounts Generally Billed (AGB) means pursuant to Internal Revenue Code Section 501(r)(5), in the case of emergency or other medically necessary care, a patient eligible for financial assistance will not be charged more than an individual who has insurance covering such care.

B. AGB Percentage means a percentage of gross charges that a hospital facility uses to determine the AGB for any emergency or other medically necessary care it provides to an

individual who is eligible for assistance under the FAP.

C. Application Period means the time period in which an individual may apply for financial assistance. To satisfy this criteria, the organization allows individuals 365 days after the date of discharge or 240 days from the date the individual is provided with the first post-discharge billing statement (whichever is greater) to apply for financial assistance.

D. Covered Services means Emergency Medical Care or other Medically Necessary services provided to the Hospital's inpatients and outpatients. Patients who reside in the State of New Jersey who need emergency services can receive care and qualify for a discount if they meet certain income levels as described below. Non–New Jersey residents requiring immediate medical attention for an emergency medical condition may also apply for charity care. Services available to non-New Jersey residents shall include only those not reasonably available at an alternative non-New Jersey site at the time services are requested. Elective procedures and services that are not deemed medically necessary (e.g., cosmetic surgery) are not eligible for financial assistance.

E. Emergency Medical Condition is restrictively defined as a serious medical situation requiring immediate treatment, in which delay would cause serious risk to life or health.

F. Emergency Medical Care means medical care required to be provided for Emergency Medical Conditions pursuant to the Emergency Medical Treatment and Labor Act, section 1867 of the Social Security Act (42 U.S.C. 1395dd) to individuals, regardless of their eligibility for Financial Assistance under this policy. More specifically, Emergency Medical Care refers to services required to be provided under Subchapter G of Chapter IV of Title 42 of the Code of Federal Regulations and Treas. Reg. § 1.501(r)-4(c) (or any successor regulations), to the extent such regulations are applicable to the Hospital.

G. Extraordinary Collection Action (ECA) means actions taken by the Hospital against an individual relating to obtaining payment of a bill for care covered under this FAP.

H. FAP-Eligible Individual means an individual eligible for financial assistance under this Policy without regard to whether the individual has applied for financial assistance.

I. Hospital means Salem County Hospital Corp. dba Salem Medical Center.

J. Medically Necessary means those services necessary to prevent, diagnose, correct or cure conditions in a person that cause acute suffering; endanger life; result in illness or infirmity; interfere with his/her capacity for normal activity; or threaten some significant handicap.

K. Notification Period means 120-day period, which begins on the date of the 1st post discharge billing statement, in which no ECAs may be initiated against the patient.

L. Patient Access Department means the operating unit of the Hospital responsible for billing and collecting self-pay accounts for hospital services.

M. Plain Language Summary (PLS) of the FAP means a written statement that notifies an individual that the Hospital offers financial assistance under a FAP and provides necessary information in language that is clear, concise, and easy to understand. The PLS must be offered at intake or discharge and in any bill notifying a Responsible Individual about a possible ECA.

N. Responsible Individual means the patient and any other individual having financial responsibility for the patient's account. There may be more than one Responsible Individual.

ARTICLE IV. GENERAL POLICY STANDARDS:

The Hospital will render inpatient and outpatient Covered Services to all New Jersey residents who are in need of such Covered Services, regardless of the ability of the patient. 4.1 to pay for such services and regardless of whether and to what extent such patients may qualify for financial assistance pursuant to this FAP.

4.2 The Hospital will not engage in any actions that discourage individuals from seeking emergency medical care, such as by demanding that emergency department patients pay before receiving treatment or by permitting debt collection activities in the emergency department or other areas where such activities could interfere with the provision of emergency care.

4.3 The Hospital's FAP, application for financial assistance and Plain Language Summary ("PLS") are all available on-line at the following website: www.smc.health.

4.4 The PLS is offered to all Responsible Individuals as part of the intake process.

4.5 The Hospital's FAP, application for financial assistance and PLS are available in English, Spanish and in the primary language of populations with limited proficiency in English that constitute the lesser of 1,000 individuals or 5% of the community served by the Hospital's primary service area. Every effort will be made to ensure that the FAP, application for financial assistance and PLS are clearly communicated to Responsible Individuals whose primary languages are not included among the available translations.

4.6 Paper copies of the FAP, application for financial assistance and PLS are available upon request by mail, without charge, and are provided in various areas throughout the Hospital facilities including admissions departments, emergency departments, and the Patient Access Department listed below. Applications for financial assistance can be submitted in person, by mail, by fax or by e-mail.

Salem County Hospital Corp.
Attn: Patient Access Department
310 Salem Woodstown Road
Salem, New Jersey 08079
(856) 878-6894 | (856) 935-4122

4.7.1 If Responsible Individuals need assistance obtaining paper copies of the FAP, the application for financial assistance or the PLS, or if they need other assistance, they can reach the Patient Access Department at (856)878-6894 or visit the Patient Access Department at the address listed above.

4.8 Signs or displays that notify and inform Responsible Individuals about the availability of financial assistance will be conspicuously posted throughout the Hospital, including in admissions areas, outpatient clinic areas, the emergency department, and the Patient Access Department. Notices will also be posted in

Spanish.

4.9 The Hospital is committed to offering financial assistance to eligible patients who do not have the ability to pay for emergency and other medically necessary health care services in whole or in part. In order to accomplish this charitable goal, the Hospital will widely publicize this FAP, the application for financial assistance and the PLS in the communities it serves through collaborations with local social service and non-profit agencies.

4.10.1 Patients or Responsible Individuals may request financial assistance. Patients or Responsible Individuals may be referred to financial counselors by the Hospital's employees, referring physicians or others. Financial counselors will explain the requirements for the available financial assistance programs and will determine whether a patient is eligible for an available financial assistance program.

4.10.2 Those Responsible Individuals requesting financial assistance will be required to complete the Hospital application for financial assistance (including the certification pages) and to provide the supporting documentation set forth in the application in order to be considered for financial assistance. Translated materials and interpreters will be used, as required, to allow for meaningful communication with individuals who have limited English proficiency.

4.10.3 Some services, including but not limited to, physician fees, anesthesiology fees, radiology interpretation and outpatient prescriptions are separate from hospital charges and may not be eligible for financial assistance through the Hospital. The Hospital will make an initial determination for eligibility for any medical assistance programs available and refer the patient or Responsible Individual to the appropriate program. Patients are expected to cooperate with this process. If the patient declines to be screened or does not timely complete the medical assistance application, the Hospital may bill the Responsible Individual, consistent with its billing practices for other patients, and implement ECAs.

4.11 A patient may apply for financial assistance at any time during the Application Period (defined above).

4.12 Presumptive Financial Assistance Eligibility: There are instances when a patient may appear eligible for Financial Assistance, but the formal application process and documentation requirements were not completed. For these cases, the Hospital may use outside sources of information from software vendors (*e.g.*, Transunion, Experian, etc.) to assist in estimating patient income to determine Presumptive Financial Assistance eligibility. Presumptive eligibility may be based on prior FAP Eligibility or may also be determined on the basis of individual life circumstances that may include:

4.12.1 State-funded prescription programs;

4.12.2 Homeless or received care from a homeless clinic;

4.12.3 Participation in Women, Infants and Children programs (WIC);

4.12.4 Food stamp eligibility;

4.12.5 Subsidized school lunch program eligibility;

4.12.6 Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down);

4.12.7 Low income/subsidized housing is provided as a valid address; and

4.12.8 Patient is deceased with no known estate

4.12.9 If the patient is presumptively eligible for less than the most generous assistance available, the Hospital will notify the patient regarding the basis for the presumptive FAP eligibility determination and the way to apply for more generous assistance available under the FAP. The Hospital will also give the patient a reasonable period of time to apply for more generous assistance before initiating ECAs to obtain the discounted amount owed for the Covered Services.

ARTICLE V. FINANCIAL ASSISTANCE PROGRAMS:

Patients of the Hospital may qualify for free or discounted care under the various programs described below. In each case, the Hospital will be deemed to have provided financial assistance in an amount equal to the gross charges for services provided, net of amounts paid by the patient or the patient's insurer (if any) and any governmental reimbursement or payment for such services. The Hospital will report such net amounts (subject to application of a cost-to- charge ratio, in cases where financial assistance is appropriately reported based on costs rather than charges) as financial assistance provided by the organization. New Jersey State Programs include Charity Care, Eligibility for Discounted Care, Catastrophic Illness in Children Relief Fund, New Jersey Victims of Crime Compensation Office, and Self-Pay Discounts, each as more particularly described below:

5.1 Charity Care: Charity Care is a State program available to New Jersey residents who:

- ❖ Have no health insurance coverage or have coverage that pays only for part of the bill;
- ❖ Are ineligible for any private or government sponsored coverage (such as Medicaid); and
- ❖ Meet both the income and assets eligibility criteria established by the State.

(a) Screening. Patients will be screened for the Charity Care program which covers (i) 100% of charges for patients with family gross income less than or equal to 200% of the federal poverty level; and (ii) a portion of charges for patients with family gross income greater than 200% but less than or equal to 300% of the federal poverty level, all in accordance with the guidelines set forth at Appendix B. Patients will also be screened for reduced Charity Care program which may cover 20%, 40%, 60%, or 80% of charges.

(b) Criteria required in order to be eligible for Charity Care: The Charity Care eligibility limits are an individual asset limit of $7,500 and family asset limit of $15,000. For purposes of this Section, family members whose assets must be considered are defined in N.J.A.C. 10:52-11.8(a) as follows:

(i) Family size for an adult applicant includes the applicant, spouse, any minor children whom he or she supports, and adults for whom the applicant is legally responsible.

(ii) The family size for a minor applicant includes both parents, the spouse of a parent, minor siblings and any adults in the family for whom the applicant's parent(s) are legally responsible.

(iii) If an applicant documents that he or she has been abandoned by a spouse or parent, that spouse or parent shall not be included as a family member. A pregnant female counts as two family members.

(c) Required Documentation Includes:

(i) Proper patient and family identification documents. This can include any of the following: driver's license, social security card, alien registry card, birth certificate, baptismal certificate, paycheck stub, passport, visa, death certificate, employee identification, or attestation that the person is homeless and does not possess any of the above identification documents. Other identification documentation may be acceptable in accordance with N.J.A.C. §§ 10:52-11.5 and 11.6.

(ii) Proof of New Jersey residence as of the date of service. This can include any of the following: driver's license, voter registration card, union membership card, insurance or welfare plan identification card, student identification card, utility bill, federal income tax return, state income tax return, or an unemployment benefits statement. (Note: under certain circumstances, emergency care is an exception to the New Jersey residency requirement). Pursuant to N.J.A.C. §§ 10:52-11.7, for these purposes, emergency medical condition shall be restrictively defined as a serious medical situation requiring immediate treatment, in which delay would cause serious risk to life or health. Services available to non-New Jersey residents shall include only those not reasonably available at an alternative non-New Jersey site at the time services are requested.

(iii) Proof of gross income. This should include the detail required by the Hospital to determine the patient's actual gross income for the 12 months preceding services, 3 months preceding services, or one month immediately preceding services. Proof of income may include:

- Federal or State income tax return
- pay check stubs
- W–2 forms

- a letter from an employer on company letterhead stating the applicant's income, or

- a statement of the gross benefit amount from any governmental agency providing benefit to the applicant (e.g., annual benefits statement from Social Security).

(iv) Proof of assets as of the date of service. These are items which are readily convertible into cash such as stocks, bonds, IRAs, CDs, checking and savings accounts, or equity in a non-primary residence.

(v) Patients admitted through the emergency room. The Hospital will appropriately notify patients admitted through the emergency room of the availability of charity care and assess/document the patient's eligibility based upon the criteria outlined in N.J.A.C. §10:52-11.16.

(d) Determination of Eligibility. The Patient Access Department will make a determination of whether the applicant is eligible no later than ten (10) working days from the day the completed initial application was received. If the application is incomplete (*e.g.*, a request for income/asset proof is not provided or is inadequate), a written denial will be issued within ten (10) working days, which will provide detail of the additional documentation needed to obtain approval. An uninsured applicant has up to 365 days from the discharge date to reapply for Charity Care with the required documentation. Applicants who are ineligible may reapply at a future date when they present for services and their financial circumstances have changed.

(e) Coverage/Award. The NJ Charity Care Program covers charges that are billed by an acute care hospital for Covered Services that would be payable under the State's Medicaid program if the patient were eligible for Medicaid. A patient eligible for Charity Care will receive either free care or a discount off of gross charges, in accordance with the guidelines set forth at Appendix B.

5.2 Eligibility for Discounted Care Under N.J.S.A. 26:2H-12.52: Uninsured patients who are New Jersey residents with family gross income below 500% of the federal poverty level will be eligible to receive discounted care in accordance with Section IV.B. of the FAP. The documentation requirements applicable to Charity Care assets forth above apply to eligibility determinations under this Section, except that the individual and family asset thresholds shall not apply to eligibility for discounted care under this Section.

5.3 Catastrophic Illness in Children Relief Fund Program: The State of New Jersey's Catastrophic Illness in Children Relief Fund Program provides financial assistance to families of children with a catastrophic illness. Information about eligibility, eligible expenses, and applying for assistance can be found at http://www.state.nj.us/humanservices/cicrf/home/.

5.4 New Jersey Victims of Crime Compensation Office: The State of New Jersey has established the New Jersey Victims of Crime Compensation Office to compensate victims of crime for losses and expenses, including certain medical expenses, resulting from certain

criminal acts. Information about eligibility, eligible expenses, and applying for assistance can be found at http://www.nj.gov/oag/njvictims/application.html.

5.5 Self-Pay Discounts: Uninsured patients who are New Jersey residents with family gross income below 500% of the federal poverty level will have a self-pay discount applied to their account in accordance with this Section. Upon submission of an application for financial assistance and a determination that a patient is eligible for financial assistance under the FAP, a patient will not be charged more than the amount charged by the Hospital to insured patients for those same services. Uninsured patients who are New Jersey residents with family gross income below 500% of the federal poverty level who do not qualify for Federal or State funded financial assistance programs (with the exception of Charity Care) will be charged as follows:

(a) Inpatients: Patients receiving Covered Services as an inpatient will be charged the lesser of AGB or the appropriate Medicare rate plus 15% for the service received.

(b) Outpatients: Patients receiving Covered Services as an outpatient will be charged the lesser of AGB or the appropriate Medicare rate plus 15% for the service received.

5.6 Amounts Generally Billed. Annually, the Hospital will calculate the AGB percentage utilizing the Look-back method. The AGB percentage is calculated by dividing the Medicare fee-for-service program + Private Health Insurers claims by the gross charges associated with those claims. The resulting AGB percentage is multiplied by the gross charges for specific procedures to determine the AGB amount. Please refer to Appendix C for the Hospital's AGB %.

An individual determined to be FAP-eligible will not be charged more than AGB for emergency and other medically necessary healthcare services pursuant to IRC Section 501(r)(5). AGB is the maximum amount charged to any FAP eligible individual. In accordance with this FAP, a FAP-eligible individual will be charged the lesser of AGB or any other discounted rates for which they qualify for under this FAP.

ARTICLE VI. BILLING AND COLLECTION POLICY.

6.1 This Section sets forth the billing and collection policies and procedures of the Hospital and explains the actions that may be taken if a bill for medical care, including a bill for a remaining balance after financial assistance discounts are applied, is not paid. Collection agencies and attorneys acting on behalf of the Hospital will be provided with a copy of this FAP.

6.2 Each billing statement will include a conspicuous notice regarding the availability of financial assistance, along with a telephone number for the Hospital's Patient Financial Services Office where a patient or Responsible Individual can receive information about the FAP and assistance with the application for financial assistance. The billing statement will also include the website address where copies of the FAP, application for financial assistance, and PLS can be obtained.

Notification period: The Hospital will bill Responsible Individuals for any outstanding balance as soon as the patient balance is confirmed. For uninsured patients, the first post-discharge billing statement will mark the beginning of the 120-day notification period in which no extraordinary collection actions ("ECA") (defined below) may be initiated against the Responsible Individual. For insured or underinsured patients, the first post-

discharge billing statement reflecting processing by an insurer will mark the beginning of the 120-day.notification period in which no ECAs may be initiated against the Responsible Individual (the "120-day notification period").

6.3 When a Responsible Individual is delinquent in payment, a notice will be sent to the Responsible Individual offering to discuss the billing statement to determine if financial assistance or a new or revised payment plan is needed. The Hospital may accommodate Responsible Individuals who request and establish payment plans.

6.4 At least three (3) separate account statements will be mailed to the last known address of each Responsible Individual. At least 120 days must elapse between the first post-discharge bill and initiation of ECAs (as discussed below).

6.5 At least one of the statements sent during this time will include written notice that informs the Responsible Individual about the ECAs that may be taken if the Responsible Individual does not apply for financial assistance under the FAP or pay the amount due by the Billing Deadline. Such statement must be provided to the Responsible Individual at least 30 days before the deadline specified in the statement, if commencing ECAs.

6.6 When no payment has been received at the end of the 120-day notification period and a Responsible Individual has not applied for financial assistance or arranged with the Hospital's Patient Financial Services Office for an alternate payment plan, the Responsible Individual's account will be subject to ECAs.

6.7 Extraordinary Collection Actions (ECAs): ECA refers to any action against an individual related to obtaining payment such as selling an individual's debt to another party; reporting adverse information about the Responsible Individual to consumer credit reporting agencies or credit bureaus; deferring or denying or requiring a payment before providing medically necessary care because of an individual's nonpayment of one or more bills for previous care covered under the Hospital's FAP; or other actions that require a legal or judicial process including:

(a) Placing a lien on an individual's property (other than a lien that the Hospital is entitled to assert under state law on the proceeds of a judgment, settlement, or compromise owed to an individual (or his or her representative) as a result of personal injuries for which the Hospital provided care);

(b) Foreclosing on an individual's real property;

(c) Attaching or seizing an individual's bank account or any other personal

property;

(d) Commencing a civil action against an individual;

(e) Causing an individual's arrest;

(f) Causing an individual to be subject to a writ of body attachment; and

(g) Garnishing an individual's wages.

6.8 All collection agencies affiliated with the Hospital have a copy of and must follow the Hospital's Financial Assistance Policy and will refer any Responsible Individual needing assistance back to the Hospital for evaluation and reduction of a bill based on annual income and family size.

6.9 Responsible Individuals will receive a written notice 30 days prior to any account being forwarded to a collection agency or the initiation of any other ECA. A reasonable effort to orally notify the Responsible Individual by telephone at the last known telephone number must also be made. During all conversations, the Responsible Individual will be informed about the financial assistance that may be available under the FAP.

6.10 The Hospital prohibits collections against any patient who is eligible for Medicaid at the time services are rendered.

6.11 The Hospital will not send an account to collection if a Financial Assistance application is pending.

6.12 After the commencement of ECAs is permitted, external collection agencies shall be authorized to file litigation, obtain judgment liens and execute upon such judgment liens using lawful means of collection; provided, however, that prior written approval from the Patient Financial Services Department shall be required before any legal action may be initiated and prior approval of the Patient Financial Services Department shall be required before collection agencies may use any means of collection that involves physical detention or arrest of any Responsible Individual.

6.13 Collection agencies are prohibited from forcing the sale of or foreclosure on a Responsible Individual's primary residence.

6.14 If the Hospital refers or sells patient debts to another party during the Application Period, the written agreement with such party must obligate such party to:

(a) Refrain from engaging in ECAs until the Billing Deadline;

(b) Suspend any ECAs if the individual submits a FAP application during the Application Period;

(c) If the Responsible Individual is determined to be FAP-eligible, ensure that the individual does not pay and is not obligated to pay more than required, and to reverse any ECA previously taken; and

(d) Obtain similar provisions in a written agreement if such party refers or sells

the debt to another party.

6.15 The PLS must be offered in any bill notifying a Responsible Individual about a possible ECA.

6.16 Financial assistance availability and office phone numbers are printed on the bottom of all Hospital bills, along with the website address where copies of the FAP, FAP application form and PLS may be obtained

6.17 If an incomplete application for financial assistance is received, the Hospital will provide the Responsible Individual with written notice that describes the additional information or documentation required to make a FAP-eligibility determination. The Hospital will inform Third Parties that an incomplete application for financial assistance was submitted and Third Parties will suspend any ECAs to obtain payment for care for a 30-day period.

6.18 If a completed application for financial assistance is received, the Hospital will ensure that the following will take place:

6.18.1 ECAs against the Responsible Individual will be suspended;

6.18.2 An eligibility determination will be made and documented in a timely manner;

6.18.3 The Hospital will notify the Responsible Individual in writing of the determination and the basis for the determination;

6.18.4 An updated billing statement will be provided which will indicate the amount owed by the FAP-eligible Responsible Individual (if applicable), and how that amount was determined;

6.18.5 If applicable, any amounts paid in excess of the amount owed by the FAP-eligible Responsible Individual will be refunded accordingly; and

6.18.6 Third Parties will take all reasonable available measures to reverse any ECAs taken against the Responsible Individuals to collect the debt, such as vacating a judgment or lifting a levy or lien.

References:

Section 501(r) of the Internal Revenue Code of 1986, as amended; Code of Federal Regulations - Internal Revenue Service, 26 CFR § 1.501(r)-1 et seq.; N.J.S.A. § 26:2H-12.52, 12.53 (Cap Upon Fees for Health Care Services for Certain Uninsured Persons; N.J.S.A. § 26:2H- 12.53 Sliding Scale Fees Based Upon Income); N.J.A.C. § 10:52-11.1 et seq. (Hospital Services Manual - Charity Care)

APPENDIX A
PROVIDER LISTING

All employed physicians of Salem Medical Center that provide emergency and other medically necessary healthcare services at the hospital follow the Financial Assistance Policy.

There are currently no other physicians or other healthcare providers that provide emergency or other medically necessary healthcare services at the hospital that follow the Financial Assistance Policy.

APPENDIX B

CHARITY CARE AND REDUCED CHARITY CARE ELIGIBILITY CRITERIA
Effective: January 12, 2022 (updated per FPL criteria each year)

Patient Must Meet Both the Income and Assets Criteria

INCOME CRITERIA

Percentage of Charges Paid By Patient When
Gross Annual Income is Within the Following Ranges

	Patient Pays 0% Of Charges	**Patient Pays 20% Of Charges**	**Patient Pays 40% Of Charges**	**Patient Pays 60% Of Charges**	**Patient Pays 80% Of Charges**	**Patient Pays 100% Of Charges**
Family Size	**<=200%**	**>200<=225%**	**>225<=250%**	**>250<=275%**	**>275<=300%**	**>300%**
1	$27,180 or less	$27,181 to $30,578	$30,579 to $33,975	$33,976 to $37,373	$37,374 to $40,771	$40,772 or more
2	$36,620 or less	$36,621 to $41,198	$41,199 to $45,775	$45,776 to $50,353	$50,354 to $54,930	$54,931 or more
3	$46,060 or less	$46,061 to $51,818	$51,819 to $57,575	$57,576 to $63,333	$63,334 to $69,090	$69,091 or more
4	$55,500 or less	$55,501 to $62,438	$62,439 to $69,375	$69,376 to $76,313	$76,314 to $83,250	$83,251 or more
5	$64,940 or less	$64,941 to $73,058	$73,059 to $81,175	$81,176 to $89,293	$89,294 to $97,410	$97,411 or more
6	$74,380 or less	$74,381 to $83,678	$83,679 to $92,975	$92,976 to $102,273	$102,274 to $111,570	$111,571 or more
7	$83,820 or less	$83,821 to $94,298	$94,299 to $104,775	$104,776 to $115,253	$ 115,254 to $125,730	$125,731 or more
8	$93,260 or less	$93,261 to $104,918	$104,919 to $116,575	$116,576 to $128,233	$128,234 to $139,890	$139,891 or more
For families with more than 8 members, see https://aspe.hhs.gov/poverty-guidelines						
*A pregnant woman is counted as 2 family members.						
If patients on the 20% to 80% sliding fee scale are responsible for qualified out-of-pocket paid medical expenses in excess of 30% of their gross annual income (*i.e.*, bills unpaid by other parties), then the amount in excess of 30% is considered hospital care payment assistance (charity care).						

ASSETS CRITERIA

Individual assets cannot exceed $7,500 and family assets cannot exceed $15,000.

APPENDIX C

AGB

The Hospital's calculated AGB % is 13.22% based on Look-Back method as prescribed in IRC §501(r).