

Title: Financial Assistance Policy	Original Date	5/90
Facility: Graham Health System	Review Date:	12/99, 3/02
Standard: None Cited	Revision Date	10/96, 5/06, 12/07, 4/09, 2/10, 3/10, 12/13, 1/15, 10/15, 6/16, 11/16, 10/17, 11/17, 07/18, 01/19, 06/19, 02/20, 06/20, 01/21, 6/21, 03/22, 01/23, 02/24, 02/25, 2/26
Approved By: SVP of Hospital Operations & CFO Graham Board of Trustees	Effective Date:	February 2026

PURPOSE

Graham Health System (GHS) is a not-for-profit health system serving the needs of Fulton, Mason, McDonough, Knox, Peoria and surrounding counties. GHS provides emergency & urgent medically necessary care to patients regardless of their ability to pay or availability of third-party insurance coverage. In the event that third-party insurance coverage is not available, accounts will be reviewed for alternative payment sources. An allocation is made each year for funds to be available for patients who qualify for financial assistance.

Financial assistance is made available for income eligible patients according to financial need. Whenever possible, a determination of eligibility for financial assistance will be initiated by a Patient Financial Advocate prior to, or at the time of admission, procedure, and/or licensed practitioner consultation. All discounts as described throughout this policy only apply to services provided and billed by GHS, which encompasses Graham Hospital, Graham Emergency Room, Graham Medical Group, Graham Home Medical Equipment and Graham Skilled Nursing. Emergency admission, treatment, screening and/or stabilization services will not be delayed or denied due to an inability to pay. This policy does not apply to the Graham Health System’s Walnut Terrace Nursing Home Facility.

POLICY

GHS provides financial assistance for medically necessary services to individuals who are without the financial resources to fulfill their payment obligations for health care received at a GHS facility. This policy includes discounts on all medically necessary services that are billed by GHS. See Attachment I for a complete list of licensed practitioners that are both covered by and excluded from this policy.

The AVP of Hospital Operations & CFO has established requirements related to qualifications for application and related discounts under this policy, which shall be consistent with the Fair Patient Billing Act, the Hospital Uninsured Patient Discount Act and regulations prescribed hereunder. The Senior Director of Revenue Cycle shall be responsible for implementing the policy according to the requirements. GHS shall file its annual Hospital Financial Assistance Report as required by statute or regulatory agency.

GHS will provide, upon request, a copy of this policy to any member of the public and any regulatory agency. In addition, information about financial assistance and contact information will be made available in all registration areas through signage and brochures and on GHS’ publicly available website.

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DEFINITIONS

The following terms are meant to be interpreted as follows within this policy:

1. Amounts Generally Billed (AGB): The amounts billed to patients eligible for financial assistance seeking emergency or medically necessary care.
 - a. GHS will apply the “look-back method” when determining AGB. This will be completed by multiplying the gross charges for that care by the AGB percentage. The AGB percentage will be calculated annually using the CMS Provider Statistical and Reimbursement System Report ran for the prior fiscal year. The total allowed amounts will be divided by the total gross charges for all providers of the health system to calculate an overall AGB percentage.
2. Charity Care: Healthcare services provided which are not expected to result in cash inflows; medically necessary services rendered to individuals meeting established criteria, without expected payment.
3. Emergency Care: Immediate care which is necessary to prevent putting the patient’s health in serious jeopardy, serious impairment to bodily functions, and/or serious dysfunction of any organs or body parts.
4. Extraordinary Collection Actions (ECA): Any actions taken by GHS (or any agent of GHS, including a collection agency) against an individual related to obtaining a bill covered under this policy, that requires a legal or judicial process (such as a court order or judgment). Placing an account with a third party for collections is not an ECA.
5. Health Savings Account: A tax-advantaged account that can be used to pay for current or future healthcare expenses.
6. Medically Necessary: Hospital services or care rendered either inpatient or outpatient, to a patient in order to diagnose, alleviate, correct, cure, or prevent the onset or worsening of conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, and threaten to cause or aggravate a handicap, or result in overall illness or infirmity. Annual preventive office visits will be covered under Charity Care for adults. Age-appropriate well-child visits will be covered for children.
7. Financial assistance: A discount provided to a patient under the terms and conditions a hospital offers to qualified patients or as required by law.
8. Uninsured: The patient is not covered under a policy of health insurance and is not a beneficiary under a public or private health insurance, health benefit, or other health coverage program, including high deductible insurance plans, workers’ compensation, accident liability insurance, or other liability.
9. Urgent Care: Services necessary in order to avoid the onset of illness or injury, disability, death, or serious impairment or dysfunction if not treated within 12 hours.

PROCEDURE

Hospital financial assistance programs available to uninsured patients include **Charity Care, Discounted Care and the Uninsured Patient Discount** (in accordance with 210 ILCS 89 – Hospital Uninsured Patient Discount Act). Patient Financial Advocates are available to discuss the various Financial Assistance Program options available to GHS patients.

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Determining Eligibility for Financial Assistance:

Financial assistance will generally be provided on a prospective basis unless there is evidence of a pending application for public aid and/or social security disability coverage at the date of the application.

Applications are available upon registration, or to anyone requesting an application at any time. If requested by phone, an application will be mailed. Applications can also be found on the GHS website (www.grahamhealthsystem.org). Eligibility will be approved for a maximum of one year, beginning with the date of approval by GHS.

- **Eligibility Requirements:**

- The patient is receiving, scheduled to receive, or has received a medically necessary service as defined by this policy.
- The patient has utilized all available funds in their Health Savings Account (HSA). The patient must present documentation supporting insufficient funds at each instance requesting assistance.
- The patient satisfies the requirements of Patient Responsibilities under this policy.

- **Application Requirements:**

- A fully completed GHS Financial Assistance Application
- A copy of their most recent federal tax return
- Proof of income for applicant (and spouse if applicable), such as but not limited to recent pay stubs, unemployment payment stubs, Health Savings Account statement, Investment income, Social Security, Disability; or sufficient information on how patients are currently supporting themselves
- Listing of all assets and supporting documentation; either from financial institutions or other third-party verifications
- Other information as requested by the Patient Financial Advocate

- **Application Guidelines:**

- All completed applications will be acknowledged within 30 days, informing the patient of the decision regardless of assistance awarded.
- Applications will be approved by an appropriate GHS Designee.
- Applications will be accepted up to 240 days from the first billing period.
- Incomplete applications will result in suspension of ECAs for a reasonable amount of time during the notification and application period (120 days and 240 days from service, respectively). Patients will be billed full charges if they do not apply for financial assistance.

The Federal Poverty Income Guidelines will be used as a calculation base for Charity Care/Discounted Care. Patients with income up to 300% of the Federal Poverty Guideline may be awarded full, or partial, financial assistance through evaluation of the completed application and provided information.

Federal Poverty Guidelines (FPL) for CY 2026

People in Family Unit	Federal Poverty Guideline
1	\$ 15,960
2	\$ 21,640
3	\$ 27,320
4	\$ 33,000
5	\$ 38,680
6	\$ 44,360
7	\$ 50,400
8	\$ 55,720

Calculating Financial Assistance:

GHS will provide a discount from its medically necessary charges to any uninsured patient who applies for and qualifies for financial assistance. Eligible patients will not be charged more than the amounts generally billed (AGB) to individuals with insurance covering such care for emergency or other medically necessary services. Graham Health System's AGB Discount is 71.73% for 2026. Those eligible for the uninsured discount may not be charged more than 20% of their annual family income over a period of one year.

Once eligibility is determined and approved, bills for medically necessary services will be further reduced by the following:

0% - 180% of FPL	100% Discount off AGB
181% - 190% of FPL	90% Discount off AGB
191% - 200% of FPL	80% Discount off AGB
201% - 210% of FPL	66% Discount off AGB
211% - 220% of FPL	53% Discount off AGB
221% - 230% of FPL	39% Discount off AGB
231% - 240% of FPL	25% Discount off AGB
241% - 250% of PFL	5% Discount off AGB
251% - 300% of FPL	AGB Only

Presumptive Charity: Presumptive charity/exceptions to the application process, based on ability to pay, include:

- Soft credit checks by a collection agency may determine eligibility status for those unable to provide an application
- Accounts deemed uncollectible by a contracted collection agency
- Out of state Medicaid patients may meet charity status if emergent
- Food stamp eligibility
- Homelessness
- Deceased with no estate
- Mental incapacitation with no one to act on patient's behalf
- Medicaid eligibility, but not on date of service or for non-covered service

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- Incarceration in a penal institution
- Patient enrolled in an organized community-based program providing access to medical care that assesses and documents limited low-income financial status as criteria. Patient or family income must be below 180% federal poverty level to be eligible for 100.0% assistance.
- Special circumstances such that income exceeds poverty guidelines, but medical bills are high, the Senior Director of Revenue Cycle and/or SVP of Hospital Operations & CFO may determine partial or full eligibility provided proper documentation is available.
- Circumstances where patient does not complete an application and there is adequate information to support that patient's inability to pay will be forwarded to the Senior Director of Revenue Cycle and/or the SVP of Hospital Operations & CFO for consideration.

Prompt-Pay Discounting

Patients who do not qualify for financial assistance discounting will be eligible for a 20.0% prompt-pay discount (for medically necessary services), if paid prior to the date of service, on the date of service or within 30 days from the first statement date. The patient is responsible for calling the Business Office to request a 20.0% discount if not paid at time of service. If actual billed charges exceed the estimated amount paid at the time of service, a 20.0% prompt-pay discount will be applied to the total charge amount. Financial assistance discounts and prompt-pay discounts cannot be combined, nor combined with any other discount offered by GHS, or its affiliates.

This prompt-pay discount only applies to Graham Hospital, Graham Home Medical Equipment and Graham Skilled Nursing balances. It does not apply to any balances for services provided at Graham Medical Group (GMG). Professional fees of all GMG Surgeons, for surgeries performed at Graham Hospital, are allowed the 20.0% discount, if all other criteria have been met. Professional anesthesia fees are also allowed the 20.0% discount.

Patients who were provided an estimate at time of service and chose not to pay are not eligible for the prompt-pay discount after services have been provided.

Notwithstanding any requirements of this policy, individual uninsured cases may be considered for financial assistance at the sole discretion of the SVP of Hospital Operations & CFO and President & CEO.

BILLING PROCEDURES

- A. Uninsured patients will be screened for eligibility under Medicaid or other state programs as soon after admission as possible. Patient Financial Advocates will meet with uninsured patients and patients with deductibles and co-insurance to identify the payment source, to make payment arrangements, and/or to provide information regarding financial assistance. Financial counseling is available to all patients to address concerns regarding financial options.
- B. Co-payment and deductible amounts (or estimated amounts thereof) are requested from Clinic, Imaging, and Same Day Surgery patients at pre-registration or registration.
- C. All uninsured and self-pay patients presenting to Graham Medical Group, who do not qualify for assistance, are requested to pay \$75 on the day of service in order to be seen. This is not considered payment in full, only a down payment toward services rendered. The balance will be billed to the patient or guarantor.

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- D. Self-Pay patients who choose to have an elective service performed at GHS will receive an estimate of their total financial responsibility. Payment requirements for elective services and amounts due are outlined below:
- a. Amount Due Less than \$10,000: The patient shall pay the full amount prior to receiving the service less a 20.0% discount.
 - b. Amount Due Greater than \$10,000: The patient shall pay the first \$10,000, less the 20.0% discount. Payment of the balance due will follow the GHS Financial Assistance Policy.
- E. If the patient is eligible for financial assistance, per established criteria, and needs a semi-elective surgery, the AGB discount may be applied.
- F. Self-pay OB patients, who are eligible for financial assistance, will receive the AGB discount and will be responsible for paying the remaining balance prior to delivery. Payment plans will be set up by the Patient Financial Advocates.
- G. It is the patient's responsibility to provide GHS with all necessary information to bill their insurance(s). GHS staff will complete and submit claims on the patient's behalf. Patients will be billed for balances remaining after third-party payments and adjustments are applied. Even though insurance is carried, the patient is ultimately responsible for providing payment for services rendered. If the patient's insurance rejects or denies payment for services, GHS will bill the patient, unless GHS is contractually prohibited from doing so.
- H. If an Uninsured patient receives an Uninsured Discount and subsequently provides valid insurance information, the Uninsured Discount will be reversed when GHS bills the third party.
- I. The patient billing cycle begins with the production of a final bill (in the case of Uninsured patients) or with payment or denial by the insurer (in the case of Insured patients). The billing cycle is as follows:
- Day 1 – 1st statement
 - Day 30 – 2nd statement
 - Day 60 – 3rd statement
 - Day 90 – 4th statement
 - Day 120 – Collection Notice sent to patient, requesting payment or contact from patient
 - Day 150 – If payment in full has not been received, the account may be turned over to an external collection agency
- J. Patient concerns are handled by the GHS Patient Financial Advocates. Any unresolved patient concerns are referred to the Senior Director of Revenue Cycle. If questions regarding patient charges arise, the Director of the clinical department is consulted. If there is a material dispute regarding the charges on the patient's bill, the collection process may be put on hold until the dispute is resolved. Write-offs completed as resolution to a patient concern or patient care issue must be approved by the President & CEO.

NON-PAYMENT

Unresolved Patient accounts, in which financial assistance has not been requested, may be referred to a collection agency 150 days after the patient bill is produced. Patients whose accounts have been referred to a collection agency are to request financial assistance.

GHS requires the approval of the Senior Director of Revenue Cycle to engage in an extraordinary collection action (ECA) on a patient account. The Senior Director of Revenue Cycle has the final authority and responsibility for determining whether GHS made reasonable efforts to determine whether a patient is eligible for financial assistance prior to engaging in ECAs. Either will confirm the following actions were taken with regard to a patient prior to approving ECAs on the patient's account:

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- The patient received the notice of an ECA no earlier than 120 days after first billing;
- The notice of a potential ECA specified the potential actions that would be taken if the patient did not submit a completed FAP application or pay the amount due by the deadline (specified in the notice); and
- The potential ECA notice was provided to the patient 30 days prior to the ECA deadline. The Senior Director of Revenue Cycle will also inspect the patient's billing file prior to approving ECAs on the patient's account.
- The following communications will be noted in the billing file:
 - A plain language summary application for financial assistance was provided before discharge;
 - All billing statements and other billing communication were provided in plain language; ○ Any oral communication with the patient provided financial assistance information in plain language; and
 - At least one notice of potential ECA was provided to the patient.
- The collection agency is authorized by GHS to take the following ECAs to obtain payment of a patient bill. The collection agency is not authorized to pursue these ECAs at any time GHS itself would be prohibited from pursuing ECAs:
 - Placing a lien or foreclosing on an individual's property;
 - Attaching or seizing individual's bank account or any other personal property; ○ Garnishing wages;
 - Filing a civil lawsuit

PATIENT RESPONSIBILITIES

This policy requires the cooperation of the patient, as a condition of receiving assistance. That cooperation includes, but is not be limited to, the following:

- The patient must cooperate with GHS by providing information on third-party insurance coverage. If GHS finds that there is a reasonable basis to believe that the patient may qualify for such coverage, the patient must cooperate in applying for third-party insurance coverage that may be available to pay for the uninsured patient's medically necessary care, including coverage from a health insurer, a health care service plan, Medicare, Medicaid, automobile insurance, worker's compensation, or other insurance available under the Affordable Care Act.
- The patient must provide GHS with financial and other information requested to determine eligibility for financial assistance. Generally, information to support application materials must be received within 30 days of the date of service or discharge.
- Generally, the patient, or a person, acting on their behalf must request assistance from GHS. GHS has full discretion to identify specific cases for potential charity needs based on financial and other information that is made available to the organization.
- The patient who has a payment obligation to GHS must cooperate to establish and comply with a financial plan. The patient who enters into a financial plan agreement shall promptly inform the appropriate GHS billing entity of any change in circumstances that will impair their ability to comply with the financial plan.
- The patient must notify GHS of any change in financial status that could disqualify the patient for financial assistance.

- Any patient who fails to satisfy their responsibility under this policy may be billed by GHS and is subject to collection activities consistent with organizational billing and collection policies and practices for patients who do not qualify for assistance under this policy.

FINANCIAL ASSISTANCE PROGRAM: PUBLICATION

The Financial Assistance Policy (FAP), FAP application, and plain language summary are available on the GHS website at www.grahamhealthsystem.org. The FAP, FAP application, and plain language summary are also available by request, free of charge, by mail, from a Patient Financial Advocate, or in paper form at any GHS patient registration and cashier areas.

Employees shall refer any patient who requests financial assistance or who indicates that they are unable to pay the entire amount of their account balance to a Patient Financial Advocate by calling the Business Office. Employees other than those persons working in the Business Office shall not make specific representations or promises to patients concerning whether a patient may qualify for any type or amount of financial assistance. Notwithstanding the foregoing, coworkers in the Emergency Department shall follow EMTALA policies and procedures in responding to inquiries from Emergency Department patients regarding charges and related

CONTACT INFORMATION

Graham Health System
Business Office/Patient Financial Advocate
210 W Walnut Street, Canton, IL 61520
Phone: 309-649-6818

Attachment I
As of February 2026

Providers Covered by Financial Assistance Policy

Adams, Sue
Agarwal, Devashish
Ambrose, Steven
Anderson, Deidra
Babcock, Malinda
Bailey, Erin
Bailey, William
Barnes, Stephanie
Barnhart, Brett
Baxter, Wyatt
Behymer, Ashley
Belchuk, Stanislav
Bernard, Dwayne
Bowers, Joshua
Brooks, Margaret
Bruening, Kari
Bryant, Andrew
Bucher, Bailey
Bugos, Jessica
Cao, David
Chamberlin, Jason
Chapa, Naveen
Chiou, Andy
Colston, Rebecca
Cousins, Dawn
Covlin, Michael
Crawford, Alyssa
Crouse, Nancy
Dean, David
DeCapp, Kylee
Derham, Alivia
Deschler, Thomas
Deushane, Ryan
DeYoung, Mark
Dickenson, April
Dively, Jenna
Dorman, Jordan
Downing, Jacey
Durdle, Katelyn
Dwyer, Rozana
Eeten, Lynette
Elbuluk, Osama

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Elks-Cedillo, Rene
Endale, Bruk
Erickson, Hannah
Farr, Breann
Farragher, Andrew
Fawcett, Gretchen
Feather, Glen
Garner, Michelle
Gibbs, Cody
Glaser, Bethany
Graham, Angela
Green, Troy
Gross, Amanda
Grossberg, Scott
Grzanich, Jared
Haerian, Hafez
Hargan, Paul
Hay, Marshall
Hicks, Brandi
Hlubocky, James
Hoffmeister, Dean
Holman, Shana
Holthaus, Angela
Howard, Ashley
Hubbard, Renee
Hurst, Daniel
Huston, Jason
Ifft, Keith
Inness, Courtney
Iverson, Tracy
Jackson, Kristen
Jimenez, Juan
Johnson, Crystal
Joyner, Scott
Kelly, Christina
Kerans, Alison
Khoie, Behrang
Knutson, Dawn
Krock, Kenneth
Kuntz, Elizabeth
Kuntz, Martin
Lampe, Chad
Lawrence, Andrea
Lemaster, Jennifer
Lentz, Gynger
Locke, Michelle

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McCarthy, Kyle
McDorman, Christina
McLean, Aaron
McMillin, Matthew
Medearis, Louise
Miller, Melanie
Miller, Morgan
Marlow, Hope
Moazzam, Farnaz
Morton, Douglas
Muzaffar, Momin
Nelson, Leah
Newsome, Kendall
Omoba, Emmanuel
Omor, Sophia
Parry, Brent
Patterson, Thomas
Phillips, Benjamin
Promisson, Carley
Punch, Gregory
Putnam, Abby
Queenan, James
Rakoff, Alan
Regehr, Michelle
Renick, Patrick
Reynolds, Courtney
Ridgeway, Rebekah
Roach, Samantha
Roberts, Jennifer
Royer, LaDawna
Ruff, Jake
Scherer, Michael
Schifano, Michael
Schifferer, Tessa
Shaw, Gary
Sisk, Audrea
Smith, Jimmie
Snider, Nathalie
Stein, Joseph
Stone, Cassie
Sullivan, Stephanie
Sussman, Mitchell
Tan, Ernesto
Trimble, Angie
Vaysberg, Anatoliy
Verma, Saurabh

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Vyas, Bimal
Wagenbach, Caitlyn
Wagner, Dara
Weber, Stephanie
Weidman, Matthew
Weis, Blake
Well, Marci
Westhafer, Stephen
Wigginton, Christine
Williams, Melissa
Wilkinson, Joshua
Wilson, Angela
Wold, Amber
Woods, Sharon
Worlow, Kandi
Wynn, Shawn
Yockey, Brett
Yocum, Danielle

Providers Not Covered by Financial Assistance Policy

Peoria Tazewell Pathology Group (PTPG)
OSF
Illinois Cancer Care
Dr. Fayman