Background (BG)

BG1. Submit articles of organization, joint ventures, and other organizational information.

See attached "Regions Hospital Articles of Incorporation," "Bylaws" and "IRS Determination Letter."

BG2. Provide current or recent Internal Revenue Service (IRS) forms, charity care/financial assistance policies, and billing/collection agreements.

See attached "Regions Hospital 2023 Form 990" (most recent 990 that has been filed with the IRS), "Financial Assistance Policy" and "Billing and Collections Policy."

BG3. Describe community engagement activities that have informed the proposal and a list of stakeholders and affected parties that were identified in planning for the project.

Regions Hospital's proposal has been informed in part by the findings of its 2024 Community Health Needs Assessment (CHNA), which was developed through broad community engagement (see attached "Regions Hospital 2024 Community Health Needs Assessment"). Our CHNA identified access to care as a top priority for our community.

While community members voiced strong concern about access barriers, they don't have access to detailed occupancy, transfer or forecast modeling data. As a result, Regions is uniquely positioned to connect these community-identified priorities to operational evidence.

Our internal data confirm persistent over-occupancy, high levels of patient boarding and transfer constraints, and rising patient acuity — conditions that validate community concerns and demonstrate that current inpatient capacity is insufficient to meet future demand.

The CHNA engagement process helped Regions identify stakeholders and affected parties relevant to this proposal, including:

- Ramsey County residents, particularly low-income and underserved populations who rely heavily on Regions as a safety net hospital. (A safety net hospital is a type of medical facility that by legal obligation or mission provides health care for individuals regardless of their insurance status or ability to pay.)
- Community-based organizations working in mental health, housing and health equity.
- Local public health departments and state agency partners.
- Patients and families who participated in surveys and focus groups to identify access barriers.
- Partner organizations in the east metro health system that collaborate on care coordination and community health priorities.

Project Description (PD)

PD1. Address whether the 85-bed expansion would in any way impact existing service lines such as the 120 mental health beds. Identify any reduction, elimination, or relocation of any existing service.

The proposed expansion adds 85 licensed inpatient beds for medical/surgical (med/surg) care on Regions Hospital's existing campus. It doesn't reduce, eliminate or relocate any current services. Mental health capacity remains at 120 inpatient beds in its dedicated space; no changes to psychiatric services are proposed as part of this project. By adding med/surg capacity to the existing campus — while maintaining mental health at 120 beds and preserving all other services — Regions can reduce over-occupancy and improve timely access without disrupting established service lines or community access points.

PD2. Provide additional detail on the services and unit breakdown for the planned "incremental" bed openings between 2026 and 2033.

- **Immediately:** Regions could apply 21 bed licenses to its current boarding unit that supports inpatient pending patients for better geographical care, resource allocation and efficiency, decompression of the emergency department (ED) and decreased length of stay (LOS).
- **Near future:** Beds would be added in 12-bed increments when demand calls for it. Beds would be placed in existing spaces by relocating other services. In the long term, if there are additional care demands competing for the same space, more extensive construction may be needed.
- **Long term:** Future, yet-to-be-planned construction would drive the use of the remaining bed licenses. Future capacity would be activated through major construction to make use of the remaining licenses. Regions is working on preliminary, high-level conceptual planning activities to validate potential scenarios and options.

PD3. Provide cost estimates for the entire project and phases.

- HealthPartners has conducted initial high-level conceptual planning. Estimates are determined after a detailed advanced planning process, which takes place once additional bed licenses have been secured. This avoids unnecessary architectural fees.
- Currently, the average rough order of magnitude cost estimate for the renovation of a 12-bed acute care inpatient unit is $7 million to $9 million. We can anticipate an annual cost escalation of 3%-5% (excludes additional capital to relocate any displaced services).
- The timing and phasing of each 12-bed acute care inpatient unit depends on inpatient bed capacity at the time, and demand for more beds, including the availability of capital funds and other resources to activate additional beds.

Need for Project (NP)

NP1. Make available all details from modeling/forecasts of future inpatient demand noted in the application including assumptions, sources of input data, and other factors not already noted in the application.

- Regions' 2025 bed-need model projects adult med/surg demand through 2033 using projected discharges × length of stay (LOS) ÷ 365, calibrated to an 85% occupancy target.
- Inputs include an October 2022-September 2023 Epic baseline (inpatient/observation), Sg2 Impact of Change® and all-payer claims, Claritas Pop-Facts®, and 2021 Centers for Medicare & Medicaid Services (CMS) Limited Data Set (LDS); obstetrics/neonatology, psychiatry, and rehabilitation services (rehab) are excluded.
- Key assumptions are a 4% increase in LOS for rising acuity, constant non-med/surg capacity, and HealthPartners Direct referral growth; results show a mid-80s additional staffed-bed need by 2033 (details and sensitivity tests are in the attached workbook and slides).

NP2. Research, evidence on ideal occupancy rates, and other relevant data on the clinical risks of lack of capacity for patients needing time-sensitive specialized care noted in the application.

Ideal inpatient hospital occupancy rates are generally considered to be below 85%. Exceeding this threshold is associated with increased clinical risks, including higher inpatient and 30-day mortality, delays in care, and compromised patient safety.[1][2][3] Regions Hospital currently has a 96% sustained capacity rate.

Multiple studies have demonstrated that as occupancy rates rise above 80%-85%, hospitals experience longer transfer delays from critical care units, increased emergency department boarding and a reduced ability to accept interhospital transfers for time-sensitive specialized care such as stroke, trauma and ST-segment elevation myocardial infarction (STEMI), a type of heart attack.[4][5][3]

- High occupancy leads to delays in intensive care unit (ICU) admission and transfer, which are associated with increased mortality and morbidity, particularly for patients with acute deterioration or those requiring specialized interventions.[6]
- The Society of Critical Care Medicine highlights that delayed ICU admission due to lack of bed availability is linked to increased mortality, and rationing access during capacity strain can result in suboptimal care for high-acuity patients.[6]
- Limiting interhospital transfers during periods of high census can harm patients at outlying hospitals who depend on tertiary centers for specialized, time-sensitive treatments, potentially widening disparities in access to care.[5]

Queueing models suggest that wait times for inpatient beds increase rapidly as occupancy approaches 100%, and optimal occupancy levels may vary by service line, but consistently, occupancy above 85%-90% is associated with adverse outcomes.[7][1][2] Maintaining surge capacity and flexible resource planning is essential to mitigate these risks and ensure timely access to specialized care.[8][6]

References

1. High Levels of Bed Occupancy Associated With Increased Inpatient and Thirty-Day Hospital Mortality in Denmark. Madsen F, Ladelund S, Linneberg A. Health Affairs (Project Hope). 2014;33(7):1236-44. doi:10.1377/hlthaff.2013.1303.

2. The Effect of Time-Varying Capacity Utilization on 14-Day in-Hospital Mortality: A Retrospective Longitudinal Study in Swiss General Hospitals. Sharma N, Moffa G, Schwendimann R, et al. BMC Health Services Research. 2022;22(1):1551. doi:10.1186/s12913-022-08950-y.

3. Hospital Occupancy and Emergency Department Boarding During the COVID-19 Pandemic. Janke AT, Melnick ER, Venkatesh AK. JAMA Network Open. 2022;5(9):e2233964. doi:10.1001/jamanetworkopen.2022.33964.

4. Associations Between Hospital Occupancy, Intensive Care Unit Transfer Delay and Hospital Mortality. Ofoma UR, Montoya J, Saha D, et al. Journal of Critical Care. 2020;58:48-55. doi:10.1016/j.jcrc.2020.04.009.

5. Emergency Department Boarding, Inpatient Census, and Interhospital Transfer Acceptances. Greenwood-Ericksen M, Kamdar N, Swenson K, et al. JAMA Network Open. 2025;8(5):e2512299. doi:10.1001/jamanetworkopen.2025.12299.

6. ICU Admission, Discharge, and Triage Guidelines: A Framework to Enhance Clinical Operations, Development of Institutional Policies, and Further Research. Nates JL, Nunnally M, Kleinpell R, et al. Critical Care Medicine. 2016;44(8):1553-602. doi:10.1097/CCM.0000000000001856.

7. Use of a Novel Patient-Flow Model to Optimize Hospital Bed Capacity for Medical Patients. Hu Y, Dong J, Perry O, et al. Joint Commission Journal on Quality and Patient Safety. 2021;47(6):354-363. doi:10.1016/j.jcjq.2021.02.008.

8. System-Level Planning, Coordination, and Communication: Care of the Critically Ill and Injured During Pandemics and Disasters: CHEST Consensus Statement. Dichter JR, Kanter RK, Dries D, et al. Chest. 2014;146(4 Suppl):e87S-e102S. doi:10.1378/chest.14-0738.

NP3. A description of factors that are leading to increased length of patient stays.

Average length of stay (ALOS) at Regions is under upward pressure from three major interacting drivers:

- Higher clinical acuity and multimorbidity among admitted patients
- Hospital throughput constraints at high occupancy
- External discharge barriers tied to post-acute capacity, payer processes, and social needs

The following items describe the principal factors observed across service lines:

1. Throughput and capacity constraints inside the hospital

- Sustained high occupancy limits bed turnover, producing step-down (ICU → med/surg) and admission delays from the ED and post-anesthesia care unit (PACU). Each cascade

extends total bed days for patients who are clinically ready to move but can't due to a lack of beds.

- Procedure/surgery sequencing delays when appropriate post-op beds (ICU, intermediate care, specialty units) are unavailable at the planned time, extending pre-op boarding and total LOS.
- Isolation requirements (e.g., C. difficile, novel respiratory viruses) constrain room assignment and slow internal moves. This prolongs stays for patients waiting for appropriate rooms.

2. Rising clinical complexity

- Higher acuity and multimorbidity (e.g., advanced heart failure, sepsis, polytrauma with chronic disease) require longer stabilization and recovery periods.
- Post-acute medical needs (complex wound care, prolonged IV antibiotics, high oxygen/ventilator weaning) lengthen inpatient days when step-down settings can't be secured promptly.
- Medication reconciliation and titration for polypharmacy and substance-use comorbidity can extend time to a safe discharge plan.

3. Post-acute placement barriers

- Skilled nursing facility (SNF) and inpatient rehab (IRF) waitlists — especially for higher-acuity or behavioral-health overlay cases — delay discharge readiness-to-placement.
- Long-term acute care (LTAC) scarcity in the east metro requires out-of-area transfers or continued acute care days for patients needing LTAC-level services.
- Psychiatric and neurocognitive placement constraints [e.g., limited geriatric psych, traumatic brain injury (TBI) or memory care beds] for medically stable patients with behavioral needs prolong acute stays.
- Preadmission screening and resident review/Omnibus Budget Reconciliation Act (PASRR/OBRA) Level II evaluations for patients with severe mental illness, intellectual disability or related conditions being considered for Medicaid-certified nursing facilities add required review time before SNF placement can occur.

4. Payer and administrative processes

- Medicaid eligibility determinations and renewals (coverage applications, redeterminations) can delay acceptance by post-acute providers.
- Prior authorization for SNF/IRF/home health/durable medical equipment (DME) and coverage denials/appeals defer discharge to the appropriate level of care.
- Network limitations (post-acute providers out of network or lacking contracted capacity) reduce placement options, extending LOS while alternatives are negotiated.

5. Legal decision-making and guardianship

Discharge planning pauses pending court-appointed guardianship or identification of an authorized decision-maker, including public guardianship backlogs, for patients lacking capacity

without an existing surrogate. This extends hospital days despite medical readiness to be discharged.

6. Social needs and safety considerations

- Lack of safe housing, people without housing, or unsafe home environments extend stays while shelter, supportive housing or home modifications are arranged.
- Limited caregiver availability (family unable to provide required care) and transportation barriers impede timely discharge, even when clinical criteria are met.
- Language access/health literacy needs can lengthen time needed to educate patients and safely arrange services.

7. Operational timing factors

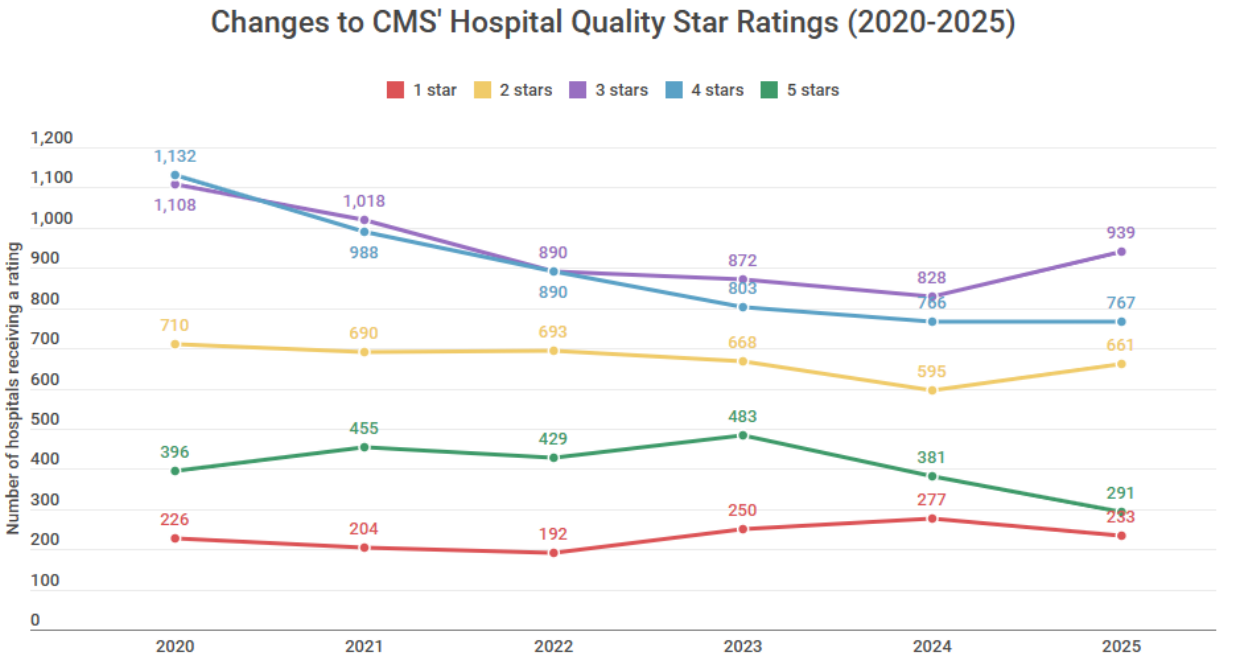
- Weekend/holiday and after-hours constraints across courts, payers, transport and receiving facilities slow key steps (authorizations, evaluations and transfers).
- Seasonal surges (e.g., influenza/RSV/COVID) strain both acute and post-acute systems simultaneously, compounding the effects above.

NP4. Measures of quality under previous staffing and occupancy levels.

Measures of Quality – Regions Hospital (July 2025)

At Regions Hospital, we're deeply committed to becoming and sustaining a high-reliability organization. This means building a culture and designing processes that prevent system failures, and when failures do occur, responding swiftly and effectively to minimize harm. Reliability is a daily discipline we strive to deliver on through our vision of safe, high-quality and equitable care for every patient we serve.

One way we measure our progress is through the Centers for Medicare & Medicaid Services (CMS) Overall Hospital Quality Star Rating. This nationally recognized benchmark evaluates hospitals on quality, safety, patient experience and outcomes. The CMS rating reflects how well we're delivering on our promise to patients, families and the community. It's a measure of accountability, a signal of trust to the public and a guidepost for our relentless pursuit of excellence. There are 48 unique measurements that fall into a domain within the CMS star rating. Nationally, there's generally a downward trend of hospitals obtaining an increased star rating.



Source: CMS

Regions' quality performance, as rated in the July 2025 CMS star ratings, reflects an overall 4-star rating, with a 3-star patient experience rating, demonstrating strengths in mortality and safety of care, with all scored measures in these domains meeting or exceeding the national average. The 4-star rating reflects that Regions is performing better than 73.5% of all hospitals that have a star rating.

The hospital's standardized scores for mortality (0.95) and safety of care (0.56) indicate sustained improvement over the previous year, with no measures in these domains performing below national benchmarks.

Readmission rates have shown year-over-year improvement, moving from a negative standardized score in 2024 (-0.45) to near parity with the national average in 2025 (0.07), with all individual readmission measures at or above the national average. The hospital's overall summary score improved to 0.3 in 2025, reflecting positive trends in clinical outcomes and patient safety.

Regions star rating results: 2022-2025

	2022	2023	2024	2025
Overall Star Rating	★★★☆☆	★★★☆☆	★★★☆☆	★★★★☆
Patient Survey Rating	★★★☆☆	★★★☆☆	★★★☆☆	★★★☆☆
Overall Summary Score	-0.25	-0.16	0.03	0.3

Regions year-over-year standardized group comparison: 2024-2025

	Reporting Period	Standardized Group Score		Measure Group Weight	Number of Scored Measures		Number of Measures Better than National Avg		Number of Measures Same as National Avg		Number of Measures Worse than National Avg	
		2024	2025		2024	2025	2024	2025	2024	2025	2024	2025
Safety of Care	July 1, 2020 – December 31, 2023	0.19	0.56	22%	7	8	2	2	5	6	0	0
Mortality	July 1, 2020 – June 30, 2023	0.59	0.95	22%	7	7	0	0	7	7	0	0
Readmission	July 1, 2020 – December 31, 2022	-0.45	0.07	22%	11	11	0	0	11	11	0	0
Patient Experience	January 1, 2023 – December 31, 2023	0.07	-0.04	22%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Timely and Effective Care	January 1, 2022 – March 31, 2024	-0.5	-0.3	12%	10	11	N/A	N/A	N/A	N/A	N/A	N/A

Regions continues to maintain strong performance on hospital-acquired conditions (HAC), as demonstrated in the table below.

2024 HAC performance

CLABSI	18 PREDICTED[1]	10 ACTUAL	↓	**44%**
CAUTI	22 PREDICTED[1]	11 ACTUAL	↓	**50%**
C. difficile	142 PREDICTED[1]	59 ACTUAL	↓	**58%**
MRSA Bacteremia	12 PREDICTED[1]	6 ACTUAL	↓	**50%**
COLON SSI	8 PREDICTED[1]	6 ACTUAL	↓	**25%**
ABD HYST SSI	1 PREDICTED[1]	2 ACTUAL	↑	**100%**
HIP SSI*	4 PREDICTED[1]	6 ACTUAL	↑	**50%**
KNEE SSI*	2 PREDICTED[1]	4 ACTUAL	↑	**100%**
HAND HYGIENE	96% 2023	96% 2024	–	**Sustained Performance**
CENTRAL LINE CATHETER DAYS	29,101 PREDICTED[1]	21,346 ACTUAL	↓	**27%**
URINARY (FOLEY) CATHETER DAYS	24,949 PREDICTED[1]	18,251 ACTUAL	↓	**27%**

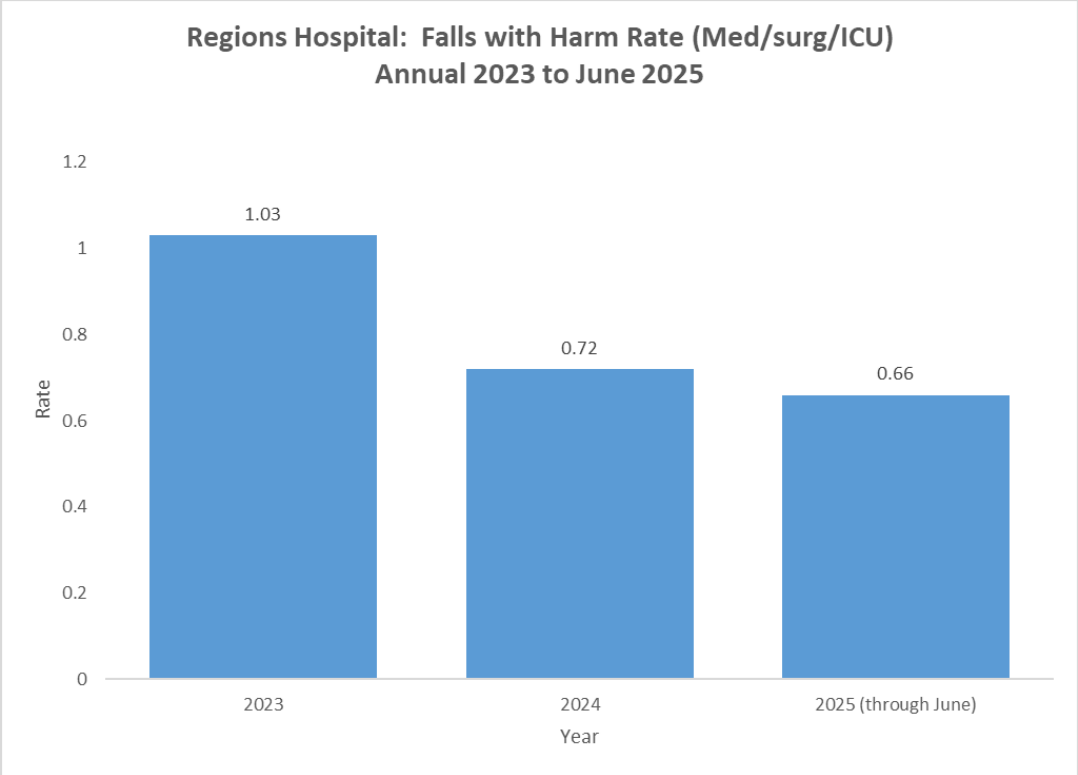
2023 HAC performance

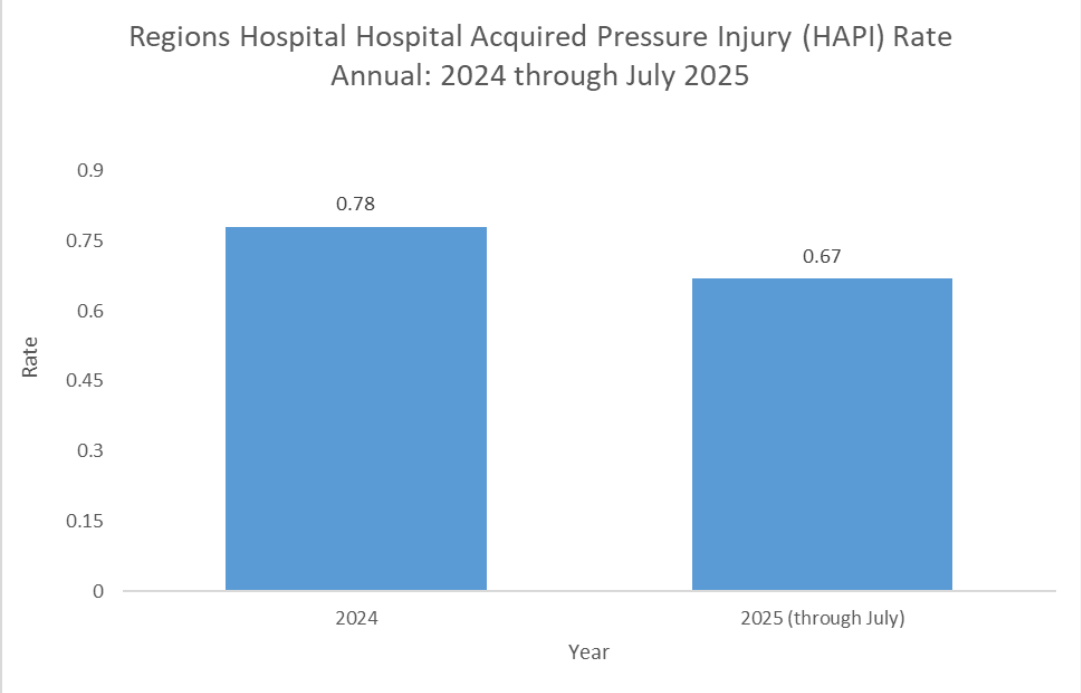
CLABSI	19 PREDICTED[1]	17 ACTUAL	↓	11%
CAUTI	22 PREDICTED[1]	9 ACTUAL	↓	59%
C. difficile	123 PREDICTED[1]	39 ACTUAL	↓	68%
MRSA Bacteremia	11 PREDICTED[1]	7 ACTUAL	↓	36%
COLON SSI	8 PREDICTED[1]	6 ACTUAL	↓	25%
ABD HYST SSI	1 PREDICTED[1]	0 ACTUAL	↓	100%
HIP SSI*	3 PREDICTED[1]	0 ACTUAL	↓	100%
KNEE SSI*	2 PREDICTED[1]	4 ACTUAL	↑	100%
HAND HYGIENE	96% 2022	96% 2023	–	Sustained Performance
CENTRAL LINE CATHETER DAYS	29,186 PREDICTED[1]	21,868 ACTUAL	↓	25%
URINARY (FOLEY) CATHETER DAYS	25,011 PREDICTED[1]	18,026 ACTUAL	↓	28%

Patient Safety Data

Reporting Year [Q4-Q3]	Falls with injury	Pressure Injuries
2022	14	6
2023	14	10
2024	10	16
2025 (Q4 2024 – July 2025)	8	15

- From 2023 to mid-2025, the falls-with-harm rate on med/surg and ICU units improved by 35.9%, decreasing from 1.03 in 2023 to 0.72 in 2024 (a 30.1% reduction) and further to 0.66 through June 2025 (an additional 8.3% reduction).
- The hospital-acquired pressure injury (HAPI) rate improved by 14.1%, declining from 0.78 in 2024 to 0.67 through July 2025.





Reference

1. Advisory. (2025, August 13). *CMS star ratings*. Advisory. https://www.advisory.com/daily-briefing/2025/08/13/cms-star-ratings

NP5. Feedback from emergency medical services, clinics and other hospitals.

- While Regions has not yet solicited formal comment letters from external entities specific to this proposal, our transfer and access data provide clear, objective evidence that emergency medical services (EMS), clinics and peer hospitals are attempting to place patients at Regions that we can't accommodate in real time due to limited bed availability.
- We are confident feedback from EMS will be received, and we will encourage partners to submit written comments in the MDH public comment window to supplement these quantitative indicators.

Quantitative indicators of partner demand and access constraints.

- HealthPartners Direct, which manages consults, direct admissions and ED transfers across our system, logged 11,708 direct admission requests to Regions from January 2023-June 2025. Of that total, 2,196 requests (18.8%) were declined due to capacity at the time of the request and 5,882 were clinically accepted but waitlisted because no bed was immediately available — i.e., 69% of requests were not placed when needed.
- These figures exclude ED transfers. If ED transfers are included, total transfer-related admission requests to Regions in this period rise to 28,635, underscoring the scope of regional demand for placement at the hospital.
- The overwhelming majority of declined admission requests from 2023 to mid-2025 were capacity-related (93% overall; improving to 86% in the first half of 2025) with bed availability as the barrier instead of clinical acceptance.

Placement on the transfer waitlist occurs only after a clinician has accepted the patient; it's used when no bed is immediately available. This results in delays that EMS agencies and referring hospitals experience firsthand while attempting to move patients to the appropriate level of care. Even when waitlisted patients are ultimately admitted (87% from January 2023-June 2025), the delay itself can pose clinical risk for time-sensitive and specialized care, which reflects access constraints for partners trying to place patients at Regions.

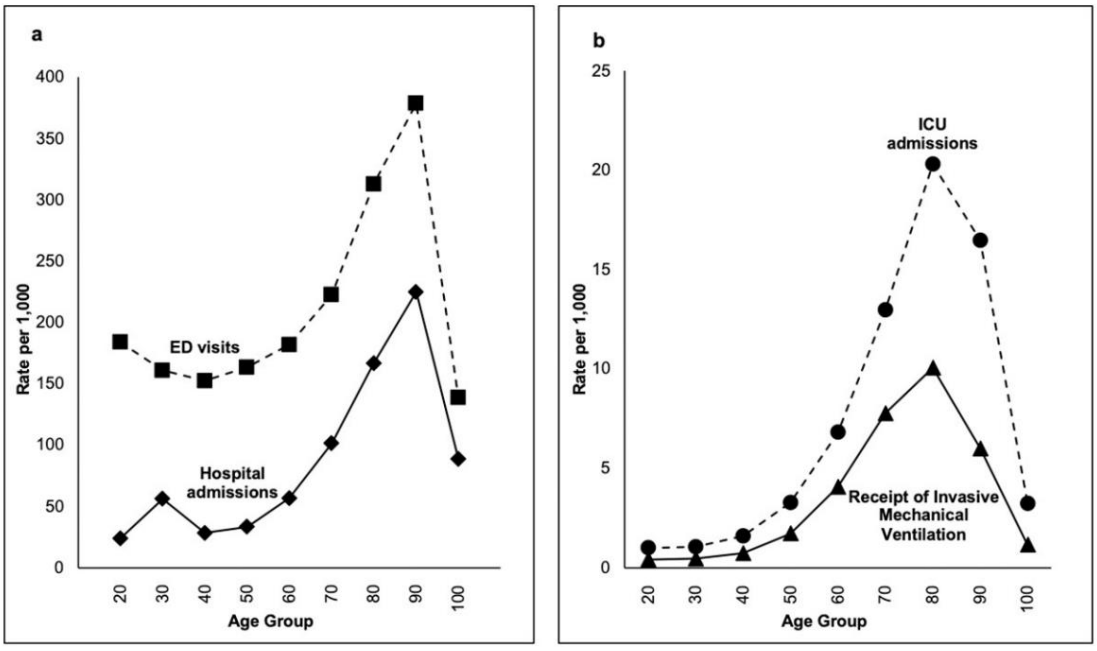
HealthPartners Direct data and historical patterns constitute strong, objective evidence that EMS agencies, clinics and other hospitals are actively attempting to send patients to Regions and bed capacity, not clinical acceptance, is the binding constraint. Adding licensed med/surg beds is expected to reduce declines and waitlisting, strengthen regional referral pathways and improve timely access for EMS and referring clinicians.

NP6. Provide relevant data on the incidence or prevalence of disease, behavioral risk factors, and acuity mix for the primary service area as it relates to proposed hospital services, with attention given to populations that are medically underserved, those on public coverage, and uninsured.

- Considerations of incidence and prevalence of the local community are discussed on pages 8-9 of the latest Regions CHNA (attached).
- Projections point to a continued aging of the population in the east metro in the coming years. From 2024-2033, the overall population of Ramsey, Dakota and Washington counties is projected to increase by 3.8%. This overall population growth understates the impact of demographics on hospital use moving forward. Ramsey, Dakota and Washington counties residents ages 75 and older are expected to grow by 39.5% over this timeframe. Since hospital use rates climb significantly as people age, this will translate into an increase in inpatient bed needs across the region.[1] Aging will continue beyond 2033, too. Growth from 2024-2040 is projected at 5.8% across all ages and an extremely high 58.2% for ages 75-plus in this area.

Hospital and ICU admission rates per 1,000 show the increase in utilization of hospital services as patients age.

Figure: *Hospital and Intensive Care Use Rates per 1,000 by Age[2]*

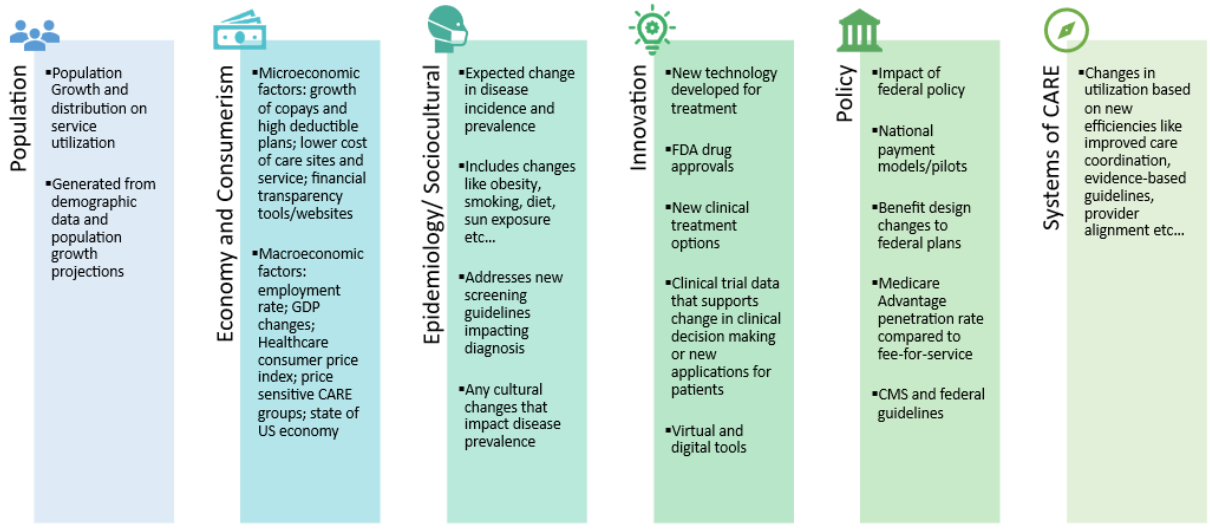


To forecast needs, HealthPartners and Regions leverage Sg2 Impact of Change Demand Forecast, an industry standard for health care services demand forecasting. This demand forecast for the market integrates several "impact factors," which include incidence and prevalence of disease, risk factors, acuity mix and more.

Figure: *Sg2 Impact of Change® Market Forecast Approach*

CARE = Clinical Alignment and Resource Effectiveness.
Note: Analysis excludes 0–17 age group.
Sources: : Impact of Change®, 2025; HCUP National Inpatient Sample (NIS). Healthcare Cost and Utilization Project (HCUP) 2021. Agency for Healthcare Research and Quality, Rockville, MD; Proprietary Sg2 All-Payer Claims Data Set, 2023; The following 2023 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2025; Sg2 Analysis, 2025.

Figure: *Sg2 Impact Factors*



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1. Analysis of Minnesota State Demographic Center Projections, 2024 – 2054 <https://mn.gov/admin/demography/data-by-topic/population-data/our-projections/>
2. Tillmann BW, Fu L, Hill AD, Scales DC, Fowler RA, Cuthbertson BH, et al. (2021) Acute healthcare resource utilization by age: A cohort study. PLoS ONE 16(5): e0251877. https://doi.org/10.1371/journal.pone.0251877

NP7. Describe potential linkages between the inpatient expansion and investments in primary care and post-acute care services. For example, describe how the project might contribute to continuity of care and care coordination.

Demand for urgent, emergent and inpatient care will grow as the demand for primary and post-acute care continues to grow with an increasing illness burden throughout our surrounding community. The area is already witnessing a decrease in access points for primary care due to clinic closures, which will impact vulnerable populations.

As the east metro community's safety net hospital and Level 1 trauma center, Regions doesn't have an adequate supply of bed licenses to meet the community's pent-up needs today, let alone the growing and increasingly complex needs of patients into the future.

Additional licenses are critically important for managing a growing and more medically complex population. Gaps in the coordination will balloon and continuity of care will diminish without these additional bed licenses.

NP8. Provide more detail on alternatives to the proposed inpatient expansion that Regions considered and briefly noted in the application, such as expanded outpatient programs, increased home care, and other efforts to reduce unnecessary inpatient care.

We continue to explore and exhaust all potential alternative resources for our patients to avoid unnecessary admissions and expand community partnerships.

- We have developed targeted initiatives within the ED that provide an interdisciplinary approach for patients to urgently connect them to the right resources to avoid unnecessary admissions in addition to the palliative care ED program.
- We've also added a rapid response program to expand access to our ambulatory programs (can be used within the ED and before arrival of the ED to provide care in the home rather than the hospital).
- We're continually expanding/modifying our programs (care consultants, home-based medicine, complex care) to meet the needs of our patients.
- In addition to our own internal programs, we're constantly working to expand and evaluate our community partnerships in all levels of care to ensure we can meet the individual needs of the populations we serve.
- Regions Hospital manages capacity constraints by leveraging system-wide coordination and targeted investments in local care delivery. Through the HealthPartners Direct team, physicians are available 24/7/365 to consult with referring clinicians and ensure patients are directed to the most appropriate hospital within the system.
- At the same time, investments in clinical resources at hospitals such as Methodist (St. Louis Park) and Lakeview (Stillwater) help keep care local and prevent unnecessary transfers to Regions.

This combination of centralized triage and strengthened community capacity ensures patients receive the right care in the right place, preserves inpatient capacity for complex cases, and supports high-quality, accessible care across the system.

Transitions Clinic
In summer 2024, HealthPartners Hospital Medicine clinicians launched a new outpatient follow-up model: the Transitions Clinic. This clinic coordinates follow-up visits with a hospital-based physician within 72 hours of discharge from Regions. Initially focused on patients with congestive heart failure (CHF) or chronic obstructive pulmonary disease (COPD), the program is actively expanding to include additional qualifying conditions.

The clinic's purpose is to bridge the critical gap between hospital discharge and a patient's primary care follow-up. Visits — available virtually or in person — provide opportunities for patient education, medication adjustments and proactive support to help patients stay on their expected recovery path. Early results show that patients seen through the Transitions Clinic experience better disease control and lower readmission rates, outcomes we attribute directly to this innovative model of care.

Advanced Care Primary Care Clinic
In 2025, HealthPartners created a new clinic, inside an existing specialty care space, designed to help patients avoid costly emergency department visits and hospital admissions. The Advanced Care Primary Care (ACPC) Clinic coordinates care for patients with complex needs at risk of needing a hospital visit.

The ACPC Clinic model is designed for patients with complex health needs and brings together a team of experts from many specialties to support the patient's entire care journey. Each day, the care team meets to review recent visits and prepare for upcoming ones. If a patient goes to the ED or is hospitalized, the team follows up quickly to understand what happened and provides the right next steps to support the patient.

- Patients are referred to the clinic by their primary care clinicians and often have existing health conditions or other factors, such as inadequate social support or food insecurity, that can lead to more serious health issues.
- Schedulers help patients set up appointments, and clinic-support teams resolve any issues that may prevent a visit. Video visits and telephonic support also help ensure easy access to care.
- Care is coordinated across settings and may include primary and specialty care, home care, pharmacy, palliative care, care management and coordination, social work and behavioral health.
- The team closely monitors patients and provides timely follow-up.
- Enhanced care coordination includes support for transferring patients between care settings.

- The ACPC team also works with a patient's health plan care coordinator to ensure they receive all eligible benefits and services.

The first clinic opened in St. Louis Park, and a second location is set to open in fall 2025 inside one of HealthPartners' existing St. Paul clinics.

NP9. Describe whether Regions took into consideration the potential effect of recent federal actions related to health care financing and coverage eligibility that are expected to increase hospital uncompensated care and may impact any part of the expansion plan.

Recent changes related to health care financing and coverage eligibility will apply pressure on demand for hospital services at Regions, further exacerbating the need for additional beds to serve the community's need. As some Medicaid enrollees roll off Medicaid due to changing eligibility requirements, these now-uninsured patients may forgo or ration preventive care and instead go to the ED needing emergency care. Even more emergency care burden in Ramsey County has been placed on Regions since the closure of St. Joseph's Hospital.

We expect newly passed Medicaid and MinnesotaCare eligibility and re-enrollment requirements to increase uncompensated care volumes and incentivize patients to forgo or ration preventive care – likely leading to a corresponding increase in severity of cases by the time they arrive. Regions' commitment to serve all patients, regardless of their ability to pay, remains unchanged. As we have described, our proposed expansion is essential to meet the needs of our community. Meeting community needs may result in an increase in uncompensated care, but we believe such an increase is preferable to being forced to turn away community members due to a lack of beds.

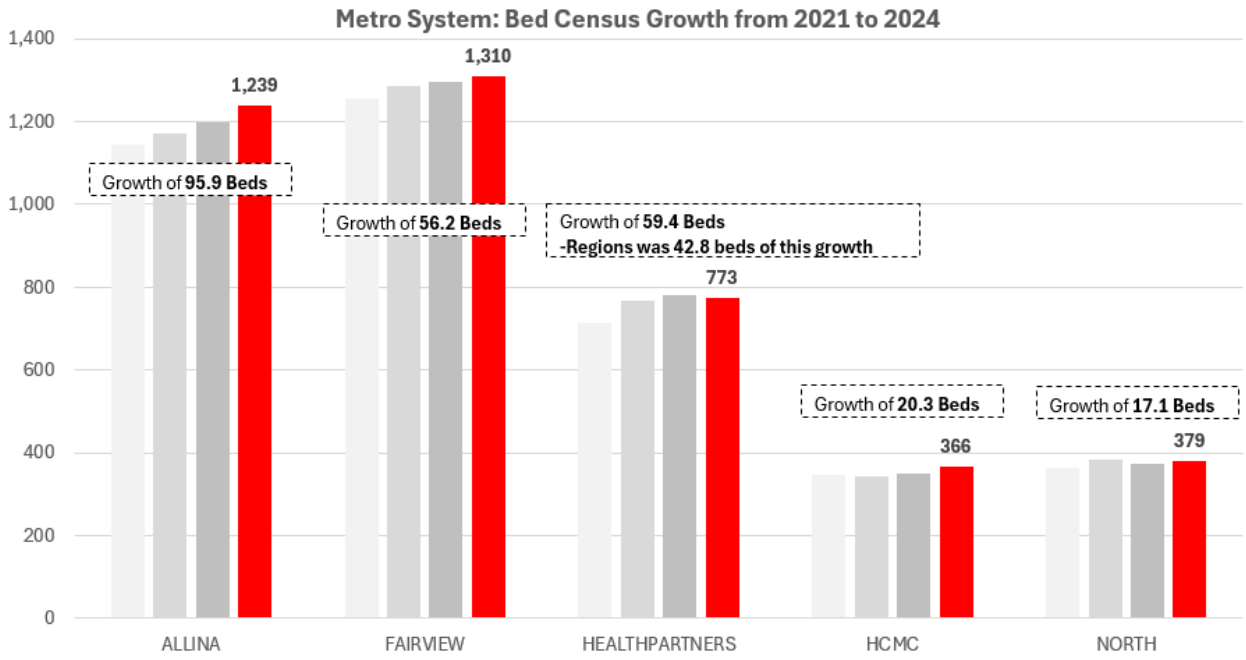
Impact on Other Hospitals (IOH)

IOH1. Provide an analysis of the impact of the 85-bed expansion on all hospitals serving the east metro area. Please provide any internal projections on how additional inpatient volume may result in new patient revenue and expenses at Regions, and how these changes may affect patient volume, revenue, and expenses at other facilities. Please provide this information by payer categories (i.e., commercial, Medicaid, Medicare, uninsured, and other payers).

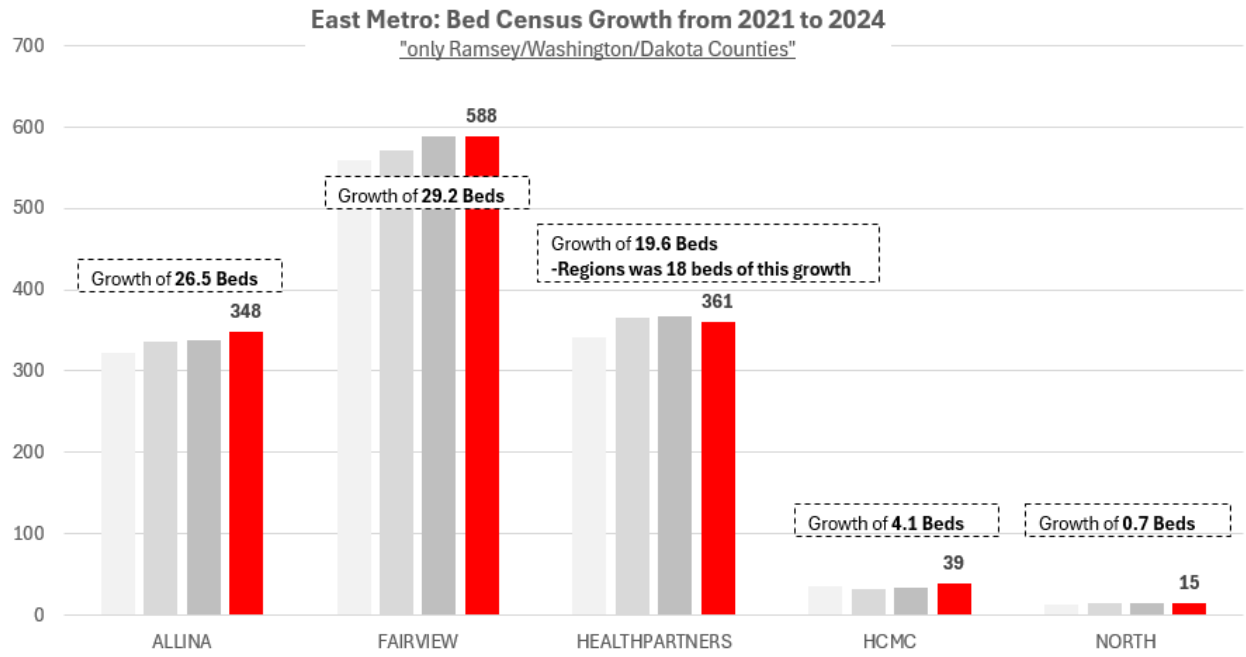
Regarding internal projections: Accommodating more patients is vital to meet our community's health needs. There will be an associated increase in revenue, but with it comes an increase in our costs over time, which likely does little to improve our margin.

Regarding how it affects other facilities:

- Looking across metro hospital systems, growth of inpatient bed census exceeded 50 beds from 2021-2024 in each of the three largest systems: Allina, M Health Fairview and HealthPartners.
- For Allina and M Health Fairview, inpatient growth was allowed through their surplus bed licenses. For HealthPartners, Regions Hospital's growth of 42.8 beds was only achieved with the legislative approval of 45 bed licenses at the end of 2021. Medicare beds were 68% of this growth.
- Legislative bed license approval did not negatively impact other hospitals' ability to grow during this time.



- For east metro patients living in Ramsey, Washington and Dakota counties receiving hospital inpatient care from 2021-2024, there was continued bed growth across the three largest systems.
- For Allina and M Health Fairview, inpatient growth exceeded 20 beds. M Health Fairview facilities grew more than any other system at 29.2 beds, despite the closing of St. Joe's hospital in 2021.
- For HealthPartners, Regions Hospital's growth of 18 beds, again, was only achieved with legislative approval.
- Legislative bed license approval did not negatively impact other hospitals' ability to grow in east metro counties during this time.



IOH2. Describe how the specific proposed inpatient services (e.g., cardiology, neurology, orthopedics, etc.) will expand existing services or result in the adoption of new services at Regions Hospital and to what extent these services are already available at other hospitals serving the East Metro Area.

- Regions' request for 85 additional bed licenses is intended to expand throughput in existing adult med/surg and critical care services, not to introduce new service lines. This will relieve current bottlenecks and improve timely access to care.
- Regions Hospital currently has a 96% sustained capacity rate, well above the 80%-85% benchmark for Level I trauma centers. Sustained high occupancy increases the risk of delayed care and can compromise patient outcomes.
- From January 2023-June 2025, 18.8% of direct admission requests were declined for capacity and another 5,882 clinically accepted patients were waitlisted due to no immediate bed, which shows unmet access within existing services, not a need to add new ones.
- Added capacity will primarily support general medicine, surgery, cardiology, orthopedics/trauma, neurology and intensive care. These core specialties are also offered at other east metro hospitals, but Regions is the only Level I adult and pediatric trauma center and verified burn center in the east metro.
- Recent utilization data show admissions growth in cardiology, neurology and orthopedics among the fastest rising at Regions, underscoring that incremental capacity will be used by existing programs.
- The Regions Hospital Burn Center also serves patients and partners with health care facilities throughout the Midwest region. Additional beds expand Regions' distinctive regional role.

- Closures and service changes at Bethesda (LTAC) and St. Joseph's (ED and med/surg) hospitals shifted additional demand to the remaining east metro hospitals, including Regions. Added beds help absorb this regional capacity loss without duplicating services.
- No new service lines are being proposed. The proposed 85 bed licenses will be used for adult general medicine, surgery, cardiology, orthopedics/trauma, neurology and intensive care. They will decompress med/surg units and ICUs and enable Regions to accommodate sustained general acute care demand.

Anticipated service-specific effects of added capacity

- **Cardiology and cardiothoracic/vascular surgery:** Shorter time-to-bed for acute coronary syndrome (ACS)/heart failure and post-procedure patients; reduced PACU holding (growth trend already observed).
- **Neurology/neurosurgery:** Faster admission from ED and referring hospitals for stroke and complex neuro cases; improved step-down flow from neuro ICU.
- **Orthopedics/trauma:** Increase access for high-acuity trauma and fracture care within a Level I environment; improve transitions from intensive care to general care (ICU to floor).
- **General medicine and ICU:** Decompression of medicine units and critical care capacity, improving placement for complex medical patients and enabling timely transfers.

The proposal does not reduce, eliminate or relocate existing services at Regions or anywhere else; it increases licensed inpatient capacity so that patients who already rely on Regions' multidisciplinary programs — particularly trauma, burn, neuro, surgical, and complex medicine — can be admitted without delay. This is an access and throughput expansion within established services helping to provide timely admission at safe occupancy levels.

IOH3. Provide a staffing plan that includes detailed personnel classifications (i.e., physicians, licensed practical nurses, registered nurses, nursing aides, etc.) for all proposed new units of the hospital, including full-time equivalent (FTE) hour amounts for each position per 24-hour period and the anticipated number of patient days per 24-hour period.

21-bed unit: 96% capacity rate = 20 staffed beds	Registered nurse	Nursing assistant	Health unit coordinator	Care manager (social worker or RN case manager)	Environmental services	Clinician
Days (0700-1500)	**6**	**3**	**1**	**1.5**	**1.25**	**1.75**
Evening1 (1500-1900)	**6**	**2**	**1**		**0.5**	
Evening2 (1900-2300)	**6**	**2**	**1**			
Night (2300-0700)	**5**	**2**	**1**			
24-HR TOTAL	23	9	4	1.5	1.75	1.75
Total hired FTE	27.37	11.66	4.2	2.1	2.45	2.45
Total hired head count	39	17	5	3	3	

Two 12-bed units. 24 beds total 96% capacity rate = 23 staffed beds	Registered nurse	Nursing assistant	Health unit coordinator	Care manager (social worker or RN case manager)	Environmental services	Clinician
Days (0700-1500)	**7**	**3**	**1**	**1.5**	**1.25**	**2**
Evening1 (1500-1900)	**7**	**3**	**1**		**0.5**	
Evening2 (1900-2300)	**7**	**3**	**1**			
Night (2300-0700)	**6**	**3**	**1**			
24-HR TOTAL	27	12	4	1.5	1.75	2
Total hired FTE	28.19	14.69	4.2	2.1	2.45	2.45
Total hired head count	40	21	5	3	3	

IOH4. List existing vacancy rates for relevant personnel (e.g., registered nurses, licensed-practical nurses, and nurse aides) for the primary service area.

As of September 2025, Regions Hospital reports a registered nurse (RN) vacancy rate of 2.47% and a nursing assistant (NA/CNA) vacancy rate of 7.95% for inpatient services. Licensed practical nurses (LPNs) are not used in Regions' inpatient staffing model. Taken together, these vacancy levels are modest and consistent with our recent experience, maintaining safe staffing on med/surg units. Based on current hiring pipelines and our phased activation approach, we're prepared to fill, if necessary, incremental inpatient roles tied to the project.

Appendix

Abbreviations and acronyms glossary

- **ACS:** Acute coronary syndrome
- **ALOS:** Average length of stay
- **C. diff:** Clostridioides difficile infections
- **CAUTI:** Catheter-associated trinary tract infections
- **CDC:** Centers for Disease Control and Prevention
- **CHF:** Congestive heart failure
- **CHNA:** Community Health Needs Assessment
- **CLABSI:** Central line-associated bloodstream infections
- **CMS:** Centers for Medicare & Medicaid Services
- **CNA:** Certified nursing assistant
- **COPD:** Chronic obstructive pulmonary disease
- **DME:** Durable medical equipment
- **ED:** Emergency department
- **FTE:** Full-time equivalent
- **HAC:** Hospital-acquired conditions
- **HAPI:** Hospital-acquired pressure injury
- **ICU:** Intensive care unit
- **IRF:** Inpatient rehab facility
- **LDS:** Limited Data Set
- **LOS:** Length of stay
- **LPN:** Licensed practical nurse
- **LTAC:** Long-term acute care
- **MRSA:** Methicillin-resistant staphylococcus aureus
- **NA:** Nursing assistant
- **NHSN:** National Healthcare Safety Network (at the CDC)
- **OBRA**: Omnibus Budget Reconciliation Act
- **PACU:** Post-anesthesia care unit
- **PASRR:** Preadmission screening and resident review

- **RN:** Registered nurse
- **SNF:** Skilled nursing facility
- **SSI:** Surgical site infections
- **STEMI:** ST-segment elevation myocardial infarction
- **TBI:** Traumatic brain injury

Internal Revenue Service

Department of the Treasury

P. 0. Box 2508
Cincinnati, OH 45201

Date: February 7, 2000

Person to Contact:
Linda A. Hill 31-01768
Customer Service Representative
Toll Free Telephone Number: 877-829-5500

Regions Hospital
P.O. Box 1309
Minneapolis, MN 55440-1309

Fax Number:
513-263-3756

Federal Identification Number:
41-0956618

Dear Sir or Madam:

This letter is in response to your telephone request for a copy of your organization's determination letter. This letter will take the place of the copy you requested.

Our records indicate that a determination letter issued in February 1987 granted your organization exemption from federal income tax under section 501(c)(3) of the Internal Revenue Code. That letter is still in *effect.*

Based on information subsequently submitted, we classified your organization as one that is not a private foundation within the meaning of section 509(a) of the Code because it is an organization described in 'ctions 509(a)(1) and 170(b)(1)(A)(iii).

This classification was based on the assumption that your organization's operations would continue as stated in the application. If your organization's sources of support, or its character, method of operations, or purposes have changed, please let us know so we can consider the effect of the change on the exempt status and foundation status of your organization.

Your organization is required to file Form 990, Return of Organization Exempt from Income Tax, only if its gross receipts each year are normally more than $25,000. If a return is required, it must be filed by the 15th day of the fifth month after the end of the organization's annual accounting period. The law imposes a penalty of $20 a day, up to a maximum of $10,000, when a return is filed late, unless there is reasonable cause for the delay.

All exempt organizations (unless specifically excluded) are liable for taxes under the Federal Insurance Contributions Act (social security taxes) on remuneration of $100 or more paid to each employee during a calendar year. Your organization is not liable for the tax imposed under the Federal Unemployment Tax Act (FUTA). ,

Organizations that are not private foundations are not subject to the excise taxes under Chapter 42 of the Code. However, these organizations are not automatically exempt from other federal excise taxes.

Donors may deduct contributions to your organization as provided *in* section 170 of the Code. Bequests, legacies, devises, transfers, or gifts to your organization or for its use are deductible for federal estate and t tax purposes if they meet the applicable provisions of sections 2055,.2106, and 2522 of *the* Code.

Regions Hospital
41-0956618

Your organization is not required to file federal income tax returns unless it is subject to the tax on unrelated business income under section 511 of the Code. If your organization is subject to this tax, it must file an income tax return on the Form 990-T, Exempt Organization Business Income Tax Return. In this letter, we are not determining whether any of your organization's present or proposed activities are unrelated trade or business as defined in section 513 of the Code.

The law requires you to make your organization's annual return available for public inspection without charge for three years after the due date of the return. You are also required to make available for public inspection a copy of your organization's exemption application, any supporting documents and the exemption letter to any individual who requests such documents in person or in writing. You can charge only a reasonable fee for reproduction and actual postage costs for the copied materials. The law does not require you to provide copies of public inspection documents that are widely available, such as by posting them on the Internet (World Wide Web). You may be liable for a penalty of $20 a day for each day you do not make these documents available for public inspection (up to a maximum of $10,000 in the case of an annual return).

Because this letter could help resolve any questions about your organization's exempt status and foundation status, you should keep it with the organization's permanent records.

If you have any questions, please call us at the telephone number shown in the heading of this

letter. This letter affirms your organization's exempt status.

Sincerely,

Robert C. Padilla
Manager, Customer Service

1A-64

#4/23

MINNESOTA SECRETARY OF STATE
AMENDMENT OF ARTICLES OF INCORPORATION

BEFORE COMPLETING THIS FORM, PLEASE READ INSTRUCTIONS LISTED BELOW.

CORPORATE NAME: (List the name of the company prior to any desired name change)

St. Paul-Ramsey Medical Center, Incorporated

This amendment is effective on the day it is filed with the Secretary of State, unless you indicate another date, no later than 30 days after filing with the Secretary of State.

September 15, 1997

The following amendment(s) of articles regarding the above corporation were adopted: (Insert full text of newly amended article(s) indicating which article(s) is (are) being amended or added.) If the full text of the amendment will not fit in the space provided, attach additional numbered pages. (Total number of pages including this form ____)

ARTICLE I

The name of this corporation shall be Regions Hospital.

This amendment has been approved pursuant to Minnesota Statutes chapter 302A or 317A. I certify that I am authorized to execute this amendment and I further certify that I understand that by signing this amendment, I am subject to the penalties of perjury as set forth in section 609.40 as if I had signed this amendment under oath.

(Signature of Authorized Person)

INSTRUCTIONS

1. Type or print with blank ink.
2. A Filing Fee of: $35.00, made payable to the Secretary of State.
3. Return completed forms to:

Secretary of State
180 State Office Building
100 Constitution Ave.
St. Paul, MN 55155-1299
(612)296-2803

0922134-0 Rev. 2/95

421121

FOR OFFICE USE ONLY

STATE OF MINNESOTA
DEPARTMENT OF STATE
FILED
AUG 20 1997
Secretary of State

Secretary of State

Internal Revenue Service
District Director

Department of the Treasury

Date: FEB 18 1987

Employer Identification Number: 41-6156618

Case Number: 3663490176O

Person to Contact:

Contact Telephone Number:

Accounting Period Ending:

Form 990 Required: ☑ Yes ☐ No

Caveat Applies:

ST PAUL-RAMSEY MEDICAL CENTER INCORPORATED
640 JACKSON STREET
ST PAUL, MN 55101

Dear Applicant:

Based on information supplied, and assuming your operations will be as stated in your application for recognition of exemption, we have determined you are exempt from Federal income tax under section 501(c)(3) of the Internal Revenue Code.

We have further determined that you are not a private foundation within the meaning of section 509(a) of the Code, because you are an organization described in section

If your sources of support, or your purposes, character, or method of operation change, please let us know so we can consider the effect of the change on your exempt status and foundation status. In the case of an amendment to your organizational document or bylaws, please send us a copy of the amended document or bylaws. Also, you should inform us of all changes in your name or address.

As of January 1, 1984, you are liable for taxes under the Federal Insurance Contributions Act (social security taxes) on remuneration of $100 or more you pay to each of your employees during a calendar year. You are not liable for the tax imposed under the Federal Unemployment Tax Act (FUTA).

Since you are not a private foundation, you are not subject to the excise taxes under Chapter 42 of the Code. However, you are not automatically exempt from other Federal excise taxes. If you have any questions about excise, employment, or other Federal taxes, please let us know.

Donors may deduct contributions to you as provided in section 170 of the Code. Bequests, legacies, devises, transfers, or gifts to you or for your use are deductible for Federal estate and gift tax purposes if they meet the applicable provisions of Code sections 2055, 2106, and 2522.

(over)

file Form 990 only if your gross receipts each year are normally more than $25,000. If a return is required, it must be filed by the 15th day of the fifth month after the end of your annual accounting period. The law imposes a penalty of $10 a day, up to a maximum of $5,000, when a return if filed late, unless there is reasonable cause for the delay.

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You need an employer identification number even if you have no employees. If an employer identification number was not entered on your application, a number will be assigned to you and you will be advised of it. Please use that number on all returns you file and in all correspondence with the Internal Revenue Service.

If the heading of this letter indicates that a caveat applies, the caveat below is an integral part of the letter.

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If you have any questions, please contact the person whose name and telephone number are shown in the heading of this letter.

Sincerely yours,

District Director

Internal Revenue Service
District Director

Department of the Treasury

Date: FEB 18 1987

Employer Identification Number: 41-0956618

Case Number: 3663490176O

Person to Contact:

Contact Telephone Number:

Accounting Period Ending:

Form 990 Required: ☑ Yes ☐ No

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District Director

Internal Revenue Service

Department of the Treasury

P. O. Box 2508
Cincinnati, OH 45201

Date: February 7, 2000

Person to Contact:
Linda A. Hill 31-01768
Customer Service Representative
Toll Free Telephone Number:
877-829-5500
Fax Number:
513-263-3756
Federal Identification Number:
41-0956618

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This letter affirms your organization's exempt status.

Sincerely,

Robert C. Padilla
Manager, Customer Service

HealthPartners®

System-Wide Policy

Title:	**Policy Number:**
Billing and Collections Policy	RC-04

PURPOSE: To describe HealthPartners' hospitals and clinics approach to obtaining payment for care provided to patients. In the event of nonpayment, HealthPartners is committed to making reasonable efforts to determine whether a patient is eligible for financial assistance before initiating collection actions. HealthPartners' Patient Financial Services Department has the authority and responsibility for determining whether HealthPartners has made reasonable efforts to determine whether an individual is eligible for financial assistance and whether HealthPartners is authorized to engage in specific collection actions described in this Billing & Collections Policy.

DEFINITIONS: Not Applicable

POLICY: HealthPartners may engage in collection activities for purposes of obtaining payment for care. Certain collection activities are more significant than others and require specific written notice to patients, as described in this Policy. However, HealthPartners is not required to provide written notice to patients when engaging in other, less significant collection activities.

HealthPartners **is not** required to provide notice to patients before engaging in the following collection activities:

- Sending patient billing statements that include due and past due dates;
- Attempting to negotiate a settlement of the amount owed;
- Referring a patient account to a third-party debt collection agency or law firm; or
- Sending letters or making phone calls, either from HealthPartners, HealthPartners' collection agency, or other agent of HealthPartners.

If a HealthPartners hospital engages extraordinary collection actions as defined under federal law, the hospital **is** required to provide notice to patients beforehand. HealthPartners' hospitals do not engage in the following forms of extraordinary collection actions:

- Selling a patient's debt to a collection agency or law firm; and
- Reporting adverse information about the patient to consumer credit reporting agencies or credit bureaus.

More information about extraordinary collection actions can be found by visiting the IRS hospital billing and collections website.[1] HealthPartners' hospitals have zero tolerance for abusive, harassing, oppressive, false, deceptive, or misleading language or conduct by its debt collection attorney and agencies, their agents or employees, and hospital employees responsible for collecting medical debt from patients.

PROCEDURE:

Billing Procedures:

- HealthPartners has policies and procedures in place to ensure the timely and accurate submission of claims to third-party payers. HealthPartners will not bill patients for amounts exceeding what the patient would have been responsible for had the third-party payer paid the claim or any amount denied due to HealthPartners' billing error. HealthPartners will not refer any bill to a third-part debt collection agency or attorney for collection while a claim for payment is pending with a third-party payer, with which HealthPartners has a contract.
- Uninsured patients may receive a discount consistent with the requirements of state law.
- Except for patients receiving Medical Assistance or who have complete insurance coverage, HealthPartners will send patients statements for balances due for services received by HealthPartners. Statements sent by HealthPartners will include phone numbers and contact information for patients to call for financial or other assistance.
- Patients may question or dispute bills received from HealthPartners. HealthPartners will return calls and answer inquiries regarding billing questions from patients in a timely manner. If the patient notifies HealthPartners, HealthPartners' debt collection agency, or HealthPartners' debt collection attorney that the patient does not owe a bill, all collection activity will be suspended until documentation is provided that the patient owes the debt or that a third-party payer has paid all obligated amounts.

Collection Procedures:

- To the extent permitted by state law, HealthPartners may use automated collection procedures, in-house collection services, telephone, collection letters, attorney services, and outside collection agencies to collect on accounts due.
- Accounts requiring more intense collection efforts may be referred by HealthPartners to outside collection agencies or attorneys.
- HealthPartners will not refer any medical debt to a third-party debt collection agency or attorney if the patient has made payments on the debt in accordance with the terms of a payment plan agreed to by HealthPartners.

[1]https://www.irs.gov/charities-non-profits/billing-and-collections-section-501r6#:~:text=Extraordinary%20Collection%20Actions,-ECAs%20are%20defined&text=Foreclosing%20on%20an%20individual's%20real,Causing%20an%20individual's%20arrest

- Neither HealthPartners nor its debt collection agencies will report any patient to a credit reporting agency because of the patient's failure to pay a medical bill.
- HealthPartners may determine a patient's medical debt is satisfied or uncollectible when: (1) a patient pays their debt in full, whether in a lump sum or according to the terms of a payment plan; (2) the patient qualifies for financial assistance, HealthPartners determines that the patient is eligible for financial assistance under its Financial Assistance Policy, or the patient is eligible for other discounts; or (3) HealthPartners determines that after following the steps in this Policy and making reasonable collection efforts that HealthPartners will no longer pursue payment.

EFFORTS TO DETERMINE ELIGIBILITY FOR FINANCIAL ASSISTANCE

Applications and Notifications:
HealthPartners will accept and process applications for financial assistance beginning on the date the care was provided to the patient and ending **240 days** after (1) the first post-discharge billing statement for hospital and hospital outpatient department services or (2) the first billing statement to include the date care was received for all other services. HealthPartners will take steps to notify patients about HealthPartners' Financial Assistance Policy and HealthPartners hospitals will not engage in Extraordinary Collection Actions for at least **120 days** from the date of the patient's first post-discharge billing statement. If the patient's account involves multiple episodes of care, HealthPartners will not engage in collection actions for at least **120 days** from the first post-discharge billing statement for the most recent episode of care.

At least **30 days** before a HealthPartners hospital begins Extraordinary Collection Actions for nonpayment, the hospital will do the following:

- Provide a written notice informing the patient that:
    - Financial assistance is available for eligible individuals;
    - The hospital may take identified Extraordinary Collection Actions to obtain payment; and
    - The hospital may begin Extraordinary Collection Actions 30 days after the date of the letter notice.
- Enclose a plain language summary of the hospital's Financial Assistance Policy with the notice letter; and
- Attempt to contact the patient by phone (or in person if possible) to verbally notify the patient of the hospital's Financial Assistance Policy and how the patient may obtain assistance with the application process.

Where deferral or denial of care are allowed by state law, if HealthPartners decides to defer or deny care due to nonpayment for prior care, HealthPartners will do the following:

- Provide the patient with a written notice that includes:
    - A Financial Assistance Policy application form; and
    - A statement that financial assistance is available for eligible individuals and a deadline after which HealthPartners will no longer accept financial assistance applications for the patient's prior care.

- Process any application for financial assistance received by the patient before the deadline on an expedited basis.

Incomplete Applications:
If during HealthPartners' application period HealthPartners receives an application for financial assistance that is incomplete or deficient, HealthPartners will do the following:

- Suspend any current collection actions;
- Provide the patient with a written notice describing the additional information or documentation that must be submitted before the application can be processed and how to contact HealthPartners to do so; and
- If a patient completes a previously incomplete application for financial assistance within HealthPartners' application period, HealthPartners will promptly make a determination as set forth in the Complete Applications section below.

Complete Applications:
If HealthPartners receives a complete application for financial assistance during HealthPartners' application period, HealthPartners will do the following in a timely manner:

- Suspend any current collection actions; and
- Make a determination of financial assistance eligibility and identify the basis for the determination.

If HealthPartners determines that a patient is eligible for financial assistance, it will do the following:

- If the patient is eligible for discounted (but not free) care, HealthPartners will provide the patient with a billing statement that indicates how the amount was determined and information regarding HealthPartners' financial assistance calculations;
- For HealthPartners' hospital charges, refund any amount the patient has paid for hospital care that exceeds the amount for which the patient is determined to be personally responsible; and
- Take all reasonably available measures to reverse any collection actions that may have been initiated against the patient.

Presumptive Eligibility Determinations:
HealthPartners may make presumptive eligibility determinations for financial assistance. This means that HealthPartners may determine that a patient is eligible for financial assistance based on information HealthPartners already has, or other information HealthPartners obtains, without obtaining additional information directly from the patient. If HealthPartners presumptively determines that a patient is eligible for financial assistance, but eligible for less than the most generous assistance, HealthPartners will do the following:

- Notify the patient of the determination and inform the patient about how to apply for more generous financial assistance;
- Give the patient a reasonable amount of time to apply for more generous assistance; and
- Process a completed application for more generous assistance as described above in this Policy.

HealthPartners will not make financial assistance presumptive eligibility determinations for elective services (purely cosmetic or other non-medically necessary services) as well as any balances that should be paid by insurance (including workers' compensation, automobile, or other liability insurance).

THIRD PARTY DEBT COLLECTION AGENCIES:

HealthPartners' collection process may result in referring the patient's account to a third-party debt collection agency. Before referring any patient account to a debt collection agency, HealthPartners will confirm[2] that

- If the patient's account includes hospital services, and the hospital is a Minnesota hospital, the hospital complied with the requirements in Minnesota Statutes section 144.587, unless the patient declined to participate;
- There is a reasonable basis to believe that the patient owes the debt;
- All known third-party payers have been properly billed by HealthPartners, such that any remaining debt is the financial responsibility of the patient, and HealthPartners will not bill the patient for any amount that an insurance company is obligated to pay;
- The patient has been given a reasonable opportunity to apply for financial assistance, if the facts and circumstances suggest that the patient may be eligible for financial assistance; and
- Where the patient has indicated an inability to pay the full amount of the debt in one payment and provided reasonable verification of the inability to pay the full amount of the debt in one payment if requested by HealthPartners, HealthPartners has offered the patient a reasonable payment plan.

If the patient submits an application for financial assistance after HealthPartners has referred the patient's account to a debt collection agency, HealthPartners and the debt collection agency will follow the process described in the above section "Efforts to Determine Eligibility for Financial Assistance."

HealthPartners will do the following to monitor relationships with all third-party debt collection agencies:

- Maintain a written contract with any debt collection agency utilized to collect debt from patients. The contract will require the debt collection agency to act in accordance with the terms of the agreement, applicable laws, and this Policy.
- Will not pay any debt collection agency any performance bonus, contingency bonus, or other similar payment which is calculated on the basis of the amount or percentage of debt collected from two or more patients. This does not prohibit HealthPartners from paying a debt collection agency a percentage of the debt collected from the patient, provided that HealthPartners has established adequate contractual controls to ensure that the collection agency acts in a manner consistent with applicable agreements and HealthPartners' mission.
- Train the debt collection agencies regarding HealthPartners' Financial Assistance Policy and how patients may obtain more information or submit a financial assistance application with HealthPartners.
- Require the debt collection agency and any attorneys utilized by it to maintain a log of all oral and written complaints received by any patient concerning the conduct of the agency. The log must be

[2] In Minnesota, a designated employee within the HealthPartners system with knowledge of the hospital's patient financial screening policies will complete affidavit of expert review before referring a patient's account including hospital services to a debt collection agency.

provided to HealthPartners at least six (6) times per year. Failure of the agency to log and provide all patient complaints may result in termination of HealthPartners contract with the agency.

- Require the debt collection agency and any attorneys it utilizes to keep a record of the date, time, and purpose of all communications to or from HealthPartners' patients.
- Evaluate annually the debt collection agencies' performance, based on total level of service, net recovery rates, customer feedback and compliance with expectations in this Policy.
- Have patient accounts reviewed by the appropriate authorized individual before referral to a debt collection agency.

DEBT COLLECTION LITIGATION

HealthPartners will not give a collection agency or attorney any blanket authorization to take legal action against a patient for the collection of medical debt. No lawsuit will be filed against any patient to collect medical debt until reviewed by an authorized Patient Financial Services manager who verifies that[3]:

- If patient's account includes hospital services, and the hospital is a Minnesota hospital, the hospital complied with the requirements in Minnesota Statutes section 144.587, unless the patient declined to participate;
- There is a reasonable basis to believe that the patient owes the debt;
- All known third-party payers have been properly billed, and the remaining debt is the financial responsibility of the patient, and HealthPartners will not bill the patient for any amount that an insurance company is obligated to pay;
- If the patient has indicated an inability to pay the full amount of the debt in one payment and provided reasonable verification of the inability to pay the full amount of the debt in one payment if requested by HealthPartners, HealthPartners offered the patient a reasonable payment plan; and
- The patient has been given an opportunity to submit a Financial Assistance Program application if the facts and circumstances suggest that the patient may be eligible for financial assistance.

When engaging debt collection attorneys and/or law firms, HealthPartners will maintain a written agreement that requires that the attorney and/or law firm act in conformance with the terms of the agreement, applicable law, this Policy, and if the HealthPartners hospital is located in Minnesota, the Minnesota Attorney General Hospital Billing Agreement. The following requirements shall apply to the contractual relationship to ensure patient accounts remain proper to pursue in litigation and that HealthPartners retains control over the litigation:

[3] In Minnesota, a designated Patient Financial Services manager within the HealthPartners system with knowledge of the hospital's patient financial screening policies will complete affidavit of expert review and ensure that it is served with the summons and complaint if the patient's medical debt includes hospital services.

- HealthPartners' General Counsel's Office shall oversee the collection of debt on behalf of its hospitals. The General Counsel's Office shall also be consulted by the attorney and/or law firm in cases where default judgment may be appropriate.[4]
- HealthPartners will train the attorney and/or law firm regarding HealthPartners' Financial Assistance Policy and how patients may obtain more information or submit a financial assistance application with HealthPartners.
- HealthPartners will annually audit for compliance with applicable agreements and this Policy.
- HealthPartners will annually evaluate performance, based on total level of service, net recovery rates, customer feedback, and compliance with expectations in this Policy. The HealthPartners hospital's CEO will review and determine annually whether to issue or renew any contract.
- HealthPartners will not pay any performance bonus, contingency bonus, or other similar payment which is calculated based on the amount or percentage of debt collected from two or more patients. HealthPartners may pay a percentage of the debt collected from the patient, provided that HealthPartners has established adequate contractual controls to ensure that the attorney and/or law firm acts in a manner consistent with applicable agreements and HealthPartners' mission.
- The attorney and/or law firm will not directly contact a patient known to be represented by an attorney regarding the collection of that debt unless the patient's attorney has granted permission.
- All debt collection attorneys and/or law firms must follow the processes required by state law and contracts with HealthPartners when pursuing litigation to collect medical debt from HealthPartners patients.

GARNISHMENTS

HealthPartners and its debt collection agencies and attorneys will not garnish the wages or bank account(s) of any patient unless a judgment against the patient is obtained in court for the amount of the debt. HealthPartners will not give debt collection agencies and attorneys and/or law firms blanket authorization to pursue garnishments of a patient's bank account(s) or wages.

Before initiating a proceeding for garnishment of a patient's wages or bank account, an authorized Patient Financial Services manager must authorize the garnishment for that particular patient before proceeding.[5] The authorized individual must verify that:

[4] Minnesota hospitals will complete an additional affidavit of expert review attesting to the requirements of Minnesota Statutes section 144.587, subd. 1(a)(7). Before requesting a default judgment against a patient, the Minnesota hospital execute an affidavit to verify that (1) the patient has not called or written the hospital, its debt collection agency, or its debt collection attorney in response to the complaint; (2) the hospital is unaware of patient having a sickness, disability, illness, infirmity, or age-related reason that would render the patient unable to answer the complaint; or (3) the patient received service of the complaint.

[5] In Minnesota, a designated Patient Financial Services manager within the HealthPartners system with knowledge of the hospital's patient financial screening policies will complete affidavit of expert review and ensure that it is served with the garnishment action.

- If patient's account includes hospital services, and the hospital is a Minnesota hospital, the hospital complied with the requirements in Minnesota Statutes section 144.587, unless the patient declined to participate;
- There is a reasonable basis to believe that the patient owes the debt;
- All known third-party payers have been properly billed, and the remaining debt is the financial responsibility of the patient, and HealthPartners will not bill the patient for any amount that an insurance company is obligated to pay;
- The patient has been given an opportunity to submit a Financial Assistance Program application if the facts and circumstances suggest that the patient may be eligible for financial assistance.
- If the patient has indicated an inability to pay the full amount of the debt in one payment and provided reasonable verification of the inability to pay the full amount of the debt in one payment if requested by HealthPartners, HealthPartners offered the patient a reasonable payment plan; and
- There is no reasonable basis to believe that the patient's or guarantor's wages or funds at a financial institution are likely to be exempt from garnishment.

If a patient submits a written claim that the patient's account or wages are exempt from garnishment, HealthPartners' debt collection attorney and/or law firm shall not object to the claim of exemption without first obtaining the specific approval of HealthPartners' General Counsel's Office. In deciding whether to grant such approval in the specific case, the General Counsel's Office will review all information submitted by the patient in support of the patient's claim for exemption.

RELATED DOCUMENTS: Not Applicable

REFERENCE MATERIALS:
IRS Hospital billing and collections website
Minnesota Statutes sections 144.587-144.589

ADDITIONAL INFORMATION: Not Applicable

COMMITTEE/POLICY SPONSOR AND OWNER:
VP of Revenue Cycle
Law Department Leadership
Amery Hospital and Clinic Board
Hudson Hospital Board
HealthPartners/GHI Board
Hutchinson Health Board
Lakeview Health/Stillwater Medical Group Board
Olivia Hospital and Clinic Board
Park Nicollet Methodist Hospital
Regions Hospital Board
Westfields Hospital Board

Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)
Do not enter social security numbers on this form as it may be made public.
Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2023

Open to Public Inspection

A For the 2023 calendar year, or tax year beginning **and ending**

B Check if applicable: Address change; Name change; Initial return; Final return/ terminated; Amended return; Application pending

C Name of organization
REGIONS HOSPITAL

Doing business as

Number and street (or P.O. box if mail is not delivered to street address) | Room/suite
8170 33RD AVENUE SOUTH, PO BOX 1309

City or town, state or province, country, and ZIP or foreign postal code
MINNEAPOLIS, MN 55440-1309

F Name and address of principal officer: ALITA R. RISINGER
640 JACKSON STREET, ST. PAUL, MN 55101

D Employer identification number
41-0956618

E Telephone number
952-883-6000

G Gross receipts $ 1,059,450,178.

H(a) Is this a group return for subordinates? Yes [X] No

H(b) Are all subordinates included? Yes No
If "No," attach a list. See instructions

H(c) Group exemption number

I Tax-exempt status: [X] 501(c)(3) 501(c) ( ) (insert no.) 4947(a)(1) or 527

J Website: WWW.REGIONSHOSPITAL.COM

K Form of organization: [X] Corporation Trust Association Other

L Year of formation: 1986

M State of legal domicile: MN

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities: TO IMPROVE THE HEALTH OF OUR PATIENTS AND COMMUNITY BY PROVIDING HIGH QUALITY HEALTH CARE.

2 Check this box if the organization discontinued its operations or disposed of more than 25% of its net assets.

3	Number of voting members of the governing body (Part VI, line 1a)	3	16
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	10
5	Total number of individuals employed in calendar year 2023 (Part V, line 2a)	5	7385
6	Total number of volunteers (estimate if necessary)	6	291
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	0.
b	Net unrelated business taxable income from Form 990-T, Part I, line 11	7b	0.

Revenue

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	8,985,867.	10,222,138.
9	Program service revenue (Part VIII, line 2g)	924,804,151.	1,025,302,091.
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	7,254,390.	23,020,458.
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	286,503.	591,805.
12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	941,330,911.	1,059,136,492.

Expenses

13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	508,591.	406,580.
14	Benefits paid to or for members (Part IX, column (A), line 4)	0.	0.
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	574,490,669.	621,622,514.
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
b	Total fundraising expenses (Part IX, column (D), line 25) 1,395,000.		
17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	352,637,882.	371,861,733.
18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	927,637,142.	993,890,827.
19	Revenue less expenses. Subtract line 18 from line 12	13,693,769.	65,245,665.

Net Assets or Fund Balances

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	1,088,798,516.	1,176,881,850.
21	Total liabilities (Part X, line 26)	363,324,533.	354,437,906.
22	Net assets or fund balances. Subtract line 21 from line 20	725,473,983.	822,443,944.

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge.

Sign Here

Signature of officer
ALITA R. RISINGER , CFO
Type or print name and title

Date 11/13/2024

Paid Preparer Use Only

Print/Type preparer's name: HOLLY K. MOEN	Preparer's signature: Holly Moen	Date: 11/7/24	Check if self-employed	PTIN: P01800653
Firm's name: KPMG LLP			Firm's EIN: 13-5565207	
Firm's address: 350 N 5TH STREET, SUITE 600 MINNEAPOLIS, MN 55401			Phone no. 612-305-5000	

May the IRS discuss this return with the preparer shown above? See instructions [X] Yes No

Part III Statement of Program Service Accomplishments

Check if Schedule O contains a response or note to any line in this Part III X

1 Briefly describe the organization's mission:
TO IMPROVE THE HEALTH OF OUR PATIENTS AND COMMUNITY BY PROVIDING HIGH QUALITY HEALTH CARE WHICH MEETS THE NEEDS OF ALL PEOPLE. OUR VISION IS TO BE THE PATIENT-CENTERED HOSPITAL OF CHOICE OF OUR COMMUNITY.

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? ..... Yes X No
If "Yes," describe these new services on Schedule O.

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? ..... Yes X No
If "Yes," describe these changes on Schedule O.

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

4a (Code:) (Expenses $ 904,550,026. including grants of $ 406,580.) (Revenue $ 1,025,868,896.)
SEE SCHEDULE O - EXEMPT PURPOSE AND ACHIEVEMENTS FOR A DESCRIPTION OF PROGRAM SERVICE ACCOMPLISHMENTS

4b (Code:) (Expenses $ including grants of $) (Revenue $)

4c (Code:) (Expenses $ including grants of $) (Revenue $)

4d Other program services (Describe on Schedule O.)
(Expenses $ including grants of $) (Revenue $)

4e Total program service expenses 904,550,026.

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1	X	
2	Is the organization required to complete *Schedule B, Schedule of Contributors*? See instructions	2	X	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		X
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II*	4	X	
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Rev. Proc. 98-19? *If "Yes," complete Schedule C, Part III*	5		X
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D, Part I*	6		X
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II*	7		X
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		X
9	Did the organization report an amount in Part X, line 21, for escrow or custodial account liability; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV*	9		X
10	Did the organization, directly or through a related organization, hold assets in donor-restricted endowments or in quasi-endowments? *If "Yes," complete Schedule D, Part V*	10		X
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X, as applicable.			
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D, Part VI*	11a	X	
b	Did the organization report an amount for investments - other securities in Part X, line 12, that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII*	11b		X
c	Did the organization report an amount for investments - program related in Part X, line 13, that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII*	11c		X
d	Did the organization report an amount for other assets in Part X, line 15, that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX*	11d	X	
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*	11e	X	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X*	11f	X	
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI and XII*	12a		X
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional*	12b	X	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		X
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		X
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at $100,000 or more? *If "Yes," complete Schedule F, Parts I and IV*	14b		X
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or other assistance to or for any foreign organization? *If "Yes," complete Schedule F, Parts II and IV*	15		X
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or other assistance to or for foreign individuals? *If "Yes," complete Schedule F, Parts III and IV*	16		X
17	Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I.* See instructions	17		X
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18		X
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		X
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	20a	X	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	X	
21	Did the organization report more than $5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	21	X	

Part IV Checklist of Required Schedules *(continued)*

			Yes	No
22	Did the organization report more than $5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	22		X
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5, about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J*	23	X	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a*	24a	X	
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b		X
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c		X
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d		X
25a	**Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I*	25a		X
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I*	25b		X
26	Did the organization report any amount on Part X, line 5 or 22, for receivables from or payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons? *If "Yes," complete Schedule L, Part II*	26		X
27	Did the organization provide a grant or other assistance to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity (including an employee thereof) or family member of any of these persons? *If "Yes," complete Schedule L, Part III*	27		X
28	Was the organization a party to a business transaction with one of the following parties? (See the Schedule L, Part IV, instructions for applicable filing thresholds, conditions, and exceptions):			
a	A current or former officer, director, trustee, key employee, creator or founder, or substantial contributor? *If "Yes," complete Schedule L, Part IV*	28a		X
b	A family member of any individual described in line 28a? *If "Yes," complete Schedule L, Part IV*	28b		X
c	A 35% controlled entity of one or more individuals and/or organizations described in line 28a or 28b? *If "Yes," complete Schedule L, Part IV*	28c		X
29	Did the organization receive more than $25,000 in noncash contributions? *If "Yes," complete Schedule M*	29		X
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	30		X
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	31		X
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	32		X
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? *If "Yes," complete Schedule R, Part I*	33		X
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1*	34	X	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a		X
b	If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2*	35b		
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	36	X	
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI*	37		X
38	Did the organization complete Schedule O and provide explanations on Schedule O for Part VI, lines 11b and 19? **Note:** All Form 990 filers are required to complete Schedule O	38	X	

Part V Statements Regarding Other IRS Filings and Tax Compliance

Check if Schedule O contains a response or note to any line in this Part V ☐

				Yes	No
1a	Enter the number reported in box 3 of Form 1096. Enter -0- if not applicable	1a	0		
b	Enter the number of Forms W-2G included on line 1a. Enter -0- if not applicable	1b	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c			

Part V Statements Regarding Other IRS Filings and Tax Compliance *(continued)*

				Yes	No
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	**2a**	7385		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?		**2b**	X	
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?		**3a**		X
b	If "Yes," has it filed a Form 990-T for this year? *If "No" to line 3b, provide an explanation on Schedule O*		**3b**		
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?		**4a**		X
b	If "Yes," enter the name of the foreign country _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?		**5a**		X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		**5b**		X
c	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?		**5c**		
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?		**6a**		X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?		**6b**		
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?		**7a**		X
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?		**7b**		
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?		**7c**		X
d	If "Yes," indicate the number of Forms 8282 filed during the year	**7d**			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?		**7e**		X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?		**7f**		X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?		**7g**		
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?		**7h**		
8	**Sponsoring organizations maintaining donor advised funds.** Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?		**8**		
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the sponsoring organization make any taxable distributions under section 4966?		**9a**		
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?		**9b**		
10	**Section 501(c)(7) organizations.** Enter:				
a	Initiation fees and capital contributions included on Part VIII, line 12	**10a**			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	**10b**			
11	**Section 501(c)(12) organizations.** Enter:				
a	Gross income from members or shareholders	**11a**			
b	Gross income from other sources. (Do not net amounts due or paid to other sources against amounts due or received from them.)	**11b**			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?		**12a**		
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	**12b**			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state? **Note:** See the instructions for additional information the organization must report on Schedule O.		**13a**		
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	**13b**			
c	Enter the amount of reserves on hand	**13c**			
14a	Did the organization receive any payments for indoor tanning services during the tax year?		**14a**		X
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation on Schedule O*		**14b**		
15	Is the organization subject to the section 4960 tax on payment(s) of more than $1,000,000 in remuneration or excess parachute payment(s) during the year? If "Yes," see the instructions and file Form 4720, Schedule N.		**15**		X
16	Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O.		**16**		X
17	**Section 501(c)(21) organizations.** Did the trust, or any disqualified or other person engage in any activities that would result in the imposition of an excise tax under section 4951, 4952 or 4953? If "Yes," complete Form 6069.		**17**		

Part VI Governance, Management, and Disclosure. *For each "Yes" response to lines 2 through 7b below, and for a "No" response to line 8a, 8b, or 10b below, describe the circumstances, processes, or changes on Schedule O. See instructions.*

Check if Schedule O contains a response or note to any line in this Part VI X

Section A. Governing Body and Management

				Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	1a	16		
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain on Schedule O.				
b	Enter the number of voting members included on line 1a, above, who are independent	1b	10		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2			X
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, trustees, or key employees to a management company or other person?	3			X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4			X
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5			X
6	Did the organization have members or stockholders?	6		X	
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a		X	
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b		X	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:				
a	The governing body?	8a		X	
b	Each committee with authority to act on behalf of the governing body?	8b		X	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses on Schedule O*	9			X

Section B. Policies *(This Section B requests information about policies not required by the Internal Revenue Code.)*

			Yes	No
10a	Did the organization have local chapters, branches, or affiliates?	10a		X
b	If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?	10b		
11a	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	11a	X	
b	Describe on Schedule O the process, if any, used by the organization to review this Form 990.			
12a	Did the organization have a written conflict of interest policy? *If "No," go to line 13*	12a	X	
b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	X	
c	Did the organization regularly and consistently monitor and enforce compliance with the policy? *If "Yes," describe on Schedule O how this was done*	12c	X	
13	Did the organization have a written whistleblower policy?	13	X	
14	Did the organization have a written document retention and destruction policy?	14	X	
15	Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?			
a	The organization's CEO, Executive Director, or top management official	15a	X	
b	Other officers or key employees of the organization	15b	X	
	If "Yes" to line 15a or 15b, describe the process on Schedule O. See instructions.			
16a	Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	16a		X
b	If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?	16b		

Section C. Disclosure

17 List the states with which a copy of this Form 990 is required to be filed MN

18 Section 6104 requires an organization to make its Forms 1023 (1024 or 1024-A, if applicable), 990, and 990-T (section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.

☐ Own website ☐ Another's website ☒ Upon request ☐ Other *(explain on Schedule O)*

19 Describe on Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.

20 State the name, address, and telephone number of the person who possesses the organization's books and records

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Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

Check if Schedule O contains a response or note to any line in this Part VII X

Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

1a Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
- List all of the organization's **current** key employees, if any. See the instructions for definition of "key employee."
- List the organization's five **current** highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (box 5 of Form W-2, box 6 of Form 1099-MISC, and/or box 1 of Form 1099-NEC) of more than $100,000 from the organization and any related organizations.
- List all of the organization's **former** officers, key employees, and highest compensated employees who received more than $100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than $10,000 of reportable compensation from the organization and any related organizations.

See the instructions for the order in which to list the persons above.

☐ Check this box if neither the organization nor any related organization compensated any current officer, director, or trustee.

(A) Name and title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC/ 1099-NEC)	(E) Reportable compensation from related organizations (W-2/1099-MISC/ 1099-NEC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) ANDREA M. WALSH	0.50									
DIRECTOR	54.50	X						0.	2,738,020.	892,297.
(2) PENNY D. CERMAK	0.50									
DIRECTOR	59.50	X						0.	1,383,266.	284,988.
(3) MEGAN M. REMARK	51.50									
DIRECTOR & PRESIDENT	3.50	X		X				0.	965,209.	314,288.
(4) MARK R. SANNES, MD	0.50									
DIRECTOR	59.50	X						0.	999,887.	169,547.
(5) NANCY L. EVERT	0.50									
SECRETARY & HPI GENERAL COUNSEL	54.50			X				0.	811,272.	238,674.
(6) SUNNY KAUL, MD	0.50									
DIRECTOR	44.50	X						0.	897,009.	58,656.
(7) BRET C. HAAKE, MD	0.50									
VPMA & CHIEF MEDICAL OFFICER	54.50			X				0.	730,568.	113,054.
(8) ALITA RISINGER	47.50									
CFO	2.50			X				0.	574,234.	112,052.
(9) JEROME C. SIY, MD	0.50									
DIRECTOR	49.50	X						0.	535,290.	100,863.
(10) TYLER R. SCHMIDTZ	49.00									
VP EAST METRO SURGERY	1.00			X				423,586.	0.	64,029.
(11) CHRISTINE M BOESE	0.00									
FORMER VP PATIENT CARE	0.00						X	458,283.	0.	24,623.
(12) KIMBERLY T. EGAN	0.50									
VP HUMAN RESOURCES	49.50			X				0.	411,732.	66,856.
(13) DEBRA A. RUDQUIST	0.50									
VP REGIONS & AMERY PRESIDENT	49.50			X				409,934.	0.	64,811.
(14) STEVEN M. MASSEY	1.00									
VP REGIONS & WESTFIELD PRESIDENT	49.00			X				409,116.	0.	64,799.
(15) THOMAS J. BOROWSKI	1.00									
VP REGIONS & HUDSON PRESIDENT	49.00			X				406,663.	0.	64,760.
(16) ANTHONY C. GRUNDHAUSER	45.00									
VP REGIONS HOSP FOUNDATION	0.00			X				353,358.	0.	62,962.
(17) BRADLEY L. PLOWMAN	50.00									
FINANCE DIRECTOR	0.00					X		319,807.	0.	62,106.

Part VII **Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees** *(continued)*

(A) Name and title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC/ 1099-NEC)	(E) Reportable compensation from related organizations (W-2/1099-MISC/ 1099-NEC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(18) JENNIFER G. HINES, MD	0.50									
DIRECTOR	34.50	X						0.	290,532.	89,669.
(19) DERRICK M. BERNDT	48.00									
NURSE ANESTHETIST	0.00					X		317,244.	0.	49,345.
(20) GEORGEANN J. MARK	65.00									
REGISTERED NURSE	0.00					X		313,382.	0.	49,364.
(21) JOHN M. CLARK	59.50									
VP FINANCE	0.50			X				317,545.	0.	40,401.
(22) NALY T. YANG	40.00									
NURSE ANESTHETIST	0.00					X		288,483.	0.	54,438.
(23) DANIAL N. LEVIE	40.00									
NURSE ANESTHETIST	0.00					X		276,819.	0.	55,200.
(24) MARY JO MORRISON	60.00									
VP QUALITY	0.00			X				282,265.	0.	47,188.
(25) DEBRA R. KELLY	45.00									
SYSTEM EXECUTIVE DIRECTOR	0.00			X				282,887.	0.	36,089.
(26) ROCHELLE JOHNSON	49.50									
VP PCS & CNO (MAR-DEC)	0.50			X				255,513.	0.	47,452.
1b Subtotal								5,114,885.	10,337,019.	3,228,511.
c Total from continuation sheets to Part VII, Section A								0.	179,908.	46,240.
d Total (add lines 1b and 1c)								5,114,885.	10,516,927.	3,274,751.

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 of reportable compensation from the organization 965

		Yes	No
3 Did the organization list any **former** officer, director, trustee, key employee, or highest compensated employee on line 1a? *If "Yes," complete Schedule J for such individual*	3	X	
4 For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than $150,000? *If "Yes," complete Schedule J for such individual*	4	X	
5 Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? *If "Yes," complete Schedule J for such person*	5		X

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than $100,000 of compensation from the organization. Report compensation for the calendar year ending with or within the organization's tax year.

(A) Name and business address	(B) Description of services	(C) Compensation
KRAUS-ANDERSON CONST. CO. 501 S. EIGHTH ST., MINNEAPOLIS, MN 55404	CONSTRUCTION	8,303,068.
UNIVERSITY OF MINNESOTA 1300 S 2ND ST, MINNEAPOLIS, MN 55454	PHYSICIAN SERVICES	8,261,350.
HEALTH SYSTEMS COOP LAUNDRIES 725 MINNEHAHA AVE E, ST PAUL, MN 55106-4441	CLEANING & LAUNDRY	3,390,535.
LANGUAGE LINE SOLUTIONS PO BOX 202564, DALLAS, TX 75320-2564	INTERUPTER	3,204,745.
FAVORITE HEALTHCARE STAFFING PO BOX 26225, OVERLAND PARK, KS 66225	STAFFING	2,526,088.

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 of compensation from the organization 68

SEE PART VII, SECTION A CONTINUATION SHEETS

Part VII **Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees** *(continued)*

(A) Name and title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (check all that apply)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(27) HEIDI G. CONRAD	0.00									
FORMER CFO	0.00						X	0.	179,908.	46,240.
(28) ARMANDO CAMACHO	0.50									
DIRECTOR & VICE CHAIR	0.00	X		X				0.	0.	0.
(29) ACOOA ELLIS	0.24									
DIRECTOR	0.00	X						0.	0.	0.
(30) ANGELA DILLOW	0.86									
DIRECTOR AND CHAIR	0.00	X		X				0.	0.	0.
(31) MARCELLO NAPOL	0.50									
DIRECTOR	0.00	X						0.	0.	0.
(32) SATASHA GREEN-STEPHENS	0.50									
DIRECTOR	0.00	X						0.	0.	0.
(33) BECCA HAGEN	0.50									
DIRECTOR	0.00	X						0.	0.	0.
(34) SANGEETA JAIN	0.50									
DIRECTOR	0.00	X						0.	0.	0.
(35) LANCE WHITACRE	0.56									
DIRECTOR & TREASURER	0.00	X		X				0.	0.	0.
(36) LINDA HANSON	0.26									
DIRECTOR	0.00	X						0.	0.	0.
(37) TRISTA MATASCASTILLO	0.50									
DIRECTOR	0.00	X						0.	0.	0.
Total to Part VII, Section A, line 1c									179,908.	46,240.

Part VIII Statement of Revenue

Check if Schedule O contains a response or note to any line in this Part VIII ☐

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514
Contributions, Gifts, Grants and Other Similar Amounts	1a	Federated campaigns	1a				
	b	Membership dues	1b				
	c	Fundraising events	1c				
	d	Related organizations	1d	3,738,642.			
	e	Government grants (contributions)	1e	6,483,496.			
	f	All other contributions, gifts, grants, and similar amounts not included above	1f				
	g	Noncash contributions included in lines 1a-1f	1g	$			
	h	**Total.** Add lines 1a-1f		10,222,138.			
Program Service Revenue			Business Code				
	2a	PATIENT SERVICES	623990	961,529,116.	961,529,116.		
	b	CONTRACT REVENUE	623990	39,979,718.	39,979,718.		
	c	MEDICAL RETAIL	561000	19,965,964.	19,965,964.		
	d	CAFETERIA	445200	2,716,831.	2,716,831.		
	e	PARKING	812930	1,110,462.	1,110,462.		
	f	All other program service revenue					
	g	**Total.** Add lines 2a-2f		1,025,302,091.			
Other Revenue	3	Investment income (including dividends, interest, and other similar amounts)		23,020,458.			23,020,458.
	4	Income from investment of tax-exempt bond proceeds					
	5	Royalties					
			(i) Real	(ii) Personal			
	6a	Gross rents 6a	25,000.				
	b	Less: rental expenses 6b	0.				
	c	Rental income or (loss) 6c	25,000.				
	d	Net rental income or (loss)		25,000.			25,000.
			(i) Securities	(ii) Other			
	7a	Gross amount from sales of assets other than inventory 7a					
	b	Less: cost or other basis and sales expenses 7b					
	c	Gain or (loss) 7c					
	d	Net gain or (loss)					
	8a	Gross income from fundraising events (not including $ _____ of contributions reported on line 1c). See Part IV, line 18 8a					
	b	Less: direct expenses 8b					
	c	Net income or (loss) from fundraising events					
	9a	Gross income from gaming activities. See Part IV, line 19 9a					
	b	Less: direct expenses 9b					
	c	Net income or (loss) from gaming activities					
	10a	Gross sales of inventory, less returns and allowances 10a	880,491.				
	b	Less: cost of goods sold 10b	313,686.				
	c	Net income or (loss) from sales of inventory		566,805.	566,805.		
Miscellaneous Revenue			Business Code				
	11a						
	b						
	c						
	d	All other revenue					
	e	**Total.** Add lines 11a-11d					
	12	**Total revenue.** See instructions		1,059,136,492.	1,025,868,896.	0.	23,045,458.

Part IX Statement of Functional Expenses

Section 501(c)(3) and 501(c)(4) organizations must complete all columns. All other organizations must complete column (A).

Check if Schedule O contains a response or note to any line in this Part IX ☐

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21	406,580.	406,580.		
2 Grants and other assistance to domestic individuals. See Part IV, line 22				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	1,950,678.		1,950,678.	
6 Compensation not included above to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	477,532,200.	435,651,867.	40,780,333.	1,100,000.
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	11,998,701.	10,966,189.	1,032,512.	
9 Other employee benefits	130,039,207.	120,328,731.	9,710,476.	
10 Payroll taxes	101,728.	101,728.		
11 Fees for services (nonemployees):				
a Management				
b Legal	276,883.		276,883.	
c Accounting	109,503.		109,503.	
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees				
g Other. (If line 11g amount exceeds 10% of line 25, column (A), amount, list line 11g expenses on Sch O.)	31,611,194.	26,976,843.	4,634,351.	
12 Advertising and promotion	1,103,891.	176,839.	927,052.	
13 Office expenses	4,650,938.	4,011,853.	639,085.	
14 Information technology	13,060,713.	1,384,279.	11,676,434.	
15 Royalties				
16 Occupancy	15,594,882.	13,914,970.	1,679,912.	
17 Travel	899,910.	790,066.	109,844.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	928,389.	645,328.	283,061.	
20 Interest	7,716,967.	7,392,936.	324,031.	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	45,747,570.	41,854,291.	3,893,279.	
23 Insurance	3,471,874.	157,884.	3,313,990.	
24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses on line 24e. If line 24e amount exceeds 10% of line 25, column (A), amount, list line 24e expenses on Schedule O.)				
a MEDICAL AND OTHER SUPPL	207,389,657.	207,253,297.	136,360.	
b MAINTENANCE AND REPAIR	16,280,503.	15,811,645.	468,858.	
c TAXES & ASSESSMENTS	13,067,479.	13,067,479.		
d MISCELLANEOUS EXPENSE	8,132,715.	2,757,002.	5,080,713.	295,000.
e All other expenses	1,818,665.	900,219.	918,446.	
25 **Total functional expenses.** Add lines 1 through 24e	993,890,827.	904,550,026.	87,945,801.	1,395,000.
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ☐ if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

Check if Schedule O contains a response or note to any line in this Part X ☐

				(A) Beginning of year		(B) End of year
Assets	1	Cash - non-interest-bearing		14,374,400.	1	8,778,469.
	2	Savings and temporary cash investments		244,000,499.	2	313,912,488.
	3	Pledges and grants receivable, net			3	
	4	Accounts receivable, net		112,166,049.	4	125,026,594.
	5	Loans and other receivables from any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons			5	
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B)			6	
	7	Notes and loans receivable, net			7	
	8	Inventories for sale or use		13,028,740.	8	13,629,593.
	9	Prepaid expenses and deferred charges		5,039,558.	9	2,851,835.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 1,002,692,246.			
	b	Less: accumulated depreciation	10b 699,488,325.	321,119,194.	10c	303,203,921.
	11	Investments - publicly traded securities		312,914,885.	11	340,018,123.
	12	Investments - other securities. See Part IV, line 11			12	
	13	Investments - program-related. See Part IV, line 11			13	1,686,183.
	14	Intangible assets			14	
	15	Other assets. See Part IV, line 11		66,155,191.	15	67,774,644.
	16	**Total assets.** Add lines 1 through 15 (must equal line 33)		1,088,798,516.	16	1,176,881,850.
Liabilities	17	Accounts payable and accrued expenses		117,337,821.	17	127,060,260.
	18	Grants payable			18	
	19	Deferred revenue		6,394,735.	19	1,005,113.
	20	Tax-exempt bond liabilities		180,088,594.	20	179,227,844.
	21	Escrow or custodial account liability. Complete Part IV of Schedule D			21	
	22	Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons			22	
	23	Secured mortgages and notes payable to unrelated third parties			23	
	24	Unsecured notes and loans payable to unrelated third parties			24	
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D		59,503,383.	25	47,144,689.
	26	**Total liabilities.** Add lines 17 through 25		363,324,533.	26	354,437,906.
Net Assets or Fund Balances		**Organizations that follow FASB ASC 958, check here** ☒ **and complete lines 27, 28, 32, and 33.**				
	27	Net assets without donor restrictions		691,917,212.	27	784,375,944.
	28	Net assets with donor restrictions		33,556,771.	28	38,068,000.
		Organizations that do not follow FASB ASC 958, check here ☐ **and complete lines 29 through 33.**				
	29	Capital stock or trust principal, or current funds			29	
	30	Paid-in or capital surplus, or land, building, or equipment fund			30	
	31	Retained earnings, endowment, accumulated income, or other funds			31	
	32	Total net assets or fund balances		725,473,983.	32	822,443,944.
	33	Total liabilities and net assets/fund balances		1,088,798,516.	33	1,176,881,850.

Part XI Reconciliation of Net Assets

Check if Schedule O contains a response or note to any line in this Part XI X

1	Total revenue (must equal Part VIII, column (A), line 12)	1	1,059,136,492.
2	Total expenses (must equal Part IX, column (A), line 25)	2	993,890,827.
3	Revenue less expenses. Subtract line 2 from line 1	3	65,245,665.
4	Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A))	4	725,473,983.
5	Net unrealized gains (losses) on investments	5	21,551,653.
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain on Schedule O)	9	10,172,643.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B))	10	822,443,944.

Part XII Financial Statements and Reporting

Check if Schedule O contains a response or note to any line in this Part XII .....

			Yes	No
1	Accounting method used to prepare the Form 990: ☐ Cash ☒ Accrual ☐ Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain on Schedule O.			
2a	Were the organization's financial statements compiled or reviewed by an independent accountant?	2a		X
	If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both: ☐ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis			
b	Were the organization's financial statements audited by an independent accountant?	2b	X	
	If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both: ☐ Separate basis ☒ Consolidated basis ☐ Both consolidated and separate basis			
c	If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?	2c	X	
	If the organization changed either its oversight process or selection process during the tax year, explain on Schedule O.			
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Uniform Guidance, 2 C.F.R. Part 200, Subpart F?	3a		X
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why on Schedule O and describe any steps taken to undergo such audits	3b		

SCHEDULE A
(Form 990)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.
Attach to Form 990 or Form 990-EZ.
Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2023

Open to Public Inspection

Name of the organization	Employer identification number
REGIONS HOSPITAL	41-0956618

Part I Reason for Public Charity Status. (All organizations must complete this part.) See instructions.

The organization is not a private foundation because it is: (For lines 1 through 12, check only one box.)

1 ☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**
2 ☐ A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E (Form 990).)
3 ☒ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**
4 ☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state: _____
5 ☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II.)
6 ☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**
7 ☐ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II.)
8 ☐ A community trust described in **section 170(b)(1)(A)(vi).** (Complete Part II.)
9 ☐ An agricultural research organization described in **section 170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land-grant college of agriculture (see instructions). Enter the name, city, and state of the college or university: _____
10 ☐ An organization that normally receives (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions, subject to certain exceptions; and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)
11 ☐ An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).**
12 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2)**. See **section 509(a)(3).** Check the box on lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g.

a ☐ **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. **You must complete Part IV, Sections A and B.**
b ☐ **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). **You must complete Part IV, Sections A and C.**
c ☐ **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). **You must complete Part IV, Sections A, D, and E.**
d ☐ **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). **You must complete Part IV, Sections A and D, and Part V.**
e ☐ Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.
f Enter the number of supported organizations .....
g Provide the following information about the supported organization(s).

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-10 above (see instructions))	(iv) Is the organization listed in your governing document? Yes	(iv) No	(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
Total						

Part II **Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)**

(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Calendar year (or fiscal year beginning in)	(a) 2019	(b) 2020	(c) 2021	(d) 2022	(e) 2023	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 **Public support.** Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in)	(a) 2019	(b) 2020	(c) 2021	(d) 2022	(e) 2023	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
11 **Total support.** Add lines 7 through 10						

12 Gross receipts from related activities, etc. (see instructions) 12

13 **First 5 years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** ☐

Section C. Computation of Public Support Percentage

14 Public support percentage for 2023 (line 6, column (f), divided by line 11, column (f)) 14 %

15 Public support percentage from 2022 Schedule A, Part II, line 14 15 %

16a **33 1/3% support test - 2023.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ☐

b **33 1/3% support test - 2022.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ☐

17a **10% -facts-and-circumstances test - 2023.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the facts-and-circumstances test, check this box and **stop here.** Explain in Part VI how the organization meets the facts-and-circumstances test. The organization qualifies as a publicly supported organization ☐

b **10% -facts-and-circumstances test - 2022.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the facts-and-circumstances test, check this box and **stop here.** Explain in Part VI how the organization meets the facts-and-circumstances test. The organization qualifies as a publicly supported organization ☐

18 **Private foundation.** If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ☐

Part III Support Schedule for Organizations Described in Section 509(a)(2)

(Complete only if you checked the box on line 10 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in)	(a) 2019	(b) 2020	(c) 2021	(d) 2022	(e) 2023	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 **Total.** Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 **Public support.** (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in)	(a) 2019	(b) 2020	(c) 2021	(d) 2022	(e) 2023	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included on line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13 **Total support.** (Add lines 9, 10c, 11, and 12.)						

14 **First 5 years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** ☐

Section C. Computation of Public Support Percentage

15 Public support percentage for 2023 (line 8, column (f), divided by line 13, column (f))	15	%
16 Public support percentage from 2022 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for **2023** (line 10c, column (f), divided by line 13, column (f))	17	%
18 Investment income percentage from **2022** Schedule A, Part III, line 17	18	%

19a **33 1/3% support tests - 2023.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ☐

b **33 1/3% support tests - 2022.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ☐

20 **Private foundation.** If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions ☐

Part IV Supporting Organizations

(Complete only if you checked a box on line 12 of Part I. If you checked box 12a, Part I, complete Sections A and B. If you checked box 12b, Part I, complete Sections A and C. If you checked box 12c, Part I, complete Sections A, D, and E. If you checked box 12d, Part I, complete Sections A and D, and complete Part V.)

Section A. All Supporting Organizations

			Yes	No
1	Are all of the organization's supported organizations listed by name in the organization's governing documents? *If "No," describe in* **Part VI** *how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.*	1		
2	Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? *If "Yes," explain in* **Part VI** *how the organization determined that the supported organization was described in section 509(a)(1) or (2).*	2		
3a	Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? *If "Yes," answer lines 3b and 3c below.*	3a		
b	Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? *If "Yes," describe in* **Part VI** *when and how the organization made the determination.*	3b		
c	Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? *If "Yes," explain in* **Part VI** *what controls the organization put in place to ensure such use.*	3c		
4a	Was any supported organization not organized in the United States ("foreign supported organization")? *If "Yes," and if you checked box 12a or 12b in Part I, answer lines 4b and 4c below.*	4a		
b	Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? *If "Yes," describe in* **Part VI** *how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.*	4b		
c	Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? *If "Yes," explain in* **Part VI** *what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.*	4c		
5a	Did the organization add, substitute, or remove any supported organizations during the tax year? *If "Yes," answer lines 5b and 5c below (if applicable). Also, provide detail in* **Part VI,** *including (i) the names and EIN numbers of the supported organizations added, substituted, or removed; (ii) the reasons for each such action; (iii) the authority under the organization's organizing document authorizing such action; and (iv) how the action was accomplished (such as by amendment to the organizing document).*	5a		
b	**Type I or Type II only.** Was any added or substituted supported organization part of a class already designated in the organization's organizing document?	5b		
c	**Substitutions only.** Was the substitution the result of an event beyond the organization's control?	5c		
6	Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? *If "Yes," provide detail in* **Part VI.**	6		
7	Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (as defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? *If "Yes," complete Part I of Schedule L (Form 990).*	7		
8	Did the organization make a loan to a disqualified person (as defined in section 4958) not described on line 7? *If "Yes," complete Part I of Schedule L (Form 990).*	8		
9a	Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons, as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? *If "Yes," provide detail in* **Part VI.**	9a		
b	Did one or more disqualified persons (as defined on line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? *If "Yes," provide detail in* **Part VI.**	9b		
c	Did a disqualified person (as defined on line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? *If "Yes," provide detail in* **Part VI.**	9c		
10a	Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? *If "Yes," answer line 10b below.*	10a		
b	Did the organization have any excess business holdings in the tax year? *(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.)*	10b		

Part IV Supporting Organizations *(continued)*

			Yes	No
11	Has the organization accepted a gift or contribution from any of the following persons?			
a	A person who directly or indirectly controls, either alone or together with persons described on lines 11b and 11c below, the governing body of a supported organization?	**11a**		
b	A family member of a person described on line 11a above?	**11b**		
c	A 35% controlled entity of a person described on line 11a or 11b above? *If "Yes" to line 11a, 11b, or 11c, provide detail in* **Part VI.**	**11c**		

Section B. Type I Supporting Organizations

			Yes	No
1	Did the governing body, members of the governing body, officers acting in their official capacity, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's officers, directors, or trustees at all times during the tax year? *If "No," describe in* **Part VI** *how the supported organization(s) effectively operated, supervised, or controlled the organization's activities. If the organization had more than one supported organization, describe how the powers to appoint and/or remove officers, directors, or trustees were allocated among the supported organizations and what conditions or restrictions, if any, applied to such powers during the tax year.*	**1**		
2	Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? *If "Yes," explain in* **Part VI** *how providing such benefit carried out the purposes of the supported organization(s) that operated, supervised, or controlled the supporting organization.*	**2**		

Section C. Type II Supporting Organizations

			Yes	No
1	Were a majority of the organization's directors or trustees during the tax year also a majority of the directors or trustees of each of the organization's supported organization(s)? *If "No," describe in* **Part VI** *how control or management of the supporting organization was vested in the same persons that controlled or managed the supported organization(s).*	**1**		

Section D. All Type III Supporting Organizations

			Yes	No
1	Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (i) a written notice describing the type and amount of support provided during the prior tax year, (ii) a copy of the Form 990 that was most recently filed as of the date of notification, and (iii) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided?	**1**		
2	Were any of the organization's officers, directors, or trustees either (i) appointed or elected by the supported organization(s) or (ii) serving on the governing body of a supported organization? *If "No," explain in* **Part VI** *how the organization maintained a close and continuous working relationship with the supported organization(s).*	**2**		
3	By reason of the relationship described on line 2, above, did the organization's supported organizations have a significant voice in the organization's investment policies and in directing the use of the organization's income or assets at all times during the tax year? *If "Yes," describe in* **Part VI** *the role the organization's supported organizations played in this regard.*	**3**		

Section E. Type III Functionally Integrated Supporting Organizations

1 *Check the box next to the method that the organization used to satisfy the Integral Part Test during the year* **(see instructions).**

- **a** ☐ The organization satisfied the Activities Test. *Complete* **line 2** *below.*
- **b** ☐ The organization is the parent of each of its supported organizations. *Complete* **line 3** *below.*
- **c** ☐ The organization supported a governmental entity. *Describe in* **Part VI** *how you supported a governmental entity (see instructions).*

			Yes	No
2	Activities Test. **Answer lines 2a and 2b below.**			
a	Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? *If "Yes," then in* **Part VI identify those supported organizations and explain** *how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.*	**2a**		
b	Did the activities described on line 2a, above, constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? *If "Yes," explain in* **Part VI** *the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.*	**2b**		
3	Parent of Supported Organizations. **Answer lines 3a and 3b below.**			
a	Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? *If "Yes" or "No" provide details in* **Part VI.**	**3a**		
b	Did the organization exercise a substantial degree of direction over the policies, programs, and activities of each of its supported organizations? *If "Yes," describe in* **Part VI** *the role played by the organization in this regard.*	**3b**		

Part V Type III Non-Functionally Integrated 509(a)(3) Supporting Organizations

1 ☐ Check here if the organization satisfied the Integral Part Test as a qualifying trust on Nov. 20, 1970 (*explain in* **Part VI**). **See instructions.** All other Type III non-functionally integrated supporting organizations must complete Sections A through E.

Section A - Adjusted Net Income		(A) Prior Year	(B) Current Year (optional)
1 Net short-term capital gain	**1**		
2 Recoveries of prior-year distributions	**2**		
3 Other gross income (see instructions)	**3**		
4 Add lines 1 through 3.	**4**		
5 Depreciation and depletion	**5**		
6 Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	**6**		
7 Other expenses (see instructions)	**7**		
8 **Adjusted Net Income** (subtract lines 5, 6, and 7 from line 4)	**8**		

Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1 Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):			
a Average monthly value of securities	**1a**		
b Average monthly cash balances	**1b**		
c Fair market value of other non-exempt-use assets	**1c**		
d **Total** (add lines 1a, 1b, and 1c)	**1d**		
e **Discount** claimed for blockage or other factors (*explain in detail in* **Part VI**):			
2 Acquisition indebtedness applicable to non-exempt-use assets	**2**		
3 Subtract line 2 from line 1d.	**3**		
4 Cash deemed held for exempt use. Enter 0.015 of line 3 (for greater amount, see instructions).	**4**		
5 Net value of non-exempt-use assets (subtract line 4 from line 3)	**5**		
6 Multiply line 5 by 0.035.	**6**		
7 Recoveries of prior-year distributions	**7**		
8 **Minimum Asset Amount** (add line 7 to line 6)	**8**		

Section C - Distributable Amount			Current Year
1 Adjusted net income for prior year (from Section A, line 8, column A)	**1**		
2 Enter 0.85 of line 1.	**2**		
3 Minimum asset amount for prior year (from Section B, line 8, column A)	**3**		
4 Enter greater of line 2 or line 3.	**4**		
5 Income tax imposed in prior year	**5**		
6 **Distributable Amount.** Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions).	**6**		

7 ☐ Check here if the current year is the organization's first as a non-functionally integrated Type III supporting organization (see instructions).

Part V Type III Non-Functionally Integrated 509(a)(3) Supporting Organizations *(continued)*

Section D - Distributions		Current Year
1 Amounts paid to supported organizations to accomplish exempt purposes	1	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	2	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	3	
4 Amounts paid to acquire exempt-use assets	4	
5 Qualified set-aside amounts (prior IRS approval required - *provide details in* **Part VI**)	5	
6 Other distributions (*describe in* **Part VI**). See instructions.	6	
7 **Total annual distributions.** Add lines 1 through 6.	7	
8 Distributions to attentive supported organizations to which the organization is responsive (*provide details in* **Part VI**). See instructions.	8	
9 Distributable amount for 2023 from Section C, line 6	9	
10 Line 8 amount divided by line 9 amount	10	

Section E - Distribution Allocations (see instructions)	(i) Excess Distributions	(ii) Underdistributions Pre-2023	(iii) Distributable Amount for 2023
1 Distributable amount for 2023 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2023 (reasonable cause required - *explain in* **Part VI**). See instructions.			
3 Excess distributions carryover, if any, to 2023			
a From 2018			
b From 2019			
c From 2020			
d From 2021			
e From 2022			
f **Total** of lines 3a through 3e			
g Applied to underdistributions of prior years			
h Applied to 2023 distributable amount			
i Carryover from 2018 not applied (see instructions)			
j Remainder. Subtract lines 3g, 3h, and 3i from line 3f.			
4 Distributions for 2023 from Section D, line 7: $			
a Applied to underdistributions of prior years			
b Applied to 2023 distributable amount			
c Remainder. Subtract lines 4a and 4b from line 4.			
5 Remaining underdistributions for years prior to 2023, if any. Subtract lines 3g and 4a from line 2. For result greater than zero, *explain in* **Part VI.** See instructions.			
6 Remaining underdistributions for 2023. Subtract lines 3h and 4b from line 1. For result greater than zero, *explain in* **Part VI**. See instructions.			
7 **Excess distributions carryover to 2024.** Add lines 3j and 4c.			
8 Breakdown of line 7:			
a Excess from 2019			
b Excess from 2020			
c Excess from 2021			
d Excess from 2022			
e Excess from 2023			

Part VI **Supplemental Information.** Provide the explanations required by Part II, line 10; Part II, line 17a or 17b; Part III, line 12; Part IV, Section A, lines 1, 2, 3b, 3c, 4b, 4c, 5a, 6, 9a, 9b, 9c, 11a, 11b, and 11c; Part IV, Section B, lines 1 and 2; Part IV, Section C, line 1; Part IV, Section D, lines 2 and 3; Part IV, Section E, lines 1c, 2a, 2b, 3a, and 3b; Part V, line 1; Part V, Section B, line 1e; Part V, Section D, lines 5, 6, and 8; and Part V, Section E, lines 2, 5, and 6. Also complete this part for any additional information. (See instructions.)

SCHEDULE C
(Form 990)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

For Organizations Exempt From Income Tax Under Section 501(c) and Section 527

Complete if the organization is described below. Attach to Form 990 or Form 990-EZ.
Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2023

Open to Public Inspection

If the organization answered "Yes" on Form 990, Part IV, line 3, or Form 990-EZ, Part V, line 46 (Political Campaign Activities), then:

- Section 501(c)(3) organizations: Complete Parts I-A and B. Do not complete Part I-C.
- Section 501(c) (other than section 501(c)(3)) organizations: Complete Parts I-A and C below. Do not complete Part I-B.
- Section 527 organizations: Complete Part I-A only.

If the organization answered "Yes" on Form 990, Part IV, line 4, or Form 990-EZ, Part VI, line 47 (Lobbying Activities), then:

- Section 501(c)(3) organizations that have filed Form 5768 (election under section 501(h)): Complete Part II-A. Do not complete Part II-B.
- Section 501(c)(3) organizations that have NOT filed Form 5768 (election under section 501(h)): Complete Part II-B. Do not complete Part II-A.

If the organization answered "Yes" on Form 990, Part IV, line 5 (Proxy Tax) (see separate instructions) or Form 990-EZ, Part V, line 35c (Proxy Tax) (see separate instructions), then:

- Section 501(c)(4), (5), or (6) organizations: Complete Part III.

Name of organization	Employer identification number
REGIONS HOSPITAL	41-0956618

Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

1 Provide a description of the organization's direct and indirect political campaign activities in Part IV.
2 Political campaign activity expenditures ..... $
3 Volunteer hours for political campaign activities .....

Part I-B Complete if the organization is exempt under section 501(c)(3).

1 Enter the amount of any excise tax incurred by the organization under section 4955 ..... $
2 Enter the amount of any excise tax incurred by organization managers under section 4955 ..... $
3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year? ..... ☐ Yes ☐ No
4a Was a correction made? ..... ☐ Yes ☐ No
b If "Yes," describe in Part IV.

Part I-C Complete if the organization is exempt under section 501(c), except section 501(c)(3).

1 Enter the amount directly expended by the filing organization for section 527 exempt function activities ..... $
2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities ..... $
3 Total exempt function expenditures. Add lines 1 and 2. Enter here and on Form 1120-POL, line 17b ..... $
4 Did the filing organization file **Form 1120-POL** for this year? ..... ☐ Yes ☐ No
5 Enter the names, addresses, and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments. For each organization listed, enter the amount paid from the filing organization's funds. Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC). If additional space is needed, provide information in Part IV.

(a) Name	**(b)** Address	**(c)** EIN	**(d)** Amount paid from filing organization's funds. If none, enter -0-.	**(e)** Amount of political contributions received and promptly and directly delivered to a separate political organization. If none, enter -0-.

Part II-A Complete if the organization is exempt under section 501(c)(3) and filed Form 5768 (election under section 501(h)).

A Check ☐ if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures).

B Check ☐ if the filing organization checked box A and "limited control" provisions apply.

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	(a) Filing organization's totals	(b) Affiliated group totals
1a Total lobbying expenditures to influence public opinion (grassroots lobbying)		
b Total lobbying expenditures to influence a legislative body (direct lobbying)		
c Total lobbying expenditures (add lines 1a and 1b)		
d Other exempt purpose expenditures		
e Total exempt purpose expenditures (add lines 1c and 1d)		
f Lobbying nontaxable amount. Enter the amount from the following table in both columns.		
g Grassroots nontaxable amount (enter 25% of line 1f)		
h Subtract line 1g from line 1a. If zero or less, enter -0-		
i Subtract line 1f from line 1c. If zero or less, enter -0-		

If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:
not over $500,000,	20% of the amount on line 1e.
over $500,000 but not over $1,000,000,	$100,000 plus 15% of the excess over $500,000.
over $1,000,000 but not over $1,500,000,	$175,000 plus 10% of the excess over $1,000,000.
over $1,500,000 but not over $17,000,000,	$225,000 plus 5% of the excess over $1,500,000.
over $17,000,000,	$1,000,000.

j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? ☐ **Yes** ☐ **No**

4-Year Averaging Period Under Section 501(h)

(Some organizations that made a section 501(h) election do not have to complete all of the five columns below. See the separate instructions for lines 2a through 2f.)

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	**(a)** 2020	**(b)** 2021	**(c)** 2022	**(d)** 2023	**(e)** Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

Part II-B Complete if the organization is exempt under section 501(c)(3) and has NOT filed Form 5768 (election under section 501(h)).

For each "Yes" response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.	(a) Yes	(a) No	(b) Amount
1 During the year, did the filing organization attempt to influence foreign, national, state, or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a Volunteers?		X	
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?	X		
c Media advertisements?		X	
d Mailings to members, legislators, or the public?		X	
e Publications, or published or broadcast statements?	X		
f Grants to other organizations for lobbying purposes?		X	
g Direct contact with legislators, their staffs, government officials, or a legislative body?	X		57,957.
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?	X		
i Other activities?	X		
j Total. Add lines 1c through 1i			57,957.
2a Did the activities in line 1 cause the organization to not be described in section 501(c)(3)?		X	
b If "Yes," enter the amount of any tax incurred under section 4912			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

Part III-A Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6).

			Yes	No
1	Were substantially all (90% or more) dues received nondeductible by members?	1		
2	Did the organization make only in-house lobbying expenditures of $2,000 or less?	2		
3	Did the organization agree to carry over lobbying and political campaign activity expenditures from the prior year?	3		

Part III-B Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6) and if either (a) BOTH Part III-A, lines 1 and 2, are answered "No" OR (b) Part III-A, line 3, is answered "Yes."

1	Dues, assessments and similar amounts from members	1	
2	Section 162(e) nondeductible lobbying and political expenditures **(do not include amounts of political expenses for which the section 527(f) tax was paid).**		
a	Current year	2a	
b	Carryover from last year	2b	
c	Total	2c	
3	Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues	3	
4	If notices were sent and the amount on line 2c exceeds the amount on line 3, what portion of the excess does the organization agree to carryover to the reasonable estimate of nondeductible lobbying and political expenditures next year?	4	
5	Taxable amount of lobbying and political expenditures. See instructions	5	

Part IV Supplemental Information

Provide the descriptions required for Part I-A, line 1; Part I-B, line 4; Part I-C, line 5; Part II-A (affiliated group list); Part II-A, lines 1 and 2 (see instructions); and Part II-B, line 1. Also, complete this part for any additional information.

PART II-B, LINE 1, LOBBYING ACTIVITIES:

THE HOSPITAL PAYS FOR CERTAIN CORPORATE AND EMPLOYEE PROFESSIONAL

ASSOCIATION MEMBERSHIPS. A PORTION OF SUCH MEMBERSHIP DUES POTENTIALLY

COULD BE USED BY THE PROFESSIONAL ASSOCIATIONS FOR LOBBYING ACTIVITIES.

THE HOSPITAL COST OF DIRECT CONTACT WITH LEGISLATORS, THEIR STAFFS,

Part IV Supplemental Information *(continued)*

GOVERNMENT OFFICIALS, OR LEGISLATIVE BODIES CONSISTS OF:

LOBBYISTS	$30,300
LOBBYING DUES	$27,000
ADMINISTRATIVE COST	$ 657
TOTAL	$57,957

SCHEDULE D
(Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

Complete if the organization answered "Yes" on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.
Attach to Form 990.
Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2023

Open to Public Inspection

Name of the organization
REGIONS HOSPITAL

Employer identification number
41-0956618

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.

Complete if the organization answered "Yes" on Form 990, Part IV, line 6.

		(a) Donor advised funds	(b) Funds and other accounts
1	Total number at end of year		
2	Aggregate value of contributions to (during year)		
3	Aggregate value of grants from (during year)		
4	Aggregate value at end of year		

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? ☐ Yes ☐ No

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? ☐ Yes ☐ No

Part II Conservation Easements.

Complete if the organization answered "Yes" on Form 990, Part IV, line 7.

1 Purpose(s) of conservation easements held by the organization (check all that apply).

☐ Preservation of land for public use (for example, recreation or education)
☐ Preservation of a historically important land area
☐ Protection of natural habitat
☐ Preservation of a certified historic structure
☐ Preservation of open space

2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year.

			Held at the End of the Tax Year
a	Total number of conservation easements	2a	
b	Total acreage restricted by conservation easements	2b	
c	Number of conservation easements on a certified historic structure included on line 2a	2c	
d	Number of conservation easements included on line 2c acquired after July 25, 2006, and not on a historic structure listed in the National Register	2d	

3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year _____

4 Number of states where property subject to conservation easement is located _____

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? ☐ Yes ☐ No

6 Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year _____

7 Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year _____

8 Does each conservation easement reported on line 2d above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? ☐ Yes ☐ No

9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.

Complete if the organization answered "Yes" on Form 990, Part IV, line 8.

1a If the organization elected, as permitted under FASB ASC 958, not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide in Part XIII the text of the footnote to its financial statements that describes these items.

b If the organization elected, as permitted under FASB ASC 958, to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items.

(i) Revenue included on Form 990, Part VIII, line 1 $ _____

(ii) Assets included in Form 990, Part X $ _____

2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under FASB ASC 958 relating to these items:

a Revenue included on Form 990, Part VIII, line 1 $ _____

b Assets included in Form 990, Part X $ _____

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets *(continued)*

3 Using the organization's acquisition, accession, and other records, check any of the following that make significant use of its collection items (check all that apply).

a ☐ Public exhibition
b ☐ Scholarly research
c ☐ Preservation for future generations
d ☐ Loan or exchange program
e ☐ Other _____

4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.

5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? ☐ Yes ☐ No

Part IV Escrow and Custodial Arrangements

Complete if the organization answered "Yes" on Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21.

1a Is the organization an agent, trustee, custodian, or other intermediary for contributions or other assets not included on Form 990, Part X? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIII and complete the following table:

		Amount
c Beginning balance	1c	
d Additions during the year	1d	
e Distributions during the year	1e	
f Ending balance	1f	

2a Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided in Part XIII ☐

Part V Endowment Funds

Complete if the organization answered "Yes" on Form 990, Part IV, line 10.

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance					
b Contributions					
c Net investment earnings, gains, and losses					
d Grants or scholarships					
e Other expenditures for facilities and programs					
f Administrative expenses					
g End of year balance					

2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:

a Board designated or quasi-endowment _____%
b Permanent endowment _____%
c Term endowment _____%

The percentages on lines 2a, 2b, and 2c should equal 100%.

3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:

		Yes	No
(i) Unrelated organizations?	3a(i)		
(ii) Related organizations?	3a(ii)		
b If "Yes" on line 3a(ii), are the related organizations listed as required on Schedule R?	3b		

4 Describe in Part XIII the intended uses of the organization's endowment funds.

Part VI Land, Buildings, and Equipment

Complete if the organization answered "Yes" on Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		6,394,223.		6,394,223.
b Buildings		652,636,574.	435,759,970.	216,876,604.
c Leasehold improvements		8,692,826.	7,189,739.	1,503,087.
d Equipment		316,580,222.	255,501,603.	61,078,619.
e Other		18,388,401.	1,037,013.	17,351,388.
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, line 10c, column (B))*				303,203,921.

Part VII Investments - Other Securities

Complete if the organization answered "Yes" on Form 990, Part IV, line 11b. See Form 990, Part X, line 12.

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely held equity interests		
(3) Other		
(A)		
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
Total. (Col. (b) must equal Form 990, Part X, line 12, col. (B))		

Part VIII Investments - Program Related.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11c. See Form 990, Part X, line 13.

(a) Description of investment	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
Total. (Col. (b) must equal Form 990, Part X, line 13, col. (B))		

Part IX Other Assets

Complete if the organization answered "Yes" on Form 990, Part IV, line 11d. See Form 990, Part X, line 15.

	(a) Description	(b) Book value
(1)	DEBT INSURRANCE COSTS	1,328,500.
(2)	INTEREST IN N.A. OF RHF	38,068,407.
(3)	RIGHT OF USE ASSET	28,206,365.
(4)	OTHER	171,372.
(5)		
(6)		
(7)		
(8)		
(9)		
Total. *(Column (b) must equal Form 990, Part X, line 15, col. (B))*		67,774,644.

Part X Other Liabilities

Complete if the organization answered "Yes" on Form 990, Part IV, line 11e or 11f. See Form 990, Part X, line 25.

1.	(a) Description of liability	(b) Book value
(1)	Federal income taxes	
(2)	LONG TERM DEBT CURRENT PORTION	8,035,126.
(3)	POST RETIREMENT BENEFITS	1,913,297.
(4)	PROFESSIONAL LIABILITY RESERVE	11,911,074.
(5)	LEASE OBLIGATION	25,285,192.
(6)		
(7)		
(8)		
(9)		
Total. *(Column (b) must equal Form 990, Part X, line 25, col. (B))*		47,144,689.

2. Liability for uncertain tax positions. In Part XIII, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FASB ASC 740. Check here if the text of the footnote has been provided in Part XIII ... X

Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return

Complete if the organization answered "Yes" on Form 990, Part IV, line 12a.

1	Total revenue, gains, and other support per audited financial statements			1	
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:				
a	Net unrealized gains (losses) on investments	2a			
b	Donated services and use of facilities	2b			
c	Recoveries of prior year grants	2c			
d	Other (Describe in Part XIII.)	2d			
e	Add lines **2a** through **2d**			2e	
3	Subtract line **2e** from line **1**			3	
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIII.)	4b			
c	Add lines **4a** and **4b**			4c	
5	Total revenue. Add lines **3** and **4c.** *(This must equal Form 990, Part I, line 12.)*			5	

Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return

Complete if the organization answered "Yes" on Form 990, Part IV, line 12a.

1	Total expenses and losses per audited financial statements			1	
2	Amounts included on line 1 but not on Form 990, Part IX, line 25:				
a	Donated services and use of facilities	2a			
b	Prior year adjustments	2b			
c	Other losses	2c			
d	Other (Describe in Part XIII.)	2d			
e	Add lines **2a** through **2d**			2e	
3	Subtract line **2e** from line **1**			3	
4	Amounts included on Form 990, Part IX, line 25, but not on line 1:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIII.)	4b			
c	Add lines **4a** and **4b**			4c	
5	Total expenses. Add lines **3** and **4c.** *(This must equal Form 990, Part I, line 18.)*			5	

Part XIII Supplemental Information

Provide the descriptions required for Part II, lines 3, 5, and 9; Part III, lines 1a and 4; Part IV, lines 1b and 2b; Part V, line 4; Part X, line 2; Part XI, lines 2d and 4b; and Part XII, lines 2d and 4b. Also complete this part to provide any additional information.

PART X, LINE 2:

THE HOSPITAL IS INCLUDED IN THE HEALTHPARTNERS, INC. (HP) CONSOLIDATED AUDITED FINANCIAL STATEMENT.

JUDGMENT IS REQUIRED IN DETERMINING HP'S EFFECTIVE TAX RATE AND IN EVALUATING ITS TAX POSITION. HP ESTABLISHES ACCRUALS FOR UNCERTAIN TAX POSITIONS WHEN, DESPITE THE BELIEF THAT HP'S TAX RETURN POSITIONS ARE FULLY SUPPORTABLE, HP BELIEVES THAT ITS POSITION MAY NOT BE FULLY SUSTAINED, PRIMARILY GIVEN THE RISKS ASSOCIATED WITH TAX LITIGATION OR DISPUTES. THE UNCERTAIN TAX POSITION ACCRUALS ARE ADJUSTED IN LIGHT OF CHANGING FACTS AND CIRCUMSTANCES, SUCH AS THE PROGRESS OF TAX AUDITS, CASE LAW, AND EMERGING LEGISLATION. HP'S EFFECTIVE TAX RATE INCLUDES THE IMPACT

Part XIII Supplemental Information *(continued)*

OF CHANGES TO THE ACCRUALS FOR UNCERTAIN TAX POSITIONS. HP CLASSIFIES

INTEREST AND PENALTIES ON TAX-RELATED MATTERS AS INCOME AND OTHER TAX

EXPENSE IN THE CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET

ASSETS. HP RECORDED NO LIABILITIES AT DECEMBER 31, 2023 OR 2022 FOR

UNRECOGNIZED TAX BENEFITS.

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

Complete if the organization answered "Yes" on Form 990, Part IV, question 20a.
Attach to Form 990.
Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2023

Open to Public Inspection

Name of the organization

REGIONS HOSPITAL

Employer identification number

41-0956618

Part I Financial Assistance and Certain Other Community Benefits at Cost

			Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	X	
b	If "Yes," was it a written policy?	1b	X	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year: ☐ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities			
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.			
a	Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: ☐ 100% ☐ 150% ☒ 200% ☐ Other _____ %	3a	X	
b	Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: ☐ 200% ☐ 250% ☐ 300% ☐ 350% ☐ 400% ☒ Other 2000 %	3b	X	
c	If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.			
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4	X	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	X	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b	X	
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c		X
6a	Did the organization prepare a community benefit report during the tax year?	6a		X
b	If "Yes," did the organization make it available to the public?	6b		

Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			20,882,000.		20,882,000.	2.10%
b Medicaid (from Worksheet 3, column a)			207,547,204.	179,823,592.	27,723,612.	2.79%
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total.** Financial Assistance and Means-Tested Government Programs			228,429,204.	179,823,592.	48,605,612.	4.89%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			14,158,000.	2,783,000.	11,375,000.	1.14%
f Health professions education (from Worksheet 5)			26,798,000.	13,481,000.	13,317,000.	1.34%
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)						
j **Total.** Other Benefits			40,956,000.	16,264,000.	24,692,000.	2.48%
k **Total.** Add lines 7d and 7j			269,385,204.	196,087,592.	73,297,612.	7.37%

Part II Community Building Activities.

Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

		(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1	Physical improvements and housing						
2	Economic development						
3	Community support						
4	Environmental improvements						
5	Leadership development and training for community members						
6	Coalition building						
7	Community health improvement advocacy						
8	Workforce development						
9	Other						
10	Total						

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

				Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1		X	
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount	2	22,562,000.		
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit	3			
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.				

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	390,302,000.		
6	Enter Medicare allowable costs of care relating to payments on line 5	6	415,625,000.		
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-25,323,000.		
8	Describe in Part VI the extent to which any shortfall reported on line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used:				

☐ Cost accounting system ☒ Cost to charge ratio ☐ Other

Section C. Collection Practices

9a	Did the organization have a written debt collection policy during the tax year?	9a		X	
b	If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI	9b		X	

Part IV Management Companies and Joint Ventures

(owned 10% or more by officers, directors, trustees, key employees, and physicians - see instructions)

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %

Part V Facility Information

Section A. Hospital Facilities

(list in order of size, from largest to smallest - see instructions)

How many hospital facilities did the organization operate during the tax year? 1

Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility):	Licensed hospital	Gen. medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
1 REGIONS HOSPITAL 640 JACKSON STREET ST. PAUL, MN 55101 WWW.REGIONSHOSPITAL.COM 361114	X	X		X			X			

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

(complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)

Name of hospital facility or letter of facility reporting group: REGIONS HOSPITAL

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 1

		Yes	No
Community Health Needs Assessment			
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1		X
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2		X
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	3	X	
If "Yes," indicate what the CHNA report describes (check all that apply):			
a [X] A definition of the community served by the hospital facility			
b [X] Demographics of the community			
c [X] Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d [X] How data was obtained			
e [X] The significant health needs of the community			
f [X] Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g [X] The process for identifying and prioritizing community health needs and services to meet the community health needs			
h [X] The process for consulting with persons representing the community's interests			
i [X] The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j [ ] Other (describe in Section C)			
4 Indicate the tax year the hospital facility last conducted a CHNA: 20 21			
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	X	
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	X	
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b		X
7 Did the hospital facility make its CHNA report widely available to the public?	7	X	
If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a [X] Hospital facility's website (list url): WWW.HEALTHPARTNERS.COM/CARE/HOSPITALS/REGIONS/ABOUT/COMMUNITY			
b [ ] Other website (list url):			
c [X] Made a paper copy available for public inspection without charge at the hospital facility			
d [ ] Other (describe in Section C)			
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	X	
9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 22			
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	X	
a If "Yes," (list url): HTTPS://WWW.HEALTHPARTNERS.COM/CARE/HOSPITALS/REGIONS/ABOUT/COMMUNITY-BENE			
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.			
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a		X
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? **$**			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group: REGIONS HOSPITAL

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	X	
	If "Yes," indicate the eligibility criteria explained in the FAP:			
a	[X] Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 % and FPG family income limit for eligibility for discounted care of 2000 %			
b	[ ] Income level other than FPG (describe in Section C)			
c	[ ] Asset level			
d	[X] Medical indigency			
e	[X] Insurance status			
f	[X] Underinsurance status			
g	[X] Residency			
h	[ ] Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	X	
15	Explained the method for applying for financial assistance?	15	X	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
a	[X] Described the information the hospital facility may require an individual to provide as part of their application			
b	[X] Described the supporting documentation the hospital facility may require an individual to submit as part of their application			
c	[X] Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	[ ] Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	[ ] Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	X	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	[X] The FAP was widely available on a website (list url): SEE PART V, PAGE 8			
b	[X] The FAP application form was widely available on a website (list url): SEE PART V, PAGE 8			
c	[X] A plain language summary of the FAP was widely available on a website (list url): SEE PART V, PAGE 8			
d	[X] The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	[X] The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	[X] A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g	[X] Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h	[X] Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	[X] The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by Limited English Proficiency (LEP) populations			
j	[ ] Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

Name of hospital facility or letter of facility reporting group: REGIONS HOSPITAL

			Yes	No
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	17	X	
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:			
a	☐ Reporting to credit agency(ies)			
b	☐ Selling an individual's debt to another party			
c	☐ Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP			
d	☐ Actions that require a legal or judicial process			
e	☐ Other similar actions (describe in Section C)			
f	☒ None of these actions or other similar actions were permitted			
19	Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	19		X
	If "Yes," check all actions in which the hospital facility or a third party engaged:			
a	☐ Reporting to credit agency(ies)			
b	☐ Selling an individual's debt to another party			
c	☐ Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP			
d	☐ Actions that require a legal or judicial process			
e	☐ Other similar actions (describe in Section C)			

20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply):

- **a** ☒ Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs (if not, describe in Section C)
- **b** ☒ Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)
- **c** ☒ Processed incomplete and complete FAP applications (if not, describe in Section C)
- **d** ☒ Made presumptive eligibility determinations (if not, describe in Section C)
- **e** ☐ Other (describe in Section C)
- **f** ☐ None of these efforts were made

Policy Relating to Emergency Medical Care

21	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	21	X	
	If "No," indicate why:			
a	☐ The hospital facility did not provide care for any emergency medical conditions			
b	☐ The hospital facility's policy was not in writing			
c	☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)			
d	☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)

Name of hospital facility or letter of facility reporting group: REGIONS HOSPITAL

		Yes	No
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care:		
a	[X] The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period		
b	[X] The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
c	[ ] The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
d	[ ] The hospital facility used a prospective Medicare or Medicaid method		
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? **23**		X
	If "Yes," explain in Section C.		
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? **24**		X
	If "Yes," explain in Section C.		

Part V Facility Information *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

REGIONS HOSPITAL:

PART V, SECTION B, LINE 5: TO COMPREHENSIVELY UNDERSTAND AND DESCRIBE THE NEEDS OF THE COMMUNITIES HEALTHPARTNERS SERVES, WE SYSTEMATICALLY IDENTIFIED A LIST OF PUBLICLY AVAILABLE DATA SOURCES AND A LIST OF INTERNALLY AVAILABLE HEALTHPARTNERS DATA SOURCES. WITH THE CHNA WORKGROUP THAT HAD EXPERTISE FROM PUBLIC HEALTH, HEALTHCARE AND EPIDEMIOLOGY, WE CAREFULLY REVIEWED THE LIST TO IDENTIFY OPPORTUNITIES WITH A SPECIFIC LENS TOWARDS INCLUDING MEMBERS WITH UNIQUE INSIGHT INTO NEEDS OF OUR UNDERSERVED COMMUNITIES WHERE HEALTH AND OTHER DISPARITIES EXIST. TO FURTHER ROUND OUT UNDERSTANDING, WE SOUGHT ADDITIONAL DATA SOURCES TOGETHER WITH OUR COMMUNITY PARTNERS. WHERE OPPORTUNITIES STILL REMAIN FOR BETTER UNDERSTANDING DUE TO LACK OF CURRENTLY AVAILABLE DATA, WE HAVE NOTED IN THE REPORT. FOR EXAMPLE, WE IDENTIFIED SPECIFIC GAPS IN DATA AVAILABLE TO UNDERSTAND THE COVID-19 PANDEMIC CONTEXT AND THE INFLUENCE OF STRUCTURAL RACISM ON THE NEEDS AREAS. THUS, WE SPECIFICALLY DESIGNED OUR QUALITATIVE COMMUNITY CONVERSATIONS AND OUR QUANTITATIVE HEALTHPARTNERS PROVIDER SURVEYS TO FILL THESE GAPS.

HEALTHPARTNERS PROVIDER SURVEYS: SELECT HEALTHPARTNERS STAFF WHO PROVIDE DIRECT CARE FOR OUR PATIENTS WERE INVITED BY HOSPITAL LEADERS AND THE CHNA EXPERT PANEL MEMBERS TO COMPLETE A BRIEF WEB SURVEY ABOUT THE NEEDS OF THE PATIENTS THEY SERVE. THE SURVEY WAS DEVELOPED BY AN EXPERT SURVEY METHODOLOGIST WITH INPUT FROM THE CHNA WORKGROUP. OVERALL, 444 PROVIDERS INCLUDING DOCTORS, CARE COORDINATORS, PHARMACISTS, PHYSICAL OR OCCUPATIONAL THERAPISTS, DIETITIANS, NURSES, AND SOCIAL WORKERS COMPLETED SURVEYS ACROSS ALL HEALTHPARTNERS HOSPITALS. DESCRIPTIVE STATISTICS AND A

Part V Facility Information *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

THEMATIC ANALYSIS WERE COMPLETED AND INCLUDED IN THE NEEDS AREA SUMMARIES

BELOW.

COMMUNITY CONVERSATIONS: A TOTAL OF 41 COMMUNITY CONVERSATIONS WERE HELD

OR ATTENDED BY HEALTHPARTNERS WORKGROUP MEMBERS. RESULTS WERE SUMMARIZED

AND KEY THEMES AND QUOTES WERE ADDED TO THE NEEDS AREA SUMMARIES

THROUGHOUT. ADDITIONAL DETAILS ABOUT THE COMMUNITY CONVERSATIONS CAN BE

FOUND IN THE APPENDIX OF THE HOSPITAL'S 2021 CHNA AT

HTTPS://WWW.HEALTHPARTNERS.COM/CARE/HOSPITALS/REGIONS/ABOUT/COMMUNITY-BENEF

IT.

REGIONS HOSPITAL:

PART V, SECTION B, LINE 6A: OTHER HOSPITAL FACILITIES INCLUDED IN THE

2021 HEALTHPARTNERS CHNA WERE:

- HUDSON HOSPITAL, HUDSON, WI.
- WESTFIELDS HOSPITAL, NEW RICHMOND, WI.
- LAKEVIEW MEMORIAL HOSPITAL ASSOCIATION, STILLWATER, MN.
- PARK NICOLLET METHODIST HOSPITAL, ST. LOUIS PARK, MN
- AMERY REGIONAL MEDICAL CENTER, AMERY, WI.
- HUTCHINSON HEALTH, HUTCHINSON MN
- HEALTHPARTNERS RC, DBA OLIVIA HOSPITAL AND CLINIC, OLIVIA MN

REGIONS HOSPITAL:

PART V, SECTION B, LINE 11: IN 2023, SEVERAL TACTICS WERE IMPLEMENTED TO

HELP ADDRESS THE NEEDS IDENTIFIED IN OUR CHNA AND DESCRIBED IN OUR

Part V Facility Information *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

IMPLEMENTATION PLAN. HIGHLIGHTS OF THE 2023 ACTIVITIES AND RESULTS ARE

INCLUDED BELOW.

PRIORITY 1: ACCESS TO CARE

IN 2023, THE COMMUNITY PARAMEDICINE PROGRAM SERVED 444 PATIENTS, OF WHICH

174 WERE ADMITTED TO OUR HOSPITAL@HOME PROGRAM. THE TEAM COMPLETED 1196

HOME VISITS IN TOTAL. MUCH OF THE PROGRESS EXPERIENCED BY THE COMMUNITY

PARAMEDICINE PROGRAM IN 2023 RESULTED FROM THE IMPLEMENTATION OF A ROBUST

HOSPITAL@HOME PROGRAM.

PRIORITY 2: ACCESS TO HEALTH

HEALTHPARTNERS AND THE HOSPITAL SYSTEMATICALLY COLLECT DATA ON RACE,

ETHNICITY, AND LANGUAGE PREFERENCES DIRECTLY FROM PATIENTS AND MEMBERS IN

A VARIETY OF WAYS, ALL OF THEM VOLUNTARY. DATA IS USED TO CONTINUALLY

MONITOR THE QUALITY OF CARE DELIVERED AND PATIENT EXPERIENCE BY RACE AND

LANGUAGE TO ADDRESS IDENTIFIED HEALTH DISPARITIES IN TREATMENT, OUTCOMES,

AND SERVICE.

RESPONSIBILITY FOR MONITORING DISPARITY DATA LIES WITH THE

INTERDISCIPLINARY REGIONS HEALTH EQUITY COMMITTEE AS WELL AS WITH LEADERS

IN OUR QUALITY AND EXPERIENCE DEPARTMENTS. THE COMMITTEE FOCUSES ON:

1. WORKING WITH LEADERS TO INCLUDE DIVERSITY, EQUITY, AND INCLUSION GOALS

INTO THEIR ANNUAL PLANS.

2. ADDRESSING DISPARITIES BY RACE IN PATIENT EXPERIENCE.

3. ACTIVELY ADDRESSING FOOD INSECURITY IN OUR COMMUNITY AS PART OF OUR

COMMUNITY HEALTH NEEDS ASSESSMENT IMPLEMENTATION PLAN.

4. MAINTAINING REDUCTION IN AFRICAN AMERICAN DUAL ELIGIBLE READMISSIONS.

Part V Facility Information *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

5. INCREASING AWARENESS OF DIVERSITY, EQUITY, INCLUSION, AND ANTI-RACISM

THROUGH AN INTERNAL AND EXTERNAL COMMUNICATION PLAN

6. INTEGRATING MEDICAL RESIDENTS INTO THE HOSPITAL'S STRATEGY TO ELIMINATE

HEALTH CARE DISPARITIES.

PRIORITY 3: MENTAL HEALTH AND WELL-BEING

THE HOSPITAL OPERATES A 120-BED, ALL PRIVATE ROOM, ACUTE ADULT INPATIENT

PSYCHIATRIC FACILITY. THE HOSPITAL ALSO HAS A DEDICATED AREA IN OUR

EMERGENCY DEPARTMENT TO SAFELY ASSESS AND PROVIDE CARE FOR THOSE PATIENTS

WHO PRESENT WITH MENTAL HEALTH CARE NEEDS. THE HOSPITAL CARED FOR 3,699

PATIENTS IN THEIR INPATIENT PSYCHIATRIC FACILITY, WHO STAYED FOR A TOTAL

OF 41,767 DAYS.

PRIORITY 4: NUTRITION AND PHYSICAL ACTIVITY

THE HOSPITAL FOOD & NUTRITION SERVICES DEPARTMENT ALSO DONATED 9,000

POUNDS OF FOOD TO LOCAL FOOD SHELTERS IN 2023.

PRIORITY 5: SUBSTANCE ABUSE

THE HOSPITAL'S BEHAVIORAL HEALTH DEPARTMENT IS THE LEADING PROVIDER OF

COMPREHENSIVE MENTAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT SERVICES

IN THE TWIN CITIES EAST METRO AREA AND WESTERN WISCONSIN. THE HOSPITAL

PROVIDES SUPPORT FOR HOVANDER HOUSE, A SHORT-TERM CRISIS STABILIZATION

PROGRAM SERVING INDIVIDUALS WITH MENTAL ILLNESS AND/OR SUBSTANCE USE

PROBLEMS

REGIONS HOSPITAL

Part V Facility Information *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

PART V, LINE 16A, FAP WEBSITE:

HEALTHPARTNERS.COM/CARE/HOSPITALS/REGIONS/PATIENT-GUEST/PATIENT-INFORMATION

REGIONS HOSPITAL

PART V, LINE 16B, FAP APPLICATION WEBSITE:

HEALTHPARTNERS.COM/CARE/HOSPITALS/REGIONS/PATIENT-GUEST/PATIENT-INFORMATION

REGIONS HOSPITAL

PART V, LINE 16C, FAP PLAIN LANGUAGE SUMMARY WEBSITE:

HEALTHPARTNERS.COM/CARE/HOSPITALS/REGIONS/PATIENT-GUEST/PATIENT-INFORMATION

PART V, SECTION B, LINE 13

THE HOSPITAL FINANCIAL ASSISTANCE POLICY (FAP) EXPLAINS THE ELIGIBILITY CRITERIA FOR FREE AND DISCOUNTED CARE AS FOLLOWS: FEDERAL POVERTY GUIDELINES (FPG) FAMILY INCOME LIMIT FOR ELIGIBILITY FOR FREE CARE AT 200%; AND UNLIMITED FPG FAMILY INCOME FOR ELIGIBILITY FOR DISCOUNTED CARE.

PART V, SECTION B, LINE 3E

THE HOSPITAL ADDRESSES THE SIGNIFICANT HEALTH NEEDS OF THE COMMUNITY THROUGH OUR CHNA.

Part V Facility Information *(continued)*

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

(list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year? 6

Name and address	Type of facility (describe)
1 HEALTHPARTNERS SPECIALTY CENTER 435 PHALEN BOULEVARD ST. PAUL, MN 55132	REGIONS SAME DAY SURGERY, PAIN CLINIC, & DIGESTIVE CAR
2 HEALTHPARTNERS SPECIALTY CENTER 401 PHALEN BOULEVARD ST. PAUL, MN 55130	REGIONS IMAGING CTR., PULMONARY FUNCTION TESTING, HAND/PHYS./SPEECH THERAPY
3 REGIONS CARDIOPULMONARY REHABILITATION 2575 UNIVERSITY AV., SUITE 140 WESTGAT ST. PAUL, MN 55114	CARDIOPULMONARY REHABILITATION CLINIC
4 HEALTHPARTNERS SLEEP CENTER 2688 MAPLEWOOD DRIVE MAPLEWOOD, MN 55109	SLEEP HEALTH CENTER
5 REGIONS PHYSICAL THERAPY CLINIC 295 PHALEN BLVD. ST. PAUL, MN 55130	PHYSICAL THERAPY CLINIC
6 REGIONS HOSPITAL HAND & PT CLINIC 2220 RIVERSIDE AVE., 5TH FLOOR MINNEAPOLIS, MN 55454	HAND AND PHYSICAL THERAPY

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8, and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (for example, open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART I, LINE 3C:

THE HOPSITAL PARTICIPATES IN A MINNESOTA ATTORNEY GENERAL'S (MN AG) AGREEMENT THAT GIVES ALL PATIENTS AT LEAST THE SAME DISCOUNT AS OUR HIGHEST VOLUME COMMERCIAL PAYER. THE HOSPITAL APPLIES THE MN AG OR THE 501R DISCOUNT, WHICHEVER IS GREATER.

PART I, LINE 7:

THE HOSPITAL USES THE COST-TO-CHARGE RATIO METHOD WHEN CALCULATING THE AMOUNTS REPORTED ON PART I. LINE 7. THE COST-TO-CHARGE RATIO WAS DERIVED USING WORKSHEET 2, RATIO OF PATIENT CARE-COST-TO-CHARGE, FROM THE SCHEDULE H INSTRUCTIONS.

PART III, LINE 2:

THE HOSPITAL USES A HISTORIC BAD DEBT PERCENTAGE THAT IS ROUTINELY MONITORED, REVIEWED, AND UPDATED IN ORDER TO OBTAIN THE BEST ESTIMATE OF THE CURRENT YEAR'S BAD DEBT.

PART III, LINE 4:

Part VI Supplemental Information *(Continuation)*

BAD DEBT EXPENSE REPRESENTS THE UNPAID OBLIGATION FOR CARE PROVIDED TO PATIENTS WHO HAVE BEEN DETERMINED TO BE ABLE TO PAY, BUT HAVE NOT DEMONSTRATED A WILLINGNESS TO DO SO. BAD DEBT INCLUDES ANY UNPAID PATIENT RESPONSIBILITY THAT MAY INCLUDE, BUT IS NOT LIMITED TO, DEDUCTIBLES, CO-INSURANCE, CO-PAYMENTS AND NON-COVERED SERVICES.

BAD DEBT EXPENSE IS CALCULATED USING THE COST-TO-CHARGE RATIO FROM THE WORKSHEETS PROVIDED IN SCHEDULE H INSTRUCTIONS. BAD DEBT EXPENSE IS CURRENTLY EXCLUDED FROM THE COMMUNITY BENEFIT CALCULATION PER THE MINNESOTA HOSPITAL ASSOCIATION (MHA).

PART III, LINE 8:

THE HOSPITAL MEDICARE COST IS DERIVED BASED ON THE RATIO OF MEDICARE FFS CHARGES TO TOTAL CHARGES MULTIPLIED BY TOTAL EXPENSES (LESS CHARITY CARE & BAD DEBT). NONE OF THE MEDICARE FFS LOSS REPORTED ON SCHEDULE H, PART III, LINE 7 IS TREATED AS COMMUNITY BENEFIT ON SCHEDULE H, PART I, LINE 7A.

PART III, LINE 9B:

COLLECTIONS PRACTICES

THE HOSPITAL DEBT COLLECTION POLICY CONTAINS PROVISIONS ON COLLECTION PRACTICES TO BE FOLLOWED FOR PATIENTS WHO ARE KNOWN TO BE ELIGIBLE FOR CHARITY CARE OR FINANCIAL ASSISTANCE. THE HOSPITAL WILL NOT REFER ANY ACCOUNT TO A THIRD PARTY DEBT COLLECTION AGENCY UNLESS IT HAS CONFIRMED THAT:

- THERE IS REASONABLE BASIS TO BELIEVE THAT THE PATIENT OWES THE DEBT.
- ALL KNOWN THIRD-PARTY PAYERS HAVE BEEN PROPERLY BILLED, AND THE PATIENT IS RESPONSIBLE FOR THE REMAINING DEBT.
- IF THE PATIENT HAS INDICATED AN INABILITY TO PAY THE FULL AMOUNT, THE

Part VI Supplemental Information *(Continuation)*

PATIENT HAS BEEN OFFERED A REASONABLE PAYMENT PLAN. THE HOSPITAL WILL NOT REFER PATIENTS TO DEBT COLLECTION AGENCIES WHO ARE PERFORMING AS SPECIFIED IN THEIR PAYMENT PLANS.

- THE PATIENT HAS BEEN GIVEN AN OPPORTUNITY TO SUBMIT A CHARITY CARE (FINANCIAL ASSISTANCE) APPLICATION. IF THE PATIENT HAS SUBMITTED AN APPLICATION FOR CHARITY CARE, ALL COLLECTION ACTIVITY WILL BE SUSPENDED UNTIL THE APPLICATION HAS BEEN PROCESSED.

PART VI, LINE 2:

TO COMPREHENSIVELY UNDERSTAND AND DESCRIBE THE NEEDS OF THE COMMUNITIES HEALTHPARTNERS SERVES, WE SYSTEMATICALLY IDENTIFIED A LIST OF PUBLICLY AVAILABLE DATA SOURCES AND A LIST OF INTERNALLY AVAILABLE HEALTHPARTNERS DATA SOURCES. WITH THE CHNA WORKGROUP THAT HAD EXPERTISE FROM PUBLIC HEALTH, HEALTHCARE AND EPIDEMIOLOGY, WE CAREFULLY REVIEWED THE LIST TO IDENTIFY OPPORTUNITIES WITH A SPECIFIC LENS TOWARDS INCLUDING MEMBERS WITH UNIQUE INSIGHT INTO NEEDS OF OUR UNDERSERVED COMMUNITIES WHERE HEALTH AND OTHER DISPARITIES EXIST. TO FURTHER ROUND OUT UNDERSTANDING, WE SOUGHT ADDITIONAL DATA SOURCES TOGETHER WITH OUR COMMUNITY PARTNERS. WHERE OPPORTUNITIES STILL REMAIN FOR BETTER UNDERSTANDING DUE TO LACK OF CURRENTLY AVAILABLE DATA, WE HAVE NOTED IN THE REPORT. FOR EXAMPLE, WE IDENTIFIED SPECIFIC GAPS IN DATA AVAILABLE TO UNDERSTAND THE COVID-19 PANDEMIC CONTEXT AND THE INFLUENCE OF STRUCTURAL RACISM ON THE NEEDS AREAS. THUS, WE SPECIFICALLY DESIGNED OUR QUALITATIVE COMMUNITY CONVERSATIONS AND OUR QUANTITATIVE HEALTHPARTNERS PROVIDER SURVEYS TO FILL THESE GAPS.

HEALTHPARTNERS PROVIDER SURVEYS: SELECT HEALTHPARTNERS STAFF WHO PROVIDE DIRECT CARE FOR OUR PATIENTS WERE INVITED BY HOSPITAL LEADERS AND THE CHNA

Part VI Supplemental Information *(Continuation)*

EXPERT PANEL MEMBERS TO COMPLETE A BRIEF WEB SURVEY ABOUT THE NEEDS OF THE PATIENTS THEY SERVE. THE SURVEY WAS DEVELOPED BY AN EXPERT SURVEY METHODOLOGIST WITH INPUT FROM THE CHNA WORKGROUP. OVERALL, 444 PROVIDERS INCLUDING DOCTORS, CARE COORDINATORS, PHARMACISTS, PHYSICAL OR OCCUPATIONAL THERAPISTS, DIETITIANS, NURSES, AND SOCIAL WORKERS COMPLETED SURVEYS ACROSS ALL HEALTHPARTNERS HOSPITALS. DESCRIPTIVE STATISTICS AND A THEMATIC ANALYSIS WERE COMPLETED AND INCLUDED IN THE NEEDS AREA SUMMARIES BELOW.

COMMUNITY CONVERSATIONS: A TOTAL OF 41 COMMUNITY CONVERSATIONS WERE HELD OR ATTENDED BY HEALTHPARTNERS WORKGROUP MEMBERS. RESULTS WERE SUMMARIZED AND KEY THEMES AND QUOTES WERE ADDED TO THE NEEDS AREA SUMMARIES THROUGHOUT. ADDITIONAL DETAILS ABOUT THE COMMUNITY CONVERSATIONS CAN BE FOUND IN THE APPENDIX OF THE HOSPITAL'S 2021 CHNA.

PART VI, LINE 3:

THE HOSPITAL IS THE PRIMARY "SAFETY NET" HOSPITAL FOR LOW-INCOME UNINSURED AND UNDERINSURED PEOPLE IN THE EAST METRO. IN 2023 ALONE, THE HOSPITAL PROVIDED $50.2 MILLION IN CHARITY CARE CHARGES ($20.9 MILLION IN CHARITY CARE COSTS) TO CARE FOR 31,942 PATIENTS WHO DID NOT HAVE INSURANCE OR COULD NOT AFFORD CARE. CHARITY CARE REPRESENTED 2.0 PERCENT OF THE HOSPITAL'S TOTAL OPERATING EXPENSES. OF THE 57,222 TOTAL PATIENT ACCOUNTS WRITTEN OFF IN 2023, 17,674 WERE PURE SELF-PAY PATIENTS WITH NO COVERAGE AND NO ABILITY TO PAY. APPROXIMATELY 14 PERCENT OF THESE SELF-PAY PATIENTS WERE BETWEEN THE AGES OF 18 AND 24. THE REMAINING 39,548 PATIENTS HAD SOME COVERAGE BUT WERE UNABLE TO PAY THE "PATIENT RESPONSIBILITY" PORTION OF THEIR BILL.

Part VI Supplemental Information *(Continuation)*

TO INFORM AND EDUCATE PATIENTS ON ITS CHARITY CARE PROGRAM AND GOVERNMENT PROGRAMS, THE HOSPITAL HAS DEVELOPED AN EXTENSIVE FINANCIAL COUNSELING PROGRAM. THE PROGRAM WAS STARTED IN THE EMERGENCY DEPARTMENT IN 1995 BUT HAS SINCE THEN, THE PROGRAM HAS BEEN IMPLEMENTED THROUGHOUT THE HOSPITAL. INFORMATION IS AVAILABLE IN PATIENT WELCOME MATERIALS, AT ALL CHECK- IN AREAS, ON THE WEBSITE AND THROUGH THE FINANCIAL COUNSELING STAFF.

PART VI, LINE 4:

THE HOSPITAL IS LOCATED IN RAMSEY COUNTY IN DOWNTOWN ST. PAUL. REGIONS HOSPITAL IS IN CLOSE PROXIMITY TO THE STATE CAPITOL, POPULAR ENTERTAINMENT ATTRACTIONS AND NUMEROUS LARGE CORPORATE HEADQUARTERS AND IS VISIBLE FROM INTERSTATE 94. THE HOSPITAL IS THE LARGEST PROVIDER OF CHARITY CARE IN THE EAST METRO AND IS ONE OF ONLY FOUR CERTIFIED LEVEL 1 ADULT AND PEDIATRIC TRAUMA CENTERS IN THE STATE OF MINNESOTA. THIS CERTIFICATION REQUIRES REGIONS HOSPITAL TO HAVE SELECT MEDICAL AND SURGICAL SPECIALISTS AVAILABLE TWENTY-FOUR HOURS A DAY.

ACCORDING TO THE U.S. CENSUS BUREAU, RAMSEY COUNTY HAD A POPULATION OF 552,352 IN 2020. APPROXIMATELY 33.9% WERE NON-WHITE, 12.6% OF INDIVIDUALS IN RAMSEY COUNTY ARE LIVING IN POVERTY, AND 6.9% ARE WITHOUT INSURANCE. IN 2022, REGIONS HOSPITAL PROVIDED ACUTE INPATIENT CARE TO PATIENTS FROM 78 OF THE 87 COUNTIES IN THE STATE OF MINNESOTA . AS THE STATE'S SECOND-LARGEST SAFETY-NET HOSPITAL, REGIONS PROVIDES CARE TO EVERYONE, REGARDLESS OF THEIR ABILITY TO PAY.

THE HOSPITAL SERVES A DIVERSE PATIENT POPULATION. THE HOSPITAL AND HEALTHPARTNERS ARE ONE OF THE FIRST IN THE NATION TO GATHER SELF-REPORTED DATA FROM PATIENTS ON RACE, COUNTRY OF ORIGIN AND LANGUAGE PREFERENCE.

Part VI Supplemental Information *(Continuation)*

OF THE HOSPITALS 29,683 2023 INPATIENT CASES, 35.7% WERE PATIENTS OF COLOR. FOR THESE SAME ADMISSIONS, 2,802 PATIENTS (9.4%) REPORTED A LANGUAGE OTHER THAN ENGLISH AS THEIR PRIMARY PREFERENCE.

PART VI, LINE 5:

THE HOSPITAL CONTINUALLY INVESTS - THROUGH EXPENDITURES AND IN-KIND CONTRIBUTIONS OR OTHER SUPPORT - IN ACTIVITIES THAT IMPROVE THE HEALTH OF THE COMMUNITY AND THE REGION. THE HOSPITAL IS GOVERNED BY A COMMUNITY-BASED BOARD OF DIRECTORS AND THE MEDICAL STAFF IS ORGANIZED IN THE PUBLIC'S INTEREST. SUPPORT MAY INCLUDE DIRECT EXPENDITURES, RAISING FUNDS THROUGH EMPLOYEE OR COMMUNITY INITIATIVES, DONATING STAFF TIME, PARTICIPATING IN COMMUNITY PARTNERSHIPS AND INITIATIVES AND /OR PROVIDING FREE SERVICES OR EQUIPMENT. MORE INFORMATION ABOUT REGIONS COMMUNITY BENEFIT AND COMMUNITY HEALTH EFFORTS IS DETAILED IN SCHEDULE O.

PART VI, LINE 6:

AFFILIATED HEALTH CARE SYSTEM

PLEASE SEE SCHEDULE O: DISCUSSION OF EXEMPT PURPOSE AND ACHIEVEMENTS "I. CORPORATE STRUCTURE, PURPOSE, GOVERNANCE."

PART VI, LINE 7, LIST OF STATES RECEIVING COMMUNITY BENEFIT REPORT:

MN,WI

SCHEDULE I
(Form 990)

Department of the Treasury
Internal Revenue Service

Grants and Other Assistance to Organizations, Governments, and Individuals in the United States

Complete if the organization answered "Yes" on Form 990, Part IV, line 21 or 22.

Attach to Form 990.

Go to www.irs.gov/Form990 for the latest information.

OMB No. 1545-0047

2023

Open to Public Inspection

Name of the organization
REGIONS HOSPITAL

Employer identification number
41-0956618

Part I General Information on Grants and Assistance

1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? ☐ Yes ☒ No

2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States.

Part II Grants and Other Assistance to Domestic Organizations and Domestic Governments. Complete if the organization answered "Yes" on Form 990, Part IV, line 21, for any recipient that received more than $5,000. Part II can be duplicated if additional space is needed.

1 (a) Name and address of organization or government	(b) EIN	(c) IRC section (if applicable)	(d) Amount of cash grant	(e) Amount of noncash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of noncash assistance	(h) Purpose of grant or assistance
CATHOLIC CHARITIES 215 OLD 6TH ST ST. PAUL, MN 55102	41-1302487	501(C)(3)	378,718.	0.			PROGRAM SUPPORT
COMMONBOND COMMUNITIES 1080 MONTREAL AVE ST. PAUL, MN 55116	41-1260469	501(C)(3)	10,000.	0.			PROGRAM SUPPORT

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table ..... 2.

3 Enter total number of other organizations listed in the line 1 table .....

Part III **Grants and Other Assistance to Domestic Individuals.** Complete if the organization answered "Yes" on Form 990, Part IV, line 22. Part III can be duplicated if additional space is needed.

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of noncash assistance

Part IV **Supplemental Information.** Provide the information required in Part I, line 2; Part III, column (b); and any other additional information.

PART I, LINE 2:

THE HOSPITAL MANAGEMENT STAFF REVIEW THE MISSION AND PURPOSE OF POTENTIAL GRANTEE ORGANIZATIONS TO ASSURE CONSISTENCY WITH REGIONS' MISSION AND PURPOSE. AMOUNTS SUBSEQUENTLY GRANTED ARE SUBJECT TO THE HOSPITAL'S FORMAL SPENDING APPROVAL AND DOCUMENTATION PROCESS BASED ON AMOUNT OF THE EXPENDITURE.

SCHEDULE J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees
Complete if the organization answered "Yes" on Form 990, Part IV, line 23.
Attach to Form 990.
Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2023

Open to Public Inspection

Name of the organization

REGIONS HOSPITAL

Employer identification number

41-0956618

Part I Questions Regarding Compensation

			Yes	No
1a	Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.			
	☐ First-class or charter travel	☐ Housing allowance or residence for personal use		
	☐ Travel for companions	☐ Payments for business use of personal residence		
	☐ Tax indemnification and gross-up payments	☐ Health or social club dues or initiation fees		
	☐ Discretionary spending account	☐ Personal services (such as maid, chauffeur, chef)		
b	If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	**1b**		
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked on line 1a?	**2**		
3	Indicate which, if any, of the following the organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.			
	☒ Compensation committee	☒ Written employment contract		
	☒ Independent compensation consultant	☒ Compensation survey or study		
	☐ Form 990 of other organizations	☒ Approval by the board or compensation committee		
4	During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:			
a	Receive a severance payment or change-of-control payment?	**4a**	X	
b	Participate in or receive payment from a supplemental nonqualified retirement plan?	**4b**	X	
c	Participate in or receive payment from an equity-based compensation arrangement?	**4c**		X
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.			
	Only section 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.			
5	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:			
a	The organization?	**5a**		X
b	Any related organization?	**5b**		X
	If "Yes" on line 5a or 5b, describe in Part III.			
6	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:			
a	The organization?	**6a**	X	
b	Any related organization?	**6b**	X	
	If "Yes" on line 6a or 6b, describe in Part III.			
7	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described on lines 5 and 6? If "Yes," describe in Part III	**7**		X
8	Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III	**8**		X
9	If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	**9**		

Part II **Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees.** Use duplicate copies if additional space is needed.

For each individual whose compensation must be reported on Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that aren't listed on Form 990, Part VII.

Note: The sum of columns (B)(i)-(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual.

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC and/or 1099-NEC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1) ANDREA M. WALSH	(i)	0.	0.	0.	0.	0.	0.	0.
DIRECTOR	(ii)	1,479,700.	1,099,313.	159,007.	816,281.	76,016.	3,630,317.	117,009.
(2) PENNY D. CERMAK	(i)	0.	0.	0.	0.	0.	0.	0.
DIRECTOR	(ii)	837,843.	528,150.	17,273.	229,689.	55,299.	1,668,254.	0.
(3) MEGAN M. REMARK	(i)	0.	0.	0.	0.	0.	0.	0.
DIRECTOR & PRESIDENT	(ii)	616,122.	306,751.	42,336.	264,033.	50,255.	1,279,497.	27,048.
(4) MARK R. SANNES, MD	(i)	0.	0.	0.	0.	0.	0.	0.
DIRECTOR	(ii)	635,566.	305,625.	58,696.	108,508.	61,039.	1,169,434.	41,983.
(5) NANCY L. EVERT	(i)	0.	0.	0.	0.	0.	0.	0.
SECRETARY & HPI GENERAL COUNSEL	(ii)	503,395.	251,362.	56,515.	206,367.	32,307.	1,049,946.	36,575.
(6) SUNNY KAUL, MD	(i)	0.	0.	0.	0.	0.	0.	0.
DIRECTOR	(ii)	703,527.	19,000.	174,482.	24,750.	33,906.	955,665.	0.
(7) BRET C. HAAKE, MD	(i)	0.	0.	0.	0.	0.	0.	0.
VPMA & CHIEF MEDICAL OFFICER	(ii)	541,746.	164,908.	23,914.	66,326.	46,728.	843,622.	0.
(8) ALITA RISINGER	(i)	0.	0.	0.	0.	0.	0.	0.
CFO	(ii)	452,971.	40,000.	81,263.	72,026.	40,026.	686,286.	0.
(9) JEROME C. SIY, MD	(i)	0.	0.	0.	0.	0.	0.	0.
DIRECTOR	(ii)	489,168.	25,000.	21,122.	72,528.	28,335.	636,153.	0.
(10) TYLER R. SCHMIDTZ	(i)	318,217.	94,742.	10,627.	26,592.	37,437.	487,615.	0.
VP EAST METRO SURGERY	(ii)	0.	0.	0.	0.	0.	0.	0.
(11) CHRISTINE M BOESE	(i)	6,351.	99,072.	352,860.	8,045.	16,578.	482,906.	0.
FORMER VP PATIENT CARE	(ii)	0.	0.	0.	0.	0.	0.	0.
(12) KIMBERLY T. EGAN	(i)	0.	0.	0.	0.	0.	0.	0.
VP HUMAN RESOURCES	(ii)	288,845.	113,537.	9,350.	24,750.	42,106.	478,588.	0.
(13) DEBRA A. RUDQUIST	(i)	307,131.	91,223.	11,580.	26,592.	38,219.	474,745.	0.
VP REGIONS & AMERY PRESIDENT	(ii)	0.	0.	0.	0.	0.	0.	0.
(14) STEVEN M. MASSEY	(i)	308,224.	91,092.	9,800.	26,592.	38,207.	473,915.	0.
VP REGIONS & WESTFIELD PRESIDENT	(ii)	0.	0.	0.	0.	0.	0.	0.
(15) THOMAS J. BOROWSKI	(i)	306,830.	88,583.	11,250.	26,592.	38,168.	471,423.	0.
VP REGIONS & HUDSON PRESIDENT	(ii)	0.	0.	0.	0.	0.	0.	0.
(16) ANTHONY C. GRUNDHAUSER	(i)	263,012.	79,204.	11,142.	26,592.	36,370.	416,320.	0.
VP REGIONS HOSP FOUNDATION	(ii)	0.	0.	0.	0.	0.	0.	0.

Part II **Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees.** Use duplicate copies if additional space is needed.

For each individual whose compensation must be reported on Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that aren't listed on Form 990, Part VII.

Note: The sum of columns (B)(i)-(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual.

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC and/or 1099-NEC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(17) BRADLEY L. PLOWMAN	(i)	227,412.	45,772.	46,623.	26,257.	35,849.	381,913.	0.
FINANCE DIRECTOR	(ii)	0.	0.	0.	0.	0.	0.	0.
(18) JENNIFER G. HINES, MD	(i)	0.	0.	0.	0.	0.	0.	0.
DIRECTOR	(ii)	136,161.	11,760.	142,611.	65,585.	24,084.	380,201.	0.
(19) DERRICK M. BERNDT	(i)	236,877.	0.	80,367.	25,398.	23,947.	366,589.	0.
NURSE ANESTHETIST	(ii)	0.	0.	0.	0.	0.	0.	0.
(20) GEORGEANN J. MARK	(i)	115,516.	7,138.	190,728.	25,275.	24,089.	362,746.	0.
REGISTERED NURSE	(ii)	0.	0.	0.	0.	0.	0.	0.
(21) JOHN M. CLARK	(i)	239,813.	70,175.	7,557.	25,638.	14,763.	357,946.	0.
VP FINANCE	(ii)	0.	0.	0.	0.	0.	0.	0.
(22) NALY T. YANG	(i)	142,422.	10,000.	136,061.	18,066.	36,372.	342,921.	0.
NURSE ANESTHETIST	(ii)	0.	0.	0.	0.	0.	0.	0.
(23) DANIAL N. LEVIE	(i)	187,457.	10,000.	79,362.	21,771.	33,429.	332,019.	0.
NURSE ANESTHETIST	(ii)	0.	0.	0.	0.	0.	0.	0.
(24) MARY JO MORRISON	(i)	139,661.	92,645.	49,959.	21,990.	25,198.	329,453.	0.
VP QUALITY	(ii)	0.	0.	0.	0.	0.	0.	0.
(25) DEBRA R. KELLY	(i)	221,774.	53,513.	7,600.	21,847.	14,242.	318,976.	0.
SYSTEM EXECUTIVE DIRECTOR	(ii)	0.	0.	0.	0.	0.	0.	0.
(26) ROCHELLE JOHNSON	(i)	223,078.	25,000.	7,435.	18,688.	28,764.	302,965.	0.
VP PCS & CNO (MAR-DEC)	(ii)	0.	0.	0.	0.	0.	0.	0.
(27) HEIDI G. CONRAD	(i)	0.	0.	0.	0.	0.	0.	0.
FORMER CFO	(ii)	0.	179,908.	0.	33,699.	12,541.	226,148.	0.
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							

Part III Supplemental Information

Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

PART I, LINES 4A-B:

SCHEDULE J, PART II COLUMN B III, INCLUDES SEVERANCE FOR THE FOLLOWING OFFICER

CHRISTINE BOESE $311,189

DEFERRED COMPENSATION IN COLUMN C OF SCHEDULE J, PART II INCLUDES AMOUNTS FROM A NONQUALIFIED 457(F) PLAN FOR THE FOLLOWING DIRECTORS AND OFFICERS:

ANDREA M. WALSH $ 314,063

PENNY D. CERMAK $ 125,285

MEGAN M. REMARK $ 66,213

NANCY L. EVERT $ 54,148

MARK R. SANNES $ 78,228

ALITA R. RISINGER $34,771

PART I, LINE 6:

THE HOSPITAL OFFICERS, DIRECTORS AND KEY EMPLOYEES ARE EMPLOYED BY REGIONS HOSPITAL OR BY GROUP HEALTH PLAN, INC. (GHI) OR PARK NICOLLET HEALTH

Part III Supplemental Information

Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

SERVICES (PNHS), RELATED ORGANIZATIONS. COMPENSATION REPORTED IN FORM 990, PART VII INCLUDES ANY COMPENSATION DERIVED FROM EITHER THE HOSPITAL'S, PNHS' OR GHI'S LEADERSHIP INCENTIVE PROGRAM, WHICH INCENT AND REWARD BUSINESS LEADERS WHO HELP THE ORGANIZATION ACHIEVE STATED BUSINESS AND/OR HEALTH IMPROVEMENT GOALS FOR A SPECIFIC FISCAL YEAR. THE PROGRAMS ARE A KEY ELEMENT OF THE PARTICIPANT'S TOTAL COMPENSATION PACKAGE.

THE LEADERSHIP INCENTIVE PROGRAMS' REWARDS ARE BASED ON POSITION IN THE ORGANIZATION (E.G., SENIOR VICE PRESIDENT, VICE PRESIDENT, DIRECTOR, MANAGER, OTHER SPECIFICALLY IDENTIFIED LEADERS) AND THE ACHIEVEMENT OF BUSINESS AND HEALTH IMPROVEMENT GOALS ESTABLISHED IN A VARIETY OF AREAS. GOALS WILL BE RELATED TO THE ORGANIZATION'S STRATEGIC PLAN AND WILL BE BALANCED. THESE AREAS MAY INCLUDE, BUT ARE NOT LIMITED TO, PATIENT SATISFACTION, EMPLOYEE SATISFACTION, WORK ENVIRONMENT, HEALTH EQUITY, HEALTHCARE AFFORDABILITY MEASURES, HEALTH CARE AND CARE DELIVERY MARKET SHARE, STRATEGIC CAPABILITIES, HOSPITAL AND CLINIC QUALITY MEASURES, FINANCIAL PERFORMANCE (OPERATING INCOME), ETC., AND WILL BE DEFINED ANNUALLY FOR EACH YEAR'S PROGRAM.

Part III Supplemental Information

Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

AN OPERATING INCOME THRESHOLD MUST BE MET FOR ANY PAYMENT TO BE MADE FROM THE PROGRAM AND THERE IS A CAP ON THE MAXIMUM INCENTIVE POTENTIALLY AVAILABLE TO EACH PARTICIPANT.

FORM 990, SCHEDULE J, PART II - PRIOR REPORTED COMPENSATION

COLUMN (F) INCLUDES AMOUNTS PAID TO PARTICIPANTS IN THE CURRENT YEAR, WHICH WERE PREVIOUSLY REPORTED IN COLUMN (C) OF PRIOR YEARS' 990'S, AS RETIREMENT AND DEFERRED COMPENSATION, FOR THE FOLLOWING DIRECTORS, OFFICERS AND FORMER OFFICER:

ANDREA M. WALSH	$ 117,009
MEGAN M. REMARK	$ 27,048
NANCY L. EVERT	$ 36,575
MARK R SANNES	$ 41,983

ANY ANALYSIS OF EARNINGS FOR THE CURRENT YEAR, FOR THESE PARTICIPANTS OF THE PLAN, SHOULD EXCLUDE THE AMOUNT IN COLUMN F AS PART OF THE ANALYSIS SINCE THOSE EARNINGS WERE ALREADY REPORTED IN COLUMN (C) OF PREVIOUS YEARS' 990'S.

SCHEDULE K (Form 990)
Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

Complete if the organization answered "Yes" on Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
Attach to Form 990. Go to www.irs.gov/Form990 for instructions and the latest information.

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Part I Bond Issues

SEE PART VI FOR COLUMNS (A) AND (F) CONTINUATIONS

	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled financing	
							Yes	No	Yes	No	Yes	No
A	HRA OF THE CITY OF ST. PAUL, MN HEALTH CARE REVENUE BONDS-SERIES 201	52-1440935	NONE99999	03/18/14	30,860,000.	REFUND SERIES 1998 BONDS & EXPANSION OF REGIONS HO		X		X		X
B	HRA OF THE CITY OF ST. PAUL, MN HEALTH CARE REVENUE BONDS-SERIES 201	52-1440935	NONE99999	09/26/18	25,000,000.	SERIES 2018A		X		X		X
C	HRA OF THE CITY OF ST. PAUL, MN HEALTH CARE REVENUE BONDS-SERIES 201	52-1440935	NONE99999	09/26/18	25,000,000.	SERIES 2018B		X		X		X
D	HRA OF THE CITY OF ST. PAUL, MN HEALTH CARE REVENUE BONDS	52-1440935	792905DJ7	06/11/15	331,886,593.	REFUNDING SERIES 2006, 2008C, 2009		X		X		X

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired	18,405,000.	6,485,000.	6,485,000.	19,430,000.
2	Amount of bonds legally defeased				
3	Total proceeds of issue	30,860,000.	25,000,000.	25,000,000.	331,886,593.
4	Gross proceeds in reserve funds				
5	Capitalized interest from proceeds				
6	Proceeds in refunding escrows				
7	Issuance costs from proceeds	257,873.	252,918.	252,918.	2,528,203.
8	Credit enhancement from proceeds				
9	Working capital expenditures from proceeds				
10	Capital expenditures from proceeds		24,747,883.	24,747,883.	
11	Other spent proceeds	30,602,127.			329,358,390.
12	Other unspent proceeds				
13	Year of substantial completion	2001	2020	2020	2009
		Yes / No	Yes / No	Yes / No	Yes / No
14	Were the bonds issued as part of a refunding issue of tax-exempt bonds (or, if issued prior to 2018, a current refunding issue)?	X /	/ X	/ X	X /
15	Were the bonds issued as part of a refunding issue of taxable bonds (or, if issued prior to 2018, an advance refunding issue)?	/ X	/ X	/ X	X /
16	Has the final allocation of proceeds been made?	X /	X /	X /	X /
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X /	X /	X /	X /

Part III Private Business Use

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?		X		X		X		X
2	Are there any lease arrangements that may result in private business use of bond-financed property?		X		X		X	X	
3a	Are there any management or service contracts that may result in private business use of bond-financed property?	X			X		X	X	
b	If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?		X						X
c	Are there any research agreements that may result in private business use of bond-financed property?		X		X		X		X
d	If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
4	Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government	%		%		%		%	
5	Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government	%		%		%		%	
6	Total of lines 4 and 5	%		%		%		%	
7	Does the bond issue meet the private security or payment test?		X		X		X		X
8a	Has there been a sale or disposition of any of the bond-financed property to a non-governmental person other than a 501(c)(3) organization since the bonds were issued?		X		X		X		X
b	If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of	%		%		%		%	
c	If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?								
9	Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?	X		X		X			X

Part IV Arbitrage

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate?		X		X		X		X
2	If "No" to line 1, did the following apply?								
a	Rebate not due yet?	X		X		X			X
b	Exception to rebate?		X		X		X		X
c	No rebate due?		X		X		X	X	
	If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed								
3	Is the bond issue a variable rate issue?		X		X		X		X

Part IV Arbitrage *(continued)*

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
4a Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X		X		X		X
b Name of provider								
c Term of hedge								
d Was the hedge superintegrated?								
e Was the hedge terminated?								
5a Were gross proceeds invested in a guaranteed investment contract (GIC)?		X		X		X		X
b Name of provider								
c Term of GIC								
d Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
6 Were any gross proceeds invested beyond an available temporary period?		X		X		X		X
7 Has the organization established written procedures to monitor the requirements of section 148?	X		X		X		X	

Part V Procedures To Undertake Corrective Action

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
Has the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation isn't available under applicable regulations?	X		X		X		X	

Part VI Supplemental Information. Provide additional information for responses to questions on Schedule K. See instructions.

SCHEDULE K, PART I, BOND ISSUES:

(A) ISSUER NAME:

HRA OF THE CITY OF ST. PAUL, MN HEALTH CARE REVENUE BONDS-SERIES 2014AA

(F) DESCRIPTION OF PURPOSE:

REFUND SERIES 1998 BONDS & EXPANSION OF REGIONS HOSPITAL FACILITY

(A) ISSUER NAME:

HRA OF THE CITY OF ST. PAUL, MN HEALTH CARE REVENUE BONDS-SERIES 2018A

(A) ISSUER NAME:

HRA OF THE CITY OF ST. PAUL, MN HEALTH CARE REVENUE BONDS-SERIES 2018B

PART I, AND PART II, LINE 3 - DIFFERENCES IN AMOUNTS

DIFFERENCES BETWEEN THE ISSUE PRICE (PART I) AND TOTAL PROCEEDS (PART II, LINE 3) ARE DUE TO INVESTMENT EARNINGS.

PART I, COLUMN (F) - DESCRIPTION OF PURPOSE

A. REFUND BONDS ISSUED 10/30/2003. FUND VARIOUS PROJECTS & EQUIPMENT.

B. REFUND REGIONS HOSPITAL 2006 BONDS ISSUED 11/30/2006. REFUND PARK NICOLLET HEALTH SERVICES 2008C AND 2009 BONDS ISSUED 08/14/2008 AND

SEE PART VI SUPPLEMENTAL INFORMATION SHEET

Part VI **Supplemental Information.** Provide additional information for responses to questions on Schedule K. See instructions. *(continued)*

12/31/2009, RESPECTIVELY. THE NEW OBLIGATED GROUP FOR THE 2015A SERIES
INCLUDES GROUP HEALTH PLAN, INC., HEALTHPARTNERS, INC., HEALTHPARTNERS
ADMINISTRATORS, INC., REGIONS HOSPITAL, HEALTHPARTNERS INSURANCE
COMPANY, PARK NICOLLET HEALTH SERVICES, PARK NICOLLET METHODIST
HOSPITAL, PARK NICOLLET CLINIC, PARK NICOLLET HEALTH CARE PRODUCTS AND
PNMC HOLDINGS.

PART III, LINE 3B - REVIEW OF MANAGEMENT OR SERVICE CONTRACTS
THE HOSPITAL USES INTERNAL LEGAL COUNSEL TO REVIEW ANY MANAGEMENT OR
SERVICE CONTRACTS RELATING TO THE FINANCED PROPERTY. IF IT ENCOUNTERS
UNUSUAL OR COMPLEX CONTRACTS IT WILL ENGAGE BOND COUNSEL OR OTHER
OUTSIDE COUNSEL.
SCHEDULE K, PART V - PROCEDURES TO UNDERTAKE CORRECTIVE ACTION
WRITTEN PROCEDURES HAVE BEEN IN PLACE SINCE 2011.
PART IV, ARBITRAGE, LINE 2C
D. THE ARBITRAGE REBATE WAS CALCULATED 7/28/2015

SCHEDULE O
(Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information.
Attach to Form 990 or Form 990-EZ.
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FORM 990, PART III, LINE 4A, DESCRIPTION OF PROGRAM SERVICE:

FORM 990, PART III, LINE 4A - EXEMPT PURPOSE AND ACHIEVEMENTS

CORPORATE STRUCTURE, PURPOSE, GOVERNANCE

REGIONS HOSPITAL (THE HOSPITAL) IS A MINNESOTA NONPROFIT CORPORATION RECOGNIZED AS EXEMPT FROM FEDERAL INCOME TAX UNDER INTERNAL REVENUE CODE ("IRC") SECTION 501(C)(3) AND IS PART OF THE FAMILY OF HEALTHPARTNERS ORGANIZATIONS ("HEALTHPARTNERS"). HEALTHPARTNERS IS A NONPROFIT ORGANIZATION WITH A MISSION OF IMPROVING HEALTH AND WELL-BEING IN PARTNERSHIP WITH ITS PATIENTS, MEMBERS AND COMMUNITY. AN INTEGRATED SYSTEM OF CARE AND COVERAGE, FOUNDED IN 1957, HEALTHPARTNERS IS AN INTEGRATED HEALTH CARE ORGANIZATION, PROVIDING HEALTH CARE SERVICES AND HEALTH PLAN FINANCING AND ADMINISTRATION.

HEALTHPARTNERS' MISSION IS TO IMPROVE HEALTH AND WELL-BEING IN PARTNERSHIP WITH OUR MEMBERS, PATIENTS, AND COMMUNITY. HEALTHPARTNERS SEEKS TO TRANSFORM HEALTH CARE THROUGH A RELENTLESS FOCUS ON THE TRIPLE AIM - PROVIDING EXCEPTIONAL EXPERIENCE FOR THE INDIVIDUAL, IMPROVING THE HEALTH OF THE POPULATION, AND MAINTAINING AFFORDABILITY.

HEALTHPARTNERS, INC. (HPI) IS A MINNESOTA NONPROFIT CORPORATION AND LICENSED HEALTH MAINTENANCE ORGANIZATION (HMO) RECOGNIZED AS EXEMPT FROM FEDERAL INCOME TAX UNDER INTERNAL REVENUE CODE (IRC) SECTION 501(C)(4) AND IS THE PARENT ENTITY OF HEALTHPARTNERS ORGANIZATIONS REFERRED TO COLLECTIVELY AS "HEALTHPARTNERS". HEALTHPARTNERS INCLUDES

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AN ARRAY OF TAX-EXEMPT AND TAXABLE ORGANIZATIONS.

HEALTHPARTNERS PROVIDES A FULL RANGE OF HEALTH CARE DELIVERY AND HEALTH PLAN SERVICES INCLUDING INSURANCE, PATIENT CARE, ADMINISTRATION AND HEALTH AND WELL-BEING PROGRAMS. HEALTHPARTNERS HEALTH PLANS SERVE MORE THAN 1.8 MILLION MEDICAL AND DENTAL MEMBERS NATIONWIDE. HEALTHPARTNERS MEDICAL CARE SYSTEM INCLUDES MORE THAN 2,000 EMPLOYED PHYSICIANS AND DENTISTS, EIGHT OWNED HOSPITALS WITH OVER 1,000 ACUTE CARE BEDS, OVER 100 PRIMARY AND SPECIALTY CARE MEDICAL FACILITIES AND DENTAL FACILITIES WITH PRACTICES IN MINNESOTA AND WESTERN WISCONSIN SERVING MORE THAN 1.34 MILLION PATIENTS. HEALTHPARTNERS HEALTH PLANS CONTRACT WITH OTHER PRIMARY AND SPECIALTY MEDICAL FACILITIES AND DENTAL FACILITIES, PHYSICIAN GROUPS, HOSPITALS, AND RELATED HEALTHCARE PROVIDERS TO SERVE PLAN MEMBERS. HEALTHPARTNERS ALSO PROVIDES MEDICAL EDUCATION AND TRAINING TO MEDICAL PROFESSIONALS AND CONDUCTS RESEARCH AND FUNDRAISING ACTIVITIES THAT SUPPORT THE HEALTH CARE DELIVERY SYSTEM.

HEALTHPARTNERS COLLABORATES WITH OTHER PLANS, CARE PROVIDERS AND OTHER COMMUNITY AND BUSINESS ORGANIZATIONS IN THE REGION AND THROUGHOUT THE NATION TO INCREASE ACCESS, CREATE AND SHARE QUALITY MEASURES AND INITIATIVES, PARTICIPATE IN DEVELOPMENT OF PUBLIC POLICY, AND COLLABORATE IN IMPROVEMENTS THAT SUPPORT THE TRIPLE AIM. AMONG HEALTHPARTNERS' SIGNATURE INITIATIVES ARE TOTAL COST OF CARE MEASUREMENTS (A NATIONALLY RECOGNIZED METRIC, ENABLING MEASUREMENT AND INCENTIVES BASED ON COORDINATION AND EVIDENCE-BASED PRACTICES), MENTAL HEALTH (REDUCING STIGMA, AND ASSURING ACCESS TO HIGH QUALITY CARE IN THE MOST APPROPRIATE SETTINGS), CHILDREN'S HEALTH (IMPROVING CHILD HEALTH BY PROMOTING EARLY BRAIN DEVELOPMENT, PROVIDING FAMILY CENTERED

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CARE, AND STRENGTHENING COMMUNITIES), EQUITY, INCLUSION, AND ANTI-RACISM (ADDRESSING HEALTH EQUITY, ELIMINATING HEALTH CARE DISPARITIES, INCREASING DIVERSITY AND INCLUSION IN OUR WORKPLACES, BUILDING AN ANTI-RACIST CULTURE, AND DEEPENING OUR COLLECTIVE UNDERSTANDING OF CULTURAL HUMILITY) AND SUSTAINABILITY (ENERGY EFFICIENCY, WASTE REDUCTION, AND RESOURCE MANAGEMENT).

A COMPLETE LISTING OF ALL ORGANIZATIONS WITHIN HEALTHPARTNERS, AND THE RELATIONSHIP BETWEEN THEM, CAN BE FOUND ON SCHEDULE R WITHIN THIS 990 RETURN. DETAILED INFORMATION ABOUT THE COMMUNITY BENEFIT ACTIVITIES AND ACCOMPLISHMENTS OF EACH TAX-EXEMPT ORGANIZATION CAN BE FOUND IN THE INDIVIDUAL FORM 990 RETURN FOR THAT ORGANIZATION.

HEALTHPARTNERS, INC. (HPI) IS THE PARENT ENTITY OF HEALTHPARTNERS AND IS THE SOLE CORPORATE MEMBER OF HPI-RAMSEY. HPI IS A MINNESOTA NON-PROFIT CORPORATION AND LICENSED HEALTH MAINTENANCE ORGANIZATION (HMO) RECOGNIZED AS EXEMPT FROM FEDERAL INCOME TAX UNDER INTERNAL REVENUE CODE (IRC) SECTION 501(C)(4).

HPI-RAMSEY IS THE SOLE CORPORATE MEMBER OF THE FOLLOWING NON-PROFIT CORPORATIONS ALL OF WHICH ARE EXEMPT UNDER IRC SECTION 501(C)(3): THE HOSPITAL (A FULL SERVICE HOSPITAL AND LEVEL 1 TRAUMA CENTER), REGIONS HOSPITAL FOUNDATION, CAPITOL VIEW TRANSITIONAL CARE CENTER, LAKEVIEW HEALTH (WHICH IS THE PARENT ENTITY OF LAKEVIEW MEMORIAL HOSPITAL ASSOCIATION, INC. AND STILLWATER MEDICAL GROUP), AND, RH-WISCONSIN, INC., A WISCONSIN NON-STOCK CORPORATION. RH-WISCONSIN, TOGETHER WITH GROUP HEALTH PLAN, INC. (A STAFF MODEL HMO), ARE THE SOLE CORPORATE MEMBERS OF THREE TAX-EXEMPT WISCONSIN HOSPITALS - HUDSON HOSPITAL,

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INC., WESTFIELDS HOSPITAL, INC., AND AMERY REGIONAL MEDICAL CENTER, INC.

THE HOSPITAL, A LEADING FULL-SERVICE HOSPITAL PROVIDING OUTSTANDING MEDICAL AND SURGICAL CARE, HAS SERVED THE TWIN CITIES AND SURROUNDING REGION FOR OVER 140 YEARS. THE MISSION OF THE HOSPITAL IS TO IMPROVE THE HEALTH OF ITS PATIENTS AND THE COMMUNITY BY PROVIDING HIGH QUALITY HEALTH CARE, WHICH MEETS THE NEEDS OF ALL PEOPLE. THE HOSPITAL IS THE SECOND LARGEST PROVIDER OF CHARITY CARE IN MINNESOTA AND IS ONE OF ONLY FOUR CERTIFIED LEVEL 1 ADULT AND PEDIATRIC TRAUMA CENTERS IN THE STATE OF MINNESOTA.

BENEFITS TO PATIENTS AND THE COMMUNITY IN 2023

FINANCIAL ASSISTANCE:

THE HOSPITAL IS THE PRIMARY "SAFETY NET" HOSPITAL FOR LOW-INCOME UNINSURED AND UNDERINSURED PEOPLE IN THE EAST METRO. IN 2023 ALONE, THE HOSPITAL PROVIDED $50.2 MILLION IN CHARITY CARE CHARGES ($20.9 MILLION IN CHARITY CARE COSTS) TO CARE FOR 31,942 PATIENTS WHO DID NOT HAVE INSURANCE OR COULD NOT AFFORD CARE. CHARITY CARE REPRESENTED 2 PERCENT OF THE HOSPITAL'S TOTAL OPERATING EXPENSES. OF THE 57,222 TOTAL PATIENT ACCOUNTS WRITTEN OFF IN 2023, 17,674 WERE PURE SELF-PAY PATIENTS WITH NO COVERAGE AND NO ABILITY TO PAY. APPROXIMATELY 14 PERCENT OF THESE SELF-PAY PATIENTS WERE BETWEEN THE AGES OF 18 AND 24. THE REMAINING 39,548 PATIENTS HAD SOME COVERAGE BUT WERE UNABLE TO PAY THE "PATIENT RESPONSIBILITY" PORTION OF THEIR BILL.

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THE HOSPITAL DEFINES CHARITY CARE AS THE COST OF CARE DELIVERED TO PATIENTS WHO ARE WILLING, BUT UNABLE, TO PAY FOR THE SERVICES THEY RECEIVE. THIS INCLUDES PATIENTS WHOSE CHARGES ARE FORGIVEN OR REDUCED BECAUSE OF INABILITY TO PAY, PATIENTS WHO ARE UNABLE TO PAY THE BALANCE LEFT BY A THIRD-PARTY PAYER, AND PATIENTS FOR WHOM UNUSUAL CIRCUMSTANCES OR SPECIAL FINANCIAL HARDSHIP WARRANT SPECIAL CONSIDERATION.

THE HOSPITAL IS COMMITTED TO PROVIDING NEEDED SERVICES EVEN AT A FINANCIAL LOSS. FOR EXAMPLE, IN 2023, THE HOSPITAL PROVIDED INPATIENT AND OUTPATIENT EMERGENCY SERVICES TO SELF-PAY PATIENTS TOTALING $40.4 MILLION IN CHARGES. APPROXIMATELY $12.7 MILLION OF THESE CHARGES WERE WRITTEN OFF BY THE HOSPITAL AT A NET LOSS.

REGIONS PAID $16.1 MILLION IN 2023 IN MINNESOTA HEALTH CARE TAXES, EQUAL TO 1.7 PERCENT OF ITS NET REVENUE FROM PATIENT CARE SERVICES. THE FUNDS RAISED BY THIS TAX ARE EARMARKED BY THE STATE OF MINNESOTA TO INCREASE HEALTH CARE ACCESS FOR MINNESOTANS WHO ARE OTHERWISE UNABLE TO FULLY PAY FOR HEALTH CARE SERVICES.

GOVERNMENT SPONSORED MEANS TESTED HEALTH CARE:

THE HOSPITAL PROVIDES INPATIENT AND OUTPATIENT CARE, INCLUDING EMERGENCY DEPARTMENT SERVICES, TO MANY MEDICARE, MEDICAID, SEXUAL ASSAULT NURSE EXAMINER (SANE), AND OTHER GOVERNMENT PROGRAM PATIENTS. IN 2023, PATIENTS FROM GOVERNMENT PROGRAMS FOR SENIORS CONSTITUTED 45.1 PERCENT OF REGIONS' CHARGES, PATIENTS FROM GOVERNMENT PROGRAMS FOR THE POOR CONSTITUTED 21.7 PERCENT OF THE HOSPITAL'S CHARGES, AND CHARITY

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CASES WERE 2.4 PERCENT OF CHARGES. ONLY 30.8 PERCENT OF CHARGES WERE FOR COMMERCIAL PATIENTS. ALTHOUGH MOST OF THE HOSPITAL'S REIMBURSEMENT COMES FROM GOVERNMENT PROGRAMS, THESE PROGRAMS OFTEN DO NOT COMPENSATE HOSPITALS FOR THE FULL COST OF PROVIDING CARE.

FORM 990, PART III, LINE 4A - EXEMPT PURPOSE AND ACHIEVEMENTS

COMMUNITY BENEFIT SERVICES

EQUITABLE CARE:

HEALTHPARTNERS AND THE HOSPITAL SYSTEMATICALLY COLLECT DATA ON RACE, ETHNICITY, AND LANGUAGE PREFERENCES DIRECTLY FROM PATIENTS AND MEMBERS IN A VARIETY OF WAYS, ALL OF THEM VOLUNTARY. DATA IS USED TO CONTINUALLY MONITOR THE QUALITY OF CARE DELIVERED AND PATIENT EXPERIENCE BY RACE AND LANGUAGE TO ADDRESS IDENTIFIED HEALTH DISPARITIES IN TREATMENT, OUTCOMES, AND SERVICE.

RESPONSIBILITY FOR MONITORING DISPARITY DATA LIES WITH THE INTERDISCIPLINARY REGIONS HEALTH EQUITY COMMITTEE AS WELL AS WITH LEADERS IN OUR QUALITY AND EXPERIENCE DEPARTMENTS. THE COMMITTEE FOCUSES ON:

1. WORKING WITH LEADERS TO INCLUDE DIVERSITY, EQUITY, AND INCLUSION GOALS INTO THEIR ANNUAL PLANS.

2. ADDRESSING DISPARITIES BY RACE IN PATIENT EXPERIENCE.

3. ACTIVELY ADDRESSING FOOD INSECURITY IN OUR COMMUNITY AS PART OF OUR COMMUNITY HEALTH NEEDS ASSESSMENT IMPLEMENTATION PLAN.

4. MAINTAINING REDUCTION IN AFRICAN AMERICAN DUAL ELIGIBLE

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READMISSIONS.

5. INCREASING AWARENESS OF DIVERSITY, EQUITY, INCLUSION, AND

ANTI-RACISM THROUGH AN INTERNAL AND EXTERNAL COMMUNICATION PLAN

6. INTEGRATING MEDICAL RESIDENTS INTO REGIONS' STRATEGY TO ELIMINATE

HEALTH CARE DISPARITIES.

FINANCIAL COUNSELING:

TO SECURE ACCESS TO ONGOING MEDICAL CARE, AND TO MITIGATE CHARITY CARE

WRITE-OFFS, THE HOSPITAL ESTABLISHED A FINANCIAL COUNSELING PROGRAM IN

1995. SINCE THEN, THE PROGRAM HAS BEEN IMPLEMENTED THROUGHOUT THE

HOSPITAL TO INCLUDE THE EMERGENCY DEPARTMENT AND REGIONS-BASED

OUTPATIENT CLINICS.

IN 2023, THE HOSPITAL EMPLOYED, 15 PATIENT FINANCIAL COUNSELORS (PFC),

19 REGISTRATION FINANCIAL SPECIALISTS (RFS), TWO FINANCIAL COUNSELING

TEAM LEADS AND A RAMSEY COUNTY WORKER DEDICATED TO HELP PATIENTS ENROLL

IN GOVERNMENT PROGRAMS OR FIND OTHER SOURCES OF COVERAGE.

SPECIFICALLY, THE PFCS AND RFSS CAN SCREEN PATIENTS FOR ELIGIBILITY FOR

AVAILABLE PROGRAMS AND OFFER ASSISTANCE COMPLETING APPLICATIONS WITH

MINNESOTA HEALTH CARE PROGRAMS, THE HOSPITAL MEDICAL ASSISTANCE/CHARITY

CARE APPLICATIONS, AND SETTING UP PAYMENT PLANS. THE HOSPITAL

EMERGENCY DEPARTMENT PROVIDES FINANCIAL COUNSELING 24 HOURS A DAY,

SEVEN DAYS A WEEK, WHILE THE INPATIENT UNITS DEPARTMENTS PROVIDE

COUNSELING SEVEN DAYS A WEEK DURING NORMAL BUSINESS HOURS.

CLINIC-BASED FINANCIAL COUNSELING IS ALSO AVAILABLE DURING NORMAL

BUSINESS HOURS. IN 2014, PFSS AND RFSS WERE ALSO ENROLLED AS CERTIFIED

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APPLICATION COUNSELORS WITH THE MNSURE INSURANCE EXCHANGE, ALLOWING THEM THE ABILITY TO FURTHER ASSIST IN ENROLLING IN MINNESOTA MA, MINNESOTACARE AND QUALIFIED HEALTH PLANS VIA THE STATE INSURANCE EXCHANGE. IN 2023 WE HAVE MAINTAINED THE CERTIFIED APPLICATION COUNSELORS STATUS WITH ALL STAFF AND CONTINUE TO ONBOARD NEW PFC'S AND RFS'S WITH THIS CERTIFICATION. IN LATE 2016 THE HOSPITAL ALSO STARTED PARTICIPATING AS A MEDICAID PRESUMPTIVE ELIGIBILITY PROVIDER. THIS MEANT THE REGISTRATION AND FINANCIAL COUNSELING STAFF COMPLETED ADDITIONAL TRAINING ON SCREENING INDIVIDUALS FOR PRESUMPTIVE ELIGIBILITY, WHICH PROVIDES PATIENTS WITH A TEMPORARY FORM OF MEDICAID ON DATE OF SERVICE. IN 2023 THE HOSPITAL COMPLETED 272 PRESUMPTIVE ELIGIBILITY APPLICATIONS FOR PATIENTS WITH NO HEALTH INSURANCE COVERAGE.

DESPITE PPE CHALLENGES AND NAVIGATING VARIOUS CHANGES IN OPERATIONAL WORKFLOWS DUE TO THE COVID PANDEMIC, IN 2023 PFCS AND RFSS COMPLETED 2,273 APPLICATIONS, SUCCESSFULLY ENROLLING 1,695 INDIVIDUALS IN GOVERNMENT HEALTH CARE PROGRAMS. THIS PROVIDED APPROXIMATELY $3.2 MILLION TO THE HOSPITAL FOR CARE THAT OTHERWISE WOULD HAVE BEEN CONSIDERED CHARITY CARE. FOR 2023, THE MINNESOTA HEALTH CARE PROGRAMS APPLICATION BREAKDOWN WAS AS FOLLOWS: IN THE EMERGENCY DEPARTMENT AND OUTPATIENT CLINICS, 347 APPLICATIONS WERE SUCCESSFULLY OPENED; FOR INPATIENT UNITS, 1,348 APPLICATIONS WERE SUCCESSFULLY OPENED. WE ANTICIPATE HIGHER VOLUMES IN 2024 NOW THAT THE PHE (PUBLIC HEALTH EMERGENCY) HAS ENDED AND PATIENTS WILL HAVE TO RENEW COVERAGES -- WHICH MEANS AN INCREASE IN APPLICATIONS BEING COMPLETED.

EMERGENCY PREPAREDNESS:

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THE HOSPITAL IS A LEADER IN EMERGENCY MANAGEMENT FOR THE EAST METRO. WORKING AT THE ONLY LEVEL 1 ADULT AND PEDIATRIC TRAUMA CENTER IN THE EAST METRO, THE HOSPITAL STAFF ARE PREPARED FOR ANY SITUATION THAT MAY ARISE AND COLLABORATE WITH OTHER HOSPITALS AND PUBLIC SAFETY OFFICIALS TO ENSURE THAT PLANNING AND RESPONSE PLANS ARE INTEGRATED. PHYSICIANS FROM THE HOSPITAL EMS PROVIDE MEDICAL DIRECTION TO MANY FIRST RESPONSE AGENCIES IN THE EAST METRO FROM THE LARGE, URBAN ST. PAUL FIRE DEPARTMENT TO THE MORE RURAL, VOLUNTEER ST. CROIX VALLEY FIRE DEPARTMENT IN AFTON, MN. THE HOSPITAL'S PARTICIPATION IN AN INSPECTION CONDUCTED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES RECEIVED HIGH MARKS FOR EMERGENCY MANAGEMENT AND OVERALL PLAN OF SUSTAINABILITY.

THE HOSPITAL EMERGENCY MEDICINE PHYSICIANS PROVIDE CONSULTATION TO EMS SERVICES THROUGHOUT MINNESOTA VIA THE EAST METRO MEDICAL RESOURCE CONTROL CENTER (EMRCC). THIS PUBLIC-PRIVATE PARTNERSHIP WITH THE MN DEPT. OF PUBLIC SAFETY SERVES AS THE FLIGHT CONTROL CENTER FOR AMBULANCES INBOUND TO EDS THROUGHOUT THE METRO REGION OF MINNESOTA. IN ADDITION TO ASSISTING EMS CREWS WITH PHYSICIAN CONSULTATION, EMRCC IS TASKED WITH DEPLOYING FEDERAL CHEMPACK ASSETS IN THE EVENT OF A NERVE AGENT RELEASE, DISTRIBUTING AMBULANCES IN THE EVENT OF A MASS CASUALTY INCIDENT AND PROVIDING REAL TIME SITUATIONAL AWARENESS OF EVOLVING CLINICAL TRENDS. THE LATTER FUNCTION HAS LED TO THE RAPID IDENTIFICATION OF CLUSTERS OF DRUG OVERDOSES LATER LINKED TO SYNTHETIC OPIOIDS. IN THESE CASES, OUR PARTNERSHIP WITH LOCAL LAW ENFORCEMENT AND PUBLIC HEALTH LED TO NEWS RELEASES TO NOTIFY THE PUBLIC OF THE ACUTE RISK TO MITIGATE FURTHER CITIZEN HARM.

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THE HOSPITAL HAS A DECONTAMINATION SITE READY TO HANDLE ANY MAJOR EVENT. THE HOSPITAL CAN DECONTAMINATE UP TO 10 AMBULATORY AND FIVE NON-AMBULATORY PATIENTS IN THE EVENT OF BIOLOGICAL, CHEMICAL, OR NUCLEAR INCIDENTS AND IS COMPLETELY COMPLIANT WITH THE OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION. OUR CHEMICAL DECONTAMINATION CAPABILITIES ARE TESTED ANNUALLY IN CONJUNCTION WITH A MASS CASUALTY DRILL THAT INVOLVES OUR COMMUNITY PARTNERS AND PUBLIC SAFETY AGENCIES. WE ARE ALSO THE DESIGNATED TRAUMA CENTER FOR RADIOLOGICAL EMERGENCIES ARISING FROM XCEL'S PRAIRIE ISLAND NUCLEAR POWER PLANT AND OUR ABILITY TO TREAT THIS UNIQUE POPULATION IS VERIFIED IN PERSON EVERY TWO YEARS BY MINNESOTA HOMELAND SECURITY AND EMERGENCY MANAGEMENT.

THE HOSPITAL IS A MEMBER OF THE METROPOLITAN HOSPITAL COMPACT, ALONG WITH 31 OTHER TWIN CITIES HOSPITALS. THE HOSPITAL HAS PLAYED A VITAL ROLE IN THE DEVELOPMENT OF COMMUNITY WIDE PLANNING TO IMPROVE EMERGENCY MANAGEMENT THROUGHOUT HEALTH CARE AND ESTABLISH INTERFACING WITH PUBLIC SAFETY, INCLUDING CITY AND COUNTY EMERGENCY MANAGERS. A SPECIFIC RECENT EXAMPLE OF OUR LEADERSHIP IN THIS REALM WAS THE HOSPITAL'S ABILITY TO COORDINATE A METRO WIDE ELIMINATION OF AMBULANCE DIVERT AT THE HEIGHT OF THE COVID PANDEMIC. ADDITIONALLY, THE HOSPITAL COLLABORATES WITH CITY, COUNTY, AND STATE PUBLIC HEALTH OFFICIALS TO PLAN APPROPRIATELY FOR PANDEMIC EVENTS. THE HOSPITAL IS A DESIGNATED CLOSED POD DISPENSING (CPD) SITE. A CPD IS AN ANTIBIOTIC DISPENSING SITE FOR ANTHRAX PROPHYLAXIS WHEN THERE IS AN IMMEDIATE THREAT OR KNOWN EXPOSURE TO THE PUBLIC.

THE HOSPITAL SET UP ITS INCIDENT COMMAND STRUCTURE IN MARCH OF 2020 IN RESPONSE TO COVID-19 TO HELP NAVIGATE THE COORDINATION OF LOCAL,

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REGIONAL, AND STATE RESPONSE PLANS. THE PANDEMIC CAUSED SEVERE SUPPLY CHAIN DISRUPTIONS, STAFFING AND SPACE CHALLENGES, AND HIGH BED CAPACITY AT ALL HOSPITALS WITHIN THE STATE. THE INCIDENT COMMAND TEAM WAS COMMITTED TO ALL FOUR PHASES OF EMERGENCY MANAGEMENT (PLANNING, RESPONSE, RECOVERY, AND MITIGATION) AND PROVIDING CONTINUITY OF EXCEPTIONAL CARE TO OUR PATIENTS.

MULTILINGUAL HEALTH RESOURCES EXCHANGE:

THE MULTILINGUAL HEALTH RESOURCES EXCHANGE (EXCHANGE) IS A COLLABORATION AMONG MANY MINNESOTA ORGANIZATIONS (INCLUDING HOSPITALS, CLINIC SYSTEMS, HEALTH PLANS, PUBLIC HEALTH AGENCIES AND COMMUNITY GROUPS) TO SHARE TRANSLATED HEALTH MATERIALS AND INFORMATION TO MEET THE HEALTH EDUCATION AND INFORMATION NEEDS OF PEOPLE WITH LIMITED ENGLISH PROFICIENCY. THE HOSPITAL WAS INSTRUMENTAL IN STARTING THE EXCHANGE IN 2001. MEMBERS OF THE EXCHANGE CONTRIBUTE MATERIALS TRANSLATED BY THEIR ORGANIZATION TO THE EXCHANGE WEBSITE (WWW.HEALTH-EXCHANGE.NET), WHERE ALL PARTNER ORGANIZATIONS CAN DOWNLOAD THEM FOR USE WITH THEIR CLIENTS AND PATIENTS. THIS GREATLY INCREASES THE AMOUNT OF HEALTH EDUCATION AVAILABLE IN LANGUAGES OTHER THAN ENGLISH FOR ALL PARTICIPATING ORGANIZATIONS.

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HEALTH PROFESSION EDUCATION:

THE HOSPITAL IS A MAJOR TEACHING HOSPITAL IN MINNESOTA, TRAINING FELLOW AND RESIDENT PHYSICIANS AND ADVANCED PRACTICE CLINICIANS, AS WELL AS MEDICAL AND ADVANCED PRACTICE STUDENTS FROM ACROSS THE STATE. IN

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PARTNERSHIP WITH THE HEALTHPARTNERS INSTITUTE, THE UNIVERSITY OF MINNESOTA MEDICAL SCHOOL AND HENNEPIN HEALTHCARE, THE HOSPITAL TRAINS MORE THAN 600 RESIDENT PHYSICIANS (160 FTES) FROM 30 DIFFERENT TRAINING PROGRAMS ANNUALLY.

AREAS OF RESIDENCY AND FELLOWSHIP TRAINING INCLUDED:

ANESTHESIA, EMERGENCY MEDICAL SERVICES, EMERGENCY MEDICINE, FAMILY MEDICINE, FOOT & ANKLE SURGERY, HAND SURGERY, INTERNAL MEDICINE, AND MEDICAL SUBSPECIALTIES (SUCH AS GASTROENTEROLOGY, CARDIOLOGY, ETC.), NEUROLOGY, OBSTETRICS & GYNECOLOGY, OCCUPATIONAL MEDICINE, ORTHOPEDICS, OTOLARYNGOLOGY, PEDIATRIC EMERGENCY MEDICINE, PLASTIC SURGERY, SURGERY AND UROLOGY.

IN ADDITION, THE FACULTY FROM THE HOSPITAL AND HEALTHPARTNERS CLINICS TEACH AND SUPPORT 300+ MEDICAL STUDENT CLINICAL ROTATIONS AND 200+ NURSE PRACTITIONER AND PHYSICIAN ASSISTANT STUDENT CLINICAL ROTATIONS. RESIDENT PHYSICIANS AND STUDENTS PROVIDED CARE IN MANY HIGH-INTENSITY AREAS OF THE HOSPITAL, INCLUDING THE EMERGENCY DEPARTMENT, INTENSIVE CARE, SURGICAL SUITES AND MEDICAL PATIENT UNITS. THEY PROVIDE CARE FOR PATIENTS FROM UNDERSERVED AND DISADVANTAGED COMMUNITIES.

RESIDENTS AND STUDENTS CONTRIBUTED TO MEDICAL RESEARCH, QUALITY AND PATIENT SAFETY INITIATIVES, AND THE ACADEMIC ENVIRONMENT THAT SUSTAINS THE HOSPITAL'S AND HEALTHPARTNERS' CUTTING-EDGE APPROACH TO CARE.

THE OFFICE OF HEALTH PROFESSIONAL EDUCATION (OHPE) AT THE HOSPITAL, A BRANCH OF THE HEALTHPARTNERS INSTITUTE, MANAGES ALL MEDICAL AND

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ADVANCED PRACTICE STUDENT AND GRADUATE MEDICAL EDUCATIONAL ACTIVITIES ACROSS THE HEALTHPARTNERS SYSTEM, INCLUDING MANAGING TRAINING CONTRACTS AND INSTITUTIONAL AFFILIATION AGREEMENTS, AND FACILITATING CLINICAL ROTATIONS AND OBSERVATIONS FOR MANY PROSPECTIVE AND CURRENT STUDENTS IN MEDICAL EDUCATION PROGRAMS.

OHPE ALSO OVERSEES AND ENSURES COMPLIANCE WITH INSTITUTIONAL AND PROGRAM REQUIREMENTS OF THE ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION (ACGME) AND COUNCIL OF PODIATRIC MEDICAL EDUCATION (CPME). OHPE FURTHER ENSURES COMPLIANCE WITH POLICIES AND PROCEDURES AND MANAGES ALL OPERATIONAL ASPECTS OF THE UNDERGRADUATE AND GME TRAINING ACTIVITIES AT THE VARIOUS CLINICS AND HOSPITALS IN THE HEALTHPARTNERS SYSTEM.

EMERGENCY MEDICAL SERVICES (EMS):

THE HOSPITAL EMS DELIVERS 24-HOUR MEDICAL DIRECTION AND CONSULTATION TO A DIVERSE GROUP OF PRE-HOSPITAL PROVIDERS IN MINNESOTA AND WESTERN WISCONSIN. ONE UNIQUE WAY IS BY PROVIDING A CUSTOMIZED RESOURCE DIRECTORY. THIS DIRECTORY INCLUDES BEST PRACTICE GUIDELINES AND STATE REGULATIONS, ALONG WITH A CUSTOMIZED MEDICAL DIRECTION PLAN FOR EACH ORGANIZATION BASED ON ITS LOCAL RESOURCES AND ENVIRONMENT. THE DEPARTMENT CURRENTLY REPRESENTS 18 SERVICES WITH 1,500 PROVIDERS, INCLUDING RURAL VOLUNTEER FIREFIGHTERS AND EMERGENCY MEDICAL TECHNICIANS, URBAN PARAMEDICS, AND SUBURBAN PUBLIC SAFETY PERSONNEL.

COMMUNITY PARAMEDIC AND HOSPITAL@HOME:

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THE HOSPITAL HAS A COMMUNITY PARAMEDICINE PROGRAM TO SUPPORT PATIENTS IN THEIR HOME AFTER A VISIT TO THE HOSPITAL, AND TO SERVE OUR GROWING HOSPITAL@HOME PROGRAM. THE COMMUNITY PARAMEDIC, UNDER THE ORDERS OF A PHYSICIAN, WILL MAKE ONE OR MORE HOME VISITS TO PROVIDE ACUTE MEDICAL CARE, MEDICATION ADMINISTRATION, LAB SAMPLE COLLECTION, PATIENT EDUCATION, AND PREVENT UNNECESSARY HOSPITAL READMISSIONS AND EMERGENCY DEPARTMENT RETURN VISITS. THESE HOME VISITS ALSO INCLUDE PHYSICAL ASSESSMENTS, MEDICATION RECONCILIATION, EDUCATION, HOME SAFETY ASSESSMENT AND CONNECTIONS TO COMMUNITY AND HEALTH CARE RESOURCES. IN 2023, THE COMMUNITY PARAMEDICINE PROGRAM SERVED 444 PATIENTS, OF WHICH 174 WERE ADMITTED TO OUR HOSPITAL@HOME PROGRAM. THE TEAM COMPLETED 1,196 HOME VISITS IN TOTAL. MUCH OF THE PROGRESS EXPERIENCED BY THE COMMUNITY PARAMEDICINE PROGRAM IN 2023 RESULTED FROM THE IMPLEMENTATION OF A ROBUST HOSPITAL@HOME PROGRAM.

LIFE LINK III:

THE HOSPITAL IS A CORPORATE MEMBER (ALONG WITH NINE OTHER LOCAL AND/OR REGIONAL HEALTH SYSTEMS) OF LIFE LINK III, A CRITICAL CARE TRANSPORT SERVICE THAT PROVIDES HELICOPTER AND AIRPLANE OPTIONS TO THE MOST SEVERELY ILL AND INJURED TRAUMA PATIENTS. BY COLLABORATING ACROSS THE COMMUNITY AND GREATER REGION, THESE AREA HEALTH CARE SYSTEMS AVOID DUPLICATION OF EXPENSIVE AIR TRANSPORT SERVICES, THEREBY REDUCING THE COST OF HEALTH CARE.

EAST MEDICAL RESOURCE CONTROL CENTER (EMRCC):

EMRCC SERVES AS THE ONLINE TRIAGE LIAISON BETWEEN EMERGENCY MEDICAL

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SERVICES (EMS) AMBULANCE CREWS AND DESTINATION HOSPITALS. EMRCC PROVIDES MEDICAL CONTROL COMMUNICATIONS TO AMBULANCE SERVICES AND PRE-HOSPITAL EMERGENCY CARE PROVIDERS IN THE EAST METRO COUNTIES OF DAKOTA, RAMSEY AND WASHINGTON IN MINNESOTA AND AREAS OF WESTERN WISCONSIN. EMRCC IS IN CONTACT WITH METRO AREA EMERGENCY DEPARTMENTS. THE COMMUNICATIONS CENTER ITSELF IS IN THE HOSPITAL EMERGENCY CENTER. EMRCC STAFF PROVIDES AMBULANCE PERSONNEL WITH A SINGLE CONTACT POINT FOR RELAYING PATIENT INFORMATION, AN EMS GUIDELINE RESOURCE, SYSTEM HOSPITAL DIVERSION INFORMATION AND MEDICAL RESOURCE ACCESS, COORDINATION OF MASS CASUALTIES, CONTINUOUS QUALITY IMPROVEMENT (CQI) AND EMS CALL DATA COLLECTION. GIVEN ITS CRISIS PLANNING AND ITS RELATIONSHIPS WITH SIMILAR AGENCIES AND THE STATE OF MINNESOTA, THE EMRCC WAS ABLE TO REACT WELL TO BOTH THE PANDEMIC AND CIVIL UNREST. AS A RECOGNIZED VITAL COMMUNITY RESOURCE, THE HOSPITAL MAINTAINED SUPPORT FOR THE EMRCC AFTER STATE FUNDING WAS DISCONTINUED. IN 2023, THE EMRCC RESPONDED TO 93,329 TELEPHONE AND RADIO CALLS.

BURN AND TRAUMA SERVICES:

THE HOSPITAL IS THE ONLY EAST METRO LEVEL I ADULT AND LEVEL I PEDIATRIC TRAUMA CENTER, AND ONE OF TWO VERIFIED ADULT AND PEDIATRIC BURN CENTERS IN THE STATE. THE TRAUMA PROGRAM TRACKS BURN AND TRAUMA-RELATED INJURIES FOR EACH SPECIFIC REGISTRY USED FOR PERFORMANCE IMPROVEMENT, QUALITY ASSURANCE AND PUBLIC HEALTH REPORTING. THE BURN CENTER AND THE TRAUMA CENTER ARE EACH VERIFIED BY THE AMERICAN COLLEGE OF SURGEONS, AS A LEVEL I ADULT TRAUMA CENTER AND A LEVEL I PEDIATRIC TRAUMA CENTER AND THE AMERICAN BURN ASSOCIATION AS A VERIFIED ADULT AND PEDIATRIC BURN CENTER. THE HOSPITAL BURN CENTER PROVIDES REGIONAL BURN CARE IN THE

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UPPER MIDWEST. IT HAS PROVEN SUCCESS WITH ITS TELEMEDICINE PROGRAM AVAILABLE FOR INITIAL AND ON-GOING CARE. THIS SERVICE IMMEDIATELY ASSISTS RURAL PHYSICIANS MANAGING AN UNCOMMON EMERGENCY - THE CRITICALLY INJURED BURN PATIENT PRIOR TO TRANSFERRING THE PATIENT TO THE BURN CENTER. WHEN THE PATIENT RETURNS TO THEIR COMMUNITY, SOMETIMES FOLLOW-UP CARE CAN BE MANAGED VIA TELEMEDICINE IN COLLABORATION WITH THE PATIENT'S PRIMARY CARE PROVIDER. THIS LEADS TO A REDUCTION IN TIME, EXPENSE AND ANXIETY FOR THE PATIENT AND THEIR FAMILY.

MINNESOTA STATE TRAUMA SYSTEM:

THE HOSPITAL IS REPRESENTED ON THE MINNESOTA STATE TRAUMA ADVISORY COUNCIL (STAC). DR. MICHAEL MCGONIGAL, FORMER DIRECTOR OF TRAUMA SERVICES, SERVES AS THE CHAIR OF STAC. THE HOSPITAL STAFF PARTICIPATED IN SUBCOMMITTEES ASSOCIATED WITH STAC, INCLUDING THE LEVEL I AND II TRAUMA PROGRAM MANAGER GROUP (TRACY LARSEN AND HEIDI ALTAMIRANO, CHAIR). TRAUMA LEADERSHIP PROVIDES A CONSULTATIVE ROLE TO HOSPITALS IN MINNESOTA BY HELPING THEM PREPARE FOR THEIR STATE TRAUMA SYSTEM HOSPITAL VERIFICATION SITE REVIEWS. THIS IS A SERVICE PROVIDED TO THE FACILITIES AT NO COST. IN ADDITION, THE DIRECTOR OF TRAUMA AND BURN PROGRAMS, AND PEDIATRIC TRAUMA PROGRAM MANAGER CONDUCT STATE TRAUMA SYSTEM HOSPITAL SITE VISITS FOR TRAUMA DESIGNATION. ADDITIONALLY, THE HOSPITAL PROVIDES REPRESENTATION ON THE MINNESOTA - METRO REGION TRAUMA ADVISORY COMMITTEE THAT REPORTS TO STAC.

MINNESOTA METRO REGIONAL TRAUMA ADVISORY COMMITTEE (RTAC):

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THE MN-METRO RTAC SYSTEM COORDINATES WITH THE METRO AREAS' ADULT AND PEDIATRIC TRAUMA CENTERS TO TREAT SEVERE TRAUMA PATIENTS FROM RAMSEY, WASHINGTON, SCOTT, DAKOTA, HENNEPIN, WRIGHT, CARVER, AND ANOKA COUNTIES IN MINNESOTA. DR. PATEI IYEGHA, DIRECTOR OF TRAUMA SERVICES, THE HOSPITAL, IS A MEMBER OF THE RTAC AS IS BRIAN MYER, MD. THE DIRECTOR OF BURN AND TRAUMA (HEIDI ALTAMIRANO) ALSO PARTICIPATES ON THE RTAC GERIATRIC SUBCOMMITTEE.

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.WISCONSIN REGIONAL TRAUMA ADVISORY COMMITTEE REGION 1 SUBCOMMITTEE:

THE HOSPITAL IS AN ACTIVE MEMBER OF THE WISCONSIN REGIONAL TRAUMA ADVISORY COMMITTEE (RTAC), WHICH WAS CREATED TO SERVE AS THE REGIONAL TRAUMA SYSTEM FOR A PORTION OF THE WESTERN WISCONSIN REGION. THE SYSTEM COORDINATES WITH THE HOSPITAL AS THE AREA'S ONLY LEVEL I ADULT AND LEVEL I PEDIATRIC TRAUMA CENTERS TO TREAT SEVERE TRAUMA PATIENTS FROM PIERCE, POLK, AND ST. CROIX COUNTIES IN WISCONSIN. TRAUMA MEDICAL LEADERSHIP PROVIDES A CONSULTATIVE ROLE TO HOSPITALS IN WISCONSIN BY HELPING THEM PREPARE FOR THEIR STATE TRAUMA SYSTEM HOSPITAL VERIFICATION SITE REVIEWS. THIS IS A SERVICE PROVIDED TO THE FACILITIES AT NO COST. ADDITIONALLY, THE HOSPITAL STAFF PARTICIPATED IN TRAUMA AND EMERGENCY CONFERENCES SUCH AS LOCAL AND REGIONAL EMERGENCY NURSING ASSOCIATION CONFERENCES, EMS, AND TRAUMA EDUCATION. SEVERAL COMMUNITY GRAND ROUND EDUCATIONAL EVENTS ARE PROVIDED BY PROFESSIONAL STAFF.

REGIONS SANE PROGRAM 2023 UPDATE ON COMMUNITY BENEFITS

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THE HOSPITAL SEXUAL ASSAULT NURSE EXAMINER (SANE) PROGRAM IS A TEAM OF NURSES WHO ARE SPECIALLY TRAINED TO PROVIDE COMPREHENSIVE, COMPASSIONATE CARE TO VICTIMS OF SEXUAL ASSAULT, AGES 13 AND OLDER. THE PROGRAM WAS FOUNDED IN 2002 BY DR. MARY CARR AND EXPANDED UNDER THE LEADERSHIP OF ELLEN JOHNSON TO INCLUDE LAKEVIEW HOSPITAL (2011) AND THREE M HEALTH FAIRVIEW LOCATIONS; WOODWINDS, ST. JOSEPH'S, AND ST. JOHN'S (2013). RESPONSE TO ST. JOSEPH'S ENDED IN 2022 WHEN THE FACILITY CLOSED.

OUR TEAM IS CURRENTLY COMPRISED OF 22 PER DIEM SANES, INCLUDING THE SUPERVISOR AND EDUCATOR, THAT PROVIDE 24/7 RESPONSE TO HOSPITALS. THE LEADERSHIP TEAM INCLUDES OUR MEDICAL DIRECTOR, SUPERVISOR, AND A SANE EDUCATOR.

IN 2023 WE HAD 416 EXAM RESPONSES AMONG ALL LOCATIONS. THIS WAS AN INCREASE FROM THE 397 RESPONSES WE HAD IN 2022. TWENTY-THREE OF THOSE EXAMS WERE FORENSIC SUSPECT EXAMS CONDUCTED IN COORDINATION WITH MULTIPLE RAMSEY COUNTY LAW ENFORCEMENT AGENCIES.

EXAMS FOR VICTIMS OF SEXUAL ASSAULT:

WE PARTNER CLOSELY WITH TWO COMMUNITY ADVOCACY AGENCIES TO ENSURE OUR PATIENTS RECEIVE ADDITIONAL CRISIS SUPPORT DURING AN EXAM AND HAVE ACCESS TO RESOURCES AFTER DISCHARGE. RAMSEY COUNTY SEXUAL VIOLENCE SERVICES (SOS) RESPONDS TO OUR TWO RAMSEY COUNTY SITES, THE HOSPITAL AND ST. JOHN'S. CANVAS HEALTH IS OUR ADVOCACY PARTNER FOR OUR WASHINGTON COUNTY SITES, LAKEVIEW AND WOODWINDS. ADVOCATES ARE AVAILABLE IN PERSON OR BY PHONE DURING THE EXAM AND PROVIDE FOLLOW-UP COMMUNICATION AND COORDINATION OF SERVICES FOR VICTIMS AFTER THE EXAM.

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ELLEN JOHNSON AND ABBIE FLIEGEL CONDUCTED TWO VOLUNTEER ADVOCATE TRAININGS FOR SOS AT THE HOSPITAL AS PART OF THEIR VOLUNTEER ORIENTATION THIS PAST YEAR.

SUSPECT EXAMS:

THIS PROCESS REQUIRES CONTINUAL COLLABORATION BETWEEN OUR PROGRAM AND ALL LAW ENFORCEMENT AGENCIES REQUESTING AN EXAM. TO SUPPORT THIS, WE FACILITATED TWO TRAININGS IN 2023 FOR RAMSEY COUNTY SEX CRIMES INVESTIGATORS. WE CONTINUED THIS PAST YEAR WITH THE BEST-PRACTICE GUIDELINE IMPLEMENTED IN 2021 OF CONDUCTING THESE EXAMS OUTSIDE OF THE HOSPITAL. EXAMS ARE PRIMARILY DONE AT THE RAMSEY COUNTY LAW ENFORCEMENT CENTER (LEC) TO BEST SUPPORT OUR HOSPITAL AND COMMUNITY. BENEFITS INCLUDE IMPROVED VICTIM SAFETY DURING EXAMS, SUPPORT OF THE HOSPITAL EMERGENCY DEPARTMENT'S HIGH PATIENT VOLUMES, COMMUNITY SAFETY BY LIMITING TRANSPORT OF SUSPECTS BETWEEN THE LEC AND HOSPITAL, AND SUPPORT OF INVESTIGATORS' WORKFLOW AS THIS PROCESS TAKES EXTENSIVE TIME TO EXECUTE.

IN ADDITION, OUR PROGRAM SUPPORTED THE TRAINING OF ALL RAMSEY COUNTY PATROL OFFICERS BY PROVIDING EDUCATION ON THE MEDICAL FORENSIC EXAM DURING THREE PATROL OFFICER ACADEMIES IN 2023. THIS TRAINING WAS DEVELOPED TO IMPROVE COLLABORATION AND RESPONSE TO REPORTS OF SEXUAL ASSAULT IN RAMSEY COUNTY AND IS OUTLINED AS AN IMPROVEMENT EFFORT IN THE IMPLEMENTATION PLAN FOR SYSTEMS CHANGE DEVELOPED BY COUNTY ATTORNEY JOHN CHOI AND THE RAMSEY COUNTY ATTORNEY'S OFFICE IN 2018.

TRAINING AND DEVELOPMENT OF THE SANE WORKFORCE:

OUR TEAM IS HEAVILY INVOLVED IN SANE TRAINING AND DEVELOPMENT

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THROUGHOUT MINNESOTA AND THE UNITED STATES. BELOW IS A LIST OF OUR CONTRIBUTIONS IN 2023:

- THE HOSPITAL COORDINATED THREE 40-HOUR SANE COURSES IN MINNESOTA. THE 40-HOUR COURSE WAS DEVELOPED THROUGH EDUCATION GUIDELINES OUTLINED BY THE INTERNATIONAL ASSOCIATION OF FORENSIC NURSES (IAFN) AND IS REQUIRED TRAINING FOR SANES TO PRACTICE WITHIN THIS ROLE. PARTICIPANTS WERE ABLE TO ATTEND THIS COURSE FREE OF CHARGE THROUGH TWO FEDERAL HEALTH SERVICES AND RESOURCES (HRSA) GRANTS AWARDED; ONE TO THE UNIVERSITY OF MINNESOTA SCHOOL OF NURSING RE LAB AND THE OTHER TO HENNEPIN ASSAULT RESPONSE TEAM'S TRAIN TO RETAIN PROGRAM. THE COURSE IS ONE OF ONLY 26 IN-PERSON TRAININGS AVAILABLE IN THE U.S.

- WE HOSTED FIVE IAFN CLINICAL SKILLS LABS AT THE HOSPITAL EMS IN OAKDALE. LAB DEVELOPMENT AND COORDINATION WAS FACILITATED OUR STAFF. SKILLS LABS PROVIDE HANDS-ON EXPERIENCE FOR NEW SANES OR SANES WITH LIMITED EXPERIENCE TO PRACTICE EXAM STEPS AND MOCK EXAM SCENARIOS WITH LIVE PATIENT TEACHING ASSISTANTS, OR MODELS. THIS 16-HOUR TRAINING WAS DEVELOPED IN 2016 AND HAS SUPPORTED SANES THROUGHOUT THE COUNTRY IN GAINING CONFIDENCE AND COMPETENCE WITH THE SKILL SETS NECESSARY FOR THIS UNIQUE TO THIS ROLE. IT IS JUST ONE OF 14 LOCATIONS AVAILABLE THROUGHOUT THE U.S. TO OFFER THIS TYPE OF TRAINING. CLASS ENROLLMENT INCREASED IN 2023 AFTER THE TEN-PARTICIPANT RESTRICTION DUE TO THE COVID-19 PANDEMIC WAS REMOVED. REVENUE FROM HOSTING SKILLS LABS HAS PROVIDED OPPORTUNITY TO AWARD THE SANE TEAM WITH CONTINUING EDUCATION SCHOLARSHIPS.

- IN 2022 THE HOSPITAL SANE PROGRAM PARTNERED WITH THE UNIVERSITY OF MINNESOTA SCHOOL OF NURSING RE LAB TO DEVELOP TWO PROGRAMS FUNDED THROUGH THE FEDERAL HRSA GRANT MENTIONED ABOVE. RE LAB WAS AWARDED THE GRANT TO SUPPORT SANES PRACTICING IN RURAL COMMUNITIES AND/OR CARING

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FOR UNDER-SERVED POPULATIONS.

- ONE OF THE PROGRAMS IS A MENTORING OPPORTUNITY THAT PARTNERS EXPERIENCED SANES WITH SANES SEEKING SUPPORT AND MENTORSHIP FOR THEIR PRACTICE, OFTEN BECAUSE THEY PRACTICE ALONE IN THEIR COMMUNITY OR HAVE LIMITED RESOURCES FOR THEIR ON-GOING TRAINING AND DEVELOPMENT. THE PROJECT IS COORDINATED BY A SANE FROM THE HOSPITAL, SARAH HOFFMAN, AND FIVE OF THE NINE MENTORS INVOLVED ARE PART OF THE HOSPITAL TEAM AS WELL.

- THE SECOND PROGRAM DEVELOPED IN 2022 WITH RE LAB WAS A CLINICAL RESIDENCY WHERE SANES COMPLETE A SHADOWING EXPERIENCE WITH THE HOSPITAL TEAM. THIS INNOVATIVE PROGRAM IS ONE OF JUST A FEW SANE RESIDENCIES AVAILABLE IN THE U.S. PARTICIPANTS RECEIVE SOME DIDACTIC TRAINING AND ARE ON CALL FOR ANY CASES THAT OCCUR FOR UP TO 10 DAYS DURING THEIR STAY IN THE TWIN CITIES. IN 2023 WE HOSTED 11 RESIDENTS FROM AROUND THE U.S.

- IN ADDITION, RE LAB HOSTS MANY IN-PERSON AND VIRTUAL CLINICAL SIMULATION LABS THAT OUR TEAM HAS SUPPORTED AS EXPERT CASE DEBRIEFERS AND INSTRUCTORS. THE SIMULATIONS ARE OPPORTUNITIES FOR NURSING AND ADVANCED PRACTICE NURSING STUDENTS TO GAIN EXPERIENCE IN TRAUMA-INFORMED HISTORY TAKING AND INTERACTING WITH VICTIMS OF SEXUAL ASSAULT.

- PARTICIPATION WITH THE BOARD OF THE MINNESOTA CHAPTER OF THE IAFN HAS BEEN CONSISTENT OVER THE YEARS.

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COMMUNITY BUILDING ACTIVITIES

ENVIRONMENTAL IMPROVEMENTS:

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THE HOSPITAL CONTINUES TO BE A LEADER IN RECYCLING, RESOURCE CONSERVATION AND WASTE REDUCTION TO BETTER THE LIVES OF OUR PATIENTS, MEMBERS, AND STAFF THROUGH SUSTAINABLE PRACTICES. THE HOSPITAL HAS IMPLEMENTED MANY PROGRAMS AROUND HAZARDOUS WASTE REDUCTION BY RECYCLING LABORATORY SOLVENTS AND PREFERENTIALLY PURCHASING ITEMS THAT ARE SAFE FOR THE ENVIRONMENT. IN 2023, THE HOSPITAL DONATED OVER EIGHT TONS OF EQUIPMENT TO LOCAL NON-PROFIT ORGANIZATIONS AND MISSION GROUPS. IN TOTAL, THE HOSPITAL RECYCLED OVER 930 TONS OF MATERIALS. THE HOSPITAL ALSO COLLECTED 936 POUNDS OF MEDICATIONS FROM OUR COMMUNITY THROUGH OUR MEDICINE TAKE BACK PROGRAM AND RESPONSIBLY DISPOSED OF IT. THE HOSPITAL FOOD & NUTRITION SERVICES DEPARTMENT ALSO DONATED 9,000 POUNDS OF FOOD TO LOCAL FOOD SHELTERS IN 2023. ADDITIONALLY, OUR COMMUNITY SOLAR GARDEN SUBSCRIPTION AGREEMENT PRODUCED OVER 8.2 MILLION KILOWATT HOURS OF CLEAN RENEWABLE ENERGY AND SAVED US OVER $234,000 ON UTILITY BILLS.

THE HOSPITAL TAKES ADVANTAGE OF OPPORTUNITIES TO BE MORE SUSTAINABLE WITH RESPECT TO NEW CONSTRUCTION, REMODELS, CHEMICALS AND ENERGY MANAGEMENT. THE HOSPITAL SUSTAINABILITY TEAM CONTINUES TO ESTABLISH SPECIFIC GOALS AROUND REDUCTIONS IN WASTE, PAPER USAGE, AND ENERGY CONSUMPTION, AS WELL AS EDUCATING AND ENCOURAGING STAFF TO RECYCLE MORE ACROSS THE ORGANIZATION. IN 2024, THE HOSPITAL HAS RECEIVED A TOP 25 AWARD AND TOP 10 CIRCLE OF EXCELLENCE AWARDS FOR WASTE, GREENING THE OR, AND ENERGY FROM PRACTICE GREEN HEALTH FOR OUR SUSTAINABILITY EFFORTS.

NATIONAL RECOGNITION

Name of the organization: REGIONS HOSPITAL

Employer identification number: 41-0956618

HEALTHPARTNERS WAS NAMED TO THE IBM WATSON HEALTH 15 TOP HEALTH SYSTEMS LIST.

THE HOSPITAL WAS NAMED A BEST REGIONAL HOSPITAL BY U.S. NEWS & WORLD REPORT.

RANKED HIGH PERFORMING IN SEVEN PROCEDURES/CONDITIONS BY U.S. NEWS & WORLD REPORT INCLUDING STROKE, HEART ATTACK, AND HEART & KIDNEY FAILURE.

THE MINNESOTA DEPARTMENT OF HEALTH'S 2022 STROKE QUALITY IMPROVEMENT AWARD FOR OUTSTANDING ACHIEVEMENT, RECEIVED FOR OUR COMPREHENSIVE STROKE CENTER'S WORK IN REDUCING TIME BETWEEN EMERGENCY ROOM ARRIVAL AND START OF ENDOVASCULAR TREATMENT.

PRACTICE GREENHEALTH 2024 ENVIRONMENTAL EXCELLENCE AWARD

FORM 990, PART IV, LINE 24A

HEALTHPARTNERS INC., ALONG WITH RELATED ORGANIZATIONS, IS JOINTLY LIABLE FOR THE TAX EXEMPT BONDS HELD BY HEALTHPARTNERS INC. UNDER A MASTER TRUST AGREEMENT. THE MEMBERS OF THE JOINTLY LIABLE GROUP, WHICH IS COLLECTIVELY REFERRED TO AS THE "OBLIGATED GROUP", INCLUDE PARK NICOLLET HEALTH SERVICES, PARK NICOLLET CLINIC, PARK NICOLLET METHODIST HOSPITAL, PNMC HOLDINGS, REGIONS HOSPITAL, PARK NICOLLET HEALTH CARE PRODUCTS, GROUP HEALTH PLAN INC, HEALTHPARTNERS ADMINISTRATORS INC., AND HEALTHPARTNERS INSURANCE COMPANY. IN ADDITION TO THE TAX EXEMPT

Name of the organization: REGIONS HOSPITAL

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BONDS LISTED IN THIS SCHEDULE K, THE OTHER OUTSTANDING TAX EXEMPT BONDS OF THE HEALTHPARTNERS OBLIGATED GROUP ARE REPORTED SOLELY ON THE SCHEDULE K OF REGIONS HOSPITAL.

FORM 990, PART VI, SECTION A, LINE 6:

HPI RAMSEY IS THE SOLE CORPORATE MEMBER OF THE HOSPITAL.

FORM 990, PART VI, SECTION A, LINE 7A:

HPI-RAMSEY, AS THE SOLE CORPORATE MEMBER OF THE HOSPITAL, APPOINTS UP TO 12 MEMBERS OF THE UP TO 19 MEMBER BOARD OF DIRECTORS.

FORM 990, PART VI, SECTION A, LINE 7B:

HPI RAMSEY, AS THE SOLE CORPORATE MEMBER OF THE HOSPITAL, APPROVES ACTIONS AS FOLLOWS: AMENDMENT OF ARTICLES OR BYLAWS, ANNUAL OPERATING AND CAPITAL BUDGETS AND LONG-RANGE PLANS, UNBUDGETED SPECIAL PROJECTS IN EXCESS OF $1,000,000, GUARANTEEING THE DEBT OF ANY OTHER PERSON OR ENTITY IN EXCESS OF $1,000,000, A LOAN OR OTHER INDEBTEDNESS IN EXCESS OF $1,000,000, MERGER OR CONSOLIDATION WITH ANOTHER CORPORATION, DISPOSITION OF SUBSTANTIALLY ALL ASSETS, DISSOLUTION, APPOINTMENT OF THE CHAIR OF THE BOARD AND PRESIDENT.

FORM 990, PART VI, SECTION B, LINE 11B:

THE HOSPITAL'S 990 RETURN HAS A COMPREHENSIVE REVIEW PROCESS THAT IS FOLLOWED BEFORE IT IS PRESENTED TO THE GOVERNING BODY. THE REVIEW PROCESS INCLUDES A LAYERED REVIEW BY THE TAX DEPARTMENT OF GHI, THE MANAGEMENT TEAM OF THE HOSPITAL, THE ORGANIZATION'S INTERNAL LEGAL DEPARTMENT AND THE HOSPITAL'S OUTSIDE INDEPENDENT ACCOUNTANTS. EACH ONE OF THOSE AREAS HAS AN OPPORTUNITY TO REVIEW, ASK QUESTIONS AND MAKE COMMENTS BACK TO THE TAX

Name of the organization: REGIONS HOSPITAL

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DEPARTMENT OF GHI BEFORE THE FORM 990 IS COMPLETED AND PRESENTED TO THE GOVERNING BODY OF THE HOSPITAL. THE HOSPITAL MAKES AVAILABLE, TO THE FINANCE AND AUDIT COMMITTEE OF REGIONS' BOARD OF DIRECTORS AND TO THE FULL BOARD OF DIRECTORS, A COPY OF THE 990 FOR REVIEW AND COMMENT PRIOR TO THE FILING OF THE 990 RETURN. THIS COPY IS PROVIDED TO THE FINANCE AND AUDIT COMMITTEE AND THE FULL BOARD OF DIRECTORS IN A PRE-MEETING PACKET, AND IS AN AGENDA ITEM AT THE COMMITTEE MEETING. THIS PROCESS IS NOTED AND DOCUMENTED IN THE WRITTEN COMMITTEE MINUTES OF THE MEETING. THESE MINUTES ARE PRESENTED TO THE FULL BOARD OF DIRECTORS.

FORM 990, PART VI, SECTION B, LINE 12C:

THE HOSPITAL BOARD MONITORS POTENTIAL CONFLICTS OF INTEREST ON THE PART OF ITS BOARD MEMBERS, PRINCIPAL OFFICERS, MEMBERS OF COMMITTEES WITH BOARD DELEGATED POWERS, AND KEY EMPLOYEES ("COVERED PERSONS") BY MAINTAINING A CONFLICT OF INTEREST POLICY. UNDER THE POLICY, COVERED PERSONS ANNUALLY ARE PROVIDED WITH A COPY OF THE POLICY AND ASKED TO COMPLETE A QUESTIONNAIRE IDENTIFYING ANY POTENTIAL CONFLICTS OF INTERESTS. THE GENERAL COUNSEL OF HEALTHPARTNERS REVIEWS THE QUESTIONNAIRE RESPONSES AND DEVELOPS A REPORT DETAILING ANY POTENTIALLY MATERIAL CONFLICTS FOR THE PRESIDENT AND CHAIR OF THE BOARD. A VERBAL SUMMARY IS ALSO GIVEN TO THE FULL BOARD OR APPROPRIATE COMMITTEE ENDING WITH A REMINDER TO COVERED PERSONS OF THE POLICY'S MANDATE THAT EACH PERSON IS OBLIGATED TO DISCLOSE ANY NEW POTENTIAL CONFLICTS AS THEY MAY ARISE THROUGHOUT THE YEAR. BOARD AGENDAS AND EXECUTIVE DECISIONS ARE MONITORED IN RELATION TO THIS POLICY. IF A DISCLOSED CONFLICT OF INTEREST IMPACTS AN AGENDA ITEM OR DECISION, THE COVERED PERSON WOULD BE EXCLUDED FROM VOTING AND MAY BE EXCLUDED FROM RECEIVING INFORMATION AND/OR PARTICIPATING IN DELIBERATIONS, DEPENDING ON THE CIRCUMSTANCES.

Name of the organization
REGIONS HOSPITAL

Employer identification number
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FORM 990, PART VI, SECTION B, LINE 15:

THE HOSPITAL'S PRESIDENT AND ITS OFFICERS ARE EMPLOYED BY EITHER GROUP HEALTH PLAN, INC. (GHI), PARK NICOLLET HEALTH SERVICES (PNHS), BOTH OF WHOM ARE RELATED ORGANIZATIONS, OR BY THE HOSPITAL. GHI, PNHS AND THE HOSPITAL HAVE AN ANNUAL PROCESS TO REVIEW THE MARKET COMPARABILITY OF THE TOTAL COMPENSATION OF THE HOSPITAL'S PRESIDENT AND OTHER OFFICERS. EVERY THREE YEARS, THE INDEPENDENT COMPENSATION COMMITTEE OF THE GHI BOARD OF DIRECTORS (THE "COMMITTEE"), RETAINS AN EXTERNAL COMPENSATION EXPERT TO CONDUCT AN EXTENSIVE MARKET COMPARABILITY REVIEW FOR ALL OFFICERS OF THE ORGANIZATION. THE REVIEW INCLUDES ALL COMPONENTS OF TOTAL COMPENSATION: BASE SALARY, ANNUAL INCENTIVES, BENEFITS AND PERQUISITES. THE MARKET SURVEY RESULTS ARE PRESENTED TO, REVIEWED BY AND APPROVED BY THE APPROPRIATE COMMITTEE. BASED ON THIS DATA, EITHER THE EXECUTIVE COMMITTEE OF REGIONS HOSPITAL OR THE COMPENSATION COMMITTEE OF GHI (THE "COMMITTEES") DETERMINE MINIMUM AND MAXIMUM TOTAL COMPENSATION RANGES FOR EACH EMPLOYED OFFICER. IN INTERIM YEARS, GHI'S HUMAN RESOURCES STAFF, UNDER THE COMMITTEES' DIRECTION, UPDATES CHANGES IN THE SALARY STRUCTURE BASED ON THE SAME INDEPENDENT STUDIES PERFORMED BY THE COMPENSATION CONSULTANT FOR THE COMMITTEE. FOR CERTAIN POSITIONS FULL INDEPENDENT REVIEWS ARE PERFORMED TO SET SALARY RANGES BASED ON THE COMPETITIVE MARKET DATA SPECIFIC TO THOSE POSITIONS. THE COMMITTEE REVIEWS AND APPROVES EACH YEAR'S COMPENSATION RESULTS.

IN ALL CASES, COMMITTEE MEMBERS COMPLETE AN ANNUAL CONFLICT OF INTEREST SURVEY TO ASSURE THE COMPENSATION COMMITTEE MEMBERS' INDEPENDENCE AND THIS IS UPDATED AT ANY MEETING AT WHICH DECISIONS ARE BEING MADE. STAFF (OTHER THAN THE SECRETARY TO THE BOARD) IS NOT IN THE ROOM DURING DELIBERATIONS OR VOTE INCLUDING EXECUTIVE SESSIONS, AND CONTEMPORANEOUS MINUTES ARE KEPT.

Name of the organization: REGIONS HOSPITAL

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WITH THE HOSPITAL BOARD OF DIRECTORS INPUT, THE CEO AND PRESIDENT OF GHI CONDUCTS THE ANNUAL PERFORMANCE REVIEW AND, WITH REGION HOSPITAL'S BOARD APPROVAL, DETERMINES THE COMPENSATION OF THE HOSPITAL PRESIDENT. THE CEO AND PRESIDENT OF GHI ALSO DETERMINES THE COMPENSATION OF OTHER GHI-EMPLOYED REGIONS OFFICERS WITHIN THE COMPENSATION RANGES DETERMINED BY THE COMMITTEE. ANY EXCEPTIONS TO COMPENSATION IN EXCESS OF THE APPROVED RANGES ARE APPROVED BY THE COMMITTEE. THE HOSPITAL BOARD HAS DELEGATED TO THE HOSPITAL PRESIDENT THE ACCOUNTABILITY TO CONDUCT ANNUAL PERFORMANCE REVIEWS AND DETERMINE THE COMPENSATION OF ALL REGIONS-EMPLOYED OFFICERS WITHIN THE COMPENSATION RANGES DETERMINED BY THE COMMITTEE. ANY EXCEPTIONS IN EXCESS OF THE APPROVED RANGES NEED TO BE APPROVED BY THE EXECUTIVE COMMITTEE.

TOTAL COMPENSATION IS APPROPRIATELY DOCUMENTED ON THE FORM 990 AND ON THE EMPLOYEE'S W-2

FORM 990, PART VI, SECTION C, LINE 19:

THE HOSPITAL FINANCIAL STATEMENTS AND 990 RETURNS ARE MADE AVAILABLE TO ANY PERSON WHO REQUESTS THE INFORMATION FROM THE HOSPITAL OR HEALTHPARTNERS.

REGIONS' ARTICLES OF INCORPORATION ARE AVAILABLE TO ANY PERSON WHO REQUESTS THE INFORMATION THROUGH THE MINNESOTA SECRETARY OF STATE'S OFFICE.

990, PART VII, SECT A, LN 1A, COL B AVERAGE HOURS - RELATED ORGANIZATIONS

AVERAGE WEEKLY HOURS: THE COMPENSATED BOARD MEMBERS AND OFFICERS OF THE HOSPITAL ARE EMPLOYED AND COMPENSATED BY THE HOSPITAL, GHI OR PARK NICOLLET. THE COMPENSATED BOARD MEMBERS AND OFFICERS DEVOTE THEIR TIME TO MULTIPLE RELATED ORGANIZATIONS. REPORTED AVERAGE HOURS WORKED ARE BASED ON THEIR TOTAL COMPENSATION FROM ALL RELATED ORGANIZATIONS.

Name of the organization: REGIONS HOSPITAL

Employer identification number: 41-0956618

FORM 990, PART XI, LINE 9, CHANGES IN NET ASSETS:

FASB 136 ADJUSTMENT	4,511,636.
CAPITAL TRANSFER	5,661,007.
TOTAL TO FORM 990, PART XI, LINE 9	10,172,643.

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.

Attach to Form 990.

Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2023

Open to Public Inspection

Name of the organization
REGIONS HOSPITAL

Employer identification number
41-0956618

Part I **Identification of Disregarded Entities.** Complete if the organization answered "Yes" on Form 990, Part IV, line 33.

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity

Part II **Identification of Related Tax-Exempt Organizations.** Complete if the organization answered "Yes" on Form 990, Part IV, line 34, because it had one or more related tax-exempt organizations during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) Section 512(b)(13) controlled entity? No
HEALTHPARTNERS, INC. - 41-1693838 8170 33RD AVE. S., PO BOX 1309 MPLS., MN 55440-1309	HYBRID STAFF MODEL/NETWORK MODEL HEALTH MAINTENANCE ORGANIZATION	MINNESOTA	501(C)(4)		N/A		X
HPI-RAMSEY - 41-1793333 8170 33RD AVE. S., PO BOX 1309 MPLS., MN 55440-1309	CORPORATE PLANNING AND OVERSIGHT	MINNESOTA	501(C)(3)	509(A)(3) TYPE I	HEALTHPARTNERS, INC.		X
GROUP HEALTH PLAN, INC. - 41-0797853 8170 33RD AVE. S., PO BOX 1309 MPLS., MN 55440-1309	STAFF MODEL HEALTH MAINTENANCE ORGANIZATION	MINNESOTA	501(C)(3)	170(B)(1)(A)(III)	HEALTHPARTNERS, INC.		X
RH WISCONSIN, INC. - 20-2287016 8170 33RD AVE. S., PO BOX 1309 MPLS., MN 55440-1309	CORPORATE PLANNING AND OVERSIGHT	WISCONSIN	501(C)(3)	509(A)(3) TYPE I	HPI - RAMSEY		X

Part II **Continuation of Identification of Related Tax-Exempt Organizations**

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled organization? Yes	(g) Section 512(b)(13) controlled organization? No
HEALTHPARTNERS INSTITUTE - 41-1670163 8170 33RD AVE. S., PO BOX 1309 MPLS., MN 55440-1309	HEALTHCARE EDUCATION AND RESEARCH	MINNESOTA	501(C)(3)	509(A)(3) TYPE I	HEALTHPARTNERS, INC.		X
CAPITOL VIEW TRANSITIONAL CARE CENTER - 41-2011453, 8170 33RD AVE. S., PO BOX 1309, MPLS., MN 55440-1309	TRANSITIONAL CARE SERVICES, STEP DOWN FROM INPATIENT HOSPITAL	MINNESOTA	501(C)(3)	170(B)(1) (A)(III)	HPI - RAMSEY		X
REGIONS HOSPITAL FOUNDATION - 41-1888902 8170 33RD AVE. S., PO BOX 1309 MPLS., MN 55440-1309	PROVIDE SUPPORT TO HOSPITAL AND COMMUNITY HEALTH	MINNESOTA	501(C)(3)	170(B)(1) (A)(VI)	HPI - RAMSEY		X
RHSC, INC. - 41-1891928 8170 33RD AVE. S., PO BOX 1309 MPLS., MN 55440-1309	HEALTHCARE STAFFING AND INTENSE REHAB SERVICES	MINNESOTA	501(C)(3)	509(A)(3) TYPE II	HEALTHPARTNERS, INC.		X
HUDSON HOSPITAL, INC. - 39-0804125 8170 33RD AVE. S., PO BOX 1309 MPLS., MN 55440-1309	HOSPITAL	WISCONSIN	501(C)(3)	170(B)(1) (A)(III)	RH-WISCONSIN, INC		X
HUDSON HOSPITAL FOUNDATION, INC. - 39-1279567, 8170 33RD AVE. S., PO BOX 1309, MPLS., MN 55440-1309	PROVIDE SUPPORT TO HOSPITAL AND COMMUNITY HEALTH	WISCONSIN	501(C)(3)	170(B)(1) (A)(VI)	HUDSON HOSPITAL, INC.		X
LAKEVIEW HEALTH FOUNDATION - 41-1386635 8170 33RD AVE. S., PO BOX 1309 MPLS., MN 55440-1309	PROVIDE SUPPORT TO HOSPITAL AND COMMUNITY HEALTH	MINNESOTA	501(C)(3)	170(B)(1) (A)(VI)	LAKEVIEW HEALTH		X
LAKEVIEW MEMORIAL HOSPITAL ASSOCIATION, INC. - 41-0811697, 8170 33RD AVE. S., PO BOX 1309, MPLS., MN 55440-1309	HOSPITAL	MINNESOTA	501(C)(3)	170(B)(1) (A)(III)	LAKEVIEW HEALTH		X
STILLWATER MEDICAL GROUP - 83-0379473 8170 33RD AVE. S., PO BOX 1309 MPLS., MN 55440-1309	CLINIC STAFF AND FACILITIES	MINNESOTA	501(C)(3)	509(A)(3) TYPE I	LAKEVIEW HEALTH		X
LAKEVIEW HEALTH - 30-0221189 8170 33RD AVE. S., PO BOX 1309 MPLS., MN 55440-1309	CORPORATE PLANNING AND OVERSIGHT	MINNESOTA	501(C)(3)	509(A)(3) TYPE II	HPI - RAMSEY		X
WESTFIELDS HOSPITAL, INC. - 39-0808442 8170 33RD AVE. S., PO BOX 1309 MPLS., MN 55440-1309	HOSPITAL	WISCONSIN	501(C)(3)	170(B)(1) (A)(III)	RH-WISCONSIN, INC		X
WESTFIELDS HOSPITAL FOUNDATION, INC. - 39-1770913, 8170 33RD AVE. S., PO BOX 1309, MPLS., MN 55440-1309	PROVIDE SUPPORT TO HOSPITAL AND COMMUNITY HEALTH	WISCONSIN	501(C)(3)	170(B)(1) (A)(VI)	WESTFIELDS HOSPITAL, INC.		X

Part II **Continuation of Identification of Related Tax-Exempt Organizations**

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled organization? Yes	(g) Section 512(b)(13) controlled organization? No
PARK NICOLLET HEALTH SERVICES - 36-3465840 6500 EXCELSIOR BLVD. ST. LOUIS PARK, MN 55426	CORPORATE PLANNING AND OVERSIGHT	MINNESOTA	501(C)(3)	509(A)(2)	HEALTHPARTNERS, INC.		X
PARK NICOLLET FOUNDATION - 23-7346465 6500 EXCELSIOR BLVD. ST. LOUIS PARK, MN 55426	SUPPORT TO RELATED ENTITIES AND COMMUNITY HEALTH	MINNESOTA	501(C)(3)	170(B)(1)(A)(VI)	PARK NICOLLET HEALTH SERVICES		X
PARK NICOLLET METHODIST HOSPITAL - 41-0132080, 6500 EXCELSIOR BLVD., ST. LOUIS PARK, MN 55426	HOSPITAL	MINNESOTA	501(C)(3)	170(B)(1)(A)(III)	PARK NICOLLET HEALTH SERVICES		X
PARK NICOLLET HEALTH CARE PRODUCTS - 01-0638901, 6500 EXCELSIOR BLVD., ST. LOUIS PARK, MN 55426	DURABLE MEDICAL EQUIPMENT, AND OTHER HEALTH CARE RETAIL SALES	MINNESOTA	501(C)(3)	509(A)(3) TYPE I	PARK NICOLLET HEALTH SERVICES		X
PARK NICOLLET CLINIC - 41-0834920 6500 EXCELSIOR BLVD. ST. LOUIS PARK, MN 55426	CLINIC SERVICES	MINNESOTA	501(C)(3)	170(B)(1)(A)(III)	PARK NICOLLET HEALTH SERVICES		X
PNMC HOLDINGS - 41-1741792 6500 EXCELSIOR BLVD. ST. LOUIS PARK, MN 55426	HEALTHCARE REAL ESTATE	MINNESOTA	501(C)(3)	509(A)(3) TYPE I	PARK NICOLLET HEALTH SERVICES		X
AMERY REGIONAL MEDICAL CENTER, INC. - 39-0908320, 8170 33RD AVE. S., PO BOX 1309, MPLS., MN 55440-1309	HOSPITAL	WISCONSIN	501(C)(3)	170(B)(1)(A)(III)	RH-WISCONSIN, INC		X
AMERY REGIONAL MEDICAL CENTER FOUNDATION, INC. - 39-1726539, 8170 33RD AVE. S., PO BOX 1309, MPLS., MN 55440-1309	PROVIDE SUPPORT TO HOSPITAL AND COMMUNITY HEALTH	WISCONSIN	501(C)(3)	170(B)(1)(A)(VI)	AMERY REGIONAL MEDICAL CENTER, INC.		X
HUTCHINSON HEALTH - 84-1715908 8170 33RD AVE. S., PO BOX 1309 MPLS., MN 55440-1309	HOSPITAL	MINNESOTA	501(C)(3)	170(B)(1)(A)(III)	PARK NICOLLET HEALTH SERVICES		X
HUTCHINSON HEALTH FOUNDATION - 36-3317820 8170 33RD AVE. S., PO BOX 1309 MPLS., MN 55440-1309	PROVIDE SUPPORT TO HOSPITAL	MINNESOTA	501(C)(3)	170(B)(1)(A)(VI)	HUTCHINSON HEALTH		X
HEALTHPARTNERS RC - 84-4261122 8170 33RD AVE. S., PO BOX 1309 MPLS., MN 55440-1309	HOSPITAL	MINNESOTA	501(C)(3)	170(B)(1)(A)(III)	PARK NICOLLET HEALTH SERVICES		X
OLIVIA HOSPITAL & CLINIC FOUNDATION - 41-1839619, 8170 33RD AVE. S., PO BOX 1309, MPLS., MN 55440-1309	PROVIDE SUPPORT TO HOSPITAL	MINNESOTA	501(C)(3)	509(A)(3) TYPE I	HEALTHPARTNERS RC		X

Part III **Identification of Related Organizations Taxable as a Partnership.** Complete if the organization answered "Yes" on Form 990, Part IV, line 34, because it had one or more related organizations treated as a partnership during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership

Part IV **Identification of Related Organizations Taxable as a Corporation or Trust.** Complete if the organization answered "Yes" on Form 990, Part IV, line 34, because it had one or more related organizations treated as a corporation or trust during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity? Yes	(i) No
HEALTHPARTNERS ADMINISTRATORS, INC. - 41-1629390, 8170 33RD AVE. S., PO BOX 1309, MPLS., MN 554401309	THIRD PARTY ADMINISTRATOR	MN	HEALTHPARTNERS, INC.	C CORP					X
HEALTHPARTNERS ASSOCIATES, INC. - 52-2365151 8170 33RD AVE. S., PO BOX 1309 MPLS., MN 554401309	MEDICAL CLINIC STAFFING AND ASSET MANAGEMENT	MN	HEALTHPARTNERS ADMINISTRATORS, INC.	C CORP					X
HEALTHPARTNERS SERVICES, INC. - 41-1683568 8170 33RD AVE. S., PO BOX 1309 MPLS., MN 554401309	MEDICAL CLINIC STAFFING AND ASSET MANAGEMENT	MN	HEALTHPARTNERS ADMINISTRATORS, INC.	C CORP					X
HEALTHPARTNERS INSURANCE COMPANY - 41-1683523, 8170 33RD AVE. S., PO BOX 1309, MPLS., MN 554401309	MEDICAL AND DENTAL INSURANCE	MN	HEALTHPARTNERS ADMINISTRATORS, INC.	C CORP					X
DENTAL SPECIALTIES, INC. - 45-1297583 8170 33RD AVE. S., PO BOX 1309 MPLS., MN 554401309	PROFESSIONAL DENTAL SERVICES	MN	HEALTHPARTNERS ADMINISTRATORS, INC.	C CORP					X

Part V **Transactions With Related Organizations.** Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35b, or 36.

Note: Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule.		Yes	No
1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?			
a Receipt of **(i)** interest, **(ii)** annuities, **(iii)** royalties, or **(iv)** rent from a controlled entity	1a		X
b Gift, grant, or capital contribution to related organization(s)	1b	X	
c Gift, grant, or capital contribution from related organization(s)	1c	X	
d Loans or loan guarantees to or for related organization(s)	1d		X
e Loans or loan guarantees by related organization(s)	1e		X
f Dividends from related organization(s)	1f		X
g Sale of assets to related organization(s)	1g		X
h Purchase of assets from related organization(s)	1h		X
i Exchange of assets with related organization(s)	1i		X
j Lease of facilities, equipment, or other assets to related organization(s)	1j		X
k Lease of facilities, equipment, or other assets from related organization(s)	1k		X
l Performance of services or membership or fundraising solicitations for related organization(s)	1l	X	
m Performance of services or membership or fundraising solicitations by related organization(s)	1m	X	
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	1n		X
o Sharing of paid employees with related organization(s)	1o	X	
p Reimbursement paid to related organization(s) for expenses	1p	X	
q Reimbursement paid by related organization(s) for expenses	1q	X	
r Other transfer of cash or property to related organization(s)	1r		X
s Other transfer of cash or property from related organization(s)	1s		X

2 If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction thresholds.

	(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)	HEALTHPARTNERS, INC.	L	156,532,634.	CASH AMOUNT
(2)	HEALTHPARTNERS, INC. - RENT	P	1,442,891.	CASH AMOUNT
(3)				
(4)				
(5)				
(6)				

Part VI **Unrelated Organizations Taxable as a Partnership.** Complete if the organization answered "Yes" on Form 990, Part IV, line 37.

Provide the following information for each entity taxed as a partnership through which the organization conducted more than five percent of its activities (measured by total assets or gross revenue) that was not a related organization. See instructions regarding exclusion for certain investment partnerships.

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(e) Are all partners sec. 501(c)(3) orgs.? Yes	(e) No	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership

Part VII Supplemental Information

Provide additional information for responses to questions on Schedule R. See instructions.

2023 DEPRECIATION AND AMORTIZATION REPORT

FORM 990 PAGE 10 990

Asset No.	Description	Date Acquired	Method	Life	Conv	Line No.	Unadjusted Cost Or Basis	Bus % Excl	Section 179 Expense	* Reduction In Basis	Basis For Depreciation	Beginning Accumulated Depreciation	Current Sec 179 Expense	Current Year Deduction	Ending Accumulated Depreciation

328111 04-01-23

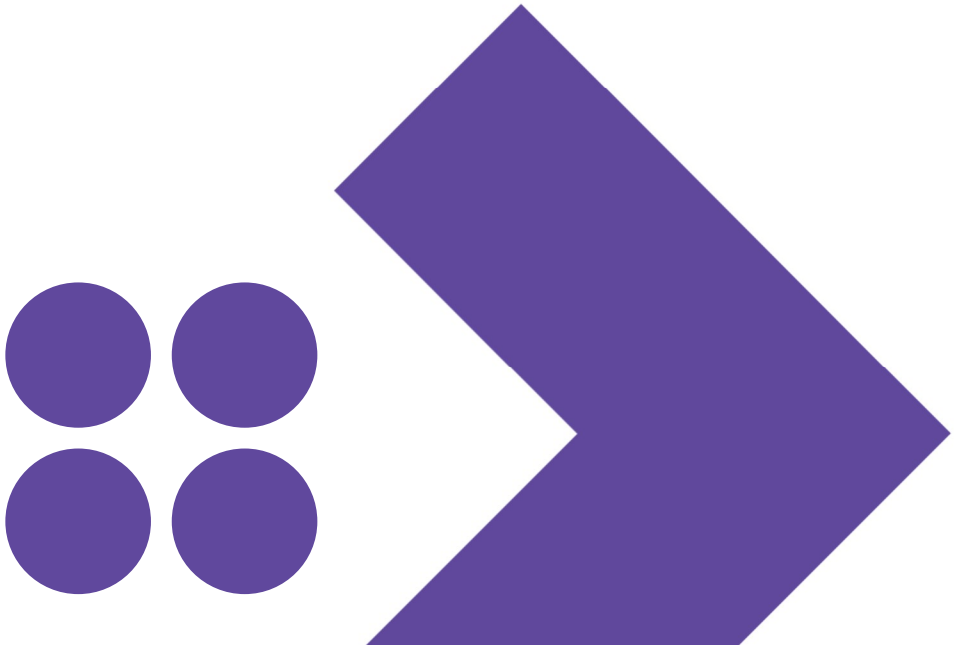
(D) - Asset disposed

* ITC, Salvage, Bonus, Commercial Revitalization Deduction, GO Zone

Regions Hospital®

Community Health Needs Assessment

December 2024



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Executive Summary

Through 2024, HealthPartners and Regions Hospital partnered with the community to conduct a comprehensive Community Health Needs Assessment (CHNA). The CHNA process is designed to identify and prioritize the health needs of the community that the hospital serves as well as identify resources to address those needs. This process is an essential component in achieving the HealthPartners mission: to improve health and well-being in partnership with our members, patients, and community.

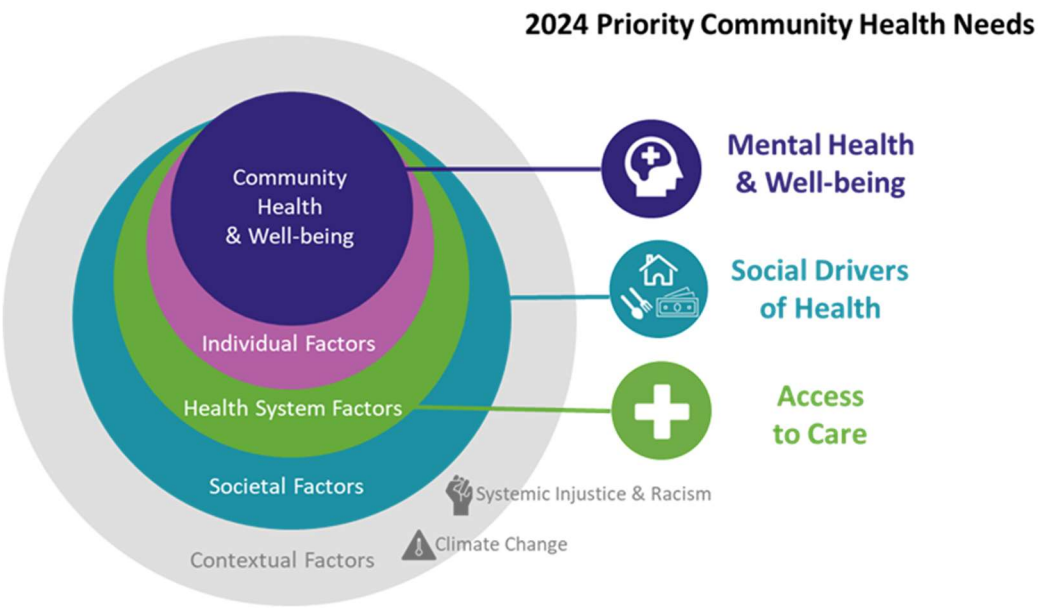
This CHNA report includes data describing the community that Regions Hospital serves, defined as the entire population of Ramsey County. While the hospital certainly serves individuals from outside of the county, the definition of a community as a single county simplifies and helps focus, helping ensure that the results can be presented clearly to the community.

Methodology

The IRS requires all nonprofit hospitals to conduct a CHNA every three years. For this CHNA cycle, HealthPartners and Regions Hospital contracted with the Center for Evaluation and Survey Research (CESR), part of HealthPartners Institute, to complete the 2024 CHNA. Our CHNA is comprised of multiple data sources, some existing for other primary purposes, with more collected specifically for this purpose.

We convened a diverse, cross-hospital CHNA workgroup to collect and interpret information and seek health system consensus while centering local priorities and voice. Types of data we gathered include HealthPartners administrative data, patient and member-reported data collected primarily for evaluation of HealthPartners community initiatives or operational purposes, and publicly available data describing the population residing in Ramsey County, county- and state-level factors, and health and well-being outcomes overall and for specific populations. We started our CHNA cycle with a prioritization process. Here, we reviewed publicly available data, facilitated internal and external stakeholder conversations, designed a community health needs prioritization survey and invited internal and external stakeholders to respond, and reviewed all inputs as a CHNA workgroup. This resulted in three prioritized community health needs we sought to understand more deeply in the second half of our CHNA year. Extensive quantitative data was gathered to describe each need and is complemented with rich qualitative data collected through numerous Community Conversations with internal stakeholders and community members facilitated by our CHNA workgroup members to gather local perspectives.

All data were organized by our Needs Areas Framework, described below, and resulted in three identified Priority Needs for this CHNA cycle. The interrelated nature of these needs areas is depicted through the graphic here, which guides the organization of our CHNA. Throughout our CHNA, we seek to describe the ways in which systemic injustice and racism and climate change impact our community health and well-being. Informed by quantitative and qualitative data, our workgroup refined the definitions and described the status and impact of each prioritized community health need.



Prioritized Community Health Needs

Mental Health and Well-being Mental health refers to a person's emotional, psychological, and social well-being, affecting how they think, feel, and act. It influences overall health and how one manages stress, builds relationships, and copes with life's challenges. Mental health can vary across the life span, based on factors including social connectedness, emotional resiliency and mental health conditions, such as depression or anxiety, that disrupt thoughts, emotions, and behaviors.

Factors contributing to mental health or mental health conditions can include biological and environmental factors, trauma, medical conditions, social drivers of health, or substance misuse. Reducing stigma helps ensure everyone can access the care and support needed to lead fulfilling lives and manage life's challenges.

Social Drivers of Health Social drivers of health are the community and environmental conditions that affect health and well-being. They include adequate and secure income, housing, food and nutrition, employment and work, education, transportation, access to childcare and interpersonal safety. They also include a sense of belonging, the natural and built environment and climate impacts.

These social drivers of health do not exist in isolation and often interconnect, overlap, and contribute to other community health needs, including Mental Health and Well-being and Access to Care.

Access to Care Access to Care means having equitable access to convenient, affordable, safe, culturally responsive and high-quality health care. It includes a care experience where people feel like they are seen, heard, known and treated as a partner in the process, without bias. Access includes factors such as the cost of care and insurance coverage, medical transportation, care coordination, navigation and use of technology. It means simplifying the complex health care system to be more understandable and accessible for all.

Next Steps

Regions Hospital, HealthPartners, and the community will continue to work together to address the needs of the community it services. An implementation strategy, a companion to this CHNA, will guide this work and will be created by May 2025. We will also evaluate progress towards goals throughout the CHNA cycle.

This Community Health Needs Assessment meets all of the federal requirements of the Patient Protection and Affordable Care Act (ACA) and the Internal Revenue Service final regulations. It was approved by the Regions Hospital Board Quality Committee on 12/03/24 and the Regions Hospital Board on 12/04/24. In accordance with federal and state requirements, this report is made widely available to the public on our website at https://www.healthpartners.com/care/hospitals/regions/about/community-health-needs/.

Community Served

About HealthPartners & Regions Hospital

HealthPartners is the largest consumer governed nonprofit health care organization in the nation, serving more than 1.2 million patients and 1.8 million medical and dental health plan members. Our mission is to improve health and well-being in partnership with our members, patients and community.

At HealthPartners, our values are excellence, compassion, partnership, and integrity. Our Partners for Better Health (PBH) goals aim to improve health, deliver a great patient experience, and make health care more affordable. In tandem with our Community Health Needs Assessment findings and implementation plans, we will work toward our vision of **health as it could be, affordability as it must be, through relationships built on trust.**

Regions Hospital is part of HealthPartners. Regions Hospital is a Level I Trauma Center serving adults and children in Minnesota and western Wisconsin for more than 140 years. As a private, non-profit teaching hospital, Regions Hospital provides outstanding care in neurosciences, heart surgery, cardiology, oncology, emergency care, burn care, orthopedic care, mental illness and more. For more information, visit www.healthpartners.com/care/hospitals/regions/.

About the Community

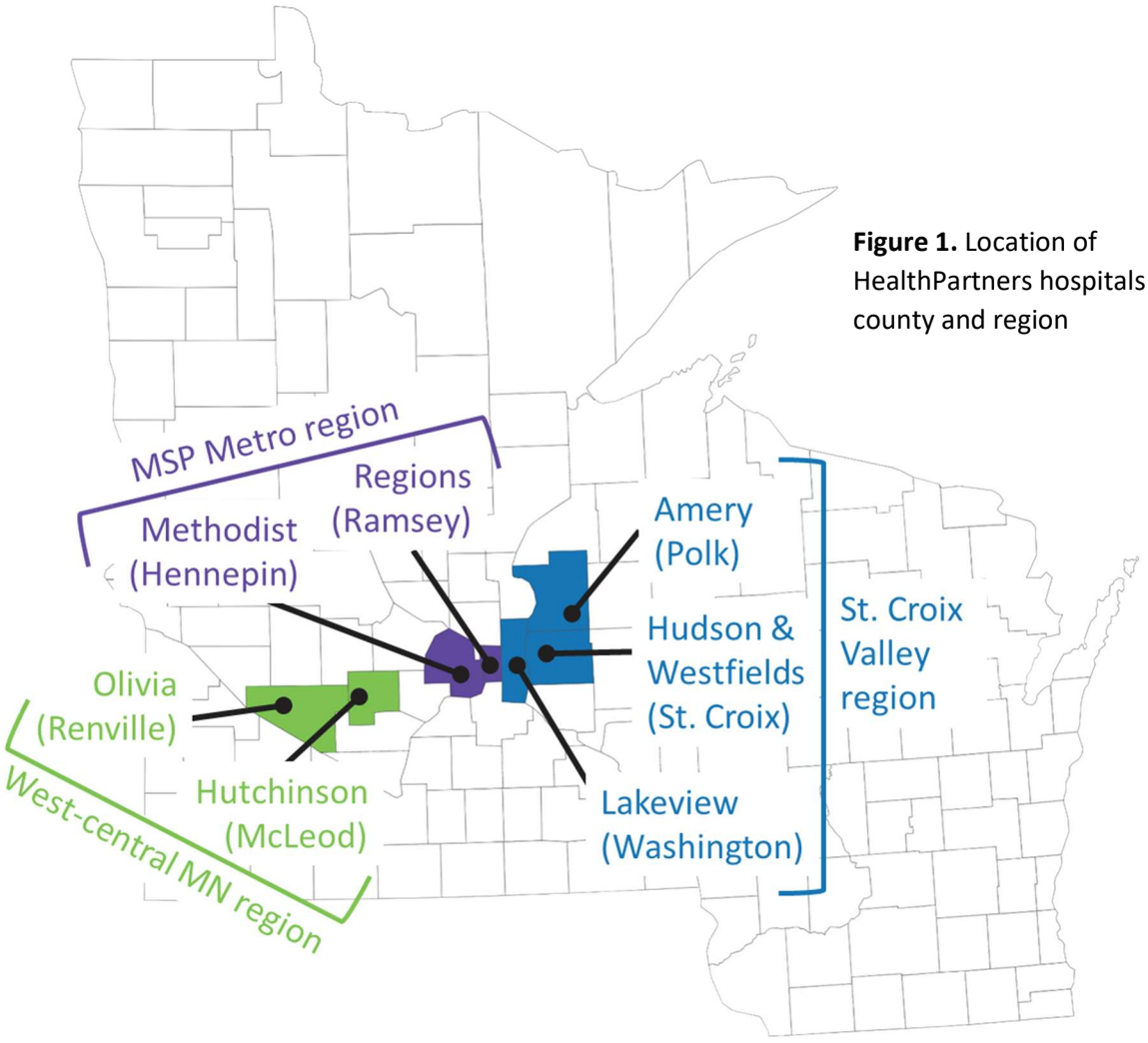


Figure 1. Location of HealthPartners hospitals by county and region

Regions Hospital is located in the city of St. Paul in Ramsey County, Minnesota. For the purposes of this report, the "community served" by Regions Hospital is people living in Ramsey County and includes medically underserved, low-income, and minority populations.

Additionally, this definition includes all patients regardless of whether (or how much) they or their insurers pay for the care received or whether they are eligible for assistance under the hospital facility's financial assistance policy. While the hospital certainly serves individuals from outside of the county, the definition of a community as a single county simplifies and helps focus, helping ensure that the results of this needs assessment can be presented clearly to the community.

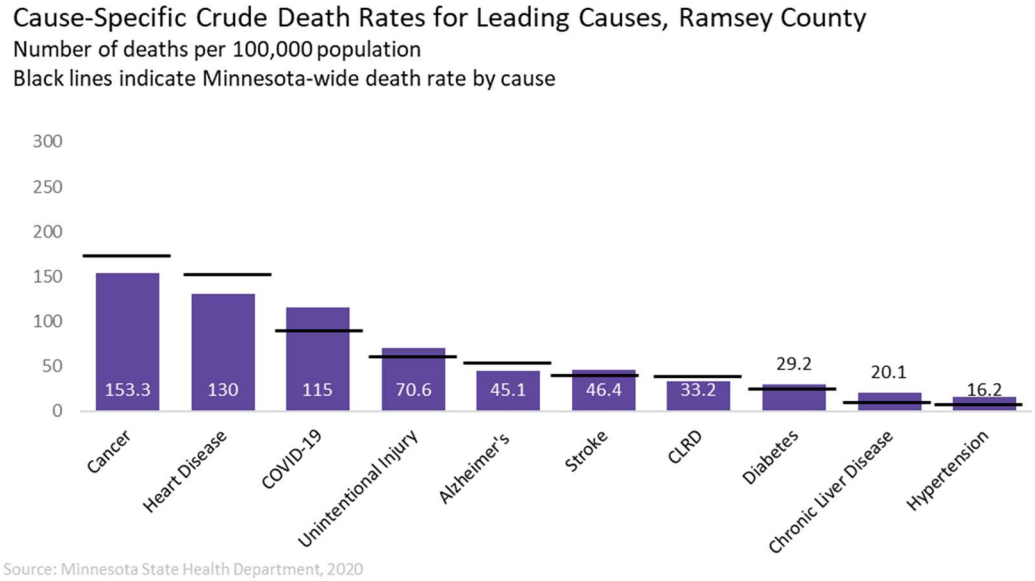
According to the 2022 American Community Survey 5-Year Estimates,[1] Ramsey County has 536,413 residents, 50.2% of whom are female.

- The median age in this county is 36.5 years, with 16.0% of the population 65 years or older.
- Nearly six in ten (59.2%) identify as **White**, with 15.3% **Asian**, 12.2% identifying as **Black or African American**, 0.6% **American Indian or Alaska native**, 0.0% **Native Hawaiian or other Pacific Islander**, and 7.9% **as more than one or some other race**.
- 7.8% identify as **Hispanic or Latino**.

There were 93,807 HealthPartners patients (age 18 and older who had an in-person or telemedicine visit with a HealthPartners provider in 2023) who lived in Ramsey County in 2023.[2]

- Of these, 91% were over 25 years old and over half (58%) were female.
- Fewer than two thirds were **White** (61%), with 15% identifying as **Black or African American**, 9% **Asian**, fewer than 1% **American Indian or Alaska Native**, fewer than 1% **Native Hawaiian or other Pacific Islander**, and fewer than 2% **some other race.**
- 4.5% reported a **Hispanic or Latino** ethnicity.
- Over 91% spoke English, with the second most common language being Hmong at 1.9%, then Spanish at 1.6%, and Somali at 1.4%.
- Among HealthPartners patients in Ramsey County, 56% use commercial insurance, 20% are covered by Medicare, and 20% are covered by Medicaid.

In the state of Minnesota in 2020, the three most common causes of death, in order, were cancer, heart disease and COVID-19.[3] In Ramsey County in 2020, the three most common causes of death, in order, were cancer, heart disease and COVID-19.[3]



According to the Minnesota Department of Health, "chronic conditions are health conditions or diseases that can last a year or more and may require ongoing medical treatment" and can impact physical and mental health and well-being.[4] Across our service area, there was no decrease in prevalence of any chronic condition in any county since 2021 and many conditions became more common.

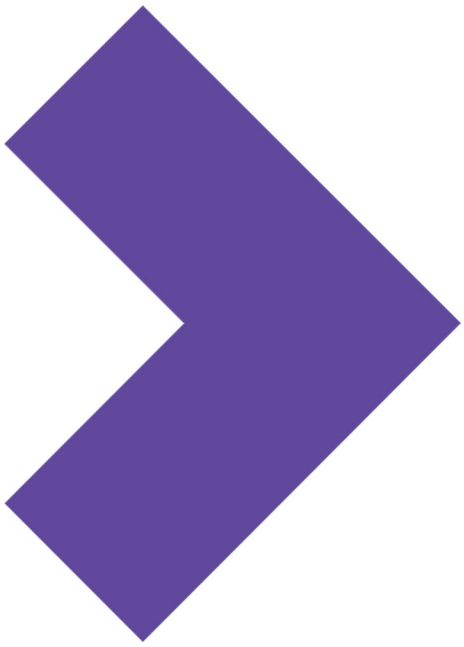
Here are common chronic conditions and their prevalence statewide and in Ramsey County in 2023[5]:

- Hypertension: 19% of Minnesotans and 18% of Ramsey County residents, the same prevalence as 2022
- High cholesterol (hyperlipidemia): 18.5% of Minnesotans and 18% of Ramsey County residents, the same prevalence as 2022
- Diabetes, Type 2: 7.2% of Minnesotans and 8% of Ramsey County residents, up from 7% in 2022
- Asthma: 6.6% of Minnesotans and 8% of Ramsey County residents, the same prevalence as 2022
- Heart disease: 4.4% of Minnesotans and 4% of Ramsey County residents, the same prevalence as 2022

Context

We know that **community health needs are complex and interconnected** – that where someone lives can impact how they can access and receive care, how they spend their time and how they feel. We acknowledge that the societal forms of racism – institutional, structural, and systemic – impact individual and community health.

Our assessment is structured in a way that seeks to understand the complex impacts of the societal factors, health system factors, and individual factors on health and well-being across the population and unique needs within special populations: by geography, by age, by race and/or ethnicity, gender, and other aspects of identity.



Systemic Injustice & Racism

Our CHNA framework is organized by a public health model that demonstrates how societal, health system, and individual factors are interconnected, and all influenced by context.[6] Systemic injustice and racism are contextual factors that shape these other factors and ultimately community health and well-being outcomes.

In April 2021, the Centers for Disease Control and Prevention (CDC) declared racism a serious public health threat.[7] But what exactly is racism? Racism refers to systems and policies, actions and attitudes that create unequal opportunities and outcomes for people based on race. It goes beyond individual prejudice, becoming more dangerous when combined with the power to discriminate, oppress or limit others' rights, whether on an individual or institutional level.

Institutions often have policies, practices and procedures that favor certain groups of people over others, which are collectively called systemic injustice. When certain racial or ethnic groups are favored or discriminated against, this is systemic racism. Unlike direct or overt discrimination, systemic injustice does not always involve intentional actions. It is a deeply rooted, complex issue where unjust systems are maintained and reinforced over time. Injustice is not a one-time event. It persists[8] because it is built into institutions and practices.

The harm caused by systemic injustice and racism is damaging for everyone. The CDC has long acknowledged that racism is a root cause of health disparities. Significant racial and ethnic health disparities are driven by factors both within and outside health care systems. For example, communities of color often face higher poverty rates, higher levels of pollution and crime, and limited access to green spaces — all of which contribute to health disparities and poor health outcomes.[9] In addition, a lack of affordable, quality health care makes it difficult to get timely treatment, which disproportionately affects people of color. Black, Hispanic, and Asian people are less likely to have health insurance, more likely to delay care because of costs, and more prone to medical debt.[10] They are also less likely to have a regular source of care or to receive timely preventive services, like vaccinations.[9]

Findings from Minnesota's African American Leadership Forum Community Harvest Report (2021)[11] highlight the interconnectedness of structural racism and the priority health needs identified in the CHNA. While the Black community viewed many health and well-being actions as within an individual's control, these actions are often made within the limiting context of systemic injustice, including traumatic and coercive environments. Community conversations held as a part of the HealthPartners CHNA further emphasized the impact of systemic injustice and racism on the priority health needs areas: Mental Health and Well-Being, Social Drivers of Health and Access to Care, especially in metro-area counties, including Hennepin and Ramsey. In rural areas, racism was less frequently or not acknowledged, with economic factors driving disparities in health being a more common topic.

HealthPartners has a long-standing commitment to health equity, focusing on reducing health care disparities, increasing workplace diversity and inclusion and addressing social factors like early childhood brain development, mental health stigma and access to food. We have the responsibility and opportunity to build stronger communities where racism -- and the inequity that results -- has no place. To advance this work, we established the Equity, Inclusion and Anti-Racism Cabinet, which provides

leadership and oversight to advance health equity and eliminate racism. The cabinet is made up of a diverse group of health equity leaders from across our organization.

The following principles at HealthPartners are foundational as we design for equity:

HealthPartners' strategic goal to advance health equity means a commitment to using a diverse, inclusive and equitable lens in the design of our work.

- We must be mindful of who is negatively impacted or left out, and,
- Consider changes to increase/improve equity and inclusion.

We have a commitment to making health care simple and affordable for everyone we serve. This will advance health equity and build trust with underserved communities. At the same time, we recognize that the most simple and affordable solution may not work for all patients, members and colleagues.

- We will simultaneously explore options for customization where it is needed to meet all needs from an equity perspective.
- Through rapid cycles of improvement, we will continue to adjust to meet the needs of all patients, members and colleagues.

Bringing an equity lens to our work

One of the key components to growing our understanding of and the application of the concept of equity to our day-to-day work is to remain curious. **Incorporating the three questions below into commonly used tools and processes will help reflect and act upon inequities and integrate equity, inclusion, and anti-racism into decision-making.** Asking ourselves each of these questions challenges us to ensure the entire population is being considered and our decisions lead to simple and affordable health care for everyone.

1. For whom is this process/policy/change **simple and affordable**?
2. Is there any group or population **negatively impacted or left out** by this process/policy/change and how?
3. What potential changes could you make to increase/improve **equity and inclusion**?

Climate Change

A healthy environment is an important foundation for good health. **Access to clean air, water, and natural areas has positive effects on physical and mental health**, while exposure to pollution increases risk of various health problems.

In recent years, our facilities and communities have faced disruptions in our environment, including heat waves, droughts, and floods. The effects of climate disruptions are interconnected with each of the priority needs areas discussed in the CHNA. As greenhouse gas emissions in our atmosphere continue to rise, these disruptions are likely to become more frequent and more severe.

Extreme heat events are already taking place in Minnesota and Wisconsin, and are expected to become more common, more severe and longer lasting. Under a conservative "lower emissions" scenario, from 2015-2044, Ramsey County is projected to see 8.3 days with a maximum temperature of over 95 degrees Fahrenheit each year, an increase of 6.7 days (419%) compared to the 1976-2005 historical average.[12]

Health effects of extreme heat events include heat-related illnesses and worsening of chronic conditions like heart disease, asthma, and chronic obstructive pulmonary disease (COPD). Extreme heat has also been associated with increases in irritability, aggression, alcohol and substance use, mental health related hospital visits, and suicide rates.[13] Lower income community members are more likely to live in areas with greater exposure to extreme temperatures,[14] and are more likely to experience income loss when extreme heat creates unsafe working conditions.[15]

Rainfall patterns are already changing, and scientists predict even more localized large storm events, which leave some areas flooded and others experiencing drought. Health impacts of flooding include physical injuries, mold exposure and waterborne disease. Emotional distress and mental disorders may also be exacerbated during flooding events.[16] Lower income and minority community members are more likely to experience these impacts, as they are more likely to live in flood-prone areas, are more likely to experience property damage, and are less likely to evacuate during a flood.[14]

Health impacts of drought include negative effects on food supply, potential concentration of groundwater contaminants and respiratory distress from dust, pollen, and wildfire smoke. Drought can also cause adverse mental health outcomes, particularly in rural or agriculture-dependent populations.[17]

HealthPartners is addressing climate change, from reducing our greenhouse gas emissions to increasing our ability to adapt to extreme weather events. As a signatory of the White House and U.S. Department of Health and Human Services Health Sector Climate Pledge, we have committed to reducing our Scope 1 and Scope 2 (organizational) emissions by 50% by 2030, and by 100% by 2050, from a 2018 baseline. As of 2023, we have reduced our organizational emissions by 24%.

HealthPartners climate resilience plan

In 2023, HealthPartners released a climate resilience plan[18] outlining the strategies and actions we will take as an organization to address and prepare for climate change and extreme weather. The plan is divided into three strategies: emergency preparedness and response, infrastructure resilience, and community health resilience. Actions in the emergency preparedness and response strategy include updating risk assessments and conducting trainings on extreme weather response, actions in the infrastructure resilience strategy include incorporating resilient design into buildings and landscapes,

and actions in the community health resilience strategy include conducting outreach to community members and partnering with community groups that are addressing climate change in at-risk populations. See the complete HealthPartners Climate Resilience Plan here: https://www.healthpartners.com/content/dam/corporate/sustainability/healthpartners-sustainability-climate-plan-report.pdf

Prioritization Process

The mission of HealthPartners is to improve health and well-being in partnership with our members, patients, and community. The Community Health Needs Assessment (CHNA) is an opportunity for our organization to identify the important health needs of the communities we serve, and to strategize and identify resources to help address those needs. This section describes our **process of gathering data and input to prioritize community health needs** across our health system.

Prioritization Approach

To identify priority community needs areas for the 2024-2026 CHNA cycle, the Center for Evaluation & Survey Research (CESR) designed and supported the HealthPartners CHNA workgroup through a consensus process.[19]

Selecting Key Informants. First, we convened a CHNA workgroup of **health system administrators** who work in one of HealthPartners eight hospitals (1-4 experts per hospital), as well as **subject matter experts** (SMEs) who work at the organization level. These hospital workgroup members and SMEs have close connections to the community, work directly in the community, or work closely with those who provide direct care and are aware of health system priorities and opportunities. Taking a health equity approach, we also engaged **community stakeholders**, such as representatives from local nonprofit and public organizations, **hospital boards and advisory committees**, and **local public health** professionals in our methodological prioritization process. Each informant was selected due to their close connection with communities in the HealthPartners service area and their knowledge of public health and/or hospital priorities and opportunities.

Identifying Possible High-Priority Community Health Needs. Using a common public health framework[6], the CHNA workgroup brainstormed a list of *possible* community health needs, organized into three interconnected factors: societal factors, health system factors, and individual factors, all of which affect community health and well-being outcomes. This framework and its accompanying image below were discussed, adapted and approved by the CHNA workgroup.

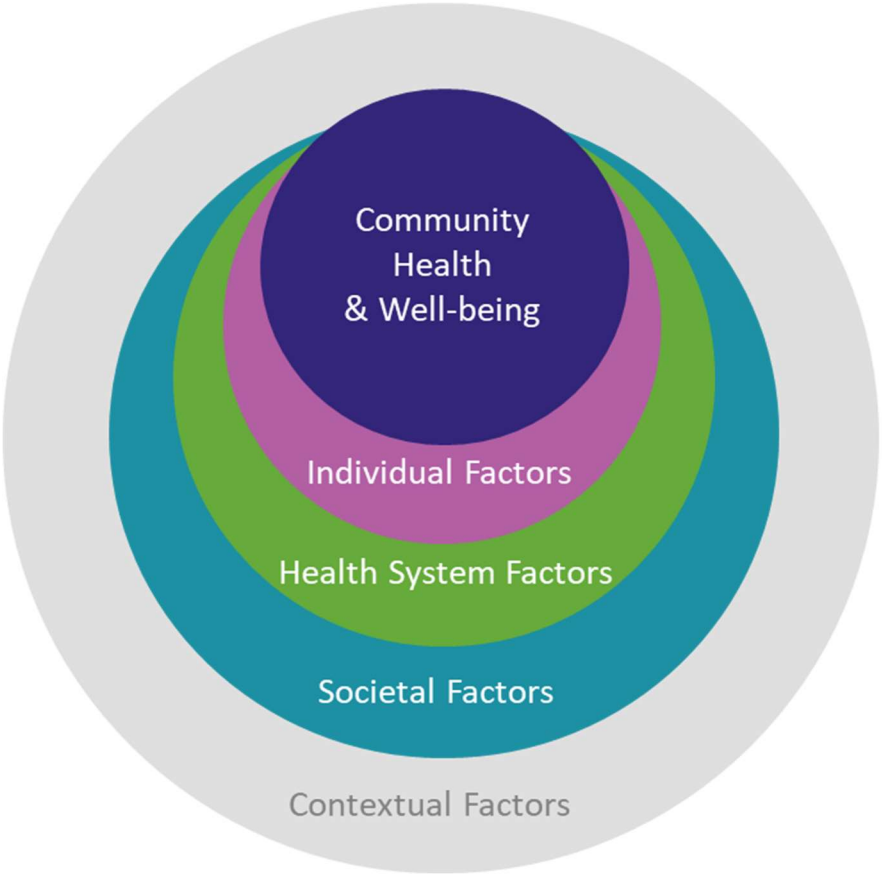


Figure 2. Framework for Organizing Community Health Needs (Adapted from McGovern 2014)[6]

Compiling a Regional Data Summary. Our team then identified six comprehensive, county-level data sources and described the current state of each brainstormed community health need:

- County Health Rankings, 2023[20]
- Minnesota Student Survey, 2022[21]
- Wisconsin Youth Risk Behavior Survey, 2021[22]
- KFF State Health Facts, 2022[23]
- Commonwealth Fund, 2022[24]
- Minnesota Community Measurement, 2022[25]

This information was compiled for each county and organized by hospital region: the Twin Cities metropolitan area, West Central Minnesota, and the St. Croix Valley (including eastern Minnesota and western Wisconsin). This regional data summary was shared with all key informants invited to participate in a qualitative discussion (described below). Participants were encouraged to review and reflect on this data prior to the discussion and were given an orientation to the data summary as well as time to review it during the discussion.

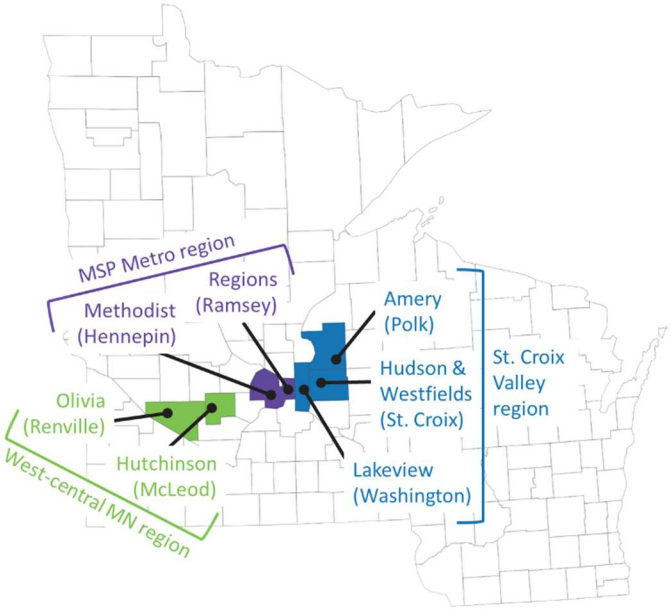


Figure 3. CHNA Communities by County and Region

Needs Area	Specific Needs
Societal Factors	• Economic Stability • Employment Stability • Housing Security • Food Security • Access to Healthy Food & Exercise Spaces • Social & Support Networks • Education & Childcare Quality & Access • Transportation Access • Public & Personal Safety • Environmental Health & Justice • Stigma • Political Climate & Civic Engagement
Health System Factors	• Just, Equitable & Trustworthy Care • Health Care Access & Availability • Health Care Workforce Availability • Health Care Quality • Health Care & Service Affordability • Health Insurance Coverage & Affordability • Emergency Preparedness • Interpretive Services & Health Communication • Long-Term Care Access & Affordability • Health System Community Engagement & Education
Individual Factors	• Use of Preventive Care Services • Eating Patterns • Physical Activity Patterns • Social Connectedness • Screen Time & Media Use • Sleep • Oral Hygiene Behaviors • Stress Management & Mindfulness • Substance Use • Sexual Health & Behaviors • Risk-Taking Behaviors
Community Health & Well-being Outcomes	• Mortality Rates • Physical Health, Chronic Disease, &/or Chronic Pain • Mental Health or Illness • Social-Emotional Health • Pregnancy & Birth Outcomes • Substance Use Disorder • Brain Health, Cognitive Impairment &/or Dementia • Infectious &/or Sexually Transmitted Diseases & Infections • Dental & Oral Health • Health Literacy
Contextual Factors	• Systemic Racism • Economic Disparities

Table 1. Table of Each Brainstormed Need, Organized by Needs Areas Framework

Engaging Subject Matter Experts and Community Stakeholders in Qualitative Discussions. The primary purpose of these conversations was to engage key informants' reflections and interpretations of the regional data summary prior to the prioritization survey (described below) so that responses were driven by available public health data. An additional purpose was to gather a more robust and nuanced understanding of prioritized health needs that emerged in the prioritization survey analysis.

A standard facilitation guide was created and used, including instructions for facilitators and notetakers for the discussion, along with guidance on how to use the regional data summary in the conversation. Specific discussion questions included:

1. Please introduce yourself and share – in ten words or less – what first comes to mind when I say "community health needs."
2. Which of the data points **affirmed** what you hear or observe related to community health needs?
3. Which of the data points **surprised** you? In what way?
4. Were there any community health needs you know about that were **missing from the data summary**? Were any data points not describing the community health need?
5. Based on the data and your experience in the community, what community health needs seem the **most important** to address?
6. The following priority health needs have been named by a member of this group [review notes]. Are we missing any priority needs that you think are important to consider?

Attendees were then invited to complete the survey; it was explained to participants that the survey results would be the primary data source used to determine HealthPartners' priority health needs for this CHNA cycle and they were strongly encouraged to participate.

Identifying Priority Health Needs via Prioritization Survey. A community health needs prioritization survey was developed using survey design best practices.[26] This 10-minute web-based survey was emailed to health professionals through each hospital's communication channels, as well as to community stakeholders, including public health professionals, by the CHNA hospital workgroup members. Survey responses were tied to county and hospital, which allowed for local survey summaries to be created.

The survey aimed to understand perspectives on priority community health needs, overall and by region. Respondents were informed that HealthPartners defines "community" as the people who live in the county where each of our eight hospitals is located. The survey asked which counties they work in and/or represent as well as what information informed their responses.

The survey asked participants to assess the importance of addressing or improving each of the possible community health needs. Respondents were then asked to identify their top five priorities (ranked #1 - #5) among the needs they identified as very important to address.

Determining Priority Community Health Needs. Analysis of survey responses resulted in a descriptive summary shared with the CHNA workgroup; results were presented overall and by hospital (with the exception of the four Valley hospitals, which were presented as a region). CESR calculated the average priority ranking of each community health need by assigning 100 points to each #1 priority, 80 points to each #2 priority, and so on, so that each #5 priority was assigned 20 points. Any need not ranked as a priority was assigned 0 points. Therefore, a higher score indicates a higher average ranking.

Table 2. Results from Prioritization Survey, Spring 2024.

	All n=589	HP System n=47	Hutchinson n=95	Methodist n=79	Olivia n=41	Regions n=63	Valley n=250
1	Mental health or illness (avg=24.75)	Housing Stability	Mental health or illness	Housing Stability	Childcare access and availability	Mental health or illness	Mental health or illness
2	Housing Stability (avg=19.08)	Healthcare access and availability	Healthcare access and availability	Food Stability	Food Stability	Housing Stability	Housing stability
3	Food Stability (avg=15.62)	Economic Stability	Childcare access and availability	Economic Stability	Mental health or illness	Food Stability	Health insurance coverage and affordability
4	Healthcare access and availability (avg=14.91)	Food Stability	Healthcare and service affordability	Mental health or illness	Employment Stability	Public and Personal Safety	Food Stability
5	Economic Stability (avg=13.21)	Public and Personal Safety	Healthcare workforce availability	Healthcare access and availability	Economic Stability	Healthcare access and availability	Healthcare access and availability

Mental health or illness was ranked #1 priority overall, on average, and was also ranked in the top 5 priority needs for all five geographic areas. Housing stability, food stability, and economic stability ranked #2, #3, and #5 overall, on average. These needs also ranked in the top 5 for four of the five geographic areas. Employment stability was a related societal factor need that was prioritized by respondents from Olivia. Finally, health care access and availability ranked #4 overall, on average, and ranked in the top 5 for four of the five geographic areas as well as respondents representing the HealthPartners system. Related health system factor needs of health care and service affordability and health care workforce availability also emerged in two geographic areas. No health system factor needs were prioritized in Olivia.

This analysis identified three *proposed* community health needs for the workgroup to review and approve. After workgroup member discussion, the following summary needs were developed:

1. Economic, employment, housing, food stability
2. Health care access, availability, affordability
3. Mental health or illness

The CHNA workgroup members met in three breakout groups representing our geographic areas: the Twin Cities metropolitan area, West Central Minnesota, and the St. Croix Valley (including eastern Minnesota and western Wisconsin) to interpret and discuss their local results. We then met as a full CHNA workgroup to reach consensus on priority health needs. Key insights from that discussion included:

- **Mental health or illness** is a large need area. Within this, the workgroup would like to explore substance use disorders, the relationship between societal and individual factors and mental illness, and how specific populations are impacted by mental health or illness. The workgroup would also like to better understand the work already happening to address mental health or illness in order to identify HealthPartners' role within this need area. The workgroup would like to call this **Mental Health & Well-being.** This was also the language used in the last CHNA cycle.

- **Economic, employment, housing, food stability** are all interconnected and the specific needs may vary by geographic region. The workgroup would like to group these needs as **Social Drivers of Health** until we better understand local needs through our CHNA process, but we will center the four needs prioritized by our communities in this phase. In addition, we will consider adding childcare to this need area as this emerged as a priority need in some of our geographic areas. Last cycle, this need area was called Access to Health, and workgroup members recalled needing to explain this language during community engagement.

- The need for **Health care access, availability, affordability** was confirmed by the CHNA workgroup members, but there was a proposal to call this need **Access to Care** to be clearer to the general public in the next phase of community engagement. This was also the language used in the last CHNA cycle.

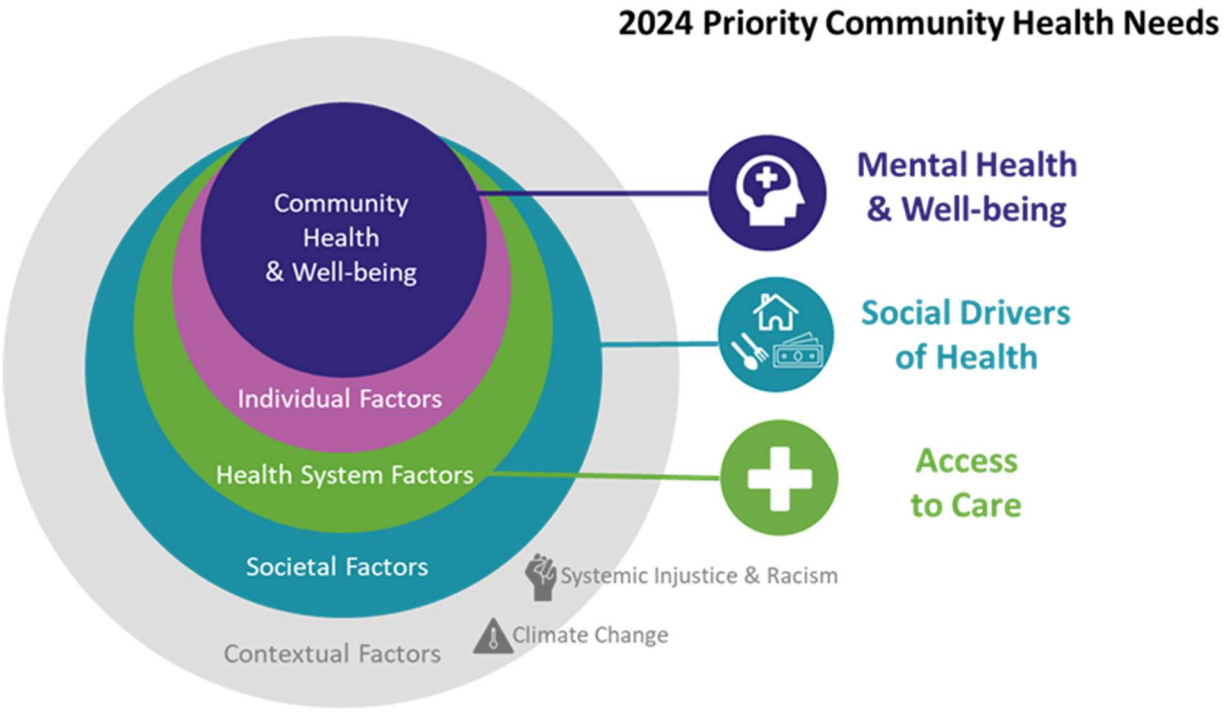


Figure 4. Approved Priority Community Health Needs, Spring 2024

CHNA Process

After identifying three shared HealthPartners priority health needs, we conducted our Community Health Needs Assessment for each hospital. Here, we describe the state of each prioritized need for the Regions Hospital community, inclusive of all individuals who live in Ramsey County:

- Mental Health & Well-being
- Social Drivers of Health
- Access to Care

To design an implementation plan that is responsive to the unique local needs, **we first must understand – both through existing quantitative data and the experiences and perspectives of those who live, work and play in the community – what's happening and how the community feels about it.**

Community Health Needs Assessment Approach

To conduct our CHNA, CESR developed a mixed-methods approach that gathered existing and new quantitative and qualitative data and interpreted data with local experts to ensure this report reflected the lived and professional expertise of the community. Much of this methodological approach mirrored the prioritization process and relied heavily on the meaningful contributions and partnership of the HealthPartners CHNA workgroup.

Quantitative Data. Throughout this section, you will find detailed quantitative data to describe each prioritized health need. Data includes county-level public health data that was available for each county served by our health system. This ensures our CHNA report captures the needs of those "medically underserved, low-income, or minority populations who live in the geographic areas from which it draws its patients," as required by the federal guidelines.[27] In addition, we include our own health system's patient data and survey data captured by the HealthPartners Institute to measure community initiatives. When possible, we also present the unique experiences or outcomes by subpopulations or identities, including race or ethnicity, gender, age group, and others. We also partnered with our CHNA workgroup members to identify local data sources that can help describe these community needs. Throughout the report, we seek to display data in ways that are meaningful and easy to interpret.

Qualitative Data. Our CHNA relies heavily on qualitative data gathered through Community and Internal Stakeholder Conversations and other engagement activities. Here, we sought to center local perspectives on a prioritized need, understand how the need impacts individuals residing in the county, and describe what work, if any, is being done at present to address this need. We also asked these stakeholders to inform our inclusion of quantitative data indicators and identify additional data sources to better describe the need with relevant data.

A common facilitation guide was created and used. The guide included instructions for facilitators and notetakers for the discussion. Facilitators could focus the conversation on one to three of the prioritized community needs, depending on the length of the meeting and the expertise and interests of the group gathered.

Specific discussion questions included:

1. Please introduce yourself and share in three words what first comes to mind when I say "[insert prioritized need]."
2. [After reviewing drafted definition of need] In your experience, what's **missing from this definition**?
3. Where do you go to learn more about this need? What **sources of information** do you know about?
4. What **current work** is happening to address this need? What is going well?
5. What are the **gaps** in resources that need to be addressed? What would make it better?

In addition, CHNA workgroup members attended other community meetings and took notes on a template designed to align with our CHNA priority questions. This data source allows our CHNA to include more local priorities and voice while minimizing the time and burden of contributing to other data collection strategies.

Summary of Community and Internal Stakeholder Engagement

CHNA workgroup members in Ramsey County held three Community Conversations and attended one community meeting, connecting with approximately 60 individuals in total. These individuals represented various stakeholder groups, including mental health advocates, non-profit leaders, the Regions Patient and Family Advisory Council, and the Regions Health Equity Committee.

A CHNA Liaison also engaged internal stakeholders and subject matter experts during twelve Community Conversations with more than 160 participants. These participants are part of several different groups, including advisory councils on community engagement and social drivers of health; colleague resource groups (LGBTQ+, Leaders of Color, Disability, and Black and African American); youth councils; health system leaders with insight on how mental well-being and access to care affect the HealthPartners' wider community.

Legend | Throughout this report we use different icons to highlight different topics and different types of data. Here is what they all mean:


Mental Health & Well-being (Priority 1)


Social Drivers of Health (Priority 2)


Access to Care (Priority 3)


This icon highlights data related to our Systemic Injustice & Racism contextual factor.


This icon highlights data related to our Climate Change contextual factor.


This icon calls out input collected from Community &/or Internal Stakeholder Conversations.


This icon calls out quantitative data from existing data sources.


This icon calls out HealthPartners Institute-administered survey results.


This icon highlights differences experienced by a specific subpopulation.

Mental Health and Well-being (Priority 1)

Mental health refers to a person's emotional, psychological, and social well-being, affecting how they think, feel, and act. It influences overall health and how one manages stress, builds relationships, and copes with life's challenges. Mental health can vary across the life span, based on factors including social connectedness, emotional resiliency and mental health conditions, such as depression or anxiety, that disrupt thoughts, emotions, and behaviors.

Factors contributing to mental health or mental health conditions can include biological and environmental factors, trauma, medical conditions, social drivers of health, or substance misuse. Reducing stigma helps ensure everyone can access the care and support needed to lead fulfilling lives and manage life's challenges.

Poor mental health may lead to poor quality of life, higher rates of chronic disease and a shorter lifespan. Communities[28] of color and low-income and rural communities experience disparities in mental health and well-being.[29-31] Underlying contextual factors such as systemic injustice, racism, and climate change also severely impact mental health and well-being through stigmatizing actions and discrimination and increasing stress and anxiety.[32,33]

Through the process described above, **Mental Health and Well-being was determined to be the highest priority community health need for the communities that HealthPartners serves**. This need is described in more detail below.

Factor 1: Social, emotional, spiritual, and physical well-being

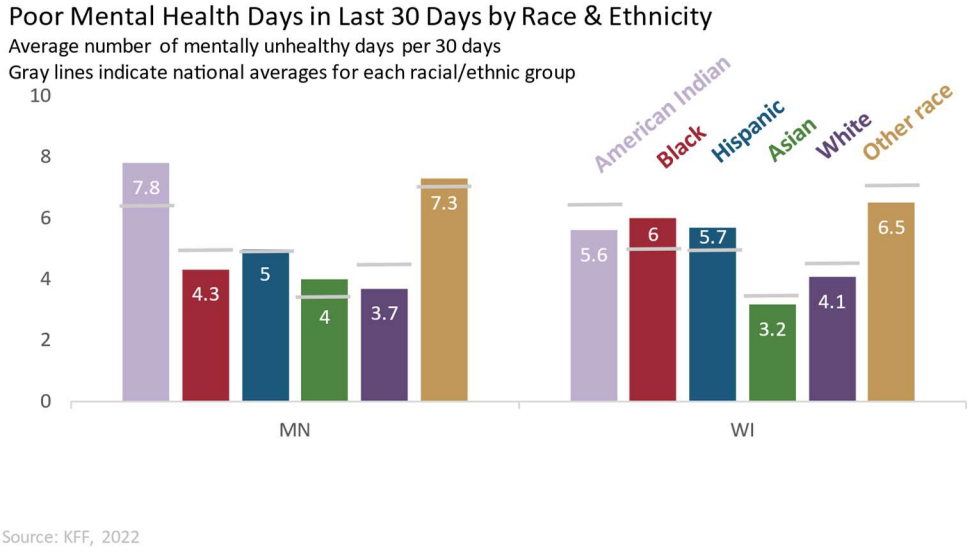
Mental health and well-being should be broadly understood as inclusive of emotional and social health. According to the Centers for Disease Control, about one in three adults in the United States feels lonely, and one in four lacks social and emotional support.[34] Social and emotional connection supports mental and physical health.

Overall, through CHNA engagement, we heard that **social isolation, sense of belonging, stress and trauma, community, and a reliance on social media** (for both news and information as well as social connection) are challenges affecting social and emotional health within the HealthPartners communities. **Building resiliency, self-care and healthy coping skills are important efforts** to combat these challenges. Some community members look to improve partnerships with schools to better support students around mental health and wellness.

In Ramsey County, community members emphasized the lingering impacts of the COVID-19 pandemic on community and sense of isolation, especially given our digital lives.

Minnesota adults report an average of **4.1 mentally unhealthy days** in the last 30 days, fewer than the national average of 4.8 days (County Health Rankings).[35]

Similarly, adults in Ramsey County report an average of 3.9 mentally unhealthy days in the last 30 days.



Source: KFF, 2022

There are **notable differences in reported mentally unhealthy days by race or ethnicity**, especially among American Indian Minnesotans and Black, Hispanic, and American Indian adults living in Wisconsin.

There is limited local, county-level data on social connections or social isolation. One measure – the number of membership organizations per capita – shows **Minnesota and Wisconsin residents having slightly more opportunities for social connection than the national average** (County Health Rankings).[35] Ramsey County had slightly fewer social connection opportunities (11.6 per 10,000 population) than the state average (12.4), though still higher than the national average (9.1).

Factor 2: Depression, anxiety, other mental health conditions

Throughout our CHNA engagement, we heard concerns from stakeholders that poor mental health and mental illnesses are affecting our children and young people at high rates, especially teen girls. During a community discussion, **students reported not feeling comfortable talking about their mental health with their parents for fear they will not understand or will minimize the issue**. For those taking care of young people, either in schools, clinics or other settings, it is important to try and understand how social drivers of health, such as housing instability, hunger or an unsafe home life (e.g., addiction, abuse), impact mental health. In general, education is needed to teach parents and adults how to talk to young people about mental health. It's also important to remember that there are **mental illnesses beyond depression and anxiety that are impacting our communities:** bipolar disorder, obsessive-compulsive disorder, schizophrenia, eating disorders, etc., should also be prioritized.

> Our communities are concerned about the mental health of our youngest community members, especially
>
> **teen girls**

In Ramsey County specifically, community members feel that mental health issues affect people of all ages and emphasized the importance of access to resources to improve and maintain mental well-being.

In 2022, nearly **1 in 4 Minnesota (23.6%) and Wisconsin (23.0%) adults had a depression diagnosis. This rate has continued to rise over time** but is similar to the nationwide prevalence of adults with depression (21.7%, BRFSS).[36]

Among HealthPartners adult patients with a visit in 2023 living in Ramsey County, 10.2% had a PHQ-9 score above 9, which represents moderate to severe depression.

According to the Health Trends Across Communities (HTAC) Dashboard, **19% of Minnesotans have depression**. Females are more likely to have depression (19%) than males (10%).[5] In Ramsey County, 16% of the population, 24% of American Indian residents, 20% of white residents, 12% of Black residents, and 12% of Hispanic/Latine residents have depression.

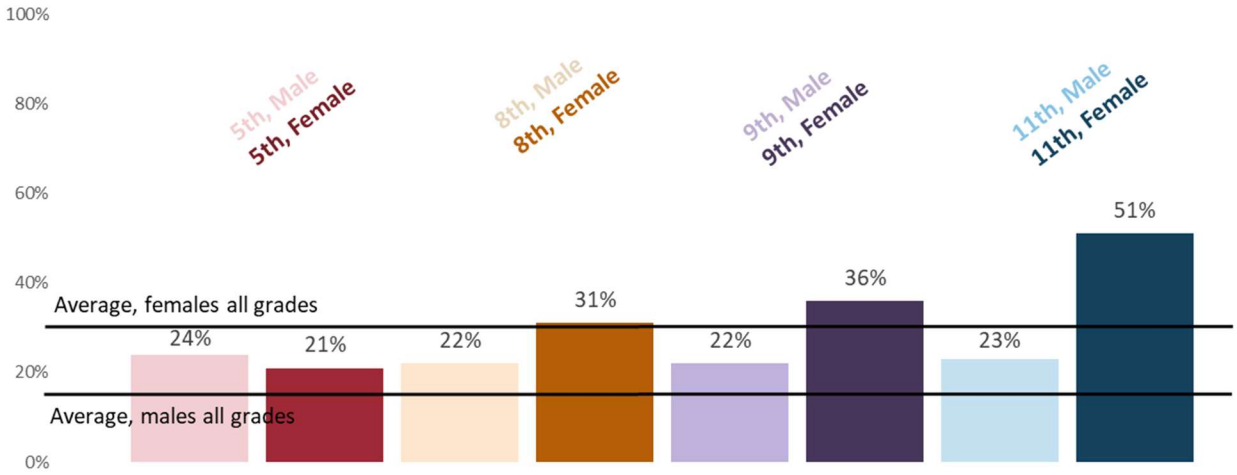
In addition, **19% of Minnesotans have anxiety**. Females are more likely to have anxiety (24%) than males (14%).[5] In Ramsey County, 20% of residents have anxiety. This includes 28% of American Indian residents and 26% of white residents.

Finally, **1.5% of Minnesota adults have suicidal ideation**, including 4% of our American Indian community members. The rate ranges from 1% to 2% in each of our HealthPartners counties.[5]

This need deeply **impacts young people**. Across the Minnesota counties HealthPartners serves[21]:

- When asked if they had ever been treated for a mental, emotional, or behavioral problem, **11th grade female students** were most likely to say they have compared to other grades and genders.
- Between 8 and 50% of students reported long-term mental health problems, with females reporting more.
- Among surveyed students, 0 to 28% reported they seriously considered attempting suicide in the last year. This is similar to results of the 2019 survey (0 to 27% of students). [37]

Percent of Students who have been Treated for Any Mental Health Problem, Ramsey County
Mental health, emotional health, or behavioral health

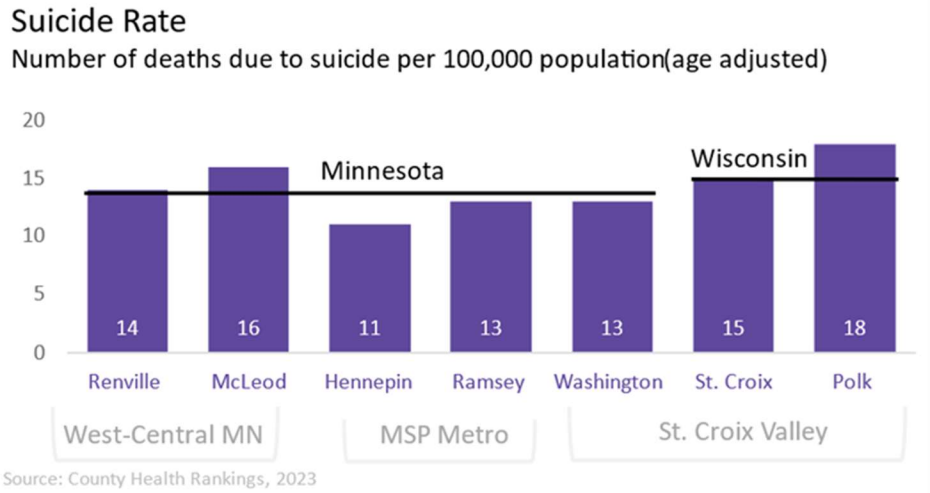


Source: Minnesota Student Survey, 2022

Direct exposure to a climate-related disaster, such as a drought or a flood, can lead to mental health conditions including anxiety, depression, and post-traumatic stress. Even people who have not been directly affected by a disaster are experiencing anxiety and dread related to climate change. Climate-related distress is particularly prevalent in young people.[38,39]

Nationwide, suicide rates have increased more than 35% since 2000.[40] According to the CDC, Americans with higher-than-average rates of suicide include American Indian and Alaska Native people, white people, veterans, people who live in rural areas, LGBTQ+ communities, and workers in certain occupations including mining and construction.

Across the HealthPartners service area, the **suicide rate** among adult residents ranges from 11 to 18 deaths per 100,000 population (County Health Rankings).[35] This is similar to the national average of 14.



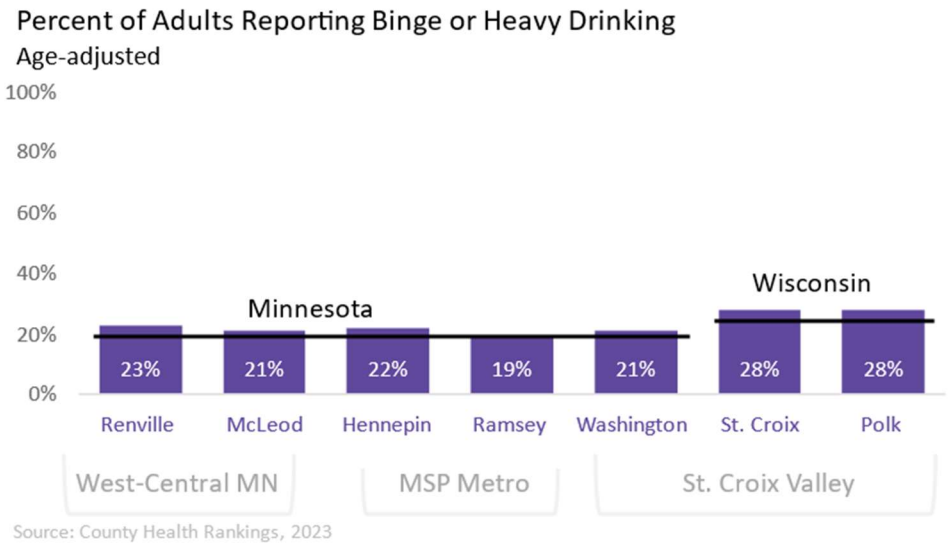
Factor 3: Substance misuse, substance use disorders

Alcohol and other substance misuse has well documented associations[41,42] with mental illness and alcohol is often used as a coping strategy among those with depression and/or anxiety. Communities of color, low-income, and rural communities are disproportionately impacted by aspects of substance misuse and substance use disorders.[43,44] Underlying contextual factors such as systemic injustice and climate change, as well as our other prioritized needs, Social Drivers of Health and Access to Care, have an impact on substance misuse and substance use disorders.

Stakeholders noted the increase in substance use during COVID-19 is still having effects on communities, and they are particularly concerned about rates of substance use among youth. During one conversation, teenagers discussed how substances are often used as a coping mechanism for other mental health problems. Other community members also called out the relationship between substance use and other mental health issues.

These themes are in line with what community members in Ramsey County shared. Specifically, community members confirmed the relationship between substance use and mental health, and discussed concerns about how the legalization of marijuana may further this concern.

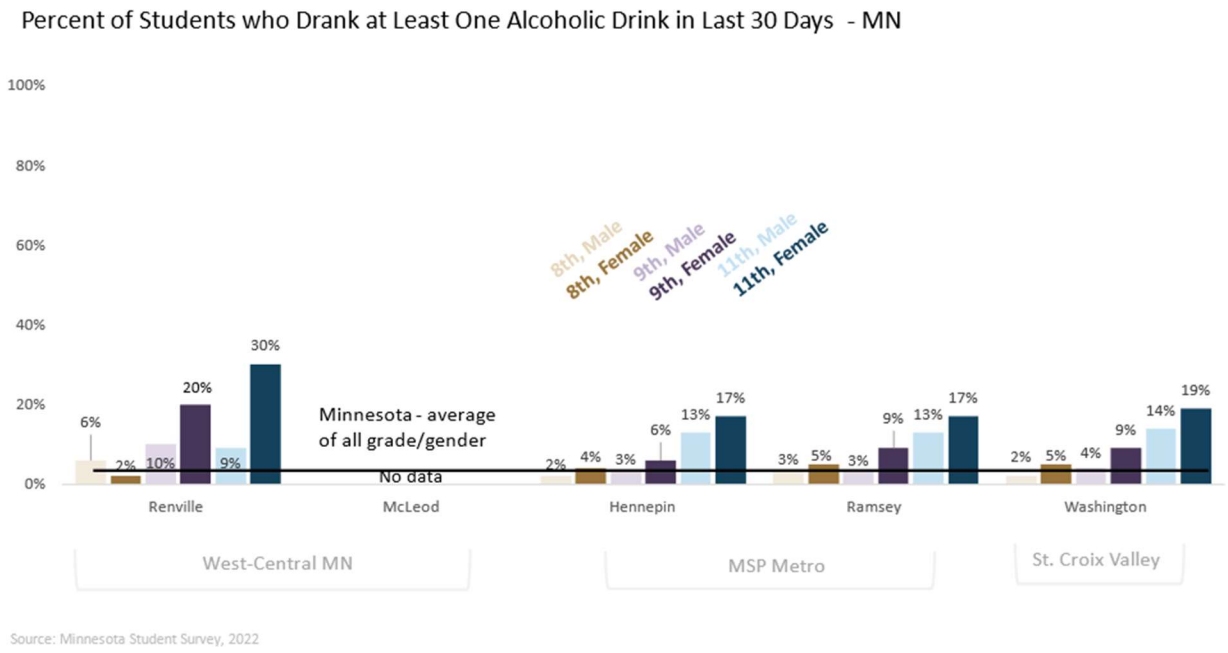
Across the counties HealthPartners serves, between 19 and 28% of adults report binge drinking, with Wisconsin counties being notably higher than Minnesota counties (County Health Rankings). Both states are above the national average of 18%.



Overall, 3% of Minnesotans have an alcohol use condition.[5] The American Indian community is disproportionately impacted, with **8% of American Indians living with an alcohol use condition statewide**. In Ramsey County, 3% of adults have an alcohol use condition, including 11% of American Indian residents, 4% of Black residents, and 4% of white residents.

A study on the impacts of **structural racism on mental health and alcohol use** found that Hispanic/Latino participants used alcohol to cope with low mood due to structural barriers, experiences of discrimination, and stigma.[45] Another study on the connection between racism and substance use found that historical trauma and chronic race-based stress were contributing factors to substance misuse among American Indian people.[46]

In Minnesota, 10% of all students report using alcohol in the last 30 days, including 16% of 11th grade males and 19% of 11th grade females (Minnesota Student Survey).[47] This is a decrease from 2019, when 22% of 11th grade males and 24% of 11th grade females reported the same alcohol use.[37]



According to Health Trends Across Communities (HTAC),[5] 1% of all Minnesotans use **opioids** but there are notable disparities by race and geography. Six percent of the American Indian and Alaska Native population use opioids statewide, with 13% of American Indians living in Hennepin County and 8% in Ramsey County using opioids.

historical trauma and chronic race-based stress contribute to substance misuse among American Indian communities

According to the Minnesota Department of Health,[48] there were 4,349 opioid-involved emergency room visits in Minnesota in 2021. This includes 611 visits in Ramsey County. There were 978 opioid overdose deaths in Minnesota in 2021, and the **opioid crisis disproportionately impacts communities of color**. The opioid overdose death rate among American Indian residents was 192 per 100,000 residents in Minnesota, compared to 19 among white Minnesotans.

Extreme heat has been associated with increases in irritability, aggression, alcohol and substance use, mental health-related hospital visits, and suicide rates. Additionally, certain psychiatric medications can interfere with a person's ability to regulate heat, leading to an increased risk of heat-related illness.

Factor 4: Stigma experienced by people with mental illness

Stigma is a set of negative beliefs, often based on misinformation, that a society has about mental illness. Make It OK is a campaign supported by HealthPartners to reduce mental illness stigma in communities we serve. (MakeItOK.org).[49]

CHNA community engagement conversations about stigma varied based on the community. Overall, we heard that stigma is present, pervasive and that it can prevent people from reaching out for help. Teens feel comfortable talking with each other about their mental health, but don't feel comfortable talking with their parents and believe their **parents would not feel comfortable with them seeking help from a therapist.** We also heard that **stigma can be experienced around mental health not just mental illness** and prejudice prevents people from seeking care.

Community members in Ramsey County shared similar themes and reported that stigma, shame, and embarrassment are barriers that keep people from seeking mental health care. In particular, community members raised concerns about stigma within the Hmong community, especially among parents of youth with mental health challenges.

As part of the Make It OK evaluation, HealthPartners conducts the IMPACT survey, surveying members in selected communities about mental illness stigma. In 2021, 57% of surveyed community members agreed there are **negative impressions, stereotypes, or stigma about mental illness** in their community. This is a significant decrease from 63% in 2019.[50]

Thirty percent of IMPACT survey respondents reported they would be at least **somewhat reluctant to seek mental illness care**, with little variability between counties. Across all counties, **people of color** were more reluctant to seek mental illness care than those who identified as white. **Men** were also more reluctant to seek mental illness care than women. People who have never received mental health care were also more reluctant to seek care than those who have in the past. Those who perceived stigma in their community, however, were no more reluctant to seek mental illness care than those who did not perceive community stigma.[50]

Additional Factors: Mental Health and Well-being

There were a few additional themes we heard throughout our CHNA engagement that are important to include, as well as callouts to work being done to improve mental health and well-being throughout our service areas. The HealthPartners programs Little Moments Count and Make It OK are two initiatives working to improve mental health and well-being system wide. Little Moments Count works to build attachments between children ages 0-3 and caregivers and brings awareness to how family dynamics impact well-being. Make It OK works to reduce the stigma around mental illness and conducts trainings that have been very well attended.

In Ramsey County, community members emphasized that mental health, physical health, social health, and emotional health are all interconnected, and that it is hard to address one area without understanding the others.

Social Drivers of Health (Priority 2)

Social drivers of health are the community and environmental conditions that affect health and well-being. They include adequate and secure income, housing, food and nutrition, employment and work, education, transportation, access to childcare and interpersonal safety. They also include a sense of belonging, the natural and built environment and climate impacts.

These social drivers of health do not exist in isolation and often interconnect, overlap, and contribute to other community health needs, including Mental Health and Well-being and Access to Care.

Communities of color and low income and rural communities disproportionately experience more health-related social needs.[51-53] Poor health is due in part to structures and systems that create systematic biases against people of color. In addition, social drivers and social needs are connected to structural and systemic inequities that create and maintain poverty in communities of color. Through this CHNA, **Social Drivers of Health was determined to be the second highest priority community health need** for the communities that HealthPartners serves. This need varies by community and is described in much more detail below.[54]

Factor 1: Economic & financial security

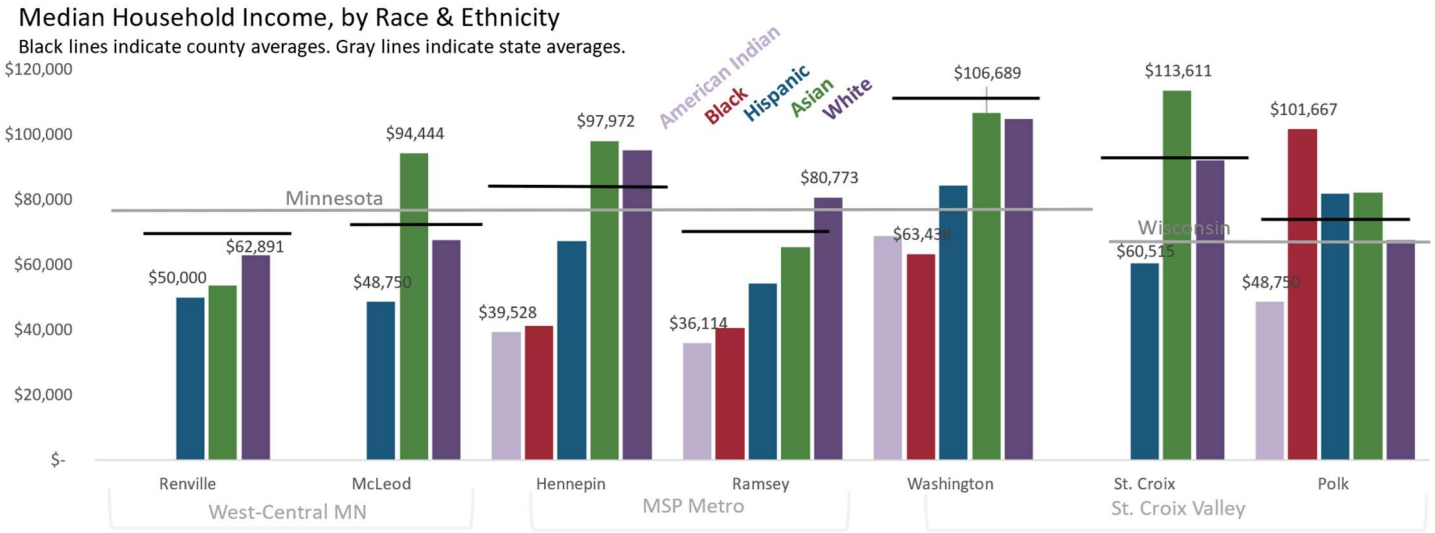
Financial insecurity is the inability of individuals or families to sustainably afford their essential needs. This can be observed in expenses exceeding income and can be experienced by anyone at or below federal poverty levels.[55]

Throughout our CHNA engagement, we heard that economic security goes beyond whether someone has a job, and it is important to have a holistic view of financial security. Economic security can also look different across geographic areas; for example, a rural community may be more dependent on a single employer, like a factory, than an urban community. The level of savings is a factor in financial security.

In Ramsey County specifically, community members shared that many people cannot keep up with the cost of living and must make difficult choices to get by; they feel that public benefits have old thresholds that are not sufficient to provide meaningful support.

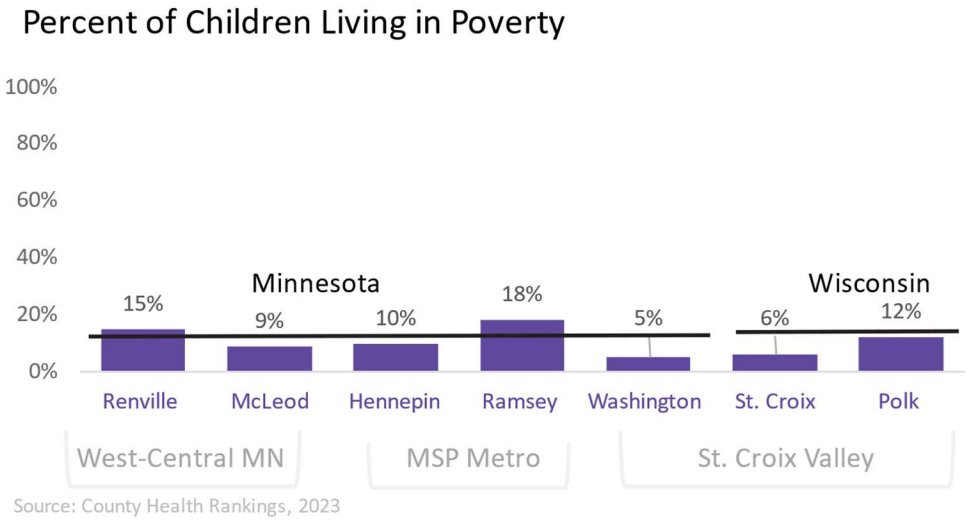
In 2022, the median household income in Minnesota ($82,338) was higher than the national average of $74,755.[56]

There are notable differences by geography and race or ethnicity. Among HealthPartners counties in Minnesota, the lowest median household income is in Renville County ($66,313) and the highest is in Washington County ($106,509).



The federal government calculates an income threshold by family size, adjusted for inflation, to determine if that family is considered in poverty and would qualify for various government support programs.[57] The counties served by HealthPartners are not immune from poverty. **Nearly one in ten adults in our service area live in poverty**.[56] Childhood poverty rates are even higher.

The adult poverty rate in Ramsey County is 13.8%, notably higher than the Minnesota state average of 9.6%. The childhood poverty rate is 18%, also notably higher than the state average of 11% and slightly higher than the national average of 16%. Of note, **37% of Black or African American children, 32% of American Indian children, and 30% of Asian children** in Ramsey County live in poverty.[35]



Source: County Health Rankings, 2023

Low-income community members are more likely to live in areas with greater exposure to climate disaster. Neighborhoods with higher poverty rates have greater concentrations of air pollutants like PM2.5 and ozone, experience increased temperature mortality impacts, and are more likely to live in flood zones.

Additionally, climate disasters impose financial challenges for community members, particularly those with lower incomes and the farming community.[58] Examples include lost earnings due to business closures or unsafe working conditions, limited access to public benefits programs and childcare, property damage with delayed or incomplete repairs, and higher prices for energy and consumer goods.

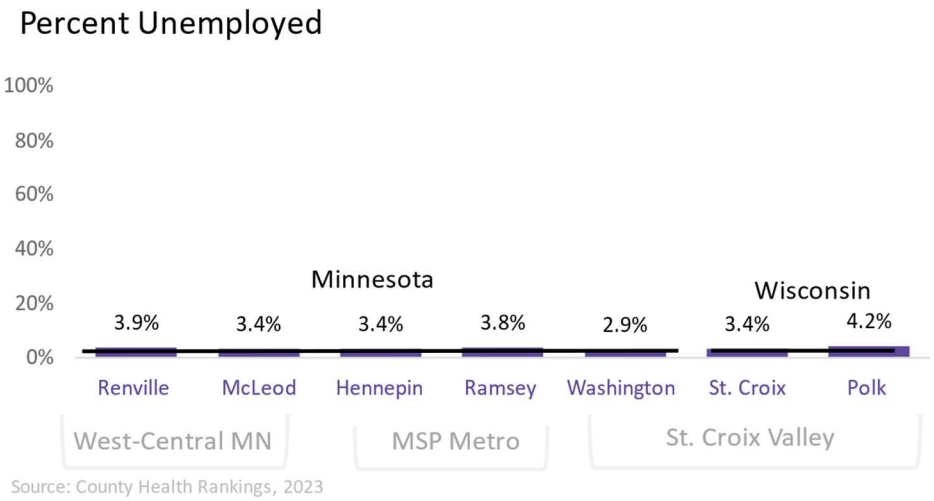
Factor 2: Employment security

Employment security can be defined as living without the fear of unemployment and the consequences of being unemployed, such as facing housing or food insecurity.[59] Employment, including *un*employment and *under*employment, impacts a community's health and well-being.

This was echoed during community and internal stakeholder engagement, where we heard that underemployment is an important indicator of employment security, along with unemployment, and should be prioritized when seeking to understand a community's employment security.

Community members in Ramsey County emphasized that there are ongoing challenges facing small-business owners and entrepreneurs in the post-pandemic economy. Some mentioned concerns about new immigrants being unable to legally work to support themselves and their families.

In 2023, unemployment was relatively low (under 5%) across all counties served by HealthPartners.[35] The national unemployment rate during the same time period was 3.7%.



Source: County Health Rankings, 2023

Community members can experience income loss when extreme weather causes businesses to close or creates unsafe conditions for workers. Outdoor workers, including those working in agriculture, are particularly susceptible to income loss due to extremes in weather and temperature.[60] These workers are more likely to be lower-income and people of color. Prolonged exposure to extreme weather conditions can affect workers' job performance, which can also result in a reduction in income.

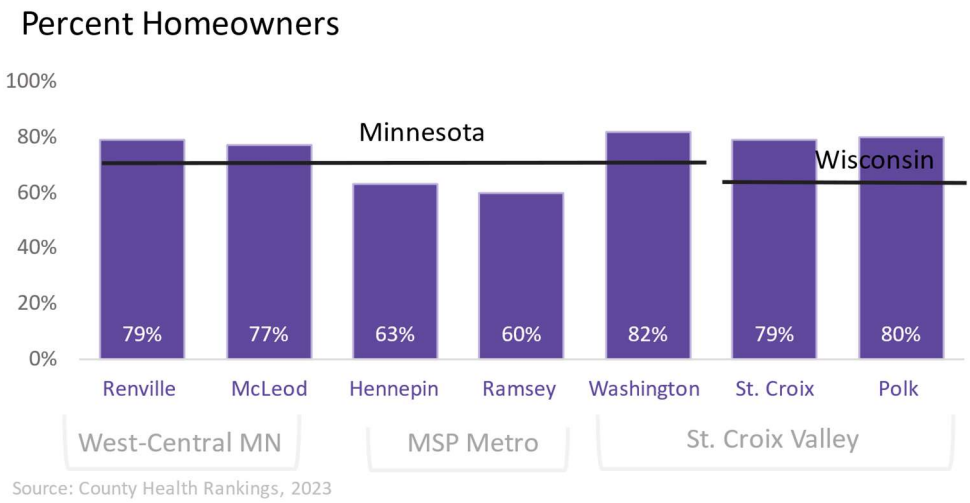
Factor 3: Housing security

Housing insecurity is when individuals and families lack the ability to access or maintain safe housing due to high housing costs relative to income, poor housing quality, unstable neighborhoods, or overcrowding.[61,62]

When discussing this topic with systemwide stakeholders, we heard that it is important to consider people who are **unhoused, unstably housed, and renting** when thinking about housing security. The burden of housing expenses on a household is also a meaningful indicator.

In Ramsey County, community members emphasized the impact of our two contextual factors: Systemic Injustice and Racism and Climate Change. For example, the history of redlining and racial segregation continues to impact housing trends in Ramsey County. In addition, climate change has a greater impact on community members in lower-cost areas with less shade. Community members also talked about ongoing issues with housing shelters in Ramsey County, including workforce shortages and resulting service disruptions.

According to the 2023 County Health Rankings,[35] 65% of housing units were owner-occupied in the United States. In Minnesota, 72% of housing units were owner-occupied. Homeownership in Ramsey County is 60%, lower than the statewide rate.



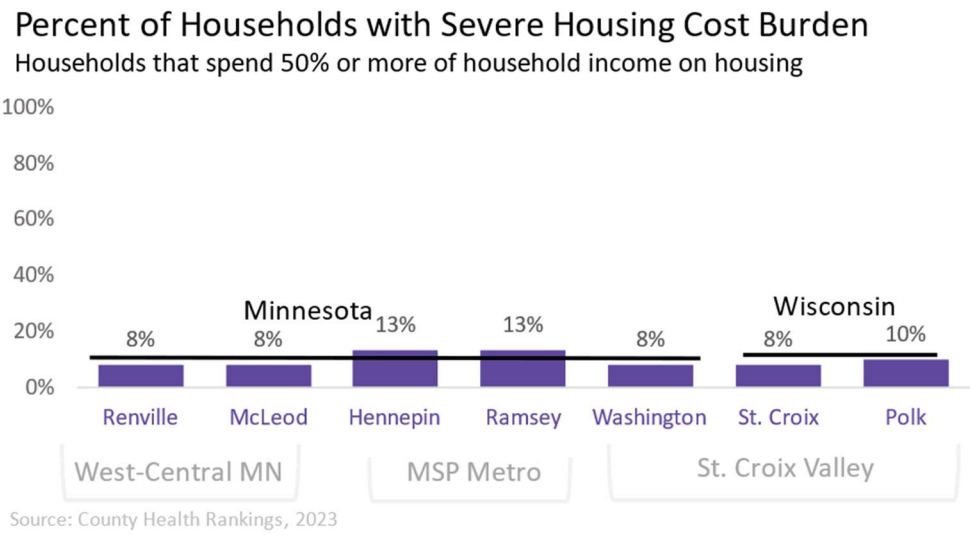
Source: County Health Rankings, 2023

There are notable differences in home-ownership by race and ethnicity across Minnesota.[63]

- In 2022, 44% of American Indian Minnesotans owned their home.
- 64% of Asian Minnesotans
- 29% of Black Minnesotans
- 49% of Hispanic/Latine Minnesotans
- 77% of white Minnesotans

Nearly one in three American households (32.5%) spend **over 30% of their income on housing**, which makes them "cost burdened." In Minnesota, nearly one in four households (23.8%) are cost burdened.[63] In Ramsey County, 31% of households are cost burdened.

Nationally, 14% of households spend **50% or more of their household income on housing**, which means they experience "severe housing cost burden" (County Health Rankings).[35] The rate is lower in both Minnesota and Wisconsin (11% of households for each state). Metropolitan counties of Hennepin and Ramsey have slightly higher severe housing cost burdens (13% in each county) than other counties in the HealthPartners service area.



County Health Rankings also reports the percentage of households that have severe housing issues.[35] In both Minnesota and Wisconsin, **13% of households meet this definition of having a severe housing issue**, which is lower than the national average of 17% of households. More (17%) households in Ramsey County have a severe housing issue.

13% of households face **severe housing issues** including overcrowding, high cost, lack of kitchen, or lack of plumbing

Lower-income families also struggle to pay rent. The median gross rent,[64] per month, for each county in our service area is:

- $652 in Renville County
- $724 in McLeod County
- $1,176 in Hennepin County
- $1,060 in Ramsey County
- $1,329 in Washington County
- $1,036 in St. Croix County
- $691 in Polk County

According to Housing Link's rental market data, rental vacancies in Hennepin County are not affordable for households earning less than half the median income.[65] For reference, the median household income in Hennepin County in 2023 was $93,668.[66]

In Central Minnesota, including Renville and McLeod counties, 97% of private market vacancies in 2022 were affordable. There were 5,603 publicly funded affordable rental units subsidized in this region, and 868 Section 8 housing choice vouchers available for regional residents.

In contrast, just 60% of these vacancies were affordable in the Twin Cities metropolitan area, including Hennepin, Ramsey, and Washington counties.[65] There were 87,796 publicly funded affordable rental units subsidized in this region, and 23,306 Section 8 housing choice vouchers available for regional residents.

Too many people in our community experience homelessness. According to the United States Interagency Council on Homelessness, affordable housing shortages, wages that do not keep up with the cost of living, failed social safety nets, and inequitable access to education, health care, and economic opportunity all contribute to homelessness.[67] In the State of Homelessness report by the National Alliance to End Homelessness, 8,393 Minnesotans (15 per 10,000 residents) and 4,861 Wisconsinites (8 per 10,000 residents) experienced homelessness on a given night in 2023.[68]

According to the 2023 Minnesota Homeless Study conducted by Wilder Research, even more people (10,522) were experiencing homelessness in Minnesota on a single night in 2023.[69]

- 191 people in Southwest Minnesota experienced homelessness last year.
- 3,897 people in Hennepin County experienced homelessness last year. More than one third of these individuals are Black (1,212 people), and a disproportionate number are American Indian (319 people).
- 1,661 people in Ramsey County experienced homelessness last year. Nearly half of these individuals are Black.
- 696 people in the Suburban Metro Area Region experienced homelessness last year.

People experiencing homelessness are more vulnerable to extreme heat events and poor air quality, due to increased exposure to the elements and higher rates of health conditions. Community members living in substandard housing, housing without air conditioning, or those who struggle to pay their electricity bills are also more vulnerable to extreme heat.

People living in substandard housing are also more vulnerable to flooding events. These homes are more likely to be located in flood-prone areas and are more susceptible to damage.

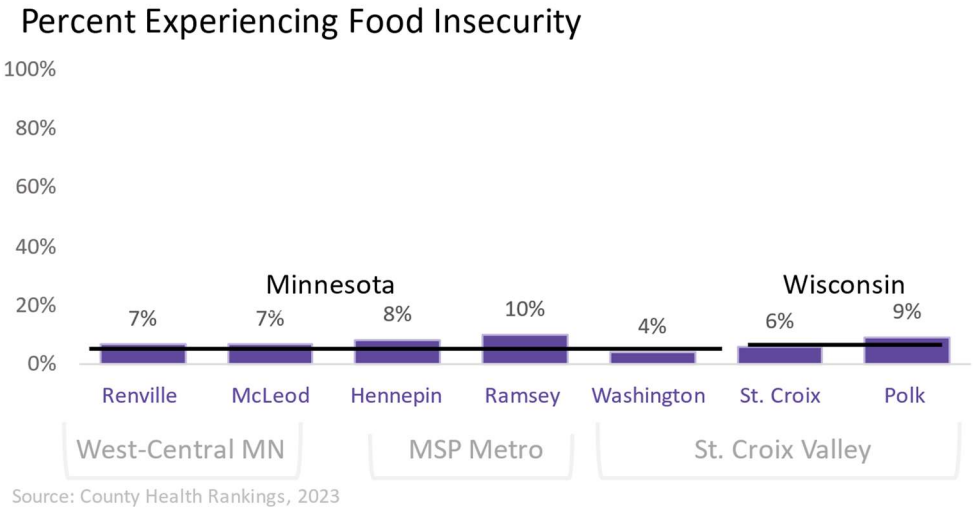
Factor 4: Food & nutrition security

Food and nutrition security is consistent access to enough food for an active, healthy life. This includes access to healthy foods and grocery stores. People living in food insecure households face a number of barriers to eating healthy that make them vulnerable to diet-related chronic diseases, including obesity, diabetes, hypertension, and heart disease. Food insecurity is influenced by factors including income, employment, race/ethnicity, and disability. Food insecurity is thought to play a role in poor health outcomes and rising health care costs.[70]

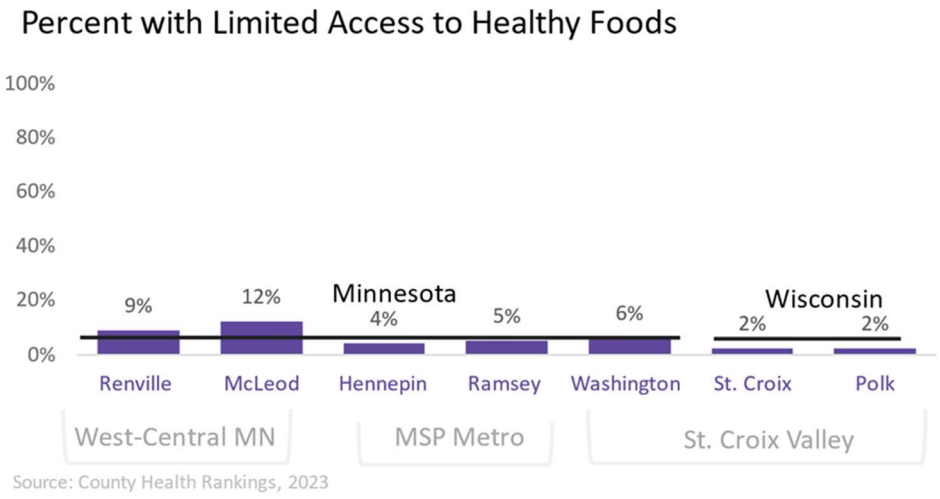
CHNA community engagement showed that access to nutritious food varies across HealthPartners communities, and food deserts are an issue in multiple areas. Stakeholders also felt that what it means to have adequate access to healthy foods needs to be better defined and understood.

Community members in Ramsey County expressed a particular concern about the rising cost of food and the limited access to nutritious food in food deserts within the county.

In 2023, 10% of Americans experienced food insecurity. **Between 4 and 10% of people in counties HealthPartners serves reported not having adequate access to food**, including 7% of Wisconsinites and 6% of Minnesotans (County Health Rankings).[35]



In addition, many of our community members have **limited access to healthy foods**. Rates in Minnesota (6%) and Wisconsin (5%) are similar to the nationwide average (6%). Among HealthPartners service areas, McLeod County faces the greatest limitations, with 12% of residents having limited access to healthy foods.[35]



In 2022, Minnesota middle and high school students were asked if they had to skip a meal in the last 30 days because their family did not have enough money to buy food.[21] Statewide, less than 4% said yes and in Ramsey County, 3-5% of students said yes.

Climate change and extreme weather threaten nearly every component of food security. Potential impacts include decreases in food availability or quality, disruptions to food distribution, increases in food costs, limited access to culturally relevant food, and increases in risk to farmworkers' safety.

Hunger Solutions Minnesota[71] supports food shelves throughout the state. In 2023, there were 7,551,147 visits to a food shelf in the state, which marks a 76% increase from 2022. Ramsey County saw a 24% increase in food shelf visits between 2022 and 2023.

According to a 2022 Ramsey County Food Assessment Report,[72] measuring community hunger and food insecurity is challenging, but intentional efforts to support food security includes administering the SNAP program. Significant inequities remain. In Ramsey County in 2021, 5% of white residents received SNAP benefits, compared to 42% of Black residents, 29% of Asian residents, 19% of American Indian residents, 12% of Hispanic residents, and 12% of residents who identify as more than one race.

Additional Factors: Social Drivers of Health

Throughout CHNA engagement, we consistently heard that the social drivers of health are interconnected and affect our mental and physical health. We also heard some specific themes that did not fit into our priority needs factors, including how **transportation** and **childcare challenges impact community members.** Additionally, stakeholders described limited language assistance, geography, and stigma preventing some community members from accessing social support services.

Ramsey County community members shared that there is a lot of overlap and bidirectionality among social determinants of health; they are hard to separate. In particular, they emphasized the language barriers experienced by community members who speak a language other than English. To improve the housing security, Ramsey County mental health case workers are piloting efforts to better connect unhoused residents with information about housing resources and availability. In addition, the City of St. Paul is working toward a guaranteed basic income for city residents.

As a system, HealthPartners has several internal groups (Social Determinants of Health Advisory Council), programs (Little Moments Count, Make It OK, PowerUp), and external partnerships (Open Arms, Habitat for Humanity, American Red Cross) working to understand and improve the social drivers of health for our communities.

> "Lack of affordable childcare is driving people to not work and then they can't afford food."

Childcare emerged as a priority theme through stakeholder engagement. **The cost and availability of childcare impacts young families throughout our service area**. The average monthly cost of childcare in Minnesota is $880 per child.[73] In Wisconsin, the average monthly cost for infant care is $769 and preschool care is $722.[74] Costs also vary widely within our service area. In Ramsey County, the average monthly cost of childcare is $1,040.[73]

Availability of childcare also varies throughout our communities. Minnesota has an average of 60 available childcare slots per 100 children aged five and under.[75] In Wisconsin, there are 14 available childcare slots per 100 children under 14.[74] In Ramsey County, there are 47 available childcare slots per 100 children aged five and under.

Another community health need that emerged in community conversations was **access to transportation,** as that can result in missed care as well as limit access to opportunities for physical activity, healthy food, and/or social connection.[76] Across the United States, 8.2% of adults lack reliable transportation. [77] In Ramsey County, 7.9% of adults lack reliable transportation.[77]

Access to Care (Priority 3)

Access to Care means having equitable access to convenient, affordable, safe, culturally responsive and high-quality health care. It includes a care experience where people feel like they are seen, heard, known and treated as a partner in the process, without bias. Access includes factors such as the cost of care and insurance coverage, medical transportation, care coordination, navigation, and use of technology. It means simplifying the complex health care system to be more understandable and accessible for all.

Communities of color, low income, and rural communities, and members of the LGBTQ+ community experience disproportionate barriers to accessing care.[78-80] Underlying contextual factors such as systemic injustice and racism impact access to care.

Access to Care is our third priority community health need and is described in much more detail in the following pages.

Factor 1: Coverage, health insurance, cost of care

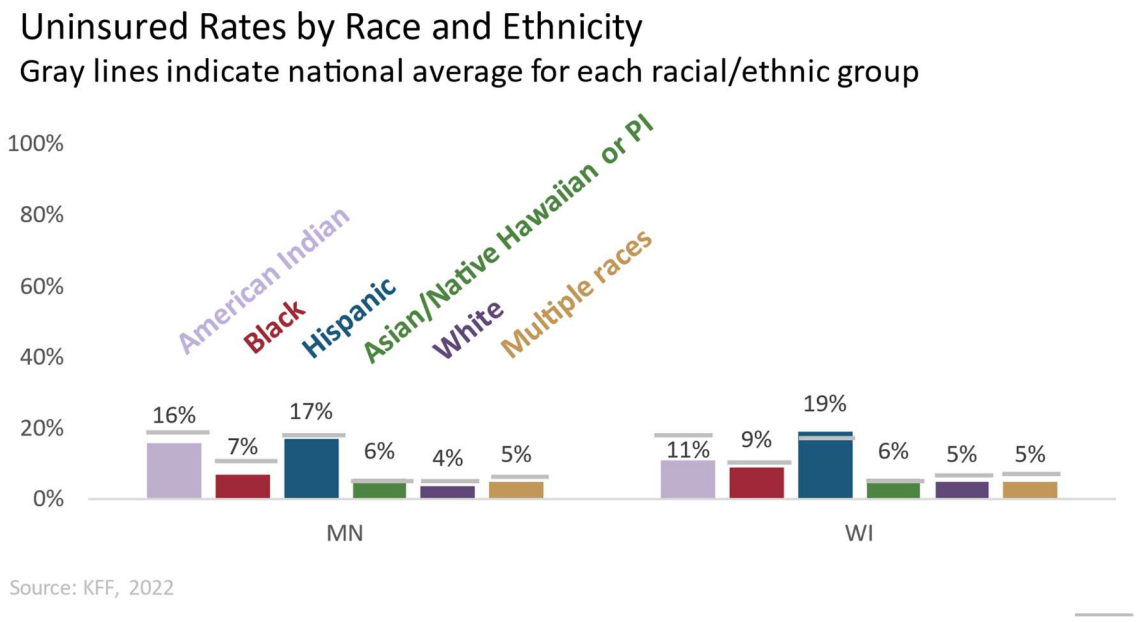
Both insurance coverage and cost of care can affect someone's ability to access health care services. Research suggests that **having insurance coverage is associated with reduced mortality**.[81]

Overall, through CHNA engagement, we heard that the cost of medical care is high, and patients do not always know or understand how they can access insurance or what their insurance covers. Even when patients have insurance, it does not always cover the care needed, or high deductible plans make getting care too expensive.

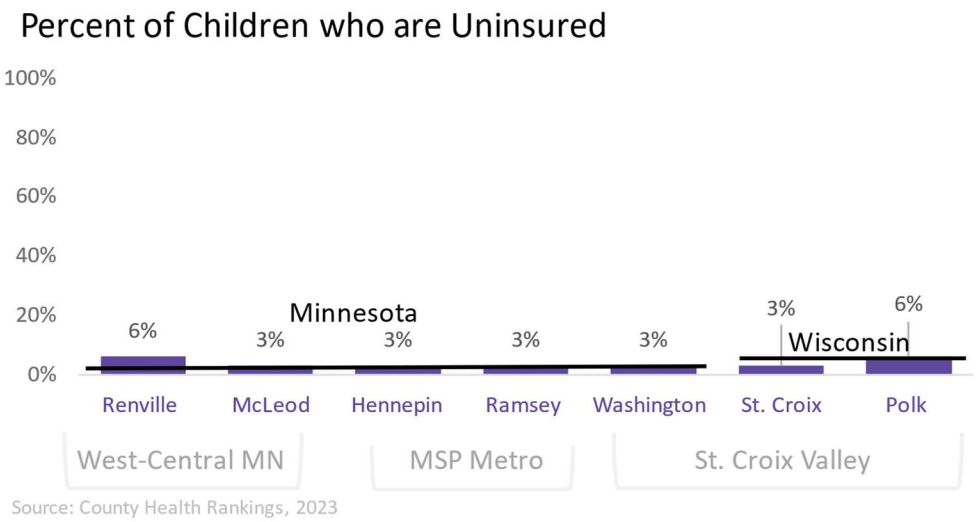
In Ramsey County specifically, community members are concerned about the unique challenges facing young people who are less likely to have insurance through their jobs. They also spoke about the cost of care and medication not being considered by providers. They identified an opportunity to better educate patients on the cost of care and how to advocate for themselves.

Across all counties HealthPartners serves, there were similar rates of uninsured adults and children compared to Minnesota and Wisconsin as a whole.[35] **All counties HealthPartners serves had adult uninsured rates lower than the national average of 12%.**

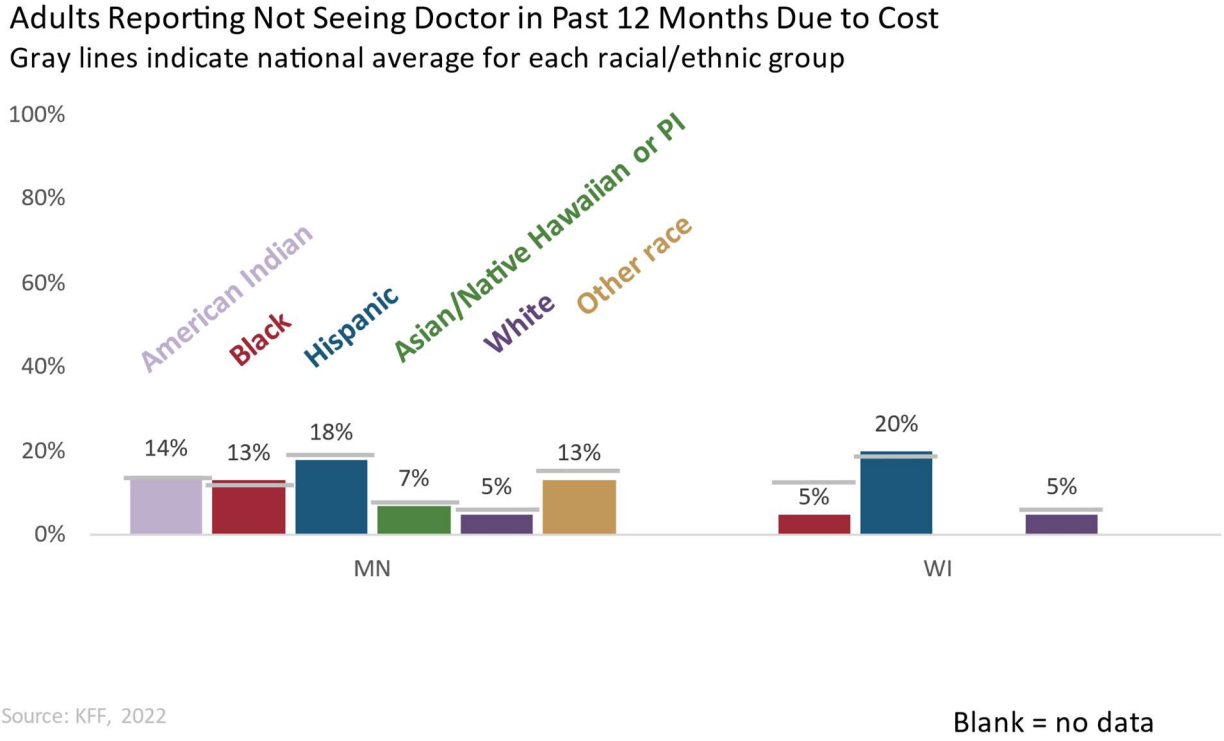
In Minnesota, data shows a large disparity for insurance coverage for Hispanic adults under age 65 (17% uninsured) and American Indian adults (16% uninsured) (KFF 2022).[82]



Across the country, 5% of children are uninsured. The rate is lower in both Minnesota (3%) and Wisconsin (4%). Of note, 6% of children in both Renville County and Polk County are uninsured.[35]



Many of our community members report choosing not to see a doctor in the past 12 months due to the cost of care. In Minnesota, 6% of all adults, including 18% of Hispanic adults, and 14% of American Indian adults did not see a provider due to cost.



In Minnesota, 9% of children are in families who had **trouble paying medical bills** in the past twelve months. This is the same as the national average (KFF 2022).[82]

Individuals without health insurance experience higher rates of temperature-related mortality impacts.[14]

Factor 2: Availability and timeliness of care, services, workforce

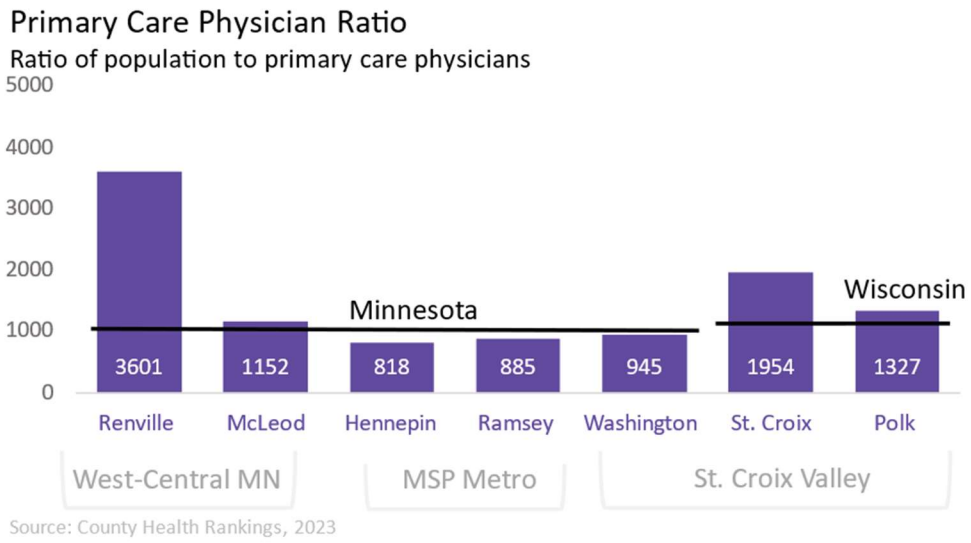
Availability of care includes availability of care providers, timeliness of appointment availability/care delays, availability of special services, availability of bilingual staff, interpreters and culturally appropriate care. Availability of care is impacted by workforce shortages, which vary by geography and by specialty.

Through CHNA engagement overall, we heard that more providers are needed across the HealthPartners service areas, and a broader representation of race, ethnicity, and physical abilities was called for. Health care systems are very difficult to navigate for many patients, so care coordination is a huge benefit when available. Finally, telehealth is seen as increasing access to health care, though this can still be improved.

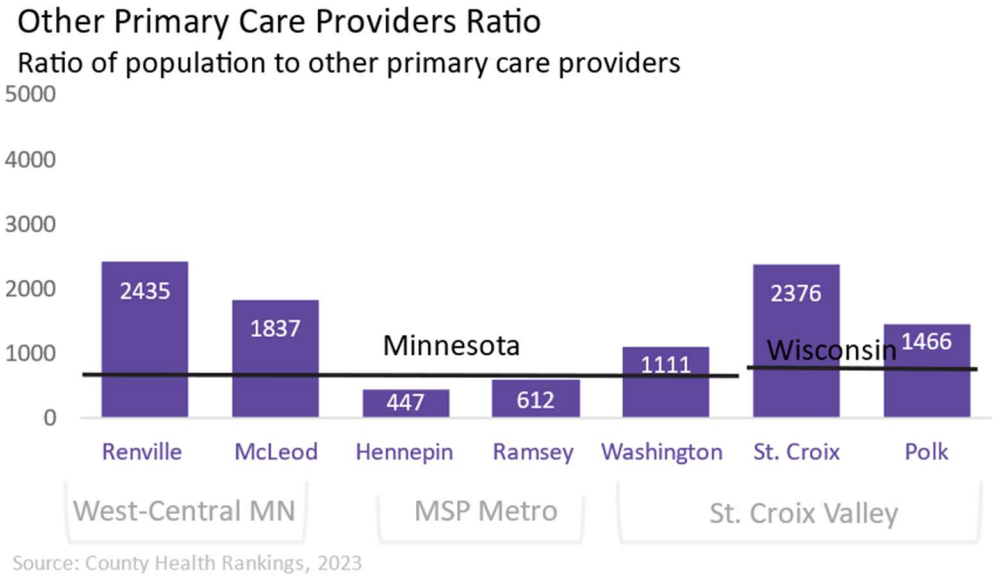
> Health care is too hard for too many patients to navigate

Community members in Ramsey County focused on navigating a complex mental health care system that has limited resources. Across specialty areas, community members are concerned about ease of finding and scheduling needed appointments, improving culturally responsive care, and making it easier for patients to find racially concordant providers.

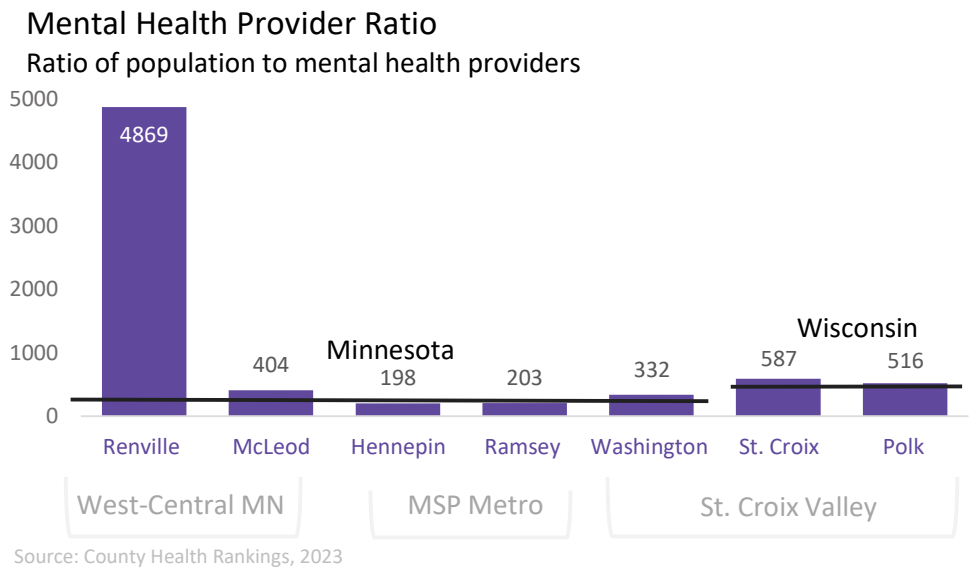
Primary care availability varied widely across counties HealthPartners serves, with some counties having **fewer primary care providers per capita** compared to their state ratio (1,110 people per 1 primary care physician in Minnesota and 1,242 per 1 primary care physician in Wisconsin) and the national average (1,330 per 1 primary care physician).[35]



Similar patterns exist for other primary care providers, including nurse practitioners, physician assistants, and clinical nurse specialists – all of whom can provide routine and preventive care in our service areas. This variation further contributes to **limited availability and timely access to care, especially in our more rural counties.**

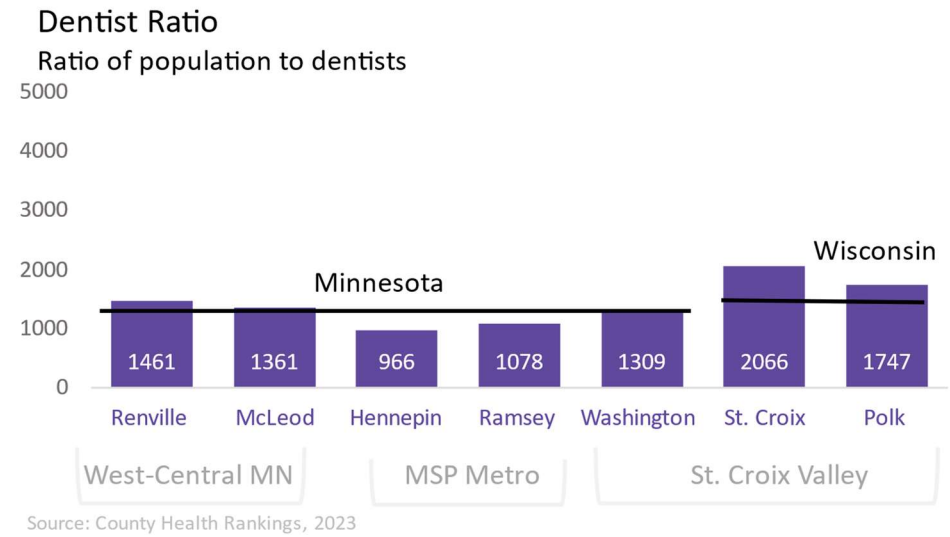


Mental health provider availability varies by geography as well. In the United States, there is, on average, one mental health care provider per 320 residents. Across Minnesota, the ratio is similar with one provider per 322 residents. Not all counties have the same level of access, however. According to the Minnesota Department of Employment and Economic Development, the demand for therapists, counselors, and mental health social workers will grow by 11.1%, 16.8%, and 6.5% over the next ten years.[83]



Source: County Health Rankings, 2023

Availability of dental providers is more similar across counties in our service area and is similar to the national average of 1 per 1,360 residents.



Source: County Health Rankings, 2023

Across Minnesota, 13.8% of the population reports not having a personal health care provider, which is comparable to the national average of 14.5%. This percentage is significantly higher among Minnesotans who identify as Hispanic (37.2%) and Asian/Native Hawaiian or Pacific Islander (26.7%).[84]

Telehealth has changed how we all access health care, but access to telemedicine services requires access to the internet.[85] According to the Social Determinants of Health Database published by the Agency for Healthcare Research and Quality,[64] 8.5% of households in Ramsey County do not have internet access.

Availability is also determined by insurance coverage.[64] In Ramsey County, there are 35 substance use disorder service facilities accepting Medicaid and 19 facilities that provide mental health services and accept Medicaid.

Property damage, damage to critical infrastructure such as electricity and water, supply and staff shortages, and transportation disruptions resulting from extreme weather events can all affect the availability of regular health care services. In a best-case scenario, these challenges make operating conditions more difficult for a short period of time; in a worst-case scenario, facilities are forced to evacuate patients and suspend operations.[86]

HealthPartners is working hard to ensure continuity of care as our climate changes. Already, our emergency management teams are considering extreme weather projections in annual Hazard Vulnerability Assessments, updating continuity of operations plans related to weather events, and educating colleagues on extreme weather risk. Additionally, our facilities utilize thorough continuity of operations plans and are proactively pursuing opportunities to increase resilience for existing and new buildings.

Factor 3: Care experience, equitable and respectful care

Care experience in this section refers to how patients perceive their interactions with the health care system. This subtopic includes the ability to get **understandable health information** from a health care provider, as well as being **treated with respect** by health care providers. Race, ethnicity, socio-economic status, gender and sexual orientation can all impact care experiences.[87]

Stakeholders emphasized that patient comfort goes beyond physical needs and should also include how they are treated by their providers (cultural sensitivity, trauma responsiveness, etc.). Not all communities feel welcomed or safe in the health care system; cultivating trust and relationships with patients is critical. We also heard the need to make our care system easier to navigate for everyone, including ensuring language services and providing care coordination.

Ramsey County community members echoed these themes and shared that the health care experience could be improved by ensuring HealthPartners care teams are culturally responsive and understand issues of systemic injustice and racism.

HealthPartners administers the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey from National Research Corporation (NRC) Health to patients who receive care at any of our hospitals. Patients are asked to rate the hospital during their stay on a scale from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible. NRC standard (known as “top box”) is to present the percent of patients who rated the hospital a 9 or 10.[88] Additionally, the survey asks respondents if they would recommend the hospital to their friends and family. Here, we present the percent who said, “definitely yes.”

In 2024, 74% of Regions Hospital patients rated the hospital a 9 or 10, an increase from 70% in 2023 and 2022. Seventy-eight percent of patients said they would definitely recommend Regions Hospital in 2024, up from 73% in 2023 and 74% of patients in 2022.

Additional Factors: Access to Care

Throughout engagement, we heard the importance of **creating partnerships to improve access to care for our communities**. At a system level, HealthPartners is working to make care more convenient and accessible for patients in various ways, including increasing the number of same-day appointments, incorporating care navigators into certain departments, offering more online care options, and recruiting providers to work in rural areas.

In Ramsey County, community members are particularly concerned about key populations: the homeless population, mental health patients, people with cognitive delays, and people with transportation needs. They reported that Ramsey County is working to launch a mobile mental health resource van that can share information in neighborhoods around the county. They also mentioned myStrength, a HealthPartners resource meant to help with anxiety and depression that providers could point patients to sooner.

Evaluation

of 2022-2024 Community Health Implementation Plan

The Community Health Needs Assessment conducted in 2021 identified the following five priorities in our community:

- Mental health and well-being
- Access to health
- Access to care
- Nutrition and physical activity
- Substance use

Each hospital developed a Community Health Implementation Plan with specific objectives and activities to address these priority Needs Areas and to serve as the implementation roadmap for 2022, 2023 and 2024. We engaged and partnered with the community to address these needs, seen through the strategies and progress shown below.

Mental Health and Well-being

***Goal**: Improve mental health and well-being.*

Strategies:

- Since 2022, the Make It OK campaign has engaged 1,113 people through virtual and in-person presentations and trained 542 Ambassadors through virtual and in-person sessions about reducing stigma of mental health and illnesses. The campaign also reached 15,000+ people through community events and 855 Ambassador subscribers through quarterly e-newsletters. In 2023, the Make It OK campaign celebrated a decade of progress with the release of the Make It OK 10-Year Report and an event attended by over 150 people. Make It OK launched a transformed website in 2024.
- Between 2022 and 2023, Little Moments Count welcomed 30 new partners and five new health care system partners to the collaborative early childhood brain development movement. Over 150,000 families were reached, more than 214,000 books were distributed and over 30,000 Think Small Parent Powered parent education text conversations occurred each year. More than 26 million media impressions occurred through Minnesota Public Radio, as well as 2.6 million digital impressions. Partnerships with cultural media outlets continued, reaching Latine, Hmong, Somali, African American and Indigenous communities. New resource pages in five languages were accessed from five countries and 24 states. A new NAZ Early Childhood & Family Toolkit, and a Successful Learner Toolkit project were launched. In 2022, the Little Moments Count Family Birth Center pilot launched, reaching over 5,000 families. In 2023, more than 7,000 families were reached during the second year of the Little Moments Count Birth Center pilot. In 2023, Little Moments Count hosted a successful hybrid 8th annual conference with more than 1,000 attendees. The fourth season of the Early Risers podcast launched in 2023.
- Behavioral Health Services completed the initial pilot of the Behavioral Health Consultant (BHC) model, continues to utilize rapid process improvement strategies and the model is scoped to all primary care regions. To-date, seven BHCs have been hired across HealthPartners, with the goal to hire at least one BHC for each region within the HealthPartners system. Results to-date indicate significantly increased numbers of patients receiving Behavioral Health Care with average access to Behavioral Health Care in fewer than five days, and very high patient satisfaction. There is also a new single scheduling phone number for outpatient behavioral health care services.
- Be Well employee well-being programs continued to offer mental health, well-being and resiliency programs and services. New additions to the Be Well offerings included 11 training series of a Mental Fitness and Psychological Safety workshop, a new Restore and Recharge program focusing on stress management and adaptability and expanded group coaching to allow for more coaching topics.
- The Well@Work clinic offered at Regions Hospital for staff. Many staff reside within Ramsey County and can benefit from the ability to schedule free or low-cost physician visits that can be accessed right at work.
- The Children's Health Council (renamed from Children's Health Initiative) implemented an automatic referral to behavioral health when a postpartum depression screening is positive. This was implemented after observing a gap in support -- Behavioral Health leaders are also creating an organization-wide postpartum program to support new mothers and ensure they are followed up with in a timely manner following a positive postpartum depression screening. In addition, a Quality Academy focused on bridging the gap between behavioral health and pediatric care and is working on implementing suggestions that came from this assessment.

- Regions Mental Health leaders focused on safely reducing patients' average length of stay and care without delay, ultimately increasing the ability to serve more patients with acute needs. The team attends monthly meetings with Ramsey County to proactively discuss case management and placement planning, ensuring that patients get timely resources and safe discharge plans.
- Individual referrals are made by the Birth Center to inpatient Mental Health and the DayBridge program for patients experiencing postpartum depression. Two tracks of in-person DayBridge groups meet with great success.
- The Caring for the Caregiver peer support services program for staff was put on hold.
- In 2024, Regions launched the Regions Care Staff connection, an onsite facilitated conversation to unpack the day-to-day stress of being a health care worker. This is offered on a monthly basis and employees receive their regular paid time during attendance.

Access to Health

Goal: *Improve access to health*

Strategies:

- An Advisory Council for Social Drivers of Health screening and referral was convened within HealthPartners to make recommendations on an approach to screening and referral for the health care system. The Advisory Council adopted a framework for an approach and completed an inventory of Social Drivers of Health activities in care, coverage and the community.
- The SuperShelf partnerships continues to transform food shelves with appealing, healthy food throughout Minnesota. This increases food access for patients and members.
- Community partnerships and participation in community collaborations remain key to advancing community health.
- The Children's Health Council (renamed from Children's Health Initiative) added Social Drivers of Health questions to the questionnaire parents receive during the Healthy Beginnings program.
- HealthPartners supports and promotes sustainability through the lens of the triple bottom-line of people, planet and prosperity. Regions Hospital has made significant strides in this area by eliminating desflurane from anesthesia machines, participating in the Express Bike bicycle drive (collecting 162 bikes), organizing a used book sale in the library, and presenting its Greening the OR successes at a regional event. In 2022, Regions Hospital was honored with a Practice Greenhealth Top 25 Environmental Excellence Award. In 2023, the hospital received this award again and also earned three PGH Circles of Excellence in energy, food, and waste.
- The commitment of the St. Paul Anchor Strategy is to deepen and expand our relationships with the St. Paul community by building more trust, employing more people and doing more business in St. Paul. We partner with Keystone Community Services to provide monthly fresh, free groceries via the Keystone Foodmobile to thousands of individuals at the Como and Midway Clinics. We partner with and promote local, minority-owned businesses; host bike, food, and toy drives; and promote volunteer opportunities throughout the year.
- In 2023, Regions screened nearly 95% of our patients for food insecurity, and 7.6% of those screened positive for food insecurity. Those who screen positive are referred to Hunger Solutions for support as needed.
- In 2023, Regions held a winter clothing and shoe drive to support the Regions Resource Room and collected over 1,825 pieces of winterwear for patients in need.

- We partner with community organizations to provide tuition assistance, mental health organizations to educate patients and provide crisis services, and local schools to encourage students to learn more about careers in health care. Our Neuroscience team is continuously working on providing stroke education to and improving care for Hmong patients.
- Regions hosts an annual food drive in partnership with Merrick Community Services, a food shelf in close proximity to the hospital and utilized by many of our patients. In 2024, we partnered with other HealthPartners clinics in the area to collect 1,387 pounds of food.

Access to Care

Goal: *Improve Access to Care*

Strategies:

- HealthPartners is committed to building an anti-racist culture. As part of this work and commitment, a clinician Unconscious Bias Training was launched, and 30 facilitators have been trained to deliver the training. More than 130 Unconscious Bias Training sessions have been facilitated and attended by HealthPartners colleagues, and the training has been transitioned to an eLearning platform. This training has a 98% completion rate. An Inclusive Leader Workshop was developed and launched, as well as a new Equity Framework that will guide our system's work around diversity, equity, inclusion and belonging. Colleague Resource Groups continue to meet around shared identities and affirm diversity and inclusion throughout the organization.
- Regions Hospital has focused on injury prevention through a variety of outreach and educational programs, including child passenger safety, car seat services, pedestrian and bicycle safety, helmet and water safety, and first aid and CPR training, as well as the Stop the Bleed program. In 2022, the hospital served 1,530 people and distributed 179 car seats through community clinics, the Buckle Up for Life grant program and the Office of Traffic Safety grant in-patient education program. In 2023, these efforts expanded significantly, serving over 2,000 people and distributing 195 car seats. The hospital also conducted safety camps, Bike Rodeos, and Bike to School events, and introduced a life jacket loaner station at Square Lake swim beach. Notably, six Safe Kids Child Passenger Safety Technician courses were held, certifying 45 new car seat technicians.
- The hospital's Community Paramedicine program provides follow-up home visits for patients discharged with congestive heart failure. In 2022, the program successfully assisted 576 patients, likely preventing 96 potential hospital readmissions. In 2023, the program served 444 patients, completing 1,196 home visits.
- The Children's Health Council (renamed from Children's Health Initiative) created workgroups to address concerns about obstetric care brought up by Black patients. From these workgroups, Community Circles and Expecting Together were implemented. Community Circles are a support group for Black women at any point in their pregnancy or postpartum journey. Expecting Together, a monthly education series with Dr. Corinne Brown-Robinson, focuses on what Black mothers can expect during their pregnancy and the care they should receive.
- The Children's Health Council has also implemented a Black Perinatal Partner program, where two dedicated staff partner with U.S. born Black patients, families, care providers and clinic teams to help patients achieve optimal health goals by providing support, education and resources with cultural understanding in a compassionate, non-judgmental way. Patients have provided feedback on the Black Perinatal Partner program, and our system is now working to expand it and partner with local community health workers.

- The Children's Health Council hosted a refresh training for providers around changes made to the teen questionnaire used during well-child visits, including how to talk to teens about health topics.
- As part of the Community Senior Care program, in partnership with the patient's primary care provider and/or the hospital, clinicians see patients in their homes during transitional times. Providers can address social determinants of health as well as co-morbidities. The program ensures that patients have a hand-off from discharge to their location of choice based on the patient's needs and complexity of care. The program works very closely with the care coordination and social worker teams to ensure patients have resources and instructions that will help the patients have a successful transition to one of the programs. Our Community Senior Care program is successfully delivering on health outcomes and safe transitions of care for our patients. We continue to build partnerships with our community partners to assure collaborative approach to care. The program continues to monitor measures of success including patient satisfaction scores, readmission rates and hospitalization rates.
- The Hospital@Home program provides hospital-level care for acutely ill patients in their home, in lieu of emergency room transfer or hospitalization. In 2022, the program served 176 patients speaking 12 different languages, preventing 19 hospital admissions and saving 802 hospital bed days. In 2023, the program served 174 patients, who experienced a total of more than 750 nights receiving acute care in the comfort of their own home.
- In 2023, Regions Patient Financial Services and registration financial specialists completed 2,762 applications, of which 1,699 were successfully enrolled in government health programs. Regions also provided $38.4 million in charity care assistance in 2023.
- In 2023, the Community Paramedicine program completed 1,690 home visits and cared for 518 unique patients.
- In 2023, staff interpreters interpreted for 26,093 inpatient and outpatient visits in Regions Hospital and Regions-owned entities. Staff interpreters also translated or reviewed translations of 86 HP projects, patient letters, and other documents in 2023.
- Regions is dedicated to building a diverse recruitment, development and retention strategy. In 2023, people of color comprised 36.6% of Regions Hospital's overall workforce; 45.9% of all new hires; 30% of all new hires in leadership positions; 18% of our leaders; and 25.9% of our professional workforce.

Nutrition and Physical Activity

Goal: *Improve nutrition and physical activity*

Strategies:

- PowerUp reached 40,000+ kids and families annually with the PowerUp Press Family Newsletter, distributed to families, schools and community. The initiative has also reached 12,600+ elementary students through the School Challenge program and has reached 45,568 kids and families at community events. In addition, new family resources have been developed including a family magazine and eight new video resources focused on eating better, moving more and feeling good. PowerUp with Plants, a new web resource with plant-based protein information, was developed and engaged nearly 200 participants in pilot activities.
- Nutrition and physical activity community collaborations remain key to advancing community health.

- The HealthPartners Teen Leadership Council (TLC) impacted 84,969 people through volunteerism in the community. The teens on the council also offer consultations for community organizations, to lend youth voice to programs or projects in the community. The council has impacted 714,145 people through consultations for HealthPartners and community organizations such as the Minnesota Department of Health, BeReal, and Washington County Public Health & Environment. The Teen Leadership Council participates in Youth Day at the Capitol each year, an opportunity for teens to meet with representatives about issues important to them. More than 250 people attended the TLC's annual meeting in 2023 and 2024 to learn about the teens' work and impact.
- The Children's Health Council (renamed from Children's Health Initiative) created an internal centralized lactation page for staff, making it easier to find information about lactation education and community resources. Following this implementation, lactation consultants have been added to clinics where free lactation cafes are held weekly. Lactation cafes continue to reach 5-12 people each week, at each clinic. In 2024, a virtual lactation partner, Nest Collaborative, was added to lactation offerings for patients to help support an easier transition for parents once baby arrives. To date, Nest Collaborative sees 5-8 patients each month, with numbers continuing to increase.
- Regions hosts an annual food drive in partnership with Merrick Community Services, a food shelf close to the hospital and utilized by many of our patients. In 2024, we partnered with other HealthPartners clinics in the area to collect 1,387 pounds of food.
- In 2023, the Regions Be Well Team supported staff well-being by leading 660 Be Well Moments, a summer on-site farmers market, and two Be Well Fairs.

Substance Use

Goal: *Reduce Substance Use*

Strategies:

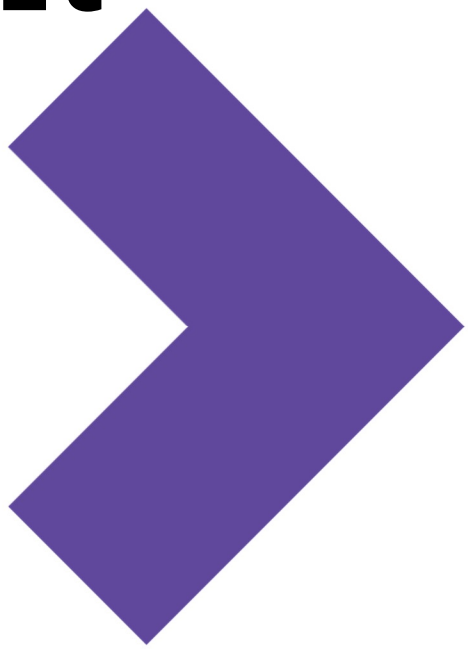
- Created a new Make It OK to Talk About Substance Use Disorder presentation, in partnership with the Programs for Change substance use recovery team. Since the presentation's launch, nine presentations have been offered to the public and 141 people have attended to learn more about substance use disorder.
- Drop boxes are located at the hospital to collect prescription medication and opioids in a secure manner. Since 2022, more than 830 pounds of medication were collected at Regions Hospital.
- A system wide Opioid Steering Committee meets quarterly to review prescribing patterns and trends. The committee reviewed ambulatory prescribing guidelines and identified care model gaps and opportunities with a defined work plan to support services in 2024.
- Opioid prescribing data for hospital and ambulatory services was reviewed and shared regularly throughout 2023. Data reviewed helped identify an opportunity to adjust the defaults in the prescription for Tramadol to reduce prescription MME and the number of pills prescribed. Prescription data reviewed indicated stable numbers from 2022 of patients who received or were prescribed a new or chronic opioid.
- Due to staffing shortages, a comprehensive consult service for substance use problems and disorders has been put on hold.
- Regions Infectious Disease physicians led an effort to improve care for patients requiring the use of IV antibiotics. In 2023, 40 patients received an inpatient Dalbavancin infusion. This showed an

average reduced length of stay of 6.1 days, a significant decrease from 2022's average length of stay of 11.3 days for patients receiving an infusion.

- The hospital has made notable progress in establishing a substance use disorder (SUD) intensive outpatient program at the Regions Hospital Outpatient Behavioral Health Clinic in Woodbury. In 2022, efforts focused on establishing a new department, applying for DHS approval, developing billing codes and processes, and creating job descriptions to support hiring. By 2023, the SUD IOP application received approval from DHS, and progress continued on refining the billing and coding infrastructure necessary for the program's launch. The new SUD IOP program is expected to open in 2024.

What's Next

Throughout the 2024 Community Health Needs Assessment process, Regions Hospital, in partnership with community and internal stakeholders, identified three priority community health needs for the community we serve: **Mental Health and Well-being, Social Drivers of Health**, and **Access to Care.** We know these needs look different within our community and across the HealthPartners service area and we will continue to seek partnerships to determine, implement, and measure strategies to address them.



Community Strengths

For more than 150 years, Regions Hospital has been providing care and compassion to the people of St. Paul and the surrounding communities. The mission of Regions Hospital is simple: to improve health and well-being in partnership with our members, patients and the community. Regions Hospital is the largest private employer in St. Paul. As the second most populous city in Minnesota, St. Paul's diverse community brings an incredible wealth of knowledge and talent, and Ramsey County communities are nationally known as attractive, livable places rich in history, diversity and opportunity. Right next door to Regions Hospital, you can find the Minnesota Department of Health and the State Capitol, both immutable reminders of the importance of our work to improve health and well-being. Ongoing partnerships with numerous community agencies and input from the patients and families we serve strengthen our ability to provide the best care possible.

Resources Available

HealthPartners has key resources available to help address the community needs identified through the CHNA process. Specifically, HealthPartners has a number of programs that work closely with the community on important issues (mental health, child development, and nutrition and physical activity, respectively) that align well with CHNA Needs Areas, including Make It OK, Little Moments Count, PowerUp, PowerUp with Plants and Faith Community Nursing. Similar initiatives such as the Teen Leadership Council, Social Drivers of Health Advisory Council, Children's Health Council and ChooseYourFish also focus on and provide resources surrounding CHNA Needs Areas. Internally, HealthPartners has an Equity, Inclusion and Anti-Racism Cabinet that provides leadership and direction to increase health equity and eliminate racism. Our comprehensive, award-winning sustainability program is taking action to reduce our impact and provide a healthier, cleaner, and more livable environment for patients, members, and the community.

As an integrated health system, HealthPartners also has close external partnerships to drive forward this important work. Additional partnership examples include SuperShelf, Reach Out and Read, Healthy Beginnings, which promotes drug, alcohol and tobacco free pregnancies, East-Metro Mental Health Roundtable, Mental Health Drug Assistance Program, food insecurity referral to Hunger Solutions, Minnesota Science Museum Sportsology exhibit and more. Finally, HealthPartners has long-standing relationships with community organizations and members of the community. Some of these include Hmong Community Stroke Education and Awareness Initiative, Minnesota Department of Health Healthy Minnesota Partnership, Early Brain Development Leadership Council, SuperShelf Leadership Team, and Center for Community Health (CCH). For a comprehensive list of partnerships, see Appendix.

CHNA Strengths, Limitations and Opportunities

The CHNA process brought together many existing data sources to identify and confirm the needs of our community. Using publicly available data is beneficial because it is efficient, drawing from validated sources that can be compared to other communities. However, where there were gaps in the data, HealthPartners' own data complemented these public datasets. Not surprisingly, many of these unique data sources are aligned with areas already established as organizational priorities, due to the existing community need. These data, along with robust community engagement facilitated during the prioritization process and the community health needs assessment process, determined and described the complexity of these community health needs.

Opportunities to further understand the specific needs of our community where gaps in existing data – whether quantitative or qualitative – remain. This can be especially true for our communities that proportionally contribute a smaller amount to the whole and may not be reliably included in many publicly available data sources. There are always additional perspectives to consider and Community Conversations to be held. As we move forward through implementation, we continue to solicit and welcome these important voices to the conversation. Throughout this CHNA process, our stakeholders emphasized the importance of building long-term, sustainable partnerships to make the biggest impact in a community. We look forward to this continued work.

Dissemination

This report has been posted on the Regions Hospital website: https://www.healthpartners.com/care/hospitals/regions/about/community-health-needs/.

Additionally, details from the report have been and will be presented to hospital leaders, decision-makers, and the community in various presentations throughout the year.

Next Steps

What we present here is a single point in time snapshot of the needs of the community that Regions Hospital serves. This interrelated framework will be used by Regions Hospital and HealthPartners to continue to work collaboratively with the community to address the needs identified in the CHNA, which will be presented in our implementation strategy.

While Regions Hospital and other HealthPartners hospitals worked together to prioritize system needs, data and inputs were tailored to the individual hospital as required by IRS guidelines. Moreover, the CHNA and the implementation strategy that follows will be presented for approval to each hospital board.

Contact Information

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Appendix

Table 1. Data sources used in 2024 CHNA

Data source name	Year(s)	Availability
Agency for Healthcare Research and Quality – Social Determinants of Health Database	Through 2022	Public
American Community Survey (ACS)	2022	Public
Behavioral Risk Factor Surveillance Survey (BRFSS)	Through 2022	Public
CDC WONDER	Varies	Public
Commonwealth Fund – State Health Data Center	Through 2023	Public
County Health Rankings	Through 2024	Public
HealthPartners electronic medical records	2020, 2023	Internal data only
IMPACT survey	2019, 2021	Internal data, public summary
KFF	2022	Public
Metro SHAPE	2018	Public
Minnesota Compass	Varies	Public
MN Community Measurement	Through 2023	Public
Minnesota Department of Employment and Economic Development – Occupations in Demand	Ongoing	Public
Minnesota Department of Health – Cardiovascular Health and Diabetes Prevalence	2021	Public
Minnesota Department of Health – 2020 County Health Tables	2020	Public
Minnesota Department of Health - Data Access Portal	Varies	Public
Minnesota Department of Health – Drug Overdose Dashboard	Through 2022	Public
Minnesota EHR Consortium – Health Trends Across Communities	Through 2023	Public
Minnesota Homeless Study – Wilder Research	2023	Public
Minnesota Student Survey	2019, 2022	Public
National Center for Health Statistics	Varies	Public
National Alliance to End Homelessness	2023-2024	Public
National Vital Statistics System	Varies	Public
SHAPE survey	2022	Public
Supershelf	2019	Public
Twin Cities Rental Revue – HousingLink	Through 2024	Public
United for ALICE – Wisconsin County Reports	2022	Public
US Census Bureau - Profiles	2020 - 2022	Public
Wisconsin Department of Health Services	Varies	Public
Wisconsin Department of Health Services – Chronic Disease Prevention Program	2018	Public
Wisconsin Department of Health Services – Leading Causes of Death Dashboard	2022	Public
Wisconsin Department of Health Services – Opioids Data	Through 2023	Public
Wisconsin Department of Health Services – WISH Query: Behavioral Risk Factor Survey Trend Data	Through 2024	Public
Wisconsin Department of Workforce Development	2023	Public
Wisconsin Youth Risk Behavior Survey (YRBS)	2019, 2021	Public

Table 2. 2024 Regions Community Engagement

Regions Hospital	
Community Conversation	**Meeting Attended**
Regions Community Meeting	Ramsey County Adult Mental Health Community Advisory Council
Regions Health Equity Committee	
Regions Patient and Family Advisory Council	

Table 3. 2024 Stakeholder Conversations

HealthPartners System Internal Stakeholder Conversations
Community Advisory Council
Advisory Council on Social Drivers of Health
Community and Advocacy Cornerstone
Social Drivers of Health Internal Stakeholders
HealthPartners Disability Colleague Resource Group
Make It OK Steering Committee
Mental Health & Well-being Internal Stakeholders
Access to Care Internal Stakeholders
Black and African American Colleague Resource Group
HealthPartners Teen Leadership Council
HealthPartners Leaders of Color Colleague Resource Group

HealthPartners System Other Stakeholder Conversations
MN Youth Council CHNA Committee

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Table 4. Committee Participation

Committee or Community Meeting Name	Purpose	Frequency
African American Breast Cancer Alliance	AABC strategy, education and discussion sessions to create collective action on BIPOC maternal and child health equity topics.	Bi-annually
AHIP Health Equity Leadership Committee	A committee of AHIP, a national trade association for health plans, of which HealthPartners is a member and Andrea Walsh, HealthPartners' President & CEO, is on the board.	
ARCH	Discuss quality metrics and how we can improve on them. For example: getting patients in for their mammogram, diabetic labs etc.	
Belonging/Welcome Week - Hutchinson Community	Planning welcome week event that focuses on welcoming and including others.	Monthly
Better Together Hennepin - Community Advisory group	Better Together Hennepin - Community Advisory Group.	Quarterly
Birth Justice Collaborative	A Hennepin County-led initiative to engage communities to co-design strategies to improve birth outcomes for the Black and American Indian communities.	
BLHS Community Education Board	Planning and facilitation and organization of community education opportunities for all age groups.	Quarterly
BOLD Community Education Board	Planning and facilitation and organization of community education opportunities for all age groups.	Quarterly
Brooklyn Center Health Resource Center Advisory Committee	Guide/advise operations and partner services for BCCS Health Resource Center.	Monthly
Brooklyn Center Health Resource Center Advisory Council	Brooklyn Center Health Resource Center Advisory Group.	Monthly
Building Bridges for Breastfeeding	Meeting with WIC, MDH and care systems and clinicians working in breastfeeding across MN.	1x/year
Burnsville Diamondhead Clinic Advisory Board	Guide/advise operations and partner services for Diamondhead Community Clinic.	Quarterly
C&TC Metro Action Group	Metro area C&TC	Quarterly
CAD Minnesota	Coalition of critical access dental providers working to advance policies that help expand access to dental care for Minnesotans served by public programs.	Bi-monthly
CDC National Hypertension Control Roundtable	Multisector action coalition to improve hypertension control nationally.	Quarterly
Center for Community Health (CCH)	A collaborative between public health agencies, non-profit health plans, and not-for-profit hospital/health systems in the seven-county metropolitan area in Minnesota. The mission is to	3x/year

	advance community health, well-being, and equity through collective understanding of needs and innovative approaches to foster community strengths.	
Center for Community Health (CCH) Assessment and Alignment Workgroup	This subgroup of CCH services as a catalyst to align the community health assessment process.	Monthly
Central C&TC	Central area C&TC	Quarterly
Central Clinic Advisory Council - SLP	Guidance and input for operations of Central Clinic – St. Louis Park Public Schools	Monthly
Child Passenger Safety Liaison, State Meeting	As a recipient of the Child Passenger Safety Hospital Liaison grant, this group has a higher level of statewide leadership responsibilities supporting child passenger safety initiatives - supporting all trained technicians and instructors within the state.	
Child Passenger Safety State Task Force	State approved individuals to serve on a child passenger safety task force to support the state occupant protection coordinator/child passenger safety initiatives and serve as a panel of experts. This task force will also oversee initiatives as well as the statewide CPS educational track at the MN TZD Annual Meeting.	
Children First Saint Louis Park Mental Wellness Committee	Convening of community leaders and Children First for directional guidance for their Youth for Change Coalition (Y4CC)	10x/year
City of Bloomington 5-year Economic Development Plan Steering Committee	HealthPartners' Vice President of Government and Community Relations was invited to participate given 8170 HP headquarters location.	
City of Hutchinson Bike & Pedestrian Committee	Collaboration to support bike and pedestrian safety.	Quarterly
Community Health Action Team (CHAT), New Richmond	CHAT meets monthly to discuss and address unmet community health needs in the area through action, networking and educational opportunities. CHAT members represent health care, human and social services, education, nonprofits, and faith communities.	Monthly
Community Health Action Team (CHAT), Stillwater	CHAT meets monthly to discuss and address unmet community health needs in the area through action, networking and educational opportunities. CHAT members represent health care, human and social services, education, nonprofits, and faith communities. CHAT's service area is Stillwater Area School District, and also extends into other areas within Washington County.	Monthly
Crow River Area Breastfeeding Coalition	Collaboration with local health departments, WIC, healthcare, business, and community members to protect, support and promote breastfeeding.	Quarterly
CONNECT-Leadership Team	Washington County Collaboration around Chemical and Mental Health.	Monthly
Dakota County Healthy Communities Collaborative	The Dakota County Healthy Communities Collaborative (DCHCC) is a resource sharing and networking collaborative. It brings together health care providers, county staff, school representatives, faith communities, law enforcement, nonprofits and other organizations to support health and well-being of Dakota County residents. Members plan the annual South of the River Mental Health Summit and other educational events across the county.	Quarterly

Dakota County Oral Task Force	Focuses on improving dental access and dental programs/services within Dakota County.	Quarterly
DHS Behavioral Health Division & MCO Monthly Meeting	For DHS to share updates on behavioral health services with MCOs.	
DHS Dental Services Advisory Committee	A subcommittee of the HSAC provides clinical guidance on the dental care benefits and coverage policies for MN Health Care Programs. Uses evidence-based research to inform recommendations used to advise the Minnesota Department of Human Services commissioner on pertinent dental policy topics.	Monthly
DHS Health Services Advisory Committee (HSAC)	Provide leadership in designing health care benefit and coverage policies for MN public health care programs. A particular focus of HSAC is evidence-based coverage policy, in which decisions regarding health care services paid for by public programs are made using the best available research on their effectiveness.	Monthly
DHS MN Medicaid 2024 Equity Partnership	Discusses DHS plans to improve health equity and how organizations can support.	Monthly
Diamondhead Clinic Advisory Board	Diamondhead Clinic Advisory Board – Burnsville	Monthly
Early Brain Development Cultural Consultant Team	A subset of the Early Brain Development Leadership Council representing leaders from key cultural communities including African American, Somali, Hmong and Latin American.	3x/year
Early Brain Development Leadership Council	Regular meetings with leaders from key community, public health and private organizations to discuss collective action on the topic of early brain development.	6x/year
East Metro Mental Health Roundtable	Accelerate improvements in the Twin Cities east metro mental health system through partnerships that deliver high quality mental health services.	
Feeding Renville County	Working alongside SHIP to meet with a variety of individuals that help feed Renville County. Looking for ways to educate our community and work better together helping our communities.	Quarterly
Governor's Workforce Development Board	The GWDB's mission is to analyze and recommend workforce development policies to the governor and legislature toward talent development, resource alignment and system effectiveness to ensure a globally competitive workforce for MN.	
Greater MSP Board	Serves as a key resource for businesses and individuals looking to relocate, invest, partner and grow in the greater Minneapolis-St. Paul region. The partnership helps by coordinating community connections and share relevant information. The partnership brings together individuals and organizations to strengthen our region's competitiveness and inclusive economic growth.	Quarterly
Growing Through Grief Advisory Board	Guidance and input into the Growing Through Grief school-based grief counseling program for K-12 students in 16 districts. Park Nicollet Foundation/Park Nicollet Hospice	Quarterly
Health and Wellbeing Advisory Committee	Advisory committee for Lakeview/Valley Health and Wellbeing with representation from multiple sectors.	

Health Care Climate Council	A leadership body of U.S.-based health systems committed to protecting their patients and employees from the health impacts of climate change and becoming anchors for resilient communities. As a group of diverse health systems from across the country committed to addressing climate change, the Climate Council uses its unified voice to set and track climate goals, share best practices with one another and the broader sector, and collectively advocate for policies that accelerate progress toward achieving climate-smart health care.	Monthly
Health Care Home MN Cares Study	Care Coordination participating with the MN Department of Health. We would be sharing information to judge the effectiveness of Care Coordination/Health Care Home for our patients.	
Health Services Advisory Committee for CAPRW HeadStart	This committee reviews initiatives to support and improve the health, well-being and safety of the Ramsey and Washington County HeadStart children and their families. This advisory committee provides expertise and resources to CAPRW (Community Action Partnership of Ramsey and Washington Counties).	
Health Trends Across Communities (HTAC) project	HTAC uses electronic health record (EHR) data to track health conditions and disparities and enhance the information available to improve community health in Minnesota.	
Healthcare Environmental Awareness and Resource Reduction Team (HEARRT Midwest)	Networking with other Minnesota based health care sustainability leaders on best practices and challenges.	Quarterly
Healthier Together Leadership team + workgroups	County-wide collaboration with representation from public health, health systems and multiple sectors in St. Croix and Pierce Counties, WI.	Monthly
Healthy Beverages Statewide Convenings	Organized and convened by Healthy Beverages Steering Group - healthy beverage advocates are convened to discuss the topic, policy options, and collective action.	3x/year
Healthy Beverages Statewide Sugary Beverage Action Steering Group	Steering group representing leaders from public health, health plans and care systems, interested in reducing consumption and health impacts of sugary drinks. Group also provided technical assistance and support of an MDH policy modeling grant related to sugary drinks and Safe Routes to School.	Monthly
Healthy Polk County	Advisory council for Polk County with representation from multiple communities.	
Hennepin Community Mental Wellbeing Action Team	Workgroup focused on physical, social, cultural, and mental wellbeing in Hennepin County.	Monthly
Hennepin County Health Improvement Program (CHIP) Community Mental Well-being Action Subgroup	Collection action subgroup working together on Hennepin County projects related to housing access, affordability and support.	6x/year
Hennepin County Health Improvement Program (CHIP) Housing Action Subgroup	Collection action subgroup working together on Hennepin County projects related to community mental well-being and trauma-informed organizations and practices.	6x/year
Hennepin County Child and Family Health Connection	Regular meetings with director of the Children and Family Health at Hennepin County to discuss topics related to children's health.	3-4x/year
Highrise Health Alliance	Highrise Health Alliance, Minneapolis Public Housing Authority (MPHA) and the Minneapolis Health Department (MHD) launched the Highrise Health Alliance (HHA) in June 2020 to build	Quarterly

	community-clinic linkages that better serve high-rise residents. The HHA is focusing on 1) access to primary care; 2) medication management and 3) mental health access as priorities.	
Hutchinson Bicycle & Pedestrian Advisory Committee	Provides advice on issues related to bicycling and pedestrian needs in Hutchinson, advocates for pedestrian and bicycling infrastructure improvements, and promotes recreational walking and bicycling in Hutchinson.	Monthly
Hutchinson Connect	Connect individuals in the Hutchinson community.	
Hutchinson Health Foundation	Facilitates community and financial support to improve the health and well-being of patients, families and community.	6x/year
ICSI Expert Panel on Social Determinants of Health	Focus on shared strategies to address social determinants of health through the care system.	TBD (on hold due to COVID 19)
Jeremiah Conference	Convening with presentations on 2nd generation learning concept and discussion on how we translate this work in the community.	1x/year
Lakeview Foundation Health & Wellbeing Advisory Committee (HWA)	Serves as the eyes and ears for Lakeview Health and provide resources and services to meet the health and wellbeing needs of the community. Members include representatives from the Community Health Action Team (CHAT), Washington County Public Health, St. Croix County Public Health, Lakeview Health, Lakeview Foundation Board and HealthPartners.	Quarterly
Little Moments County Steering Committee	In partnership with other health care systems and community organizations, build awareness and change behavior around early brain development in the first 1,000 days of life.	
Make It OK Steering Committee	Advisory committee for Make It Ok with representation from multiple communities.	
MCHP-Health Equity Committee	Newly formed group with focus on health plans, health equity.	TBD
McLeod Alliance for Victims of Domestic Violence	Support for victims of domestic violence in McLeod County.	Monthly
McLeod County Mental Health Local Advisory Council	A place for people to share their first-hand experiences with mental health challenges with county and state policymakers for the purpose of improving mental health care in their communities.	Monthly
McLeod County NAMI	Raise mental health awareness through education, support and advocacy.	Varies
MDH Equitable Health Care Task Force	The task force's charge is to examine inequities in how people experience health care based on race, religion, culture, sexual orientation, gender identity, age and disability. It will identify strategies for ensuring that all Minnesotans can receive care and coverage that is respectful and ensures optimal health outcomes.	Quarterly
MDH Health Care Homes Advisory Committee	Health Care Homes Advisory Committee to advise Commissioners on the ongoing statewide implementation of the Health Care Homes (HCH) program.	Quarterly
MDH Health Care Workforce & Education Committee	The committee was established in 1993 by the Minnesota Legislature to examine the financing of medical education and research in Minnesota's changing health care market.	Quarterly

MDH Healthy Brain Initiative – Data Action Workgroup Together	Define needs and identify solutions for the collection and dissemination of ADRD data for the next five years. Inform the dementia dashboard.	Monthly
MDH Healthy Minnesota Partnership	The Healthy Minnesota Partnership brings community partners and the Minnesota Department of Health together to improve the health and quality of life for individuals, families, and communities in Minnesota. The Partnership has been charged with developing a statewide health improvement plan around strategic initiatives that ensure the opportunity for healthy living for all Minnesotans, and that engages multiple sectors and communities across the state to implement the plan.	5x/year
MDH Maternal Mortality Review Committee	Review pregnancy associated deaths. Make recommendation for improvement for care.	
MDH Mental Well-Being & Resilience Learning Community	The purpose is to expand understanding about a public health approach to mental health by profiling current community initiatives across a continuum of public health aligned strategies.	Monthly
MDH Minnesota Health Equity Networks	The network works to connect, strengthen and amplify health equity efforts.	Quarterly
MDH Parenting Educator Forum	Statewide training and discussion forum convened by MDE to discuss current evidence, changes, issues and the field of early childhood and parent education.	Annually
MEADA of McLeod County	Education and drug awareness to educate youth, families and citizens on the dangers of drugs with a focus on methamphetamines.	Bi-monthly
Medi-Sota Board of Directors	A health care consortium currently comprised of 35 rural health care facilities in Minnesota.	
Metro Breastfeeding Networking Meetings	Convenings of public health nurses, WIC county staff across MN, and health care, plan, and other community representatives involved in breastfeeding and birth work.	3x/year
Metro TZD Steering Committee	This is a regional group of leaders from the various TZD county advisory groups. This forum discusses and shares the county initiatives, what is happening on a regional level and how we fit into the larger statewide initiative of reducing roadway fatalities to zero.	
Minneapolis Community Health Leadership Team	CLT advises, consults and makes recommendations on use of City of Minneapolis public health grants and designated budgets.	6x/year
Minnesota Breastfeeding Coalition Governance and Equity Subcommittees	Statewide coalition representing leaders and advocates collectively working together to optimize practice and support of breastfeeding.	6x/year
Minnesota Breastfeeding Coalition Steering Committee	Statewide coalition steering group representing leaders and advocates collectively working together to optimize practice and support of breastfeeding.	6x/year
Minnesota Cancer Alliance	A broad partnership dedicated to reducing the burden of cancer across the continuum from prevention and detection to survivorship and end of life care.	
Minnesota Council of Health Plans	Trade association for nonprofit health plans.	
Minnesota Council of Health Plans - Behavioral Health Workgroup	A subgroup to the Council of Health Plans Govt. Programs meeting that focuses on specific behavioral health topics and provides input and also raises awareness on issues/concerns around BH services or trends. MCOs participate in this workgroup alongside MCHP reps.	

Minnesota Electronic Health Record Consortium	Partnership between MN health systems and public health; uses data to inform health policy and practice.	Weekly
Minnesota Healthy Kids Coalition	Statewide organizational leaders in public health and private sectors engaged in collective and policy action related to physical activity and better eating for families in MN.	2-4x/year
Minnesota Healthy Kids Policy Subgroup	Policy subgroup at the State Capitol to strategize outreach and communication on issues to legislators.	2-4x/month during session
Minnesota Healthy Kids Steering Committee	Steering group of statewide stakeholders in public health and private sectors engaged in collective and policy action related to physical activity and better eating for families in MN.	Quarterly
Minnesota Hospital Association - Behavioral Health Committee	Focuses on issues related to mental health and substance use disorder treatment in Minnesota. Advocates for improved access to behavioral health services, promoting policy reforms, and addressing workforce challenges in the mental health sector.	Bi-monthly
Minnesota Hospital Association - Finance Committee	Provides guidance on financial strategies, regulations, and policies that affect health care organizations, helping them navigate economic challenges and ensure long-term sustainability.	Bi-monthly
Minnesota Hospital Association - In House Counsel Committee	Provides MHA with education, resources, and guidance on a wide range of health law issues, including regulatory compliance, hospital bylaws, and political lobbying.	Quarterly
Minnesota Hospital Association - Policy & Advocacy Committee	Advises on legislative and regulatory priorities, ensuring that hospitals can provide high-quality care while navigating evolving and complex health care regulations.	Bi-monthly
Minnesota Hospital Association - Quality and Patient Safety Committee	Provides expert guidance and oversight on quality and safety initiatives within Minnesota hospitals. It helps develop resources, strategies, and roadmaps for improving patient care.	Bi-monthly
Minnesota Hospital Association - Workforce Committee	Focuses on addressing the ongoing health care workforce challenges in Minnesota. Advises on strategies for recruitment, retention, and workforce development, including efforts to increase diversity among health care staff and enhance the workforce pipeline.	Quarterly
Minnesota Hospital Association - Board of Directors	Provides strategic direction, leadership, and governance for the MHA, guiding its advocacy efforts and initiatives aimed at improving health care quality, access, and outcomes in the state.	Quarterly
Minnesotans for a Smoke-Free Generation	A coalition of Minnesota organizations that share a common goal of saving Minnesota youth from a lifetime of addiction to tobacco, often through public policy initiatives.	Weekly during session
MN Action for Healthy Kids/MN School Nutrition Network	Statewide collaborative around student health.	Monthly
MN Children's Cabinet Connection	Regular meetings with manager of the Governor's Children's Cabinet to discuss topics related to children's health.	3-4x/year
MN Climate Action Framework - Goal 5 Team	Revising and implementing Goal 5: Healthy Lives and Communities of the MN Climate Action Framework. MDH's Climate & Health Program team leads meetings.	Quarterly
MN Community Measurement Board of Directors	MN Community Measurement Board of Directors, Executive Committee and Measurement and Reporting Committee.	Quarterly
MSP Wellness	A partnership between the Minneapolis Regional Chamber, Hennepin County Public Health, Minneapolis Health Department, and HealthPartners. These four entities work together to help	

	businesses of all sizes create healthier work environments by providing resources, technical assistance and programming.	
NAMI Local Chapter	Raise awareness and provide support and education on mental illness.	
Nancy Latimer Annual Convening	Annual Convening recognizing excellence and innovation in early learning and brain development efforts in Minnesota.	Annually
NCQA Cardiovascular Measurement Advisory Panel	Advises NCQA on cardiovascular quality measures used to evaluate health plans.	Quarterly
PACT 4	PACT 4 is a family services and children's mental health collaborative.	Quarterly
Patient & Family Advisory Committee	Helps evaluate all aspects of patient care.	
Polk & St. Croix Counties Community Health Action Team CHAT	Collaboration on community health needs in New Richmond with representation from multiple sectors.	
Polk County Healthy Minds	Advisory Committee for mental health in Polk County, WI with representation from multiple sectors.	
PowerUp Steering Committee	Advisory committee for PowerUp with representation from multiple sectors.	
Premier Environmentally Preferred Purchasing Advisory Council	The Council works with Premier to research and discuss EPP with a focus on providing members with best practices and resources to achieve measurable success in environmentally preferable purchasing.	
Prenatal to Three Policy Forums	Bipartisan convening to examine how to use collective action and policy as a tool for change to support children, ages 0-3.	Quarterly
Promise Neighborhood Early Childhood Development Coalition	St. Paul group of Promise Neighborhood and other advocates for culturally grounded early brain development and early education.	6x/year
Ramsey County Birth Equity Community Council (BECC)	Cross of cross-sector county, state, coalition, health care and other sector leaders working together to improve birth equity in Ramsey County.	Monthly
Ramsey County Healthy Families Communities Council	Ramsey County Family Health home visiting community advisory committee.	
Ramsey County Toward Zero Deaths Advisory Board	This group includes representatives from engineering, enforcement, education and EMS/Trauma to review roadway injuries and fatalities within Ramsey County, review current initiatives around reducing roadway deaths to zero and implement new initiatives within the county.	
RAPAD	Join the meetings when time allows. The RAPAD Coalition engages Renville County members in reducing underage substance use through awareness, policy, enforcement, education and training.	Quarterly
Renville County Back-the-Pack	A 501(c)3 Non-Profit that provides weekend meals to students facing food insecurities in Preschool through Grade 8 in Renville County Public Schools. Working toward alleviating hunger in our communities.	Quarterly

Renville County Housing Committee	Facilitates partnerships in the areas of housing and health equity in order to create a thriving community for our neighbors to live, learn, work and play.	Monthly
Renville County Rural Child Care Innovation Program	The long-term goal of the RCCIP program is to build a cohesive stakeholder group who will continue, after the two-year planning cycle, with First Children Finance and begin to adapt and implement the recommendations.	Quarterly
Richfield Health Resource Center Advisory Council	Guide/advise operations and partner services for Richfield Health Resource Center.	Monthly
Rural Health Community Collaboration	In conjunction with MN Department of Health employees, and Straits Health employees to develop strategies in our area to improve population health in our community.	
Safe Kids Greater East Metro/St. Croix Valley Coalition	A team of vested partners who engage in childhood injury prevention initiatives. Members represent a wide array of professionals who work with children and implement prevention programming as part of their regular business model, utilizing Safe Kids resources as well as their Level I trauma and burn centers for expertise and resource support.	
St. Paul Business Review Board	Advisory body to mayor and City Council of St. Paul to review and recommend improvements to regulations affecting businesses, simplify unnecessary rules while ensuring public health, safety, and fiscal responsibility, enhance coordination between city regulatory agencies, and advise on proposed legislative and procedural changes impacting business and the broader community.	Monthly
SAMHSA National Guidelines for Behavioral Health Crisis Care	Help define national standards for mental health crisis care (mobile crisis, emergency services, freestanding crisis centers, mental health urgent care, etc.).	
Science Museum of Minnesota Capital Campaign Steering Committee	Campaign to reimage the SMM building to expand transformative STEM-equity programs, make science exciting and relevant, support our teachers, change the face of future scientists, motivate all Minnesotans to participate in solving our most pressing challenges while celebrate the history of innovation and excellence	Quarterly
SDOH Community Convening StratisHealth	Convening/collaboration with a goal to develop a shared approach to social needs screening and referral between health systems and community partners.	
St. Louis Park Mental Health Collaborative	Builds awareness and aligns action to support mental health and well-being in our community.	Monthly
St. Paul Downtown Alliance	Nonprofit organization that represents downtown businesses, nonprofits, government entities, residents, and entrepreneurs. Together, we work to build a strong and vibrant downtown, creating a positive downtown experience for all.	Quarterly
St. Paul Ramsey County Public Health Statewide Health Improvement Program Community Leadership Team Meetings	The Minnesota Department of Health provides funding to Saint Paul – Ramsey County Public Health through the Statewide Health Improvement Partnership (SHIP) to work with a variety of partners to improve the health of our community. Saint Paul - Ramsey County Public Health is in its fourth cycle of SHIP funding. Three goals: increasing physical activity; improving access to healthy foods; reducing the use of and exposure to tobacco.	Quarterly

St. Paul Ramsey County Community Health Services Advisory Committee	The board advises, consults with or makes recommendations to the Saint Paul City Council and the Ramsey County Board of Health on matters relating to policy development, legislation, maintenance, funding, and evaluation of community health services.	Monthly
Stearns/Benton Dental Workgroup	Focuses on improving dental access and dental programs/services available in the central region.	Quarterly
Stillwater Circulator Bus Loop Advisory Committee	Guide circulator bus route and policies to best serve isolated elders.	Quarterly
Stillwater Community Health Action Team (CHAT)	Stillwater/Washington County convened by Lakeview to collaborate around community health priorities.	
Suburban Metro Area Continuum of Care Affordable Housing Workgroup	A workgroup that supports SMAC goals by discussing how to increase affordable housing.	Varies
SuperShelf Leadership Team	Collaboration with public health, nonprofits, University of MN and HealthPartners to transform food shelves to provide good food for all.	Monthly
Twin Cities Habitat for Humanity	Engages a broad network of supporters and community members to create, preserve, and promote affordable homeownership in the seven-country metro area of Minneapolis and St. Paul.	
Twin Cities Refugee Consortium	A collaboration to discuss how to continue to assist refugees resettling in MN.	Quarterly
Twin Cities Regional Breastfeeding Coalition	Coalition representing leaders and advocates collectively working together to reduce rates of disparities in breastfeeding across the metro counties.	Quarterly
Twin Cities Regional Breastfeeding Coalition School Change Subgroup	Subgroup of TCRBC working to manage a Ramsey County grant supporting site and cultural changes to support lactation in metro schools.	6x/year
U of M Duluth Labovitz School of Business Health Care Advisory Board	U of MN Duluth Labovitz School of Business Health Care Advisory Board.	Bi-annually
Valley Outreach Board of Directors	Food shelf and basic needs organization, Stillwater and East Metro.	Monthly
Washington County Breastfeeding Coalition	Coalition representing leaders and advocates collectively working together to optimize support of breastfeeding in Washington County.	6x/year
Washington County Community Leadership Team	Advisory committee for Washington County SHIP.	Monthly
Washington County CONNECT Leadership Team	Youth Mental Health Collaborative Washington County.	
Washington County Transportation Steering Committee	Address transportation needs in Washington County.	Quarterly
Well-Spring Leadership Team	Washington County Collaboration around mental well-being	
Wilder Board of Directors	Oversee organizational strategy and fiscal stewardship of Wilder.	Bi-monthly
Wilder Program Committee	Understanding of Wilder programs and connection to strategic plan and communities.	Bi-monthly

Wisconsin Hospital Association (WHA) Public Policy Council	Advisory group within WHA that helps shape and guide the association's advocacy efforts on behalf of Wisconsin hospitals and health systems, and the communities they serve.	Bi-monthly
Wisconsin Hospital Association (WHA) Board of Directors	Advocacy, education, and convening organization to collectively enhance hospital and health systems ability to provide high-quality, affordable, accessible health care for Wisconsin families and communities.	Quarterly
Workforce Innovation Board of Ramsey County	One of 16 legislatively mandated Workforce Boards in Minnesota, the WIB harnesses the collaborative power of business, government, economic development, education and the community to develop strategic solutions for workforce challenges in Ramsey County.	Monthly
YMCA of the North Board	Engage communities in MN by nurturing the potential of every child and teen, improving health and well-being, and supporting and serving our neighbors. The Y ensures everyone has the opportunity to become healthier, more confident, connected and secure.	Quarterly

HealthPartners CHNA Workgroup Members

HealthPartners' Center for Evaluation & Survey Research (CESR) was contracted to complete the 2024 Community Health Needs Assessment for all 8 HealthPartners hospitals. Housed in HealthPartners Institute, grounded in public health and health care content knowledge, and driven by a continuous learning health system culture, CESR comprises of experts in evaluation methods, survey and qualitative methods, community engagement, health communications, data visualization, and statistical analysis. Led by Jeanette Ziegenfuss, PhD, Director of Survey and Evaluation Science, with expertise from Senior Evaluation Scientist Meghan JaKa, PhD and Evaluation Scientist Maren Henderson, MPP, and project management from Evaluation & Survey Project Manager Jennifer Dinh, MPH, and Project Coordinator Laura Zibley, MPH.

Role	Name, Affiliation
CHNA Evaluators	Jeanette Ziegenfuss, CESR Director Meghan JaKa, CESR Evaluator Maren Henderson, CESR Evaluator Jen Dinh, CESR Project Manager Laura Zibley, CESR Project Coordinator
CHNA Liaisons	Marna Canterbury, Community Health DeDee Varner, Community Relations Andrea Anderson, Community Health
Hospital Partners	Katy Ellefson, Amery Hospital Tracy Marquardt, Hutchinson Health Anna Jepson, Hutchinson Health Andrea Anderson, Valley Hospitals (Hudson, Westfields, Lakeview) Jackie Edwards, Olivia Hospital & Clinic Pat Croal, Park Nicollet Foundation Paul Danicic, Park Nicollet Foundation Heather Walters, Regions Hospital Danielle Hermes, Regions Hospital Tony Grundhauser, Regions Hospital Foundation
Internal Consultants	Allison Egan, HealthPartners Sustainability Tom Kottke, Medical Director, Well-being Shaun Frost, Medical Director, Health Plan Tamika Jeune, Attorney, Legal Pahoua Hoffman, SVP of Government and Community Relations Sidney Van Dyke, Director, Health Equity and Language Access

Regions Hospital CHNA Steering Committee Members

- Tony Grundhauser, Vice President, Regions Hospital Foundation
- Danielle Hermes, Manager, Quality Improvement
- Hilary Radtke, Senior Director, Quality Improvement
- Heather Walters, Health Equity Program/Project Manager

AMENDED AND RESTATED
BYLAWS
OF
REGIONS HOSPITAL

Effective December 31, 2024

ARTICLE 1

MEMBERSHIP

Section 1.1. Voting Members. Regions Hospital ("Hospital") shall have one member with voting rights which shall be Group Health, Inc., a Minnesota nonprofit corporation (the "Member"). No amendment of this Section shall be valid or effective unless and until approved in writing by the Member. The Member shall have and be entitled to exercise fully all rights and privileges of members of nonprofit corporations under the Minnesota Nonprofit Corporation Act, as amended, Minnesota Statutes Chapter 317A, and under all other applicable law, unless otherwise provided herein.

Section 1.2. Actions by Member. All actions by the Member shall be certified in writing signed, or consented to by authenticated electronic communication, by any duly authorized officer of the Member and filed with the Secretary of the Hospital.

Section 1.3. Powers Reserved by Member. In addition to other rights reserved to the Member by these Bylaws, the Member shall have the sole and exclusive right to act with respect to the following affairs of the Hospital:

(a) Amendment of the Articles of Incorporation and the Bylaws of the Hospital as set forth in Article 8, hereof.

(b) Approval of the merger or consolidation of the Hospital with any other organization or entity; provided, however, that the Board of Directors may submit merger and consolidation proposals to the Member for its approval.

(c) Election to dissolve and wind up the affairs of the Hospital; provided, however, that the Board of Directors may submit a dissolution proposal to the Member for its approval.

(d) Sale, lease, exchange, mortgage, pledge or other disposition of all, or substantially all, of the property and assets of the Hospital; provided, however, that the Board of Directors may submit proposals for such dispositions to the Member for its approval.

(e) Appointment of the Chair of the Board of the Hospital and appointment of the President of the Hospital.

(f) Approval of long-range plans and strategies, including issues relating to strategic direction.

(g) Approval of unbudgeted special projects or grants to organizations not affiliated with the Hospital which result in payments by the Hospital in excess of $1,000,000 per project or in the aggregate in any one calendar year.

(h) Guaranteeing the debts or obligations of any other person, firm, corporation, partnership, association or other entity, in excess of $1,000,000 per debt or obligation or in the aggregate in any one calendar year.

(i) Approval of the undertaking of any loan or other similar obligation or the incurrence of any indebtedness in excess of $1,000,000 per loan or other obligation or in the aggregate in any one calendar year.

ARTICLE 2

BOARD OF DIRECTORS

Section 2.1. General. The business and affairs of the Hospital shall be managed by or under the direction of the Board of Directors. In addition to the powers conferred upon the Board of Directors by these Bylaws, the Board of Directors may exercise all powers of the Hospital and perform all acts which are not prohibited to it by law, by the Articles or by these Bylaws, all as may be amended.

Section 2.2. Responsibilities. The responsibilities of the Board of Directors include, but are not limited to, the following:

(a) Providing leadership to advance the mission, vision, and goals of the Hospital and to evaluate the Hospital's performance against these factors.

(b) Assuring coordination and integration of Hospital leadership to establish policy, maintain quality care and patient safety, and provide necessary resources.

(c) Overseeing compliance with legal and regulatory requirements.

(d) Providing guidance and resources for effective organizational management and planning.

(e) Providing for a strategic planning process which assesses the health care environment and plans for future development.

(f) Approval of annual plan and goals.

(g) Reviewing the annual operating budget and (when needed) the Hospital's long-term capital expenditure plan, which shall be approved by the Board of Directors of

HealthPartners, Inc. ("HealthPartners") as part of the consolidated operating and capital budget for the HealthPartners system.

(h) Providing input for the evaluation of, and providing challenging guidance to, the President of the Hospital.

(i) Regularly evaluating the function of the Board of Directors.

(j) Approving other documents as required by accreditation or regulatory agencies.

Section 2.3. Number and Election of Directors.

(a) The Board of Directors of the Hospital shall be composed of no fewer than fifteen (15) and no more than nineteen (19) voting directors. The composition of the Board of Directors shall be as follows:

- Up to twelve directors nominated by the Executive Committee, approved by the Board of Directors of the Hospital, and appointed by the Member, two of whom must be active members of the Medical Staff of the Hospital ("Appointed Directors").
- One director selected by and from the Ramsey County Board of Commissioners.
- Four directors appointed by the President and Chief Executive Officer of HealthPartners (the "Member Directors").
- The Chief of Staff of the Hospital.
- The Chair of the Hospital Foundation Board, or designee.

(b) The President of the Hospital shall be a non-voting member of the Board of Directors.

Section 2.4. Terms of Office.

(a) The term of office for Appointed Directors shall be three years and shall be staggered such that their terms of office shall not all expire in the same year. The Member Directors shall serve an indefinite term until their death, resignation of employment with HealthPartners or a HealthPartners affiliate, or removal by the President and Chief Executive Officer of HealthPartners.

(b) Appointed Directors may not serve more than three (3) consecutive three-year terms.

Section 2.5. Vacancies. All vacancies in Appointed Directors, including, without limitation, vacancies caused by an increase in the authorized number of directors or by resignation, removal, or death, shall be filled in the same manner as directors are appointed. Each director so elected to fill a vacancy shall hold office for the remainder of the predecessor's unexpired term.

Section 2.6. Removal of Directors. The Member may remove an Appointed Director from office with or without cause upon its own action or upon a recommendation of a majority of the Board of Directors.

Section 2.7. Annual Meeting. The annual meeting of the Board of Directors shall be held each year or on such date and time as the Board of Directors determines. The annual meeting shall be held at the principal office of the Hospital or at such other place as the Board of Directors may determine.

Section 2.8. Regular and Special Meetings; Notice. Regular meetings of the Board of Directors shall be held at least quarterly at such times, dates and places as the Board of Directors shall specify. Special meetings of the Board of Directors shall be called by the Chair or President of this Hospital. An Assistant Secretary of the Hospital shall provide notice either by mail, by electronic communication or in person, of each meeting of the Board of Directors to each director not less than five (5) nor more than thirty (30) days in advance of the meeting. Any director may waive notice of a meeting before, at, or after the meeting orally, in writing, or by attendance.

Section 2.9. Quorum; Act of Directors. At all meetings of the Board of Directors, one-half (1/2) of the directors in office shall constitute a quorum for the transaction of business. The act of a majority of the directors present at any time at which there is a quorum shall be the act of the Board of Directors, unless a greater number is required by law, the Articles of Incorporation or these Bylaws. Notwithstanding the foregoing, when a quorum has been present at a meeting of the Board of Directors, the directors present may continue to transact business until adjournment even though the withdrawal of directors originally present leaves less than a quorum.

Section 2.10. Action Without a Meeting. An action required or permitted to be taken at a Board meeting may be taken by written action without a meeting if signed by the number of directors that would be required to take the same action at a meeting of the Board of Directors at which all directors were present; provided, however, that a Board of Directors' action requiring Member approval may be taken by written action only if signed by all of the directors then in office. If any written action is taken by less than all of the directors entitled to vote, all directors entitled to vote shall be notified immediately of the text and effective date of the written action. The failure to provide such notice, however, shall not invalidate such written action. A director who has not signed or consented to the written action has no liability for the action or actions taken pursuant to the written action. A written action is effective when it is signed by all of the directors required to take the action unless a different effective time is provided in the written action.

Section 2.11. Meeting Solely by Means of Remote Communication. Any meeting among directors may be conducted solely by one or more means of remote communication through which all of the directors may participate in the meeting, if the same notice is given of a meeting by remote communication as would be required for a meeting in person, and the number of directors participating in the meeting is sufficient to constitute a quorum at a meeting. Participation in a meeting in this manner constitutes presence at a meeting.

Section 2.12. Individual Participation in Meetings by Means of Remote Communication. A director may participate in a meeting of the Board of Directors by means of conference telephone or, if authorized by the Board, by such other means of remote communication in each case through which that director, other directors so participating, and all directors physically present at the meeting may participate with each other during the meeting. Participation in a meeting in this manner constitutes presence at the meeting.

ARTICLE 3

COMMITTEES

Section 3.1. Authority, Membership, Meetings. The Board of Directors may act by and through such committees as may be specified in these Bylaws or resolutions adopted by the Board of Directors. Such committees shall have the authority to act on behalf of the Board of Directors in the management of the business of the Hospital only to the extent provided in such Bylaw, resolution or in a committee charter approved by the Board of Directors. Such committees shall at all times be subject to the direction and control of the Board of Directors. Each such committee shall have such other duties and responsibilities as are granted to it from time to time by the Board of Directors. Except as otherwise provided in these Bylaws, committee members and committee chairs shall be appointed by the Board Chair subject to approval of the Board. Committee members need not all be directors, so long as at least one (1) member is a director. Committees that deal with quality of care shall have physician representation. Unless the Board of Directors shall provide otherwise, the regular and special meetings and other actions of any such committee shall be governed by the provisions of Article 2 applicable to meetings and actions of the Board of Directors. Minutes shall be kept of all committee meetings.

Section 3.2. Executive Committee. The Executive Committee shall have authority to act on behalf of the Board of Directors with respect to matters involving the Hospital on any matter requiring attention between meetings of the Board of Directors and on such other matters as the Board of Directors directs where delay until a special board meeting can be scheduled, or where an action in writing, is infeasible. The Chair of the Board of Directors shall be the Chair of the Executive Committee. The Executive Committee includes the Vice Chair of the Board, the Treasurer, the President of the Hospital, the HealthPartners President and Chief Executive Officer, the highest ranking financial officer for HealthPartners, Inc., and the Chair of the Quality Committee. Its duties are specifically set forth in a Committee charter that is approved by the Board of Directors and may be amended from time to time.

Section 3.3. Finance Committee. The Finance Committee's role is to provide oversight and support to the financial operation of the Hospital. The Treasurer of the Board shall be the Chair of the Finance Committee. The Finance Committee shall support the efforts of the Hospital's management to achieve the current and long-term financial objectives of the Hospital. Further details about its composition and duties are specifically set forth in a Committee charter that is approved by the Board of Directors and may be amended from time to time.

Section 3.4. Quality Committee. The Quality Committee shall provide oversight of the quality of care and services provided to patients. Its composition and duties are specifically set forth in a Committee charter that is approved by the Board of Directors and may be amended from time to time.

Section 3.5. Meetings; Term of Office. Rules, procedures and other matters with respect to meetings of any committee shall be the same as stated in Article II with respect to meetings of the Board of Directors.

ARTICLE 4

BOARD OFFICERS

Section 4.1. Board Officers. The Officers of the Board of the Hospital shall be the Chair, Vice Chair, and Treasurer. Any number of offices may be held by the same person.

Section 4.2. Appointment, Terms and Duties of Officers.

(a) Chair. The Chair of the Board shall be appointed by the Member pursuant to Article 1 of these Bylaws. The Chair shall serve for a two-year term and shall hold office until his or her successor is appointed and qualified or until he or she resigns, is removed, or is disqualified to serve. The Chair may be removed, with or without cause by the Member, whenever in its judgment the best interests of the Hospital will be served thereby. The Chair of the Board shall preside at all meetings of the Board of Directors and the Executive Committee. Subject to Board of Directors approval and unless set forth otherwise in these Bylaws or Board resolution, the Chair shall appoint all committee members, subject to the approval of the Board, with the exception of the Executive Committee.

(b) Vice Chair. The Vice Chair shall be appointed by the Board of Directors at the annual meeting of the Board of Directors, shall serve for a two-year term, and shall hold office until his or her successor shall be appointed and qualified to serve or until he or she resigns, is removed, or is disqualified to serve. In the absence or disability of the Chair, the Vice Chair shall perform all the duties of the Chair and, when so acting, shall have the powers of, and be subject to all the restrictions upon, the Chair. The Vice Chair shall have such other powers and perform such other duties as may be prescribed by the Board and these Bylaws.

(c) Treasurer. The Treasurer shall be appointed by the Board of Directors at the annual meeting of the Board of Directors, shall serve for a two-year term, and shall hold office until his or her successor shall be appointed and qualified to serve or until he or she

resigns, is removed, or is disqualified to serve. The Treasurer will be the Chair of the Finance Committee and shall, if present, preside at all meetings of the Finance Committee, make reports to the Board of Directors on behalf of the Finance Committee and shall have such other authority and duties as the Board of Directors may from time to time prescribe.

(d) Other Board Officers. The Board of Directors may appoint such other Board officers as it determines to be in the best interest of the Hospital. Each such Board officer shall hold office for such period, have such authority and perform such duties as the Board and these Bylaws may from time to time prescribe. Such officers may be removed with or without cause by the Board.

ARTICLE 5

STAFF OFFICERS

Section 5.1. Staff Officers. The staff officers of the Hospital shall include the President, the Chief Financial Officer, the Secretary, and such other vice presidents or other officers as the President may recommend and as the business of the Hospital may require.

Section 5.2. Appointment, Qualifications and Terms of Staff Officers.

(a) President. The President shall be appointed by the Member pursuant to Article 1 of these Bylaws and shall serve at the pleasure of the Member and hold office until his or her successor is appointed and qualified or until he or she shall otherwise resign, be removed or disqualified. The President may be removed, with or without cause, by the Member whenever in its judgment removal will serve the best interests of the Hospital. The President shall be the chief executive officer of the Hospital and shall, subject to the control of the Board of Directors and the Member, have general supervision, direction and control of the business and affairs of the Hospital.

(b) Chief Financial Officer. The Chief Financial Officer shall perform, or properly delegate, the duties of a financial officer and shall keep or cause to be kept correct and accurate accounts of the properties and financial transactions of the Hospital and in general perform all duties incident to the office and such other duties as may be assigned from time to time by the President.

(c) Secretary. The General Counsel of HealthPartners, Inc., shall serve as the Secretary, *ex officio*. The Secretary shall perform or properly delegate the performance of the following duties: ensure that accurate minutes of all meetings of the Board of Directors are kept; keep custody of the records and documents of the Hospital; certify proceedings of the Board of Directors, when necessary; give due and timely notice of all meetings of the Board; and attest the signature of any other officer of the Hospital, when necessary.

(d) Appointment and Removal of Other Staff Officers. The President shall appoint vice presidents and such other officers or assistant officers as the President determines and as the business of the Hospital may require, each of whom shall hold office for such period,

have such authority and perform such duties as the President and these Bylaws may from time to time prescribe. The Chief Financial Officer and such other officers or assistant officers appointed by the President may be removed, with or without cause, by the President.

Section 5.3. Vacancies. A vacancy in any office because of death, resignation, removal, disqualification or any other cause shall be filled in the manner prescribed in these Bylaws for regular election or appointment to such office, provided that such vacancies shall be filled as they occur and not on an annual basis.

ARTICLE 6

MISCELLANEOUS

Section 6.1. Execution of Instruments. Deeds, mortgages, bonds, checks, contracts and other instruments pertaining to the business and affairs of the Hospital may be signed on behalf of the Hospital by the President, persons authorized by the President through delegation or policy, or such other person or persons as may be designated from time to time by the Board of Directors.

Section 6.2. Fiscal Year. The fiscal year of the Hospital shall be from January 1 to December 31.

Section 6.3 Rules of Order. The Board shall adopt such rules of order as it deems appropriate. If no rules of order have been adopted and it is necessary to consult an external source of rules, *Robert's Rules of Order* shall be used.

ARTICLE 7

INDEMNIFICATION, CONFLICT OF INTEREST, AND STANDARDS OF CONDUCT

Section 7.1. Indemnification. The Hospital shall indemnify each person who is or has been a director, officer or employee of the Hospital, and each person who is serving or who has served, at the request of the Hospital, as a director, officer, employee or agent of another corporation, partnership, joint venture, trust or other enterprise, against expenses, including attorneys' fees, judgments, fines and amounts paid in settlement, actually and reasonably incurred by such person to the fullest extent to which directors, officers and employees may be indemnified under applicable laws in effect on the date demand for indemnification is timely made. The Hospital may, to the full extent permitted by applicable law then in effect, purchase and maintain insurance on behalf of any person who may be indemnified to the extent of their right to indemnification under this section.

Section 7.2. Conflicts of Interest. The Board of Directors shall maintain and enforce the Conflict of Interest Policy that is adopted by the Board of Directors of HealthPartners, and all Directors, officers, committee members and other individuals in a position to exercise substantial influence over the affairs of the Hospital shall act in compliance with the policy.

Section 7.3 Standards of Conduct. Each Director and officer shall discharge their duties as a director or officer in good faith, in a manner which the director or officer reasonably believes to be in the best interests of the Hospital, and with the care an ordinarily prudent person in a like position would exercise under similar conditions.

ARTICLE 8

AMENDMENT OF ARTICLES OF INCORPORATION AND BYLAWS

The Articles of Incorporation and Bylaws and any part thereof may be altered, amended or repealed, and new Articles or Bylaws may be adopted only upon approval, by the Member, of such amendments proposed by the Board of Directors.

ARTICLE 9

MEDICAL STAFF

Section 9.1. General.

(a) The Board of Directors requires the establishment and organization of the Medical Staff to operate in accordance with these Bylaws and the Medical Staff Bylaws, and other "Governing Documents" as defined in the Medical Staff Bylaws as approved by the Board of Directors from time to time. The Medical Staff shall operate as an integral part of the Hospital and, through its committees and officers, shall be responsible and accountable to the Board for the discharge of those duties and responsibilities delegated to it by the Board from time to time.

(b) The Board may delegate certain responsibilities to the Medical Staff including, but not limited to, monitoring the quality of medical care provided to patients and making recommendations to the Board regarding quality of care; making recommendations to the Board concerning appointments and reappointments to the Medical Staff, privileges conferred on members of the Medical Staff, and necessary actions related to privileges; electing members to represent the Medical Staff in its relations with the Board; and adopting documents necessary for the Medical Staff to carry out its responsibilities under the Medical Staff Bylaws and other Governing Documents.

Section 9.2. Medical Staff Bylaws. The Bylaws of the Medical Staff and other Governing Documents shall delineate the standards and procedures for implementing and accomplishing the functions set forth in this Article 9, Sections 1(a) and 1(b). Such Bylaws shall describe the selection of the Chief of Staff, Chief of Staff-Elect, other leaders, and the creation of the Medical Executive Committee and its role in accomplishing the functions set forth in this Article 9.

SECRETARY'S CERTIFICATE

I, Nancy L. Evert, the Secretary of Regions Hospital (the "Corporation") certify that the attached Bylaws of the Corporation are true and correct, and that the same have not been amended, modified, or revoked as of December 31, 2024.

Nancy L. Evert, Secretary

Title: Financial Assistance Policy	Policy Number: RC-05

POLICY:

PURPOSE: To describe HealthPartners' hospitals and clinics ("HealthPartners") Financial Assistance Policy (referred to as "FAP" or "Policy"), which available to uninsured or underinsured patients based on the patient's ability to pay for emergency and other medically necessary care.

DEFINITIONS: Not Applicable

POLICY: HealthPartners is committed to providing quality medical care to our patients, including those in need of financial assistance. The Policy is available to provide episodic help; it is not meant to provide long-term free or discounted care. An application for financial assistance is valid for 12 calendar months unless another application is submitted. The financial assistance application will have a limit of a 2-year look back for eligible services rendered. Our Policy and its Appendix set forth and describe eligibility criteria, how we calculate discounts, how to apply for financial assistance, the providers delivering care in our hospitals, and our emergency medical care policy.

Patients can obtain free copies of this Policy, the Appendices, and the financial assistance application form in person at all patient registration locations. For additional information or questions about the application process, or to request copies by mail, patients can contact one of our Patient Financial Services Departments. Full contact information for each of our Patient Financial Services Departments is found in Appendix 1. Free copies of this Policy, application form, and translations can be accessed at www.healthpartners.com/fa

ELIGIBILITY CRITERIA

HealthPartners has established the following eligibility criteria for patients to receive financial assistance:

- The patient and household members may be asked to provide evidence that they have been or would be denied government benefits, such as Medicaid. Denial of benefits letter(s) from the government may be requested.[1]
- The patient must fully exhaust any available government assistance programs and any available health insurance benefits.[2]
- The patient must complete the HealthPartners Financial Assistance Application and supply all requested documentation.

[1] Patients receiving care at Amery Regional Medical Center and Hutchinson Health are **not** required to apply for or be denied benefits under government assistance programs before they may be eligible for financial assistance.

[2] Patients receiving care at Amery Regional Medical Center and Hutchinson Health are **not** required to apply for or be denied benefits under government assistance programs before they may be eligible for financial assistance.

- The patient's eligibility for free or discounted care will be based on household income, family size, and assets[3],
    - Patients must supply documentation of household assets such as cash and other liquid assets for their application to be reviewed.
    - Liquid assets include cash and property that can be easily converted to cash, such as savings and checking accounts, stocks, bonds, certificates of deposit, life annuities and money market accounts. Retirement funds (e.g. 401K, IRA accounts and deferred annuities) are excluded from liquid assets. Documentation of liquid assets may be requested.
    - Any liquid assets exceeding $20,000 are included in the income calculation.
- HealthPartners provides full or partial assistance to all uninsured and underinsured patients whose family income is less than or equal to 400% of the Federal Poverty Level (FPL). HealthPartners offers payment plans to all uninsured and underinsured patients whose family income is at or above 401% of the FPL.

HOW TO APPLY FOR FINANCIAL ASSISTANCE

For information on how to apply for financial assistance, please see Appendix 1.

FINANCIAL ASSISTANCE CALCULATION

HealthPartners calculates a patient's level of financial assistance as follows:

HealthPartners **Financial Assistance Discount Calculation:**

1. Patient household size and income is collected on the financial assistance application and other information provided.
2. Patient responsibility balance on their hospital account is collected from our electronic health record system.
3. Using household size and income, we calculate the patient's location on the Federal Poverty Level.
4. If the patient is at or below 200% of the Federal Poverty Level, they will receive a full discount (100%).
5. Patients with a gross income and family size that place them above 200% of the FPL will receive partial financial assistance as follows:

FPL Score	Discount
200% or less	100% Discount
201-300%	75% Discount
301-400%	50% Discount

Amounts Generally Billed Discount ("AGB") Calculation:

"Amounts Generally Billed" (AGB) is a term that refers to amounts that are typically billed to individuals who have insurance covering emergency or other medically necessary care. AGB calculations for each HealthPartners hospital may be found in Appendix 2. After a patient's eligibility for financial assistance under this policy is determined, a financial assistance-eligible patient will not be charged more than AGB

[3] Asset verification and review is **not** applicable to patients receiving care at Amery Regional Medical Center and Hutchinson Health.

to insured patients by the HealthPartners care delivery location for emergency or other medically necessary care.

Presumptive Eligibility:
HealthPartners may presumptively determine that a patient is eligible for financial assistance based on a prior eligibility determination or meeting certain circumstances for financial assistance, which include:

- Homelessness;
- Medically necessary services not covered or payable under a Medicaid program or federal grant rendered to a qualified recipient;
- Qualification and effective date for Medicaid following the service dates; or
- Deceased.

Excluded services include elective services (cosmetic services or other non-medically necessary), as well as balances that should be paid by insurance, like Medicare, Medicaid, automobile, workers' compensation or liability insurance. HealthPartners may also use a third-party, vendor-provided estimate of a patient's family size and income to assign an FPL level to use in the discount table above. HealthPartners may also choose to grant presumptive eligibility in rare or unusual patient situations not specifically set forth in this FAP. In making presumptive eligibility determinations, if the presumptive discount is not the most generous discount available, HealthPartners will notify patients and provide a reasonable amount of time for the patients to personally apply for additional financial assistance.

LIST OF PROVIDERS IN HOSPITAL

HealthPartners hospitals are required to list all providers, other than the hospital itself, delivering emergency or other medically necessary care in the hospital and specify which providers are covered by this Policy and which are not. This provider list is maintained in a separate document. Patients can request a paper copy by contacting the Patient Financial Services location where they received care or by clicking here: www.healthpartners.com/fa. Full contact information for each of our Patient Financial Services Departments is found in Appendix 1.

EMERGENCY MEDICAL CARE POLICY

HealthPartners provides care, without discrimination, for emergency medical conditions to patients regardless of their ability to pay or eligibility for financial assistance. HealthPartners prohibits any action(s) that discourage patients from seeking emergency medical care. Examples of prohibited conduct include: an employee or agent of a HealthPartners hospital demanding that emergency department patients pay before receiving treatment for emergency medical care or permitting debt collection activities that interfere with the provision of emergency medical care. HealthPartners hospitals comply with all applicable requirements of the Emergency Medical Treatment and Labor Act (EMTALA), including the provision of medical screening examinations, stabilizing treatment, and referring or transferring a patient to another facility when appropriate. HealthPartners hospitals provide all emergency services in accordance with CMS conditions of participation.

SEPARATE BILLING & COLLECTIONS POLICY

The actions that HealthPartners may take in the event of nonpayment are described in a separate Billing & Collections Policy. A free copy of HealthPartners' hospitals and clinics Billing & Collections Policy can be viewed and downloaded on our website at www.healthpartners.com/fa

HealthPartners

Title: Financial Assistance Policy Appendix 1	Policy Number: RC-05

Purpose: This Appendix describes how to apply for financial assistance.

Definitions: Not Applicable.

Policy:

HOW TO APPLY FOR FINANCIAL ASSISTANCE

1. HealthPartners patients can complete their financial assistance application by logging into their online account, printing the application from our website at www.healthpartners.com/fa or obtaining a copy by calling or visiting the Patient Financial Services Department for the location they receive care. Patient Financial Services locations are open for phone calls on Monday–Friday from 8:00 a.m.–4:30 p.m.

Amery Hospital and Clinic: 715-268-8000
Amery Hospital & Clinic – Patient Financial Services
265 Griffin Street East
Amery, WI 54001

HealthPartners Clinic, Stillwater: 651-439-6528
HealthPartners Clinic Stillwater Business Office (Tuesday-Friday)
1500 Curve Crest Blvd
Stillwater, MN 55082

HealthPartners Medical Group Clinics: 651-265-1999

Hudson Hospital and Clinic: 715-531-6200
Hudson Hospital & Clinic – Patient Financial Services
405 Stageline Road
Hudson, WI 54016

Hutchinson Health: 320-484-4493
Hutchinson Health – Patient Financial Services
1095 MN-15
Hutchinson, MN 55350

Lakeview Homecare & Hospice: 651-430-8709

Lakeview Hospital: 651-430-4533
Lakeview Hospital – Patient Financial Services
927 West Churchill Street
Stillwater, MN 55082

Park Nicollet Health Services, including Methodist Hospital: 952-993-7672
Park Nicollet Health Services – Patient Financial Services
3800 Park Nicollet Blvd
St. Louis Park, MN 55416

Olivia Hospital and Clinic: 320-523-8300
HealthPartners RC, Business Office
100 Health Way
Olivia, MN 56277

Regions Hospital: 651-254-4791
Regions Hospital – Patient Financial Services
Mail Stop 11102S
640 Jackson St
Saint Paul, MN 55101

TRIA: 952-993-5463

Westfields Hospital and Clinic: 715-243-2600
Westfields Hospital & Clinic – Patient Financial Services
535 Hospital Road
New Richmond, WI 54017

2. Patients must complete the Financial Assistance Application **and** provide appropriate income and asset[4] verification(s) in one of the following ways:

    a. By Mail:
    PO BOX 773217
    Detroit, MI 48277-3217

    b. By Email: hpfinancialassistance@healthpartners.com

    c. By Fax: Patient Financial Services, 952-993-7672

    d. Online: By logging into the patient's online account

3. Appropriate household income verification(s) include: a copy of the most recent, current Federal 1040 tax return, benefit letter for Social Security, unemployment or disability benefits, and alimony agreement documentation. If a patient does not file taxes or the patient's income has decreased since their last tax filing, the patient may also provide the last 60 days of pay stubs.
4. Patients may contact Patient Financial Services at the number listed for the HealthPartners entity where they received care in #1 above with questions about the application or to arrange/schedule an appointment with a Financial Counselor.

[4] Asset verification and review is **not** applicable to patients receiving care at Amery Regional Medical Center and Hutchinson Health.

5. Designated staff in Patient Financial Services are available to assist patients by phone or in person with completing the application.
6. In-person assistance is also available in applying for government programs such as Medical Assistance. Patients may also contact the department of Human Services in the county in which they reside or Minnesota residents may call MNsure at 1-855-366-7873 and Wisconsin residents may call Wisconsin Medical Assistance at 608-266-1865. Patients may contact Patient Financial Services at the number listed for the HealthPartners entity where they received care in #1 above with questions about a government programs application or to find a location where a representative is available to meet with in person.

HealthPartners

Title: Financial Assistance Policy Appendix 2	Policy Number: RC-05

Purpose: This Appendix describes AGB calculations for each HealthPartners hospital.

Definitions: Not Applicable.

Policy:

AMOUNTS GENERALLY BILLED DISCOUNT ("AGB") CALCULATION

"Amounts Generally Billed" (AGB) is a term that refers to amounts that are typically billed to individuals who have insurance covering emergency or other medically necessary care. AGB calculations for each HealthPartners hospital may be found in the chart below. After a patient's eligibility for financial assistance under this policy is determined, a financial assistance-eligible patient will not be charged more than AGB to insured patients by the HealthPartners care delivery location for emergency or other medically necessary care.

The AGB percentage is calculated by dividing the sum of all a HealthPartners hospital or hospital outpatient location's claims for medically necessary care allowed by health insurers during a prior 12-month period by the sum of the associated gross charges for those claims. This calculation, also called the "Look-Back Method," is calculated annually by HealthPartners.

Amery Hospital and Clinic	47.86%
Hudson Hospital and Clinic	54.89%
Hutchinson Health	53.00%
Lakeview Hospital	61.32%
Methodist Hospital	68.21%
Olivia Hospital	36.30%
Regions Hospital	65.63%
Westfields Hospital	47.40%

Care System Growth & Market Development

Regions Hospital Bed Needs

Modeling Background

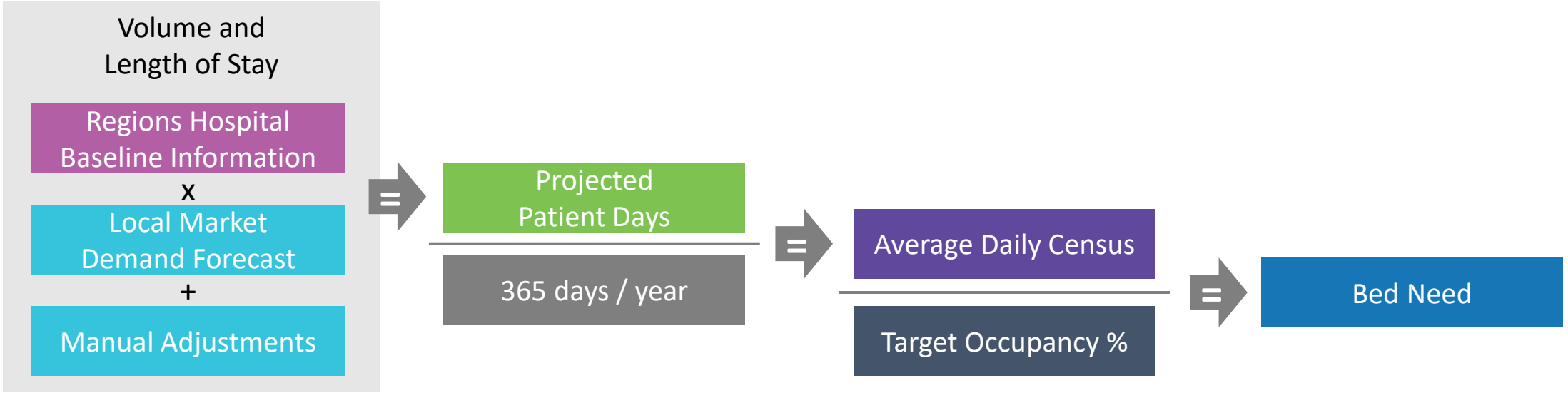
September 2025

HealthPartners

- Approach
- Sources
- Assumptions
- Results

Approach

The bed needs model looks at projected discharges, length of stay, and occupancy targets to determine total bed need



Sources

- Internal Data
  - Source: HP Epic
  - Discharges, observation and extended recovery volumes, days, & length of stay
  - Baseline: October 2022 – September 2023
  - Exclusions: Neonatology, Newborns, Obstetrics, Psychiatry & Rehab
- Market Demand
  - Source:
    - Inpatient: Impact of Change®; Claritas Pop-Facts® Sg2 Market Demand Forecast Version: 2023
    - Outpatient: Impact of Change®; Claritas Pop-Facts® Sg2 Market Demand Forecast Version: 2023v2
      - Sg2 Analytics Version 2023: Proprietary Sg2 All-Payer Claims Data Set, 2021; The following 2021 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility
  - Forecast: 2023 - 2033
  - Regions primary service area
  - Ages 18+

Key Assumptions

Bed Type	Volume Trend	Target Occupancy	Length of Stay Trend
Medical-Surgical Care	• Market growth – Inpatient, applied at DRG level	85%	Increase by 0.2 days (+4%) from 5.63 to 5.88 by 2033
Intensive Care	• ICU days growth tied to projected growth in DRGs with ICU flags • 3 beds added for ECMO program growth	75%	n/a
Medical Observation	• Market growth – Observation visits at aggregate level	80%	Stable at 1.31 days
Surgical Observation / Extended Recovery / SDEX	• Market growth – Procedure level	Non-SDEX: 90% SDEX: n/a	Ext Rec: Stable at 0.98 days SDEX: Stable
Birth Center	• Not modeled – Assume constant level of beds available (42)		
Inpatient Rehabilitation	• Not modeled – Assume constant level of beds available (21)		
Inpatient Mental Health	• Not modeled – Assume constant level of beds available (120)		

Assumptions: Manual adjustments

Program/Service	Changes Integrated into Model
Lakeview Shift	• Adjustments made for some shift of services to the new Lakeview Hospital
HP Direct	• +690 cases/yr to account for cases turned away from Regions due to capacity in 2023
Oncology	• Small market share increase due to 2025 addition of Oncology services in Woodbury
Gyn Onc	• Upward adjustment due to temporary volume dip during baseline period
Pulmonology	• Removed dip from projections, resulting in assumption of steady volumes through 2033
ECMO	• 3 additional ICU beds added to model to account for ECMO impact

Future Regions Bed Needs

Regions is estimated to need an additional 88 hospital beds over the next decade;
28 due to bed shortages today, and 60 due to future increases in demand

Bed Type	Physical Beds	Modeled Bed Need	Projected Bed Need		Current Deficit	Demand Growth
	Sept 2025	Baseline	2028	2033	Sept 2025 beds vs. Baseline Need	Baseline Need vs. Projected 2033 Need
Med/Surg	310	337	373	384	27	47
ICU	50	52	55	62	2	10
Observation/Extended Recovery/SDEX	29	28	29	30	-1	2
Subtotal	**389**	**417**	**457**	**477**	**28**	**60**
Maternal	38	38	38	38		
Mental Health	120	120	120	120		
Rehab	21	21	21	21		
Overall Hospital	**568**	**596**	**636**	**656**		

Maternal, Mental Health, and Inpatient Rehab beds held constant

Baseline = Oct '22 – Sept '23
Note: Modeled baseline bed need shows modeled bed need based on actual discharges/days.

Bed Needs Model Sensitivities

Med-Surg Average Length of Stay

2033 Estimate: 5.88

+/- 3 hrs per patient
(0.125 Days)

=

+/-9 Beds Needed

Med-Surg Inpatient Discharge Volume

2033 Estimate: 23,015

+/-1 patient per day
(365 patients per year)

=

+/-6 Beds Needed

Med-Surg Target Occupancy

2033 Assumption: 85%

+/-1 percentage point
(e.g., from 85% to 86%)

=

-/+4 Beds Needed

Changes calculated for Med-Surg only
IP discharges and observation visits exclude OB/Neonatology/Newborns, Psychiatry, and Rehab

Updated: 6/14/2024

Appendix

Sensitivity of Bed Need to Changes in Assumptions

Change in Projected 2033 Med-Surg ALOS

Hours Δ	Bed Δ	Bed Need
-5	-15	641
-3	-9	647
-1	-3	653
0	**0**	**656**
+1	+3	659
+3	+9	665
+5	+15	671

Change in Projected 2033 Med-Surg Discharges

Discharges Δ	Bed Δ	Bed Need
-600	-11	645
-365	-6	650
-200	-3	653
0	**0**	**656**
+200	+3	659
+365	+6	662
+600	+11	667

Change in Projected 2033 Target Med-Surg Occupancy

Occupancy Rate	Bed Δ	Bed Need
80%	+24	680
85%	**+0**	**656**
88%	-14	642
90%	-22	634

Inpatient Service Line Summary

	Historical Discharges			Projected Discharges											
Inpatient Service Line	2021	2022	Baseline	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	10-YR Δ	10-YR Δ %
Burn	212	230	284	284	284	284	284	284	284	284	301	310	310	26	9%
Cardiovascular	3,506	3,421	3,506	3,537	3,577	3,619	3,673	3,711	3,754	3,789	3,815	3,842	3,859	353	10%
Chemical Dependency	857	904	819	816	824	835	847	859	863	875	880	883	889	70	9%
ENT	114	123	126	126	125	124	123	123	122	121	121	121	121	(5)	-4%
Gastroenterology	1,732	1,635	1,663	1,662	1,659	1,664	1,668	1,677	1,684	1,693	1,699	1,708	1,710	47	3%
General Medicine	3,865	3,700	3,930	3,987	4,061	4,120	4,179	4,213	4,248	4,287	4,306	4,335	4,356	426	11%
General Surgery	2,024	2,040	2,132	2,137	2,152	2,174	2,194	2,223	2,238	2,250	2,260	2,268	2,275	143	7%
Gynecology	113	80	92	91	88	85	82	82	82	82	82	82	81	(11)	-12%
MSDRG Not Coded	19	17	21	21	21	21	21	21	21	21	21	21	21	-	0%
Neurology	1,723	1,695	1,763	1,763	1,762	1,766	1,780	1,801	1,821	1,844	1,870	1,892	1,914	151	9%
Neuro-Spine	474	498	528	527	528	530	534	535	537	541	544	544	545	17	3%
Neurosurgery	504	539	577	576	571	580	597	615	637	650	663	677	682	105	18%
Not Assigned	-	-	2	692	692	692	692	692	692	692	692	692	692	690	34500%
Oncology	864	910	1,055	1,108	1,114	1,129	1,147	1,173	1,174	1,166	1,151	1,146	1,137	82	8%
Ophthalmology	36	49	44	44	44	44	44	45	45	45	45	45	45	1	2%
Orthopedics	1,609	1,632	1,821	1,824	1,836	1,853	1,869	1,653	1,598	1,614	1,629	1,639	1,648	(173)	-10%
Pulmonology	1,984	1,721	1,595	1,541	1,545	1,555	1,562	1,576	1,581	1,588	1,594	1,596	1,599	4	0%
Urology	1,178	1,051	1,116	1,114	1,117	1,120	1,118	1,118	1,119	1,123	1,124	1,128	1,129	13	1%
TOTAL	**20,814**	**20,245**	**21,074**	**21,850**	**22,000**	**22,195**	**22,415**	**22,402**	**22,499**	**22,666**	**22,799**	**22,927**	**23,015**	**1,941**	**9%**
Medical Discharges															
TOTAL	**14,361**	**13,843**	**14,232**	**14,629**	**14,720**	**14,819**	**14,929**	**15,030**	**15,118**	**15,221**	**15,282**	**15,347**	**15,396**	**1,164**	**8%**
Surgical Discharges															
TOTAL	**6,434**	**6,385**	**6,819**	**7,198**	**7,257**	**7,352**	**7,463**	**7,349**	**7,358**	**7,421**	**7,494**	**7,557**	**7,596**	**777**	**11%**

*Projected increases in volumes due to HP Direct are categorized under the "Not Assigned" IP service line
Excludes OB/Neonatology/Newborns, Psychiatry, and Rehab

ALOS assumptions by Service Line over time

	ALOS	Projected ALOS										
Inpatient Service Line	Baseline	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	10-YR Δ %
Burn	16.3	16.8	17.2	17.6	17.8	18.0	18.2	18.4	18.5	18.6	18.7	15%
Cardiovascular	4.4	4.4	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.4	1%
Chemical Dependency	4.5	4.6	4.6	4.6	4.7	4.7	4.8	4.8	4.8	4.8	4.8	7%
ENT	3.1	3.2	3.3	3.3	3.4	3.4	3.4	3.4	3.5	3.5	3.5	10%
Gastroenterology	3.8	4.0	4.0	4.1	4.2	4.2	4.3	4.3	4.3	4.3	4.3	12%
General Medicine	5.6	5.7	5.7	5.7	5.8	5.8	5.8	5.8	5.8	5.8	5.9	5%
General Surgery	8.9	8.9	8.9	9.0	9.0	9.1	9.1	9.2	9.2	9.2	9.3	4%
Gynecology	2.8	2.9	2.9	3.0	3.0	3.0	3.1	3.1	3.1	3.1	3.1	10%
MSDRG Not Coded	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	1%
Neurology	6.0	6.0	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1	1%
Neuro-Spine	5.9	6.0	6.1	6.2	6.2	6.3	6.3	6.3	6.4	6.4	6.4	8%
Neurosurgery	6.9	7.0	7.0	7.0	7.1	7.1	7.2	7.2	7.3	7.3	7.4	7%
Not Assigned	5.6	5.6	5.6	5.6	5.5	5.5	5.5	5.6	5.6	5.6	5.6	-1%
Oncology	5.5	5.5	5.6	5.6	5.6	5.6	5.6	5.7	5.7	5.7	5.7	4%
Ophthalmology	2.9	2.9	3.0	3.0	3.0	3.0	3.0	3.1	3.1	3.1	3.0	6%
Orthopedics	5.7	5.7	5.8	5.8	5.9	5.9	5.9	5.9	5.9	5.9	6.0	5%
Pulmonology	4.5	4.5	4.5	4.5	4.5	4.6	4.6	4.6	4.6	4.6	4.6	1%
Urology	4.9	5.0	5.1	5.1	5.2	5.2	5.2	5.1	5.1	5.1	5.1	4%
TOTAL	**5.6**	**5.7**	**5.7**	**5.8**	**5.8**	**5.8**	**5.8**	**5.9**	**5.9**	**5.9**	**5.9**	**4%**

Assumption made “Not Assigned” service line has same Baseline ALOS as overall IP ALOS. Increases in volumes via HP Direct are included in the “Not Assigned” service line.
Excludes OB/Neonatology/Newborns, Psychiatry, and Rehab

Most Common ICU DRGs at Regions Hospital & 10-year Projected Growth

DRG Code and Name	MED/SURG	Baseline (ICU Days)	10-YR Δ %
871 Septicemia or Severe Sepsis w/o MV >96 hours w MCC	MED	1,300	19%
003 ECMO or trach w MV >96 hrs or PDX exc face, mouth & neck w maj O.R.	SURG	1,011	16%
870 Septicemia or Severe Sepsis w MV >96 hours	MED	1,006	45%
853 Infectious & parasitic diseases w O.R. procedure w MCC	SURG	755	17%
004 Trach w MV >96 hrs or PDX exc face, mouth & neck w/o maj O.R.	SURG	564	6%
025 Craniotomy & endovascular intracranial procedures w MCC	SURG	445	9%
023 Cranio w Major Dev Impl/Acute Complex CNS Pdx w MCC Or Chemo Implant	SURG	372	50%
927 Extensive burns or full thickness burns w MV >96 hrs w skin graft	SURG	365	8%
207 Respiratory system diagnosis w ventilator support 96 > hours	MED	333	10%
917 Poisoning & toxic effects of drugs w MCC	MED	324	3%
208 Respiratory system diagnosis w ventilator support <=96 hours	MED	265	22%
064 Intracranial hemorrhage or cerebral infarction w MCC	MED	256	11%
698 Other kidney & urinary tract diagnoses w MCC	MED	243	13%
957 Other O.R. procedures for multiple significant trauma w MCC	SURG	222	2%
236 Coronary bypass w/o cardiac cath w/o MCC	SURG	182	5%
246 Perc cardiovasc proc w drug-eluting stent w MCC or 4+ vessels/stents	SURG	182	13%

Baseline is Oct 2022 thru Sept 2023
Source: HBI Stewardship – Hospital – Volume – Inpatient and Observation report
Forecast Source: Impact of Change®; Claritas Pop-Facts® Sg2 Market Demand Forecast Version: 2023

Impact Factors – What is considered in projections?

Population

- Population Growth and distribution on service utilization
- Generated from demographic data and population growth projections

Economy and Consumerism

- Microeconomic factors: growth of copays and high deductible plans; lower cost of care sites and service; financial transparency tools/websites
- Macroeconomic factors: employment rate; GDP changes; Healthcare consumer price index; price sensitive CARE groups; state of US economy

Epidemiology/ Sociocultural

- Expected change in disease incidence and prevalence
- Includes changes like obesity, smoking, diet, sun exposure etc…
- Addresses new screening guidelines impacting diagnosis
- Any cultural changes that impact disease prevalence

Innovation

- New technology developed for treatment
- FDA drug approvals
- New clinical treatment options
- Clinical trial data that supports change in clinical decision making or new applications for patients
- Virtual and digital tools

Policy

- Impact of federal policy
- National payment models/pilots
- Benefit design changes to federal plans
- Medicare Advantage penetration rate compared to fee-for-service
- CMS and federal guidelines

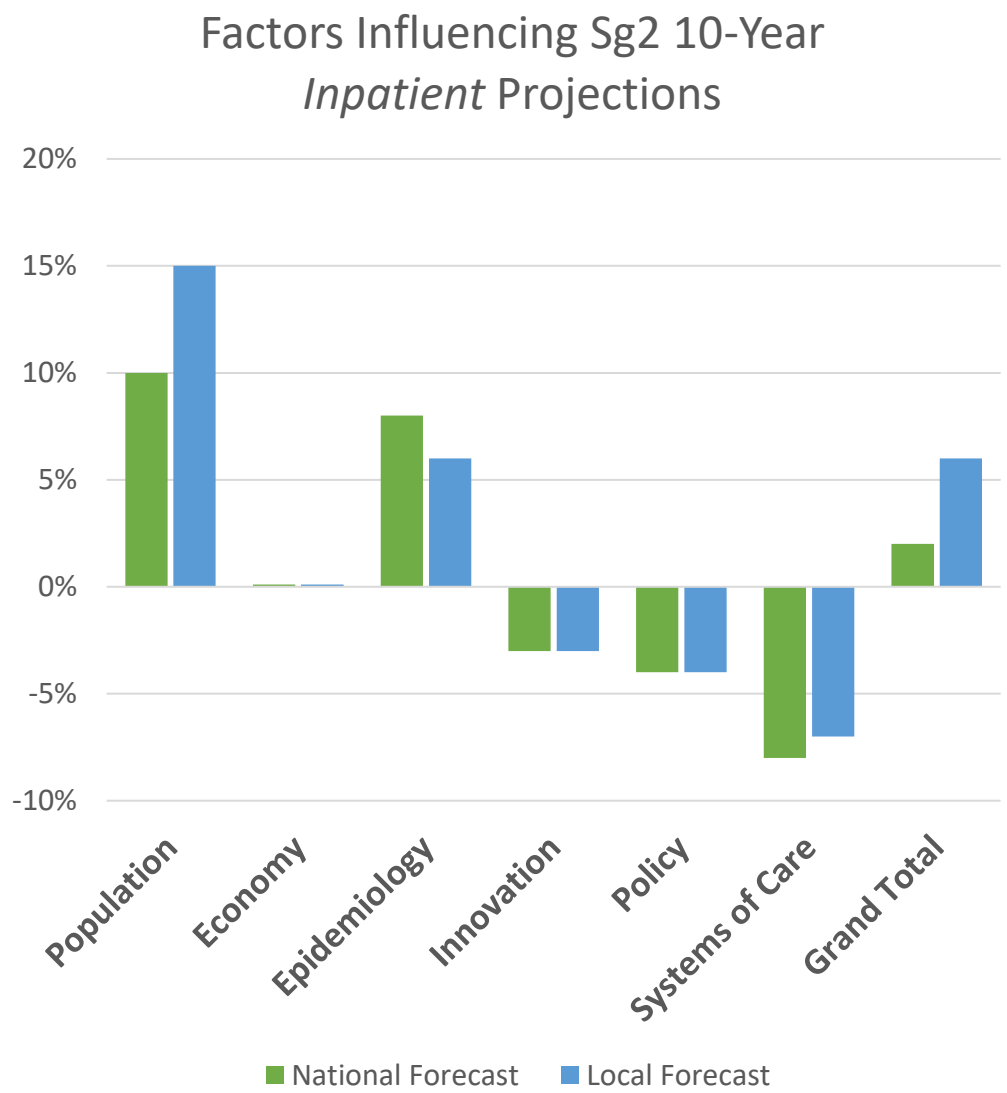
Systems of CARE

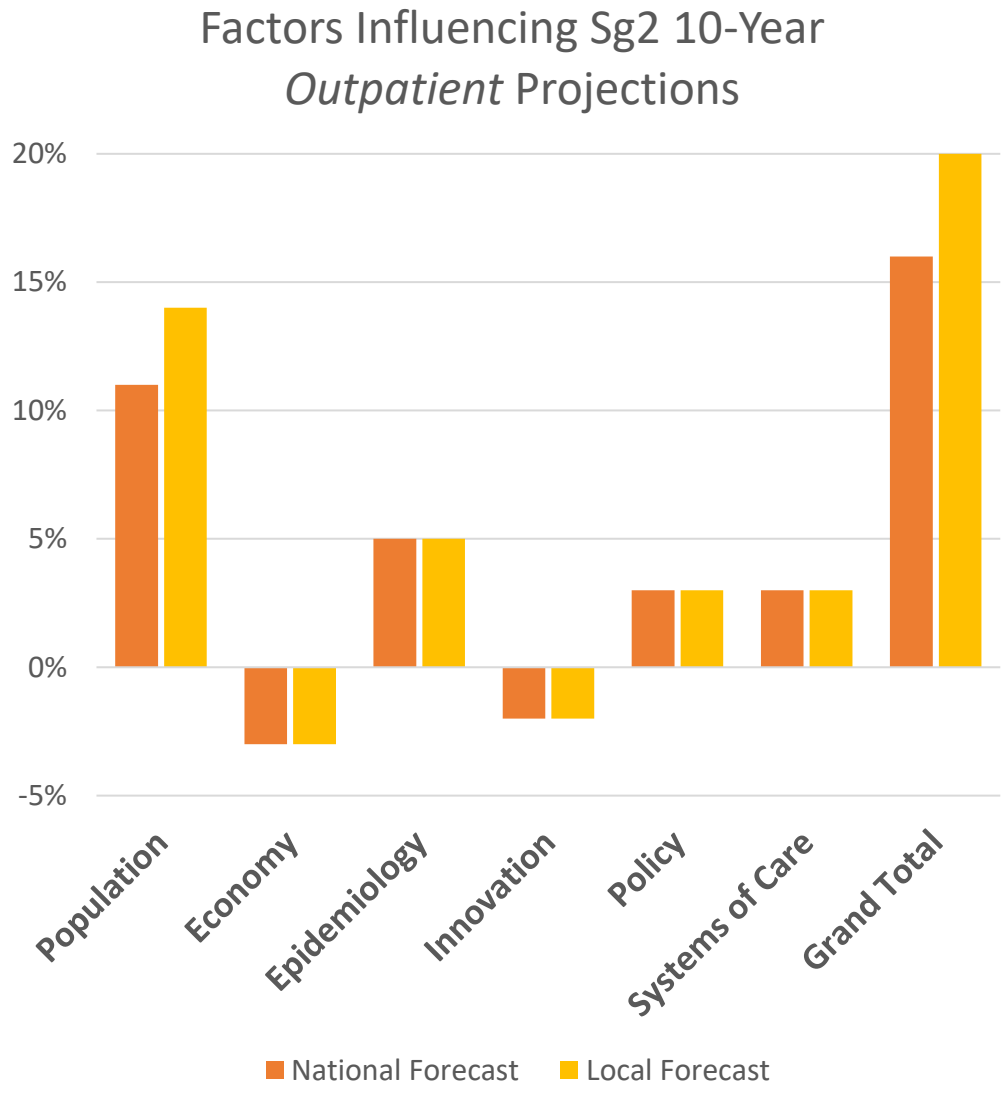
- Changes in utilization based on new efficiencies like improved care coordination, evidence-based guidelines, provider alignment etc…

Source: Sg2 Impact of Change®; Claritas Pop-Facts® - 2023

Impact Factors – All Service Lines

The Twin Cities 65+ population is projected to grow 17% over the next 5 years; compared to 14% nationally. This population utilizes care at a greater rate and our projected local volumes have been adjusted to reflect this.





Source: Sg2 Impact of Change®; Claritas Pop-Facts® - 2023 **Notes:** Local Market is defined as the HealthPartners Service Area; Patients 0-17 excluded