NOT A NEW ISSUE

ASCENSION HEALTH ALLIANCE

$30,585,000* State of Connecticut Health and Educational Facilities Authority Variable Rate Revenue Bonds (Ascension Health Credit Group) Series 1999B

CUSIP No. 20774YEK9† Dated: Date of Original Issuance Mandatory Tender: February 1, 2012

$100,000,000 Indiana Health Facility Financing Authority Revenue Bonds (Ascension Health Credit Group) Series 2001A-2

CUSIP No. 454798SF7† Purchase Date: February 1, 2017 Interest Rate: Series 1999B Bonds: 1.55% Series 2001A-2 Bonds: 1.60% Price: 100%

This Reoffering Circular (this “Reoffering Circular”) contains certain information describing the reoffering of the (i) 30,585,000* State of Connecticut Health and Educational Facilities Authority Variable Rate Revenue Bonds (Ascension Health Credit Group) Series 1999B (the “Connecticut Bonds”) and (ii) $100,000,000 Indiana Health Facility Financing Authority Revenue Bonds (Ascension Health Credit Group) Series 2001A-2 (the “Indiana Bonds” and together with the Connecticut Bonds, the “Bonds”), each in a new Long-Term Interest Rate Period effective February 1, 2012 to February 1, 2017 (the “Purchase Date”). The Connecticut Bonds were issued pursuant to a Bond Indenture, dated as of November 1, 1999 (the “Connecticut Bond Indenture”), between the State of Connecticut Health and Educational Facilities Authority (the “Connecticut Authority”) and U.S. Bank National Association, as successor bond trustee (the “Bond Trustee”). The Indiana Bonds were issued pursuant to a Bond Indenture dated as of December 1, 2001 (the “Indiana Bond Indenture”) and together with the Connecticut Bond Indenture, the “Bond Indentures”), between the Indiana Finance Authority (successor to the Indiana Health Facility Financing Authority) (the “Indiana Authority”) and the Bond Trustee, as successor bond trustee. Capitalized terms used but not defined herein shall have the meanings set forth in the Reoffering Circular dated February 18, 2009 (the “2009 Reoffering Circular”) relating to the Bonds, incorporated by reference herein.

The proceeds of the Connecticut Bonds were loaned by the Connecticut Authority to two Connecticut Borrowers (as hereinafter defined) pursuant to separate Loan Agreements, each dated as of November 1, 1999 (the “Connecticut Loan Agreements”), each between the Connecticut Authority and the applicable Connecticut Borrower. The proceeds of the Indiana Bonds were loaned by the Indiana Authority to Ascension Health ("Ascension Health") pursuant to a Loan Agreement dated as of December 1, 2001 (the “Indiana Loan Agreement”) and together with the Connecticut Loan Agreements, the “Loan Agreements”) between the Indiana Authority and Ascension Health.

The Connecticut Bonds are secured by two Obligations (“Senior Obligations No. 4 and No. 5”), each issued pursuant to a Master Trust Indenture dated as of November 1, 1999, as amended and supplemented (the “Senior Master Indenture”), among Ascension Health, the other Obligated Group Members (as defined in the Senior Master Indenture, the “Senior Obligated Group Members”) and U.S. Bank National Association, as master trustee (the “Senior Master Trustee”), and a Supplemental Master Trust Indenture for Master Indenture Obligation No. 4 and a Supplemental Master Trust Indenture for Master Indenture Obligation No. 5, each dated as of November 1, 1999, between Ascension Health, acting on behalf of itself and the other Senior Obligated Group Members, and the Senior Master Trustee. The Indiana Bonds are secured by an Obligation ("Senior Obligation No. 30") and together with Senior Obligations No. 4 and No. 5, the “Senior Obligations”) issued pursuant to the Senior Master Indenture and a Supplemental Master Trust Indenture for Master Indenture Obligation No. 30, dated as of December 1, 2001, between Ascension Health, acting on behalf of itself and the other Senior Obligated Group Members, and the Senior Master Trustee. On December 22, 2011, Ascension Health Alliance, a Missouri nonprofit corporation formed on September 13, 2011 and the sole corporate member of Ascension Health, became a member of the Senior Credit Group and, on December 22, 2011, was appointed the Senior Credit Group Representative under the Senior Master Indenture. The Senior Obligations are joint and several obligations of Ascension Health Alliance and the other Senior Obligated Group Members.

The Bonds are currently assigned and are expected to continue to carry as of February 1, 2012, the municipal bond ratings of “AA+ F1+,” “Aa1/VMIG 1” and “AA+/A-1+” by Fitch Ratings, Moody’s Investors Service, Inc. and Standard & Poor's Ratings Services (a division of The McGraw Hill Companies, Inc.), respectively. The short-term ratings on the Bonds are based on a self-liquidity obligation of Ascension Health.

Neither the Connecticut Authority nor the Indiana Authority has participated in the preparation of this Reoffering Circular, each makes no representation with respect hereto and neither the Connecticut Authority nor the Indiana Authority is in any manner responsible for any of the information contained herein or for the remarketing of the Bonds.

Other than as provided herein, the 2009 Reoffering Circular has not been updated since its date. This Reoffering Circular has been prepared for use by Citigroup Global Markets Inc. and Morgan Stanley & Co. LLC for the sole purpose of providing information relating to the matters set forth herein.

This Reoffering Circular should only be read in conjunction with the 2009 Reoffering Circular incorporated herein by reference.

Citigroup Morgan Stanley

The date of this Reoffering Circular is January 25, 2012.

* Reflects the defeasance of $1,315,000 of the Connecticut Bonds on February 23, 2010 to be redeemed on February 1, 2012.
† Copyright 2012, American Bankers Association. CUSIP data herein is provided by Standard & Poor's CUSIP Service Bureau, a division of The McGraw-Hill Companies, Inc. The CUSIP numbers are provided for convenience and reference only.
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Reoffering Circular
Relating to the

$30,585,000
State of Connecticut Health and Educational Facilities Authority
Variable Rate Revenue Bonds
(Ascension Health Credit Group)
Series 1999B

$100,000,000
Indiana Health Facility Financing Authority
Revenue Bonds
(Ascension Health Credit Group)
Series 2001A-2

Purpose of this Reoffering Circular

The purpose of this Reoffering Circular (this “Reoffering Circular”), including the cover page hereto, is to set forth information in connection with the reoffering of the (i) $30,585,000* State of Connecticut Health and Educational Facilities Authority Variable Rate Revenue Bonds (Ascension Health Credit Group) Series 1999B (the “Connecticut Bonds”) and (ii) $100,000,000 Indiana Health Facility Financing Authority Revenue Bonds (Ascension Health Credit Group) Series 2001A-2 (the “Indiana Bonds”, the Connecticut Bonds and the Indiana Bonds are referred to individually as a “Series” and collectively, as the “Bonds”), each in a new Long-Term Interest Rate Period effective February 1, 2012 to February 1, 2017 (the “Purchase Date”). The Connecticut Bonds were issued pursuant to a Bond Indenture, dated as of November 1, 1999 (the “Connecticut Bond Indenture”), between the State of Connecticut Health and Educational Facilities Authority (the “Connecticut Authority”) and Wells Fargo Bank, National Association, as successor bond trustee (the “Bond Trustee”). The Indiana Bonds were issued pursuant to a Bond Indenture dated as of December 1, 2001 (the “Indiana Bond Indenture” and together with the Connecticut Bond Indenture, “the Bond Indentures”), between the Indiana Finance Authority (successor to the Indiana Health Facility Financing Authority) (the “Indiana Authority”) and the Bond Trustee, as successor bond trustee.

The proceeds of the Connecticut Bonds were loaned by the Connecticut Authority to Hall-Brooke Behavioral Health Services, Inc., a Connecticut not for profit corporation (“Hall-Brooke”) and St. Vincent’s Medical Center, a Connecticut not for profit corporation (“St. Vincent’s” and together with Hall-Brooke, the “Connecticut Borrowers”) pursuant to separate Loan Agreements, each dated as of November 1, 1999 (the “Connecticut Loan Agreements”), each between the Connecticut Authority and the applicable Connecticut Borrower. The proceeds of the Indiana Bonds were loaned by the Indiana Authority to Ascension Health (“Ascension Health”) pursuant to a Loan Agreement dated as of December 1, 2001 (the “Indiana Loan Agreement” and together with the Connecticut Loan Agreements, the “Loan Agreements”) between the Indiana Authority and Ascension Health.

The Connecticut Bonds are secured by two Obligations (“Senior Obligations No. 4 and No. 5”), each issued pursuant to a Master Trust Indenture dated as of November 1, 1999, as amended and supplemented (the “Senior Master Indenture”), among Ascension Health, the other Obligated Group Members (as defined in the Senior Master Indenture, the “Senior Obligated Group Members”) and U.S. Bank National Association, as master trustee (the “Senior Master Trustee”), and a Supplemental Master Trust Indenture for Master Indenture Obligation No. 4 and a Supplemental Master Trust Indenture for Master Indenture Obligation No. 5, each dated as of November 1, 1999, between Ascension Health, acting on behalf of itself and the other Senior Obligated Group Members, and the Senior Master Trustee. The Indiana Bonds are secured by an Obligation (“Senior Obligation No. 30” and together with Senior Obligations No. 4 and No. 5, the “Senior Obligations”) issued pursuant to the Senior Master Indenture and a Supplemental Master Trust Indenture for Master Indenture Obligation No. 30, dated as of December 1, 2001, between Ascension Health, acting on behalf of itself and the other Senior Obligated Group Members, and the Senior Master Trustee. On December 21, 2011, Ascension Health Alliance, a Missouri nonprofit corporation formed on September 13, 2011 and the sole corporate member of Ascension Health, became a member of the Senior Credit Group and, on December 22, 2011, was appointed the Senior Credit Group Representative under the Senior Master Indenture. The Senior Obligations are joint and several obligations of Ascension Health Alliance and the other Senior Obligated Group Members.

Reference is made to the Reoffering Circular dated February 18, 2009 (the “2009 Reoffering Circular”) relating to the Bonds, which is on file with the Municipal Securities Rulemaking Board (the “MSRB”) on its Electronic

* Reflects the defeasance of $1,315,000 of the Connecticut Bonds on February 23, 2010 to be redeemed on February 1, 2012.
Municipal Market Access (“EMMA”) system and incorporated herein by reference, for a summary description of the Bonds, including a description of the security for the Bonds.

Neither the Connecticut Authority nor the Indiana Authority has participated in the preparation of this Reoffering Circular, each makes no representation with respect hereto and neither the Connecticut Authority nor the Indiana Authority is in any manner responsible for any of the information contained herein or for the remarketing of the Bonds.

While in a Long-Term Interest Rate Period, the Bonds operate in the manner described under the captions, “THE BONDS – General,” “ – Payment of Principal and Interest” and “ – Interest Rates and Rate Periods – Long-Term Interest Rate Period” in the 2009 Reoffering Circular. Reference is made to the information under such captions in the 2009 Reoffering Circular for a description of the Bonds while in Long-Term Interest Rate Period.

The Bonds are subject to mandatory redemption prior to the Purchase Date. The Connecticut Borrowers are obligated to provide funds for the purchase of the Connecticut Bonds on the Purchase Date. Ascension Health is obligated to provide funds for the purchase of the Indiana Bonds on the Purchase Date. See “THE BONDS – Purchase of Bonds” in the 2009 Reoffering Circular.

The Connecticut Bonds are subject to mandatory redemption prior to the Purchase Date. Both the Connecticut Bonds and the Indiana Bonds are subject to extraordinary redemption prior to maturity under certain circumstances described in the 2009 Reoffering Circular. The Bonds are not subject to optional redemption prior to the Purchase Date. See “THE BONDS – Redemption” in the 2009 Reoffering Circular.

The Mandatory Sinking Account Payments table relating to the Connecticut Bonds on page 10 of the 2009 Reoffering Circular has been amended to reflect the $1,315,000 of the Bonds previously defeased and to be redeemed on February 1, 2012. As a result of such defeasance and redemption, the Mandatory Sinking Account Payment on November 15, 2013 and 2014 have been amended to $745,000 and $640,000, respectively.

Description of the Bonds

Set forth in the 2009 Reoffering Circular under the caption “THE BONDS” is a summary description of the Bonds. The summary is qualified in its entirety by reference to the Bond Indentures, and is not to be considered as a full statement of the provisions of each such document.

Reoffering of the Bonds

The Bonds currently bear interest at a Long-Term Interest Rate in a Long-Term Interest Rate Period ending January 31, 2012. The Bonds are subject to mandatory tender on February 1, 2012 (the first day of a new Interest Rate Period; see “THE BONDS – Purchase of Bonds” in the 2009 Reoffering Circular).

The Bonds are being reoffered and will bear interest at a Long-Term Interest Rate in a new period beginning February 1, 2012 and ending on January 31, 2017, subject to mandatory tender on the Purchase Date. Interest on the Bonds in the new Long-Term Interest Rate Period will be payable on each May 15 and November 15, beginning May 15, 2012 and on the Purchase Date. See “THE BONDS – General” and “ – Payment of Principal and Interest” in the 2009 Reoffering Circular.

Bondholders’ Risks

Except as noted herein and in the 2009 Reoffering Circular, the Bonds are payable solely from and secured by Loan Repayments made pursuant to the separate Loan Agreements and payments made pursuant to the Senior Obligations. No representation or assurance can be made that revenues will be realized by Ascension Health, the Connecticut Borrowers (with respect to the Connecticut Bonds) or other Senior Credit Group Members in amounts sufficient to make the payments under the Loan Agreements or Senior Obligations and thus, to pay principal of, redemption premium and interest on the Bonds and the purchase price. Other than as described below, the risks that
may affect the Bonds and the Senior Credit Group are described under the caption “BONDHOLDERS’ RISKS” in the 2009 Reoffering Circular.

**Market Risk**

As of September 30, 2011, Ascension Health had approximately $454.9 million principal amount outstanding of variable rate bonds bearing interest at weekly interest rates which could be put upon seven days notice and $320.5 million of “remarketing windows” bonds which could be put after a 30-day remarketing period plus a 6-month notification period. None of these variable rate bonds are supported by dedicated letters of credit or other dedicated liquidity facilities. Ascension Health, however, has a $1 billion general purpose line of credit which may be used to purchase certain unremarketed tendered bonds. If these variable rate bonds cannot be remarketed following their tender, or converted to another interest rate mode, Ascension Health will be required to pay the tender price of tendered and unremarketed bonds not paid with this general purpose line of credit with its own funds. In addition, the interest rates on such bonds from time to time has fluctuated significantly and may increase Ascension Health’s cost of capital.

**Impact of Market Turmoil**

The disruption of the credit and financial markets in the last several years has led to volatility in the securities markets, significant losses in investment portfolios, increased business failures and consumer and business bankruptcies, and is a major cause of the current economic crisis. In response to that disruption, the Dodd-Frank Wall Street Reform and Consumer Protection Act (the “Financial Reform Act”) was enacted and approved by the President on July 21, 2010. The Financial Reform Act includes broad changes to the existing financial regulatory structure, including the creation of new federal agencies to identify and respond to risks to the financial stability of the United States. Additional legislation is pending or under active consideration by Congress and regulatory action is being considered by various Federal agencies and the Federal Reserve Board and foreign governments, which are intended to increase the regulation of domestic and global credit markets. The effects of the Financial Reform Act and of these legislative, regulatory and other governmental actions, if implemented, are unclear.

The health care sector, including Ascension Health and the Senior Credit Group, have been materially adversely affected by this market turmoil. The consequences of this market turmoil have generally included, among other things, realized and unrealized investment portfolio losses, increased borrowing costs and periodic disruption of access to the capital markets. For a discussion of the effects of these factors on Ascension Health and the Senior Credit Group, see APPENDIX A – “FINANCIAL AND OPERATING INFORMATION – Management’s Discussion Of Financial Performance” in the 2010 Official Statement (as hereinafter defined).

The economic crisis is adversely affecting the operations of the Senior Credit Group. Patient service revenues and inpatient volumes have not increased as historic trends would otherwise indicate. Unemployment rates remain high nationally and substantially so in certain market areas in which Senior Credit Group Members own and operate health care facilities, which has resulted in increases in self-pay admissions, increased levels of bad debt and uncompensated care, reduced demand for elective procedures, and reduced availability and affordability of health insurance. The economic crisis is also increasing stresses on the budgets of states in which Senior Credit Group Members are located, potentially resulting in reductions in Medicaid payment rates or Medicaid eligibility standards, and delays of payment of amounts due under Medicaid and other state or local payment programs.

In February 2009, the American Recovery and Reinvestment Act of 2009 (the “Recovery Act”) was enacted and includes several provisions that are intended to provide financial relief to the health care sector. These provisions include, among other things, a requirement that states promptly reimburse healthcare providers, and a subsidy to the recently unemployed for health insurance premium costs. The Recovery Act also establishes a framework for the implementation of a nationally-based health information technology program. For more information on this program, see “The HITECH Act” below.
Federal Budget Cuts

The recently enacted Budget Control Act of 2011 (the “BCA”) mandates significant reductions and spending caps on the federal budget for fiscal years 2012-2021. The BCA also created a Joint Select Committee on Deficit Reduction (the “Super Committee”) to develop a plan by November 23, 2011 to further reduce the federal deficit in the amount of $1.5 trillion. As the Super Committee failed to act on or before November 23, 2011, a 2% reduction in Medicare spending, among other reductions, could be triggered to take effect in 2013. The Medicaid program would be exempt from such automatic reductions.

At this time, it is unclear whether such automatic reductions will go into effect as planned in 2013, or if such provisions will be challenged, and, if challenged successfully, what the result will be. If effective, these reductions could be implemented disproportionately for hospitals and/or teaching hospitals and could have an adverse effect on the financial condition of the Senior Credit Group, which could be material. Further, with no long-term resolution in place for federal deficit reduction, hospital and physician reimbursement are likely to continue to be targets for reductions with respect to any interim or long-term federal deficit reduction efforts.

Health Care Reform

In March, 2010, the Patient Protection and Affordable Care Act (the “Health Care Reform Act”) was enacted and approved by the President.

Some of the provisions of the Health Care Reform Act took effect immediately, while others will take effect or will be phased in over time, ranging from a few months following approval to ten years. Because of the complexity of the Health Care Reform Act generally, additional legislation is likely to be considered and enacted over time. The Health Care Reform Act will also require the promulgation of substantial regulations with significant effects on the health care industry and third-party payors. In response, third-party payors and suppliers and vendors of goods and services to health care providers are expected to impose new and additional contractual terms and conditions. Thus, the health care industry will be subjected to significant new statutory and regulatory requirements and contractual terms and conditions, and consequently to structural and operational changes and challenges, for a substantial period of time.

A significant component of the Health Care Reform Act is reformation of the sources and methods by which consumers will pay for health care for themselves and their families and by which employers will procure health insurance for their employees and dependents and, as a consequence, expansion of the base of consumers of health care services. One of the primary drivers of the Health Care Reform Act is to provide or make available, or subsidize the premium costs of, health care insurance for some of the millions of currently uninsured (or underinsured) consumers who fall below certain income levels. The Health Care Reform Act proposes to accomplish that objective through various provisions, summarized as follows: (i) the creation of active markets (referred to as exchanges) in which individuals and small employers can purchase health care insurance for themselves and their families or their employees and dependents, (ii) providing subsidies for premium costs to individuals and families based upon their income relative to federal poverty levels, (iii) mandating that individual consumers obtain and certain employers provide a minimum level of health care insurance, and providing for penalties or taxes on consumers and employers that do not comply with these mandates, (iv) expansion of private commercial insurance coverage generally through such reforms as prohibitions on denials of coverage for pre-existing conditions and elimination of lifetime or annual cost caps, and (v) expansion of existing public programs, including Medicaid, for individuals and families. The Congressional Budget Office (“CBO”) has estimated that in federal fiscal year 2015, 19 million consumers who are currently uninsured will become insured, followed by an additional 11 million consumers in federal fiscal year 2016. To the extent all or any of those provisions produce the expected result, an increase in utilization of health care services by those who are currently avoiding or rationing their health care can be expected and bad debt expenses may be reduced. Associated with increased utilization will be increased variable and fixed costs of providing health care services, which may or may not be offset by increased revenues.

Some of the specific provisions of the Health Care Reform Act that may affect hospital operations, financial performance or financial conditions, including those of the Members of the Senior Credit Group, are described below. This listing is not, is not intended to be, nor should be considered by the reader as, comprehensive.
The Health Care Reform Act is complex and comprehensive, and includes a myriad of new programs and initiatives and changes to existing programs, policies, practices and laws.

At this time, management cannot predict the aggregate effect of the Health Care Reform Act upon Ascension Health.

- Commencing upon enactment through September 30, 2019, the annual Medicare market basket updates for hospitals will be reduced. Beginning October 1, 2011, the market basket updates will be subject to productivity adjustments. The reductions in market based updates and the productivity adjustments will have a disproportionately negative effect upon those providers that are relatively more dependent upon Medicare than other providers. Additionally, the reductions in market basket updates will be effective prior to the periods during which insurance coverage and the insured consumer base will expand, which may have an interim negative effect on revenues. The combination of reductions to the market basket updates and the imposition of the productivity adjustments may, in some cases and in some years, result in reductions in Medicare payment per discharge on a year-to-year basis.

- Commencing October 1, 2010 through September 30, 2019, payments under the “Medicare Advantage” programs (Medicare managed care) will be reduced, which may result in increased premiums or out-of-pocket costs to Medicare beneficiaries enrolled in Medicare Advantage plans. Those beneficiaries may terminate their participation in those plans and opt for the traditional Medicare fee-for-service program. The reduction in payments to Medicare Advantage programs may also lead to decreased payments to providers by managed care companies operating Medicare Advantage programs. All or any of these outcomes will have a disproportionately negative effect upon those providers with relatively high dependence upon Medicare managed care revenues.

- Commencing October 1, 2011, health care insurers will be required to include quality improvement covenants in their contracts with hospital providers, and will be required to report their progress on such actions to the Secretary of Health and Human Services (“HHS”). Commencing January 1, 2015, health care insurers participating in the health insurance exchanges will be allowed to contract only with hospitals that have implemented programs designed to ensure patient safety and enhance quality of care. The effect of these provisions upon the process of negotiating contracts with insurers or the costs of implementing such programs cannot be predicted.

- Commencing October 1, 2012, a value-based purchasing program will be established under the Medicare program designed to provide incentive payments to hospitals based on performance on quality and efficiency measures. These incentive payments are funded through a pool of money collected from all hospital providers.

- Commencing October 1, 2013, Medicare disproportionate share hospital (“DSH”) payments will be reduced initially by 75%. DSH payments will be increased thereafter to account for the national rate of consumers who do not have health care insurance and are provided uncompensated care. Commencing October 1, 2013, each state’s Medicaid DSH allotment from federal funds will be reduced.

- Expansion of Medicaid programs to a broader population with incomes up to 133% of federal poverty levels. CBO has estimated that 16 million consumers who are currently uninsured will become newly eligible for Medicaid through 2019 as a result of this expansion. Providers operating in markets with large Medicaid and uninsured populations are anticipated to benefit from increased revenues resulting from increased utilization and reductions in bad debt or uncompensated care. The increase in utilization can also be expected to increase in costs of providing that care, which may or may not be balanced by increased revenues.
• Commencing October 1, 2012, Medicare payments that would otherwise be made to hospitals that have a high rate of potentially preventable readmissions of Medicare patients for certain clinical conditions will be reduced by specified percentages to account for those excess and “preventable” hospital readmissions.

• Commencing October 1, 2014, Medicare payments to certain hospitals for hospital-acquired conditions will be reduced by 1%. Commencing July 1, 2011, federal payments to states for Medicaid services related to health care-acquired conditions will be prohibited.

• With varying effective dates, the Health Care Reform Act enhances the ability to detect and reduce waste, fraud, and abuse in public programs through provider enrollment screening, enhanced oversight periods for new providers and suppliers, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs, and by requiring Medicare and Medicaid program providers and suppliers to establish compliance programs. The Health Care Reform Act requires the development of a database to capture and share health care provider data across federal health care programs and provides for increased penalties for fraud and abuse violations, and increased funding for anti-fraud activities.

• Effective for tax years commencing immediately after approval, additional requirements for tax-exemption will be imposed upon tax-exempt hospitals, including obligations to adopt and publicize a financial assistance policy; limit charges to patients who qualify for financial assistance to the amount generally charged to insured patients; and control the billing and collection processes. Additionally, effective for tax years commencing March 23, 2012, tax-exempt hospitals must conduct a community needs assessment and adopt an implementation strategy to meet those identified needs. Failure to satisfy these conditions may result in the imposition of fines and the loss of tax-exempt status.

• The establishment of an Independent Payment Advisory Board to develop proposals to improve the quality of care and limitations on cost increases. Beginning January 15, 2019, if the Medicare growth rate exceeds the target set by the Health Care Reform Act, the Board is required to develop proposals to reduce the growth rate and require the Secretary of HHS to implement those proposals, unless Congress enacts legislation related to the proposals.

The Health Care Reform Act creates a Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models and to implement various demonstration programs and pilot projects to test, evaluate, encourage and expand new payment structures and methodologies to reduce health care expenditures while maintaining or improving quality of care, including bundled payments under Medicare and Medicaid, and comparative effectiveness research programs that compare the clinical effectiveness of medical treatments and develop recommendations concerning practice guidelines and coverage determinations. Other provisions encourage the creation of new health care delivery programs, such as accountable care organizations or combinations of provider organizations, which voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program. The outcomes of these projects and programs, including their effect on payments to providers and financial performance, cannot be predicted.

Efforts to repeal provisions of the Health Care Reform Act are pending in Congress and the constitutionality of the Health Care Reform Act is being challenged in courts across the country. In September 2011, the Obama administration and twenty-six states filed separate petitions asking the United States Supreme Court to review an appeals court decision. On November 14, 2011, the Supreme Court announced that it will hear the challenges to the Health Care Reform Act and address the following issues: (i) the constitutionality of the insurance mandate; (ii) whether some or all of the Health Care Reform Act must fail if the insurance mandate is stricken; (iii) the constitutionality of the Medicaid expansion and (iv) whether the Anti-Injunction Act, which requires a tax to be assessed and collected before it can legally be challenged, bars the Supreme Court from hearing the case until a penalty for violation of the individual insurance mandate is imposed. The Supreme Court is expected to rule on the issues in June 2012. The ultimate outcome of legislative attempts to repeal or amend the Health Care Reform Act and legal challenges to the Health Care Reform Act is unknown.
Management of Ascension Health is analyzing the Health Care Reform Act and will continue to do so in order to assess the effects of the legislation and evolving regulations on current and projected operations, financial performance and financial condition. However, management cannot predict with any reasonable degree of certainty or reliability any interim or ultimate effects of the legislation.

**Congressional Hearings**

In recent years, three congressional committees have conducted hearings and other proceedings inquiring into various practices of nonprofit hospitals and healthcare providers. The Health Care Reform Act, discussed above, contains many features from previous tax exemption reform proposals. It does not mandate specific levels of charity care for nonprofit hospitals, but it does include a set of sweeping changes applicable to charitable hospitals exempt under Section 501(c)(3) of the Code. The Health Care Reform Act (a) imposes new eligibility requirements for 501(c)(3) hospitals, coupled with an excise tax for failures to meet certain of those requirements; (b) requires mandatory IRS review of the hospital’s entitlement to exemption; (c) sets forth new reporting requirements, including information related to community health needs assessments and audited financial statements; and (d) imposes further reporting requirements on the Secretary of the Treasury regarding charity care levels.

**Internal Revenue Service Examination of Compensation Practices**

In February 2009, the IRS issued its Hospital Compliance Project Final Report (the “IRS Final Report”) that examined tax-exempt organizations’ practices and procedures with regard to compensation and benefits paid to their officers and other defined “insiders.” The IRS Final Report indicates that the IRS (i) will continue to heavily scrutinize executive compensation arrangements, practices and procedures and (ii) in certain circumstances, may conduct further investigations or impose fines on tax-exempt organizations.

**Actions by Purchasers of Hospital Services and Consumers**

Major purchasers of hospital services could take action to restrain hospital charges or charge increases. As a result of increased public scrutiny, it is also possible that the pricing strategies of hospitals may be perceived negatively by consumers, and hospitals may be forced to reduce fees for their services. Decreased utilization could result, and hospitals’ revenues may be negatively impacted. In addition, consumers and groups lobbying on behalf of consumers are increasing pressure for hospitals and other healthcare providers to be transparent and provide information about costs and quality of services that may affect future consumer choices about where to receive health care services.

**Charity Care**

Hospitals are permitted to obtain tax-exempt status under the Code because the provision of health care historically has been treated as a “charitable” enterprise. This treatment arose before most Americans had health insurance, when charitable donations were required to fund the health care provided to the sick and disabled. Some commentators and others have taken the position that, with the onset of employer health insurance and governmental reimbursement programs, there is no longer any justification for special tax treatment for the health care industry, and the availability of tax-exempt status should be eliminated. Federal and state tax authorities are also beginning to demand that tax-exempt hospitals justify their tax-exempt status by documenting their charitable care and other community benefits.

As described above under the caption, “Health Care Reform,” the Health Care Reform Act imposes additional requirements for tax-exemption upon tax-exempt hospitals, including obligations to adopt and publicize a financial assistance policy; limit charges to patients who qualify for financial assistance to the amounts generally billed to insured patients; and control the billing and collection processes. Additionally, effective for tax years commencing March 23, 2012, tax-exempt hospitals must conduct a community needs assessment and adopt an implementation strategy to meet those identified needs.
Failure to complete a community health needs assessment in any applicable three-year period can result in a penalty on the organization of up to $50,000, in addition to possible revocation of status as a section 501(c)(3) organization.

The Health Care Reform Act also imposes new reporting and disclosure requirements on hospital organizations. The IRS is required to review information about a hospital’s community benefit activities at least once every three years. The Health Care Reform Act requires the Secretary of the Treasury, in consultation with the Secretary of HHS, to submit annually a report to Congress with information regarding the levels of charity care, bad debt expenses, unreimbursed costs of government programs, as well as costs incurred by tax-exempt hospitals for community benefit activities. The Secretary of the Treasury, in consultation with the Secretary of HHS, must conduct a study of the trends in these amounts, and subject a report on such study to Congress not later than five years after the date of enactment of the Health Care Reform Act. These statutorily mandated requirements for periodic review and submission of reports relating to community benefit provided by section 501(c)(3) hospital organizations may increase the likelihood that Congress will consider additional requirements for section 501(c)(3) hospital organizations in the future and may increase IRS scrutiny of particular 501(c)(3) hospital organizations.

### Additional Medicare Risks

Hospitals participating in Medicare are subject to audits and retroactive audit adjustments with respect to reimbursements claimed under the Medicare program. The Members of the Senior Credit Group receive payments for various services provided to Medicare patients based upon charges or other reimbursement methodologies that are then reconciled annually based upon the preparation and submission of annual cost reports. Estimates for the annual cost reports are reflected as amounts due to/from third-party payors and represent several years of open cost reports due to time delays in the fiscal intermediaries’ audits and the basic complexity of billing and reimbursement regulations. These estimates are adjusted periodically based upon correspondence received from the fiscal intermediary. Medicare regulations also provide for withholding Medicare payment in certain circumstances if it is determined that an overpayment of Medicare funds has been made. In addition, under certain circumstances, payments may be determined to have been made as a consequence of improper claims subject to the Federal False Claims Act or other federal statutes, subjecting the Members of the Senior Credit Group to civil or criminal sanctions. Management of Ascension Health is not aware of any situation whereby a material Medicare payment is being withheld from the Members of the Senior Credit Group.

The Centers for Medicare and Medicaid Services, (“CMS”) enlists Recovery Audit Contractors (“RACs”) to further assure accurate payments to providers. RACs search for potentially improper Medicare payments from prior years that may not have been detected through CMS’s existing program integrity efforts. RACs are private contractors, paid on a contingency fee basis and use their own software and review processes to determine areas for review. Once a RAC identifies a potentially improper claim as a result of an audit, it applies an assessment to the provider’s Medicare reimbursement in an amount estimated to equal the overpayment from the provider pending resolution of the audit. Such audits may result in reduced reimbursement for past alleged overpayments and may slow future Medicare payments to providers pending resolution of appeals process with RACs. Under the Health Care Reform Act, recovery audits were expanded to include Medicaid by requiring states to contract with RACs to conduct such audits. It is unknown what, if any, future impact such reviews will have on the revenues of the Senior Credit Group. See the caption, “Health Care Reform,” above for changes to the Medicare program in the Health Care Reform Act.

### Additional Medicaid Risks

The Health Care Reform Act makes changes to Medicaid funding and substantially increases the potential number of Medicaid beneficiaries, as well as federal financial support for that increased enrollment, and expanded the RAC Medicare program to include Medicaid, using state-based RAC contracts. Management of the Corporation cannot predict the effect of these changes to the Medicaid program on the operations, results from operations or financial condition of Ascension Health or the Senior Credit Group.
Additional Private Health Plans and Managed Care Risks

Ascension Health management anticipates that the Health Care Reform Act will substantially alter the commercial health care insurance industry. The Health Care Reform Act imposes, over time, increased regulation of the industry, the use and availability of state-based exchanges in which health insurance can be purchased by certain groups and segments of the population, the extension of subsidies and tax credits for premium payments by some consumers and employers and the imposition upon commercial insurers of certain terms and conditions that must be included in contracts with providers. In addition, the Health Care Reform Act imposes many new obligations on states related to health care insurance. It is unclear how the increased federal oversight of state health care may affect future state oversight or affect Ascension Health and the other Members of the Senior Credit Group. The effects of these changes upon the financial condition of any third-party payor that offer health care insurance, rates paid by third-party payors to providers and thus the revenues of the Senior Credit Group, and upon the operations, results of operations and financial condition of the Senior Credit Group cannot be predicted.

State Laws

States are increasingly regulating the delivery of health care services. Much of this increased regulation has centered on the managed care industry. State legislatures have cited their right and obligation to regulate and oversee health care insurance and have enacted sweeping measures that aim to protect consumers and, in some cases, providers. For example, a number of states have enacted laws mandating a minimum of 48-hour hospital stays for women after delivery; laws prohibiting “gag clauses” (contract provisions that prohibit providers from discussing various issues with their patients); laws defining “emergencies,” which provide that a health care plan may not deny coverage for an emergency room visit if a layperson would perceive the situation as an emergency; and laws requiring direct access to obstetrician-gynecologists without the requirement of a referral from a primary care physician.

Due to this increased state oversight, the Senior Credit Group Members could become subject to a variety of state health care laws and regulations affecting health care providers. In addition, the Senior Credit Group Members could be subject to state laws and regulations prohibiting, restricting, or otherwise governing PPOs, third-party administrators, physician-hospital organizations, independent practice associations or other intermediaries, fee-splitting, the “corporate practice of medicine,” selective contracting, “any willing provider” laws and “freedom of choice” laws, coinsurance and deductible amounts, insurance agency and brokerage, quality assurance, utilization review, and credentialing activities, provider and patient grievances, mandated benefits, rate increases, and many other practices.

Dependence Upon Third-Party Payors

The Senior Credit Group Members’ ability to develop and expand their services and, therefore, profitability, is dependent upon their ability to enter into contracts with third-party payors at competitive rates. There can be no assurance that they will be able to attract third-party payors, and where they do, no assurance can be given that they will be able to contract with such payors on advantageous terms. The inability of the Senior Credit Group Members to contract with a sufficient number of such payors on advantageous terms could have a material adverse effect on the Senior Credit Group Members’ future operations and financial results.

Alternative or Integrated Delivery System Development

The Health Care Reform Act encourages the development of health care delivery models that are designed to enhance quality and reduce cost and that will effectively require greater integration between and collaboration among hospitals and physicians by allowing accountable care organizations (“ACOs”) that meet quality thresholds to share in the savings achieved for the Medicare Program. The Health Care Reform Act requires the Secretary of HHS to implement a shared savings program through ACOs requiring integration between hospitals and physicians, that will deliver health care services to Medicare beneficiaries, and to implementation a demonstration project to develop ACOs for pediatric patients under the Medicaid program.
False Claims Act

The federal False Claims Act, or FCA makes it illegal to submit or present a false, fictitious or fraudulent claim for payment or approval for payment for which the federal government provides, or reimburses at least some portion of the requested money or property. The Health Care Reform Act amends the FCA by expanding the number of activities that are subject to enforcement as violations of the FCA, including, among other actions, failure to report and return to a federal health care program a known overpayment within 60 days of having indentified the overpayment or, for cost-reporting entities, the date (if later) on which a hospital cost report is due. FCA investigations and cases have become common in the health care field and may cover a range of activity from intentionally inflated billings, to highly technical billing infractions, to allegations of inadequate care. Violation or alleged violation of the FCA most often results in settlements that require multi-million dollar payments and compliance agreements. The FCA also permits individuals to initiate civil actions on behalf of the government in lawsuits called “qui tam” actions. Qui tam plaintiffs, or “whistleblowers,” share in the damages recovered by the government or recovered independently if the government does not participate. The FCA has become one of the government’s primary weapons against health care fraud. FCA violations or alleged violations could lead to settlements, fines, exclusion or reputation damage that could have a material adverse impact on a hospital.

The HITECH Act

Provisions in the Health Information Technology for Economic and Clinical Health Act (the “HITECH Act”), enacted as part of the Recovery Act, increase the maximum civil monetary penalties for violations of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and grant enforcement authority of HIPAA to state attorneys general. The HITECH Act also (i) extends the reach of HIPAA beyond “covered entities,” (ii) imposes a breach notification requirement on HIPAA covered entities, (iii) limits certain uses and disclosures of individually identifiable information and (iv) restricts covered entities’ marketing communications.

The HITECH Act also established programs under Medicare and Medicaid to provide incentive payments for the “meaningful use” of certified electronic health record (“EHR”) technology. Beginning in 2011, the Medicare and Medicaid EHR incentive programs will provide incentive payments to eligible professionals and eligible hospitals for demonstrating meaningful use of certified EHR technology. Health care providers demonstrate their meaningful use of EHR technology by meeting objectives specified by the Centers for Medicare and Medicaid Services for using health information technology and by reporting on specified clinical quality measures. Beginning in 2015, hospitals and physicians who have not satisfied the performance and reporting criteria for demonstrating meaningful use will have their Medicare payments significantly reduced.

Security Breaches and Unauthorized Releases of Personal Information

Federal and state authorities are increasingly focused on the importance of protecting the confidentiality of individuals’ personal information, including patient health information. Many states have enacted laws requiring businesses to notify individuals of security breaches that result in the unauthorized release of personal information. In some states, notification requirements may be triggered even where information has not been used or disclosed, but rather has been inappropriately accessed. State consumer protection laws may also provide the basis for legal action for privacy and security breaches and frequently, unlike HIPAA, authorize a private right of action. In particular, the public nature of security breaches exposes health organizations to increased risk of individual or class action lawsuits from patients or other affected persons, in addition to government enforcement. Failure to comply with restrictions on patient privacy or to maintain robust information security safeguards, including taking steps to ensure that contractors who have access to sensitive patient information maintain the confidentiality of such information, could consequently damage a health care provider’s reputation and materially adversely affect business operations.

Proposed Legislation Regarding Limitations or Elimination of Tax-Exempt Status of the Bonds

Current and future legislative proposals, if enacted into law, clarification of the Code or court decisions may cause interest on the Bonds to be subject, directly or indirectly, to federal income taxation or to be subject to or exempted from state income taxation, or otherwise prevent Beneficial Owners from realizing the full current benefit of the tax status of such interest. As one example, on September 12, 2011, the Obama Administration announced a
legislative proposal entitled the American Jobs Act of 2011. For tax years beginning on or after January 1, 2013, the American Jobs Act of 2011, generally would limit the exclusion from gross income of interest on obligations like the Bonds to some extent for taxpayers who are individuals and whose income is subject to higher marginal income tax rates. Other proposals have been made that could significantly reduce the benefit of, or otherwise affect, the exclusion from gross income of interest on obligations like the Bonds. The introduction or enactment of any such legislative proposals, clarification of the Code or court decisions may also affect, perhaps significantly, the market price for, or marketability of, the Bonds. Prospective purchasers of the Bonds should consult their own tax advisors regarding any pending or proposed federal or state tax legislation, regulations or litigation and regarding the impact of future legislation, regulations or litigation, as to which Bond Counsel expresses no opinion.

**Bond Examinations**

The IRS has added a new Schedule H to IRS Form 990, on which hospitals and health systems will be required to report how they provide community benefit and to specify certain billing and collection practices. The IRS has also added a new Schedule K to IRS Form 990. This new schedule requests detailed information related to all outstanding bond issues of nonprofit borrowers, including, for bonds issued after 2002, information regarding operating, management and research contracts as well as private business use compliance. Filers must complete the entire schedule for tax years beginning in 2009.

Although Ascension Health believes that its expenditure and investment of bond proceeds, use of property financed with tax-exempt debt and record retention practices comply with all applicable laws and regulations, there can be no assurance that an IRS review triggered by information submitted on a Schedule H or Schedule K would not adversely affect the market value of the Bonds or of other outstanding tax-exempt indebtedness of the Senior Credit Group. Additionally, the Bonds or other tax-exempt obligations issued for the benefit of the Senior Credit Group Members, may be, from time to time, subject to examinations by the IRS. Ascension Health believes that the Bonds and other tax-exempt obligations issued for the benefit of the Senior Credit Group Members, properly comply with the tax laws. In addition, Bond Counsel rendered a separate opinion with respect to the tax-exempt status of the Bonds upon their issuance. No ruling with respect to the tax-exempt status of the Bonds has been or will be sought from the IRS, however, and the opinions of counsel are not binding on the IRS or the courts. There can be no assurance that any IRS examination of the Bonds will not adversely affect the market value of the Bonds.

**Information Technology**

The ability to adequately price and bill healthcare services and to accurately report financial results depends on the integrity of the data stored within information systems. Information systems require an ongoing commitment of significant resources to maintain, protect and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving systems and regulatory standards. There can be no assurance that efforts to upgrade and expand information systems capabilities, protect and enhance these systems, and develop new systems to keep pace with continuing changes in information processing technology will be successful or that additional systems issues will not arise in the future.

Electronic media are also increasingly being used in clinical operations, including the conversion from paper to electronic medical records, computerization of order entry functions and the implementation of clinical decision-support software. The reliance on information technology for these purposes imposes new expectations on physicians and other workforce members to be adept in using and managing electronic systems. It also introduces risks related to patient safety, and to the privacy, accessibility and preservation of health information. Technology malfunctions or failure to understand and use information systems properly could result in the dissemination of or reliance on inaccurate information, as well as in disputes with patients, physicians and other health care professionals. Health information systems may also be subject to different or higher standards or greater regulation than other information technology or the paper-based systems previously used by health care providers, which may increase the cost, complexity and risks of operations. All of these risks may have adverse consequences on hospitals and health care providers.

Future government regulation and adherence to technological advances could result in an increased need of the Senior Credit Group Members to implement new technology. Such implementation could be costly and is
subject to cost overruns and delays in application, which could negatively affect the financial condition of the Senior Credit Group.

CMS recently announced required transitions for medical diagnosis and procedure coding. Such changes will affect coding for everyone covered by HIPAA and must be used on all HIPAA transactions, including outpatient claims with dates of service, and inpatient claims with dates of discharge on and after October 1, 2013. If such changes are not effectively impacted, claims and other transactions could be rejected and would be required to be resubmitted. In addition, standards for electronic health care transactions are also required to be changed, including transactions for claims, eligibility inquiries and remittance advices. If providers do not conduct electronic health transactions consistent with such changes, they could experience delays in claim reimbursement.

Preparing for such new requirements, including potential updated software installation, staff training, changes to business operations and workflows, internal and external testing will take time. In addition, there is no assurance that the Senior Credit Group will timely or adequately implement such changes, resulting in delays in reimbursement discussed above, which could negatively affect the operations of the Senior Credit Group.

Cost of Capital

From time to time, Congress has considered and is considering revisions to the Internal Revenue Code that may prevent or limit access to the tax-exempt debt market to borrowers or issuers such as the Senior Credit Group Members. Such legislation, if enacted into law, may have the effect of increasing the capital costs of the Senior Credit Group Members.

Remarketing Agent

On and after the Purchase Date, each Series of Bonds will be remarketed in accordance with the related Bond Indenture by Citigroup Global Markets Inc. and Morgan Stanley & Co. LLC.

Ascension Health Alliance and the Ascension Health Alliance Senior Credit Group

Ascension Health Alliance is a Missouri nonprofit corporation formed on September 13, 2011 and is the sole corporate member of Ascension Health. Through Ascension Health, Ascension Health Alliance is the indirect sole corporate member of certain non-profit corporations that own and operate acute care hospitals and other health care facilities and service providers with approximately 15,660 available beds as of June 2011.

On December 21, 2011, Ascension Health Alliance became a member of the Ascension Health Senior and Subordinate Credit Groups under the Senior and Subordinate Master Indentures and, on December 22, 2011, was appointed as (i) the Senior Credit Group Representative under the Senior Master Indenture and (ii) the Subordinate Credit Group Representative under the subordinate master trust indenture dated as of February 1, 2005, as supplemented (the “Subordinate Master Indenture”), among Ascension Health, other corporations that are subordinated obligated group members thereunder from time to time, and U.S. Bank National Association, as subordinate master trustee.

Information concerning Ascension Health and the Ascension Health Alliance Senior Credit Group is incorporated by reference to Appendix A to the Official Statement dated March 17, 2010 related to the $678,990,000 Michigan State Hospital Finance Authority Refunding and Project Revenue Bonds (Ascension Health Senior Credit Group) Series 2010F (the “2010 Official Statement”) which is on file on the MSRB’s EMMA system. In addition, see the supplemental information detailing Ascension Health Alliance attached hereto as EXHIBIT I and the supplemental information updating Appendix A to the 2010 Official Statement attached hereto as EXHIBIT II.

Continuing Disclosure; Financial Information

Ascension Health, on behalf of itself and the other Senior Credit Group Members, has complied with its continuing disclosure undertakings pursuant to Securities and Exchange Commission Rule 15c2-12 for each of the
past five years. Ascension Health, on behalf of itself and the other Senior Credit Group Members, has also undertaken all responsibilities for any continuing disclosure to Holders of the Bonds as described below, and the Authority shall have no liability to the Holders of the Bonds or any other person with respect to Securities and Exchange Commission Rule 15c2-12.


Ascension Health, on behalf of itself and the other Senior Credit Group Members, has covenanted for the benefit of Holders and Beneficial Owners of the Bonds to provide, an Annual Report (an “Annual Report”) no later than 180 days following the end of Ascension Health’s fiscal year. Each Annual Report shall provide certain financial and operating data relating to the Senior Credit Group. Ascension Health has also covenanted to provide, in a Quarterly Report (a “Quarterly Report”), certain quarterly unaudited financial information for the first three quarters of each fiscal year relating to the Senior Credit Group no later than 60 days following the end of each of the first three quarters of Ascension Health’s fiscal year. The specific nature of the information to be contained in the Annual Report and Quarterly Report is described under the caption “CONTINUING DISCLOSURE” in the 2009 Reoffering Circular.

Financial information may also be obtained from Ascension Health online at the following web address: http://www.ascensionhealth.org/about/op_finance/public/community_invest.asp. No assurances can be given that Ascension Health will continue to make such information available on its website.

Ratings

The Bonds are currently assigned and are expected to continue to carry as of February 1, 2012, the municipal bond ratings of “AA+/F1+,” “Aa1/VMIG 1” and “AA+/A-1+” by Fitch Ratings, Moody’s Investors Service, Inc. and Standard & Poor’s Ratings Services (a division of The McGraw Hill Companies, Inc. (collectively, the “Rating Agencies”), respectively. The short-term ratings on the Bonds are based on a self-liquidity obligation of Ascension Health. There is no assurance that the ratings mentioned above will remain in effect for any given period of time or that they might not be lowered or withdrawn entirely by the Rating Agencies, if in their judgment circumstances so warrant. Any downward change in or withdrawal of any ratings might have an adverse effect on the market price or marketability of the Bonds.

Documents Incorporated By Reference

Copies of the documents referenced in this Reoffering Circular, including the 2009 Reoffering Circular, Appendix A to the 2010 Official Statement, the 2011 Annual Report and the 2011 Quarterly Report are available from the MSRB’s EMMA system.
EXHIBIT I

Information Concerning Ascension Health Alliance
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>General</td>
<td>1</td>
</tr>
<tr>
<td>CHANGES TO THE COMPOSITION OF THE SENIOR CREDIT GROUP</td>
<td>1</td>
</tr>
<tr>
<td>FINANCIAL AND OPERATING INFORMATION</td>
<td>2</td>
</tr>
<tr>
<td>General</td>
<td>2</td>
</tr>
<tr>
<td>Changes to Financial Information</td>
<td>2</td>
</tr>
<tr>
<td>CORPORATE STRUCTURE AND MANAGEMENT</td>
<td>2</td>
</tr>
<tr>
<td>Sponsorship and Members</td>
<td>2</td>
</tr>
<tr>
<td>Ascension Health Ministries</td>
<td>2</td>
</tr>
<tr>
<td>Board of Directors</td>
<td>3</td>
</tr>
<tr>
<td>Management</td>
<td>3</td>
</tr>
<tr>
<td>Committees</td>
<td>7</td>
</tr>
<tr>
<td>Incorporation by Reference</td>
<td>7</td>
</tr>
<tr>
<td>LIST OF MEMBERS OF THE ASCENSION HEALTH ALLIANCE SENIOR CREDIT GROUP</td>
<td>8</td>
</tr>
</tbody>
</table>
INTRODUCTION

General

Ascension Health Alliance is a Missouri nonprofit corporation formed on September 13, 2011 and is the sole corporate member of Ascension Health. Ascension Health Alliance is the parent organization of a national health system consisting primarily of nonprofit corporations that own and operate local healthcare facilities, or Health Ministries. The Health Ministries that are part of Ascension Health Alliance were formerly part of the Daughters of Charity National Health System, the Sisters of St. Joseph Health System or the Carondelet Health System. From time to time in this EXHIBIT I, Ascension Health Alliance, its affiliated corporations and the Health Ministries are referred to collectively as the System.

In addition to serving as the sole corporate member of Ascension Health, Ascension Health Alliance serves as the member or shareholder of various other System subsidiaries, including Seton Institute, Ascension Health Insurance Limited, Ascension Health Resources and Supply Group, LLC, Clinical Holdings Corporation, Catholic Healthcare Investment Management Company, Ascension Health Ventures, LLC, Ascension Health Leadership Academy, LLC, and AH Holdings, LLC. Through Ascension Health, Ascension Health Alliance is the indirect sole corporate member of certain nonprofit corporations that own and operate acute care hospitals and other health care facilities and service providers with approximately 15,660 available beds as of June 30, 2011. As of June 30, 2011, these corporations owned and operated 68 general acute care hospitals, two long-term acute care hospitals, five psychiatric hospitals and two rehabilitation hospitals, with more than 113,500 employees. Ascension Health Alliance is the largest nonprofit Catholic health care system in the United States.

On December 21, 2011, Ascension Health Alliance became a member of the Ascension Health Senior and Subordinate Credit Groups and on December 22, 2011, was appointed as (i) the Senior Credit Group Representative under the Master Trust Indenture, dated as of November 1, 1999, as amended and supplemented, among Ascension Health, the other corporations that are senior obligated group members thereunder from time to time and U.S. Bank National Association, as Senior Master Trustee and (ii) the Subordinate Credit Group Representative under the subordinate master trust indenture dated as of February 1, 2005, as supplemented, among Ascension Health, other corporations that are subordinate obligated group members thereunder from time to time, and U.S. Bank National Association, as subordinate master trustee. Each of the Senior Master Indenture and the Subordinate Master Indenture provides for the creation of a Senior Credit Group and a Subordinate Credit Group, respectively. Both of the Senior Credit Group and the Subordinate Credit Group is comprised of Obligated Group Members, Designated Affiliates and Limited Designated Affiliates. The Subordinate Master Indenture requires that the members of the Subordinate Credit Group are identical to the members of the Senior Credit Group. References in this EXHIBIT I shall be made to the Senior Credit Group.

As the sole corporate member of Ascension Health, Ascension Health Alliance has retained certain reserved powers over Ascension Health. These reserved powers permit Ascension Health Alliance to, among others, (i) approve the articles of incorporation and bylaws of Ascension Health, (ii) appoint or remove members of the Board of Trustees, including the Chair of the Board of Trustees, subject to ratification by Ascension Health Ministries (as described under the heading “CORPORATE STRUCTURE AND MANAGEMENT – Ascension Health Ministries below), (iii) approve the sale, transfer or substantial change in use of all or substantially all of the assets of Ascension Health or any Senior Credit Group member, (iv) approve the merger, dissolution or consolidation of Ascension Health or any Senior Credit Group member, (v) approve the capital allocation plan for Ascension Health and (vi) approve the incurrence of debt by Ascension Health and any Senior Credit Group member.

CHANGES TO THE COMPOSITION OF THE SENIOR CREDIT GROUP

The corporate structure of Ascension Health Alliance is designed to accommodate the addition of new affiliates with other health care providers and health care systems. Additional entities may become Members of the Senior Credit Group. Ascension Health Alliance has adopted strategies encouraging the Members of the Senior Credit Group to explore regional integrated delivery networks with other healthcare providers in their respective service areas. These activities could lead to the addition of other nonprofit corporations to the Senior Credit Group, the withdrawal of current Members from the Senior Credit Group, or the purchase or divestiture of assets. The ongoing nature of these activities is such that management is unable to conclude whether they will result in any form
of affiliation or divestiture or the addition of Members to or the withdrawal of Members from the Senior Credit Group, other than those described herein.

FINANCIAL AND OPERATING INFORMATION

General


Changes to Financial Information

Catholic Healthcare Investment Management Company (“CHIMCO”) was formed in 2010 and became operational in 2011. CHIMCO is a tax-exempt subsidiary of Ascension Health Alliance whose purpose is to manage the investment portfolio of Ascension Health Alliance, as well as related entities of Ascension Health Alliance and like-minded not-for-profit partners. CHIMCO is structuring CHIMCO Alpha Fund, LLC, a limited liability company, whose purpose is to operate as an investment vehicle for the Senior Credit Group Members to pool their investments and cash, to benefit from professional management by CHIMCO and from economies of scale, and to exercise all the powers necessary or incidental to, or in support of, its investment opportunities. It is anticipated that the majority of Ascension Health’s long term operating funds will be held in CHIMCO Alpha Fund, LLC. The CHIMCO Alpha Fund, LLC is expected to be a consolidated entity of Ascension Health Alliance. As a result, the consolidated financial statements of Ascension Health Alliance are expected to experience increases in certain financial statement line items including, but not limited to, investments, liabilities, investment return, and noncontrolling interests. These changes will have no impact on the unrestricted net assets attributable to Ascension Health Alliance.

CORPORATE STRUCTURE AND MANAGEMENT

Sponsorship and Members

Ascension Health Alliance is sponsored by Ascension Health Ministries, a public juridic person. The founding participating entities of Ascension Health Ministries are:

(1) Daughters of Charity of St. Vincent de Paul in the United States, St. Louise Province;

(2) Congregation of St. Joseph; and

(3) Congregation of the Sisters of St. Joseph of Carondelet.

Ascension Health Ministries

The founding participating entities of Ascension Health Ministries have appointed the following individuals, comprised of both religious and lay individuals, to serve as the initial members of Ascension Health Ministries. These individuals will serve one to three year terms. Ascension Health Ministries holds certain reserved powers over Ascension Health Alliance.
The individuals appointed to serve as members of Ascension Health Ministries are as follows:

**Members**

Sr. Mary Catherine (Kay) Ryan, CSJ, Chair
Andre Delbecq, D.B.A.
Sr. Mary Kay Hadican, CSJ
Mr. John “Jack” W. Logue
Sr. Barbara Moore, CSJ
Mr. Gino Pazzaglini
Mr. LeRoy Rheault
Sr. Mary Ann Rodgers, CSJ
Sr. Mary Walz, DC

**Board of Directors**

The business, property, affairs and funds of Ascension Health Alliance are managed, supervised and controlled by the Board of Directors, who exercise all powers of Ascension Health Alliance not reserved to Ascension Health Ministries and in accordance with Ascension Health Alliance system policy and subject to the limitations contained in Ascension Health Alliance’s Articles of Incorporation and Bylaws and applicable law. The Board of Directors consists of five to nine Board members, as fixed from time to time by Ascension Health Ministries (as of the date of this Private Placement, there are five Board members). Actions of the Board of Directors are taken by majority vote of a quorum.

The current members of the Board of Directors are as follows:

**Members**

Sr. Kathleen Kelly, CSJ (Board Chair)
Sr. Theresa Peck, DC
Fr. Dennis Holtschneider, CM
Anthony Tersigni, EdD., FACHE, President and CEO
Ms. Agnieszka Winkler

**Management**

The current senior management of Ascension Health Alliance is as follows (CEO is listed first, and all others are listed in alphabetical order):

**Anthony R. Tersigni, EdD, FACHE, President and Chief Executive Officer.** Dr. Anthony Tersigni serves as President and CEO of Ascension Health Alliance. He previously served as President and CEO of Ascension Health since June 18, 2004. Prior to his appointment as President and CEO, he served as Ascension Health's Executive Vice President and Chief Operating Officer from January 2001 through December 2003. He was interim CEO for the System beginning in January 2004. From 1995 to 2000, Dr. Tersigni was President and Chief Executive Officer at St. John Health, Detroit, Michigan, Ascension Health’s largest integrated health system. He also served the St. John system as Executive Vice President and Chief Operating Officer from 1994 to 1995. He has held senior leadership positions for numerous other healthcare organizations, including the Sisters of St. Joseph Health System, Ann Arbor, Michigan; Sisters of Charity Healthcare Systems, Cincinnati, Ohio; The Detroit Medical Center, Detroit; Michigan; and Hospital Corporation of America, Nashville, Tennessee. Since 1985, Dr. Tersigni has been a Clinical Professor of Health and Behavioral Sciences at Oakland University. Dr. Tersigni has served as a board member of many professional organizations and is currently a board member of the Detroit Economic Club, The National Catholic Bioethics Center, and serves as national development co-chair for the Society of St. Vincent DePaul. He also serves on the Boards of the United Way of Greater St. Louis, Inc. and the St. Louis Regional Business Council, and is a member of the Coalition to Protect America’s Health Care and the St. Louis Regional Commerce and Growth Association. He is currently Chairman of the Healthcare Leadership Council and recently served as Chairman of the Board of the Catholic Health Association of the United States. Dr. Tersigni has been listed as one of Modern Healthcare’s 100 Most Powerful People in Healthcare from 2005 to 2011. He is the
recipient of many professional awards. Dr. Tersigni holds a doctorate in the field of leadership/organizational development from Western Michigan University, Kalamazoo, Michigan.

Sr. Bernice Coreil, DC, Senior Executive Advisor to the President. Sr. Bernice Coreil, DC, is the Senior Executive Advisor to the President at Ascension Health Alliance. She received a bachelor's degree in business administration in 1969, from Regis College, Denver, Colorado, graduating magna cum laude; a master’s degree in health care administration in 1972, from George Washington University, Washington, D.C.; and an honorary doctorate in 2006 from Aquinas Institute of Theology, St. Louis, Missouri. Her experience in health ministry ranges from Business Manager to Chief Executive Officer, and in Provincial Leadership as Health Councillor and Visitatrix of the Daughters of Charity, West Central Province. Prior to the formation of Ascension Health, Sr. Bernice served as Senior Vice President for System Integration for the Daughters of Charity National Health System from 1993 to 1999. Sr. Bernice currently serves as a member of several professional organizations including: Diplomat of the American College of Healthcare Executives; Mercy Housing Strategic Health Care Partners; Seton Institute; Catholic Charities USA; Lifetime Advanced Member, Healthcare Financial Management Association; Chair, of Incardinate Word Foundation; Board of Incardinate Word Foundation; Hospital Sisters Health System Board; Marian Health System Board; and Ascension Health Ventures Board. Sr. Bernice is the recipient of the 1994 Samuel Cardinal Stritch Award for Health Affairs, and received the Archbishop John L. May Leadership Award for Distinguished Health Care Ministry from the Archbishop’s Commission on Community Health in 1997. Sr. Bernice also received the American College of Healthcare Executives Senior Level Healthcare Executive Regents Award at the 1999 Missouri Hospital Association Convention. In 2003, she received the Lifetime Achievement award from the Catholic Health Association.

John D. Doyle, Executive Vice President. John D. Doyle serves as Executive Vice President of Ascension Health Alliance and the President and Chief Executive Officer of AH Holdings, LLC, a subsidiary of Ascension Health Alliance. In this role he has responsibility for a portfolio of companies designed to add value to the organization by providing services to the Health Ministries of Ascension Health and other health systems in the United States and internationally. Mr. Doyle’s responsibilities also include overseeing incubation of transformational/disruptive solutions and innovative relationships that have the potential to accelerate Ascension Health’s accomplishment of the Strategic Direction. In his role as Chief Strategy Officer of Ascension Health, Mr. Doyle has responsibility for developing and ensuring implementation of Ascension Health’s overall Strategic Direction. As General Manager of Transformational Development, the innovation center of Ascension Health, Mr. Doyle provides the overall vision and management of that group, which has been renamed and incorporated into AH Holdings. Mr. Doyle was previously Senior Vice President, Strategic Business Development & Innovation for Ascension Health. Before joining Ascension Health’s System Office, Mr. Doyle was Executive Vice President for Strategic Development for St. Vincent Hospitals and Health Services, overseeing strategic planning, network development, managed care, marketing, corporate communications and government affairs. Prior to that tenure, Mr. Doyle owned and operated a consulting firm that provided strategic planning and marketing services to a diverse client list in a variety of industries. Mr. Doyle is a former Vice President of Marketing, Public Affairs and Product Line Management for MacNeal Health Network in Chicago and served as director of marketing and public relations for the Educational Services Unit of ITT Corp. He began his career with St. Jude Children's Research Hospital. Mr. Doyle earned a bachelor’s degree from Butler University, Indianapolis, Indiana, and a master’s degree from Ball State University, Muncie, Indiana.

David Erickson, Chief Investment Officer. David Erickson serves as Chief Investment Officer at Ascension Health Alliance. In this role, he has responsibility for the administration, management and coordination of System investments. In this context, the CIO formulates recommendations to the Chief Financial Officer and the Board’s Finance Committee and the full Board of Directors. Previously, Mr. Erickson served as Chief Investment Officer of Ascension Health. Mr. Erickson came to Ascension Health from the University of Wisconsin Foundation, where as Chief Investment Officer he supervised an investment team that managed over $2.2 billion in assets. His previous experience included serving as Vice President and Investment Strategist for Strong Capital Management in Wisconsin, and in leadership roles with PNC Bank/PNC Capital Markets in Pennsylvania, Chemical Bank in New York, and Firstar Bank in Wisconsin. He has a bachelor’s degree in economics from Wheaton College, Wheaton, Illinois, and is a Chartered Financial Analyst.

Robert J. Henkel, FACHE, Executive Vice President. Robert J. Henkel serves as Executive Vice President of Ascension Health Alliance. Mr. Henkel also assumed the role of President and Chief Executive Officer of Ascension Health on January 1, 2012, after having served as President, Healthcare Operations and Chief

EXHIBIT I-4
Operating Officer for Ascension Health. Previously Mr. Henkel served as President of the Great Lakes and Mid-Atlantic States Operating Group at Ascension Health. In that role, he was responsible for healthcare operations in Connecticut, Maryland, Michigan, New York, Wisconsin and Washington, D.C. Mr. Henkel has held executive positions with numerous other healthcare organizations, including the Daughters of Charity National Health System, St. Louis, Missouri; Mount Sinai Medical Center, Miami Beach, Florida; SSM Health Care in St. Louis, Missouri; and Montefiore Medical Center, Bronx, New York. He currently serves as Board Chair of Marian Middle School in St. Louis, Missouri, Board Member of the CHAN Healthcare Auditors, member of the University of Rochester Graduate School of Business Health Sciences Board, fellow of the American College of Healthcare Executives, and member of the Healthcare Executives Network. He has also served as the Chairman of the Columbia-St. Mary’s Board of Trustees, Milwaukee, Wisconsin. Mr. Henkel received a bachelor’s degree in economics from Union College, Schenectady, New York, and a master’s degree in public health from the University of Pittsburgh, Pennsylvania.

**Joseph R. Impicciche, Executive Vice President and General Counsel.** Joseph Impicciche is the Executive Vice President and General Counsel for Ascension Health Alliance. He is responsible for providing legal counsel to the corporation, Board of Directors and executive management. He coordinates legal services for major projects and transactions, leads system-to-system affiliation initiatives, assists with business development activities, and manages outside legal relationships on behalf of the organization. Previously, he served as Senior Vice President, Legal Services and General Counsel for Ascension Health. Prior to joining Ascension Health, Mr. Impicciche was a Partner in a private law firm with a major concentration in public finance, business and tax law for nonprofit organizations. He also served as General Counsel for St. Vincent Health in Indianapolis, Indiana. Because of his expertise, Mr. Impicciche has made presentations on tax and business related subjects to numerous organizations. He is a member of the Indianapolis and Indiana State Bar Associations, the Missouri State Bar Association and the National Association of Bond Lawyers. He has served on the Board of numerous organizations, including currently, St. Joseph Institute for the Deaf in St. Louis, of the St. Louis Zoo Friends Association and on the St. Louis Zoo Endowment and before coming to St. Louis, the Heart Center of Indiana, the Indianapolis Association of Wabash Men, Community Action of Greater Indianapolis and the Indianapolis Humane Society. He was recognized in the Indianapolis Monthly “Indiana Super Lawyers 2004” in March 2004. Mr. Impicciche earned a juris doctorate from Indiana University School of Law, Indianapolis, Indiana, and a master’s degree in health care administration from Indiana University. He received a bachelor’s degree from Wabash College, Crawfordsville, Indiana, where he was a Lilly Scholar. He was an adjunct professor of commercial law at Indiana University, Indianapolis, School of Business for fifteen years, and was an adjunct professor at Indiana University Law School, Indianapolis, from 1999 to 2003. He is now an adjunct professor at Saint Louis University Law School.

**Susan Nestor Levy, Executive Vice President.** Susan Nestor Levy serves as the Executive Vice President of Ascension Health Alliance, and is also the Executive Director of Seton Institute, a subsidiary of Ascension Health Alliance. In her role as Executive Director of Seton Institute, she has responsibility for international outreach efforts for Ascension Health Alliance at improving the health and living status of targeted global populations. Prior to these roles, she served as Chief Advocacy Officer of Ascension Health. Prior to joining Ascension Health, Ms. Levy served as the Executive Director of Policy in the Office of Policy and Representation for the Blue Cross and Blue Shield Association in Washington, D.C. As Executive Director, she was responsible for formulating the Association’s national policy on healthcare legislation. Prior to joining the Blue Cross and Blue Shield Association, Ms. Levy served as the Medicare Part A legislative and policy expert to the United States Senate Committee on Finance. During this tenure, Ms. Levy was one of a small number of health staff to the U.S. Congress during the historic Clinton health reform debate. Additionally, Ms. Levy worked for Health One Corporation (now Allina) in Minnesota where she held positions of increasing responsibility, including Vice President of Strategic Development and Director of Hospital Planning. Prior to joining Health One, she was Director of Services for the Aged and Director of Planning for Mercy Health Services (now Trinity Health) in Michigan. Ms. Levy currently serves as Board Member of the David A. Winston Health Policy Fellowship; a Board Member of the Daughters of Charity West Central Foundation; a Board Member of the American Red Cross St. Louis Chapter; a Member of the National Advisory Council for the Department of Health Administration in the School of Public Health at Saint Louis University; and an Advisory Board Member for the St. Louis University School of Law Center for Health Law Studies. Ms. Levy received a bachelor’s degree from the University of Notre Dame, South Bend, Indiana, and holds a master’s degree in hospital and health services administration from Saint Louis University, St. Louis, Missouri.

**Sr. Maureen McGuire, DC, Executive Vice President, Mission Integration.** Sr. Maureen McGuire is Executive Vice President, Mission Integration for Ascension Health Alliance and Senior Vice President, Mission

**EXHIBIT I-5**
Integration for Ascension Health. In these roles, she provides leadership in creating strategy and initiatives in the areas of mission and values integration, workplace spirituality, ethics, leadership formation and spiritual care. Her work supports the efforts of health ministry CEOs, Vice Presidents for Mission Integration and executive teams in their leadership of Ascension Health Alliance and Ascension Health as a ministry continuing the healing mission of Jesus. Immediately prior to joining the senior leadership team of Ascension Health in 2002, Sr. Maureen served as Vice President, Service Culture Development for the Catholic Health System (CHS) of Western New York in Buffalo, and concurrently as Vice President, Mission Integration for Mount St. Mary’s Hospital and Health Center in Lewiston, New York. She also had served as Vice President, Mission Integration for Sisters of Charity Hospital in Buffalo, New York, and participated in the early formation of CHS while in that role. Prior to entering the healthcare ministry, Sr. Maureen held various leadership and direct service roles in professional social work. She began as a caseworker and counselor in child welfare and mental health settings in Philadelphia, Pennsylvania. She then served as a supervisor at the Family Life Bureau of the Diocese of Allentown in two large rural counties, where she initiated programs of lay formation in 84 parishes preparing married couples to serve as facilitators of programs for engaged couples. She then assumed a leadership role as part of Catholic Charities of the Diocese of Albany, New York, serving as Executive Director of Catholic Family and Community Services in two counties. In this capacity she worked with an interfaith local Board to develop a wide variety of community-based services. In 1992, she initiated the Nazareth Residence for Mothers and Children in Roxbury, Massachusetts, one of the first transitional housing programs in the nation for homeless women and children affected by HIV/AIDS. Sr. Maureen served for six years as Seminary Directress of the Daughters of Charity of St. Vincent De Paul, working with the new members of the community and developing the interprovincial formation program for the five US provinces. Sr. Maureen earned her bachelor’s degree, summa cum laude, from St. Joseph College in Emmitsburg, Maryland, and received her master’s of social work from Temple University in Philadelphia, Pennsylvania, in 1977.

**David Pryor, M.D., Executive Vice President and Chief Medical Officer.** David B. Pryor, MD, is the Executive Vice President and Chief Medical Officer of Ascension Health Alliance. In this role he is responsible for providing leadership to transformational initiatives that would benefit from his expertise in clinical excellence. Prior to joining Ascension Health, Dr. Pryor was Senior Vice President and Chief Information Officer for Allina Health System in Minneapolis, Minnesota. Prior to Allina, Dr. Pryor was President of the New England Medical Center Hospitals in Boston, Massachusetts. Dr. Pryor began his rise to prominence in clinical excellence at Duke University Medical Center in Durham, North Carolina, where he served as a practicing cardiologist and Director of the cardiology consultation service, the section of Clinical Epidemiology and Biostatistics, the Duke Database for Cardiovascular Disease, and clinical program development. In his 15 years at Duke, Dr. Pryor chaired numerous committees including the Patient Care Subcommittee, the Duke University Heart Center Database Committee, the Quality Care Task Force and the Medical Center Computer Advisory Committee. Dr. Pryor has served on the editorial boards of the American Journal of Medical Quality, the American Journal of Managed Care, the International Journal of Cardiology, Cardiology Emergency Decisions, and as a reviewer for numerous other medical journals. He has authored more than 250 publications and has been the principal investigator of a number of significant research investigations. Dr. Pryor also has participated on numerous national and international committees including the Earnest Codman Awards Committee (JCAHO National Quality Awards, 1997-1999); The Advisory Council for Performance Measurement for the Joint Commission (1995 - present, chairman 1998-2003), the national scientific session committees for the American Medical Informatics Association (AMIA) 2000 Spring Congress, the American College of Cardiology, 1991-92, and the American Heart Association, 1994-96. He was listed as one of Modern Healthcare’s 100 Most Influential People in Healthcare in 2002 and 2005 and as one of Modern Healthcare’s 50 Most Powerful Physician Executives in 2006 and 2008. He received the CareScience Executive Leadership Award in 2006. In addition to his position at Ascension Health, Dr. Pryor’s academic appointments include Consulting Associate Professor of Medicine at Duke University Medical Center and Adjunct Professor at Saint Louis University School of Public Health. Dr. Pryor is a graduate of the University of Michigan Medical School in Ann Arbor, Michigan, and he completed his medical internship and residency at Pennsylvania Hospital in Philadelphia, and his fellowship in cardiovascular diseases at Duke University in Durham, North Carolina.

**Anthony J. Speranzo, Executive Vice President and Chief Financial Officer.** Anthony J. (Tony) Speranzo is the Executive Vice President and Chief Financial Officer of Ascension Health Alliance and the Senior Vice President and Chief Financial Officer of Ascension Health. Mr. Speranzo is a proven leader with extensive healthcare experience and expertise in treasury functions, debt management, investments, and mergers and acquisitions. Prior to joining Ascension Health in 2002, Mr. Speranzo served as Managing Director at U.S. Bancorp Piper Jaffray (USBPJ) in Newport Beach, California. While there, he was responsible for strategic financial
advisory services related to mergers, acquisitions, and divestitures, private debt placements, valuations and strategic market planning. His clients included hospitals, integrated health systems, medical group practices and managed care organizations nationwide. He entered investment banking in 1996 as Vice President and Manager, Corporate Finance for John Nuveen & Co., Inc. in Irvine, California. At John Nuveen, he was responsible for the development and management of the health care corporate finance division within the investment banking operation. Prior to 1996, Mr. Speranzo spent 11 years at the St. Joseph Health System in Orange, California, holding several positions, including Vice President, Finance and Operations and Senior Vice President, Chief Financial Officer. Mr. Speranzo has served on several hospital and corporate boards. Mr. Speranzo received his bachelor’s degree in economics from the University of Massachusetts in Boston, Massachusetts. He went on to complete his master’s degree in finance from Suffolk University in Boston, Massachusetts.

Committees

The bylaws of Ascension Health Alliance create standing committees (the Audit Committee, the Executive Committee and the Finance Committee) and authorize the creation of special committees from time to time by the Board of Directors.

**Audit Committee.** The Audit Committee is responsible for (a) examining the accuracy and validity of the financial and statistical information used by the Board of Directors and Finance Committee or by external agencies to evaluate Ascension Health Alliance’s financial affairs; (b) reviewing activities that support the preparation of reliable financial statements and the maintenance of financial controls; (c) evaluating audit performance; (d) overseeing corporate compliance; and (e) appointing the System auditor.

**Executive Committee.** The Executive Committee consists of the officers of the Board of Directors and the President and CEO of Ascension Health Alliance. The Executive Committee is responsible for (a) developing and recommending to the Board of Directors policies and actions with respect to executive evaluation and compensation; (b) reviewing and recommending changes to the bylaws of Ascension Health Alliance; (c) preparing for consideration by the Sponsors Council a slate of nominees for the Board of Directors; (d) overseeing Board development; and (e) taking any other action permitted by law, the articles of incorporation or the bylaws in lieu of a meeting of the Board of Directors.

**Finance Committee.** The Finance Committee is responsible for (a) reviewing and recommending to the Board of Directors the guidelines for the consolidated operating and capital budget for Ascension Health Alliance and its affiliates; (b) developing and recommending to the Board of Directors a long range financial plan for the System; (c) monitoring the financial condition of Ascension Health Alliance; (d) making recommendations on financial issues; and (e) maintaining current knowledge of the management and investment of all the endowment, trust and other funds of Ascension Health Alliance.

System Office and Affiliated Organizations

Information concerning the Ascension Health Alliance System Office and Ascension Health Alliance’s affiliated organizations are incorporated herein by reference to the information under the headings “System Office” and “Affiliated Organizations” in EXHIBIT II attached hereto.

Incorporation by Reference

Information concerning the Ascension Health Alliance Credit Groups is incorporated by reference to Appendix A to the Official Statement dated March 17, 2010 related to the $678,990,000 Michigan State Hospital Finance Authority Refunding and Project Revenue Bonds (Ascension Health Senior Credit Group) Series 2010F (the “2010 Official Statement”) which is on file on the MSRB’s EMMA system. In addition, see the supplemental information updating Appendix A to the 2010 Official Statement attached hereto as EXHIBIT II. To the extent such incorporated information describes Ascension Health, such incorporated information shall also describe Ascension Health Alliance, other than as described herein.
LIST OF MEMBERS OF THE ASCENSION HEALTH ALLIANCE SENIOR CREDIT GROUP

Senior Credit Group Representative and Senior Obligated Group Member
● Ascension Health Alliance – St. Louis, Missouri

Senior Obligated Group Members

Alabama
● St. Vincent’s Hospital – Birmingham, Alabama
● St. Vincent’s East – Birmingham, Alabama
● St. Vincent’s Blount – Birmingham, Alabama
● St. Vincent’s Health System – Birmingham, Alabama
● Seton Health Corporation of South Alabama – Mobile, Alabama
● Providence Hospital – Mobile, Alabama

Arizona
● Carondelet Health Network - Tucson, Arizona
● Holy Cross Hospital, Inc. - Nogales, Arizona

Arkansas
● Daughters of Charity Services of Arkansas – Gould, Arkansas

Connecticut
● St. Vincent’s Health Services Corporation – Bridgeport, Connecticut
● St. Vincent’s Medical Center – Bridgeport, Connecticut
● St. Vincent’s Special Needs Center, Inc. – Bridgeport, Connecticut
● Hall-Brooke Behavioral Health Services, Inc. – Westport, Connecticut

District of Columbia
● Providence Hospital - Washington, D.C.

Florida
● St. Catherine Laboure Manor, Inc. – Jacksonville, Florida
● St. Vincent’s Medical Center, Inc. – Jacksonville, Florida
● St. Vincent’s Health System, Inc. – Jacksonville, Florida
● St. Vincent’s Ambulatory Care, Inc. – Jacksonville, Florida
● Sacred Heart Health System, Inc. – Pensacola, Florida

Idaho
● St. Joseph Regional Medical Center, Inc. - Lewiston, Idaho

Indiana
● St. Mary’s Warrick Hospital, Inc. – Boonville, Indiana
● St. Vincent Clay Hospital, Inc. – Brazil, Indiana
● St. Vincent Carmel Hospital, Inc. – Carmel, Indiana
● St. Vincent Madison County Health System, Inc. – Elwood, Indiana
● Mission and Ministry, Inc. – Evansville, Indiana
● St. Mary’s Medical Center of Evansville, Inc. – Evansville, Indiana
- St. Mary’s Health System of America, Inc. – Evansville, Indiana
- Seton Health Corporation of Southern Indiana – Evansville, Indiana
- St. Mary’s At Home, Inc. – Evansville, Indiana
- St. Vincent Health, Inc. – Indianapolis, Indiana
- St. Vincent Hospital and Health Care Center, Inc. – Indianapolis, Indiana
- Central Indiana Health System Cardiac Services, Inc. – Indianapolis, Indiana
- St. Vincent Seton Specialty Hospital, Inc. – Indianapolis, Indiana
- St. Vincent Frankfort Hospital, Inc. – Indianapolis, Indiana
- St. Vincent New Hope, Inc. – Indianapolis, Indiana
- St. Joseph Hospital & Health Center, Inc. – Kokomo, Indiana
- St. Vincent Jennings Hospital, Inc. – North Vernon, Indiana
- St. Vincent Williamsport Hospital, Inc. – Williamsport, Indiana
- St. Vincent Randolph Hospital, Inc. – Winchester, Indiana

**Louisiana**
- Daughters of Charity Services of New Orleans – New Orleans, Louisiana

**Maryland**
- St. Agnes HealthCare, Inc. - Baltimore, Maryland
- Villa St. Catherine, Inc. – Emmitsburg, Maryland

**Michigan**
- St. Mary’s of Michigan – Saginaw, Michigan
- Providence Hospital and Medical Centers, Inc. – Southfield, Michigan
- St. John Health – Warren, Michigan
- Medical Resources Group – Warren, Michigan
- Eastwood Community Clinics – Detroit, Michigan
- St. John Hospital and Medical Center – Detroit, Michigan
- St. John River District Hospital – East China, Michigan
- St. John Macomb – Oakland Hospital – Detroit, Michigan
- Father Murray Nursing Center – Detroit, Michigan
- Borgess Health Alliance, Inc. – Kalamazoo, Michigan
- Borgess Medical Center - Kalamazoo, Michigan
- Visiting Nurses Home Care, Inc. – Kalamazoo, Michigan
- Visiting Nurse and Hospice Services of Southwest Michigan – Kalamazoo, Michigan
- Borgess Nursing Home, Inc. – Kalamazoo, Michigan
- Genesys Health System – Grand Blanc, Michigan
- Genesys Home Health & Hospice, Inc. – Grand Blanc, Michigan
- Genesys Practice Partners – Grand Blanc, Michigan
- Center for Gerontology – Grand Blanc, Michigan
- Genesys Regional Medical Center – Grand Blanc, Michigan
- Standish Community Hospital, Inc. – Saginaw, Michigan
- Saint Mary’s Health – Saginaw, Michigan
- St. Joseph Health System – Tawas City, Michigan
Missouri

- Ascension Health – St. Louis, Missouri
- Daughters of Charity Foundation - St. Louis, Missouri
- Carondelet Health System, Inc. - St. Louis, Missouri
- Carondelet Health - Kansas City, Missouri
- St. Joseph Medical Center - Kansas City, Missouri
- Carondelet Home Care Services, Inc. – Kansas City, Missouri
- Seton Center, Inc. – Kansas City, Missouri
- St. Mary’s Medical Center – Blue Springs, Missouri
- Ascension Health – IS, Inc. – St. Louis, Missouri

Tennessee

- Saint Thomas Network – Nashville, Tennessee
- St. Thomas Hospital - Nashville, Tennessee
- Seton Corporation - Nashville, Tennessee
- Hickman Community Home Care, Inc. – Nashville, Tennessee
- Hickman Community Health Care Services – Nashville, Tennessee
- Baptist Health Care Affiliates, Inc. – Nashville, Tennessee
- Middle Tennessee Medical Center, Inc. – Murfreesboro, Tennessee

Texas

- Seton Healthcare – Austin, Texas
- The Seton Cove, Inc. – Austin, Texas
- Daughters of Charity Services of San Antonio – San Antonio, Texas
- Providence Health Services of Waco – Waco, Texas
- Providence Health Alliance – Waco, Texas

Washington

- Our Lady of Lourdes Hospital at Pasco - Pasco, Washington

Wisconsin

- Columbia St. Mary's, Inc. - Milwaukee, Wisconsin
- St. Mary’s Hospital Ozaukee, Inc. - Mequon, Wisconsin
- Columbia St. Mary’s Hospital of Milwaukee, Inc. – Milwaukee, Wisconsin
- Seton Health Corporation of Wisconsin – Milwaukee, Wisconsin
- Sacred Heart Rehabilitation Institute, Inc. – Milwaukee, Wisconsin
Senior Designated Affiliates

*Indiana*
- Ascension Health Ministry Service Center, LLC – Indianapolis, Indiana

*Missouri*
- Ascension Health Resource and Supply Management Group, LLC – St. Louis, Missouri

Senior Limited Designated Affiliates

*New York*
- Our Lady of Lourdes Memorial Hospital, Inc. – Binghamton, New York $44,035
- Mount St. Mary’s Hospital of Niagara Falls – Lewiston, New York 32,755
- St. Mary’s Hospital at Amsterdam - Amsterdam, New York 8,933

<table>
<thead>
<tr>
<th>Liability to Senior Obligated Group as of September 30, 2011 (Dollars in Thousands)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York</td>
</tr>
<tr>
<td>Our Lady of Lourdes Memorial Hospital, Inc. – Binghamton, New York</td>
</tr>
<tr>
<td>Mount St. Mary’s Hospital of Niagara Falls – Lewiston, New York</td>
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<tr>
<td>St. Mary’s Hospital at Amsterdam - Amsterdam, New York</td>
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</tbody>
</table>
EXHIBIT II

Supplemental Information Concerning the Ascension Health Alliance Senior Credit Group

The information contained in this EXHIBIT II has been obtained from Ascension Health Alliance.
EXHIBIT II-1

INTRODUCTION

Information concerning the Ascension Health Alliance Senior Credit Group is incorporated by reference to (i) EXHIBIT I and (ii) Appendix A to the Official Statement dated March 17, 2010, related to the $678,990,000 Michigan State Hospital Finance Authority Refunding and Project Revenue Bonds (Ascension Health Senior Credit Group) Series 2010F which is on file on the MSRB’s EMMA system.

CHANGES TO THE INTRODUCTION

General

The information under the heading “General” has been deleted in its entirety and replaced with the following:

Ascension Health is a Missouri nonprofit corporation formed in August 1999. Ascension Health, directly or through local “parent” organizations, is the sole corporate member of certain nonprofit corporations that own and operate acute care hospitals and other health care facilities and service providers with approximately 15,660 available beds as of June 30, 2011. As described in EXHIBIT I hereto, Ascension Health Alliance is the sole corporate member of Ascension Health.

CHANGES TO THE COMPOSITION OF THE ASCENSION HEALTH ALLIANCE SENIOR CREDIT GROUP

Alexian Brothers Health System

On September 9, 2011, Ascension Health signed a definitive agreement whereby Ascension Health will become the sole corporate member of Alexian Brothers Health System (“Alexian Brothers”). The transaction closed on January 1, 2012. Ascension Health does not currently intend that Alexian Brothers will become both a Senior Obligated Group Member and a Subordinate Obligated Group Member until all indebtedness secured under a master trust indenture related to Alexian Brothers is discharged.

Alexian Brothers is a Catholic healthcare organization which is comprised of four hospital facilities located in Illinois, with 867 licensed beds. Alexian Brothers oversees operations of acute and specialty care hospitals, physician services and ambulatory care clinics in Illinois, as well as senior living facilities, rehabilitation services and community-based programming for the elderly in Missouri, Tennessee and Wisconsin. For its fiscal year ended December 31, 2010, Alexian Brothers reported approximately $1.3 billion of assets, $477.7 million of long-term debt, $457.8 million of net assets, and $881.4 million of net patient and resident service revenues.

The Care Group, LLC (Indianapolis, Indiana)

The information under the heading “The Care Group, LLC (Indianapolis, Indiana)” has been deleted in its entirety and replaced with the following:

Effective July 1, 2010, St. Vincent Health, Inc., a Senior Credit Group Member, acquired the medical practice of The Care Group, LLC (“TCG”), along with certain related businesses. TCG is a physician group that provides a wide variety of diagnostic and treatment options throughout the State of Indiana.

Seton Health System, Inc. (Troy, New York)

The information under the heading “Seton Health System, Inc. (Troy, New York)” has been deleted in its entirety and replaced with the following:

Effective October 1, 2011, Seton Health System, Inc. (“Seton Health”), a Senior Limited Designated Affiliate, became part of a new nonprofit health system with Catholic Health East, a Pennsylvania nonprofit
corporation and Northeast Health, Inc., a New York not for profit corporation. Ascension Health’s membership interest in Seton Health has changed from sole corporate member to a member having limited voting rights. Seton Health has withdrawn from the Ascension Health Credit Groups.

CHANGES TO FINANCIAL AND OPERATING INFORMATION

Indebtedness and Certain Liabilities

Ascension Health has implemented a $1 billion line of credit backed by a Senior Obligation, which is a multi-purpose facility that serves as liquidity support (for both the taxable commercial paper program and tax-exempt variable debt) and as a source of general liquidity. In connection with the $1 billion line of credit, the commercial paper program capacity is being increased from $250 million to $1 billion. The $1 billion credit facility is replacing the previously existing $250 million and $500 million lines of credit.

A separate line of credit with a commercial bank, which is dedicated to covering failed repayment of draws on various individual letters of credit issued by the same bank for the benefit of Ascension Health and its health ministries, which is secured by a Subordinate Obligation issued by Ascension Health in December 2006 in a principal amount not to exceed $100 million, is expected to be extended through December 2012.

Litigation

The information under the heading “Litigation” has been deleted in its entirety and replaced with the following:

Nursing Litigation

In 2006, nurses in the cities of Albany, New York; Chicago, Illinois; Detroit, Michigan; Memphis, Tennessee; and San Antonio, Texas, filed lawsuits alleging that hospitals in each of those metropolitan areas conspired to unlawfully suppress compensation for nurses. Seton Health in Troy, New York, and St. John Providence Health System in Detroit, Michigan were named in the lawsuits filed in Albany, New York and Detroit, Michigan, respectively. The plaintiffs in the Albany and Detroit cases moved for class certification. In the Albany action, the District Court for the Northern District of New York certified a class on the issue of whether there has been actual adverse effect on competition as a whole in the Albany market, but determined that injury-in-fact and damages must be individually determined. The court in Detroit has not ruled on the plaintiffs’ motion to certify a litigation class. Seton Health and St. John Providence Health System have reached settlement agreements in these cases. The court in Albany granted final approval of the settlement. In Detroit, the court granted final approval of the settlement on September 2, 2010. Ascension Health, Seton Health and St. John Providence Health System have admitted no liability in connection with these settlement agreements. Seton Health has paid $744,739 into a fund to be distributed to nurses who are members of the settlement class. St. John Providence Health System has paid $13,583,475 into a fund to be distributed to nurses who are members of the class. If a litigation class is not certified in Detroit, St. John Providence Health System will be refunded $10,183,065. Approximately 80% of the cost of these settlements will be covered by existing insurance.

In addition, another case involving wages paid to per diem and traveler temporary nurses has been filed in Phoenix, Arizona alleging that 41 hospitals have conspired with and through the Arizona Hospital and Healthcare Association to pay below market wages. Carondelet Health Network was named as a defendant. The plaintiffs in this case are seeking class action status and the District Court of Arizona has certified a class of per diem temporary nurses and denied a class of traveler temporary nurses. Carondelet Health Network and all defendant hospitals except the Abrazo Health System have reached agreement with plaintiffs and have executed settlement documents. The plaintiffs’ motion for preliminary approval of this settlement has been granted. The parties are now beginning the notice and claims process. The parties have requested and received a stay of this litigation while settlement proceedings continue.
Wage and Hour Litigation

On January 4, 2010 a Collective Action Complaint asserting failure to pay overtime properly was filed in federal court against St. John Providence Health System, St. John Hospital and Medical Center and at least ten unnamed individual management defendants. A court-issued scheduling order requires the parties to engage in an “initial” phase of discovery in order to determine whether the class should be “conditionally certified.” In December 2010, the plaintiff filed her motion requesting conditional certification. The hearing on this motion was held on March 3, 2011, and the Judge subsequently conditionally certified a class of hourly registered nurses (rather than all hourly associates). On May 4, 2011, notice was mailed to registered nurses that were employed within the St. John Providence Health System (SJPHS) between March 2008 and March 2011. As of the June 18, 2011 deadline, 381 of these individuals have opted in. The case is in the discovery phase.

MFN Litigation

On January 21, 2011, a lawsuit was filed against Ascension Health and its Michigan Health Ministries relating to the Blue Cross Blue Shield Most Favored Nation (MFN) clause contained in Blue Cross MFN-plus contracts. The lawsuit was brought by the City of Pontiac, Michigan. Defense counsel has been engaged and discovery is being conducted.

Arbitration

The information under the heading “Arbitration” has been deleted in its entirety and replaced with the following:

In 2005, Ascension Health outsourced a significant portion of its information technology services to an unrelated third party. Disputes arose between Ascension Health and the unrelated third party during the term of the contract, which resulted in ongoing arbitration between the parties in accordance with the dispute resolution provisions of the contract. In November 2009, Ascension Health elected to terminate the contract for cause and paid a termination fee in accordance with the terms of the contract. The unrelated third party disputed the for-cause characterization of the termination. A final hearing in the matter was scheduled to begin November 1, 2011. Before going to hearing, however, the parties agreed to a settlement. In the opinion of management of Ascension Health, the settlement amount is not material to the financial condition of the Senior Credit Group.

Liquidity, Investment Policies and Income

The second and third paragraph under the heading “Liquidity, Investment Policies and Income” have been deleted in its entirety. See the information under the heading “Affiliated Organizations – Catholic Healthcare Investment Management Company” below for a description of the investment vehicle for the Senior Credit Group Members.

Symphony

Symphony is an enterprise resource planning initiative being undertaken by Ascension Health and its health ministries. Through Symphony, Ascension Health anticipates implementing new operational practices in Finance, Human Resources, and Supply Chain, enabled by information technology. Symphony is intended to facilitate efficiency, focus resources, and provide analytic capabilities that will improve operational and clinical decisions, both at the local Health Ministry and Systemwide levels, by providing a single, centralized source of information into a shared database, allowing for immediate information access and retrieval and reducing or eliminating data inaccuracy and duplication. The Symphony initiative is expected to be fully implemented in 2015. As of the date of this Reoffering Circular, Symphony’s cumulative cost is estimated to be approximately $840 million over the life of the initiative.
CHANGES TO CORPORATE STRUCTURE AND MANAGEMENT

Sponsorship and Members; Sponsors Council

The information under the headings “Sponsorship and Members” and “Sponsors Council” has been deleted in its entirety.

Board of Trustees

The information under the heading “Board of Trustees” has been deleted in its entirety and replaced with the following:

The business, property, affairs and funds of Ascension Health are managed, supervised and controlled by the Board of Trustees, who exercise all powers of Ascension Health not reserved to Ascension Health Alliance and in accordance with Ascension Health system policy and subject to the limitations contained in Ascension Health’s Articles of Incorporation and Bylaws and applicable law. The Board of Trustees consists of ten to fifteen Board members, as fixed from time to time by Ascension Health Alliance (as of the date of this Reoffering Circular, there are ten Board members). Actions of the Board of Trustees are taken by majority vote of a quorum, except for appointment of the members of the boards of trustees of the organizations to which Ascension Health serves as the sole or controlling corporate member and approval of Ascension Health System’s Integrated Strategic Operational and Financial Plan, including the annual System scorecard and System initiatives, which require a two-thirds supermajority vote.

The current members of the Board of Trustees are as follows:

<table>
<thead>
<tr>
<th>Members</th>
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<tbody>
<tr>
<td>Anthony R. Tersigni, EdD., FACHE (Interim Board Chair)</td>
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<tr>
<td>Mr. Stephen Dufilho</td>
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<tr>
<td>Sr. Mary Fran Johnson, CSJ</td>
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<tr>
<td>Sr. Kieran Kneaves, DC</td>
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<tr>
<td>Sr. M. Martin “Marty” McEntee, DC</td>
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<tr>
<td>Sr. Jean Rhoads, DC</td>
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<td>Ciro V. Sumaya, MD, MPHTM</td>
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<tr>
<td>Herbert J. Vallier</td>
</tr>
<tr>
<td>Andrew Van de Ven, PhD</td>
</tr>
<tr>
<td>Bruce Vladeck, PhD</td>
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</table>

Management

The information under the heading “Management” has been deleted in its entirety. Following the appointment of Robert J. Henkel as President and Chief Executive Officer of Ascension Health, Mr. Henkel has assembled the following leadership team. Ascension Health is actively working to finalize the management team by appointing a new Chief Financial Officer and Chief Advocacy Officer. The current senior management of Ascension Health is as follows (CEO is listed first, and all others are listed in alphabetical order.

Robert J. Henkel, FACHE, President and Chief Executive Officer. Robert J. Henkel assumed the role of President and Chief Executive Officer of Ascension Health on January 1, 2012, after having served as President, Healthcare Operations and Chief Operating Officer for Ascension Health. He also serves as Executive Vice President of Ascension Health Alliance. Previously Mr. Henkel served as President of the Great Lakes and Mid-Atlantic States Operating Group at Ascension Health. In that role, he was responsible for healthcare operations in Connecticut, Maryland, Michigan, New York, Wisconsin and Washington, D.C. Mr. Henkel has held executive positions with numerous other healthcare organizations, including the Daughters of Charity National Health System, St. Louis, Missouri; Mount Sinai Medical Center, Miami Beach, Florida; SSM Health Care in St. Louis, Missouri; and Montefiore Medical Center, Bronx, New York. He currently serves as Board Chair of Marian Middle School in...
St. Louis, Missouri, Board Member of the CHAN Healthcare Auditors, member of the University of Rochester Graduate School of Business Health Sciences Board, fellow of the American College of Healthcare Executives, and member of the Healthcare Executives Network. He has also served as the Chairman of the Columbia-St. Mary’s Board of Trustees, Milwaukee, Wisconsin. Mr. Henke received a bachelor’s degree in economics from Union College, Schenectady, New York, and a master’s degree in public health from the University of Pittsburgh, Pennsylvania.

Mark D. Barner, Chief Information Officer and Chief Executive Officer Ascension Health Information Services (AHIS). Mark D. Barner currently serves in a dual role as Senior Vice President and Chief Information Officer for Ascension Health and as Chief Executive Officer of Ascension Health Information Services. AHIS is a wholly-owned subsidiary of Ascension Health dedicated to information technology for 28 Health Ministries within Ascension Health as well as the System Office. Mr. Barner’s duties include management of IT operations, strategy, project execution and service delivery. Mr. Barner previously served as the Chief Information Officer for the Seton Family of Hospitals, headquartered in Austin, Texas. He also served as a Regional Chief Information Officer for AHIS, responsible for the Southwest Region. Prior to joining Seton and Ascension Health, Mr. Barner was employed by EDS for 19 years, where he was responsible for state and local government contracts. He has also served as Regional Vice President for an internet consulting company, which had projects in the retail, airline, insurance and healthcare industries and as an executive with Dell in the healthcare area. Mr. Barner brings 26 years of executive experience in technology services, outsourcing and large-scale contract administration related to customer experience, IT strategy and relationship management. During his five years at Seton and AHIS, he has led a matrixed organization of over 830 IT professionals in 20 states and the District of Columbia. Projects included infrastructure efforts that range from wireless initiatives, radio frequency identification technologies, business continuity and single sign-on for password and identity management. He has also worked on multi-year projects to advance electronic health record strategies to include online nursing and clinical documentation, order sets and computerized physician order entry. Mr. Barner is active in the College of Healthcare Information Management Executives and Healthcare Information and Management Systems Society.

Charles J. Barnett, FACHE, President, Healthcare Operations and Chief Operating Officer. Charles J. Barnett serves as President, Healthcare Operations and Chief Operating Officer of Ascension Health. Mr. Barnett oversees operations at all Health Ministries and Ascension Health’s Ministry Market Leaders and has responsibility for Ascension Health’s enterprise resource planning, IT, facilities, and supply chain functions. He previously served as Texas/Missouri Ministry Market Leader with Ascension Health and as President and CEO of Seton Healthcare in Austin, Texas. Prior to joining Seton Healthcare, Mr. Barnett served as Vice President and Chief Operating Officer of Inova Health System and Fairfax Hospital in Falls Church, Virginia and was Executive Vice President at St. Joseph Medical Center, part of the Sisters of Charity Healthcare System of Cincinnati. Mr. Barnett has served as Chairman of the Greater Austin Chamber of Commerce, the Capitol Area United Way, Austin Partners in Education, Children’s Optimal Health and the Texas Catholic Healthcare Association. He is the recipient of many professional awards. Mr. Barnett earned a master’s degree in healthcare administration from Xavier University, Cincinnati and a bachelor’s degree and a master’s degree from the University of Cincinnati. He became board-certified in healthcare management in 2008, earning his Fellow designation from the American College of Healthcare Executives. Additionally, he has authored articles on a variety of healthcare issues and has presented at numerous national healthcare conferences.

Scott Caldwell, Senior Vice President and Chief Supply Chain Officer. Scott Caldwell is a Senior Vice President and the Chief Supply Chain Officer at Ascension Health. In this role, he has responsibility for supply chain strategy and operations. Mr. Caldwell has more than 25 years of successful supply chain leadership and an extensive background in supply chain logistics, contracting, complex operating room delivery systems, waste management, cost process controls and cost/use reduction efforts with physician preference items. Mr. Caldwell came to Ascension Health from Deloitte Consulting LLP, where he was Director, National Practice Leader, Provider Supply Chain Consulting. Prior to his work at Deloitte Consulting LLP, Mr. Caldwell held several management positions for healthcare related consulting firms and suppliers after a successful tenure in the hospitality industry. He holds a bachelor’s degree in general management and a master’s degree in business administration from the University of Tennessee.
Eric S. Engler, Senior Vice President, Strategic Planning & Development. Eric S. Engler is the Senior Vice President, Strategic Planning & Development of Ascension Health and has responsibility for the development, implementation and management of Ascension Health’s overall System strategy, as well as the exploration and development of new opportunities across the continuum of care. Prior to joining Ascension Health in 2001, Mr. Engler served as the Director of Financial Planning and Analysis for Reuters, PLC, and Bridge Information Systems, Inc., both providers of financial market data services. He also has served as a Transaction Services Director for PricewaterhouseCoopers, LLP. Mr. Engler is a Certified Public Accountant and he holds a master’s degree in business administration from the University of Chicago Graduate School of Business and a bachelor’s degree in accountancy from the University of Illinois.

Ann G. Esposito, Senior Vice President and Program Executive, Symphony. Ann G. Esposito is Senior Vice President and Program Executive, Symphony at Ascension Health. Ms. Esposito is responsible for leading design and implementation of Symphony, a System-wide strategy to enhance standardization of Finance, Supply Chain and Human Resources processes enabled by software applications to produce integrated clinical, operational and financial information. Ms. Esposito previously served as Vice President and Executive Program Director at Hoffmann-LaRoche, an international pharmaceutical company. She led the organization’s largest business transformation program, including replacing and consolidating IT transactional and data warehouse systems, establishing a shared service center, and designing and implementing global HR processes on a single IT application platform. Ms. Esposito has also held senior level roles in Supply Chain, Finance and Human Resources IT Systems at Hoffmann-LaRoche, and held executive positions at Schering-Plough and Mutual Benefit Life Insurance. Ms. Esposito received a master’s degree in finance from Seton Hall University, South Orange, New Jersey, and a bachelor’s degree in mathematics from Montclair State University, Upper Montclair, New Jersey.

Ziad Haydar, MD, Senior Vice President, Clinical Excellence and Chief Medical Officer. Dr. Ziad Haydar is the Senior Vice President, Clinical Excellence and Chief Medical Officer of Ascension Health. Dr. Haydar leads Ascension Health’s Clinical Excellence initiatives, including collaboration with physician, nursing and executive leaders across the organization, to build on its nationally recognized patient safety initiatives. Dr. Haydar has also facilitated the strategic vision in the area of population health and has supported the organization’s shared learning in the areas of practice management as well as other aspects of the physician enterprise. Dr. Haydar joined Ascension Health in 2010 as Vice President, Clinical Excellence and Physician Integration. Prior to joining Ascension Health, he previously was an executive with Baylor Health Care System in Dallas, where he served as the Vice President for Health Care Improvement and Director of the Center for Health Care Improvement. Dr. Haydar received a medical degree from American University of Beirut, trained in Family Medicine at the Medical University of South Carolina, and completed a fellowship in geriatrics and gerontology at Johns Hopkins University School of Medicine, Baltimore. He also obtained a master’s degree in business administration from the Cox School of Business at Southern Methodist University, Dallas.

Challis M. Lowe, Senior Vice President, Organizational Development and Human Resources. Challis M. Lowe is Senior Vice President, Organizational Development and Human Resources. She leads Ascension Health’s work in all aspects of strategic organizational development and the continued development of the human resource capability across the Health Ministries including OD/HR strategy that supports the Strategic Direction, metrics and reporting, organizational development, strategic talent management, leadership and associate development, compensation and benefits and associate engagement. Ms. Lowe provides leadership to Ascension Health’s System Office and AHIS HR services, building relationships and alignment within the Health Ministry CHRO community. Ms. Lowe brings extensive human resource leadership experience to her role, serving in leadership roles at large national and international organizations. Most recently, she served as Executive Vice President of Human Resources for Dollar General Corp., a $10 billion discount retailer with 8,300 locations and more than 70,000 employees. She has also held leadership positions at Ryder System, a global logistics and transportation services company, and Beneficial Finance, an international consumer finance company. She spent the early part of her career in line management roles in banking and in a global commercial finance company. Ms. Lowe holds a master’s degree in business administration from Northwestern University’s Kellogg Graduate School of Management and has served on the Boards of The Executive Leadership Council and Florida A&M University.

Christine Kocot McCoy, Senior Vice President, Legal Services and General Counsel. Christine Kocot McCoy is the Senior Vice President, Legal Services and General Counsel for Ascension Health. She is responsible
for leading Ascension Health Legal Services and Risk Management. As General Counsel, Ms. McCoy provides legal counsel to the organization, Board of Trustees and executive management. She leads affiliation initiatives; assists with business development activities; and manages outside legal relationships on behalf of Ascension Health. In Risk Management, Ms. McCoy is responsible for leading the associate health and safety, claims management, insurance, and loss prevention programs for Ascension Health and its Health Ministries. Previously she served as Vice President, Risk Management for Ascension Health. Prior to joining Ascension Health, Ms. McCoy was a partner with the law firm of Armstrong Teasdale, LLP where she focused her practice in the areas of medical malpractice and employment litigation. Ms. McCoy represented hospitals and physicians in malpractice matters in Missouri and Illinois state and federal courts and she represented management in employment and labor-related matters before federal and state courts and local agencies in Missouri, Illinois, and Washington, D.C. Additionally, Ms. McCoy also served as an Assistant Attorney General acting as Associate General Counsel for the Missouri Department of Labor, Division of Labor Standards. Ms. McCoy holds a juris doctorate from Saint Louis University School of Law in St. Louis and a bachelor’s degree in business from Eastern Illinois University in Charleston, Illinois. She is a licensed member of the Missouri and Illinois bar associations and is a member of the Metropolitan St. Louis Bar Association, the American Bar Association, and the St. Louis Association of Risk Managers.

Stephen D. LeResche, Vice President, Communications. Stephen D. LeResche is Vice President, Communications of Ascension Health. In this position, Mr. LeResche leads development and implementation of communications and marketing strategies for Ascension Health and he also oversees corporate meetings and travel. Prior to joining Ascension Health, Mr. LeResche served as Vice President-Public Communications for Anheuser-Busch Companies, Inc. He also has served as a Senior Vice President for Fleishman-Hillard, Inc. Before his work in corporate communications, Mr. LeResche was an award-winning reporter in both print and broadcast journalism. Mr. LeResche is a member of the Boards of Directors for the Arts and Education Council of Greater St. Louis and the Make-A-Wish Foundation of Greater St. Louis. He also is a member of the Chancellor’s Public Relations Council for Washington University in St. Louis. Mr. LeResche received a bachelor of journalism degree from the University of Missouri at Columbia.

Sr. Maureen McGuire, DC, Senior Vice President, Mission Integration. Sr. Maureen McGuire is Senior Vice President, Mission Integration for Ascension Health and Executive Vice President, Mission Integration for Ascension Health Alliance. In these roles, she provides leadership in creating strategy and initiatives in the areas of mission and values integration, workplace spirituality, ethics, leadership formation and spiritual care. Her work supports the efforts of health ministry CEOs, Vice Presidents for Mission Integration and executive teams in their leadership of Ascension Health Alliance and Ascension Health as a ministry continuing the healing mission of Jesus. Immediately prior to joining the senior leadership team of Ascension Health in 2002, Sr. Maureen served as Vice President, Service Culture Development for the Catholic Health System (CHS) of Western New York in Buffalo, and concurrently as Vice President, Mission Integration for Mount St. Mary's Hospital and Health Center in Lewiston, New York. She also had served as Vice President, Mission Integration for Sisters of Charity Hospital in Buffalo, New York, and participated in the early formation of CHS while in that role. Prior to entering the healthcare ministry, Sr. Maureen held various leadership and direct service roles in professional social work. She began as a caseworker and counselor in child welfare and mental health settings in Philadelphia, Pennsylvania. She then served as a supervisor at the Family Life Bureau of the Diocese of Allentown in two large rural counties, where she initiated programs of lay formation in 84 parishes preparing married couples to serve as facilitators of programs for engaged couples. She then assumed a leadership role as part of Catholic Charities of the Diocese of Albany, New York, serving as Executive Director of Catholic Family and Community Services in two counties. In this capacity she worked with an interfaith local Board to develop a wide variety of community-based services. In 1992, she initiated the Nazareth Residence for Mothers and Children in Roxbury, Massachusetts, one of the first transitional housing programs in the nation for homeless women and children affected by HIV/AIDS. Sr. Maureen served for six years as Seminary Directress of the Daughters of Charity of St. Vincent De Paul, working with the new members of the community and developing the interprovincial formation program for the five US provinces. Sr. Maureen earned her bachelor’s degree, summa cum laude, from St. Joseph College in Emmitsburg, Maryland, and received her master’s of social work from Temple University in Philadelphia, Pennsylvania, in 1977.

Juli K. Shields, Chief Compliance Officer and Vice President, Legal Services and Associate General Counsel. Juli K. Shields is the Chief Compliance Officer and Vice President, Legal Services and Associate General Counsel for Ascension Health. In this role, Ms. Shields provides legal services to Ascension Health, manages the
use of outside legal services and conducts legal-related business services. Prior to joining Ascension Health in 2006, Ms. Shields was an attorney shareholder with Hall Render Killian Heath & Lyman, P.C. where she was responsible for practice development, all HIPAA-related project management and general partnership duties. Ms. Shields also previously served as Vice President and General Counsel at Kendrick Memorial Hospital, Inc. in Mooresville, Indiana where she was responsible for managing all legal work required by the hospital and she served as corporate secretary as well as Corporate Compliance Officer and Risk Manager. Ms. Shields received a juris doctorate from Indiana University School of Law and a bachelor’s degree in American studies and history from Franklin College of Indiana. Ms. Shields is a member of the Missouri State Bar Association and the American Bar Association.

Ministry Market Leaders

The Ministry Market Leaders under the heading “Ministry Market Leaders” have been deleted in their entirety and replaced with the following:

**Baltimore/District of Columbia** (includes all facilities in the State of Maryland and the District of Columbia) – Bonnie Phipps, CEO of St. Agnes HealthCare, Inc., is the Ministry Market Leader.

**Gulf Coast/Florida** (includes all facilities in Mobile, Alabama and the State of Florida) – Laura Kaiser, CEO of Sacred Heart Health System, is the Ministry Market Leader.

**Indiana/Wisconsin** (includes all facilities in the States of Indiana and Wisconsin) – Vince Caponi, CEO of St. Vincent Health, Inc., is the Ministry Market Leader.

**Michigan** (includes all facilities in the State of Michigan) – Patricia Maryland, DrPH, President and CEO of St. John Providence Health System, is the Ministry Market Leader.

**Nashville/Birmingham** (includes all facilities in Birmingham, Alabama and the State of Tennessee) – Michael H. Schatzlein, MD, MBA, CEO of Saint Thomas Health Services, is the Ministry Market Leader.

**New York/Connecticut** (includes all facilities in the States of New York and Connecticut) – Susan Davis, RN, EdD, President and CEO of St. Vincent’s Health Services, is the Ministry Market Leader.

**Texas/Missouri/West** (includes all facilities in the States of Texas, Missouri, Arizona, Idaho and Washington) – Charles Barnett, President and CEO of Seton Healthcare Family, is the Ministry Market Leader.

Committees

The section entitled “Committees” has been amended by adding the following Model Community Committee, created by the Board of Trustees of Ascension Health in September 2010:

**Model Community Committee.** The Model Community Committee oversees the Model Community initiative, one of the long-term strategies set forth in Ascension Health’s Strategic Direction. The committee’s primary focus is to assure the creation and maintenance of a positive organizational climate for Ascension Health’s associates.

The paragraph entitled “Strategic Planning Committee” has been deleted in its entirety and replaced with the following:

**Strategic Planning Committee.** The Strategic Planning Committee is responsible for (a) assisting management in developing the long-term Strategic Direction of Ascension Health, (b) reviewing and monitoring the progress of the Strategic Direction through the annual Integrated Strategic, Operational and Financial Plan and other performance mechanisms, (c) making appropriate recommendations on strategic issues arising for Ascension
Health, (d) providing an annual review of the organization’s transformational innovation agenda and advice and counsel for new items of increased interest, and (e) evaluating the overall performance of the organization in developing and implementing strategy.

System Office

The paragraphs entitled “Information Technology,” “Strategic Development” and “Supply Chain” have been deleted in their entirety and replaced with the following:

**Information Technology.** Ascension Health, through Ascension Health-IS, Inc., a Missouri non-profit corporation in which Ascension Health is the sole corporate member, currently provides technology solutions for the Health Ministries throughout the United States and assists the Health Ministries in the selection, implementation, operation and improvement of the cost effectiveness of clinical and administrative information technologies. Ascension Health operates numerous platforms from every major vendor in the health care industry and provides consulting support to the Health Ministries and the System Office as they develop information technologies in response to the changing health care environment.

**Strategic Development.** The Strategic Development function ensures accountability, focus and rigor in the development and implementation of Ascension Health’s Strategic Direction. Strategic Development works with the leaders of Ascension Health to ensure effective management and continued advancement of strategic initiatives toward realization of Ascension Health’s Vision.

**Resource and Supply Management Group.** The System Office provides a sourcing, procurement and operations model that continuously implements sustainable non-labor expense reductions in collaboration with its Health Ministries, physicians and associates, while ensuring that a high level of quality is maintained and accepted for end users. Resource and supply management provides contracting, sourcing, implementation and data integrity of supplies.

Affiliated Organizations

The section entitled “Affiliated Organizations” has been amended by adding the following affiliated organizations:

**Ascension Health Care Network.** Ascension Health and Oak Hill Capital Partners announced the formation of a joint venture called “Ascension Health Care Network” (“AHCN”), to acquire hospitals and other health care related businesses. Ascension Health will manage this new venture. AHCN and its affiliated health care businesses will not be members of the Ascension Health Alliance Senior Credit Group or the Subordinate Credit Group. As such, financial information for the Senior Credit Group incorporated by reference herein excludes all financial information related to AHCN.

**Catholic Healthcare Investment Management Company.** Catholic Healthcare Investment Management Company (“CHIMCO”) was formed in 2010 and became operational in 2011. CHIMCO is a tax-exempt subsidiary of Ascension Health Alliance whose purpose is to manage the investment portfolio of Ascension Health Alliance, as well as related entities of Ascension Health Alliance and like-minded not-for-profit partners. CHIMCO offers expertise in the areas of asset allocation, manager selection and risk management. CHIMCO strives to provide participating investors benefits such as increased returns, flexible investment choices, investment asset class diversification, access to quality managers, administrative ease, cost economies and socially responsible investment choices. To fulfill this mission, CHIMCO is in the process of registering with the SEC as a registered investment advisor. Additionally, CHIMCO will be structuring CHIMCO Alpha Fund, LLC, a limited liability company, whose purpose is to operate as an investment vehicle for the Senior Credit Group Members to pool their investments and cash, to benefit from professional management by CHIMCO and from economies of scale, and to exercise all the powers necessary or incidental to, or in support of, its investment activities. It is anticipated that the majority of Ascension Health Alliance’s long term operating funds will be held in CHIMCO Alpha Fund, LLC.
The section entitled “Affiliated Organizations” has been further amended to reflect the name change of “Seton Institute” to “Ascension Health Global Mission” effective January 3, 2012.

Insurance

The section entitled “General and Professional Liability Insurance” has been deleted in its entirety and replaced with the following:

**Professional and General Liability Insurance.** The Senior Credit Group Members whose corporate member is Ascension Health are self-insured through a grantor trust and wholly owned captive insurance company, Ascension Health Insurance, Ltd. (AHIL). For Senior Credit Group Members, the trust and captive provide professional and general liability coverage on a claims-reported basis with a self-insured retention of $10 million per medical incident/occurrence with no aggregate. An additional $140 million of excess professional liability and $185 million of umbrella liability is written through AHIL. AHIL retains $5 million per occurrence and $5 million annual aggregate for professional liability. AHIL also retains a 20% quota share of the first $25 million of professional liability and umbrella excess. The remaining excess coverage is reinsured by commercial carriers. Self-insured entities in the states of Indiana and Wisconsin are provided professional liability coverage on an occurrence basis with limits in compliance with participation in the Patient Compensation Funds. Fronting arrangements are utilized for Senior Credit Group Members in Wisconsin and Pennsylvania that are not qualified self-insurers.

AHIL offers primary professional and general liability coverage for affiliates of Ascension Health. Professional liability and general liability coverage is on a claims-reported basis, with limits up to $1,000,000 per medical incident/occurrence and $3 million annual aggregate. AHIL also offers physician professional liability coverage through insurance or reinsurance arrangements to non-employed physicians practicing at Ascension Health’s various facilities. The primary limits range from $100,000 to $1,000,000 per claim with various aggregate limits.

The section entitled “Other Insurance Coverages” has been deleted in its entirety and replaced with the following:

**Other Insurance Coverages.** Commercial policies are maintained for property, directors’ and officers’ liability, employment practices liability, automobile, cyber and other miscellaneous coverages in amounts consistent with levels generally carried by similar health care entities, and are in compliance with applicable state requirements.