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Form **990****Return of Organization Exempt From Income Tax**

OMB No 1545-0047

2010Open to Public
InspectionDepartment of the Treasury
Internal Revenue ServiceUnder section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except black lung
benefit trust or private foundation)

The organization may have to use a copy of this return to satisfy state reporting requirements

A For the 2010 calendar year, or tax year beginning, 2010, and ending, 20**B** Check if applicable

<input type="checkbox"/>	Address change
<input type="checkbox"/>	Name change
<input checked="" type="checkbox"/>	Initial return
<input type="checkbox"/>	Terminated
<input type="checkbox"/>	Amended return
<input type="checkbox"/>	Application pending

C Name of organization

CHILDREN'S HEALTHCARE OF ATLANTA GROUP RETURN

Doing Business As

Number and street (or P O box if mail is not delivered to street address)

Room/suite

1584 TULLIE CIRCLE

City or town, state or country, and ZIP + 4

ATLANTA, GA 30329

F Name and address of principal officer

DONNA HYLAND

1600 TULLIE CIRCLE ATLANTA, GA 30329

D Employer identification number

90-0779996

E Telephone number

(404) 785-7944

G Gross receipts \$ 1,015,909,518.**H(a)** Is this a group return for affiliates? ☒ Yes ☐ No**H(b)** Are all affiliates included? ☒ Yes ☐ No
If "No," attach a list (see instructions)**I** Tax-exempt status ☒ 501(c)(3) ☐ 501(c)() (insert no) ☐ 4947(a)(1) or ☐ 527**J** Website: WWW.CHOA.ORG**H(c)** Group exemption number 5857**K** Form of organization ☒ Corporation ☐ Trust ☐ Association ☐ Other ☐ **L** Year of formation **M** State of legal domicile**Part I Summary**

Activities & Governance	1	Briefly describe the organization's mission or most significant activities OUR MISSION IS TO ENHANCE THE LIVES OF CHILDREN THROUGH EXCELLENCE IN PATIENT CARE, RESEARCH AND EDUCATION.		
	2	Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets		
	3	Number of voting members of the governing body (Part VI, line 1a)	3	61.
	4	Number of independent voting members of the governing body (Part VI, line 1b)	4	55.
	5	Total number of individuals employed in calendar year 2010 (Part V, line 2a)	5	7,483.
	6	Total number of volunteers (estimate if necessary)	6	6,500.
	Revenue	7a	Total gross unrelated business revenue from Part VIII, column (C), line 12	7a
b		Net unrelated business taxable income from Form 990-T, line 34	7b	0.
8		Contributions and grants (Part VIII, line 1h)	Prior Year	Current Year
9		Program service revenue (Part VIII, line 2g)	125,997,789.	61,662,282.
10		Investment income (Part VIII, column (A), lines 3, 4, and 7d)	874,689,706.	913,844,890.
11		Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	3,584,208.	12,902,924.
12		Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	8,555,882.	10,357,406.
13		Grants and similar amounts paid (Part IX, column (A), lines 1-3)	1,012,827,585.	998,767,502.
14		Benefits paid to or for members (Part IX, column (A), line 4)	67,771,839.	10,861,170.
15		Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	0.	0.
Expenses	16a	Professional fundraising fees (Part IX, column (A), line 11e)	478,563,312.	485,060,549.
	b	Total fundraising expenses (Part IX, column (D), line 25)	0.	0.
	17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24f)	10,525,080.	
	18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	328,745,642.	331,290,391.
	19	Revenue less expenses. Subtract line 18 from line 12	875,080,793.	827,212,110.
	20	Total assets (Part X, line 15)	137,746,792.	171,555,392.
	21	Total liabilities (Part X, line 26)	Beginning of Current Year	End of Year
	22	Net assets or fund balances. Subtract line 21 from line 20	2,194,078,474.	2,244,228,882.
			826,646,155.	649,407,679.
			1,367,432,319.	1,594,821,203.

Part II Signature Block

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

Sign Here	Signature of officer	Date			
	<i>Robert Fowler</i>	11/14/11			
Paid Preparer Use Only	Type or print name and title				
	<i>Robert Fowler, CEO</i>				
	Print/Type preparer's name	Preparer's signature			
	Date	Check if self-employed			
	<i>Claire Steinke</i>	<i>Claire Steinke</i>	11/11/2011	<input type="checkbox"/>	PTIN
	Firm's name	Firm's EIN			
	<i>ERNST & YOUNG U.S. LLP</i>	<i>34-6565596</i>			
	Firm's address	Phone no			
	<i>55 IVAN ALLEN BLVD, SUITE 1000 ATLANTA, GA 30308</i>	<i>404-874-8300</i>			

May the IRS discuss this return with the preparer shown above? (see instructions) ☐ Yes ☒ No

For Paperwork Reduction Act Notice, see the separate instructions.

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Part III Statement of Program Service AccomplishmentsCheck if Schedule O contains a response to any question in this Part III ☐ Yes ☒ No**1** Briefly describe the organization's mission:OUR MISSION IS TO ENHANCE THE LIVES OF CHILDREN THROUGH EXCELLENCE IN
PATIENT CARE, RESEARCH AND EDUCATION.**2** Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? ☐ Yes ☒ No

If "Yes," describe these new services on Schedule O

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? ☐ Yes ☒ No

If "Yes," describe these changes on Schedule O

4 Describe the exempt purpose achievements for each of the organization's three largest program services by expenses. Section 501(c)(3) and 501(c)(4) organizations and section 4947(a)(1) trusts are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported**4a** (Code _____) (Expenses \$ 651,951,902 including grants of \$ 10,861,170) (Revenue \$ 921,387,581)
SEE SCHEDULE O**4b** (Code _____) (Expenses \$ _____ including grants of \$ _____) (Revenue \$ _____)**4c** (Code _____) (Expenses \$ _____ including grants of \$ _____) (Revenue \$ _____)**4d** Other program services (Describe in Schedule O)

(Expenses \$ _____ including grants of \$ _____) (Revenue \$ _____)

4e Total program service expenses **▶** 651,951,902.

R O M L I F H G D B A

Part IV Checklist of Required Schedules

	Yes	No
1 Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A	X	
2 Is the organization required to complete Schedule B, Schedule of Contributors? (see instructions)	X	
3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? If "Yes," complete Schedule C, Part I		X
4 Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? If "Yes," complete Schedule C, Part II		X
5 Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? If "Yes," complete Schedule C, Part III		
6 Did the organization maintain any donor advised funds or any similar funds or accounts where donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? If "Yes," complete Schedule D, Part I		X
7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? If "Yes," complete Schedule D, Part II		X
8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III		X
9 Did the organization report an amount in Part X, line 21; serve as a custodian for amounts not listed in Part X, or provide credit counseling, debt management, credit repair, or debt negotiation services? If "Yes," complete Schedule D, Part IV		X
10 Did the organization, directly or through a related organization, hold assets in term, permanent, or quasi-endowments? If "Yes," complete Schedule D, Part V	X	
11 If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable		
a Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI	X	
b Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VII		X
c Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VIII		X
d Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part IX	X	
e Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X	X	
f Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? If "Yes," complete Schedule D, Part X		X
12 a Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI, XII, and XIII		X
b Was the organization included in consolidated, independent audited financial statements for the tax year? If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI, XII, and XIII is optional	X	
13 Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E		X
14 a Did the organization maintain an office, employees, or agents outside of the United States?		X
b Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, and program service activities outside the United States? If "Yes," complete Schedule F, Parts I and IV		X
15 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or assistance to any organization or entity located outside the United States? If "Yes," complete Schedule F, Parts II and IV		X
16 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or assistance to individuals located outside the United States? If "Yes," complete Schedule F, Parts III and IV		X
17 Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? If "Yes," complete Schedule G, Part I (see instructions)		X
18 Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? If "Yes," complete Schedule G, Part II	X	
19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? If "Yes," complete Schedule G, Part III		X
20 a Did the organization operate one or more hospitals? If "Yes," complete Schedule H	X	
b If "Yes" to line 20a, did the organization attach its audited financial statements to this return? Note. Some Form 990 filers that operate one or more hospitals must attach audited financial statements (see instructions)		X

Part IV Checklist of Required Schedules (continued)

	Yes	No
21 Did the organization report more than \$5,000 of grants and other assistance to governments and organizations in the United States on Part IX, column (A), line 1? <i>If "Yes," complete Schedule I, Parts I and II.</i>	21 X	
22 Did the organization report more than \$5,000 of grants and other assistance to individuals in the United States on Part IX, column (A), line 2? <i>If "Yes," complete Schedule I, Parts I and III.</i>	22 X	
23 Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? <i>If "Yes," complete Schedule J.</i>	23 X	
24 a Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25.</i>	24a	X
b Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b	
c Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c	
d Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d	
25 a Section 501(c)(3) and 501(c)(4) organizations. Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I.</i>	25a	X
b Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? <i>If "Yes," complete Schedule L, Part I.</i>	25b	X
26 Was a loan to or by a current or former officer, director, trustee, key employee, highly compensated employee, or disqualified person outstanding as of the end of the organization's tax year? <i>If "Yes," complete Schedule L, Part II.</i>	26	X
27 Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor, or a grant selection committee member, or to a person related to such an individual? <i>If "Yes," complete Schedule L, Part III.</i>	27	X
28 Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions)	28a	X
a A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV.</i>	28b X	
b A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV.</i>	28c X	
c An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? <i>If "Yes," complete Schedule L, Part IV.</i>	29 X	
29 Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M.</i>	30	X
30 Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M.</i>	31	X
31 Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I.</i>	32	X
32 Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? <i>If "Yes," complete Schedule N, Part II.</i>	33 X	
33 Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? <i>If "Yes," complete Schedule R, Part I.</i>	34 X	
34 Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Parts II, III, IV, and V, line 1.</i>	35 X	
35 Is any related organization a controlled entity within the meaning of section 512(b)(13)?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
a Did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? <i>If "Yes," complete Schedule R, Part V, line 2.</i>	36	X
36 Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2.</i>	37	X
37 Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? <i>If "Yes," complete Schedule R, Part VI.</i>	38 X	
38 Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11 and 19? Note. All Form 990 filers are required to complete Schedule O		

Form 990 (2010)

Part V Statements Regarding Other IRS Filings and Tax ComplianceCheck if Schedule O contains a response to any question in this Part V. ☐

	Yes	No
1a Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a 29	
b Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b 0	
c Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c X	
2a Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a 7,483	
b If at least one is reported on line 2a, did the organization file all required federal employment tax returns? Note. If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)	2b X	
3a Did the organization have unrelated business gross income of \$1,000 or more during the year?	3a	X
b If "Yes," has it filed a Form 990-T for this year? If "No," provide an explanation in Schedule O	3b	
4a At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a	X
b If "Yes," enter the name of the foreign country ▶ See instructions for filing requirements for Form TDF 90-22.1, Report of Foreign Bank and Financial Accounts		
5a Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a	X
b Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b	X
c If "Yes," to line 5a or 5b, did the organization file Form 8886-T?	5c	
6a Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible?	6a	X
b If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b	
7 Organizations that may receive deductible contributions under section 170(c).		
a Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor?	7a X	
b If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b X	
c Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c	X
d If "Yes," indicate the number of Forms 8282 filed during the year	7d	
e Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e	X
f Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f	X
g If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7g	
h If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h	
8 Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations. Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year?	8	
9 Sponsoring organizations maintaining donor advised funds.		
a Did the organization make any taxable distributions under section 4966?	9a	
b Did the organization make a distribution to a donor, donor advisor, or related person?	9b	
10 Section 501(c)(7) organizations. Enter:		
a Initiation fees and capital contributions included on Part VIII, line 12	10a	
b Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b	
11 Section 501(c)(12) organizations. Enter:		
a Gross income from members or shareholders	11a	
b Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them)	11b	
12a Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041?	12a	
b If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b	
13 Section 501(c)(29) qualified nonprofit health insurance issuers.		
a Is the organization licensed to issue qualified health plans in more than one state? Note. See the instructions for additional information the organization must report on Schedule O	13a	
b Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b	
c Enter the amount of reserves on hand	13c	
14a Did the organization receive any payments for indoor tanning services during the tax year?	14a	X
b If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O	14b	

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

Check if Schedule O contains a response to any question in this Part VI ☒ X

Section A. Governing Body and Management

	Yes	No
1a Enter the number of voting members of the governing body at the end of the tax year 1a 61		
b Enter the number of voting members included in line 1a, above, who are independent 1b 55		
2 Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee? 2		X
3 Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person? . . . 3		X
4 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? 4		X
5 Did the organization become aware during the year of a significant diversion of the organization's assets? 5		X
6 Does the organization have members or stockholders? 6	X	
7a Does the organization have members, stockholders, or other persons who may elect one or more members of the governing body? 7a	X	
b Are any decisions of the governing body subject to approval by members, stockholders, or other persons? 7b	X	
8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following		
a The governing body? 8a	X	
b Each committee with authority to act on behalf of the governing body? 8b	X	
9 Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O 9		X

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

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

Section C. Disclosure

17 List the states with which a copy of this Form 990 is required to be filed **ATTACHMENT 1**

18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you make these available. Check all that apply.
☐ Own website ☐ Another's website ☒ Upon request

19 Describe in Schedule O whether (and if so, how), the organization makes its governing documents, conflict of interest policy, and financial statements available to the public

20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization. **TOM BREMS 1584 TULLIE CIRCLE ATLANTA, GA 30329**
 404-785-7944

Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent ContractorsCheck if Schedule O contains a response to any question in this Part VII. ☒ **X****Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees****1a** Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.

- List all of the organization's **current** key employees, if any. See instructions for definition of "key employee."

- List the organization's five **current** highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than \$100,000 from the organization and any related organizations.

- List all of the organization's **former** officers, key employees, and highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations.

- List all of the organization's **former** directors or trustees that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations.

List persons in the following order: individual trustees or directors; institutional trustees; officers; key employees; highest compensated employees; and former such persons.

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

(A) Name and Title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (check all that apply)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) EUGENE HAYES PRESIDENT - CHOA FDN	10.00	X		X				0.	440,194.	23,363.
(2) RUTH FOWLER TREASURER- SEE SCHEDULE O	10.00	X		X				0.	619,902.	27,971.
(3) DOUG GARGES TRUSTEE - SEE SCHEDULE O	1.00	X						0.	0.	0.
(4) TRIP AGERTON TRUSTEE - CHOA FDN	1.00	X						0.	0.	0.
(5) KATHY BETTY TRUSTEE - CHOA FDN	1.00	X						0.	0.	0.
(6) ROBERT BRUCE TRUSTEE- SEE SCHEDULE O	1.00	X						64,640.	0.	0.
(7) ROBERT CAMPBELL TRUSTEE - CHOA FDN	1.00	X						0.	0.	0.
(8) ALLEN CHAN TRUSTEE - CHOA FDN	1.00	X						0.	0.	0.
(9) DEAN EISNER TRUSTEE - CHOA FDN	1.00	X						0.	0.	0.
(10) DARRELL ELLIGAN TRUSTEE - CHOA FDN	1.00	X						0.	0.	0.
(11) MOLLY FLETCHER TRUSTEE - CHOA FDN	1.00	X						0.	0.	0.
(12) BRAD FOSTER TRUSTEE - CHOA FDN	1.00	X						0.	0.	0.
(13) JONATHAN GOLDMAN TRUSTEE - CHOA FDN	1.00	X						0.	0.	0.
(14) TOM GIDDENS TRUSTEE - CHOA FDN	1.00	X						0.	0.	0.
(15) THOMAS HOLDER TRUSTEE - CHOA FDN	1.00	X						0.	0.	0.
(16) CLARENCE HORNE TRUSTEE - CHOA FDN	1.00	X						0.	0.	0.

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

(A) Name and title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (check all that apply)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(17) MARY ELLEN IMLAY TRUSTEE - CHOA FDN	1.00	X						0.	0.	0.
(18) MICHELLE JARRARD TRUSTEE - CHOA FDN	1.00	X						0.	0.	0.
(19) KEITH MASON TRUSTEE - CHOA FDN	1.00	X						0.	0.	0.
(20) RICH MCKAY TRUSTEE - CHOA FDN	1.00	X						0.	0.	0.
(21) CHARLES OGBURN TRUSTEE - CHOA FDN	1.00	X						0.	0.	0.
(22) WILLIAM PATE TRUSTEE - CHOA FDN	1.00	X						0.	0.	0.
(23) BEA PEREZ TRUSTEE - CHOA FDN	1.00	X						0.	0.	0.
(24) MARGARET REISER TRUSTEE - CHOA FDN	1.00	X						0.	0.	0.
(25) CHRISTY ROBERTS TRUSTEE - CHOA FDN	1.00	X						0.	0.	0.
(26) MICHAEL RUSSELL TRUSTEE - CHOA FDN	1.00	X						0.	0.	0.
(27) WILLIAM SCHWARTZ TRUSTEE - CHOA FDN	1.00	X						0.	0.	0.
(28) SCOTT SLADE TRUSTEE - CHOA FDN	1.00	X						0.	0.	0.
1b Sub-total								64,640.	1,060,096.	51,334.
c Total from continuation sheets to Part VII, Section A								6,174,416.	2,704,653.	415,287.
d Total (add lines 1b and 1c)								6,239,056.	3,764,749.	466,621.

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 in reportable compensation from the organization **128**

3 Did the organization list any former officer, director or trustee, key employee, or highest compensated employee on line 1a? If "Yes," complete Schedule J for such individual

	Yes	No
3		X
4	X	
5		X

4 For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? If "Yes," complete Schedule J for such individual

5 Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? If "Yes," complete Schedule J for such person

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than \$100,000 of compensation from the organization

(A) Name and business address	(B) Description of services	(C) Compensation
ATTACHMENT 3		

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 in compensation from the organization **58**

Part VIII Statement of Revenue

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512, 513, or 514
Contributions, gifts, grants and other similar amounts	1a Federated campaigns	1a				
	b Membership dues	1b				
	c Fundraising events	1c 503,079.				
	d Related organizations	1d				
	e Government grants (contributions)	1e 7,421,498.				
	f All other contributions, gifts, grants, and similar amounts not included above	1f 53,737,705.				
	g Noncash contributions included in lines 1a-1f \$	435,606.				
	h Total. Add lines 1a-1f		61,662,282.			
Program Service Revenue	Business Code					
	2a NET PATIENT SERVICE REVENUE	621110	864,845,830.	864,845,830.		
	b ICTF PRIMARY CARE	621110	8,863,874.	8,863,874.		
	c GRADUATE MEDICAL (GME) FUNDING	621110	6,528,450.	6,528,450.		
	d STATE NEONATE INCOME	621110	4,471,366.	4,471,366.		
	e HSOC- MANAGEMENT SERVICE FEES	561110	27,313,964.	27,313,964.		
	f All other program service revenue	622110	1,821,406.	1,821,406.		
	g Total. Add lines 2a-2f		913,844,890.			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)		6,292,040.			6,292,040.
	4 Income from investment of tax-exempt bond proceeds		0.			
	5 Royalties		0			
		(i) Real (ii) Personal				
	6a Gross Rents	1,930,971				
	b Less rental expenses	1,749,426				
	c Rental income or (loss)	181,545.				
	d Net rental income or (loss)		181,545.			181,545.
		(i) Securities (ii) Other				
	7a Gross amount from sales of assets other than inventory	21,102,081.				
	b Less cost or other basis and sales expenses	14,467,911.	23,286.			
	c Gain or (loss)	6,634,170	-23,286.			
	d Net gain or (loss)		6,610,884.			6,610,884.
	8a Gross income from fundraising events (not including \$ 503,079. of contributions reported on line 1c) See Part IV, line 18	a 3,534,563.				
	b Less direct expenses	b 901,393				
	c Net income or (loss) from fundraising events		2,633,170			2,633,170
	9a Gross income from gaming activities See Part IV, line 19	a				
	b Less direct expenses	b				
	c Net income or (loss) from gaming activities		0.			
	10a Gross sales of inventory, less returns and allowances	a				
b Less cost of goods sold	b					
c Net income or (loss) from sales of inventory		0				
Miscellaneous Revenue		Business Code				
11a CAFETERIA/HOSPITAL FOOD SERVICE	621110	1,983,173.	1,983,173.			
b MISCELLANEOUS OPERATING REVENUE	621110	5,559,518.	5,559,518.			
c						
d All other revenue						
e Total. Add lines 11a-11d		7,542,691.				
12 Total revenue. See instructions		998,767,502	921,387,581.	0.	15,717,639.	

Form 990 (2010)

Part IX Statement of Functional Expenses

*Section 501(c)(3) and 501(c)(4) organizations must complete all columns
All other organizations must complete column (A) but are not required to complete columns (B), (C), and (D)*

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the U S See Part IV, line 21 . . .	10,651,909.	10,651,909.		
2 Grants and other assistance to individuals in the U S See Part IV, line 22	209,261.	209,261.		
3 Grants and other assistance to governments, organizations, and individuals outside the U S See Part IV, lines 15 and 16	0.			
4 Benefits paid to or for members	0.			
5 Compensation of current officers, directors, trustees, and key employees	3,941,172.	232,207.	3,258,662.	450,303.
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	0.			
7 Other salaries and wages	396,980,492.	312,045,413.	79,521,089.	5,413,990.
8 Pension plan contributions (include section 401(k) and section 403(b) employer contributions)	17,525,209.	13,851,772.	3,673,437.	
9 Other employee benefits	40,188,406.	38,865,959.		1,322,447.
10 Payroll taxes	26,425,270.	20,886,302.	5,538,968.	
11 Fees for services (non-employees)	0.			
a Management	583,739.		583,739.	
b Legal	317,415.		317,415.	
c Accounting	0.			
d Lobbying	0.			
e Professional fundraising services See Part IV, line 17	58,363.	17,584.	40,779.	
f Investment management fees	4,638,088.	700,712.	3,931,185.	6,191.
g Other	7,185,673.	126,554.	6,417,533.	641,586.
12 Advertising and promotion	8,265,909.	4,304,836.	3,516,632.	444,441.
13 Office expenses	10,807,860.	8,981,008.	1,818,743.	8,109.
14 Information technology	0.			
15 Royalties	20,571,670.	15,167,845.	5,358,109.	45,716.
16 Occupancy	1,149,757.	621,086.	437,390.	91,281.
17 Travel	0.			
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	2,429,085.	1,133,677.	1,150,787.	144,621.
19 Conferences, conventions, and meetings	21,393,744.	21,393,744.		
20 Interest	0.			
21 Payments to affiliates	63,710,178.	37,803,415.	25,906,763.	
22 Depreciation, depletion, and amortization	4,513,854.	1,654,171.	2,859,683.	
23 Insurance				
24 Other expenses Itemize expenses not covered above (List miscellaneous expenses in line 24f. If line 24f amount exceeds 10% of line 25, column (A) amount, list line 24f expenses on Schedule O.)				
a <u>MEDICAL SUPPLIES</u>	96,631,843.	96,036,731.	594,297.	815.
b <u>PURCHASED SRVCS (NON-MEDICAL)</u>	26,489,070.	13,715,642.	11,153,392.	1,620,036.
c <u>PURCHASED SRVCS (MEDICAL)</u>	24,700,571.	24,700,561.		10.
d <u>BAD DEBT EXPENSE</u>	11,942,453.	11,942,453.		
e <u>REPAIRS AND MAINTENANCE</u>	12,454,927.	9,934,575.	2,450,958.	69,394.
f All other expenses	13,446,192.	6,974,485.	6,205,567.	266,140.
25 Total functional expenses. Add lines 1 through 24f	827,212,110.	651,951,902.	164,735,128.	10,525,080.
26 Joint Costs. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720) Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation				

Part X Balance Sheet

		(A) Beginning of year		(B) End of year
Assets	1 Cash - non-interest-bearing	69,793,107.	1	55,320,971.
	2 Savings and temporary cash investments		2	
	3 Pledges and grants receivable, net	52,120,898.	3	42,312,318.
	4 Accounts receivable, net	97,420,570.	4	93,988,778.
	5 Receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L		5	
	6 Receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions)		6	
	7 Notes and loans receivable, net		7	
	8 Inventories for sale or use	8,261,196.	8	11,431,207.
	9 Prepaid expenses and deferred charges	802,074.	9	522,488.
	10a Land, buildings, and equipment: cost or other basis Complete Part VI of Schedule D	10a 1139950711.		
	b Less accumulated depreciation	10b 594,597,784.		
		569,969,609.	10c	545,352,927.
	11 Investments - publicly traded securities	87,812,978.	11	98,179,458.
	12 Investments - other securities. See Part IV, line 11	77,554,042.	12	79,109,067.
	13 Investments - program-related See Part IV, line 11		13	
	14 Intangible assets		14	
15 Other assets. See Part IV, line 11	1,230,344,000.	15	1,318,011,668.	
16 Total assets. Add lines 1 through 15 (must equal line 34)	2,194,078,474.	16	2,244,228,882.	
Liabilities	17 Accounts payable and accrued expenses	139,179,720.	17	133,041,648.
	18 Grants payable		18	
	19 Deferred revenue		19	
	20 Tax-exempt bond liabilities		20	
	21 Escrow or custodial account liability Complete Part IV of Schedule D		21	
	22 Payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L		22	
	23 Secured mortgages and notes payable to unrelated third parties		23	
	24 Unsecured notes and loans payable to unrelated third parties		24	
	25 Other liabilities Complete Part X of Schedule D	687,466,435.	25	516,366,031.
	26 Total liabilities. Add lines 17 through 25	826,646,155.	26	649,407,679.
Net Assets or Fund Balances	Organizations that follow SFAS 117, check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.			
	27 Unrestricted net assets	1,017,017,732.	27	1,232,324,629.
	28 Temporarily restricted net assets	225,189,684.	28	228,144,987.
	29 Permanently restricted net assets	125,224,903.	29	134,351,587.
	Organizations that do not follow SFAS 117, check here <input type="checkbox"/> and complete lines 30 through 34.			
	30 Capital stock or trust principal, or current funds		30	
	31 Paid-in or capital surplus, or land, building, or equipment fund		31	
	32 Retained earnings, endowment, accumulated income, or other funds		32	
	33 Total net assets or fund balances	1,367,432,319.	33	1,594,821,203.
	34 Total liabilities and net assets/fund balances	2,194,078,474.	34	2,244,228,882.

Form **990** (2010)

Part XI Reconciliation of Net AssetsCheck if Schedule O contains a response to any question in this Part XI ☒

1	Total revenue (must equal Part VIII, column (A), line 12)	1	998,767,502.
2	Total expenses (must equal Part IX, column (A), line 25)	2	827,212,110.
3	Revenue less expenses Subtract line 2 from line 1	3	171,555,392.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	1,367,432,319.
5	Other changes in net assets or fund balances (explain in Schedule O)	5	55,833,492.
6	Net assets or fund balances at end of year. Combine lines 3, 4, and 5 (must equal Part X, line 33, column (B))	6	1,594,821,203.

Part XII Financial Statements and ReportingCheck if Schedule O contains a response to any question in this Part XII ☐

	Yes	No
1 Accounting method used to prepare the Form 990 <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O		
2a Were the organization's financial statements compiled or reviewed by an independent accountant?		X
b Were the organization's financial statements audited by an independent accountant?	X	
c If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O		
d If "Yes" to line 2a or 2b, check a box below to indicate whether the financial statements for the year were issued on a separate basis, consolidated basis, or both <input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis		
3a As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?	X	
b If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits	X	

Form **990** (2010)

SCHEDULE A
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.

▶ Attach to Form 990 or Form 990-EZ. ▶ See separate instructions.

OMB No 1545-0047

2010

Open to Public
Inspection

Name of the organization

CHILDREN'S HEALTHCARE OF ATLANTA GROUP RETURN

Employer identification number

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

The organization is not a private foundation because it is (For lines 1 through 11, check only one box.)

- 1 ☐ A church, convention of churches, or association of churches described in section 170(b)(1)(A)(i).
- 2 ☐ A school described in section 170(b)(1)(A)(ii). (Attach Schedule E)
- 3 ☒ A hospital or a cooperative hospital service organization described in section 170(b)(1)(A)(iii).
- 4 ☐ A medical research organization operated in conjunction with a hospital described in section 170(b)(1)(A)(iii). Enter the hospital's name, city, and state _____
- 5 ☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in section 170(b)(1)(A)(iv). (Complete Part II)
- 6 ☐ A federal, state, or local government or governmental unit described in section 170(b)(1)(A)(v).
- 7 ☐ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in section 170(b)(1)(A)(vi). (Complete Part II)
- 8 ☐ A community trust described in section 170(b)(1)(A)(vi). (Complete Part II)
- 9 ☐ An organization that normally receives: (1) more than 33 1/3 % of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions - subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975 See section 509(a)(2). (Complete Part III)
- 10 ☐ An organization organized and operated exclusively to test for public safety. See section 509(a)(4).
- 11 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2) See section 509(a)(3). Check the box that describes the type of supporting organization and complete lines 11e through 11h
- a ☐ Type I b ☐ Type II c ☐ Type III - Functionally integrated d ☐ Type III - Other
- e ☐ By checking this box, I certify that the organization is not controlled directly or indirectly by one or more disqualified persons other than foundation managers and other than one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2)
- f If the organization received a written determination from the IRS that it is a Type I, Type II, or Type III supporting organization, check this box ☐
- g Since August 17, 2006, has the organization accepted any gift or contribution from any of the following persons?

- (i) A person who directly or indirectly controls, either alone or together with persons described in (ii) and (iii) below, the governing body of the supported organization? _____
- (ii) A family member of a person described in (i) above? _____
- (iii) A 35% controlled entity of a person described in (i) or (ii) above? _____

	Yes	No
11g(i)		
11g(ii)		
11g(iii)		

h Provide the following information about the supported organization(s)

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-9 above or IRC section (see instructions))	(iv) Is the organization in col (i) listed in your governing document?		(v) Did you notify the organization in col (i) of your support?		(vi) Is the organization in col (i) organized in the U S ?		(vii) Amount of support
			Yes	No	Yes	No	Yes	No	
(A)									
(B)									
(C)									
(D)									
(E)									
Total									

For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ.

Schedule A (Form 990 or 990-EZ) 2010

Part II **Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)**
 (Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(f) Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 Total. Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f).						
6 Public support. Subtract line 5 from line 4						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV)						
11 Total support. Add lines 7 through 10						
12 Gross receipts from related activities, etc. (see instructions)					12	
13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here						<input type="checkbox"/>

Section C. Computation of Public Support Percentage

14 Public support percentage for 2010 (line 6, column (f) divided by line 11, column (f))	14	%
15 Public support percentage from 2009 Schedule A, Part II, line 14	15	%
16a 33 1/3 % support test - 2010. If the organization did not check the box on line 13, and line 14 is 33 1/3 % or more, check this box and stop here. The organization qualifies as a publicly supported organization	<input type="checkbox"/>	
b 33 1/3 % support test - 2009. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3 % or more, check this box and stop here. The organization qualifies as a publicly supported organization	<input type="checkbox"/>	
17a 10%-facts-and-circumstances test - 2010. If the organization did not check a box on line 13, 16a or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization	<input type="checkbox"/>	
b 10%-facts-and-circumstances test - 2009. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization	<input type="checkbox"/>	
18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions	<input type="checkbox"/>	

Schedule A (Form 990 or 990-EZ) 2010

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

(Complete only if you checked the box on line 9 of Part I or if the organization failed to qualify under Part II.
If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(f) Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 Total. Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 Public support. (Subtract line 7c from line 6)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ►	(a) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV)						
13 Total support. (Add lines 9, 10c, 11, and 12)						
14 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here	<input type="checkbox"/>					

Section C. Computation of Public Support Percentage

15 Public support percentage for 2010 (line 8, column (f) divided by line 13, column (f))	15	%
16 Public support percentage from 2009 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2010 (line 10c, column (f) divided by line 13, column (f))	17	%
18 Investment income percentage from 2009 Schedule A, Part III, line 17	18	%

19a 33 1/3 % support tests - 2010. If the organization did not check the box on line 14, and line 15 is more than 33 1/3 %, and line 17 is not more than 33 1/3 %, check this box and stop here. The organization qualifies as a publicly supported organization. ☐

b 33 1/3 % support tests - 2009. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3 %, and line 18 is not more than 33 1/3 %, check this box and stop here. The organization qualifies as a publicly supported organization. ☐

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

SCHEDULE D
(Form 990)

Department of the Treasury
Internal Revenue Service
Name of the organization

Supplemental Financial Statements

- Complete if the organization answered "Yes," to Form 990,
Part IV, line 6, 7, 8, 9, 10, 11, or 12.
► Attach to Form 990. ► See separate instructions.

OMB No 1545-0047

2010

Open to Public
Inspection

CHILDREN'S HEALTHCARE OF ATLANTA GROUP RETURN

Employer identification number

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts Complete if the organization answered "Yes" to Form 990, Part IV, line 6.

	(a) Donor advised funds	(b) Funds and other accounts
1 Total number at end of year		
2 Aggregate contributions to (during year)		
3 Aggregate grants from (during year)		
4 Aggregate value at end of year		
5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control?		<input type="checkbox"/> Yes <input type="checkbox"/> No
6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit?		<input type="checkbox"/> Yes <input type="checkbox"/> No

Part II Conservation Easements. Complete if the organization answered "Yes" to Form 990, Part IV, line 7.

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

<input type="checkbox"/> Preservation of land for public use (e g , recreation or education)	<input type="checkbox"/> Preservation of an historically important land area
<input type="checkbox"/> Protection of natural habitat	<input type="checkbox"/> Preservation of a certified historic structure
<input type="checkbox"/> Preservation of open space	

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

	Held at the End of the Tax Year
a Total number of conservation easements	2a
b Total acreage restricted by conservation easements	2b
c Number of conservation easements on a certified historic structure included in (a)	2c
d Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register	2d

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

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

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

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

7 Amount of expenses incurred in monitoring, inspecting, and enforcing conservation easements during the year ► \$ _____

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

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

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets. Complete if the organization answered "Yes" to Form 990, Part IV, line 8.

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIV, the text of the footnote to its financial statements that describes these items

b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items

(i) Revenues included in Form 990, Part VIII, line 1 ► \$ _____

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

2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items

a Revenues included in Form 990, Part VIII, line 1 ► \$ _____

b Assets included in Form 990, Part X ► \$ _____

For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule D (Form 990) 2010

Part IV **Supplemental Information.** Complete this part to provide the explanations required by Part II, line 10, Part II, line 17a or 17b, or Part III, line 12. Also complete this part for any additional information. (See instructions).

PUBLIC CHARITY STATUS OF GROUP RETURN AFFILIATES

SCHEDULE A, PART I

EGLESTON CHILDREN'S HOSPITAL AT EMORY UNIVERSITY, INC.

PUBLIC CHARITY STATUS: 170(B)(1)(A)(III) - BOX 3

SCOTTISH RITE CHILDREN'S MEDICAL CENTER, INC.

PUBLIC CHARITY STATUS: 170(B)(1)(A)(III) - BOX 3

EGLESTON AFFILIATED SERVICES, INC.

PUBLIC CHARITY STATUS: 170(B)(1)(A)(III) - BOX 3

EGLESTON PEDIATRIC GROUP, INC.

PUBLIC CHARITY STATUS: 170(B)(1)(A)(III) - BOX 3

HSOC, INC.

PUBLIC CHARITY STATUS: 170(B)(1)(A)(III) - BOX 3

MARCUS AUTISM CENTER, INC.

PUBLIC CHARITY STATUS: 509(A)(2) - BOX 9

CHILDREN'S HEALTHCARE OF ATLANTA FOUNDATION

PUBLIC CHARITY STATUS: 509(A)(1) AND 170(B)(1)(A)(VI) - BOX 7

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

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

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

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

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

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

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

b If "Yes," explain the arrangement in Part XI V and complete the following table

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

2a Did the organization include an amount on Form 990, Part X, line 21? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XI V.

Part V Endowment Funds. Complete if organization answered "Yes" to Form 990, Part IV, line 10.

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	104,663,778.	95,032,323	172,905,427		
b Contributions					
c Net investment earnings, gains, and losses	4,102,980.	11,665,264	-25,907,178.		
d Grants or scholarships					
e Other expenditures for facilities and programs	335,796.	1,900,051.			
f Administrative expenses	49,540	133,763	214,249.		
g End of year balance	108,381,422.	104,663,773.	146,784,000.		

2 Provide the estimated percentage of the year end balance held as

- a Board designated or quasi-endowment ▶ .8470 %
 b Permanent endowment ▶ 99.1530 %
 c Term endowment ▶ 0.0000 %

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

- (i) unrelated organizations
 (ii) related organizations

	Yes	No
3a(i)	X	
3a(ii)		X
3b		

b If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R?

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

Part VI Land, Buildings, and Equipment. See Form 990, Part X, line 10.

Description of investment	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		56,117,848.		56,117,848.
b Buildings		583,696,152.	238,087,712.	345,608,440.
c Leasehold improvements		13,579,471.	11,780,441.	1,799,030.
d Equipment		257,058,751.	188,028,759.	69,029,992.
e Other		229,498,489.	156,700,872.	72,797,617.
Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c))				545,352,927.

Schedule D (Form 990) 2010

Part VII Investments - Other Securities. See Form 990, Part X, line 12.

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

Part VIII Investments - Program Related. See Form 990, Part X, line 13.

(a) Description of investment type	(b) Book value	(c) Method of valuation Cost or end-of-year market value
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
(10)		
Total (Column (b) must equal Form 990, Part X, col (B) line 13)		

Part IX Other Assets. See Form 990, Part X, line 15.

(a) Description	(b) Book value
(1) DEPOSITS/NONCURRENT ASSETS	5,503,744.
(2) IC RECEIVABLES FROM PARENT	1,312,507,924.
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
(10)	
Total (Column (b) must equal Form 990, Part X, col (B) line 15)	1,318,011,668.

Part X Other Liabilities. See Form 990, Part X, line 25.

1. (a) Description of liability	(b) Amount	
(1) Federal income taxes		
(2) LONG-TERM INSURANCE RESERVES	17,694,852.	
(3) DUE TO/FROM GOVERNMENT PAYOR	12,088,471.	
(4) IC BOND LIAB TO PARENT-ECH	365,457,461.	
(5) IC BOND LIAB TO PARENT-SR	121,125,247.	
(6)		
(7)		
(8)		
(9)		
(10)		
(11)		
Total (Column (b) must equal Form 990, Part X, col (B) line 25)	516,366,031.	

2. FIN 48 (ASC 740) Footnote In Part XIV, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FIN 48 (ASC 740)

Part XI Reconciliation of Change in Net Assets from Form 990 to Audited Financial Statements

1	Total revenue (Form 990, Part VIII, column (A), line 12)	1	
2	Total expenses (Form 990, Part IX, column (A), line 25)	2	
3	Excess or (deficit) for the year Subtract line 2 from line 1	3	
4	Net unrealized gains (losses) on investments	4	
5	Donated services and use of facilities	5	
6	Investment expenses	6	
7	Prior period adjustments	7	
8	Other (Describe in Part XIV)	8	
9	Total adjustments (net). Add lines 4 through 8	9	
10	Excess or (deficit) for the year per audited financial statements Combine lines 3 and 9	10	

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

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

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

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

Part XIV Supplemental Information

Complete this part to provide the descriptions required for Part II, lines 3, 5, and 9, Part III, lines 1a and 4, Part IV, lines 1b and 2b, Part V, line 4, Part X, line 2, Part XI, line 8; Part XII, lines 2d and 4b, and Part XIII, lines 2d and 4b. Also complete this part to provide any additional information.

SEE PAGE 5

Part XIV Supplemental Information (continued)

ENDOWMENT FUNDS

SCHEDULE D PART V

THE PERMANENTLY RESTRICTED ENDOWMENT BALANCE INCLUDES \$21,666,812 OF EGGLESTON'S BENEFICIAL INTEREST IN TRUSTS AND \$79,109,066 OF SCOTTISH RITE'S BENEFICIAL INTEREST IN TRUSTS. CHILDREN'S IS THE BENEFICIARY OF THE PROPORTIONAL INCOME FROM CERTAIN PERPETUAL THIRD-PARTY TRUSTS. CHILDREN'S HAS NO ACCESS TO THE CORPUS OF THESE TRUSTS AND HAS LIMITED INPUT, AND ONLY IN SOME CASES, INTO THE INVESTMENT MIX OF THE UNDERLYING FUNDS HELD BY THE TRUSTS. THE ESTIMATED PRESENT VALUE OF FUTURE DISTRIBUTIONS TO BE RECEIVED FROM THESE TRUSTS IS USED FOR VALUATION PURPOSES.

ALL ENDOWMENT FUNDS ARE COMPRISED OF PUBLICLY TRADED AND MARKETABLE SECURITIES, WITH THE EXCEPTION OF THE SCOTTISH RITE BENEFICIAL INTEREST IN TRUSTS, WHICH ARE CLASSIFIED AS OTHER SECURITIES.

ENDOWMENT FUNDS

SCHEDULE D, PART V, LINE 1A, COLUMN C

A PORTION OF THE 2008 END OF YEAR BALANCE HAS BEEN RECLASSIFIED TO MORE ACCURATELY REFLECT ASSETS HELD, IN ACCORDANCE WITH REPORTING GUIDANCE FOR ENDOWMENT DISCLOSURES.

Part XIV Supplemental Information (continued)

INTENDED USE OF ENDOWMENT FUNDS

FORM 990, SCHEDULE D, PART V, LINE 4

ENDOWMENT FUNDS ARE UTILIZED TO PROVIDE FINANCIAL SUPPORT FOR CLINICAL, RESEARCH, TEACHING AND WELLNESS INITIATIVES AND PROGRAMS, INCLUDING A DESIGNATED PORTION FOR CHARITY CARE SERVICES.

OTHER ASSETS

SCHEDULE D, PART IX - OTHER ASSETS

THE INTERCOMPANY RECEIVABLE BALANCE REPRESENTS THE NET OF BALANCES DUE TO AND FROM AFFILIATED ENTITIES WITHIN THE CHOA HEALTHCARE SYSTEM. SOME AMOUNTS RESULT FROM TIMING DIFFERENCE OF ACTUAL CASH TRANSACTIONS THAT MAY BE CLEARED IN A FUTURE PERIOD, WHEREAS OTHER BALANCES MAY RESULT FROM TRANSACTIONS MANAGED BY ONE ENTITY ON BEHALF OF ANOTHER WHERE THERE IS NO EXPECTATION OF FUTURE SETTLEMENT (E.G CHOA IS THE COMMON PAYMASTER FOR ALL SYSTEM ENTITIES, BUT THE CORRESPONDING EXPENSE FOR THESE DISBURSEMENTS IS RECOGNIZED AT THE RESPECTIVE ENTITY WHERE THE COST INCURRED). FOR THOSE INTERCOMPANY BALANCES THAT HAVE ACCUMULATED SINCE INCEPTION, THERE IS AN OFFSETTING RECEIVABLE OR PAYABLE ON ANOTHER AFFILIATE'S FINANCIALS, SUCH THAT THESE BALANCES ARE PROPERLY ELIMINATED WHEN CHILDREN'S FINANCIALS ARE PRESENTED ON A CONSOLIDATED BASIS.

Part XIV Supplemental Information (continued)

OTHER LIABILITIES

SCHEDULE D, PART X

THE INTERCOMPANY PAYABLE REPORTED ON SCHEDULE D, PART X INCLUDES THE FILING ORGANIZATIONS ALLOCABLE SHARE OF TAX-EXEMPT BOND LIABILITIES AS PART OF THE HEALTH SYSTEM'S OBLIGATED GROUP. DETAILED INFORMATION ABOUT THE OBLIGATED GROUP'S TAX-EXEMPT BONDS IS REPORTED ON THE FORM 990 OF THE GROUP'S PARENT, CHILDREN'S HEALTHCARE OF ATLANTA, INC., EIN 58-2367819.

FIN 48 (ASC 740) FOOTNOTE

FORM 990, SCHEDULE D, PART X, LINE 2

CHILDREN'S HEALTHCARE OF ATLANTA FOLLOWS THE PROVISIONS OF ASC 740 (FIN 48), WHICH ADDRESSES LIABILITY FOR UNCERTAIN TAX POSITIONS. NO RELATED DISCLOSURES HAVE BEEN NECESSARY IN CHOA'S AUDITED FINANCIAL STATEMENTS FOR FISCAL YEARS 2010 OR 2009.

SCHEDULE G
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Name of the organization

**Supplemental Information Regarding
Fundraising or Gaming Activities**

Complete if the organization answered "Yes" to Form 990, Part IV, lines 17, 18, or 19, or if the organization entered more than \$15,000 on Form 990-EZ, line 6a
▶ Attach to Form 990 or Form 990-EZ. ▶ See separate instructions

OMB No 1545-0047

2010

**Open To Public
Inspection**

Employer identification number

CHILDREN'S HEALTHCARE OF ATLANTA GROUP RETURN

Part I Fundraising Activities. Complete if the organization answered "Yes" to Form 990, Part IV, line 17
Form 990-EZ filers are not required to complete this part.

1 Indicate whether the organization raised funds through any of the following activities. Check all that apply.

- | | |
|--|---|
| a <input type="checkbox"/> Mail solicitations | e <input type="checkbox"/> Solicitation of non-government grants |
| b <input type="checkbox"/> Internet and email solicitations | f <input type="checkbox"/> Solicitation of government grants |
| c <input type="checkbox"/> Phone solicitations | g <input type="checkbox"/> Special fundraising events |
| d <input type="checkbox"/> In-person solicitations | |

2a Did the organization have a written or oral agreement with any individual (including officers, directors, trustees or key employees listed in Form 990, Part VII) or entity in connection with professional fundraising services? ☐ Yes ☐ No

b If "Yes," list the ten highest paid individuals or entities (fundraisers) pursuant to agreements under which the fundraiser is to be compensated at least \$5,000 by the organization.

(i) Name and address of individual or entity (fundraiser)	(ii) Activity	(iii) Did fundraiser have custody or control of contributions?		(iv) Gross receipts from activity	(v) Amount paid to (or retained by) fundraiser listed in col (i)	(vi) Amount paid to (or retained by) organization
		Yes	No			
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
Total				▶		

3 List all states in which the organization is registered or licensed to solicit contributions or has been notified it is exempt from registration or licensing.

Part II Fundraising Events. Complete if the organization answered "Yes" to Form 990, Part IV, line 18, or reported more than \$15,000 of fundraising event contributions and gross income on Form 990-EZ, lines 1 and 6b. List events with gross receipts greater than \$5,000.

		(a) Event #1	(b) Event #2	(c) Other Events	(d) Total events
		HOPE&WILL BALL (event type)	SPRING CLASSIC (event type)	68. (total number)	(add col (a) through col (c))
Revenue	1 Gross receipts	838,685.	207,230.	2,991,727.	4,037,642.
	2 Less Charitable contributions	336,800.	2,200.	164,079.	503,079.
	3 Gross income (line 1 minus line 2)	501,885.	205,030.	2,827,648.	3,534,563.
Direct Expenses	4 Cash prizes			3,310.	3,310.
	5 Noncash prizes	12,966.		22,022.	34,988.
	6 Rent/facility costs	132,139.	33,961.	105,673.	271,773.
	7 Food and beverages		13,038.	23,790.	36,828.
	8 Entertainment			12,625.	12,625.
	9 Other direct expenses	49,527.	47,531.	444,811.	541,869.
	10 Direct expense summary. Add lines 4 through 9 in column (d)				(901,393.)
11 Net income summary. Combine line 3, column (d), and line 10				2,633,170.	

Part III Gaming. Complete if the organization answered "Yes" to Form 990, Part IV, line 19, or reported more than \$15,000 on Form 990-EZ, line 6a.

		(a) Bingo	(b) Pull tabs/Instant bingo/progressive bingo	(c) Other gaming	(d) Total gaming (add col (a) through col (c))
Revenue	1 Gross revenue				
Direct Expenses	2 Cash prizes				
	3 Noncash prizes				
	4 Rent/facility costs				
	5 Other direct expenses				
	6 Volunteer labor	Yes _____ % No	Yes _____ % No	Yes _____ % No	
	7 Direct expense summary. Add lines 2 through 5 in column (d)				()
	8 Net gaming income summary. Combine line 1, column d, and line 7				

9 Enter the state(s) in which the organization operates gaming activities _____

a Is the organization licensed to operate gaming activities in each of these states? ☐ Yes ☐ No

b If "No," explain _____

10 a Were any of the organization's gaming licenses revoked, suspended or terminated during the tax year? ☐ Yes ☐ No

b If "Yes," explain _____

- 11** Does the organization operate gaming activities with nonmembers? ☐ Yes ☐ No
- 12** Is the organization a grantor, beneficiary or trustee of a trust or a member of a partnership or other entity formed to administer charitable gaming? ☐ Yes ☐ No
- 13** Indicate the percentage of gaming activity operated in:
- | | | |
|--------------------------------------|------------|---|
| a The organization's facility | 13a | % |
| b An outside facility | 13b | % |
- 14** Enter the name and address of the person who prepares the organization's gaming/special events books and records.

Name ▶ _____

Address ▶ _____

- 15 a** Does the organization have a contract with a third party from whom the organization receives gaming revenue? ☐ Yes ☐ No
- b** If "Yes," enter the amount of gaming revenue received by the organization \$_____ and the amount of gaming revenue retained by the third party ▶ \$_____
- c** If "Yes," enter name and address of the third party.

Name ▶ _____

Address ▶ _____

16 Gaming manager information

Name ▶ _____

Gaming manager compensation ▶ \$_____

Description of services provided ▶ _____

☐ Director/officer

 ☐ Employee

 ☐ Independent contractor
17 Mandatory distributions

- a** Is the organization required under state law to make charitable distributions from the gaming proceeds to retain the state gaming license? ☐ Yes ☐ No
- b** Enter the amount of distributions required under state law to be distributed to other exempt organizations or spent in the organization's own exempt activities during the tax year ▶ \$_____

Part IV **Supplemental Information.** Complete this part to provide the explanation required by Part I, line 2b, columns (iii) and (v), and Part III, lines 9, 9b, 10b, 15b, 15c, 16, and 17b, as applicable. Also complete this part to provide any additional information (see instructions).

SCHEDULE H
(Form 990)

Hospitals

OMB No 1545-0047

2010

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

► Complete if the organization answered "Yes" to Form 990, Part IV, question 20.

► Attach to Form 990. ► See separate instructions.

Name of the organization

Employer identification number

CHILDREN'S HEALTHCARE OF ATLANTA GROUP RETURN

Part I Financial Assistance and Certain Other Community Benefits at Cost

	Yes	No
1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	<input checked="" type="checkbox"/>	<input type="checkbox"/>
1b If "Yes," was it a written policy?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year		
<input checked="" type="checkbox"/> Applied uniformly to all hospital facilities		
<input type="checkbox"/> Generally tailored to individual hospital facilities		
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year		
a Did the organization use Federal Poverty Guidelines (FPG) to determine eligibility for providing free care to low income individuals? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input checked="" type="checkbox"/> Other 235.0000 %		
b Did the organization use FPG to determine eligibility for providing discounted care to low income individuals? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input checked="" type="checkbox"/> Other 340.0000 %		
c If the organization did not use FPG to determine eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, to determine eligibility for free or discounted care		
4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	<input type="checkbox"/>	<input type="checkbox"/>
6a Did the organization prepare a community benefit report during the tax year?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
b If "Yes," did the organization make it available to the public?	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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

7 Financial Assistance and Certain Other Community Benefits at Cost						
Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheets 1 and 2)			21,275,388.	1,131,460.	20,143,928.	2.44
b Unreimbursed Medicaid (from Worksheet 3, column a)			374,806,950.	338,067,740.	36,739,210.	4.44
c Unreimbursed costs - other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs			396,082,338.	339,199,200.	56,883,138.	6.88
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			10,886,354.	1,184,609.	9,701,745.	1.17
f Health professions education (from Worksheet 5)			14,304,625.	6,528,450.	7,776,175.	.94
g Subsidized health services (from Worksheet 6)			30,767,491.	13,421,688.	17,345,803.	2.10
h Research (from Worksheet 7)			16,087,190.	486,507.	15,600,683.	1.89
i Cash and in-kind contributions to community groups (from Worksheet 8)			6,229,577.	0.	6,229,577.	.75
j Total Other Benefits			78,275,237.	21,621,254.	56,653,983.	6.85
k Total Add lines 7d and 7j.			474,357,575.	360,820,454.	113,537,121.	13.73

For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule H (Form 990) 2010

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development						
3 Community support						
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building			753,724.		753,724.	.09
7 Community health improvement advocacy						
8 Workforce development						
9 Other						
10 Total			753,724.		753,724.	.09

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

- 1 Does the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No 15? **1** X
- 2 Enter the amount of the organization's bad debt expense (at cost) **2** 4,889,955.
- 3 Enter the estimated amount of the organization's bad debt expense (at cost) attributable to patients eligible under the organization's financial assistance policy **3** 0.
- 4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense. In addition, describe the costing methodology used in determining the amounts reported on lines 2 and 3, and rationale for including a portion of bad debt amounts in community benefit.

Section B. Medicare

- 5 Enter total revenue received from Medicare (including DSH and IME) **5** 2,242,000.
- 6 Enter Medicare allowable costs of care relating to payments on line 5 **6** 3,299,000.
- 7 Subtract line 6 from line 5 This is the surplus (or shortfall) **7** -1,057,000.
- 8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used:
- ☐ Cost accounting system ☒ Cost to charge ratio ☐ Other **2**

Section C. Collection Practices

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

Part IV Management Companies and Joint Ventures

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				

Part V Facility Information**Section A. Hospital Facilities**

(list in order of size, measured by total revenue per facility, from largest to smallest)

How many hospital facilities did the organization operate during the tax year? 2

Name and address

1 EGLESTON CHILDREN'S HOSP AT EMORY UNIV
1405 CLIFTON ROAD NE
ATLANTA GA 30322-1062

2 SCOTTISH RITE CHILDREN'S MEDICAL CENTER
1001 JOHNSON FERRY ROAD NE
ATLANTA GA 30342-1605

3**4****5****6****7****8****9****10****11****12****13****14****15****16**

Licensed hospital

General medical & surgical

Children's hospital

Teaching hospital

Critical access hospital

Research facility

ER-24 hours

ER-other

Other (describe)

Part V Facility Information (continued)**Section C. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**
(list in order of size, measured by total revenue per facility, from largest to smallest)How many non-hospital facilities did the organization operate during the tax year? 17

Name and address	Type of Facility (describe)
1 CENTER FOR CRANIOFACIAL DISORDERS 5455 MERIDIAN MARKS RD NE STE 200 ATLANTA GA 30342-4722	TREATMENT CLINIC
2 JUDSON HAWK CLINIC FOR CHILDREN 5455 MERIDIAN MARKS RD NE STE 200 ATLANTA GA 30342-4722	DIAGNOSTIC & TREATMENT CLINIC
3 CHILDRENS AT MT ZION 2201 MOUNT ZION PKWY ALPHARETTA GA 30260-3312	OUTPATIENT CLINIC
4 CHILDRENS AT NORTHPOINT 3795 MANSELL RD DULUTH GA 30022-8247	OUTPATIENT CLINIC
5 CHILDRENS AT SATELLITE BLVD 2660 SATELLITE BLVD ATLANTA GA 30096-5803	OUTPATIENT CLINIC
6 CHILDRENS AT FORSYTH 410 PEACHTREE PKWY STE 300 ATLANTA GA 30041-7407	OUTPATIENT CLINIC
7 CHILDRENS AT TOWN CENTER 2985 GEORGE BUSBEE PKWY NW ATLANTA GA 30144-6812	OUTPATIENT CLINIC
8 CHILDRENS PRIMARY CARE CTR OF CHAMBLEE 4166 BUFORD HWY NE STE 1102 COLUMBUS GA 30345-1038	OUTPATIENT CLINIC
9 CHILDRENS AT SCOTTISH RITE CPC 5455 MERIDIAN MARKS RD NE STE 500 ATLANTA GA 30342-4723	REHABILITATION CLINIC
10 CHILDRENS PEDIATRIC DENTISTRY AND ORTHO. 5455 MERIDIAN MARKS RD NE STE 200 ATLANTA GA 30342-4722	OUTPATIENT CLINIC

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Part V Facility Information (continued)**Section C. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**
(list in order of size, measured by total revenue per facility, from largest to smallest)

How many non-hospital facilities did the organization operate during the tax year? _____

Name and address	Type of Facility (describe)
1 CHILDREN'S NEUROPSYCHOLOGY 5455 MERIDIAN MARKS RD NE STE 180 ATLANTA GA 30342-4716	OUTPATIENT CLINIC
2 CHILDREN'S SEDATION SERVICES-WEBB BRIDGE 3155 NORTH POINT PKWY STE 150 ALPHARETTA GA 30005-5481	TREATMENT CLINIC
3 CHILDREN'S ANESTHESIA SERVICES 1001 JOHNSON FERRY ROAD NE ATLANTA GA 30342-1605	TREATMENT CLINIC
4 MARCUS AUTISM CENTER 1920 BRIARCLIFF ROAD NE ATLANTA GA 30329	TREATMENT CLINIC
5 CHOA PEDIATRIC NEUROLOGY 5455 MERIDIAN MARKS RD NE STE 200 ATLANTA GA 30342-4722	TREATMENT CLINIC
6 PEDIATRIC NEUROSURGERY ASSOC. CHILDREN'S 5455 MERIDIAN MARKS RD NE STE 540 ATLANTA GA 30342-4723	TREATMENT CLINIC
7 AFLAC CANCER CENTER AT SCOTTISH RITE 5455 MERIDIAN MARKS RD NE STE 400 MACON GA 30322-1060	TREATMENT CLINIC
8	
9	
10	

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Part V Facility Information (continued)**Section B. Facility Policies and Practices**

(Complete a separate Section B for each of the hospital facilities listed in Part V, Section A)

Name of Hospital Facility: EGLESTON CHILDREN'S HOSP AT EMORY UNIVLine Number of Hospital Facility (from Schedule H, Part V, Section A): 1

		Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for 2010)			
1	During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment (Needs Assessment)? If "No," skip to line 8.	1	
If "Yes," indicate what the Needs Assessment describes (check all that apply)			
a	<input type="checkbox"/> A definition of the community served by the hospital facility		
b	<input type="checkbox"/> Demographics of the community		
c	<input type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d	<input type="checkbox"/> How data was obtained		
e	<input type="checkbox"/> The health needs of the community		
f	<input type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g	<input type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h	<input type="checkbox"/> The process for consulting with persons representing the community's interests		
i	<input type="checkbox"/> Information gaps that limit the hospital facility's ability to assess all of the community's health needs		
j	<input type="checkbox"/> Other (describe in Part VI)		
2	Indicate the tax year the hospital facility last conducted a Needs Assessment 20 <u> </u>		
3	In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3	
4	Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	4	
5	Did the hospital facility make its Needs Assessment widely available to the public?	5	
If "Yes," indicate how the Needs Assessment was made widely available (check all that apply)			
a	<input type="checkbox"/> Hospital facility's website		
b	<input type="checkbox"/> Available upon request from the hospital facility		
c	<input type="checkbox"/> Other (describe in Part VI)		
6	If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply)		
a	<input type="checkbox"/> Adoption of an implementation strategy to address the health needs of the hospital facility's community		
b	<input type="checkbox"/> Execution of the implementation strategy		
c	<input type="checkbox"/> Participation in the development of a community-wide community benefit plan		
d	<input type="checkbox"/> Participation in the execution of a community-wide community benefit plan		
e	<input type="checkbox"/> Inclusion of a community benefit section in operational plans		
f	<input type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the Needs Assessment		
g	<input type="checkbox"/> Prioritization of health needs in its community		
h	<input type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community		
i	<input type="checkbox"/> Other (describe in Part VI)		
7	Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs	7	
Financial Assistance Policy			
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
8	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	8	X
9	Used federal poverty guidelines (FPG) to determine eligibility for providing free care to low income individuals?	9	X
If "Yes," indicate the FPG family income limit for eligibility for free care <u> 2 </u> <u> 3 </u> <u> 5 </u> %			

Part V Facility Information (continued) EGGLESTON CHILDREN'S HOSP AT EMORY UNIV

	Yes	No
10 Used FPG to determine eligibility for providing <i>discounted</i> care to low income individuals? If "Yes," indicate the FPG family income limit for eligibility for discounted care <u>3</u> <u>4</u> <u>0</u> %	10 X	
11 Explained the basis for calculating amounts charged to patients? If "Yes," indicate the factors used in determining such amounts (check all that apply)	11 X	
a <input checked="" type="checkbox"/> Income level		
b <input type="checkbox"/> Asset level		
c <input checked="" type="checkbox"/> Medical indigency		
d <input checked="" type="checkbox"/> Insurance status		
e <input type="checkbox"/> Uninsured discount		
f <input type="checkbox"/> Medicaid/Medicare		
g <input type="checkbox"/> State regulation		
h <input type="checkbox"/> Other (describe in Part VI)		
12 Explained the method for applying for financial assistance?	12 X	
13 Included measures to publicize the policy within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	13 X	
a <input checked="" type="checkbox"/> The policy was posted on the hospital facility's website		
b <input type="checkbox"/> The policy was attached to billing invoices		
c <input checked="" type="checkbox"/> The policy was posted in the hospital facility's emergency rooms or waiting rooms		
d <input checked="" type="checkbox"/> The policy was posted in the hospital facility's admissions offices		
e <input type="checkbox"/> The policy was provided, in writing, to patients on admission to the hospital facility		
f <input checked="" type="checkbox"/> The policy was available on request		
g <input type="checkbox"/> Other (describe in Part VI)		

Billing and Collections

14 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy that explained actions the hospital facility may take upon non-payment?	14 X	
15 Check all of the following collection actions against a patient that were permitted under the hospital facility's policies at any time during the tax year:		
a <input type="checkbox"/> Reporting to credit agency		
b <input type="checkbox"/> Lawsuits		
c <input type="checkbox"/> Liens on residences		
d <input type="checkbox"/> Body attachments		
e <input type="checkbox"/> Other actions (describe in Part VI)		
16 Did the hospital facility engage in or authorize a third party to perform any of the following collection actions during the tax year? If "Yes," check all collection actions in which the hospital facility or a third party engaged (check all that apply)	16	X
a <input type="checkbox"/> Reporting to credit agency		
b <input type="checkbox"/> Lawsuits		
c <input type="checkbox"/> Liens on residences		
d <input type="checkbox"/> Body attachments		
e <input type="checkbox"/> Other actions (describe in Part VI)		
17 Indicate which actions the hospital facility took before initiating any of the collection actions checked in line 16 (check all that apply)		
a <input type="checkbox"/> Notified patients of the financial assistance policy on admission		
b <input type="checkbox"/> Notified patients of the financial assistance policy prior to discharge		
c <input type="checkbox"/> Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills		
d <input type="checkbox"/> Documented its determination of whether a patient who applied for financial assistance under the financial assistance policy qualified for financial assistance		
e <input type="checkbox"/> Other (describe in Part VI)		

Schedule H (Form 990) 2010

Part V Facility Information (continued) EGGLESTON CHILDREN'S HOSP AT EMORY UNIV**Policy Relating to Emergency Medical Care**

		Yes	No
18	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? If "No," indicate the reasons why (check all that apply).	X	
a	<input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions		
b	<input type="checkbox"/> The hospital facility did not have a policy relating to emergency medical care		
c	<input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)		
d	<input type="checkbox"/> Other (describe in Part VI)		

Charges for Medical Care

19	Indicate how the hospital facility determined the amounts billed to individuals who did not have insurance covering emergency or other medically necessary care (check all that apply)		
a	<input type="checkbox"/> The hospital facility used the lowest negotiated commercial insurance rate for those services at the hospital facility		
b	<input checked="" type="checkbox"/> The hospital facility used the average of the three lowest negotiated commercial insurance rates for those services at the hospital facility		
c	<input type="checkbox"/> The hospital facility used the Medicare rate for those services		
d	<input checked="" type="checkbox"/> Other (describe in Part VI)		
20	Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and to whom the hospital facility provided emergency or other medically necessary services, more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Part VI		X
21	Did the hospital facility charge any of its patients an amount equal to the gross charge for any service provided to that patient? If "Yes," explain in Part VI		X

Schedule H (Form 990) 2010

Part V Facility Information (continued)**Section B. Facility Policies and Practices**

(Complete a separate Section B for each of the hospital facilities listed in Part V, Section A)

Name of Hospital Facility: SCOTTISH RITE CHILDREN'S MEDICAL CENTERLine Number of Hospital Facility (from Schedule H, Part V, Section A): 2

2

Community Health Needs Assessment (Lines 1 through 7 are optional for 2010)

Yes No

1 During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment (Needs Assessment)? If "No," skip to line 8.

1

If "Yes," indicate what the Needs Assessment describes (check all that apply)

- a ☐ A definition of the community served by the hospital facility
- b ☐ Demographics of the community
- c ☐ Existing health care facilities and resources within the community that are available to respond to the health needs of the community
- d ☐ How data was obtained
- e ☐ The health needs of the community
- f ☐ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups
- g ☐ The process for identifying and prioritizing community health needs and services to meet the community health needs
- h ☐ The process for consulting with persons representing the community's interests
- i ☐ Information gaps that limit the hospital facility's ability to assess all of the community's health needs
- j ☐ Other (describe in Part VI)

2 Indicate the tax year the hospital facility last conducted a Needs Assessment 20

3 In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted

3

4 Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI

4

5 Did the hospital facility make its Needs Assessment widely available to the public?
If "Yes," indicate how the Needs Assessment was made widely available (check all that apply)

5

- a ☐ Hospital facility's website
- b ☐ Available upon request from the hospital facility
- c ☐ Other (describe in Part VI)

6 If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply)

- a ☐ Adoption of an implementation strategy to address the health needs of the hospital facility's community
- b ☐ Execution of the implementation strategy
- c ☐ Participation in the development of a community-wide community benefit plan
- d ☐ Participation in the execution of a community-wide community benefit plan
- e ☐ Inclusion of a community benefit section in operational plans
- f ☐ Adoption of a budget for provision of services that address the needs identified in the Needs Assessment
- g ☐ Prioritization of health needs in its community
- h ☐ Prioritization of services that the hospital facility will undertake to meet health needs in its community
- i ☐ Other (describe in Part VI)

7 Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs

7

Financial Assistance Policy

Did the hospital facility have in place during the tax year a written financial assistance policy that:

8 Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?

8

X

9 Used federal poverty guidelines (FPG) to determine eligibility for providing free care to low income individuals?

9

X

If "Yes," indicate the FPG family income limit for eligibility for free care 2 3 5 %

Part V Facility Information (continued) SCOTTISH RITE CHILDREN'S MEDICAL CENTER

	Yes	No
10 Used FPG to determine eligibility for providing <i>discounted</i> care to low income individuals? If "Yes," indicate the FPG family income limit for eligibility for discounted care <u>3</u> <u>4</u> <u>0</u> %	10 X	
11 Explained the basis for calculating amounts charged to patients? If "Yes," indicate the factors used in determining such amounts (check all that apply)	11 X	
a <input checked="" type="checkbox"/> Income level		
b <input type="checkbox"/> Asset level		
c <input checked="" type="checkbox"/> Medical indigency		
d <input checked="" type="checkbox"/> Insurance status		
e <input type="checkbox"/> Uninsured discount		
f <input type="checkbox"/> Medicaid/Medicare		
g <input type="checkbox"/> State regulation		
h <input type="checkbox"/> Other (describe in Part VI)		
12 Explained the method for applying for financial assistance?	12 X	
13 Included measures to publicize the policy within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	13 X	
a <input checked="" type="checkbox"/> The policy was posted on the hospital facility's website		
b <input type="checkbox"/> The policy was attached to billing invoices		
c <input checked="" type="checkbox"/> The policy was posted in the hospital facility's emergency rooms or waiting rooms		
d <input checked="" type="checkbox"/> The policy was posted in the hospital facility's admissions offices		
e <input type="checkbox"/> The policy was provided, in writing, to patients on admission to the hospital facility		
f <input checked="" type="checkbox"/> The policy was available on request		
g <input type="checkbox"/> Other (describe in Part VI)		

Billing and Collections

14 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy that explained actions the hospital facility may take upon non-payment?	14 X	
15 Check all of the following collection actions against a patient that were permitted under the hospital facility's policies at any time during the tax year		
a <input type="checkbox"/> Reporting to credit agency		
b <input type="checkbox"/> Lawsuits		
c <input type="checkbox"/> Liens on residences		
d <input type="checkbox"/> Body attachments		
e <input type="checkbox"/> Other actions (describe in Part VI)		
16 Did the hospital facility engage in or authorize a third party to perform any of the following collection actions during the tax year? If "Yes," check all collection actions in which the hospital facility or a third party engaged (check all that apply)	16	X
a <input type="checkbox"/> Reporting to credit agency		
b <input type="checkbox"/> Lawsuits		
c <input type="checkbox"/> Liens on residences		
d <input type="checkbox"/> Body attachments		
e <input type="checkbox"/> Other actions (describe in Part VI)		
17 Indicate which actions the hospital facility took before initiating any of the collection actions checked in line 16 (check all that apply)		
a <input type="checkbox"/> Notified patients of the financial assistance policy on admission		
b <input type="checkbox"/> Notified patients of the financial assistance policy prior to discharge		
c <input type="checkbox"/> Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills		
d <input type="checkbox"/> Documented its determination of whether a patient who applied for financial assistance under the financial assistance policy qualified for financial assistance		
e <input type="checkbox"/> Other (describe in Part VI)		

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Part V Facility Information (continued) SCOTTISH RITE CHILDREN'S MEDICAL CENTER**Policy Relating to Emergency Medical Care**

	Yes	No
18 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? If "No," indicate the reasons why (check all that apply)	X	
a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions		
b <input type="checkbox"/> The hospital facility did not have a policy relating to emergency medical care		
c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)		
d <input type="checkbox"/> Other (describe in Part VI)		

Charges for Medical Care

19 Indicate how the hospital facility determined the amounts billed to individuals who did not have insurance covering emergency or other medically necessary care (check all that apply):			
a <input type="checkbox"/> The hospital facility used the lowest negotiated commercial insurance rate for those services at the hospital facility			
b <input checked="" type="checkbox"/> The hospital facility used the average of the three lowest negotiated commercial insurance rates for those services at the hospital facility			
c <input type="checkbox"/> The hospital facility used the Medicare rate for those services			
d <input checked="" type="checkbox"/> Other (describe in Part VI)			
20 Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and to whom the hospital facility provided emergency or other medically necessary services, more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Part VI			X
21 Did the hospital facility charge any of its patients an amount equal to the gross charge for any service provided to that patient? If "Yes," explain in Part VI			X

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Part VI Supplemental Information

Complete this part to provide the following information

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7, Part II, Part III, lines 4, 8, and 9b, and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy
- 4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves
- 5 **Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.)
- 6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served
- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report

COMMUNITY BENEFIT REPORTING

PART I, LINE 6A

CHILDREN'S HEALTHCARE OF ATLANTA, INC., A RELATED ORGANIZATION, PREPARES
AND MAKES AVAILABLE TO THE PUBLIC AN ANNUAL COMMUNITY BENEFIT REPORT THAT
INCLUDES EGLESTON AND SCOTTISH RITE'S COMMUNITY BENEFITS.

SUBSIDIZED HEALTH SERVICES

PART I, LINE 7G

THE SUBSIDIZED HEALTH SERVICES REPORTED ARE FOR HOSPITAL BASED PHYSICIAN
CLINICS, INCLUDING DENTAL, ORTHODONTIC, MULTI-SPECIALTY, ETC.

BAD DEBT EXPENSE

PART I, LINE 7 COLUMN (F)

BAD DEBT EXPENSE IN THE AMOUNT OF \$11,942,453 HAS BEEN REMOVED FROM TOTAL
EXPENSE.

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7, Part II, Part III, lines 4, 8, and 9b, and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B
- 3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy
- 4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves
- 5 **Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc)
- 6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served
- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report

BAD DEBT EXPENSE

PART III, LINE 4

THE PROVISIONS FOR BAD DEBT RELATED TO PATIENT SERVICE REVENUE IS BASED

ON AN EVALUATION OF POTENTIALLY UNCOLLECTIBLE PORTIONS OF ACCOUNTS

RECEIVABLE. THE PROVISION CONSIDERED NECESSARY FOR SUCH DEBTS IS BASED ON

AN ANALYSIS OF CURRENT AND PAST DUE ACCOUNTS, COLLECTION EXPERIENCE IN

RELATION TO AMOUNTS BILLED AND OTHER RELEVANT INFORMATION. THE COSTING

METHODOLOGY USED IN DETERMINING AMOUNTS REPORTED ON LINES 2 AND 3 WAS A

RATIO OF COST TO CHARGE APPLIED TO BAD DEBT CHARGES WRITTEN OFF.

EXPLANATION OF SHORTFALL AS COMMUNITY BENEFIT

PART III, LINE 8

AS A PEDIATRIC HOSPITAL, MEDICARE VOLUMES ARE LOW, AND AS SUCH ARE NOT

SPECIFICALLY DIFFERENTIATED IN THIS YEAR'S 990. DIFFERENTIATION WILL BE

MADE IN FUTURE PERIODS. FOR PURPOSES OF THE SPECIFIC RESPONSES TO PART

III, LINE 8, MEDICARE PAYMENT AND MEDICARE CHARGES ARE ISOLATED BASED ON

PAYMENTS POSTED/RECEIVED IN THE CALENDAR YEAR. COST IS ESTIMATED USING

OVERALL COST-TO-CHARGE RATIO.

Part VI Supplemental Information

Complete this part to provide the following information

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II, Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B
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PROVISIONS ON COLLECTION PRACTICES FOR QUALIFIED PATIENTS

PART III, LINE 9B

INITIAL SCREENINGS OF ALL INPATIENT, EMERGENCY, AND SURGERY ENCOUNTERS AS

WELL AS MOST OUTPATIENT VISITS ARE CONDUCTED BY FINANCIAL COUNSELORS TO

IDENTIFY POTENTIAL INSURANCE OR OTHER COVERAGE FOR EACH PATIENT.

COUNSELORS MAKE CONTACT WITH THE FAMILIES, EITHER IN PERSON OR LETTER, TO

ASSIST THE FAMILY IN IDENTIFYING ANY PROGRAMS FOR WHICH THE

PATIENT/SERVICE MAY QUALIFY (INCLUDING MEDICAID, SCHIP, INSURANCE

COVERAGE, AND CHARITY ASSISTANCE). IF THE FAMILY CANNOT BE LOCATED OR IS

UNCOOPERATIVE AFTER A PERIOD OF TIME, THESE ACCOUNTS ARE TRANSFERRED TO

AN INTERNAL COLLECTION AREA FOR FURTHER ATTEMPTS TO OBTAIN PAYMENT OR, IF

THE PATIENT MAY QUALIFY FOR ASSISTANCE, TO SECURE A FINANCIAL ASSISTANCE

APPLICATION.

OTHER- PROVIDED FREE CARE

PART V, SECTION B, LINE 19D

BASED ON INCOME AS ATTESTED TO BY FAMILY, PROVIDED FREE CARE UP TO 235%

OF FEDERAL POVERTY GUIDELINE, "SLIDING SCALE" CARE UP TO 340% OF FEDERAL

Part VI Supplemental Information

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POVERTY GUIDELINE WITH MINIMUM WRITE OFF EQUIVALENT TO THE AVERAGE OF THE
THREE LOWEST NEGOTIATED COMMERCIAL INSURANCE PAYMENT RATES.

HOSPITAL FACILITY CHARGE

PART V, SECTION B, LINES 20&21

INITIALLY CHARGES FOR PATIENT SERVICES ARE MADE IN A CONSISTENT MANNER TO
ALL PATIENTS. PATIENTS ELIGIBLE FOR FINANCIAL ASSISTANCE ARE PROVIDED
WITH SUPPORT VIA REDUCTION TO THEIR BALANCE OWED BASED ON DOCUMENTATION
PROVIDED BY THE PATIENT AND THE HOSPITAL'S CHARITY POLICY CRITERIA.

NEEDS ASSESSMENT

PART VI, LINE 2

EGLESTON CHILDREN'S HOSPITAL AT EMORY UNIVERSITY, INC. (EGLESTON) AND
SCOTTISH RITE CHILDREN'S MEDICAL CENTER (SCOTTISH RITE) ASSESSES THE
HEALTH CARE NEEDS OF THE COMMUNITIES IT SERVES THROUGH STRATEGIC PLANNING
PROCESSES COMPLETED FOR THE CHILDREN'S HEALTHCARE OF ATLANTA SYSTEM.
CHILDREN'S MISSION IS TO ENHANCE THE LIVES OF CHILDREN THROUGH EXCELLENCE
IN PATIENT CARE, RESEARCH AND EDUCATION. CLINICALLY, CHILDREN'S SERVES A

Part VI Supplemental Information

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LARGE POPULATION OF CHILDREN, BOTH IN ATLANTA AND STATEWIDE, AND A PARTICULARLY LARGE POPULATION OF CHILDREN LIVING IN POVERTY. AS THE SOLE PROVIDER IN GEORGIA FOR MANY OF THE HEALTHCARE NEEDS OF GEORGIA'S CHILDREN, CHILDREN'S GOAL IS TO BE RESPONSIVE AND ACCESSIBLE TO THEIR EVOLVING CLINICAL NEEDS. FURTHERMORE, CHILDREN'S HAS DETERMINED THAT TO FULLY MEET THE NEEDS OF GEORGIA'S CHILDREN, WE MUST ALSO DEVELOP A ROBUST RESEARCH PROGRAM FOCUSED ON ACQUIRING NEW KNOWLEDGE AND EXPERTISE, WHICH CAN HAVE FAR REACHING IMPLICATIONS FOR PATIENTS AT CHILDREN'S AND BEYOND OUR WALLS. CHILDREN'S ALSO RECOGNIZES THAT WE MUST TRAIN THE NEXT GENERATION OF PEDIATRICIANS AND ENSURE AN ADEQUATE SUPPLY OF PHYSICIANS TO CARE FOR THE LARGE GROWING PEDIATRIC POPULATION IN GEORGIA AND TO CONDUCT PEDIATRIC RESEARCH AND TEACHING. CHILDREN'S ALSO RECOGNIZES THAT NOT ALL HEALTHCARE NEEDS CAN BE MET IN OUR FOUR WALLS, AND THAT LIMITED HEALTHCARE FUNDING NECESSITATES INVESTMENTS IN HIGH-IMPACT PREVENTION AND WELLNESS INITIATIVES.

CLINICAL

Part VI Supplemental Information

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CHILDREN'S IS THE LARGEST PEDIATRIC PROVIDER IN GEORGIA SERVING 8:10

PEDIATRIC INPATIENT CASES IN THE ATLANTA MSA AND 4:10 STATEWIDE. IN

2010, CHILDREN'S SAW 314,737 UNIQUE PATIENTS ORIGINATING FROM ALL 159

GEORGIA COUNTIES. CHILDREN'S HAS MORE BEDS THAN ANY OTHER PEDIATRIC

HEALTHCARE SYSTEM AND HAS CONSISTENTLY HIGHER VOLUMES THAN THE OTHER TOP

HOSPITALS.

CLINICAL IS A STRATEGIC FOCUS AREA AND HAS A DETAILED 5-YEAR STRATEGIC

PLAN FROM 2008 TO 2013. THE CLINICAL STRATEGIC PLAN INCLUDES GROWING AS A

PEDIATRIC CENTER OF EXCELLENCE. CHILDREN'S TREATS 7:10 MEDICINE CASES IN

THE ATLANTA MSA. MEDICINE IS AMONG THE AREAS DETERMINED FOR GROWTH AS

PART OF OUR 10-YEAR PLAN.

CLINICAL EFFORTS AT CHILDREN'S IN 2010 ALSO INCLUDED ADDRESSING CHILDREN

WITH AUTISM IN GEORGIA. THE INCIDENCE OF CHILDREN WITH AUTISM IS RISING,

PARTICULARLY IN GEORGIA WHERE 1 IN 98 CHILDREN HAVE AUTISM AS COMPARED TO

1 IN 110 NATIONALLY. CHILDREN'S IS BEHIND A CENTER THAT IS THE ONLY PLACE

IN THE SOUTH THAT PROVIDES COMPREHENSIVE AUTISM SERVICES AND HAS

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INCREASED VOLUMES 40 PERCENT SINCE 2008.

RESEARCH

LED BY PAUL SPEARMAN, M.D., CHIEF RESEARCH OFFICER AT CHILDREN'S AND VICE

CHAIR FOR RESEARCH IN THE EMORY DEPARTMENT OF PEDIATRICS, THE

EMORY-CHILDREN'S PEDIATRIC RESEARCH CENTER IS A PARTNERSHIP BETWEEN EMORY

AND CHILDREN'S HEALTHCARE OF ATLANTA. FOURTEEN KEY PRIORITY CENTERS HAVE

BEEN IDENTIFIED AS PART OF THIS PARTNERSHIP. THEY ARE: HEMATOLOGY AND

ONCOLOGY THROUGH THE AFLAC CANCER CENTER, IMMUNOLOGY AND VACCINES,

TRANSPLANT IMMUNOLOGY AND IMMUNE THERAPEUTICS, PEDIATRIC HEALTHCARE

TECHNOLOGY INNOVATION, CYSTIC FIBROSIS, DEVELOPMENTAL LUNG BIOLOGY,

ENDOTHELIAL BIOLOGY, CARDIOVASCULAR BIOLOGY, DRUG DISCOVERY, AUTISM,

NEUROSCIENCES, NANOMEDICINE, OUTCOMES RESEARCH AND PUBLIC HEALTH, AND

CLINICAL AND TRANSLATIONAL RESEARCH.

THE CENTER CREATES NEW OPPORTUNITIES FOR CLINICAL RESEARCH AT CHILDREN'S

AND IS AVAILABLE AS A RESOURCE FOR PHYSICIANS FROM THROUGHOUT CHILDREN'S

AND EMORY. THE CENTER IS A NEW CLINICAL INTERACTION RESEARCH SITE OF THE

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ATLANTA CLINICAL AND TRANSLATIONAL SCIENCE INSTITUTE, A
 MULTI-INSTITUTIONAL PARTNERSHIP SUPPORTED BY THE NATIONAL INSTITUTES OF
 HEALTH AND LED BY EMORY UNIVERSITY, ALONG WITH MOREHOUSE SCHOOL OF
 MEDICINE AND GEORGIA TECH.

THE STRATEGIC VISION BEHIND RESEARCH IS IMPORTANT TO THE COMMUNITY
 BECAUSE IN ORDER TO BE A WORLD-CLASS PEDIATRIC INSTITUTION AND IMPROVE
 THE HEALTH STATUS OF CHILDREN, CHILDREN'S DETERMINED THEY MUST DEVELOP A
 ROBUST RESEARCH PROGRAM FOCUSED ON ACQUIRING NEW KNOWLEDGE AND EXPERTISE.
 STRIDES IN RESEARCH CAN HAVE FAR-REACHING IMPLICATIONS FOR PATIENTS AT
 CHILDREN'S AND BEYOND BY HELPING IN THE DEVELOPMENT OF STANDARDS.

TEACHING
 CHILDREN'S IS THE PEDIATRIC PHYSICIAN TRAINING SITE FOR THE EMORY
 UNIVERSITY SCHOOL OF MEDICINE, MOREHOUSE SCHOOL OF MEDICINE, MEDICAL
 COLLEGE OF GEORGIA, DUKE UNIVERSITY MEDICAL CENTER, AND ATLANTA MEDICAL
 CENTER. CHILDREN'S HAS DEVELOPED A TEACHING PLAN THAT WILL INCREASE THE

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NUMBER OF RESIDENTS AND FELLOWS TRAINING AT CHILDREN'S IN ORDER TO

SUPPORT THE DESIRE FOR PREEMINENCE AS WELL AS THE PROJECTED PHYSICIAN

MANPOWER NEEDS IDENTIFIED IN KEY PEDIATRIC SUBSPECIALTIES. THE POST-

GRADUATE MEDICAL EDUCATION STRATEGIC PLAN INCLUDES PROJECTED GROWTH OF

RESIDENTS BY 10 PERCENT AND FELLOWS BY 90 PERCENT TO A TOTAL OF 312

TRAINEES BY 2018. IN 2010, CHILDREN'S REPORTED 210 TRAINED RESIDENTS AND

FELLOWS, WITH CHILDREN'S FUNDING APPROXIMATELY 157 POSITIONS. WE CONTINUE

TO PARTNER WITH OUR MEDICAL SCHOOL AFFILIATES TO DEVELOP A WORLD CLASS

TEACHING PROGRAM.

WELLNESS

IN 2010, GEORGIA HAD THE 2ND HIGHEST CHILDHOOD OBESITY RATE IN THE

COUNTRY. NEARLY 40% OF GEORGIA'S CHILDREN ARE OVERWEIGHT OR OBESE.

CHILDREN'S RECOGNIZES A SIGNIFICANT OPPORTUNITY FOR THE ORGANIZATION TO

PARTNER WITH THE STATE AND OTHER AGENCIES TO IMPROVE THE HEALTH OF

CHILDREN IN GEORGIA.

IN 2010, THE GEORGIA CHILDREN'S HEALTH ALLIANCE (GCHA) COLLABORATED WITH

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THE GEORGIA DIVISION OF PUBLIC HEALTH TO PUBLISH REFOCUS, GEORGIA'S FIRST

CHILD HEALTH REPORT. DURING THE PAST YEAR, GCHA ALSO COMPLETED A

STATEWIDE ENVIRONMENTAL ASSESSMENT OF PROGRAMS, POLICIES, CLINICAL BEST

PRACTICES AND STATISTICS IN THE AREAS OF OBESITY, BIRTH OUTCOMES, AND

CHILD ABUSE AND NEGLECT. GCHA ALSO LED A COLLABORATION OF PUBLIC AND

PRIVATE PARTNERS TO FUND AND IMPLEMENT THE STUDENT HEALTH AND PHYSICAL

EDUCATION (SHAPE) PILOT IN PREPARATION FOR A STATEWIDE ROLLOUT. DURING

THE PILOT, MORE THAN 290 PHYSICAL EDUCATION TEACHERS WERE TRAINED TO

CONDUCT A STANDARDIZED FITNESS ASSESSMENT AND PROVIDED EQUIPMENT AND DATA

SUPPORT TO 214 SCHOOLS. GCHA ALSO DEVELOPED THE TIMELINE, BUDGET AND

PROJECT PLAN FOR THE STATEWIDE IMPLEMENTATION OF SHAPE, WHICH WILL REACH

MORE THAN A MILLION GEORGIA STUDENTS DURING THE 2011-2012 SCHOOL YEAR.

CHILDREN'S HAS A STRATEGIC WELLNESS GOAL TO IMPROVE THE WELL-BEING OF

CHILDREN IN GEORGIA BY FOCUSING ON HIGH IMPACT WELLNESS INITIATIVES. THE

ORGANIZATION IS WORKING TO MAKE A DIFFERENCE BY ENLISTING HELP FROM THE

GOVERNMENT, BUSINESS LEADERS AND OTHER NON-PROFITS.

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PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE

PART VI, LINE 3

ANNUALLY, A NEWSPAPER NOTICE ADVISES THE COMMUNITY THAT THE ORGANIZATION'S HOSPITALS ARE MEDICAID PROVIDERS PARTICIPATING IN THE STATE'S INDIGENT CARE TRUST FUND AND THAT FINANCIAL ASSISTANCE FOR MEDICALLY NECESSARY HOSPITAL SERVICES MAY BE AVAILABLE. SIMILARLY, SIGNS AT ALL HOSPITAL REGISTRATION SITES PROVIDE PATIENTS AND FAMILIES WITH SIMILAR NOTICE. IN ADDITION, HOSPITAL FINANCIAL COUNSELORS ACTIVELY ENGAGE FAMILIES TO ASSIST THEM IN SECURING FINANCIAL ASSISTANCE AND WRITTEN NOTICES ADVISE FAMILIES TO CONTACT CUSTOMER SERVICE WITH ANY ISSUES CONCERNING THEIR BILLS AND POTENTIAL ASSISTANCE.

COMMUNITY INFORMATION

PART VI, LINE 4

GEOGRAPHIC

CHILDREN'S IS THE LARGEST PEDIATRIC PROVIDER IN THE STATE CARING FOR CHILDREN FROM ALL 159 GEORGIA COUNTIES IN 2010. APPROXIMATELY 5.4 MILLION PEOPLE COMPRISED THE TOTAL POPULATION IN THE 28-COUNTY ATLANTA MSA, WHICH

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IS PRIMARILY URBAN WITH ONLY 1.8 PERCENT OF THE POPULATION CATEGORIZED AS
RURAL.

DEMOGRAPHICS

OF THE 9.8 MILLION PEOPLE WHO LIVE IN GEORGIA, 2.7 MILLION (28 PERCENT)
OF THOSE ARE CHILDREN, DEFINED AS THOSE LESS THAN 18 YEARS OF AGE.
APPROXIMATELY 1.5 MILLION CHILDREN LIVE IN THE ATLANTA MSA, MAKING IT THE
SIXTH LARGEST PEDIATRIC POPULATION AMONG THE TOP 10 LARGEST METRO AREAS.
THE LARGEST POPULATION OF CHILDREN IN THE ATLANTA MSA WAS CHILDREN AGES
ZERO TO FOUR YEARS OLD (431,526.) THE POPULATION OF THE ATLANTA MSA IS
PREDOMINANTLY WHITE AT 53.4 PERCENT; 30.6 PERCENT ARE BLACK OR AFRICAN
AMERICAN; 9.7 PERCENT ARE HISPANIC OR LATINO; AND 4.1 PERCENT ARE
ASIAN/PACIFIC ISLANDER.

THE ESTIMATED AVERAGE HOUSEHOLD INCOME FOR GEORGIA RESIDENTS WAS \$67,006
AS COMPARED TO \$76,784 FOR RESIDENTS IN THE ATLANTA MSA. IN 2010,
APPROXIMATELY 33 PERCENT OF CHILDREN IN THE ATLANTA MSA AGES LESS THAN 18
LIVED IN POVERTY. A STUDY PUBLISHED IN 2006 IN THE JOURNAL PEDIATRICS

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FOUND THAT LIVING IN THE SOUTH MAY BE ONE OF THE GREATEST PREDICTORS OF

POOR HEALTH OUTCOMES FOR CHILDREN. GEORGIA RANKS POORLY ON CHILD HEALTH

AND WELL-BEING INDICATORS - 42ND IN OVERALL WELL-BEING.

EGLESTON AND SCOTTISH RITE ARE TWO OF 71 HOSPITALS IN THE ATLANTA MSA AND

TWO OF 205 IN ALL OF GEORGIA. IN 2009, APPROXIMATELY 52.66 PERCENT

(EGLESTON) AND 44.25 PERCENT (SCOTTISH RITE) OF PATIENTS WERE UNINSURED

OR MEDICAID RECIPIENTS.

PROMOTION OF COMMUNITY HEALTH

PART VI, LINE 5

THE CHILDREN'S HEALTHCARE OF ATLANTA BOARD OF TRUSTEES IS THE GOVERNING

BODY OF CHILDREN'S. IT IS COMPRISED OF VOLUNTARY COMMUNITY LEADERS WHO

SHARE A COMMITMENT TO SERVING THE COMMUNITY BY ENHANCING THE LIVES OF

CHILDREN. A MAJORITY OF THIS GOVERNING BODY IS COMPRISED OF BOARD MEMBERS

WHO RESIDE IN THE ORGANIZATION'S PRIMARY SERVICE AREA. THEY ARE NOT

EMPLOYEES OR CONTRACTORS OF THE ORGANIZATION, NOR FAMILY MEMBERS

THEREOF.

Part VI Supplemental Information

Complete this part to provide the following information

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II, Part III, lines 4, 8, and 9b, and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy
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- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.)
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report

CHILDREN'S HEALTHCARE OF ATLANTA EXTENDS MEDICAL STAFF PRIVILEGES TO ALL

QUALIFIED PHYSICIANS IN THE COMMUNITY FOR SOME OR ALL OF OUR DEPARTMENTS.

CHILDREN'S PROVIDES ACCESS TO MORE THAN 1,600 PEDIATRIC PHYSICIANS.

CHILDREN'S IS ALSO THE PEDIATRIC PHYSICIAN TEACHING SITE FOR EMORY

UNIVERSITY SCHOOL OF MEDICINE AND MOREHOUSE SCHOOL OF MEDICINE. NEW

PHYSICIANS ARE ENCOURAGED TO PARTICIPATE IN FELLOWSHIP PROGRAMS, WHICH

ARE AVAILABLE IN A VARIETY OF SPECIALTIES.

CHILDREN'S HEALTHCARE OF ATLANTA APPLIES SURPLUS FUNDS TO IMPROVEMENTS IN

PATIENT CARE, MEDICAL EDUCATION AND RESEARCH.

AFFILIATED HEALTH CARE SYSTEM

PART VI, LINE 6

EGLESTON CHILDREN'S HOSPITAL AT EMORY UNIVERSITY, INC. (EGLESTON) AND

SCOTTISH RITE CHILDREN'S MEDICAL CENTER, INC. (SCOTTISH RITE) ARE PART OF

AN AFFILIATED HEALTH CARE SYSTEM. EGLESTON AND SCOTTISH RITE ARE

WHOLLY-OWNED BY CHILDREN'S HEALTHCARE OF ATLANTA, INC. (CHILDREN'S).

Part VI Supplemental Information

Complete this part to provide the following information

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II, Part III, lines 4, 8, and 9b, and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
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- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report

CHILDREN'S CONTROLS, EITHER DIRECTLY OR INDIRECTLY, SEVERAL OTHER

ENTITIES WHICH, TOGETHER, MAKE UP THE SYSTEM. EGLESTON AND SCOTTISH RITE

PLAY A MAJOR ROLE IN PROMOTING THE HEALTH OF THE COMMUNITY THROUGH THE

SPECIALTY PEDIATRIC SERVICES OFFERED, INCLUDING: ORTHOPAEDIC,

NEUROSCIENCES, AND CRANIOFACIAL TO NAME A FEW. APPROXIMATELY 2,500 AND

3,000 OF CHILDREN'S HEALTHCARE OF ATLANTA'S MORE THAN 7,500 TOTAL

EMPLOYEES WORK AT SCOTTISH RITE PROVIDING CARE FOR THE 314,737 PATIENT

VISITS THEY MANAGED IN 2010.

IN 2010, CHILDREN'S HEALTHCARE OF ATLANTA, INC. PROMOTED THE HEALTH OF

THE OVERALL COMMUNITY AND PROVIDED 520 STAFFED BEDS AND MANAGED 740,886

PATIENT VISITS, 314,737 UNIQUE PATIENTS (FROM ALL 159 COUNTIES IN

GEORGIA), 25,067 HOSPITAL ADMISSIONS, 141,501 IN PATIENT DAYS, 709,145

OUTPATIENT VISITS, 38,868 SURGICAL PROCEDURES, 195,495 EMERGENCY

DEPARTMENT VISITS, 111,067 IMMEDIATE CARE CENTER VISITS, AND 49,226

PRIMARY CARE VISITS.

EXAMPLES OF SPECIFIC PROGRAMS OFFERED AT CHILDREN'S TO PROMOTE THE HEALTH

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7, Part II, Part III, lines 4, 8, and 9b, and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21
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- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report

OF THE COMMUNITIES SERVED BY THE SYSTEM INCLUDE:

- A FAMILY LIBRARY WHERE FAMILIES RECEIVE IMPORTANT HEALTH

INFORMATION REGARDING THEIR CHILD'S HEALTH CONDITION OR DIAGNOSIS VIA A

CONSUMER MEDICAL / HEALTH SEARCH DONE BY THE FAMILY LIBRARIANS.

- A SCHOOL PROGRAM WHERE CHILDREN'S EMPLOYS TEACHERS SO THAT PATIENTS

CAN RECEIVE INSTRUCTION DURING HOSPITALIZATIONS AND LONG CLINIC VISITS.

- A SPECIAL NEEDS CAR SEAT PROGRAM THAT IS HOSPITAL BASED AND

DESIGNED TO EDUCATE AND ASSIST PARENTS AND FAMILIES WITH CHILDREN WHO

HAVE SPECIAL TRANSPORTATION NEEDS.

- THE HEALTH LAW PARTNERSHIP (HELP), WHICH IS AN INTERDISCIPLINARY

COMMUNITY COLLABORATION AMONG GEORGIA STATE UNIVERSITY'S COLLEGE OF LAW,

THE ATLANTA LEGAL AID SOCIETY, AND CHILDREN'S HEALTHCARE OF ATLANTA TO

IMPROVE THE HEALTH AND WELL-BEING OF LOW-INCOME CHILDREN AND THEIR

FAMILIES. HELP HAS A LAW OFFICE ON THE SCOTTISH RITE CAMPUS.

- A LEVEL II TRAUMA PROGRAM THAT PROVIDES HIGH QUALITY TRAUMA CARE TO

PEDIATRIC PATIENTS. THERE ARE SIX DESIGNATED TRAUMA CENTERS IN METRO

ATLANTA. OF THOSE, CHILDREN'S IS ONE OF ONLY TWO THAT HAVE THE RESOURCES

NEEDED FOR INJURED CHILDREN. TRAUMA IS THE NUMBER 1 CAUSE OF DEATH IN

Part VI Supplemental Information

Complete this part to provide the following information

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7, Part II, Part III, lines 4, 8, and 9b, and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
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- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report

CHILDREN FROM ONE TO 21 YEARS OF AGE.

STATE FILING OF COMMUNITY BENEFIT REPORT

PART VI, LINE 7

CHILDREN'S HEALTHCARE OF ATLANTA IS NOT REQUIRED TO FILE A COMMUNITY

BENEFIT REPORT UNDER GEORGIA LAW. HOWEVER, WE PRODUCE AN ANNUAL REPORT

ILLUSTRATING OUR BENEFIT TO THE COMMUNITY AND MAKE THAT PUBLIC ON OUR

WEBSITE WWW.CHOA.ORG. THIS REPORT IS POSTED IN THE "COMMUNITY SUPPORT"

SECTION. THERE IS ALSO A SECTION TITLED "OUR IMPACT ON GEORGIA" TO SHOW

OUR BROADER IMPACT ON THE STATE.

SUPPLEMENTAL INFORMATION

PART V, SECTION B, LINE 19

BASED ON INCOME AS ATTESTED TO BY FAMILY, PROVIDED FREE CARE UP TO 235%

OF FED POV GUIDELINE, "SLIDING SCALE" CARE UP TO 340% OF FED POV

GUIDELINE WITH MINIMUM WRITE OFF EQUIVALENT TO THE AVERAGE OF THE THREE

LOWEST NEGOTIATED COMMERCIAL INSURANCE PAYMENT RATES.

Part VI Supplemental Information

Complete this part to provide the following information

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7, Part II, Part III, lines 4, 8, and 9b, and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21
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SUPPLEMENTAL INFORMATION

PART V, SECTION B, LINES 20 AND 21

INITIALLY CHARGES FOR PATIENT SERVICES ARE MADE IN A CONSISTENT MANNER TO

ALL PATIENTS. PATIENTS ELIGIBLE FOR FINANCIAL ASSISTANCE ARE PROVIDED

WITH SUPPORT VIA REDUCTION TO THEIR BALANCE OWED BASED ON DOCUMENTATION

PROVIDED BY THE PATIENT AND THE HOSPITAL'S CHARITY POLICY CRITERIA.

Part V Transactions With Related Organizations (Complete if the organization answered "Yes" to Form 990, Part IV, line 34, 35, 35a, or 36.)

Note. Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule.

1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?

	Yes	No
a Receipt of (i) interest (ii) annuities (iii) royalties or (iv) rent from a controlled entity		X
b Gift, grant, or capital contribution to other organization(s)	X	
c Gift, grant, or capital contribution from other organization(s)	X	
d Loans or loan guarantees to or for other organization(s)	X	
e Loans or loan guarantees by other organization(s)	X	
f Sale of assets to other organization(s)		X
g Purchase of assets from other organization(s)		X
h Exchange of assets		X
i Lease of facilities, equipment, or other assets to other organization(s)		X
j Lease of facilities, equipment, or other assets from other organization(s)		X
k Performance of services or membership or fundraising solicitations for other organization(s)	X	
l Performance of services or membership or fundraising solicitations by other organization(s)	X	
m Sharing of facilities, equipment, mailing lists, or other assets	X	
n Sharing of paid employees	X	
o Reimbursement paid to other organization for expenses	X	
p Reimbursement paid by other organization for expenses	X	
q Other transfer of cash or property to other organization(s)		
r Other transfer of cash or property from other organization(s)		

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

	(a) Name of other organization	(b) Transaction type (a-r)	(c) Amount involved	(d) Method of determining amount involved
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				

SCHEDULE I
(Form 990)

Department of the Treasury
Internal Revenue Service

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

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

OMB No. 1545-0047

2010

Open to Public
Inspection

Name of the organization
CHILDREN'S HEALTHCARE OF ATLANTA GROUP RETURN

Employer identification number

Part I General Information on Grants and Assistance

- 1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? ☒ Yes ☐ No
- 2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States

Part II Grants and Other Assistance to Governments and Organizations in the United States. Complete if the organization answered "Yes" to Form 990, Part IV, line 21, for any recipient that received more than \$5,000. Check this box if no one recipient received more than \$5,000. Part II can be duplicated if additional space is needed ☐

1	(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
(1)	CHILDREN'S HC OF ATLANTA AT HUGHES SPALDING 35 JESSE HILL JR DRIVE ATLANTA, GA 30303	26-2037695	501(C)(3)	4,422,332				SUPPORT FOR CAPITAL & OP'S EXPENDITURES
(2)	CHILDREN'S HC OF ATLANTA AT HUGHES SPALDING 35 JESSE HILL JR DRIVE ATLANTA, GA 30303	26-2037695	501(C)(3)	2,601,869				FUND WORKING CAPITAL DEFICIT, PER MGT
(3)	EMORY-CHILDREN'S CENTER, INC 2015 UPPERGATE DR NE ATLANTA, GA 30322	58-2298500	501(C)(3)	3,627,708				SUPPORT EXEMPT ORG PURPOSE
(4)								
(5)								
(6)								
(7)								
(8)								
(9)								
(10)								
(11)								
(12)								

- 2 Enter total number of section 501(c)(3) and government organizations 3
- 3 Enter total number of other organizations 0

Schedule I (Form 990) (2010)

For Paperwork Reduction Act Notice, see the Instructions for Form 990.

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

	(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
1	NURSING SCHOLARSHIPS	28	209,261	CASH	N/A	
2						
3						
4						
5						
6						
7						

Part IV Supplemental Information. Complete this part to provide the information required in Part I, line 2, and any other additional information.

FORM 990, SCHEDULE I

DESCRIPTION OF ORGANIZATION'S PROCEDURES FOR MONITORING THE USE OF GRANTS

CHANCES GRANTS - TUITION EQUIVALENT ASSISTANCE FOR UP TO TWO YEARS.

APPLICANTS MUST BE ACCEPTED INTO A BSN PROGRAM AND BE BILINGUAL IN

ENGLISH AND SPANISH. SCHOLARSHIP RECIPIENTS AGREE TO WORK FOR CHILDREN'S

12 MONTHS FOR EACH ACADEMIC YEAR THEY HAVE RECEIVED SUPPORT. CANDLISH

NURSING SCHOLARSHIP - CURRENT CHILDREN'S EMPLOYEES ENROLLED IN AN

ACCREDITED NURSING PROGRAM ARE ELIGIBLE FOR THIS SCHOLARSHIP.

PER MANAGEMENT AGREEMENT, HSOC, INC. HAS OVERSIGHT OF ALL HUGHES SPALDING

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

	(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
1						
2						
3						
4						
5						
6						
7						

Part IV Supplemental Information. Complete this part to provide the information required in Part I, line 2, and any other additional information.

OPERATIONS, INCLUDING THE USE OF GRANT FUNDS. THE AMOUNT OF FUNDS PROVIDED ANNUALLY TO HUGHES SPALDING FROM HSOC, INC. IS GOVERNED BY AGREED UPON TERMS OF THE MANAGEMENT CONTRACT.

**SCHEDULE J
(Form 990)**

Department of the Treasury
Internal Revenue Service

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 23.

▶ Attach to Form 990. ▶ See separate instructions.

OMB No 1545-0047

2010

Open to Public Inspection

Name of the organization

CHILDREN'S HEALTHCARE OF ATLANTA GROUP RETURN

Employer identification number

Part I Questions Regarding Compensation

1a Check the appropriate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.

- | | |
|--|--|
| <input type="checkbox"/> First-class or charter travel | <input type="checkbox"/> Housing allowance or residence for personal use |
| <input type="checkbox"/> Travel for companions | <input type="checkbox"/> Payments for business use of personal residence |
| <input type="checkbox"/> Tax indemnification and gross-up payments | <input type="checkbox"/> Health or social club dues or initiation fees |
| <input type="checkbox"/> Discretionary spending account | <input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef) |

b If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain

2 Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all officers, directors, trustees, and the CEO/Executive Director, regarding the items checked in line 1a?

3 Indicate which, if any, of the following the organization uses to establish the compensation of the organization's CEO/Executive Director. Check all that apply

- | | |
|---|---|
| <input checked="" type="checkbox"/> Compensation committee | <input checked="" type="checkbox"/> Written employment contract |
| <input checked="" type="checkbox"/> Independent compensation consultant | <input checked="" type="checkbox"/> Compensation survey or study |
| <input checked="" type="checkbox"/> Form 990 of other organizations | <input checked="" type="checkbox"/> Approval by the board or compensation committee |

4 During the year, did any person listed in Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization.

a Receive a severance payment or change-of-control payment from the organization or a related organization?

b Participate in, or receive payment from, a supplemental nonqualified retirement plan?

c Participate in, or receive payment from, an equity-based compensation arrangement?

If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III

Only section 501(c)(3) and 501(c)(4) organizations must complete lines 5-9.

5 For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of

a The organization?

b Any related organization?

If "Yes" to line 5a or 5b, describe in Part III

6 For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of

a The organization?

b Any related organization?

If "Yes" to line 6a or 6b, describe in Part III

7 For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III

8 Were any amounts reported in Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III

9 If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?

	Yes	No
1b		
2		
4a		X
4b	X	
4c		X
5a		X
5b		X
6a		X
6b		X
7		X
8		X
9		

For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule J (Form 990) 2010

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

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

Note. The sum of columns (B)(i)-(iii) must equal the applicable column (D) or column (E) amounts on Form 990, Part VII, line 1a

(A) Name	(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported in prior Form 990 or Form 990-EZ
	(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 SCOTT HODOVAL	(i) 164,780.	(ii) 41,293.	(iii) 6,822.	5,921.	11,594.	230,410.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
2 WILLIAM KEY	(i) 155,447.	(ii) 32,181.	(iii) 1,208.	5,772.	14,294.	208,902.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
3 EUGENE HAYES	(i) 236,406.	(ii) 87,182.	(iii) 116,606.	6,461.	16,902.	463,557.	72,804.
	(ii) 0.	0.	0.	0.	0.	0.	0.
4 RUTH FOWLER	(i) 342,510.	(ii) 125,139.	(iii) 152,253.	8,400.	19,571.	647,873.	99,875.
	(ii) 0.	0.	0.	0.	0.	0.	0.
5 DONALD MUELLER	(i) 182,879.	(ii) 45,100.	(iii) 577.	6,932.	16,079.	251,567.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
6 ROY SANDERS	(i) 164,915.	(ii) 0.	(iii) 9,223.	5,417.	10,622.	190,177.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
7 DONNA HYLAND	(i) 537,696.	(ii) 265,019.	(iii) 197,232.	8,081.	21,295.	1,029,323.	98,361.
	(ii) 0.	0.	0.	0.	0.	0.	0.
8 LESLIE JONES	(i) 276,004.	(ii) 78,095.	(iii) 2,139.	8,400.	11,844.	376,482.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
9 BARBARA STOLL, MD	(i) 208,800.	(ii) 28,835.	(iii) 4,687.	7,442.	1,988.	251,752.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
10 MARTHA MCGILL	(i) 178,087.	(ii) 74,388.	(iii) 920.	6,202.	12,066.	271,663.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
11 CAROLYN KENNY	(i) 436,294.	(ii) 171,972.	(iii) 10,809.	8,400.	4,104.	631,579.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
12 MARYBETH BOVA	(i) 167,062.	(ii) 44,163.	(iii) 19,079.	6,616.	7,854.	244,774.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
13 PATRICK WAGNER	(i) 130,615.	(ii) 20,307.	(iii) 9,741.	4,991.	6,774.	172,428.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
14 BETH BOATWRIGHT	(i) 129,393.	(ii) 20,609.	(iii) 271.	4,901.	10,884.	166,058.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
15 DENISE SWORDS	(i) 238,793.	(ii) 63,843.	(iii) 1,837.	8,400.	6,390.	319,263.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.
16 LINDA HITCHCOCK	(i) 139,936.	(ii) 20,210.	(iii) 3,523.	4,993.	3,873.	172,535.	0.
	(ii) 0.	0.	0.	0.	0.	0.	0.

Schedule J (Form 990) 2010

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

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

Note. The sum of columns (B)(i)-(iii) must equal the applicable column (D) or column (E) amounts on Form 990, Part VII, line 1a.

(A) Name	(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported in prior Form 990 or Form 990-EZ
	(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 JULIA JONES	(i) 168,034. (ii) 0.	(i) 41,268. (ii) 0.	(i) 847. (ii) 0.	6,163. 0.	15,895. 0.	232,207. 0.	0. 0.
2 DANIEL SALINAS, MD	(i) 334,080. (ii) 722,956.	(i) 127,262. (ii) 76,827.	(i) 25,729. (ii) 20,909.	3,774. 8,400.	21,525. 14,920.	512,370. 844,012.	0. 37,159.
3 WILLIAM BOYDSTON	(i) 552,771. (ii) 0.	(i) 123,860. (ii) 0.	(i) 17,447. (ii) 0.	8,400. 0.	13,254. 0.	715,732. 0.	0. 0.
4 BARUNASHISH BRAHMA	(i) 571,352. (ii) 0.	(i) 142,191. (ii) 0.	(i) 16,958. (ii) 0.	8,400. 0.	10,683. 0.	749,584. 0.	0. 0.
5 DAVID WRUBEL	(i) 443,383. (ii) 793,245.	(i) 70,442. (ii) 55,000.	(i) 20,895. (ii) 23,112.	8,400. 8,400.	12,946. 18,399.	556,065. 898,155.	0. 0.
6 WILLIAM BONNER	(i) 0. (ii) 0.	(i) 0. (ii) 0.	(i) 0. (ii) 0.	0. 0.	0. 0.	0. 0.	0. 0.
7 ANDREW REISNER	(i) 0. (ii) 0.	(i) 0. (ii) 0.	(i) 0. (ii) 0.	0. 0.	0. 0.	0. 0.	0. 0.
8	(i) 0. (ii) 0.	(i) 0. (ii) 0.	(i) 0. (ii) 0.	0. 0.	0. 0.	0. 0.	0. 0.
9	(i) 0. (ii) 0.	(i) 0. (ii) 0.	(i) 0. (ii) 0.	0. 0.	0. 0.	0. 0.	0. 0.
10	(i) 0. (ii) 0.	(i) 0. (ii) 0.	(i) 0. (ii) 0.	0. 0.	0. 0.	0. 0.	0. 0.
11	(i) 0. (ii) 0.	(i) 0. (ii) 0.	(i) 0. (ii) 0.	0. 0.	0. 0.	0. 0.	0. 0.
12	(i) 0. (ii) 0.	(i) 0. (ii) 0.	(i) 0. (ii) 0.	0. 0.	0. 0.	0. 0.	0. 0.
13	(i) 0. (ii) 0.	(i) 0. (ii) 0.	(i) 0. (ii) 0.	0. 0.	0. 0.	0. 0.	0. 0.
14	(i) 0. (ii) 0.	(i) 0. (ii) 0.	(i) 0. (ii) 0.	0. 0.	0. 0.	0. 0.	0. 0.
15	(i) 0. (ii) 0.	(i) 0. (ii) 0.	(i) 0. (ii) 0.	0. 0.	0. 0.	0. 0.	0. 0.
16	(i) 0. (ii) 0.	(i) 0. (ii) 0.	(i) 0. (ii) 0.	0. 0.	0. 0.	0. 0.	0. 0.

Schedule J (Form 990) 2010

Part III Supplemental Information

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

SUPPLEMENTAL COMPENSATION INFORMATION

SCHEDULE J, PART I, LINE 4B

THE FOLLOWING WERE PARTICIPANTS IN A 457(F) PLAN THAT WAS TERMINATED

12/31/09. ALL LISTED PARTICIPANTS RECEIVED DISTRIBUTIONS RELATED TO THE

TERMINATION OF THIS PLAN DURING 2010.

DONNA HYLAND	\$269,554
EUGENE HAYES	\$165,357
DANIEL SALINAS, MD	\$38,178
RUTH FOWLER	\$225,787

DONNA HYLAND IS A PARTICIPANT IN A KEYSOP PLAN. THE PLAN WAS FROZEN ON MAY 8, 2002 AND NO CONTRIBUTIONS WERE MADE AFTER THIS DATE.

SCHEDULE J SUPPLEMENTAL INFORMATION

EMPLOYEES OF CHILDREN'S HEALTHCARE OF ATLANTA, INC. HAVE THE OPTION TO

JSA

0E1505 1 000

7816CH 2217

V 10-8.2

Part III Supplemental Information

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

PARTICIPATE IN THE 403(B) PLAN OFFERED BY THE ORGANIZATION.

CHILDREN'S PROVIDES AN ANNUAL DISCRETIONARY CONTRIBUTION TO A 401(A)

RETIREMENT PLAN FOR EMPLOYEES WHO WORK AT LEAST 1,000 HOURS IN THE

CALENDAR YEAR AND ARE EMPLOYED ON 12/31/10.

ALL INDIVIDUALS ARE EMPLOYEES OF CHILDREN'S HEALTHCARE OF ATLANTA, INC.

(THE "PARENT" - EIN 58-2367819) WITH CHILDREN'S HEALTHCARE OF ATLANTA

GROUP RETURN (THE "GROUP" - EIN _____) ACTING AS THE COMMON

PAYROLL AGENT FOR THE PARENT AND ALL ENTITIES WITHIN THE GROUP.

SCHEDULE L
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions With Interested Persons

▶ **Complete if the organization answered**
"Yes" on Form 990, Part IV, line 25a, 25b, 26, 27, 28a, 28b, or 28c,
or Form 990-EZ, Part V, line 38a or 40b.
▶ **Attach to Form 990 or Form 990-EZ. ▶ See separate instructions.**

OMB No 1545-0047

2010

**Open To Public
Inspection**

Name of the organization

CHILDREN'S HEALTHCARE OF ATLANTA GROUP RETURN

Employer identification number

Part I Excess Benefit Transactions(section 501(c)(3) and section 501(c)(4) organizations only)

Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b

1	(a) Name of disqualified person	(b) Description of transaction	(c) Corrected?	
			Yes	No
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				

2 Enter the amount of tax imposed on the organization managers or disqualified persons during the year
under section 4958 ▶ \$ _____

3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization ▶ \$ _____

Part II Loans to and/or From Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 26, or Form 990-EZ, Part V, line 38a

(a) Name of interested person and purpose	(b) Loan to or from the organization?		(c) Original principal amount	(d) Balance due	(e) In default?		(f) Approved by board or committee?		(g) Written agreement?	
	To	From			Yes	No	Yes	No	Yes	No
(1)										
(2)										
(3)										
(4)										
(5)										
(6)										
(7)										
(8)										
(9)										
(10)										

Total ▶ \$ _____

Part III Grants or Assistance Benefiting Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 27

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount and type of assistance
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
(10)		

For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ.

Schedule L (Form 990 or 990-EZ) 2010

Part IV Business Transactions Involving Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28c

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) CEDRIC MILLER, MD	SEE SCHEDULE L, PART V	12,850,674.	SEE SCHEDULE L, PART V		X
(2) KEITH MASON	SEE SCHEDULE L, PART V	181,631.	SEE SCHEDULE L, PART V		X
(3) MARK CHANCY	SEE SCHEDULE L, PART V	2,029,504.	SEE SCHEDULE L, PART V		X
(4) MICHAEL B. RUSSELL	SEE SCHEDULE L, PART V	647,969.	SEE SCHEDULE L, PART V		X
(5) MICHAEL E. WALSH	SEE SCHEDULE L, PART V	7,838,950.	SEE SCHEDULE L, PART V		X
(6) STEVE CAHILLANE	SEE SCHEDULE L, PART V	250,038	SEE SCHEDULE L, PART V		X
(7) TOM GIDDENS	SEE SCHEDULE L, PART V	5,545,961.	SEE SCHEDULE L, PART V		X
(8) TERI MCCLURE	SEE SCHEDULE L, PART V	148,299	SEE SCHEDULE L, PART V		X
(9)					
(10)					

Part V Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule L (see instructions)

BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS

SCHEDULE L, PART IV

CEDRIC MILLER (B) RELATIONSHIP BETWEEN INTERESTED PERSON AND THE ORGANIZATION- CURRENT TRUSTEE FOR CHOA, ECH, SRH, EAS AND EPG (PARENT AND GROUP)

(D) DESCRIPTION OF TRANSACTION- SERVED AS AN OFFICER OF PEDIATRIC EMERGENCY MEDICINE ASSOCIATES, LLC, AN ENTITY THAT PROVIDES EMERGENCY DEPARTMENT PHYSICIAN AND MIDLEVEL STAFF TO CHOA ON A CONTRACTUAL BASIS.

KEITH MASON (B) RELATIONSHIP BETWEEN INTERESTED PERSON AND THE ORGANIZATION- CURRENT TRUSTEE FOR THE FOUNDATION (GROUP ONLY)

(D) DESCRIPTION OF TRANSACTION- SERVED AS AN EXECUTIVE OF LAW FIRM MCKENNA, LONG & ALDRIDGE, WHICH RECEIVED FEES AND EXPENSE REIMBURSEMENTS FROM CHOA FOR PROFESSIONAL SERVICES RENDERED IN 2010.

MARK CHANCY (B) RELATIONSHIP BETWEEN INTERESTED PERSON AND THE ORGANIZATION- CURRENT TRUSTEE FOR CHOA, ECH, SRH, EAS AND EPG (PARENT AND GROUP)

Part IV Business Transactions Involving Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28c

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

Part V Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule L (see instructions)

(D) DESCRIPTION OF TRANSACTION- SERVED AS AN OFFICER OF
 SUNTRUST BANKS, INC., WHICH PROVIDES GENERAL BANKING SERVICES TO
 CHILDREN'S.

MICHAEL B. RUSSELL (B) RELATIONSHIP BETWEEN INTERESTED PERSON AND THE
 ORGANIZATION- CURRENT TRUSTEE FOR THE FOUNDATION (GROUP ONLY)

(D) DESCRIPTION OF TRANSACTION- IN A JOINT VENTURE
 WITH GILBANE CONSTRUCTION, H.J. RUSSELL & COMPANY COMPLETED CONSTRUCTION
 OF THE NEW HUGHES SPALDING HOSPITAL.

MICHAEL E. WALSH (B) RELATIONSHIP BETWEEN INTERESTED PERSON AND THE
 ORGANIZATION- CURRENT TRUSTEE FOR CHOA, ECH, SRH, EAS AND EPG (PARENT AND
 GROUP)

(D) DESCRIPTION OF TRANSACTION- SERVED AS A MEMBER OF
 JPMORGAN'S MANAGEMENT TEAM, WHICH PROVIDES INVESTMENT-RELATED SERVICES TO
 CHILDREN'S.

STEVE CAHILLANE (B) RELATIONSHIP BETWEEN INTERESTED PERSON AND THE

Part IV Business Transactions Involving Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28c

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

Part V Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule L (see instructions)

ORGANIZATION- CURRENT TRUSTEE FOR CHOA, ECH, SRH, EAS AND EPG (PARENT AND GROUP)

(D) DESCRIPTION OF TRANSACTION- SERVED AS AN OFFICER OF THE COCA-COLA COMPANY, WHICH IS A FOOD AND BEVERAGE VENDOR OF CHILDREN'S.

TOM GIDDENS (B) RELATIONSHIP BETWEEN INTERESTED PERSON AND THE ORGANIZATION- CURRENT TRUSTEE FOR THE FOUNDATION (GROUP ONLY)

(D) DESCRIPTION OF TRANSACTION- SERVED AS AN OFFICER OF AFLAC, WHICH PROVIDES INSURANCE PRODUCTS TO THE EMPLOYEES OF CHILDREN'S.

TERI MCCLURE (B) RELATIONSHIP BETWEEN INTERESTED PERSON AND THE ORGANIZATION- CURRENT TRUSTEE FOR CHOA, ECH, SRH, EAS AND EPG (PARENT AND GROUP) - RESIGNED MAY-10

(D) DESCRIPTION OF TRANSACTION- SERVED AS AN OFFICER OF THE UNITED PARCEL SERVICE (UPS), WHICH PROVIDES SHIPPING SERVICES FOR CHOA. AMOUNT REPORTED REPRESENTS FULL YEAR ACTIVITY, ALTHOUGH TERI MCCLURE RESIGNED SERVICE AS TRUSTEE AS OF MAY 2010.

**SCHEDULE M
(Form 990)**

Department of the Treasury
Internal Revenue Service

Noncash Contributions

► Complete if the organizations answered "Yes" on Form 990, Part IV, lines 29 or 30.
► Attach to Form 990.

OMB No 1545-0047

2010

**Open To Public
Inspection**

Name of the organization

CHILDREN'S HEALTHCARE OF ATLANTA GROUP RETURN

Employer identification number

Part I Types of Property

	(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1 Art - Works of art				
2 Art - Historical treasures				
3 Art - Fractional interests				
4 Books and publications				
5 Clothing and household goods				
6 Cars and other vehicles				
7 Boats and planes				
8 Intellectual property				
9 Securities - Publicly traded	X	60.	435,606.	COST OR SELLING
10 Securities - Closely held stock				
11 Securities - Partnership, LLC, or trust interests				
12 Securities - Miscellaneous				
13 Qualified conservation contribution - Historic structures				
14 Qualified conservation contribution - Other				
15 Real estate - Residential				
16 Real estate - Commercial				
17 Real estate - Other				
18 Collectibles				
19 Food inventory				
20 Drugs and medical supplies				
21 Taxidermy				
22 Historical artifacts				
23 Scientific specimens				
24 Archeological artifacts				
25 Other ► ()				
26 Other ► ()				
27 Other ► ()				
28 Other ► ()				

29 Number of Forms 8283 received by the organization during the tax year for contributions for which the organization completed Form 8283, Part IV, Donee Acknowledgement

29

30 a During the year, did the organization receive by contribution any property reported in Part I, line 1-28 that it must hold for at least three years from the date of the initial contribution, and which is not required to be used for exempt purposes for the entire holding period?

b If "Yes," describe the arrangement in Part II

31 Does the organization have a gift acceptance policy that requires the review of any non-standard contributions?

32 a Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions?

b If "Yes," describe in Part II

33 If the organization did not report an amount in column (c) for a type of property for which column (a) is checked, describe in Part II

	Yes	No
30a		X
31	X	
32a	X	
33		

For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule M (Form 990) (2010)

Part II **Supplemental Information.** Complete this part to provide the information required by Part I, lines 30b, 32b, and 33. Also complete this part for any additional information.

SCHEDULE M SUPPLEMENTAL INFORMATION

SCHEDULE M, PART 1, LINE 32

SUNTRUST BANK PROCESSES NONCASH CONTRIBUTIONS ON BEHALF OF CHILDREN'S
FOUNDATION BY HANDLING THE SALE OF STOCK GIFTS TO CONVERT TO CASH.

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

Complete to provide information for responses to specific questions on
Form 990 or 990-EZ or to provide any additional information.
▶ Attach to Form 990 or 990-EZ.

OMB No 1545-0047

2010

**Open to Public
Inspection**

Name of the organization
CHILDREN'S HEALTHCARE OF ATLANTA GROUP RETURN

Employer identification number

VOLUNTEERS

FORM 990, PART I, LINE 6

CHILDREN'S RELIES ON VOLUNTEER SUPPORT TO RAISE FUNDS IN OUR COMMUNITY THROUGH ORGANIZING OR VOLUNTEERING AT EVENTS. INDIVIDUALS AND CORPORATIONS WORK WITH CHILDREN'S TO HOST AND SUPPORT NUMEROUS COMMUNITY, SPORTS AND HOLIDAY EVENTS, ALL TO BENEFIT OUR NOT-FOR-PROFIT ORGANIZATION. IN 2010, MORE THAN 5,000 VOLUNTEERS SUPPORTED CHILDREN'S IN THIS CAPACITY.

VOLUNTEERS ALSO PLAY SUCH AN IMPORTANT ROLE IN CLINICAL SETTINGS WITHIN OUR NOT-FOR-PROFIT HEALTHCARE SYSTEM THAT WE CALL THEM FRIENDS. THEY HELP BY BRINGING A SENSE OF ENTHUSIASM AND WARMTH THAT IS IMPORTANT TO OUR PATIENTS, THEIR FAMILIES AND OUR STAFF. WITH THE GUIDANCE OF THE CHILDREN'S STAFF, CHILDREN'S VOLUNTEERS WORK A SET WEEKLY SCHEDULE WITHIN ONE OF THE FOLLOWING HOSPITAL AREAS: DIRECT PATIENT CARE, CUSTOMER SERVICE AND ADMINISTRATIVE SUPPORT. HOSPITAL VOLUNTEERS CAN BE FOUND WORKING ON ALL OF OUR HOSPITAL CAMPUSES AS WELL AS SEVERAL OF OUR NEIGHBORHOOD LOCATIONS. APPROXIMATELY 1,400 ACTIVE VOLUNTEERS ASSIST AT OUR MEDICAL FACILITIES.

FOR MORE INFORMATION ON VOLUNTEER OPPORTUNITIES IN FUNDRAISING AND OTHER SUPPORT TO OUR PATIENTS AND FAMILIES, PLEASE VISIT WWW.CHOA.ORG/VOLUNTEER.

PROGRAM SERVICE ACCOMPLISHMENTS

Name of the organization

Employer identification number

CHILDREN'S HEALTHCARE OF ATLANTA GROUP RETURN

FORM 990, PART III, LINE 4

CHILDREN'S IS A PREMIER CIVIC ASSET, SERVING THE ATLANTA METROPOLITAN AREA, THE ENTIRE STATE OF GEORGIA AND THE UNITED STATES. CHILDREN'S IS THE LARGEST PEDIATRIC PROVIDER IN THE STATE CARING FOR CHILDREN FROM ALL 159 GEORGIA COUNTIES IN 2010. CHILDREN'S, ONE OF THE LEADING PEDIATRIC HEALTHCARE SYSTEMS IN THE COUNTRY, IS A NOT-FOR-PROFIT ORGANIZATION THAT BENEFITS FROM THE GENEROUS PHILANTHROPIC AND VOLUNTEER SUPPORT OF OUR COMMUNITY. OPERATING THREE HOSPITALS (CHILDREN'S AT EGGLESTON, CHILDREN'S AT HUGHES SPALDING AND CHILDREN'S AT SCOTTISH RITE) AND 17 NEIGHBORHOOD LOCATIONS (INCLUDING MARCUS AUTISM CENTER AND FIVE IMMEDIATE CARE CENTERS). WITH MORE THAN HALF A MILLION PATIENT VISITS ANNUALLY, CHILDREN'S IS RECOGNIZED FOR EXCELLENCE IN CANCER, CARDIAC AND ORTHOPAEDICS AND OFFERS ACCESS TO MORE THAN 30 PEDIATRIC SPECIALTIES.

CHILDREN'S IS RANKED ONE OF THE TOP PEDIATRIC HOSPITALS NATIONWIDE BY U.S. NEWS & WORLD REPORT AND ALSO HAS BEEN NAMED ONE OF THE "100 BEST COMPANIES TO WORK FOR" BY FORTUNE MAGAZINE.

THE PEDIATRIC POPULATION IN METRO ATLANTA IS EXPECTED TO INCREASE BY 144,000 DURING THE NEXT FIVE YEARS, REACHING 1.7 MILLION BY 2016.

THE MISSION VISION, VALUES AND EMPLOYEE PROMISE OF CHILDREN'S WERE CREATED THROUGH AN IN-DEPTH PROCESS INVOLVING EMPLOYEES, PHYSICIANS, VOLUNTEERS AND BOARD MEMBERS.

IN 2010, THE THREE HOSPITALS OPERATED BY CHILDREN'S HEALTHCARE OF

Name of the organization

Employer identification number

CHILDREN'S HEALTHCARE OF ATLANTA GROUP RETURN

ATLANTA, INC. PROVIDED 520 STAFFED BEDS AND MANAGED 740,886
PATIENT VISITS, 314,737 UNIQUE PATIENTS, 25,067 HOSPITAL ADMISSIONS,
141,501 INPATIENT DAYS, 709,145 OUTPATIENT VISITS, 38,868 SURGICAL
PROCEDURES (INPATIENT AND OUTPATIENT), 195,495 EMERGENCY DEPARTMENT
VISITS, 111,067 IMMEDIATE CARE CENTER VISITS AND 49,226 PRIMARY CARE
VISITS.

CHILDREN'S IS ALSO THE LARGEST MEDICAID PROVIDER IN THE STATE OF
GEORGIA, SERVING 8 OUT OF 10 PEDIATRIC INPATIENT MEDICAID CASES IN
ATLANTA AND 4 OUT OF 10 CASES STATEWIDE. CHILDREN'S IS
COMMITTED TO PROVIDING MEDICALLY NEEDED HEALTHCARE TO THE CHILDREN OF
GEORGIA. STATEWIDE, 44% OF GEORGIA'S CHILDREN ARE
ENROLLED IN MEDICAID OR PEACHCARE AND 13% ARE UNINSURED. EACH YEAR,
CHILDREN'S PROVIDES ABOUT \$90 MILLION OF CARE FOR WHICH WE DO NOT GET
PAID.

IN ADDITION, CHILDREN'S INVESTS IN PEDIATRIC RESEARCH, TEACHING AND CHILD
WELLNESS INITIATIVES, FOR WHICH WE ALSO DO NOT GET PAID. THE TOTAL
COMMUNITY BENEFIT PROVIDED BY CHILDREN'S IN 2010 WAS ABOUT \$123 MILLION.

CHILDREN'S SERVES AS THE PEDIATRIC PHYSICIAN TEACHING SITE FOR EMORY
UNIVERSITY SCHOOL OF MEDICINE AND MOREHOUSE SCHOOL OF MEDICINE.
CHILDREN'S TAKES THE LEAD IN TRAINING THE PEDIATRICIANS OF TOMORROW AND
INCREASED ITS TRAINING TO 115 RESIDENTS AND 97 FELLOWS IN 2010. NEW
PHYSICIANS ARE ENCOURAGED TO PARTICIPATE IN OUR FELLOWSHIP PROGRAMS,

Name of the organization

Employer identification number

CHILDREN'S HEALTHCARE OF ATLANTA GROUP RETURN

WHICH ARE AVAILABLE IN A VARIETY OF SPECIALTIES. CHILDREN'S ALSO TRAINS OTHER PEDIATRIC HEALTHCARE PROFESSIONALS, INCLUDING NURSES, EMERGENCY MEDICAL TECHNICIANS, PARAMEDICS AND PSYCHOSOCIAL EXPERTS.

CHILDREN'S OFFERS A WIDE VARIETY OF TRAINING OPPORTUNITIES TO OTHER PROFESSIONALS WHO WORK WITH CHILDREN, INCLUDING PROGRAMS FOR LAW ENFORCEMENT AGENCIES, SCHOOL NURSES, COACHES AND TEACHERS.

CHILDREN'S BELIEVES THAT TODAY'S MEDICAL DISCOVERIES COULD SAVE THE LIFE OF A CHILD TOMORROW. RESEARCH IS A CORNERSTONE OF THE CHILDREN'S HEALTHCARE OF ATLANTA MISSION. WE ARE COMMITTED TO ADVANCEMENTS IN PEDIATRIC MEDICINE AND FINDING ANSWERS TO PERPLEXING MEDICAL CONDITIONS, WORKING WITH PARTNERS SUCH AS EMORY UNIVERSITY SCHOOL OF MEDICINE, GEORGIA INSTITUTE OF TECHNOLOGY AND MOREHOUSE SCHOOL OF MEDICINE.

IN 2010, OUR RESEARCHERS INITIATED MORE THAN 600 STUDIES IN 30 SPECIALTY AREAS. AS PART OF OUR COMMUNITY HEALTH RESEARCH COLLABORATION WITH EMORY UNIVERSITY AND GEORGIA TECH, WE WORKED TO DEVELOP NEW DRUGS AND TREATMENT TECHNIQUES-LIKE A NEW CONTINUOUS RENAL REPLACEMENT THERAPY DEVICE THAT IS DESIGNED SPECIFICALLY WITH KIDS IN MIND. IT CAN BE USED ACCURATELY ON A 6-POUND CHILD, ALL THE WAY UP TO A FOOTBALL LINEBACKER.

AMONG OTHER THINGS, WE ARE WORKING ON TREATMENTS FOR AUTISM, BRAIN TUMORS, CARDIAC PROBLEMS AND SICKLE CELL DISEASE; GROWING BONE; AND USING

Name of the organization

CHILDREN'S HEALTHCARE OF ATLANTA GROUP RETURN

Employer identification number

CELL PHONES TO ENHANCE MEMORY AND ORGANIZATION FOLLOWING TRAUMATIC BRAIN INJURY. OUR 14 RESEARCH FOCUS AREAS ARE: AUTISM, CARDIOVASCULAR BIOLOGY, CLINICAL AND TRANSLATIONAL RESEARCH, CLINICAL OUTCOMES AND PUBLIC HEALTH, CYSTIC FIBROSIS, DEVELOPMENTAL LUNG BIOLOGY, DRUG DISCOVERY, ENDOTHELIAL BIOLOGY, HEMATOLOGY AND ONCOLOGY, NEUROSCIENCES, IMMUNOLOGY AND VACCINES, PEDIATRIC HEALTHCARE TECHNOLOGY, PEDIATRIC NANOMEDICINE AND TRANSPLANT IMMUNOLOGY.

OUR CHILD PROTECTION CENTER WORKS WITH LAW ENFORCEMENT, THE DIVISION OF FAMILY AND CHILDREN SERVICES (DFCS) AND CHILD ADVOCACY AGENCIES TO IDENTIFY, TREAT AND PREVENT CHILD ABUSE AND NEGLECT. IN 2010, THROUGH THE CENTER, WE TRAINED MORE THAN 2,200 PROFESSIONALS ABOUT HOW TO RECOGNIZE, REPORT AND PREVENT CHILD ABUSE IN 2010. THOSE TRAINED INCLUDED MEDICAL PERSONNEL, LAW ENFORCEMENT, CHILD ADVOCATES, SCHOOL STAFF, SOCIAL WORKERS AND MENTAL HEALTH PRACTITIONERS.

MANY SCHOOLS LACK THE PERSONNEL AND RESOURCES TO MEET THE NEEDS OF CHILDREN WITH CHRONIC AND ACUTE HEALTH ISSUES, AND SCHOOL NURSES AND ADDITIONAL CARETAKERS RELY ON EDUCATION FROM THIS PROGRAM TO HELP. IN 2010, CHILDREN'S KOHL'S SCHOOL NURSE LIAISON/CONSULTANT PROGRAM TEAM ASSISTED WITH SCHOOL RE-ENTRY FOR 614 CHILDREN FACING COMPLEX HEALTH ISSUES AFTER HOSPITALIZATION AT CHILDREN'S. THE TEAM ALSO TRAINED 1,505 SCHOOL PROFESSIONALS IN CURRENT NURSING PRACTICES FOR IMMUNIZATION, TUBERCULOSIS MANAGEMENT IN THE SCHOOL SETTING, CHILD ABUSE RECOGNITION AND REPORTING AND MANAGEMENT OF CHILDREN WITH CYSTIC FIBROSIS. IN

Name of the organization

CHILDREN'S HEALTHCARE OF ATLANTA GROUP RETURN

Employer identification number

ADDITION, THE TEAM CONSULTED ON 1,189 QUESTIONS FROM GEORGIA SCHOOL NURSES THROUGHOUT THE STATE.

CHILDREN'S SERVES AS THE LEAD AGENCY FOR SAFE KIDS GEORGIA, A STATEWIDE NETWORK FOR PREVENTING UNINTENTIONAL INJURIES AMONG CHILDREN. THESE TYPES OF INJURIES ARE THE NO. 1 CAUSE OF DEATH FOR CHILDREN FROM BIRTH TO AGE 14. IN 2010, SAFE KIDS GEORGIA-THROUGH ITS 25 LOCAL COALITIONS ACROSS 50 COUNTIES-DISTRIBUTED 139,000 EDUCATIONAL MATERIALS TO MORE THAN 213,000 PEOPLE, INCLUDING 51 PERCENT OF GEORGIA'S CHILDREN. SAFE KIDS GEORGIA DISTRIBUTED NEARLY 32,000 SAFETY DEVICES TO RESIDENTS THROUGHOUT THE STATE, INCLUDING CAR AND BOOSTER SEATS, BIKE HELMETS, SMOKE AND CARBON MONOXIDE DETECTORS, GUN LOCKS AND PERSONAL FLOTATION DEVICES.

THROUGH THE CONDUCT OF THESE ACTIVITIES, CHILDREN'S HEALTHCARE OF ATLANTA, INC. SEEKS TO TRANSFORM PEDIATRIC HEALTHCARE AND BE A LEADING VOICE FOR THE HEALTH OF GEORGIA'S CHILDREN.

DESCRIPTION OF CLASSES OF MEMBERS OR STOCKHOLDERS

FORM 990, PART VI, QUESTION 6

CHILDREN'S HEALTHCARE OF ATLANTA, INC. IS THE SOLE CORPORATE MEMEBER OF ALL SUBORDINATES EXCEPT HSOC; EGLESTON CHILDREN'S HOSPITAL IS THE SOLE CORPORATE MEMBER OF HSOC.

DESCRIPTION OF CLASSES OF PERSONS AND THE NATURE OF THEIR RIGHTS

Name of the organization

Employer identification number

CHILDREN'S HEALTHCARE OF ATLANTA GROUP RETURN

FORM 990, PART VI, QUESTION 7A

THE BYLAWS OF EGLESTON CHILDREN'S HOSPITAL AT EMORY UNIVERSITY, INC., SCOTTISH RITE CHILDREN'S MEDICAL CENTER, INC., EGLESTON AFFILIATED SERVICES, INC. AND EGLESTON PEDIATRIC GROUP, INC. PROVIDE THAT ITS TRUSTEES SHALL BE THE PERSONS THEN SERVING AS THE TRUSTEES OF CHILDREN'S HEALTHCARE OF ATLANTA, INC. THE BYLAWS OF MARCUS AUTISM CENTER AND CHILDREN'S HEALTHCARE OF ATLANTA FOUNDATION, INC. PROVIDE THAT THE TRUSTEES OF THESE ORGANIZATIONS ARE SUBJECT TO APPROVAL AND REMOVAL BY CHILDREN'S HEALTHCARE OF ATLANTA, INC.

DESCR CLASSES OF PERSONS, DECISIONS REQUIRING APPR & TYPE OF VOTING RIGHTS

FORM 990, PART VI, QUESTION 7B

CHILDREN'S HEALTHCARE OF ATLANTA, INC. (CHOA), A SECTION 501(C)(3) PUBLIC CHARITY, IS THE CORPORATE PARENT OF THE SUBORDINATES INCLUDED IN THIS GROUP RETURN. UNDER THE SUBORDINATES' BYLAWS, CERTAIN CORPORATE ACTIONS ARE SUBJECT TO THE DIRECT OR INDIRECT APPROVAL OF CHOA. THESE ACTIONS INCLUDE: APPOINTMENT OR REMOVAL OF DIRECTORS; ADOPTION OR AMENDMENT OF A STRATEGIC PLAN; ADOPTION AND/OR AMENDMENT OF THE ANNUAL BUDGET; APPROVAL OF MAJOR CAPITAL EXPENDITURES; APPROVAL OR AMENDMENT OF MAJOR CONTRACTS; THE ADDITION OR DISCONTINUATION OF SIGNIFICANT HEALTHCARE SERVICES; INCURRENCE OF DEBT IN EXCESS OF \$1 MILLION; APPROVAL OF PURCHASES, LEASES OR DISPOSALS OF ASSETS IN EXCESS OF \$250,000; PARTICIPATION IN JOINT VENTURES OR OTHER STRATEGIC RELATIONSHIPS; CREATION OF NEW AFFILIATES; MERGER, CONSOLIDATION, LIQUIDATION OR DISSOLUTION OF THE ORGANIZATION; SIGNIFICANT DISPOSITIONS OF THE ORGANIZATION'S ASSETS; AND AMENDMENT OR RESTATEMENT OF THE ORGANIZATION'S GOVERNING DOCUMENTS.

Name of the organization

Employer identification number

CHILDREN'S HEALTHCARE OF ATLANTA GROUP RETURN

DESCRIBE THE PROCESS USED BY MANAGEMENT &/OR GOVERNING BODY TO REVIEW 990

FORM 990, PART VI, QUESTION 11A

THE ORGANIZATION'S FORM 990 IS REVIEWED IN DETAIL BY THE MEMBERS OF THE
AUDIT AND FINANCE COMMITTEES, AFTER WHICH THE ENTIRE BOARD OF DIRECTORS
IS PROVIDED A COPY PRIOR TO FINAL APPROVAL AND FILING.

DESCRIPTION OF PROCESS TO MONITOR TRANSACTIONS FOR CONFLICTS OF INTEREST

FORM 990, PART VI, QUESTION 12C

CHILDREN'S BOARD OF TRUSTEES ADOPTED A CONFLICT OF INTEREST POLICY THAT
APPLIES TO AN "INTERESTED PERSON". AN INTEREST PERSON WOULD BE EVERY
DIRECTOR, TRUSTEE, MEMBER OF A BOARD COMMITTEE WITH GOVERNING BOARD
DELEGATED POWERS, OFFICER OR "KEY MANAGEMENT EMPLOYEE" OF A CHILDREN'S
ORGANIZATION WHOM HAS A DIRECT OR INDIRECT FINANCIAL INTEREST.

A KEY MANAGEMENT EMPLOYEE WOULD BE THE CHIEF EXECUTIVE OFFICER OF A
CHILDREN'S ORGANIZATION, ANY MANAGERS WHO REPORT DIRECTLY TO THE CHIEF
EXECUTIVE OFFICER OR THE BOARD OF A CHILDREN'S ORGANIZATION, ANY EMPLOYEE
OTHERWISE LISTED AS A CURRENT OR FORMER "KEY EMPLOYEE" ON THE MOST
RECENTLY FILED IRS FORM 990 OF A CHILDREN'S ORGANIZATION, OR ANY OTHER
PERSONNEL SO DESIGNATED BY THE CHIEF EXECUTIVE OFFICER.

IN CONNECTION WITH ANY ACTUAL OR POSSIBLE CONFLICT OF INTEREST, AN
INTERESTED PERSON MUST DISCLOSE THE EXISTENCE OF THE FINANCIAL INTEREST
AND BE GIVEN THE OPPORTUNITY TO DISCLOSE ALL MATERIAL FACTS TO THE
DIRECTORS OR TRUSTEES AND MEMBERS OF COMMITTEES WITH GOVERNING BOARD
DELEGATED POWERS CONSIDERING THE PROPOSED TRANSACTION OR ARRANGEMENT.

Name of the organization

CHILDREN'S HEALTHCARE OF ATLANTA GROUP RETURN

Employer identification number

AFTER DISCLOSURE OF THE FINANCIAL INTEREST AND ALL MATERIAL FACTS, AND AFTER ANY DISCUSSION WITH THE INTERESTED PERSON, SUCH INTEREST PERSON SHALL LEAVE THE GOVERNING BOARD OR COMMITTEE MEETING WHILE THE DETERMINATION OF A CONFLICT OF INTEREST IS DISCUSSED AND VOTED UPON. THE REMAINING BOARD OR COMMITTEE MEMBERS SHALL DECIDE IF A CONFLICT EXISTS.

AFTER EXERCISING DUE DILIGENCE, THE GOVERNING BOARD OR COMMITTEE SHALL DETERMINE WHETHER A) THE TRANSACTION OR ARRANGEMENT IS IN THE CHILDREN'S ORGANIZATION BEST INTEREST, IS FAIR AND REASONABLE OR B) WHETHER THE CHILDREN'S ORGANIZATION CAN OBTAIN WITH REASONABLE EFFORTS AN EQUAL OR MORE ADVANTAGEOUS TRANSACTION OR ARRANGEMENT FROM A PERSON OR ENTITY THAT WOULD NOT GIVE RISE TO A CONFLICT OF INTEREST.

THE GOVERNING BOARD OF COMMITTEE SHALL DETERMINE BY A MAJORITY VOTE OF THE DISINTERESTED DIRECTORS OR TRUSTEES WHETHER A) TO ENTER INTO THE TRANSACTION OR ARRANGEMENT; OR B) TO ENTER INTO AN EQUAL OR MORE ADVANTAGEOUS TRANSACTION OR ARRANGEMENT FROM A PERSON OR ENTITY THAT WOULD NOT GIVE RISE TO A CONFLICT OF INTEREST; OR C) TAKE NO ACTION.

EACH INTEREST PERSON OF A CHILDREN'S ORGANIZATION SHALL ANNUALLY SIGN A STATEMENT WHICH AFFIRMS THAT SUCH PERSON A) HAS RECEIVED A COPY OF THE CONFLICT OF INTEREST POLICY; B) HAS READ AND UNDERSTANDS THE POLICY; AND C) HAS AGREED TO COMPLY WITH THE POLICY. ANNUALLY, INTERESTED PERSONS

Name of the organization

CHILDREN'S HEALTHCARE OF ATLANTA GROUP RETURN

Employer identification number

WILL COMPLETE A QUESTIONNAIRE TO PROVIDE INFORMATION NEEDED IN CONNECTION WITH THE CHILDREN'S ORGANIZATION'S FILING OF ITS IRS FORM 990 WITH THE INTERNAL REVENUE SERVICE. RESULTS OF THE QUESTIONNAIRE ARE REVIEWED BY SENIOR LEADERSHIP.

OFFICES & POSITIONS FOR WHICH PROCESS WAS USED, & YEAR PROCESS WAS BEGUN FORM 990, PART VI, QUESTION 15A&B CHILDREN'S BOARD OF TRUSTEES HAS ULTIMATE DECISION-MAKING OVER EXECUTIVE COMPENSATION, AND THE COMPENSATION AND BENEFITS COMMITTEE (COMMITTEE) IS RESPONSIBLE FOR PROGRAM OVERSIGHT AND ADMINISTRATION AND FOR MAKING RECOMMENDATIONS TO THE BOARD.

THE COMPENSATION AND BENEFITS COMMITTEE IS COMPRISED OF INDEPENDENT BOARD MEMBERS AND CHARGED WITH EVALUATING THE TOTAL COMPENSATION PACKAGE OF SELECTED EMPLOYEES (CALLED "DISQUALIFIED PERSONS").

TO CARRY OUT THIS CHARGE, THE COMMITTEE ENGAGES AN INDEPENDENT THIRD PARTY EXECUTIVE COMPENSATION CONSULTING FIRM TO COMPLETE AN ANNUAL ASSESSMENT OF THE COMPETITIVENESS AND REASONABLENESS OF THE TOTAL COMPENSATION PACKAGE FOR "DISQUALIFIED PERSONS" AND OTHER EXECUTIVES.

USING MARKET DATA PROVIDED BY THE THIRD PARTY RELATING TO THE PAY, BENEFITS AND PERQUISITES PAID TO FUNCTIONALLY COMPARABLE POSITIONS IN ORGANIZATIONS COMPARABLE TO CHILDREN'S HEALTHCARE OF ATLANTA, THE COMMITTEE PROVIDES TOTAL COMPENSATION RECOMMENDATIONS.

Name of the organization

CHILDREN'S HEALTHCARE OF ATLANTA GROUP RETURN

Employer identification number

PAY RECOMMENDATIONS ARE MADE IN DECEMBER AND BOARD APPROVED CHANGES, IF ANY, ARE EFFECTIVE IN JANUARY OF THE COMING YEAR. INCENTIVE PAYOUTS ARE APPROVED IN FEBRUARY, FOR THE PRIOR YEAR'S PERFORMANCE, AND ISSUED IN MARCH.

ALL COMMITTEE RECOMMENDATIONS AND BOARD DECISIONS (RELATED TO EXECUTIVE COMPENSATION) ARE DOCUMENTED IN THE APPLICABLE MEETING MINUTES.

EXECUTIVES ARE ELIGIBLE FOR AN ANNUAL INCENTIVE, WHICH INCLUDES A MEASUREMENT FOR ACHIEVEMENT OF THE BUDGETED OPERATING MARGIN. THESE INCENTIVES ARE CALCULATED AS A CERTAIN PERCENTAGE OF THE EXECUTIVE'S BASE COMPENSATION APPROVED BY THE COMPENSATION & BENEFITS COMMITTEE.

AVAIL OF GOV DOCS, CONFLICT OF INTEREST POLICY, & FIN STMTS TO GEN PUBLIC FORM 990, PART VI, QUESTION 19
THE ORGANIZATION DOES NOT MAKE THESE DOCUMENTS AVAILABLE, CONSISTENT WITH IRS REQUIREMENTS.

DESCRIPTION OF PERSONS TITLES

FORM 990, PART VII, SECTION A

ABBREVIATION DEFINITIONS:

CHOA FDN- CHILDREN'S HEALTHCARE OF ATLANTA FOUNDATION, INC.

MAC- MARCUS AUTISM CENTER, INC.

ECH- EGLESTON CHILDREN'S HOSPITAL AT EMORY UNIVERSITY, INC.

SRCH- SCOTTISH RITE CHILDREN'S MEDICAL CENTER, INC.

HSOC- HSOC, INC.

Name of the organization

CHILDREN'S HEALTHCARE OF ATLANTA GROUP RETURN

Employer identification number

EAS- EGLESTON AFFILIATED SERVICES, INC.

EPG- EGLESTON PEDIATRIC GROUP, INC.

NAME AND TITLES:

RUTH FOWLER- TREASURER AT CHOA FDN/ MAC/ ECH/ SRCH/ HSOC/ EAS/ EPG

DOUG GARGES- TRUSTEE AT CHOA FDN/ ECH/ SRCH/ EAS/ EPG

ROBERT BRUCE - TRUSTEE AT CHOA FDN/ECH/SRCH/EAS/EPG

DONNA HYLAND- PRESIDENT AT MAC/ ECH/ SRCH/ EAS/ EPG/ HSOC, TRUSTEE AT
CHOA FDN

RICHARD ANDERSON - CHAIRMAN AT MAC, TRUSTEE AT ECH/SRCH/EAS/EPG

LESLIE JONES - SECRETARY AT MAC/ECH/SRCH/EAS/EPG/HSOC

CAROLYN KENNY- EVP, CLINICAL CARE- ECH & PRESIDENT HSOC

HOURS DEVOTED TO RELATED ORGANIZATIONS

FORM 990, PART VII

ALL MEMBERS OF CHILDREN'S HEALTHCARE OF ATLANTA EXECUTIVE TEAM WORK A
MINIMUM OF 50 HOURS PER WEEK. THE SPLIT OF THESE HOURS BETWEEN THE
PARENT AND GROUP RETURNS IS DETERMINED BY THE INDIVIDUAL'S ROLE AND
RESPONSIBILITIES AS WELL AS THE LOCATION OF THE INDIVIDUAL'S PAYROLL
EXPENSE. INDIVIDUALS WHOSE PAYROLL EXPENSE IS LOCATED AT THE PARENT SPEND
80%, OR 40 HOURS OF THEIR WORK WEEK DEVOTED TO CARRYING OUT THE GOALS AND
OBJECTIVES OF THE CHOA ORGANIZATION AS A WHOLE. THE REMAINING 20% OR 10
HOURS IS DEVOTED TO SPECIFIC GOALS AND TASKS ASSOCIATED WITH ONE OR MORE
OF THE ORGANIZATIONS REPRESENTED IN THE GROUP RETURN.

INDIVIDUALS WHOSE PAYROLL EXPENSE IS LOCATED AT THE SUBSIDIARIES SPEND

Name of the organization

Employer identification number

CHILDREN'S HEALTHCARE OF ATLANTA GROUP RETURN

80%, OR 40 HOURS OF THEIR WORK WEEK DEVOTED TO CARRYING OUT THE GOALS AND OBJECTIVES OF ONE OF MORE OF THE ENTITIES REPRESENTED IN THE GROUP RETURN. THE REMAINING 20%, OR 10 HOURS IS DEVOTED TO TASKS OR OBJECTIVES RELATED TO THE CHOA ORGANIZATION AS A WHOLE.

RECONCILIATION OF NET ASSETS

FORM 990, PART XI

OTHER CHANGES IN NET ASSETS OF FUND BALANCE

UNREALIZED GAINS:	\$25,209,500
TRANSFERS BETWEEN ENTITIES:	\$30,229,072
OTHER RECONCILING ITEMS	\$394,920

TOTAL OTHER CHANGES	\$55,833,492
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ATTACHMENT 1FORM 990, PART VI, LINE 17 - STATES

AK, AZ, CA, CO,
 FL, GA, HI, IL, KS, KY, ME, MD, MA, MI,
 MS, NH, NJ, NM, ND, OH, OK, OR,
 SC, TN, UT, WA, WV,

ATTACHMENT 2

PART VII - CONTINUATION OF OFFICERS, DIRECTORS, TRUSTEES,
 KEY EMPLOYEES AND HIGHEST COMPENSATED EMPLOYEES

(1)=IND.TRUSTEE/DIR. (2)=INS.TRUSTEE (3)=OFFICER (4)=KEY EMP. (5)=HIGHEST COMP. (6)=FORMER

(A) NAME AND TITLE	(B) HOURS	(C) POSITION						COMPENSATION FROM			
		(1)	(2)	(3)	(4)	(5)	(6)	(D) ORG.	(E) REL. ORG.	(F) OTHER	
29 TERRI THEISEN											
TRUSTEE - CHOA FDN	1.00	X						0.	0.	0.	
30 NANCY WILLIAMS											

Name of the organization	Employer identification number
CHILDREN'S HEALTHCARE OF ATLANTA GROUP RETURN	

ATTACHMENT 2 (CONT'D)

TRUSTEE - CHOA FDN	1.00	X		0.	0.	0.
31 DONALD MUELLER						
EXECUTIVE DIRECTOR - MAC	50.00	X		228,556.	0.	23,011.
32 DONNA HYLAND						
PRESIDENT - SEE SCHEDULE O	10.00	X	X	0.	999,947.	29,376.
33 RICHARD ANDERSON						
CHAIRMAN- SEE SCHEDULE O	1.00	X		0.	0.	0.
34 CHARLES SHAFFER, JR						
TRUSTEE - MAC	1.00	X		0.	0.	0.
35 WINIFRED DAVIS						
TRUSTEE - MAC	1.00	X		0.	0.	0.
36 DON CHAPMAN						
TRUSTEE- MAC/ECH/SRCH/EAS/EPG	1.00	X		0.	0.	0.
37 FREDERICK R. MARCUS, PHD						
TRUSTEE - MAC	1.00	X		0.	0.	0.
38 LARRY SMITH						
TRUSTEE - MAC	1.00	X		0.	0.	0.
39 BARBARA STOLL, MD						
SVP CHIEF ACADEMIC OFFICER	1.00	X		0.	242,322.	9,430.
40 GREGORY ABOWD						
TRUSTEE - MAC	1.00	X		0.	0.	0.
41 JOHN DYER						
TRUSTEE - MAC	1.00	X		0.	0.	0.
42 REBECCA FLICK						
TRUSTEE - MAC	1.00	X		0.	0.	0.
43 TAD HUTCHESON						
TRUSTEE - MAC	1.00	X		0.	0.	0.
44 DOUG HERTZ						
CHAIRMAN - ECH/SRCH/EAS/EPG	1.00	X		0.	0.	0.
45 TOM COLEY						
TRUSTEE - ECH/SRCH/EAS/EPG	1.00	X		0.	0.	0.
46 MARK CHANCY						
TRUSTEE - ECH/SRCH/EAS/EPG	1.00	X		0.	0.	0.
47 TERI MCCLURE						
TRUSTEE - ECH/SRCH/EAS/EPG	1.00	X		0.	0.	0.
48 JESSE SPIKES						
TRUSTEE - ECH/SRCH/EAS/EPG/HSO	1.00	X		0.	0.	0.
49 TYCHO HOWLE						
TRUSTEE - ECH/SRCH/EAS/EPG	1.00	X		0.	0.	0.
50 DAN GRAVELINE						
TRUSTEE - ECH/SRCH/EAS/EPG	1.00	X		0.	0.	0.

Name of the organization

Employer identification number

CHILDREN'S HEALTHCARE OF ATLANTA GROUP RETURN

ATTACHMENT 2 (CONT'D)

51	JOE WILLIAMS, MD							
	TRUSTEE - ECH/SRCH/EAS/EPG	1.00	X		112,225.	0.		0.
52	ELIZABETH BLAKE							
	TRUSTEE - ECH/SRCH/EAS/EPG	1.00	X		0.	0.		0.
53	CEDRIC MILLER, MD							
	TRUSTEE - ECH/SRCH/EAS/EPG	1.00	X		37,380.	0.		0.
54	THOMAS NOONAN							
	TRUSTEE - ECH/SRCH/EAS/EPG	1.00	X		0.	0.		0.
55	STEVE CAHILLANE							
	TRUSTEE - ECH/SRCH/EAS/EPG	1.00	X		0.	0.		0.
56	MICHAEL WALSH							
	TRUSTEE - ECH/SRCH/EAS/EPG	1.00	X		0.	0.		0.
57	CHRISTOPHER WOMACK							
	TRUSTEE - ECH/SRCH/EAS/EPG	1.00	X		0.	0.		0.
58	JACKIE MONTAG							
	TRUSTEE - HSOC	1.00	X		0.	0.		0.
59	MADELYN ADAMS							
	TRUSTEE - HSOC	1.00	X		0.	0.		0.
60	DANIEL SALINAS, MD							
	SVP CHIEF MEDICAL OFFICER	1.00	X		0.	487,071.		25,299.
61	LYNN GARDNER							
	TRUSTEE - HSOC	1.00	X		0.	0.		9,870.
62	TONJA BRIDGES							
	SECRETARY - CHOA FDN	1.00	X		96,114.	0.		13,728.
63	LESLIE JONES							
	SECRETARY - SEE SCHEDULE O	10.00	X		0.	356,238.		20,244.
64	CAROLYN KENNY							
	EVP- SEE SCHEDULE O	10.00	X		0.	619,075.		12,504.
65	SCOTT HODOVAL							
	VP DEVELOPMENT - CHOA FDN	50.00	X		212,895.	0.		17,515.
66	WILLIAM KEY							
	VP DEVELOPMENT - CHOA FDN	50.00	X		188,836.	0.		20,067.
67	ROY SANDERS							
	PROGRAM DIRECTOR - MAC	50.00	X		174,138.	0.		16,039.
68	MARTHA MCGILL							
	SVP OPERATIONS - ECH	50.00	X		253,395.	0.		18,268.
69	MARYBETH BOVA							
	ECH (VP OPS/ SLA-ECH)	50.00	X		230,304.	0.		14,470.
70	PATRICK WAGNER							
	DIRECTOR, HR - ECH	50.00	X		160,663.	0.		11,765.
71	BETH BOATWRIGHT							
	DIR FIN OPS - ECH/SRCH	50.00	X		150,273.	0.		15,785.

Name of the organization	Employer identification number
CHILDREN'S HEALTHCARE OF ATLANTA GROUP RETURN	

ATTACHMENT 2 (CONT'D)

72 DENISE SWORDS						
SVP OPERATIONS - SRCH	50.00	X	304,473.	0.	14,790.	
73 LINDA HITCHCOCK						
DIRECTOR, HR - SRCH	50.00	X	163,669.	0.	8,866.	
74 JULIA JONES						
VP OPERATIONS - HSOC	50.00	X	210,149.	0.	22,058.	
75 WILLIAM BOYDSTON						
PRAC DIR NEURSURGICAL SVCS	50.00	X	820,692.	0.	23,320.	
76 BARUNASHISH BRAHMA						
NEUROSURGEON	50.00	X	694,078.	0.	21,654.	
77 DAVID WRUBEL						
NEUROSURGEON	50.00	X	730,501.	0.	19,083.	
78 WILLIAM BONNER						
ANESTHESIOLOGIST	50.00	X	534,719.	0.	21,346.	
79 ANDREW REISNER						
NEUROSURGEON	50.00	X	871,356.	0.	26,799.	

ATTACHMENT 3990, PART VII- COMPENSATION OF THE FIVE HIGHEST PAID IND. CONTRACTORS

<u>NAME AND ADDRESS</u>	<u>DESCRIPTION OF SERVICES</u>	<u>COMPENSATION</u>
EMORY CHILDREN'S CENTER 2015 UPPERGATE DRIVE, NE ATLANTA, GA 30322	MEDICAL SERVICES	25,266,798.
PEDIATRIC EMERGENCY MEDICINE ASSOCIATES 2247 SALIENT ROAD MARIETTA, GA 30064	EMERGENCY SERVICES	12,850,674.
BRASFIELD & GORRIE, LLC P.O. BOX 11407 BIRMINGHAM, AL 35246-0351	CONSTRUCTION CONSLT	2,325,288.
TANGO2 P.O. BOX 17463 DENVER, CO 80217-0463	SYSTEMS CONSULTING	1,273,808.
INPROCESS CONSULTING LLC 2125 WOOD COVE DRIVE CUMMING, GA 30041	SYSTEMS CONSULTING	930,550.
TOTAL COMPENSATION		<u>42,647,118.</u>

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

OMB No. 1545-0047

2010

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

▶ Attach to Form 990. ▶ See separate Instructions.

Open to Public
Inspection

Name of the organization

CHILDREN'S HEALTHCARE OF ATLANTA GROUP RETURN

Employer identification number

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

(a) Name, address, and EIN of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) CHILDREN'S SEDATION SERVICES, LLC 1584 TULLIE CIRCLE ATLANTA, GA 30329 81-0582607	PHY SERVICES	GA	1,230,282.	0.	EGLSTON PED
(2) CHILDREN'S ANESTHESIA SERVICES, LLC 1584 TULLIE CIRCLE ATLANTA, GA 30329 20-0044124	PHY SERVICES	GA	10,449,451.	0.	EGLSTON PED
(3) CHOA CENTER FOR PAIN RELIEF, LLC 1584 TULLIE CIRCLE ATLANTA, GA 30329 32-0185406	PHY SERVICES	GA	299,527.	0.	EGLSTON PED
(4) CHOA PEDIATRIC NEUROLOGY, LLC 1584 TULLIE CIRCLE ATLANTA, GA 30329 37-1575334	PHY SERVICES	GA	105,689.	0.	EGLSTON PED
(5) PEDIATRIC NEUROSURGERY ASSOCIATES 1584 TULLIE CIRCLE ATLANTA, GA 30329 26-0833842	PHY SERVICES	GA	4,632,793.	0.	EGLSTON PED
(6) -----					

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?
(1) -----						Yes No
(2) -----						
(3) -----						
(4) -----						
(5) -----						
(6) -----						
(7) -----						

For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule R (Form 990) 2010

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1085)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) <u>MERIDIAN MARK, LLC_01-0723254</u> <u>1584 TULLIE, ATLANTA GA 30329</u>	<u>SURGERY CENTER</u>	<u>GA</u>	<u>SCOTTISH RITE</u>	<u>RELATED</u>	<u>10,917,335.</u>	<u>4,639,500.</u>		X	<u>0.</u>			X
(2) _____	_____	_____	_____	_____	_____	_____			_____			
(3) _____	_____	_____	_____	_____	_____	_____			_____			
(4) _____	_____	_____	_____	_____	_____	_____			_____			
(5) _____	_____	_____	_____	_____	_____	_____			_____			
(6) _____	_____	_____	_____	_____	_____	_____			_____			
(7) _____	_____	_____	_____	_____	_____	_____			_____			

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership
(1) <u>EMORY-EGLESTON CHILDREN'S HEART CENTER</u> <u>2835 BRANDYWINE ROAD SUITE 300 ATLANTA, GA 30329</u>	<u>CARDIAC SERVICES</u>	<u>GA</u>	<u>CHOA</u>	<u>C CORP</u>	<u>0</u>	<u>0</u>	<u>0.0000</u>
(2) <u>THE CHILDREN'S HEALTH NETWORK, INC.</u> <u>1584 TULLIE CIRCLE ATLANTA, GA 30329</u>	<u>PHO</u>	<u>GA</u>	<u>CHOA</u>	<u>C CORP</u>	<u>0</u>	<u>0</u>	<u>0.0000</u>
(3) _____	_____	_____	_____	_____	_____	_____	_____
(4) _____	_____	_____	_____	_____	_____	_____	_____
(5) _____	_____	_____	_____	_____	_____	_____	_____
(6) _____	_____	_____	_____	_____	_____	_____	_____
(7) _____	_____	_____	_____	_____	_____	_____	_____

Schedule R (Form 990) 2010

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

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

(1) Name, address, and EIN of entity	(2) Primary activity	(3) Legal domicile (state or foreign country)	(4) Are all partners section 501(c)(3) organizations?		(5) Share of end-of-year assets	(6) Disproportionate allocations?		(7) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(8) General or managing partner?	
			Yes	No		Yes	No		Yes	No
(1) _____										
(2) _____										
(3) _____										
(4) _____										
(5) _____										
(6) _____										
(7) _____										
(8) _____										
(9) _____										
(10) _____										
(11) _____										
(12) _____										
(13) _____										
(14) _____										
(15) _____										
(16) _____										

Schedule R (Form 990) 2010

Part VII **Supplemental Information**

Complete this part to provide additional information for responses to questions on Schedule R (see instructions).

Form **8868**

(Rev. January 2011)

Department of the Treasury
Internal Revenue Service**Application for Extension of Time To File an
Exempt Organization Return**

OMB No 1545-1709

► **File a separate application for each return.**

- If you are filing for an **Automatic 3-Month Extension**, complete only **Part I** and check this box ☒ **X**
- If you are filing for an **Additional (Not Automatic) 3-Month Extension**, complete only **Part II** (on page 2 of this form).

Do not complete Part II unless you have already been granted an automatic 3-month extension on a previously filed Form 8868

Electronic filing (e-file) You can electronically file Form 8868 if you need a 3-month automatic extension of time to file (6 months for a corporation required to file Form 990-T), or an additional (not automatic) 3-month extension of time. You can electronically file Form 8868 to request an extension of time to file any of the forms listed in Part I or Part II with the exception of Form 8870, Information Return for Transfers Associated With Certain Personal Benefit Contracts, which must be sent to the IRS in paper format (see instructions). For more details on the electronic filing of this form, visit www.irs.gov/efile and click on **e-file for Charities & Nonprofits**

Part I Automatic 3-Month Extension of Time. Only submit original (no copies needed).

A corporation required to file Form 990-T and requesting an automatic 6-month extension check this box and complete

Part I only ☐

All other corporations (including 1120-C filers), partnerships, REMICs, and trusts must use Form 7004 to request an extension of time to file income tax returns

Type or print File by the due date for filing your return. See instructions.	Name of exempt organization	Employer identification number
	CHILDREN'S HEALTHCARE OF ATLANTA, INC.	58-2367819
	Number, street, and room or suite no. If a P O box, see instructions	
	1584 TULLIE CIRCLE	
	City, town or post office, state, and ZIP code. For a foreign address, see instructions	
	ATLANTA, GA 30329	

Enter the Return code for the return that this application is for (file a separate application for each return)

Application Is For	Return Code	Application Is For	Return Code
Form 990	01	Form 990-T (corporation)	07
Form 990-BL	02	Form 1041-A	08
Form 990-EZ	03	Form 4720	09
Form 990-PF	04	Form 5227	10
Form 990-T (sec. 401(a) or 408(a) trust)	05	Form 6069	11
Form 990-T (trust other than above)	06	Form 8870	12

- The books are in the care of ► TOM BREMS

Telephone No ► 404 785-7944

FAX No ► 404 785-9105

- If the organization does not have an office or place of business in the United States, check this box ☐
- If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN) N/A. If this is for the whole group, check this box ☐. If it is for part of the group, check this box ☐ and attach a list with the names and EINs of all members the extension is for.

- 1 I request an automatic 3-month (6 months for a corporation required to file Form 990-T) extension of time until 08/15, 20 11, to file the exempt organization return for the organization named above. The extension is for the organization's return for
- ☒ calendar year 20 10 or
- ☐ tax year beginning _____, 20 _____, and ending _____, 20 _____

- 2 If the tax year entered in line 1 is for less than 12 months, check reason ☐ Initial return ☐ Final return
- ☐ Change in accounting period

3a If this application is for Form 990-BL, 990-PF, 990-T, 4720, or 6069, enter the tentative tax, less any nonrefundable credits. See instructions.	3a \$	0.
b If this application is for Form 990-PF, 990-T, 4720, or 6069, enter any refundable credits and estimated tax payments made. Include any prior year overpayment allowed as a credit.	3b \$	0.
c Balance Due. Subtract line 3b from line 3a. Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions.	3c \$	0.

Caution. If you are going to make an electronic fund withdrawal with this Form 8868, see Form 8453-EO and Form 8879-EO for payment instructions.

For Paperwork Reduction Act Notice, see Instructions.

Form **8868** (Rev. 1-2011)

440 POSITED

- If you are filing for an **Additional (Not Automatic) 3-Month Extension**, complete only **Part II** and check this box ☒ **X**
Note. Only complete Part II if you have already been granted an automatic 3-month extension on a previously filed Form 8868
- If you are filing for an **Automatic 3-Month Extension**, complete only **Part I** (on page 1)

Part II Additional (Not Automatic) 3-Month Extension of Time. Only file the original (no copies needed).**Type or print**

File by the extended due date for filing your return See instructions

Name of exempt organization

CHILDREN'S HEALTHCARE OF ATLANTA, INC.

Employer identification number

58-2367819

Number, street, and room or suite no If a P O box, see instructions

1584 TULLIE CIRCLE

City, town or post office, state, and ZIP code For a foreign address, see instructions

ATLANTA, GA 30329

Enter the Return code for the return that this application is for (file a separate application for each return)

01

Application Is For	Return Code	Application Is For	Return Code
Form 990	01		
Form 990-BL	02	Form 1041-A	08
Form 990-EZ	03	Form 4720	09
Form 990-PF	04	Form 5227	10
Form 990-T (sec 401(a) or 408(a) trust)	05	Form 6069	11
Form 990-T (trust other than above)	06	Form 8870	12

STOP! Do not complete Part II if you were not already granted an automatic 3-month extension on a previously filed Form 8868.

- The books are in the care of ☒ TOM BREMS

Telephone No ☒ 404 785-7944FAX No ☒ 404 785-9105

- If the organization does not have an office or place of business in the United States, check this box ☐

- If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN) 5857 If this is for the whole group, check this box ☐ If it is for part of the group, check this box ☐ and attach a list with the names and EINs of all members the extension is for.

- I request an additional 3-month extension of time until 11/15, 20 11
- For calendar year , or other tax year beginning , 20 , and ending 12/31, 20 10
- If the tax year entered in line 5 is for less than 12 months, check reason ☐ Initial return ☐ Final return
☐ Change in accounting period
- State in detail why you need the extension **ADDITIONAL TIME IS NEEDED TO GATHER ALL THE INFORMATION NECESSARY TO FILE A COMPLETE AND ACCURATE RETURN.**

8a If this application is for Form 990-BL, 990-PF, 990-T, 4720, or 6069, enter the tentative tax, less any nonrefundable credits See instructions	8a \$	0.
b If this application is for Form 990-PF, 990-T, 4720, or 6069, enter any refundable credits and estimated tax payments made Include any prior year overpayment allowed as a credit and any amount paid previously with Form 8868	8b \$	0.
c Balance Due. Subtract line 8b from line 8a Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System) See instructions	8c \$	0.

Signature and Verification

Under penalties of perjury, I declare that I have examined this form, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete, and that I am authorized to prepare this form

Signature ☒

Chris Stemb

Title ☒ Tax ManagerDate ☒ 08/09/11

Form 8868 (Rev 1-2011)

4400 POSTED