

**Hospital Authority of Jenkins County
Hospital Transparency Requirements
Alternative 990 for Non-reporting Hospitals
12/31/2024**

Organization Name
Doing Business As
Fiscal Year Start Date
Fiscal Year End Date
Employer Identification Number (EIN)
Primary Contact

Hospital Authority of Jenkins County
Jenkins County Medical Center
1/1/2024
12/31/2024
58-1158547
Andrea Graham, CEO

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Cells highlighted in blue indicates a selection from a dropdown list.
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Alternative 990 for Non-reporting Hospitals	
#N/A	
(B) Check if applicable	(C) Name of organization Hospital Authority of Jenkins County
Address Change	Doing business as Jenkins County Medical Center
Name Change	Number and street (or P.O. box if not delivered to street address) Room/suite
Initial Return	X 931 E Winthrop Avenue
Final return/terminated	City or town, state or province, country, and ZIP or foreign postal code
Amended return	Millen, GA 30442
Application pending	(F) Name and address of principal filer Andrea Graham 931 E Winthrop Avenue, Millen, GA 30442
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
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
20a	Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H
20b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?
21	Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? If "Yes," complete Schedule I, Parts I and II
22	Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? If "Yes," complete Schedule I, Parts I and III
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5, about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? If "Yes," complete Schedule J
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? If "Yes," complete Schedule R, Part I
34	Was the organization related to any tax-exempt or taxable entity? If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?
35b	If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? If "Yes," complete Schedule R, Part V, line 2
36	Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? If "Yes," complete Schedule R, Part V, line 2
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? If "Yes," complete Schedule R, Part VI

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Part V		Statements Regarding Other IRS Filings and Tax Compliance		
				Yes/No
1a	Enter the number of reported in box 3 of Form 1096. Enter -0- if not applicable.	1a		
b	Enter the number of Forms W-2G included on line 1a. Enter -0- if not applicable.	1b		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winning to prize winners?		1c	Yes
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	142	
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?		2b	Yes
3a	Did the organization have unrelated business gross income of \$1,000 or more during the year?		3a	No
b	If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in the space provided below.		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	No
b	If "Yes," enter the name of the foreign country. See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).	4b		
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?		5a	No
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		5b	
c	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?		5c	
6a	Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?		6a	No
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	No
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?		7b	
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?		7c	No
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	No
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?		7f	No
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?		7g	No
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?		7h	No
14a	Did the organization receive any payments for indoor tanning services during the tax year?		14a	No
b	If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in the space provided below.		14b	
15	Is the organization subject to the section 4960 tax on payment(s) of more than \$1,000,000 in remuneration or excess parachute payment(s) during the year?		15	No

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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 the space provided below.		
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	5	
b	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in the space provided below.	1b		
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		No
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, trustees, or key employees to a management company or other person?	3		No
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4		No
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5		No
6	Did the organization have members or stockholders?	6		No
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a		Yes
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b		Yes
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:			
a	The governing body?	8a		Yes
b	Each committee with authority to act on behalf of the governing body?	8b		Yes
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 the space provided below.	9		No
Section B. Policies (This Section B requests information about policies not required by the Internal Revenue Code.)				
10a	Did the organization have local chapters, branches, or affiliates?	10a		No
b	If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?	10b		
11a	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	11a		No
b	Describe on in the space provided below the process, if any, used by the organization to review this Form.			
12a	Did the organization have a written conflict of interest policy? If "No," go to line 13	12a		Yes
b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b		Yes
c	Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in the space provided below how this was done	12c		Yes
13	Did the organization have a written whistleblower policy?	13		Yes
14	Did the organization have a written document retention and destruction policy?	14		Yes

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. If "Yes" explain in space provided below.		15a	Yes
b	Other officers or key employees of the organization. I. If "Yes" explain in space provided below.		15b	Yes
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	No
b	If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?		16b	
Section C. Disclosure				
17	List the states with which a copy of this Form 990 is required to be filed	17	Georgia	
18	Section 6104 requires an organization to make its Forms 1023 (1024 or 1024-A, if applicable), 990, and 990-T (section 501(c) (3)s only) available for public inspection. Indicate how you made these available. Check all that apply.	18		
	Own Website			
	Another's Website			
	Upon Request			X
	Other (explain in space provided below.)			
19	Describe on in the space provided below whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.			
20	State the name, address, and telephone number of the person who possesses the organization's books and records.			
	Name		Lindsey Clay	
	Street Address - Line 1		931 East Winthrop Avenue	
	Street Address - Line 2			
	City		Millen	
	State		Georgia	
	Zip Code		30442	
	Telephone Number		478-982-4221	

Part VI	Additional Comments
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15a. Compensation proposal for CEO and executive officials are reviewed by a third party company initiated by the Board of Directors and legal counsel.

19. The organization makes its governing documents, conflict of interest policy, and financial statements available upon request or in person in the Administrative Office at 931 East Winthrop Avenue, Millen, GA 30442.

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Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors							
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. <ul style="list-style-type: none"> 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 List all of the organization's current key employees, if any. See the instructions for definition of "key employee." List the organization's five current highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (box 5 of Form W-2) 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 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 See the instructions for the order in which to list the persons above.							
Respond "No" if neither the organization nor any related organization compensated any current officer, director, or trustee.							
	(A) Name and Title	(B) Average hours per week (list any hours related to organizations below dotted line)	(C) Positions (do not check more than one box, unless person is both an officer and a director)				
			Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee
(1)	Antoine Poythress Chief Executive Officer, end 10/11/2024	40.00			x		
(2)	Andrea Graham Chief Executive Officer, start 10/1/2024	40.00			x		
(3)	Pamela Mixon Chief Operations Officer	40.00			x		
(4)	Monica Johnson Chief Nursing Officer	40.00			x		
(5)	Haley Anderson Pharmacist	40.00					x
(6)	Jeff Brantley Chairman	1.00	x		x		
(7)	Johnny Newton Board Member	1.00	x		x		
(8)	Robin Scott Board Member	1.00	x		x		
(9)	Wade Parker Board Member	1.00	x		x		

(10)	Charlie Dempsey Board Member, end 11/2024	1.00	x		x		
(11)							
(12)							
(13)							
(14)							
(15)							
(16)							
(17)							
(18)							
(19)							
(20)							
(21)							
(22)							
(23)							
(24)							
(25)							
1b	Subtotal						
c	Total from contribution sheets to Part VII, Section A						
d	Total (add lines 1b and 1c)						
2	Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization						
3	Did the organization list any former officer, director, trustee, key employee, or highest compensated employee on line 1a? If "Yes," complete Schedule J for such individual						
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 individual						

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Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors		
Section B. Independent Contractors		
1	Complete this table for your five highest compensated independent contractors that received more than \$100,000 of compensation from the organization. Report compensation for the calendar year ending with or within the organization's tax year.	
	(A) Name and business address	(B) Description of services
	Southland Emergency Medical Services	Physician Group
	TruBridge	Software
	Strategic Healthcare Partners	Consulting services
	Meridian	Pulmonary Rehabilitation
	David Samuels	Physician Group
2	Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization	6

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Schedule C Political Campaign and Lobbying Activities For Organizations Exempt From Income Tax Under Section 501(c) and Section 527		
Complete if the organization is described below.		
	Name of organization Hospital Authority of Jenkins County	Employer identification number (EIN) 58-1158547
Part I-A	Complete if the organization is exempt under section 501(c) or is a section 527 organization.	
1	Provide a description of the organization's direct and indirect political campaign activities in Part IV. See instructions for definition of "political campaign activities."	
2	Political campaign activity expenditures. See instructions	
3	Volunteer hours for political campaign activities. See instructions	
Part I-B	Complete if the organization is exempt under section 501(c)(3).	
1	Enter the amount of any excise tax incurred by the organization under section 4955	
2	Enter the amount of any excise tax incurred by organization managers under section 4955	
3	If the organization incurred a section 4955 tax, did it file Form 4720 for this year?	
4a	Was a correction made?	
b	If "Yes," describe in Part IV	
Part II-B	Complete if the organization is exempt under section 501(c)(3) and has NOT filed Form 5768 (election under section 501(h)).	
For each "Yes" response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.		
		Yes/No
		Amount
1	During the year, did the filing organization attempt to influence foreign, national, state, or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:	
a	Volunteers?	No
b	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?	No
c	Media advertisements?	No
d	Mailings to members, legislators, or the public?	No
e	Publications, or published or broadcast statements?	No
f	Grants to other organizations for lobbying purposes?	No
g	Direct contact with legislators, their staffs, government officials, or a legislative body?	No
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?	No
i	Other activities?	No
j	Total. Add lines 1c through 1i	\$ -
2a	Did the activities in line 1 cause the organization to not be described in section 501(c)(3)?	No
b	If "Yes," enter the amount of any tax incurred under section 4912	
c	If "Yes," enter the amount of any tax incurred by organization managers under section 4912	
d	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?	

Definitions:
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Lobbying A
activities inc
to influence

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campaign activities - All activities that support or oppose candidates for elective federal, state, or local office. It doesn't matter whether the candidate is elected. A candidate is one who offers himself or herself for public office. Political campaign activity doesn't include any activity to participate in the electoral process, such as voter registration or voter education, provided that it doesn't directly or indirectly support or oppose any candidate.

lobbying activities - All activities intended to influence foreign, national, state, or local legislation. Such activities include direct lobbying (attempting to influence the legislators) and grassroots lobbying (attempting to influence legislation by influencing the general public).

Suggest defining as activities that support or oppose candidates for an election

excise tax is imposed on political expenditures

suggest defining as an attempt to influence legislation (foreign, domestic, state, or local)

ctive federal, state or local office.

Definition ac

tate and local) directly or indirectly

Definition ac

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Hospital Transparency Requirements
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12/31/2024

Schedule I	Hospitals
	Name of organization Hospital Authority of Jenkins County
Part I	Financial Assistance and Certain Other Community Benefits at Cost
1a	Did the organization have a financial assistance policy (FAP) during the tax year? If "No," skip to question 6a
b	If "Yes," was it a written policy?
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the FAP to its various hospital facilities during the tax year: Applied uniformly to all hospital facilities Applied uniformly to most hospital facilities Generally tailored to individual hospital facilities
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year
a	Did the organization use federal poverty guidelines (FPG) as a factor in determining eligibility for providing free care? If "Yes," indicate which of the following was the FPG family income limit for free care: 100% 150% 200% Other
b	Did the organization use FPG as a factor in determining eligibility for providing discounted care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: 200% 250% 300% 350% 400% Other
c	If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.
4	Did the organization's FAP that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?
5a	Did the organization budget amounts for free or discounted care provided under its FAP during the tax year?
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?
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?
6a	Did the organization prepare a community benefit report during the tax year?
b	If "Yes," did the organization make it available to the public?
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

		(a) Number of activities or programs (optional)	(b) Persons served (optional)
Financial Assistance and Means-Tested Government Programs			
a	Financial assistance at cost (from Worksheet 1)		
b	Medicaid (from Worksheet 3, column a)		
c	Costs of other means-tested government programs (from Worksheet 3, column b)		
d	Total. Financial assistance and means-tested government programs	\$ -	\$ -
Other Benefits			
e	Community health improvement services and community benefit operations (from Worksheet 4)		
f	Health professions education (from Worksheet 5)		
g	Subsidized health services (from Worksheet 6)		
h	Research (from Worksheet 7)		
i	Cash and in-kind contributions for community benefit (from Worksheet 8)		
j	Total. Other benefits	\$ -	\$ -
k	Total. Add lines 7d and 7j	\$ -	\$ -

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

		(a) Number of activities or programs (optional)	(b) Persons served (optional)
1	Physical improvements and housing		
2	Economic development		
3	Community support		
4	Environmental improvements		
5	Leadership development and training for community members		
6	Coalition building		
7	Community health improvement advocacy		
8	Workforce development		
9	Other		
10	Total	\$ -	\$ -

Part III **Bad Debt, Medicare, & Collection Practices**

Section A. Bad Debt Expense			
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?		
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount		
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's FAP. Explain in Part VI the methodology used by the organization amount and the rationale, if any, for including this portion of bad debt as community benefit		
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.		
Section B. Medicare			
5	Enter total revenue received from Medicare (including DSH and IME)		
6	Enter Medicare allowable costs of care relating to payments on line 5		
7	Subtract line 6 from line 5. This is the surplus (or shortfall)		

8	Describe in Part VI the extent to which any shortfall reported on line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine reported on line 6. Check the box that describes the method used:
	Cost accounting system
	Cost to charge ratio
	Other

Section C. Collection Practices

9a	Did the organization have a written debt collection policy during the tax year?
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 qualify for financial assistance? Describe in Part VI

Part IV Management Companies and Joint Ventures (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)

	(a) Name of Entity	(b) Description of primary activity of entity
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, from largest to smallest—see instructions)

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

	Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility):	Licensed hospital	General medical & surgical	Children's hospital	Critical access hospital	Research facility
1						
2						

3					
4					
5					
6					
7					
8					
9					
10					

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility (list in order of size, from largest to smallest)

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

Name and address

1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

Part VI	Supplemental Information
	Provide the following information in the space provided below
1	Required descriptions. Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8, and 9b
2	Needs assessment. Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
3	Patient education of eligibility for assistance. Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assist the organization's FAP.
4	Community information. Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
5	Promotion of community health. Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by 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 c
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.



(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
\$ 2,883,826.00			
\$ 2,883,826.00	\$ -	\$ -	0%
\$ -	\$ -	\$ -	0%
\$ 2,883,826.00	\$ -	\$ -	0%

activities promoted the health of the communities it serves.

(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
\$ -	\$ -	\$ -	0%

		1	Yes
		2	\$ 2,503,216.00
to estimate this		3	
inancial			
		5	
		6	
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ance under federal, state, or local government programs or under
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promoting the health of the community (for example, open
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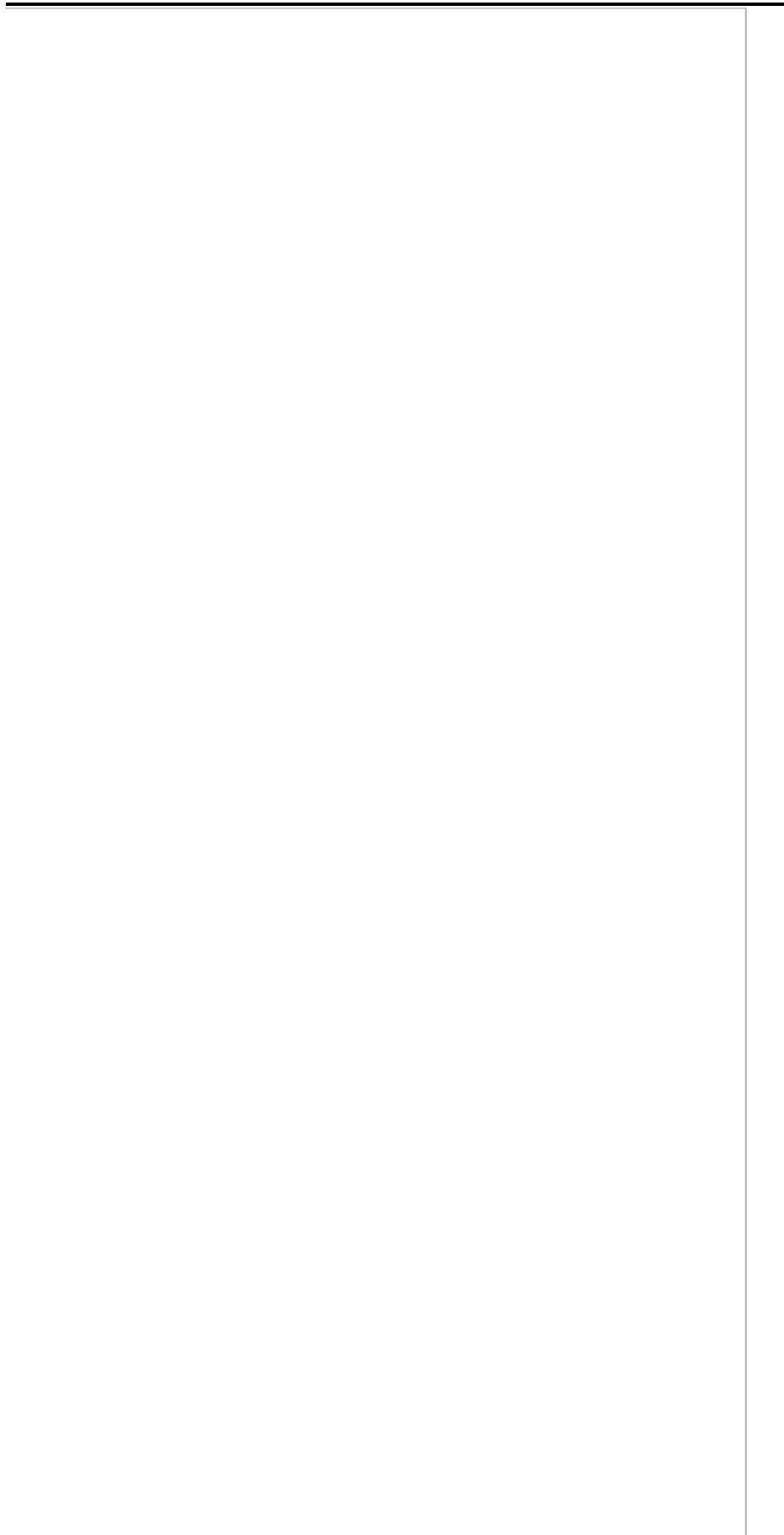
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ommunities served.

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Hospital Authority of Jenkins County
Hospital Transparency Requirements
Alternative 990 for Non-reporting Hospitals
12/31/2024

Schedule H		Hospitals	
Part V		Facility Information	
Section B. Facility Policies and Practices (complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)			
Name of hospital facility or letter of facility reporting group:		Hospital Authority of Jenkins County	
Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A)			
Community Health Needs Assessment (CHNA)			Yes/No
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1	Yes
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	
3	During the tax year or either of the 2 immediately preceding tax years, did the hospital facility conduct a CHNA? If "No," skip to line 12. If "Yes," indicate what the CHNA report describes (check all that apply):	3	Yes
a	A definition of the community served by the hospital facility	3a	X
b	Demographics of the community	3b	X
c	Existing health care facilities and resources within the community that are available to respond to the health needs of the community	3c	X
d	How data was obtained	3d	X
e	The significant health needs of the community	3e	X
f	Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	3f	X
g	The process for identifying and prioritizing community health needs and services to meet the community health needs	3g	X
h	The process for consulting with persons representing the community's interests	3h	X
i	The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA	3i	X
j	Other (describe in Section C)	3j	
4	Indicate the tax year the hospital facility last conducted a CHNA:	4	
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes
6a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	No
7	Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply):	7	Yes
a	Hospital facility's website (list url)	7a	X https://www.jenkinsmedicalcenter.c
b	Other website (list url):	7b	
c	Made a paper copy available for public inspection without charge at the hospital facility	7c	
d	Other (describe in Section C)	7d	
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes

9	Indicate the tax year the hospital facility last adopted an implementation strategy: 20		9	25
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?		10	Yes
a	If "Yes," list url:	10a	X	https://www.jenkinsmedicalcenter.c
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?		10b	
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.			
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?		12a	No
b	If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		12b	
c	If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities?			
Financial Assistance Policy (FAP)				
	Name of hospital facility or letter of facility reporting group:			Hospital Authority of Jenkins Count
	Did the hospital facility have in place during the tax year a written FAP that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? 13 If "Yes," indicate the eligibility criteria explained in the FAP:		13	Yes
a	FPG, with FPG family income limit for eligibility for free care of and FPG family income limit for eligibility for discounted care of	13a	X	200%
b	Income level other than FPG (describe in Section C below)	13b		
c	Asset level	13c		
d	Medical indigency	13d	X	
e	Insurance status	13e		
f	Underinsurance status	13f		
g	Residency	13g		
h	Other (describe in Section C below)	13h		
14	Explained the basis for calculating amounts charged to patients?		14	Yes
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):		15	Yes
a	Described the information the hospital facility may require an individual to provide as part of their application	15a		
b	Described the supporting documentation the hospital facility may require an individual to submit as part of their application	15b		
c	Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process	15c		
d	Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications	15d		
e	Other (describe in Section C below)	15e		
16	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):		16	Yes
a	The FAP was widely available on a website (list url):	16a	X	https://www.jenkinsmedicalcenter.c
b	The FAP application form was widely available on a website (list url):	16b	X	https://www.jenkinsmedicalcenter.c
c	A plain language summary of the FAP was widely available on a website (list url):	16c	X	https://www.jenkinsmedicalcenter.c
d	The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)	16d	X	
e	The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)	16e	X	
f	A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)	16f	X	
g	Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention	16g	X	

h	Notified members of the community who are most likely to require financial assistance about availability of the FAP	16h	X	
i	The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by limited-English proficiency (LEP) populations	16i	X	
j	Other (describe in Section C below)	16j		
Billing and Collections				
Name of hospital facility or letter of facility reporting group:		Hospital Authority of Jenkins Cour		
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written FAP that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?		17	Yes
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		18	Yes
a	Reporting to credit agency(ies)	18a		
b	Selling an individual's debt to another party	18b		
c	Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP	18c		
d	Actions that require a legal or judicial process	18d		
e	Other similar actions (describe in Section C)	18e		
f	None of these actions or other similar actions were permitted	18f	X	
19	Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? If "Yes," check all actions in which the hospital facility or a third party engaged:		19	No
a	Reporting to credit agency(ies)	19a		
b	Selling an individual's debt to another party	19b		
c	Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP	19c		
d	Actions that require a legal or judicial process	19d		
e	Other similar actions (describe in Section C)	19e		
20	Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) on line 19 (check all that apply):			
a	Provided a written notice about upcoming extraordinary collection actions (ECAs) and a plain language summary of the FAP at least 30 days before initiating those ECAs (if not, describe in Section C)		20a	
b	Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)		20b	
c	Processed incomplete and complete FAP applications (if not, describe in Section C)		20c	
d	Made presumptive eligibility determinations (if not, describe in Section C)		20d	
e	Other (describe in Section C)		20e	
f	None of these efforts were made		20f	
Policy Relating to Emergency Medical Care				
21	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's FAP? If "No," indicate why:		21	Yes
a	The hospital facility did not provide care for any emergency medical conditions	21a		
b	The hospital facility's policy was not in writing	21b		
c	The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)	21c		
d	Other (describe in Section C)	21d		
Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)				
Name of hospital facility or letter of facility reporting group:		Hospital Authority of Jenkins Count		

22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care:		22	Yes
a	The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period	22a	X	
b	The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period	22b		
c	The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period	22c		
d	The hospital facility used a prospective Medicare or Medicaid method	22d		
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C		23	No
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C		24	No
Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24 in the space provided below. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.				

6a. Focus groups and community meetings were conducted by partnering with the Center for Public Health Practice and Research at the Jiann-Ping Hsu College of Public Health, Georgia Southern University to complete the Community Health Needs Assessment (CHNA) for the hospital's primary service area of Jenkins County.

Note: Cells highlighted in Yellow indicate free text entry.

Cells highlighted in blue indicates a selection from a dropdown list.

Cells highlighted in gray indicate no input is required.

Blue text indicates a formula.

Definitions:

Facility reporting groups - If the organization is able to check the same checkboxes for all Part V, Section B, questions for more than one of its hospital facilities, it may file a single Section B and Section C for all facilities in that facility reporting group. For each of those facilities, the organization would assign and list the facility reporting group letter in the "Facility reporting group" column in Section A. Assign letter A to the facility reporting group with the greatest number of facilities, letter B to the group with the second greatest number of facilities, and so forth. For instance, three hospital facilities with identical answers to the Section B checkboxes would be assigned facility group letter A, while two other hospital facilities with identical answers would be assigned facility group letter B.

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Hospital Authority of Jenkins County
 Hospital Transparency Requirements
 Alternative 990 for Non-reporting Hospitals
 12/31/2024

Schedule I		Grants and Other Assistance to Organizations, Governments, and Individuals In the United States	
	Name of organization	Employer identification number (EIN)	
	Hospital Authority of Jenkins County	58-1158547	
Part I		General Information on Grants and Assistance	
			Yes/No
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
2	Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States.		
Part IV		Supplemental Information. Provide the information required in Part I, line 2; Part III, column (b); and any other additional information in the space provided below.	

Schedule C, Part II-B, 1j: The hospital authority pays membership dues to national and state organizations. A portion of those dues is allocated to lobbying activities in which those organizations participate.

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Cells highlighted in blue indicates a selection from a dropdown list.
Cells highlighted in gray indicate no input is required.
Blue text indicates a formula.

Hospital Authority of Jenkins County
Hospital Transparency Requirements
Alternative 990 for Non-reporting Hospitals
12/31/2024

Schedule I Grants and Other Assistance to Organizations, Governments, and Individuals In the United States

Part II Grants and Other Assistance to Domestic Organizations and Domestic Governments. Complete if the organization answered "Yes" on Form 990, Part IV, line 21, for any recipient that receives

1	(a) Name and address of organization or government	(b) EIN	(c) IRC Section if applicable (ex. 501c3)	(d) Amount of cash grant	(e) Amount of Noncash assistance
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					
(11)					
(12)					

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

			2
			1

t entry.
n a dropdown list.
ired.

Hospital Authority of Jenkins County
 Hospital Transparency Requirements
 Alternative 990 for Non-reporting Hospitals
 12/31/2024

Schedule I		Grants and Other Assistance to Organizations, Governments, and Individuals In the United States			
Part III		Grants and Other Assistance to Domestic Individuals. Complete if the organization answered "Yes" on Form 990, Part IV, line 22. Part III can be duplicated if additional space is needed.			
	(a) Type grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of Noncash assistance	(e) Method of valuation (book, FMV, appraisal, other)
1					
2					
3					
4					
5					
6					
7					

Hospital Authority of Jenkins County
Hospital Transparency Requirements
Alternative 990 for Non-reporting Hospitals
12/31/2024

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Schedule J Compensation Information			
Name of organization		Employer identification number (EIN)	
Hospital Authority of Jenkins County		58-1158547	
Part I Questions Regarding Compensation			
			Yes/No
1a	Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items		
	First-class or charter travel		
	Travel for companions		
	Tax indemnification and gross-up payments		
	Discretionary spending account		
	Housing allowance or residence for personal use		
	Payments for business use of personal residence		
	Health or social club dues or initiation fees		
b	Personal services (such as maid, chauffeur, chef)		
	If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain		1b
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked on line 1a?		2
3	Indicate which, if any, of the following the organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.		
	Compensation committee		
	Independent compensation consultant		
	Form 990 of other organizations		
	Written employment contract		
	Approval by the board or compensation committee		
4	During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization: If "Yes" to any of lines 4a–c, list the persons and provide the applicable amounts for each item in Part III.		
	a	Receive a severance payment or change-of-control payment?	4a No
	b	Participate in or receive payment from a supplemental nonqualified retirement plan?	4b No
	c	Participate in or receive payment from an equity-based compensation arrangement?	4c No
Only section 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5–9.			
5	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of: If "Yes" on line 5a or 5b, describe in Part III.		
	a	The organization?	5a No

b	Any related organization?	5b	No
6	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of: If "Yes" on line 6a or 6b, describe in Part III.		
a	The organization?	6a	No
b	Any related organization?	6b	No
7	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described on lines 5 and 6? If "Yes," describe in Part III	7	No
8	Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III	8	No
9	If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	9	

Part III **Supplemental Information**
Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II in the space provided below. Also complete this part for any additional information.

highlighted in Yellow indicate free text entry.
highlighted in blue indicates a selection from a dropdown list.
highlighted in gray indicate no input is required.
indicates a formula.

Hospital Authority of Jenkins County
Hospital Transparency Requirements
Alternative 990 for Non-reporting Hospitals
12/31/2024

Schedule J Compensation Information
Part II Officers. Use duplicate copies if additional space is needed.

For each individual whose compensation must be reported on Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii)

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

	(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC and/or 1099-NEC compensation			(C) Retirement and other deferred compensation
			(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation	
1	Antoine Poythress	(i)				
	Chief Executive Officer, end 10/11/2024	(ii)	218142	30644		
2	Andrea Graham	(i)				
	Chief Executive Officer	(ii)	77379			
3	Pamela Mixon	(i)				
	Chief Operating Officer	(ii)	60239			
4	Monica Johnson	(i)				
	Chief Nursing Officer	(ii)	96580			
5		(i)				
		(ii)				
6		(i)				
		(ii)				
7		(i)				
		(ii)				
8		(i)				
		(ii)				
9		(i)				
		(ii)				
10		(i)				
		(ii)				
11		(i)				
		(ii)				
12		(i)				
		(ii)				
13		(i)				
		(ii)				
14		(i)				
		(ii)				
15		(i)				
		(ii)				

16		(i)				
		(ii)				

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ding), a person elected or appointed to manage the organization's daily operations at any
ome cases, Board Chair. The officers of an organization are determined by reference to its
ited consistent with state law, but at a minimum include those officers required by
fficial and top financial official as officers.

ensation for the listed person under any retirement or other deferred compensation plan,
e organization or a related organization. Report as deferred compensation the annual
rnings or losses accrued on deferred defined contribution plan. Enter a reasonable

rnue Code.

Hospital Authority of Jenkins County
Hospital Transparency Requirements
Alternative 990 for Non-reporting Hospitals
12/31/2024

Schedule J Compensation Information
Part II Directors & Trustees. Use duplicate copies if additional space is needed.

For each individual whose compensation must be reported on Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii)

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

	(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC and/or 1099-NEC compensation			(C) Retirement and other deferred compensation
			(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation	
1		(i)				
		(ii)				
2		(i)				
		(ii)				
3		(i)				
		(ii)				
4		(i)				
		(ii)				
5		(i)				
		(ii)				
6		(i)				
		(ii)				
7		(i)				
		(ii)				
8		(i)				
		(ii)				
9		(i)				
		(ii)				
10		(i)				
		(ii)				
11		(i)				
		(ii)				
12		(i)				
		(ii)				
13		(i)				
		(ii)				
14		(i)				
		(ii)				
15		(i)				
		(ii)				

16		(i)				
		(ii)				

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ing body at any time during the tax year, but only if the member has any voting rights. A
anization isn't considered a director or trustee.

ensation for the listed person under any retirement or other deferred compensation plan,
e organization or a related organization. Report as deferred compensation the annual
rnings or losses accrued on deferred
ilable.

anue Code.

Hospital Authority of Jenkins County
Hospital Transparency Requirements
Alternative 990 for Non-reporting Hospitals
12/31/2024

Schedule J Compensation Information
Part II Key Employees. Use duplicate copies if additional space is needed.

For each individual whose compensation must be reported on Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii)

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

	(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC and/or 1099-NEC compensation			(C) Retirement and other deferred compensation
			(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation	
1		(i)				
		(ii)				
2		(i)				
		(ii)				
3		(i)				
		(ii)				
4		(i)				
		(ii)				
5		(i)				
		(ii)				
6		(i)				
		(ii)				
7		(i)				
		(ii)				
8		(i)				
		(ii)				
9		(i)				
		(ii)				
10		(i)				
		(ii)				
11		(i)				
		(ii)				
12		(i)				
		(ii)				
13		(i)				
		(ii)				
14		(i)				
		(ii)				
15		(i)				
		(ii)				

16		(i)				
		(ii)				
17		(i)				
		(ii)				
18		(i)				
		(ii)				
19		(i)				
		(ii)				
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than an officer, director, or trustee) who meets all three of

ation and all related organizations in excess of \$150,000 for

ation as a whole similar to those of officers, directors, or
n that represents 10% or more of the activities, assets,
e organization as a whole; or
ore of the organization's capital expenditures, operating

est and Responsibility Test) with the highest reportable
alendar year ending with or within the organization's tax
compensation for the listed person under any retirement or
red, sponsored, or maintained by or for the organization or a
ase in actuarial value, if any, of a defined benefit plan, but
a reasonable estimate if actual numbers aren't readily

al Revenue Code.

Hospital Authority of Jenkins County
Hospital Transparency Requirements
Alternative 990 for Non-reporting Hospitals
12/31/2024

Schedule J Compensation Information
Part II Highest Compensated Employees. Use duplicate copies if additional space is needed.

For each individual whose compensation must be reported on Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii)

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

	(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC and/or 1099-NEC compensation			(C) Retirement and other deferred compensation
			(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation	
1	Haley Anderson	(i)				
	Pharmacist	(ii)	123620			
2		(i)				
		(ii)				
3		(i)				
		(ii)				
4		(i)				
		(ii)				
5		(i)				
		(ii)				
6		(i)				
		(ii)				
7		(i)				
		(ii)				
8		(i)				
		(ii)				
9		(i)				
		(ii)				
10		(i)				
		(ii)				
11		(i)				
		(ii)				
12		(i)				
		(ii)				
13		(i)				
		(ii)				
14		(i)				
		(ii)				
15		(i)				
		(ii)				

16		(i)				
		(ii)				

	\$	-	
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Organization (including employees of a disregarded entity of the organization), other than
the organization and related organizations is greater than \$100,000 for the

Organization for the listed person under any retirement or other deferred compensation plan,
the organization or a related organization. Report as deferred compensation the annual
earnings or losses accrued on deferred
annuities.

Revenue Code.

Hospital Authority of Jenkins County
 Hospital Transparency Requirements
 Alternative 990 for Non-reporting Hospitals
 12/31/2024

Schedule R	Related Organization and Unrelated Partnerships	
	Name of organization Hospital Authority of Jenkins County	Employer identification number (EIN) 58-1158547

Part I Identification of Disregarded Entities. Complete if the organization answered "Yes" on Form 990, Part IV, line 33.					
	(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

Note: Cells highlighted in Yellow indicate free text entry.
Cells highlighted in blue indicates a selection from a dropdown list.
Cells highlighted in gray indicate no input is required.
Blue text indicates a formula.

IN)
(f) Direct controlling entity

Hospital Authority of Jenkins County
 Hospital Transparency Requirements
 Alternative 990 for Non-reporting Hospitals
 12/31/2024

Schedule R **Related Organization and Unrelated Partnerships**
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))
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					

Hospital Authority of Jenkins County
 Hospital Transparency Requirements
 Alternative 990 for Non-reporting Hospitals
 12/31/2024

Schedule R		Related Organization and Unrelated Partnerships			
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			
	(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)
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					

highlighted in Yellow indicate free text entry.
highlighted in blue indicates a selection from a dropdown list.
highlighted in gray indicate no input is required.
indicates a formula.

**Hospital Authority of Jenkins County
Hospital Transparency Requirements
Alternative 990 for Non-reporting Hospitals
12/31/2024**

Schedule R		Related Organization and Unrelated Partnerships			
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)
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					

y.
opdown list.

Hospital Authority of Jenkins County
Hospital Transparency Requirements
Alternative 990 for Non-reporting Hospitals
12/31/2024

Schedule R		Related Organization and Unrelated Partnerships	
Part V		Transactions With Related Organizations. Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35b, or 36	
Note: Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule.			Yes/No
1	During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II–IV?		
a	Receipt of (i) interest, (ii) annuities, (iii) royalties or (iv) rent from a controlled entity?	1a	No
b	Gift, grant or capital contribution to related organizations?	1b	No
c	Gift, grant or capital contribution from related organizations?	1c	No
d	Loans or loan guarantees to or for related organizations?	1d	No
e	Loans or loan guarantees by related organizations?	1e	No
f	Dividends from related organizations?	1f	No
g	Sale of assets to related organizations?	1g	No
h	Purchase of assets from related organizations?	1h	No
i	Exchange of assets?	1i	No
j	Lease of facilities, equipment or other assets to related organizations?	1j	No
k	Lease of facilities, equipment or other assets from related organizations?	1k	No
l	Performance of services or membership or fundraising solicitations for related organizations?	1l	No
m	Performance of services or membership or fundraising solicitations by related organizations?	1m	No
n	Sharing of facilities, equipment, mailing lists or other assets?	1n	No
o	Sharing of paid employees?	1o	No
p	Reimbursement paid to related organizations for expenses?	1p	No
q	Reimbursement paid by related organizations for expenses?	1q	No
r	Other transfer of cash or property to related organizations?	1r	No
s	Other transfer of cash or property from related organizations?	1s	No
2	If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction thresholds		
	(a) Name of related controlled organization	(b) Transaction type (a-s)	(c) Amount involved
1			(d) Method of determining amount involved
2			
3			
4			
5			
6			

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Hospital Authority of Jenkins County
Hospital Transparency Requirements
Alternative 990 for Non-reporting Hospitals
12/31/2024

Schedule R Related Organization and Unrelated Partnerships

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 asset):

	(a) Name, address, and EIN of entity	(b) Primary Activity	(c) Legal Domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(e) Are all partners section 501c)(3) organizations?
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					

12				
13				
14				
15				
16				

Part VII **Supplemental Information** Provide additional information for responses to questions on Schedule R in the space provided below. See instructions.

cate free text entry.
selection from a dropdown list.
input is required.

Yes
No
N/A

Alabama
Alaska
Arizona
Arkansas
California
Colorado
Connecticut
Delaware
Florida
Georgia
Hawaii
Idaho
Illinois
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
Minnesota
Mississippi
Missouri
Montana
Nebraska
Nevada
New Hampshire
New Jersey
New Mexico
New York
North Carolina
North Dakota
Ohio
Oklahoma
Oregon
Pennsylvania
Rhode Island
South Carolina
South Dakota
Tennessee
Texas
Utah

X

A
B
C
D
E
F
G
H
I
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S
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U
V
W
X
Y
Z

Vermont
Virginia
Washington
West Virginia
Wisconsin
Wyoming
American Samoa
Guam
Northern Mariana Islands
Puerto Rico
US Virgin Islands