GEORGE E. WEEMS MEMORIAL HOSPITAL
GOVERING BODY MINUTES

May 31, 2006

Board members present: Dr. Steven Miniat, Gayle Dodds, Curt Blair and Tammy Hardy. Absent: Shirley White

Staff Members present: Suzanne Osburn, Ron Wolff, Interim CEO, and Mr. Biederman.

The meeting was called to order at 5:30 PM by Gayle Dodds, Chairperson.

Approval of minutes for the Board meeting held on April 24, 2006. Motion to approve was made by Gayle Dodds and seconded by Dr Steven Miniat. Motion carried unanimously.

Old Business
Motion to accept succession plan was made by Mr. Curt Blair and seconded by Dr Steven Miniat. Motion carried unanimously.

New Business
Report on County Commission meeting made by Ron Wolff, and Mr. Biederman. It was reported that Sacred Heart, Bay Medical Center and TMH all has representatives present at the County's afternoon workshop and none submitted any meaningful proposals that would have helped Weems' situation. At the regular meeting held that same evening, the County approved executing a management agreement with Blackhawk retroactive to January 1st. A copy will be presented to each board member at the next meeting. Both gave reports on the current status of the GE dispute and its impact on timely billing for patient care services. Mr. Biederman spoke about plans to recruit a replacement CEO when Mr. Wolff's assignment ends later this summer.

A clinical operations report was submitted by Dr Steven Miniat. Copy attached. He reports no trouble with ER coverage and was very happy with the turnaround time on the new teleradiology service within the ER. The Sleep Lab is moving forward very rapidly. The designated sleep lab room has been painted and redecorated and a remote camera has been installed to monitor patients during the studies. He also reported that the new computer program in the ER will enable the physicians to improve coding for billing purposes, access web sites for professional purposes, write scripts legibly and print individualized discharge instructions for ER patients,

Mr. Wolff reported that marketing efforts for our swing bed program are under way with Medicare program for reimbursement. Letters were sent out to many physicians and outlying hospital explaining the program and criteria for patients to qualify for placement.

Mr. Biederman spoke about physician recruitment and Dr Mangal's interest in setting up a new office in Franklin County. Mr. Wolff said the Dr. Mangal is requesting active appointment for medical staff status.

Curt Blair highlighted his interest in seeing a full disclosure of the hospital's financials as stipulated in the management agreement. Mssrs. Biederman and Wolff indicated that reports of operations and income due to the county would be available in the June, meeting. Mr. Wolff commented that a truly accurate financial statement would depend heavily on the ultimate resolution of the billing issues and consolidation of the hospital's financial administration in a new IT system. He committed that Board members will receive month to month reports on admissions and activity levels in the hospital.

The need for a new contract with Dairyland was discussed for the year 2007 as they will no longer support the current outdated system. Discussion was held regarding the 2005 Medicare cost report which could only be filed by Dassee as all necessary information is in their records. Mr. Wolff reported that GE paid a CPA to gather dates and information to prepare the report, but only nine months data was available. The remaining three months data can be submitted by an amendment.

A Ship program grant was filed for a new building for Medical records. Cleaning out the barn of trash and cleaning up surgery unit. Discussions ensued about the proposed tax referendum and a possible new hospital. Mr. Biederman discussed his favorable impressions of the East Point site for a new building.

The board then entered into Executive session for confidential peer review matters.

Minute's approved_____ Date _____

GEORGE E. WEEMS MEMORIAL HOSPITAL
GOVERING BODY MINUTES

Executive Session
May 31, 2006

This document contains confidential peer review data and is not subject to disclosure under the Florida Open Records Act.

Dr Steven Miniat explained Dr. Vincent Ivers' request for endoscopic and admitting privileges at Weems Memorial. He praised Dr. Ivers training and experience indicating that his requests were unanimously approved by the medical staff. He moved for Dr Ivers to have full endoscopic and admitting privileges, Mr. Curt Blair seconded the motion. Motion carried unanimously.

There being no further business, the meeting was adjourned at 7:30 PM.

Minute's approved_____ Date _____

Governing Body
HOSPITAL AND CLINICAL SERVICES UPDATE
Stephen Miniat M.D.

1. ER Coverage

A. No problems with temporary staffing – coverage provided by Drs. Miniat, Pierce, Mangal & Ivers. In-week staffing is provided by two Nurse practitioners with both on-site and off-site supervision. Hospital covers almost all docs with a low cost malpractice policy.

B. Still looking into formation of a local group to provide permanent coverage.

2. Teleradiology Service New radiology overreading service implemented on May 1st includes an electronic storage system for films. Plain films are "electronically digitized" on a special scanner and transmitted to an off-site group of radiologists who can read and interpret them on their computer consoles. The new service will provide faster turnaround on reports as under the old system, all films had to be couriered to Panama City and reports were often delayed up to 3-4 days.

3. Sleep Lab Plans to open a new sleep lab service are well underway. The hospital has placed an order for new state-of-the-art BioLogics sleep study equipment which is more advanced than that currently used by the tertiary care hospitals in Panama City and Tallahassee. It is estimated that up to 7-8 patients per month can be referred to the new service. The BioLogics staff will train the Hospital staff on-site saving travel expenses for off-site training in Atlanta. The service will be primarily supported by the Hospital's Respiratory Therapy staff who very qualified to support the program. Studies will be monitored from the nursing station allowing back-up by the night nurses on duty.

4. ER Physician Computer Restored The Express/Logic computer program once provided by Nature Coast Physicians that was removed when their services were terminated has now been restored by the Hospital. The new system was installed on a high-speed computer and permits the ER physicians and ARNPs to write individualized prescriptions on a printer to assure legibility, print discharge instructions and code services for billing purposes.

5. Swing Beds Because of its remote distance from Panama City and Tallahassee, Weems does not generate a significant number of swing bed referrals from those two cities. The Hospital has now prepared a brochure for distribution to the large hospitals in those areas, plus a criteria checklist to simplify the referral procedure for their discharge planners. I have agreed to accept admissions for swing bed patients who meet criteria.

6. New Physical Therapist Engaged To augment services required to support the swing bed program, the Hospital has contracted with Kyle Griffin RPT, an experienced Physical Therapist with roots in the Apalachicola area, to perform patient evaluations and monitor rehabilitation services provided under the program.

GEORGE E. WEEMS MEMORIAL HOSPITAL
GOVERNING BODY SUCCESSION PLAN

(Proposed Plan)

	3/1/06	3/1/07	3/1/08	3/1/09	3/1/10
Seat 1 (G. Dodds)	Term 1 ----------			Term 2 ----------	
Seat 2 (S. White)	Term 1 ----------			Term 2 ----------	
Seat 3 (Dr. Miniat)	Term 1 ----------		Term 2 ----------		
Seat 4 (T. Hardy)	Term 1 ----------		Term 2 ----------		
Seat 5 (C. Blair)	Term 1 ---------	Term 2 ----------			Term 2

George E. Weems Memorial Hospital
Statements of Revenues, Expenses, and Changes in Net Assets
May 31, 2006

Operating Revenues	
Patient Service Revenue	3,578,988
Less: Contractual Adjustments	(988,245)
Net Patient Service Revenues	2,590,743
Other Operating Revenues	-
Total Operating Revenues	2,590,743
Operating Expenses	
Salaries and Wages	1,094,417
Employee Benefits	80,407
Professional Fees and Purchased Services	530,388 → Staff
Supplies and Other	426,026
Depreciation Expense	5,297
Bad Debt Expense	685,000
Total Operating Expenses	2,821,536
Operating Income (Loss)	(230,792)
Non-operating Revenue and Expenses	
Interest Expense	(393)
Interest Income	311
Grant Income	111,709
Miscellaneous Income	6,094
Total Non-operating Revenue and Expense	117,721
Excess of Expenses over Revenues	(113,071)
Statement of Changes in Net Assets	
Excess of Revenue over Expenses	(113,071)
Net Assets Beginning of the Year	51,755
Net Assets Current	(61,316)

This only represents expenses reported as paid on behal of the hospital by the County through May 31, 2006.

Other items may include Worker's Compensation, legal fees, and etc.

The payroll expense above includes the entire first payroll paid in January of 2006. A portion of this payroll was for December of 2005.

George E. Weems Memorial Hospital
Balance sheet
May 31, 2006

Assets

CURRENT ASSETS	
Cash and Cash Equivalents	502,225
Patient Accounts Receivable, Net of Allowances	1,551,079
Estimated Third-Party Payor Settlements	
Inventory	51,755
Prepaid Expenses and Other Current Assets	20,600
Total Current Assets	2,125,659
CAPITAL ASSETS	
Net of Accumulated Depreciation	121,832
Total Assets	2,247,491

Liabilities and Net Assets

CURRENT LIABILITIES	
Accounts Payable	193,694
Accrued Salaries, Benefits, and Payroll Liabilities	223,506
Other Accrued Liabilities	146,533
Due to Franklin County	1,745,073
Total Current Liabilities	2,308,807
NET ASSETS	(61,316)
Total Liabilities and Net Assets	2,247,491

Weems Memorial Hospital
Accounts Receivable
05/30/06

Hospital	U/R	0-30	31-60	61-90	91-120	121-150	151+	Total
Medicare Inpatient	5,432.00	73,824.96	144,471.22	103,795.08	133,256.78	89,441.00	-	550,221.04
Medicare Outpatient	-	173,125.33	164,313.57	115,482.83	111,287.00	107,626.00	-	671,834.73
Medicare Observation	-	6,394.00	2,525.00	3,443.00	6,097.00	2,679.00	-	21,138.00
Medicare Swing Bed	-	12,928.00	33,590.12	31,184.00	24,572.30	71,432.30	-	173,706.72
Blue Cross Inpatient	-	39,139.32	4,900.00	31,962.49	14,579.30	21,809.15	-	112,390.26
Blue Cross Outpatient	-	127,261.66	78,136.00	101,628.00	79,097.00	64,871.78	-	450,994.44
Employee Self Pay	-	-	-	-	-	-	-	-
Self Pay	-5654.92	191,808.61	142,357.36	153,294.06	152,014.57	118,909.58	2,407.00	755,136.26
Medicare/Self Pay	-	-		577.00	-	-	-	577.00
Workman's Comp	-	6,883.00	2,615.00	2,541.00	1,901.00	455.00	-	14,395.00
Commercial Inpatient	-	6,915.00	12,668.00	20,202.00	-	-	-	39,785.00
Commercial Outpatient	-	55,440.00	40,381.00	37,281.00	23,371.00	19,451.50	-	175,924.50
Medicaid Inpatient	-	12,806.00	12,817.90	11,969.00	27,524.00	7,282.00	-	72,398.90
Medicaid Outpatient	-	90,296.00	76,735.00	86,451.00	89,781.33	89,925.50	-	433,188.83
Medicaid HMO	-	5,677.00	1,087.00	3,795.00	3,910.00	2,919.00	-	17,388.00
Collection	-							-
Total	(222.92)	802,498.88	716,597.17	703,605.46	667,391.28	596,801.81	2,407.00	3,489,078.68

1,935,000
55% This is very conservative

Estimated Net Collection	1,554,078.69
Estimated State collection fees (approx 6.5%)	101,015.11
Round to	$ 125,000

Because the Allowances are conservative
This causes the collection expense to be low

10 Percent Self Pay Payments

GEORGE E WEEMS MEM HOSPITAL
CENSUS STATISTICAL REPORT
FOR FISCAL YEAR BEGINNING : 01/01/06
CENSUS FOR DATE : 05/31/06

`TL LOCATIONS

INPATIENTS REPORT

DRG CLS PER PATIENT TYPE	PATIENT DAYS TODAY	PATIENT DAYS MTD	PATIENT DAYS YTD	ADMISSIONS TODAY	ADMISSIONS MTD	ADMISSIONS YTD	DISCHARGES TODAY	DISCHARGES MTD	DISCHARGES YTD	DISCHARGE DAYS TODAY	DISCHARGE DAYS MTD	DISCHARGE DAYS YTD	ALOS DAYS TODAY	ALOS DAYS MTD	ALOS DAYS YTD
TOTAL (01) INPATIENT	1	61	390	0	32	159	1	32	162	3	60	400	3.0	1.9	2.5
TOTAL (02) SWING BED	0	13	197	0	1	16	0	1	16	0	13	197	.0	13.0	12.3
TOTAL INPATIENTS	1	74	587	0	33	175	1	33	178	3	73	597	3.0	2.2	3.4

GEORGE E WEEMS MEM HOSPITAL
CENSUS STATISTICAL REPORT
FOR FISCAL YEAR BEGINNING : 01/01/06
CENSUS FOR DATE : 05/31/06

*L LOCATIONS

OUTPATIENTS REPORT

DRG CLS PER PATIENT TYPE	ADMISSIONS TODAY	ADMISSIONS MTD	ADMISSIONS YTD	DISCHARGES TODAY	DISCHARGES MTD	DISCHARGES YTD
TOTAL (10) OP	17	370	1923	17	369	1921
TOTAL (11) ER	21	624	2915	21	625	2916
TOTAL (17) OBSERV	0	11	31	1	11	31
TOTAL OUTPATIENTS	38	1005	4869	39	1005	4868

Special Report » *Cinda Becker*

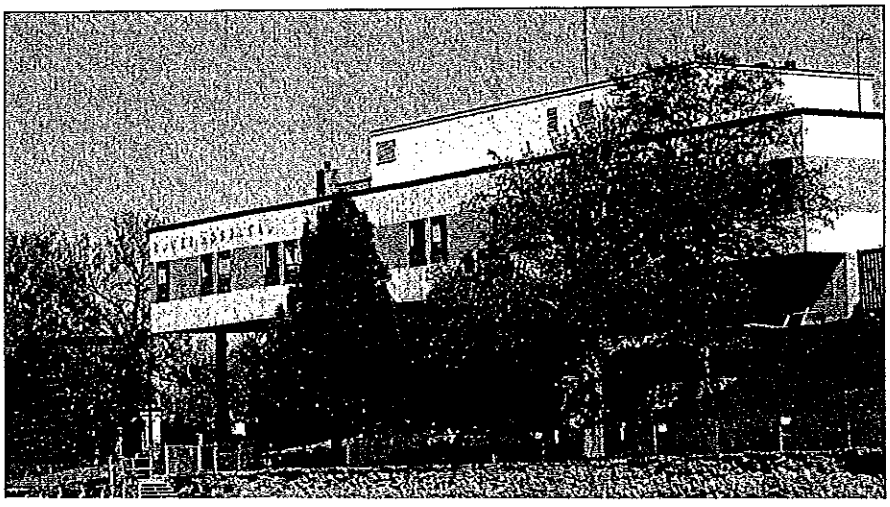
CRITICAL CONDITIONS

The number of critical-access hospitals has surged, but the program hasn't always been a financial lifesaver

After years of operating losses and an average daily census of one, E.J. Noble Hospital on the New York side of the St. Lawrence River was withering away.

By 2003, its parent, Samaritan Medical Center in Watertown, N.Y., had already discontinued acute-care services. With nearly all the medical equipment and information systems removed, there were only 15 patients left in the nursing home, "managed on an Excel spreadsheet," says Michael McLean, a consultant to the community at the time and now president and chief executive officer of what has been renamed River Hospital.

Fortunes changed only after an anonymous local benefactor and a persuasive board chairwoman, Nellie Taylor, who fired up the sparsely populated rural community, grabbed for a lifeline that promised to keep the facility above water at least in terms of caring for Medicare patients. Federal designation as a critical-access hospital in a remote region in dire need of healthcare services freed the hospital from the burden of operating under the market-driven prospective payment system in favor of cost-based payments that guaranteed that the hospital would recover its expenses, regardless of patient volume.



River Hospital, Alexandria Bay, N.Y., is one of 13 critical-access hospitals in the state and 1,279 throughout the country that are seemingly flourishing, perhaps at the expense of other less-advantaged hospitals struggling to compete under the constraints of Medicare's PPS. The explosive growth of the critical-access program, which was created by the Balanced Budget Act of 1997, raises a host of questions about the inherent fairness of a one-size-fits-all Medicare payment system as well as government policy toward the country cousins of the nation's hospitals.

"If you have 20% to 25% of hospitals and some others outside the system getting paid based on cost, maybe you need to rethink the payment system," says Nancy-Ann DeParle, former administrator of the CMS' predecessor agency HCFA, a senior adviser to JPMorgan Partners and a member of the Medicare Payment Advisory Commission. Debates over critical-access facilities as well as specialty and long-term acute-care hospitals "leave me with the question: Does it indicate a fundamental restructuring of our (payment) system is needed? It seems a lot of activity of the PPS doesn't adequately capture what is needed to pay for certain types of hospitals, and that number keeps growing," DeParle says.

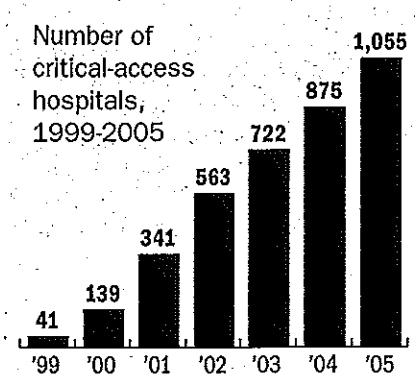
With River Hospital's sustainability still in question, it remains unclear whether the critical-access program in general represents waste-

ful life support for hopelessly dying hospitals or a life-saving jolt of adrenaline for worthy facilities lying in underserved areas.

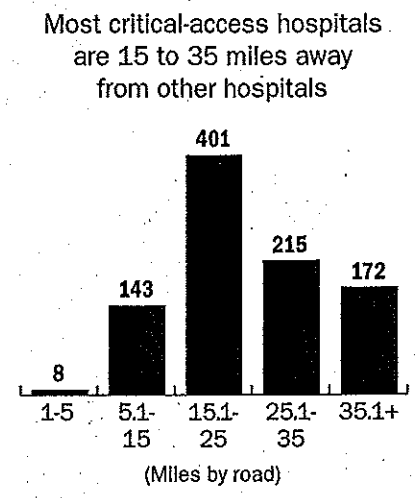
Thanks primarily to the largesse of state governors, who had no incentive for restraining the growth of the critical-access program and often waived the distance requirement for some facilities, critical-access hospitals now represent 22% of the nation's hospitals. In a June 2005 report to Congress, MedPAC observed that a few of them lie in questionably rural areas and sometimes in uncomfortably close proximity to competing hospitals operating under the efficiency-demanding constraints of the PPS.

Cost-based, efficiency-indifferent payments to these small rural hospitals, which by definition top out at 25 beds, will total about $5 billion in 2006, about $1.3 billion more than if they had remained under PPS, according to MedPAC. Because of the states' liberal use of the "necessary provider" waiver, only 18% of the critical-access hospitals are more than the required 35 miles from other providers. In 2003, approximately 17% of cost-based Medicare payments went to critical-access hospitals that were 15 miles or fewer from another hospital, raising an issue about competition between critical-access hospitals and facilities operating under PPS. The program swelled from 41 hospitals on Jan. 1, 1999, to 1,055 hospitals on Jan. 1, 2005, according to MedPAC (See chart, right).

HOW MANY?



HOW CLOSE?



Note: Based on 939 critical-access hospitals that were operating in fall 2004.

Source: Medicare Payment Advisory Commission

Critical-access hospitals up close

Though explosive in growth by numbers, a more microscopic look at the nation's stock of critical-access hospitals changes the picture. In total, critical-access hospitals supply about 29,000 of the nation's 956,000 beds, or 3%, says Rebecca Slifkin, director of the North Carolina Rural Health Research and Policy Analysis Center and senior research fellow at the Cecil G. Sheps Center for Health Services Research. Even that percentage overstates the situation because bed counts for critical-access hospitals include "swing beds," which often accommodate post-acute patients. Furthermore, the amount of Medicare money siphoned to these hospitals is a tiny fraction of what is spent on the entire Medicare program, she says. In 2002, Medicare spent $94 billion on beneficiaries discharged from hospitals, and in 2004, inpatient payments to critical-access hospitals that filed cost reports totaled $1 billion—about 1.1% of all Medicare payments for inpatient care.

"The revenues of these places are a pimple on the total hospital spending," Slifkin says. Although the numbers are not exactly comparable, "What is abundantly clear is that the order of magnitude is ridiculously small, considering all the attention this program has gotten, and all the good it has done in terms of preserving access for rural people."

DeParle notes that during discussion of the critical-access program's explosive growth, MedPAC member Ray Stowers "argued very compellingly" that the numbers were misleading in terms of dollars. And no one believed it was a case where critical-access hospitals were gaming or abusing the system to unnecessarily fatten their profit margins, she says. "It's certainly not where most of Medicare spending is going," she says.

Under the 1997 Balanced Budget Act, critical-access hospitals initially had to be at least 15 miles via secondary roads and 35 miles via primary roads from the nearest hospital or be declared a "necessary provider" by the state. The Medicare Modernization Act of 2003 reduced some restrictions but eliminated the "necessary provider" waiver, effective Jan. 1. States have set the criteria so that most (and in some cases all) of their small rural hospitals are declared necessary providers," according to MedPAC's 2005 report to Congress. However, most policymakers, including MedPAC, agree that the program has probably reached its limits after "a flurry of (conversion) activity among hospitals" before the Jan. 1 deadline.

"I suspect there will be very few additional conversions because at this point there are probably not any small rural hospitals left that will meet the mileage and would find it financially beneficial because if they would, they would have already converted," Slifkin says. Similarly, MedPAC predicted "the (critical-access hospital) program will essentially cease to add additional hospitals at the start of 2006."

"We have a theory that when certain parts of Medicare start to grow too fast—we call it the 'whackability theory'—the government will whack it," says Steven Warden, executive vice president of CIT Healthcare, a New York-based finance company. "It just doesn't appear that this is growing too fast. ... It appears to be accomplishing their objective without leading to reimbursement exploitation. It passes the smell test, if you will."

Measuring the program's impact

Under the criteria, critical-access hospitals are now limited to 25 inpatients beds, counting post-acute "swing beds." Length-of-stay for all patients is limited to an average of four days. Hospitals meeting the criteria now are reimbursed at 101% of costs.

As part of its 2005 report to Congress, MedPAC studied the financial impact of conversion on a set of 498 critical-access hospitals compared with 551 rural hospitals that operated under PPS from 1999 to 2003. In total, hospitals that converted reported more than $3 million each in cost-based Medicare payments in 2003, when critical-access hospitals received 100% of costs—a net of $850,000 more per hospital than critical-access hospitals would have received if payments had risen in line with the comparison hospitals, according to MedPAC. Most of the $850,000 was accounted for by the increased payments rather than increases in volume. For 2006, MedPAC projects that the net difference between critical-access payment rates and PPS payment rates will grow to $1 million per critical-access hospital.

The program "successfully helped low-volume hospitals remain financially viable," nearly halting closures among the group, MedPAC concludes. But the commission found it "troubling" that cost-based payment might "distort the financial incentives" to close services and control costs and give an unfair advantage over nearby competitors operating under PPS. In addition, MedPAC notes in its report that some

equipment. A teleradiology system was implemented for remote viewing of images and public kiosks were installed throughout the facility so visitors can access the Internet at no charge.

The hospital expanded its staff from 100 to 160 employees, in part by bringing on the physical fitness and therapy employees who had previously been outsourced, and also enhanced employee benefits. The result has been a "tremendous increase in inpatient and outpatient utilization," Hill says. "Part of that is due to additional physicians coming to the area, but the majority of the increase in admissions is because of changes we have made and the additional services we offer." The community's new comfort level with the hospital is evidenced by a higher acuity of patients in the ER; the hospital is now partnering with the University of Illinois at Chicago College of Medicine, further increasing its prestige, Hill boasts.

In 1999, Galena-Stauss lost $40,000 on operating revenue of $4.2 million; in 2005, the hospital earned $259,000 on total operating revenue of $8.2 million, according to Hill.

Hall says it is not surprising that it may have taken the capital markets several years to get used to the idea of critical-access hospitals just like it took six or seven years for the same markets to understand cost-based reimbursement during the early years of the Medicare program from 1965 to 1982. "A number of investment banking firms have identified this as a special focus and established funds and partnerships to accumulate a portfolio for these kinds of financing options," he says.

Anticipating greater demand to feed capital to the critical-access market, Citigroup in 2004 began investigating how to "efficiently provide capital," says Lisa Conley, a director in the healthcare finance group for the investment banking firm. But the firm has underwritten only one critical-access hospital, Okeene (Okla.) Municipal Hospital, a $7.8 million bond issued at a 7% yield to finance a renovation and addition. Conley says few critical-access hospitals are rated because of the time and expense for such small amounts of borrowing, but the relatively high yields are nevertheless attractive to investors who are "starting to get educated about the benefits of critical-access hospitals."

But the hospitals, like investors, also must change their mindset. "We found less demand than anticipated," Conley says. "I think it's just that they've been capital starved for so long, that the management of these organizations doesn't think strategically. ... I think it is going to take a while."

Conrad Flowers, president and CEO of Riverside Medical Center, a critical-access hospital in Franklinton, La., says he will not consider approaching the capital market in the next 12 months even though the hospital is now enjoying a 4.1% profit margin after years of poor financial performance before the hospital converted in 2004. At the time, Riverside reduced its number of beds from 49 to 25 to qualify and got a "necessary provider" exception from the state. In 2003, Riverside posted net income of $132,000 on $15.5 million in revenue. The following year, it earned $667,000 on $16.6 million and in 2005, Flowers says the hospital anticipates it will have "an excess" of $642,000.

Reaching those margins has been a struggle, Flowers says. Under PPS, "the expense side was not the problem; the revenue side was the problem in the equation in that reimbursement from Medicare was not commensurate with the expenses involved," Flowers says. Given "the procedures that rural hospitals do, it seemed like we were on the disproportionate end of the lower-paying procedures."

Critical-access hospitals that converted later appear to be in better financial shape than those that converted earlier, according to a report by the Flex Monitoring Team. From 2001 to 2004, about 42% of all critical-access hospitals pursued a capital loan, with 88% of those hospitals successful, resulting in more than $400 million to support approximately 227 projects. Conservatively, the Flex researchers estimate that critical-access hospitals collectively need $1.6 billion in capital. "The magnitude of these potential needs coupled with the small proportion of (critical-access hospitals) actively accessing capital markets suggests their struggle to keep pace with depreciation as well as other important operational needs is likely to remain problematic for the near future," according to the report.

Flowers: A "necessary provider" exception has boosted income.

Meanwhile, since River Hospital's rebirth on April 15, 2003, revenue has grown from $5 million to what will probably be $14 million in 2005 while margins have been close to break-even and slightly positive in 2004, says CEO McLean. But River's battle is far from over. The benefactor continues to lend much needed financial support, and the hospital still has limited access to capital to build up services.

"Samaritan believed it owned the assets of the hospitals. ... We had to finance the startup out of operations," McLean says. "When I first started shopping for capital, the banks just laughed at me."

The crisis at River occurred under a former management, says Krista Kittle, a Samaritan spokeswoman. "I think the management at the time did underestimate the commitment by the community to support the facility and its services," Kittle says. "We're working on improving the relationship. ... We commend River for its continued effort. It's a challenge." «

What do you think? Write us with your comments. Via e-mail, it's mhletters@crain.com; by fax, dial 312-280-3183.

no enough members present - met 5/31/06

GEORGE E. WEEMS MEMORIAL HOSPITAL
GOVERNING BODY MEETING
MAY 24, 2006

AGENDA

Open Session

1. Call to Order – Chairperson Gayle Dodds

2. Review and approval of minutes of April Board meeting and special meeting held on _____

3. Old Business:
   - A. Review and approval of Succession Plan – G. Dodds & R. Wolff
   - B. Report on County Commission meetings – G. Dodds & C. Blair

4. Hospital and Clinical services update – Dr. Miniat
   - A. ER Coverage
   - B. New Radiology reading service implemented 5/1/06
   - C. Plans to initiate new Sleep Lab service
   - D. Installation of new computerized ER physician coding & prescription writing system
   - E. Marketing program to increase swing bed utilization

5. Nursing Update – P. Kelly R.N.

6. Administrative update - R. Wolff

7. New Business:
   - A. Action on Dassee/GE lawsuit – R. Wolff
   - B. Review of new Blackhawk Management Agreement – R. Wolff
   - C. Proposal for new Medical Record Department building – G. Evans
   - D. Plans to reopen surgery services – R. Wolff & G. Evans
   - E. Safety complaints from AHCA & OSHA – G. Evans

8. Other Business

Executive Session

Medical Staff Credentialing Activities
- A. Dr. V. Ivers – changes in privileges
- B. Credentialing of new radiologists

GEORGE E. WEEMS MEMORAL HOSPITAL
GOVERNING BODY MEETING
MAY 31, 2006

AGENDA

Open Session

1. Call To Order – Chairperson Gayle Dodds

2. Review and approval of minutes of April 4th & April 12th meetings

3. Old Business:
   A. Review and approval of succession plan- G Dodds & R. Wolff
   B. Report on County Commission meetings – G. Dodds & C. Blair

4. New Business:
   A. Clinical operations report – Dr Miniat
   B. Marketing program to increase swing bed utilization – R. Wolff

5. Administrative Update – T. Biederman & R. Wolff
   A. Management Agreement
   B. CEO
   C. Action on Dassee/ GE lawsuit
   D. Cost Report
   E. Exemption from OSHA
   F. New Medical Records project
   G. Plans to reopen surgery services

6. Board Education – Article on Critical Access Hospitals

7. Other Business

Executive Session

Medical Staff Credentialing Activities
   A. Dr. V. Ivers – changes in privileges
   B. Credentialing of new radiologist