HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

Lloyd R. Johnson

LLOYD R. JOHNSON

In First Person: An Oral History

Lewis E. Weeks
Editor

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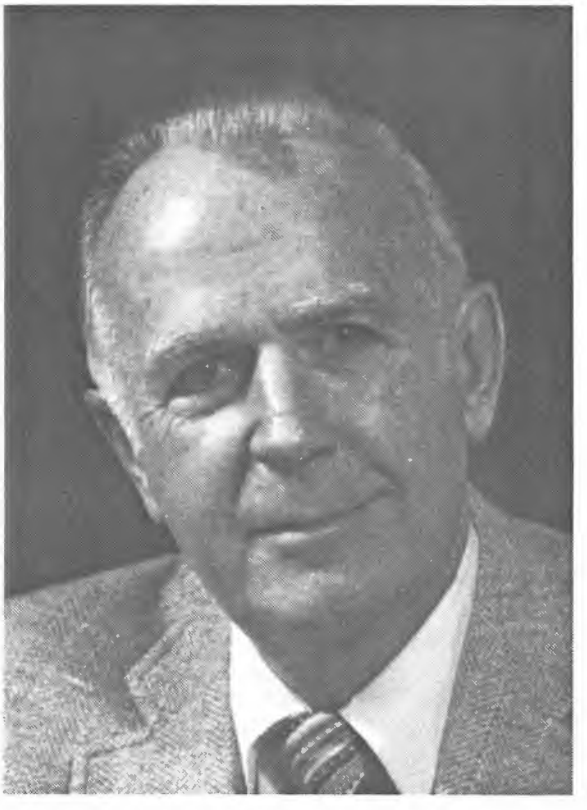

Lloyd R. Johnson

CHRONOLOGY

1922	Born in Highland Park, Michigan, April 5
1940	Graduated from High School of Commerce, Detroit, Michigan Started in Business (Retail Dairy Products Store), Hazel Park, Michigan
1941-1943	Worked as Head Secretary in Engineering Department, General Motors Research Laboratory. Attended night school Wayne State University
1943-1946	United States Air Force Lead bombardier, 390th Bomb Group
1946-1947	Engineer, General Motors Research Laboratories Attended night school Lawrence Institute of Technology
1947-1949	Managed Plumbing and Heating Contracting Company Attended night school, Detroit Air Conditioning Institute, Lawrence Institute of Technology
1949-1956	Operated Industrial-Institutional Plumbing and Heating Contracting Company, completing 36 schools, and numerous churches and other industrial buildings.
1951-present	Operated Whitehall Convalescent Homes in Michigan
1956	Built second new investor-owned nursing home at Novi, Michigan, doing all design, contracting, and plumbing and heating
1957-1976	On board of Nursing Home Association in Michigan with 5 years in presidency of two statewide organization including service on Governing Board of American Health Care Association
1961-1973	Served on Michigan Commission of Aging with last four years as acting chairman and chairman
1968-present	Developed four retirement apartment complexes in Clearwater and St. Petersburg, Florida area
1983	Acquired WAAM Radio Station in Ann Arbor, Michigan

MEMBERSHIPS & AFFILIATIONS

American Health Care Association, Member, 1951-

Ann Arbor Chamber of Commerce, Member, 1980-

Fellowship Evangelical Presbyterian Church, Member, 1980-

First Congregational Church, Ypsilanti, Member, 1969-1974

Florida Apartment House Association, Member, 1983-

Hazel Park Lodge F&AM, Life Member

Health Care Association of Michigan, Member, 1973-

Michigan Association of Broadcasters, Member, 1983-

Michigan Commission on Aging, Member, 1961-1973

Michigan Health Facilities Association, Member, 1961-1973

Michigan Nursing Home Association, Member, 1951-1969

Michigan State Chamber of Commerce, Member 1961-; Chairman of Public Affairs Committee, 1970-1971; Member of Board of Directors, 1972-1978

Military Order of World Wars, Member, 1947-

National Association of Broadcasters, Member, 1983-

North Congregational Church, Southfield, Member, 1947-1969

U.S. Chamber of Commerce, Member, 1961-

Ypsilanti Chamber of Commerce, Member, 1980-

AWARDS and HONORS

Michigan Health Facilities Association

Distinguished Service Award, 1972

Michigan Nursing Home Association

Award for years of dedicated service to the nursing home industry, 1974

Michigan State Chamber of Commerce

Plaque in Honor, 1971

Michigan State Chamber of Commerce

Plaque for leadership in public interest, 1973

Oakland County Nursing Home Association

Life membership, 1983

U.S. Citizens Congress

American Citizen Award, 1976

WEEKS:

Mr. Johnson, I'm looking at my notes now, and I note that you were born in Highland Park in 1922, and I suppose you went to school in Highland Park.

JOHNSON:

No, I was born, as I indicated in the notes there, in Highland Park -- one of the first babies born in the Highland Park General Hospital. It was a brand new hospital at that time. But my mother and father moved to Ferndale when I was six months old. Then when I was four years old I moved to Hazel Park, which is a suburban community north of Detroit, and I lived there for twenty-one years so that actually I consider Hazel Park my home town. I went through school, kindergarten through the tenth grade, in Hazel Park and then transferred to a City of Detroit specialized high school, called the Detroit High School of Commerce. It's next door to Cass Technical High School. And, in fact, I had to pay eight dollars a month tuition to go there. But I was dead set on having some tools with which to make a living. The High School of Commerce required a B average from another high school in order to admit you as a student, and then you had to major in either accounting or shorthand, and you had to minor and take a year of either accounting or shorthand, whichever was not your major. You also had to take typing, but you got courses like business law, business English, journalism, business machines. So that in effect when I graduated, as I did in 1940, I found that I had the tools that I would have gotten in about two years of business college, equivalent to about an associate degree in business. So that was pretty much my early life.

My mother was forty years old when I was born. She had been married seventeen years before and was a stepmother to a nine year old child in her first marriage, and raised this girl until she was married and then raised two

more children; one, the child of a widowed sister and the second, the child of her stepdaughter. But she always assumed that it was her that couldn't have any children. My father came along in her second marriage and had never married until age forty-two. I was pretty much a surprise coming along at age forty for my mother and age forty-five for my father. But I think this gave me a little different insight, because as I grew up I sort of shared with my mother and my father the anxiety that they felt about growing older and not having prepared too well for their older years, financially. They were products of the 19th century where a hospital was where you went to die, and knew very little about preventive medicine or anything of that kind.

When I was ten years old, my mother, who had done a lot of wallpapering in the older house that she was attempting to fix up, fell off a ladder and, of course, I know now that she fractured a hip. But she never went to a hospital and the hip healed in a poor manner and she was crippled from that point forward. She had a great deal of pain every step she took. She eventually, after two or three years, walked with a cane and a crutch. I've thought many times how different it is living in a house where someone is incapacitated -- especially being an only child. Being a boy, I had to do many things for my mother by way of nursing chores or things which you normally have to do for a person who is incapacitated. If I had had an older sister or shared it with three or four in a family, I probably would not have been as impressed with what an incapacitated person actually needs by way of extra assistance. My mother, for instance, could not put on her own shoes and stockings. That was a daily chore of putting them on for my mother in the morning, taking them off at night. And because my mother had been a very active woman we found that her health deteriorated in other ways.

Of course I was born in 1922 and was seven years old in 1929 when the so-called Great Depression started, and was eighteen when, in 1940, most people will agree that the depression sort of ended with the advent of World War II. So these were some difficult years.

My father worked three days a week for Ford Motor Company. Usually even that three days a week was interrupted with about a six weeks to three months layoff at model changeover time. I have often recalled the way the automobile factories used to call men in back to work -- Hazel Park was a community in which automobile factories had their employees. It was a blue collar neighborhood. But I can remember in those early days that about the time the model changeover was finishing up, and the automobile companies were calling the men back, usually with a penny postcard, that the men would be lined up at the mailbox looking up the street for the postman to come to see whether or not their penny postcard was arriving calling them back to work. In many instances the family was down to their last couple of jars of canned fruit and vegetables, and maybe down to fifty cents or a dollar. There were a lot of vacant lots in the community and most people kept a garden, as we did. The fresh vegetables helped because model changeover was usually in the summertime, so it helped stretch the food budget.

It was the type of situation where, in this neighborhood the only person that we knew who went to work dressed up and went to work clean and came home clean was a fellow by the name of Roy Franklin. He was a purchasing agent for Detroit Edison. I remember we used to watch him get off the bus and marvel at the fact that he came home about as clean as he went to work, where our fathers would come off the bus dirty, coming out of foundries and assembly lines and smelling of foundry sand. This fellow was sort of a neighborhood

idol that some of us could aspire to. Some day maybe, if we did things right, we would be able to go to work dressed up and come home just as clean as we left in the morning.

I honestly believe that the combination of circumstances made a lifelong impression on me with my mother being crippled and my father losing his job. There came a day, when I was in the tenth grade, fifteen years of age, that the postcard didn't come for my father. He used up a great deal of his savings going back trying to see certain supervisors to find out why he hadn't been called back. We learned later that there was a law in the Michigan legislature being proposed at that time that if someone worked longer than twenty years for a company that the company would have some responsibility towards this person should they become incapacitated or should they retire. Well, my father had nineteen years and eight months in with Ford Motor Company, and eventually learned that was the reason he was never called back. This became the beginning of a very difficult three years of my life.

I had been very ambitious. I had worked as an usher in a local theater forty hours a week after school when I was only fourteen years of age. In fact, the first job that I had I was supposed to qualify for social security, but I was only making three dollars a week. The other usher was sixteen years of age and I was supposed to be sixteen to be paying social security and so my social security -- the first two years that social security was in effect -- went in under the name of this other young man that was working with me. I went from this ushering job to many of the childhood jobs -- caddying at Oakland Hills Country Club, working at the supermarket -- but becoming more convinced all the time that I wanted something different out of this life than that which my folks were facing. The inability to afford medical care, the

hand to mouth existence, and all. I loved my folks very much even though they were not terribly compatible themselves. I used to embarrass my mother when I was a very young child because I had heard everybody tell about my father being an old bachelor when he was married, and I announced one day that when I grew up I was going to be an old bachelor like my father -- of course this was embarrassing to my mother.

But the combination of circumstances, of my father losing his job, both of them being older -- at this time my father was sixty, my mother was fifty-five -- and back in the late 1930s or middle 1930s, that was considered much older than it is today, and my determination to want something different than my folks had experienced, caused me to be almost too singleminded. I hear many times of people talking about those happy childhoods, high school days, and all I can remember is working longer and harder to try and equip myself to be a success in this life.

I had my life planned out six years ahead when I was fifteen years of age. In fact, the only thing that interrupted my plans was World War II. I went to the High School of Commerce, which was eleven miles from my home in Hazel Park and enrolled and put down the eight dollars for the first month's tuition. Then I was able to get a job in a small motion picture laboratory that was located at Cass and Vernor Highway that made what they called trailers which are short promotional films for coming attractions and advertising double features and special stage shows and such as that. That job paid me five dollars a week. As far as I was concerned I could now cover the eight dollars a month tuition and contribute something towards my folks support.

After the first semester, I came home elated one night and announced to

my folks that I had gotten a second job. The first job was from two o'clock in the afternoon until about 5:00 or 5:30 that paid me five dollars a week, and I worked eight hours on Saturday. I would leave home about 6:30 in the morning because I started my first class at the High School of Commerce at 8:00 a.m., and would hitchhike the eleven miles to the school. I had six straight classes from eight o'clock until two o'clock. Then it was just a five minute walk over to the motion picture laboratory where I worked. I would work until about 5:30, sometimes 6. Then I would hitchhike the eleven miles home, choke my dinner down in a hurry, go to work at the second place at eight o'clock and would work until 11:30 at night, sometimes studying between customers in this little store. It was a retail dairy products store and milk depot, as they were called in those days.

This I did for the next three semesters of high school and, in fact, I got five dollars a week at the first job and I had bargained for four dollars and a half a week and a quart of milk a day at the second job. Then I worked fourteen hours and a half on Saturday and six and half hours on Sunday and, in fact, I was working sixty hours a week after school and hitchhiking eleven miles back and forth every day. But, in addition to doing well enough to put food on the table. Fortunately, my folks owned their own home. It originally was a small home and they had bought another small house, moved the two of them together and finally built the two of them into one home. It was a fairly good size home, but it was heated with stove heat and it was a little less than comfortable, especially in the bedrooms. You came out and dressed and undressed behind the coal stove, as you will probably recall. But they did have this home. By covering up in the winter time the archway between the dining room and living room -- we didn't heat the living room -- and we got by

darn near all winter on about one and half tons of coal, which I recall was about seven dollars a ton in those years. And we, in effect, lived in the dining room and the small kitchen -- the three of us. But we made out very well, and luckily didn't have a lot of house payments and such, and other utilities and taxes and things were really quite modest in those days. So that nine dollars and a half a week, if you could make it every week the year around, was a considerable amount and provided a living and we were even saving a couple of dollars a week.

I graduated in June 1940, but two weeks before I graduated the woman who owned this little store where I was working -- she and the man that she had been going with and dating -- they had purchased this business together and their marriage plans floundered and their store was up for sale for twelve hundred dollars. It was a leased building, but the twelve hundred dollars covered the equipment and inventory. So I had saved two hundred dollars and agreed to purchase the store, and two weeks before I graduated from high school purchased the business in which I had been working for about eighteen months. This gave me the opportunity to have my own business, to function as head of the household, and start to dream about what it was like to have and own and operate your own business.

I can remember that the high school newspaper reported this in glowing terms, "Lloyd Johnson to run and own his business upon graduation." I recall that I was so busy and so excited and so thrilled about owning my own business that I was not going to go to the commencement exercises, and my father and mother, neither of whom had graduated from high school, a day or so before started to question me about it. When I told them I was too busy to go down there with all that nonsense with cap and gown, they both started to cry. My

father said, "Don't you realize how much this means to your mother and me?" I finally said, "For gosh sakes, okay. Knock it off. I'll go."

We hurried up and got three or four tickets and got a couple of neighbors to go. My folks didn't have an automobile so the neighbors drove. My father and mother, I guess, were very proud to see me get this high school diploma.

The job that I had taken on in this little store was again long hard hours. The store sold about six hundred quarts of milk a day, and I recall at that time that we sold milk a half gallon for thirteen cents. But all of the milk came in bottles. In addition to milk and ice cream, there was a lunch counter. There were hamburgers, ice cream sodas, pop and that type of thing. We also had a penny candy case. I recall that I did about nine dollars a day worth of sales in penny candy and I've said I never worked so hard to make a few pennies in my life as waiting there, standing behind that candy counter, waiting for the little children from the school across the street from where my store was located to decide whether they wanted rootbeer barrels or licorice candy.

Working from seven o'clock in the morning to twelve o'clock at night six days a week and twelve hours on Sunday, I came out with about forty dollars a week. And of course forty dollars a week sounds like very little today, but at that time, making it each and every week, it was a good living. I had dreams of having a whole chain of these stores, you know. Unfortunately, even though I had the ability to keep books and all, I was very altruistic and idealistic, and I couldn't believe that anyone would possibly steal from me if I let them handle my money. I was doing reasonably well there, but some of the neighborhood high school kids that were kind of rowdy would get in and

would order something from the back room, out of the cooler where we kept the milk and pop, and would steal me blind by taking the little nickel pies and cakes off the counter stuffing their pockets with them. So I wasn't doing too great even though I was working hard.

Then I hired a young man who was fifteen years of age from a poor family, who had three or four little brothers and sisters and I felt like I was doing a real good job of giving him a job and four or five dollars a week and occasionally sending home a six pack of pop for his little brothers and sisters. But this young man was a real thief. I found later that he was taking money out of the cash register with both hands and hiding it in his shoe every time I stepped out of the store for a few minutes. He was working after school in the late afternoon and evening, and it would give me an opportunity to at least get out and go someplace maybe for a half hour or so, which for an eighteen year old young man was kind of necessary. I had been almost tied up there at the place where I was spending a hundred and eight hours a week right in this little store building.

I was so lacking in suspicion that I spent nine dollars to have my cash register overhauled because I was convinced that it was not adding up properly. Finally someone suggested that maybe he was stealing from me. So I ducked out the front of the store, said I was going someplace, and then peeked around the corner through the window. The minute he thought I was out of sight he was into the cash register and taking money with both hands and putting it in his shoe. I walked in and confronted him with it, and we both ended up standing there weeping because I was so devastated and disappointed and all. The net result was that this young man had stolen enough from me that he just undermined my ability to continue operating on a full-time basis.

My father offered to come in and work days in the store and help me out of the predicament. He had been pretty much looking after my mother.

Since I had passed 140 words a minute in shorthand in high school, and had the highest typing rate in the school in the year I graduated -- 1940 -- which I recall was 78 words a minute, I went down and interviewed for a job at General Motors Research Laboratories. Charles F. Kettering, the inventor of the self-starter, was director of the laboratories and this was considered a marvelous place to work. I was hired at $115 a month as a head secretary in a mechanical engineering department. This job at General Motors was one in an expanding department and the young man that had preceded me in the job had failed. There was an eight foot by four foot conference table that was loaded high with unfinished reports -- of engineering reports, research reports, and that type of thing. I learned years later that the fellow that was head of the department was in jeopardy of losing his job that he had had for many, many years because, in effect, the money was flowing into his department but the results of their work was not coming out in report form.

But I was still under the impression that I was taking this job at General Motors Research Laboratories only so long as I could bail myself out. I was still going home and working five or six hours to eleven o'clock at night in the little store, and then working Saturdays and Sundays at the store. But as time went on the store was still not doing well and my job at General Motors was expanding rapidly, and so I eventually decided to sell the little business and put my dreams to bed, so to speak, and stick with General Motors Research Laboratories.

I was there about nineteen months, and received sixteen raises in nineteen months so they were pretty well satisfied with me there as head

secretary in this department. I ended up with two assistant secretaries, and more or less heading up a little department of three people when I was twenty years of age before I went into World War II.

But World War II came along and again I was very objective in that I didn't feel right about not going into some branch of service. I was supporting my invalid mother. My father had not worked since I was fifteen, and I had appealed a 1-A classification and had been reclassified 3-B which indicated that I was in an essential occupation at General Motors and that I was head of a family. But I couldn't quite accept the fact that I was not doing my share in World War II. So I started looking around to see where I might be able to enlist and have the opportunity to serve in the armed forces, but within a reasonable length of time be able to make enough money to support both of my folks. I checked out the merchant marine -- I couldn't swim at this time. The fellow doing the interviewing for the merchant marine told me in glowing terms how you got a special bonus every time your ship was torpedoed, and I thought that was a rather poor way to get rich.

I had seen a movie starring Pat O'Brien called the "Bombardier", and, at age twenty, idealistic and interested in what was going on, patriotic, I decided that was what I wanted to be was a bombardier and hopefully a lead bombardier in the Eighth Air Force because, in my reasoning, I felt like that was one thing I could do where I could accomplish more as an individual, if I could make it, than in any other job I could imagine in any other branch of service. Of course I wanted to get World War II out of the way so I could get back to my plans that I had made that had been interrupted.

So I enlisted in the Air Force. My mother was still an invalid, my father not working, and my training period paid only fifty dollars a month.

Then once I became an "aviation student" it jumped to seventy-five dollars a month. But at the time I enlisted it was only supposed to be four to five months before I got my wings and graduated as a second lieutenant, at which time I would be making over three hundred dollars a month.

They stretched out the programs, unfortunately, after I enlisted in the service. I had left a 1940 Studebaker Champion automobile with my folks, and my father, although he was one of the most wonderful, honest men that I have ever known, had had a problem with alcoholism. He had worked in the lumber woods for nine years as a young man. He had never married until he was forty-two, and he was, as I recognize it now, an alcoholic. Well, together with my leaving for the service, an only child -- he loved me dearly -- and my mother having such a traumatic reaction, crying for days on end, my dad started drinking again. The little automobile was sold for some four hundred and forty dollars, and unfortunately my dad didn't draw a sober breath until the four hundred and forty dollars was all gone. Of course I had banked on this to provide at least groceries for my folks for the four to five months period of time before I got that commission. I found myself worrying myself sick about my folks and their inability to get along. I'll never forget the day that I received a letter saying that my father had gotten a job at Briggs at fifty dollars a week. I felt as Atlas must have felt when he laid down the world off his shoulders, because I was only making fifty dollars a month. I was paying six dollars a month for the ten thousand dollar life insurance in case I didn't make it back, and I was trying to send my folks forty dollars a month in order to buy groceries. I was getting demerits as a aviation student because my clothes weren't as clean as they should be. I tried washing my own clothes out on the sidewalk, you know, instead of sending them to the local

laundry and it didn't work out very well. It was just a tremendous relief and a load off my back, when my father got that job.

But again, all this time with my ability to empathize, I knew what it was like to grow older not having properly prepared for those older years, not having the money, not being able to go to doctors, not having enough to buy even a ton of coal to keep the house warm enough. So it was a difficult time. Other people seem to go through these difficult times, but they don't analyze them in depth as I did. In my case, my mother with her poor health, there were times when I was fifteen, sixteen, seventeen years old that my mother would have these very, very sick spells -- we didn't quite know what they were -- but I would find myself walking until one, two o'clock in the morning when I couldn't sleep. I would go out for a long walk worrying about the fact that my mother was not going to live out the week. And so it was not a happy time in my life, as far as I'm concerned.

I know I've taken quite a bit of time discussing some of these early impressions and all, but I think it serves as an adequate preamble to many of the things which I have done in my life since that time. I came back from World War II, having attended the University of Nebraska for a number of months, having had additional training, having served as a lead bombardier in the Eighth Air Force, having lost my father three weeks before I got my wings as a bombardier. He died of a coronary occlusion. I was able to send money home to my mother so she could hire enough help in order to make out by herself.

I came back also having lost my air crew that I had trained with for many months. They were a fine bunch of young men ranging in age from nineteen to twenty-five, and I had been with them for many, many months. When we went

overseas, I had gone in to see the group bombardier and had volunteered for lead crew, because I felt like I didn't want to go through all that training and then be something less than I was trained to be. But when I went to the barracks, or Quonset huts they were in England, the rest of the crew didn't want to go along with me, because as a lead crew you were in England four or five times as long as you were if you hurried up and flew your missions.

So I said well, "I will have to fly several missions along with you fellows, but I'm sorry but I've got to do what I think is best. I'm a trained bombardier and I'm proud of it, and I think I could be a lead bombardier and I think I could be highly effective."

They flew two missions, and I was not included with the crew. They were alerted for their third mission and I went in to talk to the squadron operations officer, and he said, "Well, I understand that it's probably driving you crazy being alerted for your first mission and then not flying it two or three times in a row." So he went over and wrote my name in with my crew as the bombardier.

When the sergeant came in to wake us up at two o'clock in the morning, he said, "I'm sorry Lieutenant Johnson, you're not on here with Lieutenant Kast."

I threw my shoes on the floor and I said, "Dammit, they've done it to me again."

He came in twenty minutes later and woke me up and said he should have awakened me previously because I was flying Deputy Lead with a Lieutenant Thompson that day. I had to hurry and be transported to the flight line in a special vehicle and flew Deputy Lead that day over Hanover, Germany with another crew.

It was practically unheard of in the Eighth Air Force, especially in the

latter days, to fly anybody deputy lead or lead who hadn't had at least six or seven missions as part of a wing crew. To this day I'll never know how it was that they happened to pick me, whether it was because I made a good impression on the group bombardier, expressing my determination to be a lead bombardier, or what. Anyway, that day over Hanover, Germany, my old crew had a mid-air collision that killed seventeen men in the two airplanes. In three weeks after I had arrived at my 390th bomb group location in England, I found myself having lost everybody with whom I had been associated for some eight or nine months through all of this training. Again, this is part of the experiences that I had that I think gave me extra motivation, because I came home with the idea that somehow or other, since the good Lord had spared my life, that I had to dedicate myself to try to accomplish what each of these other eight men on my crew would have accomplished in this life had they been spared rather than myself.

Of course, as I've grown older, I realize that was an impossible task to take on, but it did give me a good deal of extra motivation. I came back to General Motors Research Laboratories, and they classified me as specifications engineer. At age twenty-four I found myself back in the prestige division of General Motors with an engineer's classification, and supposedly, a lifetime job.

We were the first division to work only seven and half hours a day. I had gotten credit for my military leave of absence so that I was entitled to three weeks vacation with pay a year, and an engineer's salary. And again all of my relatives were completely nonplused when about sixteen months later, after I had gotten married, I decided to leave General Motors Research Laboratories. In fact, I had an uncle that said to my aunt, and she quoted

him many times, "Oh, I think that boy is making a terrible mistake leaving that job."

But, again, when you grew up in a highly technological environment, like you had around Detroit, you got the impression that the only way to make a living was with technical training. I found that probably if I drew a line down the middle of a paper, and made two columns, and listed my talents in the technical side and then listed my talents on the human side of the ledger, that I had always been a lot more inclined to be interested in dealing with people. But I always had written that off in the community in which I lived because that wasn't anything you could make a living with. Nobody ever thought of anyone making a living by the fact that you got along well with people and that you had a deep respect and love for your fellow human being. That was great but it wasn't anything that resulted in a pay check.

I was discharged in November of 1945, with about a thirty day final furlough from the Air Force. The last job that I had out at Sioux Falls, South Dakota, was base recruiting officer. This was a job that called for a major to fill, but I was still a second lieutenant, and had completed eight lead missions with the Eighth Air Force, and was sort of bargaining the Air Force against General Motors Research Laboratories. In fact, I even had some idea that I might stay in as a career officer, because in effect, even though I came back to an engineer's salary, I took a ninety dollar a month cut over what the Air Force was paying me on flying status.

But I came home and, of course, my mother, who had been waiting for me to return, thought that I was going to live in the house, and work, and support her, and probably not get married. Well, that didn't last very long. I met my wife, who has been my wife for over forty years now, at the Fisher YMCA in

Detroit at a Valentine's Day dance in 1946. It was the day after Valentine's Day, the fifteenth of February. Nine weeks and six days later we were married. This was difficult for my mother to accept because she had been sitting there waiting for me to come home for three years. Of course, I was going out and making a life for myself.

I got married, started a new home -- we were building it and contracting it ourselves. All of these things that had happened to me -- the worrying about my folks, and then I was four months in an Air Force hospital in Kingman, Arizona which interrupted my training by another four months before I finally got my second lieutenant's bars. And then losing my father three weeks before I was getting my wings and then losing my air crew that I have been with for many months, then coming home and going to work at a new job again. I got out of the Air Force on Friday, went to work Monday morning, and started night school on Tuesday at Lawrence Institute of Technology to fulfill some educational requirements that I had agreed to fulfill with General Motors Research Laboratories in return for this engineering classification.

Then, having been married in April, and starting to build a new house and all, I didn't realize how emotionally traumatic all of these things probably were in my life. All of these things having happened, really, within about an eighteen month period.

I'll never forget when my wife and I went to see the movie "Twelve O'Clock High," starring Gregory Peck at the Royal Oak theater. I became more and more and more emotionally involved in that movie. When Gregory Peck came unglued at the end of the movie, I, likewise, came unglued in the audience. It was the end of the movie and I remember the lights coming on and I'm sitting there shaking all over and I'm weeping and my wife is helping me up

the aisle leaving the theater. Of course I was embarrassed because everybody was watching me that I had just completely gone to pieces. In fact, it was so upsetting to me that my wife had to drive home. I couldn't even drive the automobile. But I suddenly realized that I wasn't made out of cast iron, that I had had some deeply emotional experiences that had affected me and probably would color my attitudes in my lifetime.

After I had been married about a year and a half, I left General Motors Research Laboratories and went to work for a plumbing and heating concern that had been doing radiant floor panel heating for the new house we were building. We became very interested in this radiant panel heating. I learned after I moved to this place that they were almost bankrupt and, at age twenty-four or twenty-five, I had to pitch in and manage this company out of near bankruptcy.

After two years and nine months of managing this little company -- it was a company where the boss was in over his head and he got to the place where he depended on me so much he only showed up Wednesday afternoon and Friday to deliver the paychecks -- we started out with about nine employees and ended up with thirty-six employees after a little less than three years. Again, after managing his little business, I left him with a new building, a $30,000 inventory, four new trucks, thirty-six men, and $330,000 worth of business on the books, and started my own business.

I went into my own plumbing and heating company in September of 1949. In a six year period I did thirty-six school buildings, plus a number of small factories, and a lot of work for packing houses like Hygrade Food Products and Hammond/Standish, and a number of others around Detroit.

All of this was preliminary to my becoming interested in long term care facilities or nursing homes. But, when I was about twenty-nine years of age,

my mother, who at that time was about sixty-eight or sixty-nine, started having some little strokes. In other words, she had had a lot of painful years walking with a cane and a crutch and all this arthritis; she had had other health problems, but they were not the kind that required twenty-four hour day nursing care. I'll have to admit that the relationship between my mother and my wife was not the very best because my mother tended to resent my wife, although she eventually got over it and, as she got to know my wife much better, loved her very dearly because my wife is a wonderfully unselfish person and actually took quite a hard time from my mother because she had had the audacity to marry me after my mother sat there and waited for me to get out of the service for three years.

We tried to provide help and care for my mother as much as possible. But she started having little strokes, one of which blinded her in one eye, and another paralyzed her one hand. It was the hand that held the crutch so this made it particularly difficult for her to walk. She would think she had hold of the crutch and would start out and she would just have a handful of air. So we needed care for my mother. This was upsetting. We tried to get a lady to stay with my mother, and my mother would find fault with her. It was the old family problem as every week we would have someone new. Either my wife or I would stay with my mother while the other one would try to interview people and try to get another person to stay another week. My wife and I were both working, so obviously this was a very difficult situation. I remember it was about ten o'clock Sunday night, my wife was already asleep, and I was sitting up, pillow propped behind my head in bed, and was reading the Detroit News. I let a war whoop out of me and I said, "Hey, I think I found the answer to our problem." Here was a small nursing home for sale. We had

visited three or four nursing homes and the good ones were full and the poor ones, of course, I didn't want to take my mother to.

We investigated this, and there was a nurse that was a friend of my wife's who had worked at the Arnold Home in Detroit, and she said that she would be interested in coming and managing this place for us. Now this was going to be the ideal situation where we bought this nursing home, provided care for my mother only so long as she needed it, and then when her needs were met we would sell the nursing home and that would be that. But interestingly, we got into the nursing home and the lady who was going to manage only lasted about three for four weeks. My mother died only six weeks after we started. But there was a number of other people who had come in as patients after that. There were only three patients in this nursing home, and one of those left with the owners when they moved out. So my mother was the third patient. I'll never forget that the people who owned the place didn't even tell the other two people who were staying there that the place had changed hands. We had a Mr. Fiefer, who was a crusty little retired man in his middle eighties. The first day we took over, I walked in with his noon meal and he looked up and he said, "Who the hell are you? "

I had to stop and explain who I was because he wasn't about to accept the meal from a perfect stranger and, of course, he was upset that he hadn't been told -- which he had a perfect right to be. But overnight, practically, we were in the "nursing home business." This was in July of 1951. I'd been in the plumbing and heating business a little over two years. We had started on the proverbial shoestring, with a partner, in the plumbing and heating business. It expanded very rapidly to the point where I did not have a lot of capital to go out and buy nursing homes. But I had paid a $6,000 mortgage

down to about $4,700. The nursing home was a lease proposition. It was a converted house, a house originally built in 1868, which was the first building in Novi -- the first house, the first residence. We went to the banker and found out that we could borrow back up to the $6,000 original mortgage, which gave us $1,300. The price of the equipment and of the lease in the nursing home was $4,100. So we plunked our $1,300 down, with a monthly payment to come due every month after that and found ourselves owner of a nursing home. Interestingly, it was the type of building that was not typical for a residence. It had been used as a large restaurant for many years. The place was eventually expanded to forty-two beds, which was a fairly large nursing home in those days.

The well system, for instance, that was installed at that time had a large compression tank because it had been used for a large restaurant, so that the house had much commercial equipment in it even though it was basically a residence.

The experiences we had with some of those early patients were interesting. We had a fellow bring his wife in, a Mrs. Quinn from the Dearborn area, and it was interesting that as we met our own family need of taking care of my mother, we also became very fond of these patients who came in. It was kind of an emotional involvement where we felt that somehow or other these people could not get along without us. So we discussed this after my mother died and we said, "What are we going to do? We can't sell the place." In fact, we made one preliminary attempt to sell the place and it was to a doctor. He talked about our patients like they were a bunch of pieces of furniture. I was so offended and angry that I said to my wife that I wouldn't sell it to him if his was the only sale in the whole country. I

said he's not showing proper respect and love for these people. We had gotten to know them well, and by this time they were almost like relatives. You know, when you're caring for someone, it's just like adopting a child.

We had one little lady, Mary Quigg was her name. She had worked in a dry goods store for forty-three years in the town of Ionia, and was a very crusty little Irish lady. Of course I have always enjoyed kind of being devilish, as my mother used to say, and I remember getting a big rubber spider one time and, of course, little Mary Quigg came alone and saw this big rubber spider. She was almost sure that it was imitation, but she reached out her finger to touch it. What she didn't know was that it had a little rubber tubing and ball on the end. Just about as she reached out to touch it I squeezed the little ball and the thing hopped about two inches. Of course she let a squeal out of her.

She said, "There are two things I have always been scared of, spiders and men." I said, "Well, Miss Quigg, you're not scared of me are you?" She said, "No, you're just a boy." So I realized that if you act like a child, you're going to be treated as one, or thought of as a child. But some of those early patients that Mrs. Johnson and I took care of personally were interesting.

The first five years that we had the nursing home, I was working there evenings. At some times we were living on the premises. I moved my plumbing and heating company out next door to the nursing home so that I was there a good share of the time and we became more and more involved in the nursing home. About 1955, after we had the nursing home about four years, we made the decision that I would leave the plumbing and heating business. Well, I had three different architects call me in and say, "You can't do this."

In the meantime I had gone to night school for almost three years and had gotten a diploma in heating, ventilating and air conditioning engineering. I had become one of the best, and I may sound facetious, but I'm quoting other people, one of the best plumbing and heating estimators in institutional work. I had done the plumbing, heating, and ventilating on about thirty-six schools in six years, and had had as many as forty plumbers and fitters working for me. At the time I finally made the decision to liquidate the plumbing and heating business and build my first new nursing home I had about twenty-five employees. I often think back -- it's rather interesting that my last full year in the plumbing and heating business I made $27,000. That was 1954, and in effect it would be equivalent to about a $90,000 yearly income at today's inflation-adjusted level. And yet, I had found something that I liked to do much better, and, in effect, was changing careers for the third time.

Again these architects said, "You just can't do this. You know you've got three trucks, you've got all these men, you've got two trailer arcwelders, all this inventory, and you've got a $3 million record in institutional work of having completed this successfully, and you've got a $300,000 bondability by the bonding companies. You're just absolutely crazy at age thirty-two to throw this all over."

I said, "Well, I'm sorry. I have found something I like better, and I think my wife and I working together can make a living."

Both of us working together were making less than $20,000 a year out of the nursing home. But again, I have never regretted this. I'll never forget one individual who was a leader in the nursing home industry at that time, one of the first things he said after he met me was, "We've got to get this darn plumber out of the nursing home business."

So I was identified as a plumber, although I was never a plumber. I went in from the engineering end and I took engineering in the heating, ventilating, and air conditioning, and then became a plumbing/heating estimator. I worked pretty much in the office end all the way through, and from the accounting end. I had the accounting from my earlier training. It's kind of interesting that everything that I have done, even though I have changed careers in a major way three different times, everything I had done previously has stood me in good stead in meeting some of the challenges and becoming more of a generalist as I took on other businesses and developed other businesses.

It's interesting that 1986 is actually my fortieth year of owning my own businesses, including the two years in the first business that I was in when I was eighteen years of age.

The inventory that I had, unfortunately, when I decided to liquidate the plumbing and heating company was not an inventory that was easily disposable because I had been doing commercial, industrial, and institutional work and so that instead of having three-quarter and half inch galvinized pipe or copper pipe, I had four inch and six inch and eight inch steel pipe. I had these big arcwelders that were designed to weld large pipe rather than threaded pipe, and a lot of the drainage pipe that I had for plumbing was six inch and eight inch. So I started out, before I actually liquidated the plumbing and heating company, with the idea that I wanted to build a new nursing home that would correct all of the problems in our converted building. Now again, in 1954 and 1955, this was unheard of. There were no new nursing homes in the whole state of Michigan that were built by private interest. The banks would not loan money, or had not loaned money up until that time. And when you said you

wanted to build a new nursing home people looked at you rather confused and said, there is no such thing as a new nursing home.

I remember I went to a friend of mine that I had done several plumbing and heating jobs with who was an architect in Farmington, Charles D. Hannon, a very fine man and a very sharp architect and designer. All he could do to help me was hand me a book about the size of an unabridged dictionary on hospital design and construction. Of course I soon learned that that was completely inappropriate. So I started out almost from scratch by drawing chalk lines for proposed room sizes on the basement floor in the small home where my wife and I lived in the Redford area of northwest Detroit. I would draw different room configurations and then I would take cushions off the davenport and put them down representing beds and draw in certain size beds and things like that and see whether or not you could efficiently serve patients and decide whether or not that you had a toilet room or bathroom for every room and so on and so forth. The very interesting thing is, that the conclusions I drew from designing my own nursing home originally back there in 1954 or 1955 has almost become a standard of nursing home design in the ensuing years. I ended up with rooms that were essentially two bed rooms. There was always the thought that if you built larger than two bed rooms that you could build cheaper, but of course with the five years experience that we had already had at that time in the nursing home field, we knew that if you admitted somebody who was deaf you could always put them in a room with somebody who snored, but it was pretty hard to find three people who were deaf to put in with a person who snored. So every time you added one person to a room, you compounded the possible problem. So we had pretty much decided that a two bed room was about as ideal as we could make it -- with a sufficient

number of private rooms for those people who either needed or demanded privacy.

So we ended up with a building that I had designed. I went to an artist friend of mine who was a life-long friend, who since has become one of the finest western artists in the United States doing bronze sculpture work, and he and I together, from my rough plan, drew an artist's rendering of what we thought the building ought to look like. That is the same building that we're using today. He suggested a modified colonial architecture with four white columns out front and a high section in the middle and then the wings coming off both sides. He even suggested little items like putting white aluminum siding between the windows that would seem to stretch out and make the building look long and attractive and clean, using common brick as you would in colonial construction, but dressing it up with white millwork and doors and the aluminum siding that was easy to clean and didn't require a lot of maintenance.

So we ended up with this building and, again, having designed it myself...

WEEKS:

This is the present Whitehall building?

JOHNSON:

This is the present Whitehall building, and the first one that was constructed over at Novi. Well now, I knew I could do my own plumbing and heating. I still had my licenses and everything for the plumbing and heating business. So I went to a general contractor that I had done a couple of jobs with and who I knew fairly well -- or at least I thought I knew him pretty well -- and working with him, we came up with a price that we thought we could

build a building for. I was going to use up all of my plumbing and heating inventory I possibly could. I made arrangements with a fellow who owned a gravel pit to trade him some of this large four and six inch pipe for some loads of gravel that I was going to need as fill underneath the floor. So I was playing every angle in the book in order to try and get this building up.

I went to the City National Bank in Detroit, with whom I had been doing business for a few years, to a branch manager by the name of Frank Harris. I asked for a loan of $27,000. Understand, this on a forty bed nursing home which meant that I was going to have to provide a substantial portion of the capital or at least the intrinsic worth of the building myself, both my sweat equity labor and the plumbing and heating inventory which I intended to use up. I was rather discouraged because I talked to several other individuals who said, "Oh, you're never going to get a loan at the bank. We went and the bank just laughed at us and said, 'There was no such thing as a new nursing home.'"

The day that Frank Harris called me and said, "Your loan is approved," there was complete stoney silence on my end of the telephone. Then he said, "Well, aren't you going to say anything?"

I said, "Frank, I had it all made up in my mind of what I was going to say when you told me no, but I didn't have an answer for when you told me yes."

I let the contract for the building. I had purchased this piece of land, seven acres, in Novi. I had had an option on a piece of land earlier in the Southfield area but I had over 200 neighbors sign a petition against the rezoning of the land for a nursing home. I'll never forget how angry and irritated I was when I came home from this hearing where I had been turned

down and had to drop the option on the original piece of land. My mother-in-law, who was in her eighties at that time, said, "Well, don't these people have mothers and fathers?"

I said, "Mothers, perhaps, but fathers I doubt the way they acted tonight."

Anyway, we did get the approval of this second piece of land and had purchased it for seven thousand dollars for seven acres in Novi, located on West Ten Mile just three hundred feet west of Novi Road. And what was then quite a rural community and only about two and a half miles from our original nursing home located on Old Grand River about a mile east of Novi.

The land required a lot of moving dirt around and an excavating contractor had to be brought in to level this land out because it was an all up and down grade. There were some places the land was four and five feet below level of the road, but it was high enough elsewhere so that we didn't actually have to use a lot of fill dirt. We had to fill in the low spots with the high spots. It was the rainiest spring I think that we've ever experienced, and they were in there and it would rain one day and it would be muddy — they almost lost a piece of equipment a couple of times. Then about thirty days into the job, I got a phone call one day that the partner in this general contracting concern that had quoted me this price on the job, had stolen $5,000 from his partner, had sold his home, had gotten a mobile home or a house trailer, and had taken off for California. His partner was calling me to tell me he was not going to honor the contract and that the excavator was my problem. I'll never forget I was terribly upset because I had a firm price from him on the architectural part of the building, outside of plumbing and heating. I said to my wife, "What in the world am I going to do? I don't

know anything about being a general contractor."

My wife said, "I've met him and I know you, and I think you're at least as smart as he is and I think a lot smarter." She said, "If you go at it very carefully and make sure that whomever you hire is qualified, I think that you could do it."

She persuaded me that I could. Again I was doing my own plumbing and heating with my own two hands, and, of course, I had been doing office work, so I had hired a "good old boy" from down in Tennessee, his name was Woodrow Harmond. He got quite a kick out of the fact that I was getting blisters on my hands and all. I noticed that he quit kidding me after a few days. Of course after a couple, three weeks I worked into the hard work and developed calluses where the blisters had been. I'll never forget I was so enthusiastic about this that I was working on the job ten hours a day, then I would go home and talk to subcontractors until ten or ten-thirty in the evening, and then be up at six o'clock in the morning again.

My wife was right, I was, I guess, as smart as this other fellow, and things were going along pretty good. I got an excellent carpenter contractor and a good brick layer and a good cement contractor and all. Finally the time came when we were caught up a little bit -- we had been working seven days a week. I said to Woody, my laborer, "Would you like to take tomorrow off -- Sunday? I think we're caught up a little bit."

He said, "I sure would, Mr. Johnson. I don't know whether youuns know it or not, but we all worked sixty-three ten hour days in a row."

I said, "We have? I wasn't keeping count." I said, "Well, you said you wanted to work steady when you went to work."

He said, "I ain't never worked this steady before."

Anyway, the net result was that we built this original forty-bed nursing home in ninety-three days. We had it all ready to open. The first patient was coming in. The fellow that was painting some of this beautiful, white woodwork on the front of the building, his ladder slipped, and he dumped a can of white paint over about 150 bricks on the front of the building that had to be replaced. We had things scheduled so closely that, when the first patient, Mrs. Webb, was being brought into the building on a stretcher, we dropped mortar on the stretcher on her way in. She was a lovely person; she got a kick out of it, but we were still laying those last 150 bricks.

My wife was managing the first nursing home, and I was working over building the second place. I thought that she was going to come over there, and was breaking in this assistant to sort of take over at our first nursing home. But, she and one of our neighbors got the bright idea that they were going to save a few dollars too and decided to make thirty-one pairs of draperies for all of the windows. So instead of breaking in this person as a manager, she was busy working until midnight with one of our neighbors making all of the draperies for the new nursing home. The day we opened I found myself being in charge of the one nursing home and my wife was managing the other one. This was interesting because I had done some cooking because my mother was an invalid when I was a child, but I had never cooked for a group of people. I have always told people that I cooked for just about the better part of a year when we opened the second place. There were times when I would have the telephone propped on my shoulder, my wife would be over at the other nursing home telling me how to put the food together in order to make a special dish for the patients.

Of course, we started the second place with just a few patients. We

became a real curiosity because here was a brand new nursing home, designed as a nursing home, not a converted building, --I had people from as far away as Arizona coming to see this place. It was not only the matter of taking the inquiries from new patients and learning to cook and finishing up some of the last little things in the nursing home, but also having three or four visitors a day that wanted to see this building. They wanted to see what the floor plan was like. Actually, it was the second new nursing home in Michigan. There was one called the David Nursing Home that was right close to the Wayne University campus. It was a converted house. David Teitelbaum was the owner's name. Wayne University bought him out. He got $40,000 cash, and he went out to West Chicago Avenue and built the David Nursing Home. He opened just two weeks ahead of me. He opened the 15th of August in 1956, I opened Whitehall Convalescent Homes on the 1st of September in 1956. It was about four months later that we were actually filled up with patients.

I kept working longer and longer and longer. My wife, who, of course, is a nurse, could see that I was probably getting a little wound up with things having worked so long and so hard and then going right into the management of employees and all. She finally insisted about February that I get away for a vacation in Florida -- far enough away that they couldn't get in touch with me. I'll never forget, the first couple of days I paced the floor and kept saying I wonder what I'm doing down here. The third day, after having slept a couple of twelve-hour nights, I woke up and again, as I had at the "Twelve O'Clock High" movie years before, found myself shaking all over and hardly able to talk because I had such an emotional nervous reaction after having worked some thirteen or fourteen months without having time off -- many of it long, long, hard hours.

But it was exciting to be part of a brand new type of service. My wife is of the old-fashioned school of nursing where she has always believed that a bed sore is the result of only one thing, poor nursing care. It is necessary for every nurse, every shift, seven days a week, to turn a patient in bed who needs turning or you are going to end up with pressure sores, or decubiti, as the medical name is for these bed sores.

We had built a good reputation. I learned many years ago not to try to persuade my wife not to get up at three o'clock in the morning and go out to the nursing home if she thought that a patient needed to be seen by her for an evaluation to be made. I would get up most times and drive out with her. I remember one of the times we were driving out at three o'clock in the morning, and I ended up getting a speeding ticket from the Farmington police. I was very offended by this because there wasn't a car from any direction on the road at that time of the morning, and on a week night. I wrote a very sharp, sarcastic letter to the Farmington police department. I found out later that they had it posted on their bulletin board for about a month. They got quite a kick out of it.

The design of the first nursing home was the result of my conferring with the state fire marshal's office. They were the primary agency responsible for telling you what you should do and what they thought was in the best interest of the patient. So, in the design of the first nursing home, there was a state fire marshal's representative by the name of Glenn Tanner who worked in the fire marshal's office for many years and who was stationed at Seven Mile Road and Grand River in Detroit. He had gone out to the original nursing home and crawled around with a flashlight in the attic to look over the wiring to give me approval that it would meet the regulations that were just beginning

at that time. This new nursing home was all on one floor, no steps up or down any place, all of the windows were six-by-four picture windows or four-by-four picture windows where a person could be evacuated out of a window if need be, if the building happened to catch fire. It was protected by an electronic fire detection system that had a rate of rise thermostat that would sound a fire alarm in case you had any kind of a fire that started to raise the temperature of the building in an unusual manner. It had a large number of doors leading to the outside. We had, in the original forty-bed place nine doors that led directly to the outside -- through the nurses stations, half way down the hallways, at the ends of the hallways, near the kitchen -- with the idea in mind that nobody was more than about fifty or sixty feet from an outside doorway anywhere in the building. It had a flat roof that eliminated an attic space because it had been their experience that attic spaces were spaces where fires sometimes started and got a fairly good start before they were discovered. There was a concrete floor, with all of the plumbing and heating and a lot of the electrical located underneath the floor of the building, to avoid being in wood partitioned walls, and with doors large enough to move beds out of the doors.

I had the advantage of the fire marshal's recommendations in all of these areas. I'll never forget, when I finally had the completed plans, I walked into Glenn Tanner's office at Seven Mile and Grand River and laid the plans in front of him and said, "What do you think of your nursing home?"

He said, "What do you mean my nursing home?"

I said, "I think if you will examine it carefully, you will find that every single recommendation that you gave me" -- and I had taken it all down in shorthand, incidentally -- "is incorporated in this building."

He looked it over carefully and said, "By golly, you certainly have."

One other requirement that they asked for was that the boiler room have doors leading directly to the outside and be completely surrounded by concrete walls and a fireproof ceiling so that if anything started in the boiler room it would be isolated from the rest of the building.

We started to enjoy a lot of success. I had become active in the Nursing Home Association.

WEEKS:

Is this the state association?

JOHNSON:

That was the Michigan Nursing Home Association. I had come up to one of the first board meetings, just as a member, because I had the idea of the association taking in associate members -- people who were doing business with our industry. The idea was to have these associate members pay fifty dollars a year to indicate their support for and affiliation with your industry. The board debated it for almost three hours because some people said, "Why do we want these outsiders coming in to see what we're doing?"

I finally clinched the argument and they passed a board resolution allowing associate members because I persuaded them by saying that everyone of these people who are doing business with us and know us, if you take them in as an associate member, you've got one more person on your side who has said, I'm part of you, I'm for you. Every person you have for you is one less person you have against you. Nursing homes were starting to get some criticism. Of course, some of these people's response to criticism was to lock all the outside doors and not let anybody in. Of course that was decidedly the wrong thing to do.

In fact, Mrs. Johnson and I had discussed at great length when we started our first nursing home as to whether or not we needed visiting hours. We decided against it. We said there are valid reasons for visiting hours in a hospital with patients having complicated treatments and procedures. But we felt in a nursing home, since there had been some criticism, that we would invite people to come in any time of the day. We had some of the earlier patients who we now recognize were Alzheimer's patients, who were confused or forgetful, who would tell their people that they hadn't had anything to eat all day. We would say to the people, "She ate dinner less than an hour ago. If you ever want to know what we serve for dinner, come on out at mealtime and see. Sit there with your mother, we'll give you a cup of coffee too, so you can have a little something with your mother." We found that, again, this was a new idea in nursing homes. Other people had had very strict visiting hours. We could not see the need or reason for it. In fact, we found there were cases where our patients were a generation that had been added on to the normal life span. Many of the sons and daughters of our patients were sixty or sixty-five years of age. People were sometimes retired and had summer cottages, and they didn't want to give up their weekends going out to their cottage, but they hated to miss visiting their mother or father on weekends. So we said come on in at nine o'clock in the morning on the way out to the summer cottage. Why not? Visit your mother for forty-five minutes and then go on out and have your nice weekend and have your children and your grandchildren come.

We found that, from a public relations standpoint, it was excellent. We became known as a different kind of a nursing home where the nursing care was good, where we had nothing to hide, where we invited people in any time. In

fact, it was a little comical. We had one couple who came in; he was a retired Chrysler employee. We had to get special permission from the Department of Health to put in a double bed because they had been married sixty-three years and had never slept in twin beds and wanted to sleep together. I'll never forget how cute they were. She had her long flannel nightgown and he had his flannel nightgown, but he was bald and he wore a bed cap. The only places I had ever seen bed caps before was in some of the illustrations in " 'Twas the Night Before Christmas....she in her kerchief and I in my cap"....and it showed the illustration of a man in a bed cap. But he wore a bed cap. The family picked them up one time for a Christmas celebration at home. Of course it has always been our policy to have Christmas trees and Christmas celebrations at the home. In fact, of the thirty-five years we have spent in nursing homes, I have worked on Christmas thirty-four of the thirty-five years. This couple's family took them home. Surprisingly, they were back in about two hours. My wife whispered to me, "Isn't it a darned shame that they couldn't keep them longer than two hours." But she soon found out what the problem was. This lady bent over to one of the other ladies and and said, "Have they had the exercises yet?" She was hurrying back for our Christmas party at the nursing home.

So it was rather gratifying to know that what we were providing was so meaningful to people.

One other thing that we have done that has been probably the nicest thing we could possibly do. We discovered a company called Orchids From Hawaii and for the last fifteen or eighteen years, we have had little Vanda orchid corsages, two little orchids done up in a corsage, flown in from Hawaii and arriving about the day before Christmas. On Christmas day, we have gone

through the nursing home to all the ladies -- we distribute a present for the men at the same time, although it's not an orchid corsage obviously -- we pin this little orchid corsage on every one of our ladies and give them a kiss on the cheek and wish them a "Merry Christmas." It's the most "fun" day of the year as far as I'm concerned. I can't think of anything I'd rather do or any place I'd rather be.

One little experience I had... We have not had, because of our location, a lot of black patients over the years. We had this lady who came in. She was a black lady and she had cancer of the bladder. She came in probably three or four weeks before Christmas, and at that time was the only black patient we had. I'm sure she felt a little strange, or uneasy about it. She saw me coming down the hallway with my box of orchids and pinning them on all the ladies and giving them a big kiss on the cheek. I'm sure she had some question in her mind as to whether or not she would get her orchid and her kiss. I got to her, and of course I pinned the orchid on and put my arms around her and kissed her on the cheek and she broke into tears. She just cried uncontrollably. I put my arms around her and gave her a hug and said, "I know you're upset."

She said, "Thank you so very much. It's the first orchid I've ever had."

I have often thought how unfortunate it would have been had I had some kind of a racial hangup, because two months later the lady was gone. She had died. I have always thanked God that I didn't have any reservations whatsoever. To me a human being that has need, I don't have any problems whatsoever of loving each and every one of them, regardless of their racial, ethnic, religious background or whatever. I think part of this was, perhaps, because of the fact that I grew up thinking very highly of one of my first

cousins, from my father's family, who was Jewish. I had first cousins on my mother's side of the family that were Catholic. Now we were, I say Protestant loosely, we weren't even good Protestants I guess. At least we didn't have any religious bias that took place in our family.

When I went to this High School of Commerce in Detroit, thirty percent of my class was black. One of my best friends was a Jesse Neely who was a black fellow. In fact, as soon as I got my store going he and I planned that we were going to open a store in his neighborhood and he was going to run one dairy store and I was going to run one dairy store. We planned and schemed and all. I visited his home and his mother. I think that prejudice will never stand the test once you have one good friend who is a member of this group that you are prejudiced against. Once you have one good friend that you love and trust, then nothing else means anything to you. All of the so-called facts, or ideas, that you had that developed prejudice you start making exceptions. Once you start making exceptions, prejudice will not stand the test of exceptions. It has to be all or nothing.

We incorporated in October of 1957, as Whitehall Convalescent Homes. I had, again, being a dreamer and a planner, the idea of perhaps duplicating this forty-bed nursing home in a substantial number of locations and trying to develop what is now called a franchising situation where I would get a husband and wife, the wife being a registered nurse and the husband being somebody who could be pretty good at maintenance and mowing the lawn and yard work and things like that. Now, in those early days, we had decided in our mind that a forty-bed nursing home was an ideal size in that whoever the nursing director was had visual control of every patient every day. We didn't have a lot of documenting. We didn't have charts an inch thick. We always had a BM record

to make sure that a person's bowels were moving regularly. We had other records -- bath records to make sure that a person got their baths in on a regular basis, and a medication record. Then we had a notebook, as we called it, that told typical things. If someone who was a stroke patient appeared to be running a temperature, or might be preliminary to another stroke, we transferred this information along from shift to shift and from day to day. When people came back from their days off they read this little continuous log, so to speak, of what had happened in the nursing home. If somebody was going home with their daughter for a couple of days, that also appeared in the notebook.

We were pretty well convinced that these were adequate records. The records required by nursing homes today have proliferated to the point where I did a personal study some time ago. The additional requirements that have been put into effect the last six or seven years now cost about seven dollars a day per patient. We can't help but wonder, when we examine these requirements, whether or not the patient accrues any benefit whatsoever for these seven dollars a day worth of extra expenditures. I have insinuated a couple of times that the amount of documentation that we are doing in this country is a communist plot. That in effect they are attempting to get us to document ourselves into being a Third World nation. We have developed this proliferation of documentation to the point where, instead of your most highly skilled people going in and doing the things for patients which we always did in the early days, we have second level employees dealing with the patients and the top level licensed people sitting around documenting.

It is rather unfortunate. I have made the statement that when a nurse wears out the back of her uniform before she wears out the front of her

uniform, that's kind of a sad commentary on nursing. What we have had to do in some cases is to hire people to do documenting and hire other people to supervise and make sure that the care is excellent.

We attended a conference three or four years ago, and we were invited to outline the problem areas of being the administrator of a nursing home. I've always been one that wore my heart on my sleeve and perhaps spoke up when it would have been the better part of valor to keep my mouth shut. When I mentioned that one of the areas of concern to a nursing home administrator was the Department of Health inspections, the fellow said, "All right, next."

I said, "Wait a minute. I'm not through. Department of Health inspections — how to provide good care in spite of them."

Of course I had a Department of Health nurse who came up to me afterwards and was explaining all of the requirements and mandates by the federal government that made her require so many things of me. I said, "Well, do you consider yourself a registered professional nurse?" She said yes she did. I said it seems to me that as a registered professional that you ought to tell the federal government to "go to hell" if it didn't make sense and contributed to lesser patient care rather than more patient care. Because I had been outspoken a number of times, I sometimes haven't been too popular in certain circles of the State Health Department.

The interesting thing is -- let's go back to how nursing homes began. Most people will remember that way back in the latter part of the nineteenth century, or early part of the twentieth century, they had the county poor farms, as they called them. They usually were placed where there was a building that would house anywhere from twenty-five to fifty or seventy-five people. If someone had no children or no family and got old, they were taken

out there and they got board and room and if they could still function by working in the kitchen, or working in a garden, or helping on the farm to grow their own vegetables and all, they were required to do that. It was a very dreary existence. Even though that was a forerunner of nursing homes, what most people don't realize is that it was the social security system that actually was responsible for many of the older, smaller, converted house nursing homes.

What would happen, starting in about 1936, was that a local county welfare director would have five or six older people who had recently retired and who were maybe getting a forty, fifty, sixty dollar a month Social Security check. It was still the middle of the Great Depression, and he would likewise have some man forty-five, fifty years of age walk in and apply for welfare because he had lost his job or the company had closed or something. The conversation would go something like this. The welfare director would say, "How big a house do you have?"

"Well, I've got a big farm house out here at the edge of town."

"How many bedrooms?"

"I've got three bedrooms."

"How many kids have you got living at home yet?"

"They are all married except I have a sixteen year old daughter."

The welfare director would say, "How would you and your wife like to take in four or five of these old folks that are getting sixty or seventy dollars a month, and take care of them for their Social Security check? That way you won't have to go on welfare and I've got some place to put these five or six people who need care that I don't know what else to do with."

By this time, most of the county poor farms, so-called, had been closed

or phased out. So, in 1956, when we built this first nursing home, there were 613 nursing homes in Michigan -- more than there is today. But the average bed size was only thirteen beds. Every one of them were converted houses. Some of them were farm houses out in the country. Some of them were converted two-family flats in cities and small towns. In most instances they were being operated by a widow woman.

I remember the first Nursing Home Association meetings we went to back in the middle 1950s, there would be four or five men. The rest of the fifty or sixty or seventy people would all be women. My wife was considered somewhat of an oddball at that time because she was a registered nurse and, in addition, was also a registered x-ray and medical laboratory technician. She was probably asked at least a hundred times, "What the devil are you doing wasting your time in the nursing home business?"

As I recall, there were only two other ladies, a Mrs. Kathleen Moncrief and a Frances Sawyer, who lived in Plymouth, that were registered nurses. We, quite soon, developed an affinity for these other two ladies because they were hoping that the nursing home field would become more professional, and that better nursing care would result from more, either licensed practical nurses or registered nurses, becoming involved in nursing homes.

It was in 1956, after I completed the building, that I became active in the association. We had some of the oldtimers that were very discouraged by the new rules and regulations that went in in 1956, in Michigan. There was Public Act 139 passed in the state legislature that moved the licensure of nursing homes from the Department of Social Services, or a local welfare department, to the Department of Health. There had been licensure of nursing homes from 1950 through 1956 in the Department of Social Services. But, in

many cases, since they were the people paying for the care, it consisted of somebody from the department coming in, having a cup of coffee in the living room or the kitchen and saying, "Gee, you ought to paint up this place, it's starting to look pretty crummy."

Of course the owner would say, "If I paint the place you are going to have to pay me fifty cents a day more for the care of these patients."

She'd say, "In that case, we don't have the money. You had better leave it like it is." About an hour a year, and that was about the size of it.

I was on the original committee selected by the State Health Commissioner, Dr. Albert Heustis, to review the proposed rules. We met four or five times, and we supported this Public Act 139 that got the regulation of nursing homes over into the Department of Health. We had several ideas at that time. We thought this perhaps might stop some of the criticism that we had had leveled at us. Plus the fact that we had this tug-of-war going on all of the time between the Department of Social Service about when you said you wanted any more money for the care of patients, they would always ease back on the rules.

Interestingly, when we started in 1951, the prevailing rate in Michigan's nursing homes in southeastern Michigan was $125 a month. We found it very difficult to provide care at that rate. Our rate was about $150 a month, and we were getting people at that rate, although we still had a few of the original people who came in at $125. In order to provide good food in our original facility, my wife and I would work all day and then we would go out in the evening and would buy the loss leader of canned fruit juices, tomato juice and all, at fourteen cents a can for a forty-six ounce can. It was the loss leader — at a local supermarket. We would carry these out to the trunk

of the car. Then we would go out to the day old bread place, Koepplinger Bakeries out of Detroit, and buy two loaves of real good health bread for fifteen cents. We would buy powdered milk in hundred pound bags, and mix up milk and use a lot of that in the cooking. But we were able to provide good food and still keep our head above water and all, even at those rates of $150 a month.

We went for a nine year period, even with our new building, back in the 1950s to the early 1960s, with a rate of nine dollars a day in a two bed room. Then, with the increasing number of regulations, plus the starting of inflation and all, we had to raise rates three times in an eighteen month period. And we have had to raise them annually ever since. Of course, today our rates are still substantially below other people because we have been very conservative. Whitehall Convalescent Homes is the smallest of seven hundred companies in Michigan that is self-insured on workers' compensation.

Having started in those early days when we had to be so frugal and so careful, we have always spent money for what was important for patients, but we have never become reckless, as many people who have gotten into the field in later years, about spending money for unnecessary things where the costs of those expenditures have to be passed along to the patients or whoever is paying the bill.

My wife's parents had come to Pittsfield Township in Washtenaw County, near Ann Arbor, in 1940. Her father died in 1953 and her mother was growing older. Her mother had worked a lot in the early nursing homes, until she was eighty years old. We were talking about building another nursing home, and we had pretty much decided that the Ann Arbor area, or Ypsilanti area, was a pretty good place to build. My mother-in-law offered to give us a corner of

the farm in order to build a new nursing home out that way. Although we could tell by the expression on her face that she thought one nursing home was probably more than we ought to ever have tackled, and then when we had two and when we were talking about a third one, she would get real quiet. We could tell by the look on her face that she thought three nursing homes was absolutely crazy, but she wanted to cooperate and she was a wonderful person. So she did offer us what had been the corner pasture for a nursing home.

When we first built here in the Ann Arbor area, we were out in the country. People would ask me why we chose that site to build a nursing home. Of course I always had a standard little story I told them. I said this nursing home is exactly in the population center of Washtenaw County. It's six miles from Saline, nine miles from Milan, six miles from downtown Ypsilanti, and six miles from downtown Ann Arbor. In addition to all of that, my mother-in-law gave me the land. And that's the real reason. Because we, again, started all over again to build.

We built, essentially, from the same floor plan and the same as the first 40 beds. By February of 1958, we had expanded to 122 beds. Then, in 1959, we built another 24 beds because we found that the Ann Arbor area was very receptive to us. We also found that there was a greater demand for private rooms in the Ann Arbor area. I don't know whether it was the fact that we had a lot of retired professors, but they had had the wherewithal to pay for private rooms. Some of them liked their privacy. Many of them liked their bookshelves with their favorite books that they brought along.

Our original 40 bed nursing home had had 18 two bed rooms and four private rooms. At our original place at Novi we found that that pretty much balanced the requests of rooms and people's ability to pay for them. But when

we built our south wing of 24 beds, we built eight private rooms and eight two-bed rooms. Then in 1962, we built an additional thirty-eight beds on. Again, half of the rooms were private rooms. So that in our 102 bed facility in the Ann Arbor area we ended up with 27 private rooms out of the 102 beds, or roughly twenty-five percent of the entire building. The rest of them are two-bed rooms, except one four-bed room that we set up sort of as intensive care -- patients that required quite a bit of care. Although that really never worked out too well, we have continued to use it in that way.

By 1962, we were the second largest nursing home organization in Michigan. But again, we made a conscious decision not to keep expanding and expanding because we found that we liked the personal relationship with the patients and with their families. One of the reasons that I had left the plumbing and heating industry years before was because of the fact that I found myself to an ever greater degree dealing with things rather than people. And I was a people oriented person myself. I could see myself getting to the place where all I would be doing was just walking through or by a nursing home and saying, "I own it," or "I'm president of the company that does." I didn't want that to happen.

I had played a harmonica since I was seven years old, and I enjoyed putting patients' parties on in the facilities and bringing in groups of friends that put on square dances for the patients -- square dance demonstrations, and all different kinds of special entertainment events. We located a fellow that had little Shetland ponies. We had a regular carnival-type picnic party in the summertime, and had the ponies come out for all the children to ride. All the old folks would get a kick out of watching their grandchildren or great-grandchildren riding the ponies. A couple of the

ponies would haul a little wagon with hay in it so we had some hay rides for some of those who were either too big or too small to ride the ponies. Always this type of activity is something that we had always leaned towards. In other words, something on which you could spend the money that really meant something to people.

Again, we participated in some of the early conferences. I remember one lady whom I was talking to about what a good time our patients had at one of these parties and she looked at me real seriously and she said, "Oh, my patients couldn't stand any of that. We don't have anything of that nature. Why, it would kill my patients to participate in anything like that."

I remember my answer was, "Well, it might kill some of mine, but, by golly, they are going to die with a smile on their face anyway."

Of course, we never have, in all of these thirty-five years, we have never had an incident where a patient had any kind of a spell or heartattack because we had a good time going on. But that was an old-fashioned idea, that somehow or other, if a person had been quite ill, that everything of a frivolous or entertaining type of activity should be denied them because it might get them excited and they would die from it. Of course, they died from boredom, I think, in a lot of cases.

The development of regulations for nursing homes started out in an orderly fashion in Michigan with our original 1956 rules and regulations -- and these were very similar all over the United States. Because just as nursing home associations had their individual state affiliates and an American Nursing Home Association, the departments of health, when they got into the licensure of nursing homes, started having a national association of departments of health and comparing notes and discussing problems and

developing similar laws and regulations. Evidence of this is that in 1965-66, when Medicare and Medicaid was being proposed, Senator Ted Kennedy asked one of his aides to find out if all nursing homes were licensed. He checked through and there were only two states out of the fifty that were not licensed -- that did not have licensing programs by that time in history. So Ted Kennedy asked his aide to prepare a bill, or an amendment to Medicaid, that would require the licensure of all nursing homes. Somehow or other the communications got fouled up. Instead of requiring the licensure of all nursing homes, it required the licensure of all nursing home administrators. So, to this day, you do not have to be licensed to be the administrator of a one thousand bed hospital, but you have to be licensed to be the administrator of a sixty bed nursing home.

For those who know the history of the situation, it has become somewhat of a joke. That someone who was the administrator of a 300 bed hospital, and who transfers or comes into the nursing home field, has to, in effect, be licensed as a nursing home administrator or the home can't function with him, or her, as the administrator. But it is one of the peculiar things that happened with the advent of Medicare and Medicaid in 1965-1966.

WEEKS:

Your speaking of nursing home administrators being licensed brings a question to my mind as to whether there are qualifications that are necessary for licensure -- educational requirements and this sort of thing.

JOHNSON:

When the program was first implemented about 19 years ago, the State of Michigan asked that the association form a committee. I was a member of that committee, along with a Dr. Robert Cotton from Grass Lake who was a past

college president before he got into the nursing home field as an administrator. He was a Ph.D. doctor, not a medical doctor. Three or four of us sat down with Michigan State University officials and developed a curriculum that we thought was appropriate for people to take who wanted to become nursing home administrators. Most of us who were administrators at that time were grandfathered in. Mrs. Johnson and I both taught classes for the first couple of years, starting about 1967 or so -- Michigan State University sponsored classes in Kalamazoo, Grand Rapids, Flint, Detroit, and Jackson. We got the program under way.

Mrs. Johnson taught a class in family counseling. In our original discussions there were certain peripheral things other than accounting and nursing care that one would need to become a nursing home administrator. We got into areas like interior decorating and landscaping. I taught one class in interior decorating and landscaping, not from the standpoint of making an administrator a skilled interior decorator or landscaper, but to know certain facts about interior decorating -- for instance, don't have wallpaper that has great big red and white stripes in the living room where a patient has to spend five or six hours a day. In other words, a decorating that would be appropriate for a fancy restaurant or bar or lounge would not necessarily be appropriate for a nursing home. We stressed that monochromatic type decorating was probably much more acceptable, similar to what you use in places where people spend hours on end in a living room or dining room or a day room rather than just one hour a month.

In the landscape area, we did point out that since so many new nursing homes were being built one of the problems was getting mature trees around the building. One of the things we did in landscaping was to show them how to

build a little gazebo that would provide shade for the patients while the trees were reaching maturity because so many nursing homes were new at that time and outside shade would be ten or fifteen years away.

The other class that I taught was public relations. Again, I was not teaching a class in professional public relations, but taught people what was potential news items for the local newspaper, how to contact the paper and become friendly with them before something unfortunate happened at the nursing home, so that, at least they would have a working relationship with the local radio, TV, if they had TV, and newspaper media in their community. A year or so later, a national test was developed for nursing home administrators, and this test is given a couple of times every year for those people going into the field. It's a test that takes four to six hours to complete. The latest information that I have is that there are some 1,200 licensed nursing home administrators in Michigan, although there are only about 400 nursing homes.

Now we have about five licensed administrators in our Whitehall Convalescent Homes organization, even though we only have the two homes. But we feel that we do not want to be at the mercy of having to go out and hire someone we don't know should one of our administrators become ill or have to be off work for six months or a year.

There are requirements. Again, it's unusual because the same thing does not hold true for hospitals.

WEEKS:

This is a question that has been debated a great deal in the hospital industry, of course, whether they should be licensed. Under Medicare regulations, one of the few places where this question has been addressed, if an administrator is a graduate of an approved graduate program he

automatically is qualified.

JOHNSON:

Incidentally, they recognize that an approved program in hospital administration in not requiring additional training by people going into nursing home administration. We have one man working for us right now that was a graduate of the University of Michigan Department of Hospital Administration, who actually was an administrator of a 300 bed hospital for a number of years before he came to us. But, interestingly, he still had to go ahead and get his license as a nursing home administrator. They gave him credit for the training and experience, although he still had to take this national test, and pass it. If he had not passed that test, he would not have been able to be employed in a nursing home.

Those who are doing the regulating and those who are doing the accrediting, it seems to me -- and this is a matter of my personal opinion -- have tried to outdo each other. In other words, the original licensure standards were less than the standards for accreditation. But then, within a period of time, the licensure standards asked for everything that accreditation asked for of a hospital or a nursing home. So the accreditation people figured, what the heck, there won't be any need for us if we don't develop some additional standards that we can ask for. It's been a game of catch-up ever since, where accreditation comes along and asks for things and two or three years later, licensure comes along and asks for the same thing. There has been a spillover from hospitals to nursing homes in this particular area. When they started to experience a lot of problems with infections, secondary infections, that are developed in the hospitals -- a patient comes in and has surgery and does not have an infection, but has an infection before

he leaves the hospital -- the need for infection control committees has spilled over and is now a requirement in nursing homes. The interesting thing about all of this is one statement that I made many years ago and that was, "We ought to be extremely careful, those of us who are leaders in the nursing home field, we ought to be extremely careful, as professionals, that we don't allow ourselves to have imposed on us unnecessary standards which cost the public a good deal of money."

I have always said that when we allow nursing homes to become too expensive that society will find a way to develop a substitute for nursing homes, and to a certain extent that has happened in the last five or six years.

In nursing home care today, the prevailing rate for private pay is probably about $55 to $60 a day, on the average. Some will run as high as $80 a day. In our particular case, our present rate for a two bed, semi-private room is $47 a day. But, again, as I point out, we have done well because we can give both low price and top quality care. Whenever you can give both price and quality, you have an unbeatable combination -- no matter what the service you are providing.

There are three states, California, Michigan and North Carolina, that have developed a very active program of permit foster care homes. There have always been foster care homes since day one. The original nursing home regulations said that you could take up to three patients, or residents, in a foster care home without the necessity of licensure. About fifteen years ago a law was passed in Michigan allowing the issuing of permits for $15 a year, no licensure standards — this is not a license, this is, in effect, a permit which allows the state to know that you are there. That's about all it does.

It gives the address, the name of the owner and all...

WEEKS:

No inspection?

JOHNSON:

No inspection. They had some rather rudimentary guidelines about having a second means of egress from a second floor, if you have patients on the second floor, which is good sense as far as fire marshal's regulations are concerned. But about the only thing that they really require is that you have somebody over eighteen years of age, who is on the premises twenty-four hours a day.

Michigan and California and North Carolina are the three states that have developed a great number of beds in these foster care homes. California has more than 20,000 beds, Michigan has over 12,000 beds, and North Carolina has over 9,000 beds. We find that today, many, many people are being sent to foster care homes that would have previously been thought of as nursing home patients. In fact, certain foster care home operators have now become chain organizations, and they can take up to eight patients. In fact, here in Washtenaw County there are... You have probably read in the paper about the fact that many foster care homes have been developed in this community. In many instances this is very good, if the homes are smaller and well managed and if the people are up and around and can get to a dining room, but should be people who need custodial board and room -- and that only. But we find now that there are chains of foster care homes who are not required to have any skilled personnel, who are advertising and taking very difficult Alzheimer's patients. To me, this has almost gone full-circle. The small homes being supervised by untrained people, -- that was the nursing home industry in

Michigan when I first came into it thirty-five years ago. I'm not sure it's a good development. For the taxpayers, it's cheap. But if it is really our intention to provide excellent care, it does little good to lay on layer after layer of inspection on licensed nursing homes and then send a substantial number of people who perhaps or could have been sent to a licensed nursing home, to facilities which have little or no standards.

I have always endorsed the small, personal relationship of these small homes where a person's needs were getting meals on time and that type of thing. If a person is ninety-two years old, and can no longer drive a car, is afraid of slipping on the ice, and can't get out of the house in the winter time, that that is the type of person requiring custodial board and room. Maybe there is a daughter living in Idaho or something, but the elderly wants to stay in the locality where they lived for forty years. This is where the minister of their church is, and they can get out to church if somebody takes them -- then the foster care home does an excellent job. But I have become very concerned in the last few years that the state department of social services has actually been directing people into these facilities. In some cases these facilities have been charging $60 and $70 a day. In other words, they are not necessarily cheap.

WEEKS:

It isn't due to lack of beds in the normal nursing homes, is it?

JOHNSON:

To a certain extent that has contributed to it, but about twelve years ago, as I recall, there was a nursing home-hospital planning law that mandated planning agencies in every area of the United States so that you have to go and apply and get a certificate of need for extra nursing home beds. In

Michigan, we went ten years and they allowed absolutely no nursing home beds. During that time there was a tremendous increase in the number of people who potentially would require and need nursing home care. It almost looked like it was a situation where the state was deliberately choking off licensed nursing home beds and promoting foster care homes, so that an ever greater number of these people would go into those facilities under the SSI reimbursement, if they required government help as far as reimbursement is concerned. That rate is a little under $20 a day. Now compare that with an average Medicaid rate in Michigan of about $38 to $40, a day and obviously it's self-evident that the state is saving millions of dollars by utilizing these facilities.

I sometimes suspected that in their zeal to save money that they have laid on these layers of extra regulations on nursing homes. Let me give you an example of the type of regulation that I mean that is really not very productive. We may have a patient with us six or seven years -- and many of our patients are with us over a long period of time. In fact, one patient who has been with us the longest has been with us twenty-six and a half years, in our Novi facility. She came in with her mother. She was only aged fifty-five, mentally retarded. Her mother had cared for her as you would for a three or four year old child. This woman is eighty-one and a half years old today, and she is still alive and still being cared for at our facility. So, we may have a patient with us for six or seven years and that patient may come in after a stroke, and may be walking with a walker or with a cane, getting to the dining room. After a patient is with us six or eight months or a year, there may be further deterioration where she has to be in a wheelchair, have medications changed from time to time, as she is seen periodically by her

doctor, and she eventually dies. She may have been 84 years old when she came in with us, and maybe she is 91 when she dies. The current regulations require us to make a discharge summary. We have to go back, and it has to be a registered or a licensed nurse that does this, go back to the time of admittance and capsulize every single thing that has happened to that person in that six or seven years. That discharge summary has to be filed with that patient's final chart. No one, to my knowledge, has ever looked at those discharge summaries except the inspecting nurses when they come in once a year. They look at them and if they are not in absolute, perfect order, they write you up for that and cite you as violating the rules and regulations.

Now I have asked two or three of these people and the best answer I've ever gotten as to why they require that, is that "somebody might want to do some research someday." Of course, my answer is, "Why in the world would anybody want to do any research to find out why a 91 year old lady, after six or seven years in a nursing home, eventually dies -- when she had had some sort of debilitating illness or trauma before she came in?"

Our society most certainly wants to know why a 45 year old father of four dies of heart disease, but Good Lord, there is no way we can waste tax dollars by funding research to find out why people up in their eighties and nineties finally die after being six or seven years in a nursing home.

That's just one example of unnecessary regulation. Of course it has always been our policy to do just about all of these things that are required, except they were never written down. Now, I give as an example, and I think I have used that example in one of my newsletters that you've read, that if you take a mother of six children... Many well organized mothers of large families do an excellent job of providing for the needs of a family of six children.

But I just ask you to imagine what kind of a mess or problem you'd have if you required that mother of six children to write down every single thing she did for those children, twenty-four hours a day, seven days a week, 365 days a year. It is not the fact that we haven't always gotten some kind of a social history. We wanted to know what somebody did in life, so that when we introduced them we could say, "This is Mr. Jones. He worked forty-five years for Chrysler Corporation before he retired. He has a lovely wife and four children and nine grandchildren."

That's something we have always found out. But now this all has to be written down and documented as part of a social history. The original admittance forms that we used were a single page form, on two sides, which included the person's choice of religion, the person's nearest relative or person on call and two other people who would be on call if the first person was unavailable.

Today, it takes approximately four hours to admit a new patient because there are several pages of patients' rights that we have to have the patient (or his relative if the patient is unable to) read and sign that they have read all of these things. I don't have the exact number of pages, but I would judge close to twenty or thirty pages of stuff necessary to admit the patient under today's standards -- in addition to it taking about four hours by the time we get the patient from the front door into the patient's room and all checked in.

The regulations on food services: For every new patient we are supposed to take every food item on the plate and make an evaluation after every meal telling how much of the portion of each item that the patient ate. That is supposed to be recorded and kept for at least a minimum two-week period on

every patient. And in a skilled nursing home, it has to be kept forever. In other words, every day that that patient is there this thing is supposed to be there.

It has always been our policy to have classes and to teach people who are working as nurse aides, on what are proteins, what are carbohydrates. We didn't want somebody to say that a patient ate half her meal and have half of the meal be the bread and the pudding and leave all of the meat, or all that was protein. But, never in our wildest dreams, did we ever think that we would get to the place where we were supposed to say the person ate one-third of their pudding, four-fifths of their meat, one-half of their bread, three-quarters of their glass of milk, etc., and record all of this. It has become a very difficult thing. As these new regulations come in, it seems like they enforce them to the enth degree when they first come in. Then, when they realize the impracticality of them, and the impossibility, and the fact that if they require too much that you are going to lose the wheat in all of that chaff, that they eventually back off and they don't pay much attention to them. But you never can be quite sure which of these 170 pages of regulations that are laid on nursing homes today are going to be those things which are going to be the target for this year. In fact, it has become somewhat of a game among nursing home administrators that if somebody is scheduled to be inspected in August, you call somebody who was inspected in July and say, "What's the target for this year that they are leaning on?" Because it's physically impossible to cover all of the 170 pages of regulations all of the time. We are on the verge now of a complete new inspection procedure, which, again, is frightening to nursing home people who have become used to the old inspection procedure. But it is interesting because it was nearly twenty

years ago, before a Senate committee in the State of Michigan, that I got into a strong argument with Dr. Herman Ziel from the Department of Health, because I was criticizing the fact that they were inspecting on a quantitative basis rather than on a qualitative basis. They would get a report that some nursing home was serving poor food. What they would do was increase the required kitchen size in all nursing homes in the state, notwithstanding the fact that it may have been the nursing home with the largest kitchen that was serving the poor food. To me this made no sense.

In all honesty, what they have done is that they have used quantitative standards in order to protect their tail in court. But the way they have functioned, in effect, is that they come in and if they know that you are providing good nursing home care, they evaluate you subjectively and don't nitpick on the quantitative standards. But they have the quantitative standards in their side pocket through which they can clobber you if, in effect, they subjectively decide that you are not providing good nursing care.

These new rules and regulations, as nearly as I can tell at this juncture, and I may be critical later on depending on how they are administered, they appear to be very much like the recommendations I put into a letter to Vice President Bush over four years ago recommending that qualitative standards be developed.

In the midst of this original argument, Dr. Ziel said to me, "Lloyd Johnson, there is never any way that we can develop a qualitative standard."

My answer was, "You may not believe it, and you may not have any people who are trained to do it, but until we get the qualitative standards to nursing homes, there will continue to be public dissatisfaction and criticism and things that blow up every so often as far as nursing homes are concerned."

For instance, the bed sores that have developed within our nursing homes over the last thirty-five years you could count on the fingers of one hand. I won't sit here and tell you that we have never had any, but we usually could pinpoint where someone failed in their job when one started to develop. We have never had the deep stage three decubiti that are experienced in some medical care institutions. Some people will tell you that there is no way you can prevent bed sores if a patient can't turn over in bed by themselves. Well, there is, but they have to be turned every hour and a half, throughout the day, seven days a week, if you are going to prevent them. And the patient has to be kept properly clean.

Incidentally, because my wife is a good nurse, and because we have worked together for thirty-five years and because we've discussed all of these things, in some instances I have been sort of the advocate of good care. I got my wife into a project a few years ago -- Parke Davis printed up some 20,000 copies of these little booklets called "Operation Zero Bed Sores." We always thought that we could start to accentuate the positive -- what we were doing in nursing homes in preventing bed sores. Again, I have been the articulate one. So even though many of these ideas that I express today are the ideas and philosophy and principles of my wife, generally speaking I have been able to stand up and communicate them a little bit better. So I have found myself testifying before Senate and House committees locally and that type of thing.

We still have that philosophy today. Several years ago someone asked me, after hearing me talk about good care -- they say, "You go on and on, but can you express good nursing home care in one sentence?"

I said, "Wow! After talking about it for a half hour that's kind of a big

order."

But I worked on it over two or three days and I came up with a sentence, although it's a long one. I think it expresses it very well. We use it in our training programs and we use it in our training manuals and brochures and things. In this one sentence I said, "Our job in a nursing home is to let patients know that they are loved and respected, to keep them clean, dry, and well-nourished, and to help them do as much as they can, as well as they can, for as long as they can."

I have shown that to many people and they have said that if a nursing home does that, most certainly you are going to be doing a pretty good job. If there is any of that you aren't doing, you are falling down some place on the job.

One of the things that has disturbed me over the years is the tendency of nursing home owners and administrators to feel that their public is the state health department and the state fire marshal. Now, I think there a role to be played, and I respect it greatly, to be played in the inspection of nursing homes. But I have told some of these people, sometimes offending them, that I want to please you, if possible, but you aren't the people that I am really interested in pleasing. Our public in a nursing home is the patient, the patient's family, and the patient's doctor. I have continually reiterated this to our staff and our licensed people. We can please the health department and the fire marshal, but if somehow or other we are not pleasing the patient and the patient's family and the family doctor, we probably are not going to survive as a nursing home. That's where the primary emphasis ought to be, is in those three publics, and in that descending order. The patient is first.

In some cases it has disturbed me that there have been cases I happened to know about where a patient and his daughter, or son weren't getting along too well. The patient was brought into a nursing home and the family and the nursing home would almost gang up on the patient. In other words, the patient might have legitimate complaints, but the decision of the daughter and the director of nursing might be, that she's complained for twenty years and she has given me a hard time and she's just still in the same old pattern, when maybe the complaint was serious and necessary. That's why I say that the patient, the patient's family and the doctor, in that order. Again, some people have knocked themselves out to please the doctors because doctors refer patients. That's fine. But the doctor doesn't have to spend twenty-four hours a day, seven days a week, under the roof of that nursing home.

WEEKS:

You spoke of accreditation, you spoke of quality of care. I was wondering if there is an organization in your industry similar to the Joint Commission on Accreditation of Hospitals?

JOHNSON:

There is. In fact, it's the same organization. They have a division for the accreditation of long-term care. Again, I was in on the founding of that. I seem to be in on so many things having been an officer of the association. I was nineteen years on the board of directors of two nursing homes groups which are now merged and have become the Health Care Association of Michigan. I was three years the president of one, and two years the president of the other. I wrote the newsletter for the one organization for five years, and three years for the other. For eight years, I was the only lobbyist that the Michigan Nursing Home Association had in Lansing. We had an old fellow that

was a retired legislator who represented half a dozen accounts and he kept track of when there were going to be hearings and all, and would call me sometimes at eleven o'clock and say, "Lloyd, there is going to be a hearing at one o'clock of the Senate health and welfare committee. Can you hurry up here?"

I would jump in my car and leave everything and race up to Lansing and testify. We never had him testify, but he kept track of things so that we could do it without being in Lansing, standing around the halls all the time.

The original Blue Cross coverage of nursing homes in Michigan, I negotiated that and also the original Medicaid contract. It wasn't a contract but a plan for reimbursing nursing homes in 1966. I had served in the presidency in 1964 and 1965, and was looking forward to a nice elder statesman role as the past president. The incoming president, the first thing he asked me to do was to head up a committee to negotiate this plan for reimbursing Michigan's nursing homes under Medicaid in 1966. It was a tremendous job, and it was a job that the department of social services at the state level didn't relish because it was plowing new ground, so to speak. California was the first state to develop a Medicaid plan and I believe Michigan was second and New York was third, or New York may have been second and Michigan third. But we were pioneering in getting this program off the ground. I remember that I had a special consultant that they paid $100 a day who came and briefed me on the new Medicaid and Medicare law. By early in 1966, I probably was about as knowledgeable about Medicare and Medicaid as anybody in the country.

This fellow that we brought in as a consultant was a fellow who had sat in with the legislative committees all the way through in the development of the Title XVIII and Title XIX, Medicare/Medicaid laws. So, in many cases,

where it was very difficult to understand the fine print developed by the bureaucrats, this fellow could tell you what they had in mind in Congress when they developed that and what it really meant, although sometimes it was a little ambiguous to try to figure out.

We developed a committee of four or five people. We started out and I think we had nineteen meetings. Again, using my shorthand that I had used in my secretarial work many years before, I took copious notes at these meetings. Each time I would come back and type all these things out and send them to all of those who had been at the meeting. We had a representative from the state health department, and we had, as I recall, one of the state representatives, plus two or three members including the Assistant Director of the Michigan Department of Social Services. It was getting late in the legislative session and I found that the bureaucrats in the Department of Social Services were starting to backpedal all over the place. They wanted to start over again three or four times and I would say, "No, we discussed that way back on the nineteenth of April." Then I would quote them scripture and verse of what they had been sent that I had typed out. In other words, I became the official scribe for what was going on. Each time I had sent a covering letter saying if you don't agree that this is what we concluded at this meeting, please respond. Of course they didn't respond, so it became the record of what had gone on before.

I remember that Bernard Houston, who was Director of Social Services and a very fine man and a good friend before and after, even ducked out of his office so that he couldn't be pinned down. We ran over and nailed him down in the state capitol building right in front of the House of Representatives and finally came to an agreement.

What had happened was that under the old welfare plan it was not nearly as generous as the Medicaid plan, and you had about twenty-five percent of the patients that were "welfare supported" nursing home patients. Under the new Medicaid plan, you were going to have seventy-five percent of the people who were going to be supported by Medicaid because, for the first time in history, there was no such thing as a responsible relative. Under the old welfare program, if you had a son or a daughter making $20,000 a year, they had to contribute something, or might have to pay the whole amount. Welfare wouldn't step into the picture. But the responsible relative was completely eliminated. The only responsible relatives left was a parent for a minor child and a spouse for a spouse -- a husband was responsible for a wife, or vice-versa. But sons and daughters were completely left out of the picture.

The welfare rate at the time, in 1966, was about $7 a day for nursing home care. But the cost was about $9 a day, or a little more. But you could charge nine or ten dollars a day for private care paying patients and you could in effect subsidize the twenty-five percent of the people who had sometimes been with you three or four years and had run out of money. So you continued to care for them at what the county and the state was willing to pay. But, obviously, you could not subsidize seventy-five percent of the patients with only twenty-five percent paying privately. So the state was nonplussed by the fact that we had to go from a formula that paid $7 a day up to a formula that paid a minimum of $10 a day. In fact, our original plan called for classifying patients according to the care requirement, into four classifications and reimbursing at the rate of $10, $12, $14, and $16 a day, with only an estimated six or eight percent of the patients qualifying for the top rate of $16 a day.

We finally got it through when I made a commitment to Bernard Houston, the state social service director, that if he found, after this plan was implemented, that nursing homes were abusing it and trying to classify patients in a higher category, that I personally would go anywhere in the state to confront this person and get my people back into line. In fact, I did that in two or three instances where nursing homes were trying to classify seventy or eighty percent of their patients at $16 a day rather than a correct amount. The amazing thing was that at that time there were about 400 nursing homes in the state, but there were only two or three instances where people actually abused the program, because I went out and I laid it on the line to my people at meetings around the state that I fought very, very hard for you and I got you a plan by which you can pay fair wages, in which you can make some kind of a fair profit -- now don't foul it up. I worked very hard in getting that plan.

Michigan ended up with its first Medicaid reimbursement program -- it was considered the best plan in the nation. Of course I was very proud of this. It was very difficult.

Preceeding the Medicare/Medicaid plan for nursing homes, we operated for about a three or four year period under the old Kerr-Mills bill. I understand one of your previous interviewees was Wilbur Mills who was co-author of that bill. When that was implemented in Michigan, it created a great deal of problems for nursing homes because what it did was it classified the county-owned medical care facilities, which were county owned nursing homes and operated under the same criteria and regulations as nursing homes, but it classified those as hospitals. Now the reimbursement formula for the use of federal funds, reimbursed the state forty percent for hospital costs, but only

ten percent for nursing home costs. The net effect was that a county could have its own nursing home and spend $12 a day. From the county's standpoint it was cheaper to put the person in their own nursing home at $12 a day than it was in a privately owned nursing home at $7 a day. Because they only got seventy cents back on the one, but they got $4.80 back out of the $12 in their own nursing home. For that three or four year period of time we saw a situation develop where the counties built more than 5,000 of their own nursing home beds in Michigan.

When Medicare and Medicaid came in, it clobbered the counties in that, to this day, the state legislature still has to reimburse county owned nursing homes a little higher than they do the church-owned or the privately-owned nursing homes because they, in many cases, passed bond issues to create these monstrosities of county-owned nursing homes and they were stuck with it for twenty or thirty years. There was only a three or four year period in which they had a particular advantage. I was active in the legislature, and I had a great deal of difficulty communicating this. The fellow that was chairman of the health and welfare committee was a funeral director from the little town of Scottville in Michigan. The way I finally communicated was I said, "Well, Senator, supposing that they built a county-owned funeral home in your community and supposing that when a person died they paid them, the county-owned home, $500 for a funeral, and you, who had been there for a long time and owned your own funeral home and were a licensed funeral director, they only paid you $350. What would you think about that?"

His eyes flashed and he said, "I'd raise hell!"

I said, "Senator, I have been trying to communicate this to you for a long time now and this is just exactly what I'm doing because that's what is

happening under the Kerr-Mills situation. The county builds its own nursing home and pays itself five dollars a day more than they pay us, but they get enough money back from the federal government." So we finally got a bill passed just about six months before Medicare and Medicaid came in that equalized the relationship between county-owned nursing homes and privately-owned and church-owned nursing homes.

It was an interesting period in history, and I was right in the middle of it. Then, of course, I became chairman of the committee that negotiated the first Medicaid reimbursement. Governor Romney was governor of Michigan at that time, and I recall that the legislature, acting on the recommendations of the budget director, actually budgeted $39 million for nursing home care that year. They had to come back with supplementary appropriations three different times because it actually cost $70 million. Now, unfortunately, the director of the budget had projected it based on the county welfare rate, and added maybe a little fifty cents a day. In fact, it almost ruined nursing homes in several other states because they didn't do their homework. We went out with CPAs and got cost figures from over 100 nursing homes and analyzed all these cost figures. We had the facts in our hip pocket when we went in there to negotiate. But certain states, like Ohio, I think they settled for a $7 a day rate. When they started getting three-quarters of their patients at a rate of two dollars a day below cost, they ended up with a very difficult situation until three or four years later when they could go in and prove that their costs were actually much higher. Of course, all of this time the costs were escalating because inflation was starting to make itself known in the health care field.

WEEKS:

I did want to follow up a bit on that Joint Commission. That's a volunteer program. Have you ever asked them to come in?

JOHNSON:

Yes, I did. I sat in with the powers that be when that was organized -- the Joint Commission for the Accreditation of Nursing Homes, which I explained was an offshoot of the accreditation of hospitals. I found that their concept of nursing home care was completely out in left field when they came. I was very disappointed. I had a young lady walk into the nursing home, and again, all she was interested in was records. She didn't want to see one patient. She was a registered nurse, but I remember she had fingernails about an inch long, had her hair lacquered and done up in an upsweep. Frankly speaking, I was very disappointed because I had great hopes for that program, and was one of the early advocates of it. After this person left, I wrote and even before I heard whether it was yes or no, I wrote and withdrew my application. I said, "If you are only going to look at records and documents, then I think you are going to be very wrong in the accreditation of nursing homes."

In fact, it developed in that first year, some of the worst nursing homes and the ones that were in all kinds of trouble with the health department were able to get in there and find out what it was that they wanted to hear and tell them what they wanted to hear, and they ended up being accredited by the joint commission on accreditation while their license was being denied by the State Health Department for poor nursing home care. I'm not sure that's the case any more.

There is one thing that I would like to cover and that is what has happened in the area of medications for patients in the thirty-five years that

we have been operating nursing homes. I recall that the first seven years that we operated nursing homes, there were no tranquilizer drugs at all on the market. Some of the early tranquilizer drugs, when they first came in, were a little hard on patients in that it caused them to jaundice. In those early years, about one out of every three patients that we admitted had to be sent on to a state mental institution. We were caring for patients which we now recognize as Alzheimer's patients. It was not defined then. It was called hardening of the arteries, or organic brain syndrome, or a lot of other things -- in some cases, just senility. The state mental institutions were actually clogged with older people that could not be managed in a nursing home.

I remember how difficult it was for many of these families in the early days to have to tell them that their family member was going to have to be sent to a mental institution, because it had to appear on work records, and on insurance records, and things of that nature that their grandfather or mother or somebody was sent on to a mental institution. So we did many things to try and cope with these people. In some cases it was a matter of working with them four or five days or a week until they became at home in our nursing home.

I remember one old fellow in his late eighties by the name of Charlie Dubb, who came in. He wasn't about to stay. He had to get out and go home. The only way I could cope with it was to tell him that I would walk along with him. I remember we walked around the nursing home eighty-three times. It ended up getting dark and we were all chewed up with mosquito bites and finally old Charlie said, "I can't walk any further, I've got to get in and get to bed." We got him in and got him to bed. He was with us three or four years and never attempted to leave or cared to leave after that time.

We have seen many of these medications come into being over the years. My own mother, being in the nursing home in the early years, was taking a diuretic called Mercuhydrin, which was a mercury derivative. It was the only thing they knew that would counteract congestive heart failure. The unfortunate thing was that after you used it a number of times, one last time you used it you would have complete kidney failure and you were gone. That's, of course, what happened to my mother. She went into complete kidney failure and there was nothing anybody could do about it.

The development of the diuretics like Lasix and Diamox in the early days have proven tremendously effective in controlling congestive heart failure. Many of the medications for senile diabetes have been very effective and also the blood pressure medications that control blood pressure. At one time, the only thing anybody had was phenobarbital. That was a very old drug. They did have the digitalis in the early days, but again, digitalis has been refined into many different kinds of digitalis so that the cardiovascular types of illnesses that killed so many of these people are now being controlled beautifully. In fact, I saw some statistics not too long ago where if you take two people of an equal age, one of whom is perhaps seventy-five years of age and has no chronic illness, another one who has had a stroke, but who receives excellent care in a nursing home with proper medication and diet and activities, that their life expectancy is only three months different. The person who is perfectly healthy at seventy-five on the average will only live three months longer than the person who has had the stroke.

That was not always the case. There was one time in history where nothing could be done. In fact, they put people to bed and fed them soup until they either starved to death or died from another stroke. That was the

old-fashioned treatment and of course they persuaded themselves that they had taken care of their old folks. In some cases they did, but it was a very short period of time that they had to be cared for.

The one thing that has developed, however, with many of these medications is that we have run into a problem in the last few years with over-medication.

There was a woman a few years back who had gone to three different doctors and had gotten three different types of digitalis medication. Her pulse was only thirty when she was admitted to the nursing home. I remember another person who came in with a basket like you would buy tomatoes in, and it was chock full of medications. She took at least one pill of every one of those medications every day. She came in from California and she was almost comatose from over-medication.

The State Health Department has done a study, or I guess it's a national study, and find that the average nursing home patient is taking 6.1 medications per day. For a number of years we have known that these patients not only take too many medications, but in some cases the dosage, where they are taking three or four or five Lasix a day, they become so dehydrated that it's almost impossible to give them enough fluids to keep them from getting dried out. We now have the support -- and this is one area where we agree 100% with the health department -- to do these medication studies and try to get rid of some of these medications that seem to be ganging up on some of the older people.

In some cases we found people that were so over-medicated they would come into the nursing home and by the time we got them off of these medicines, they were reasonably well persons and within thirty days could go home again. Over-medication is a serious problem, not only is it serious from the

standpoint of making zombies, as my wife says, out of some people, but also the expense of the medication.

These are some of our views in the area of medication. Now you asked me a little earlier to comment on some of the public corporations on whose boards I have served.

In 1973, after I finished up some of my service on the State Commission on Aging, I was invited to serve on the board of Medfield Corporation in Florida. Now we had developed three apartment buildings in Florida by this time. We also had a part interest in a nursing home down there. One of the owners of the nursing home was a doctor and was Chairman of the Board of Medfield Corporation. It has been their practice to always have some out-of-state board member in order to avoid getting too many ingrown ideas from the local community. He knew I had served on the Commission on Aging and with the Nursing Home Association and in the health care area, and asked me if I would be interested in serving on their board. Between 1973 and 1978 I had twelve board meetings a year. In the meantime, in 1974, we developed another fifty-five unit apartment building down there, which was the fourth complex. It enabled me to go to Florida once a month and check up on my own construction and still be reimbursed as a board member. For the first time in all of these experiences of serving on outside boards and commissions, I started being paid for some of the experience that I had acquired all of those years.

In 1978, Medfield Corporation received a merger offer from a company called National Medical Enterprises in California, which, although their name didn't say so, was primarily a California company with twenty-three hospitals in California, one hospital in Texas, and one in Washington state. The chairman of the board asked me to investigate this merger offer on a trip that

I was making to California for another purpose. I came back with a bona fide offer of merger with the Medfield Corporation that was about sixty percent higher than our stock was selling for on the American Stock Exchange.

The board thought it was a very generous offer. Our fiduciary responsibility as board members required that we carefully evaluate this merger offer because we had many stockholders who had never received a dividend. We had not been a dividend paying corporation. Some of them had been older people in St. Petersburg, Florida, when they bought the stock. It was our judgment that if a suitable merger, which expanded their investment, could be achieved, and that they could be given a suitable dividend, that this probably was something that we had a legal responsibility to pursue. As we got into it, the president of the company was against this. He was a board member, and he had a perfect right to be against it. But the way he was choosing to fight the merger offer was to foul up the company so that we would be delisted on the American Stock Exchange. He knew that a delisted company cannot be a merger candidate -- would not be approved by the Securities and Exchange Commission.

In September of 1978, the board fired him as president and put me in as president of the corporation. This was a company with 1,500 employees, grossing $40 million a year. Of course the biggest company that I had ever been president of at that time was my own company with about $2.5 or $3 million a year. So it was quite a challenging situation. The understanding was that I would continue to negotiate and try to effectuate this merger, if possible.

It was in April, 1979, that the merger finally became a reality. It worked out as we thought it might in the fact that it was not only a very

generous merger for the shareholders of Medfield, but it gave us a seat on the board of directors of National Medical Enterprises. I was elected by the other directors to this seat on their board. I've served there for nearly eight years. I'm in my eighth year. I haven't missed a meeting yet, incidentally. I went five years on the Medfield board without missing a meeting, going from Michigan to Florida twelve times a year. There are nine board meetings a year with National Medical Enterprises. I have yet to miss a meeting.

This has been a rewarding experience to me in running my own little company, which is now $4.5 to $5 million a year, and which includes four apartment complexes in Florida with a total of 189 apartments; two nursing homes, one with 102 beds, one with 82 beds; and our original Whitehall Convalescent Home which was a converted building which is now functioning as a thirty-one bed home for the aged.

The one thing that this has enabled me to do, serving on this national board, is that I can see all of the new things that come out in the entire spectrum of the health care field. I can be aware of them and either become involved in them or take advantage of certain things or leave them alone, as my judgment dictates, in running my own little company. I have often made the statement that it is much like having a $30,000 consultant on the board of my little company by having this opportunity to see all of these accounting principles, reimbursement principles, etc., that I have been able to see.

I have also had the opportunity of having a much better understanding about the relationship between hospitals, psychiatric hospitals, and rehab hospitals and nursing homes. One of the interesting things that has developed, and is developing recently, is the campus concept of health care.

In fact, there are large hospitals, like Massachusetts General, in the east where they have been a very large, acute care, specialty hospital type of installation, but they are now, in conjunction with National Medical Enterprises, making arrangements to build congregate living and long-term care beds in almost a campus setting along with their large hospital. They own the land and we rent it on a long-term lease.

We are also doing something very similar with the University of Southern California, in the Los Angeles area. This appears to be a development where you end up with a large parking garage, maybe a ten or twelve story ambulatory care building with most of your medical staff and all of your specialties, a long-term care facility with all your levels of long-term care, perhaps a psychiatric hospital or a psychiatric wing to a general hospital, general, acute, med-surg beds, and perhaps a rehabilitative hospital.

One of the interesting developments with rehabilitation hospitals is the theory of having a complete surgical rehabilitative hospital and then satellite rehab hospitals within maybe 100 miles in four or five different directions. Those patients needing surgical rehab would go to the central location, such as the Dallas Rehab Center, which is one of National Medical's hospitals, but satellite hospitals providing occupational and physical therapy and all would provide a lesser level but would meet the needs of probably eighty-five or ninety percent of the patients and would be close to home in that rehab hospital.

WEEKS:

This is the regionalization idea.

JOHNSON:

Yes. But this campus idea -- National Medical has developed a couple of

these. One is in Slidell, Louisiana, about forty miles from New Orleans, and one in Del Ray Beach, Florida, where you have about a 200 bed acute care hospital and then a medical office building, a long-term care, psychiatric care, and rehab care, all on a forty or fifty acre campus.

Those are some of the developments in health care that are interesting.

Again, another role that I have played in the last five years is that I have been chairman of a health care committee for the Michigan State Chamber of Commerce. I have been on their board. I'm finishing up my twelfth year on their board of directors in July of this year.

One of the developments that took place -- it was many years that health care was fairly reasonable and the automobile companies and those people who paid for health care weren't particularly interested in how much health care cost. It was kind of a jungle as far as they were concerned, and they really didn't take too much interest in it. All of a sudden, Chrysler discovered one day that they were paying more for health care than they were paying for the engine in the automobiles that they were building. Suddenly they became very, very interested.

It was a dangerous situation because first-dollar coverage health care under Blue Cross, mainly in Michigan here, was negotiated by the unions in the early days when the entire health care package was $25 or $30 a month for a family. It had gotten to the place where, in projecting it ten years in the future, health care costs for the family package would run $1,000 a month, if it continued to escalate. So the Michigan State Chamber of Commerce, representing over 8,000 businesses, asked me to chair a committee. Rather than have members who were health care providers and members who were industrial concerns more or less fighting via the newspapers and the media,

they said if we can get these people to sit down around a table together and work out health care cost containment principles, this was certainly to be desired over having a dichotomy develop between those members who were health care providers and other members of the state chamber. They didn't want to be put on the spot of having to choose which memberships they were going to be on the side of.

This has worked very, very well since 1981. Unfortunately, we came up with some rather forward-looking recommendations at our first meeting, and they were so radical that we got tabled and put back a couple of years. We have accomplished many of the goals. Some thirty-five percent of Ford Motor Company salaried employees are now covered by HMOs, which is a different concept of health care. We have seen a gradual reduction in the escalation of health care costs over the last two or three or four years. In fact, it's to the point now where we have come to the conclusion that our original charge to the committee of containing health care costs have been pretty well accomplished and that perhaps some other goals ought to be established. I am in the position now of being ready and willing to turn this chairmanship over to somebody else, but I have made recommendation via letter to the State Chamber of Commerce board of directors giving them some other goals that ought to be addressed at this time.

WEEKS:

Would you care to say what those goals are?

JOHNSON:

Some of the goals might be whether or not, with the containment of health care costs -- and I strongly suspect that this may be true -- that we are starting to suffer a little bit in the quality of health care. There is one

thing about American health care: With twenty years of cost plus behind us, we have certainly developed a health care system that the rest of the world envies. National Medical Enterprises was doing a lot of work in Saudi Arabia, building or managing hospitals for the Saudi Arabians. They made it crystal clear that they did not want British style medicine, or French style medicine. They wanted American quality health care. It was all right if we brought in some people from Britain or France or the Philippine Islands, but they wanted this all to result in American quality health care. That's what they were looking for and were willing to pay for. The oil glut has somewhat cooled their ardor, but nonetheless that is what they started out wanting. So we are the envy of the rest of the world in health care.

However, there have been some developments -- they were necessary developments to contain health care costs -- but the DRGs, for instance, the diagnostic related groups, that have resulted in prospective reimbursement for hospitals has brought about some grumbling that people are being forced out of hospitals too soon. The principle of the DRG I think is well known. That is 468 diagnostic-related groups of illnesses. For instance, if a person 69 years old, covered by Medicare, required a gall bladder surgery, that classification would indicate that patient was entitled to six days in the hospital for gall bladder surgery, in order to get well enough to be sent home or to a nursing home or to some lesser care level. If the hospital, somehow or other, kept that person nine days, they still only got reimbursed for six days. But if they could get the person out of the hospital in five days, they got to keep the extra day's reimbursement. That is gradually being phased in nationwide. The only adjustment to the DRG is the prevailing wage rates in the community. This is going to make it very difficult because, in studying

this situation, we found that doctors practice medicine very differently in different parts of the country.

For instance, the cost of certain surgical procedures in New York City will sometimes be two and three times as much as the same procedure in Detroit, whereas another surgical procedure in Detroit will be twice as much as a similar one in New York City. It's not exactly that New York City is higher cost in every one of these procedures. We have found that this is the case. I think where you are dealing with national concerns like General Motors Corporation and Ford and Bendix and Burroughs Corporation and all, who have been represented on this health care committee that I had chaired, that some of these problems have to be addressed. The one thing we want to make sure is that we do things in the most efficient way, but we don't want to dilute the quality of health care in so doing.

It is interesting, though, that I saw some figures just this last week where health care in the last ten years has escalated from -- I forget the exact year, but we were paying a per capita health care expenditure of $143. It was up to something like $1,436. It had multiplied by a thousand percent in this comparatively few years.

One thing that is interesting for the public to understand is that this is not all the cost of caring for like illness with like procedures. Something I heard just recently was that 85% of the technology in today's hospitals was not there fifteen years ago. Eighty-five percent of the technology is new. This new technology, of course, in many cases such as the CAT scan machine has made much more comfortable procedures for people to go through. The old encephalograms required people to go through very painful procedures for diagnostic purposes. It is amazing that many of these new

pieces of equipment, some of which cost a million dollars or more, have made things much more comfortable and less painful for people undergoing these diagnostic procedures.

The situation with nursing homes -- I've been asked a number of times that with new medications, the fact that people are healthier, they are living longer, they are working longer in many instances -- I've been asked the question if, in my judgment, would nursing homes ever become obsolete? Would we have such a control over debilitating illness and disease that nursing homes, as we know them today, might not be needed. I've said, even though I have a large investment in nursing homes, thirty-five years of my life and a good share of my estate, I've said many times that I would be glad to store hay in those buildings if we could conquer the diseases of old age, or what are normally called diseases of old age. They are really not because people have high blood pressure when they are thirty, in some cases when they are teenagers, that's a misnomer a little bit, but it communicates to most people -- the so-called diseases of old age.

I have heard it said recently that we now think of the prime of life extending up to age seventy-five and it may be even older.

We do find that with DRGs we are being sent much sicker patients than we previously admitted to nursing homes. When those patients could be left in the hospital at cost plus, as long as the hospital had an empty bed they were kept in the hospital. Now we find there is a very urgent reason for getting those patients out of the hospital, and they are the patients in the age group coming to our nursing home. Many times we find ourselves getting phone calls from as far away as Grand Rapids asking if we have a nursing home bed.

WEEKS:

Hospitals are facing a crisis with their low occupancy.

JOHNSON:

Yes. There are tremendous changes taking place in the health care field. Now, there is one little interesting sidelight to hospitals. Under the old cost plus formula, under Medicare, a hospital could not charge less than they would charge Medicare for any procedure. If they were to do a complete blood count, for instance, and they would charge an inpatient in the hospital fifteen dollars for that complete blood count, any patient walking into the laboratory had to be charged fifteen dollars. What this did was, the hospitals suddenly became noncompetitive for the patient walking into the laboratory where they could walk up and have their blood taken in maybe two minutes' time. This brought about all kinds of laboratories being developed two or three miles down the road or sometimes across the street from the hospital who charge twelve dollars instead of fifteen for the blood count. The hospital, where it was originally the complete center for everything that went on.

Now however, under the DRGs you are reimbursed a fixed amount and they don't care what you charge at any level. So that hospitals can, in effect, go back to a two-tiered pricing structure and charge less for a complete blood count where a person walks in and has it taken in a minutes' time rather than send a technician up to the fourth floor and maybe wait outside a patient's room for ten minutes while the doctor finishes the examination, which is obviously more expensive.

So I think there are going to be some changes in the health care field where some of these things will be brought back in to the hospital. In fact

we are finding that. As we examine the statistics of hospitals, their inpatient care days have fallen to a lower percentage of occupancy, but that ambulatory procedures and outpatient procedures and outpatient surgery and all has expanded greatly, and in some cases one has more or less offset the other as far as the total volume of business that the hospital does.

WEEKS:

I'm sure that hospitals, in order to survive, have to have a lot of these outpatient or walk-in clinics, things that they normally wouldn't be able to offer. In order to offset the fact that they are contracting room and bed prices. Hospitals, as you mention, have low occupancy, but if they are in an HMO area or PPO area, they may be contracting with those organizations for beds at a much lower price than they normally would.

JOHNSON:

Yes. The name of the game is census, what is your census, because there are so many fixed costs in a hospital. In fact, some of the things that hospitals have come up with -- some have even retrofitted whole wings of hospitals into motels. If they have a patient load where people come from out of town, or a hundred miles away, they find themselves renting what was previously a hospital room as a motel room and getting $35 or $40 a night so that the person doesn't have to leave the facility in order to come and see their relative. If the weather's bad, this can be a great advantage. But it shows great ingenuity. On the other hand, some hospitals are reluctant to do it because once they give up that bed as a hospital bed, they lose it with the planning agency and they may never get it again. So there is a little reluctance to use the beds for some of these other things and taking them away from the census of hospital beds themselves in a community.

WEEKS:

Do you have any knowledge of nursing homes entering into this practice?

JOHNSON:

The state of Michigan would like, and there was a bill introduced in the legislature this past year -- which did not pass because the legislators and the health department and the department of social services that pay the bill were scared to death of it -- where they wanted to use a lot of these hospital beds and use them as swing beds where they could use them for either long-term care or acute care beds. The simple fact is that even though they would be nursing home beds, the hospitals knew they couldn't live on the nursing home rate for reimbursement so they wanted another whole area of identification calling these DUBs or discretionary use beds. They wanted a rate of $100 a day for them. Now the state was paying from $38 to $42 a day for skilled nursing home care, so the legislature and the Department of Social Services said, "Whoops! What happens if we open up 5,000 or 6,000 of these beds. The hospital is probably going to use them. If we are paying $100 a day for what we are now paying $42 or $40 a day, this could be devastating to the state budget and to the taxpayer." So the bill hasn't really gotten out of committee.

WEEKS:

The point that I'm not clear about is, does the state or the planning agency or any other agency have the power to say to a hospital, "You have to close a certain number of beds."

JOHNSON:

They have tried that in Detroit. In fact, they declared that there were 6,000 beds that were surplus beds. But the one thing that with our State

Chamber of Commerce committee is that we think that whatever happens in the health care field ought to be done through competition, the free enterprise system. If more nursing home beds are needed, and it is clearly defined, then more nursing home beds ought to be built. Now one thing that the planning agencies have done is they have locked in mediocrity in some cases. In other words, a nursing home would come under the ownership of somebody who did a very lousy job in that community, but as long as they can stagger along and just barely meet licensure requirements, no one else can build any nursing home beds in competition with them. I'm not sure that that's exactly in the best interest of the public.

On the other hand, of course, you can make a valid argument that if you over-build hospital beds and Blue Cross is reimbursing their average cost per day and you only have half of the beds filled, and Blue Cross is having to reimburse for those empty beds that are just sitting there, then that is not economical for the taxpayers and the people who pay for care. We find that the big employers are very, very strong behind the planning law. Many of the hospitals themselves would like to get rid of it. Many of the nursing homes would like to get rid of it.

Two large nursing homes that built big places went bankrupt years ago. They were in competition with me, but I never worried about competition. I always like to feel like I am the competition. We went right ahead and did well while they went bankrupt. One lost $420,000 in thirteen months. Their facility was eventually sold to the University of Michigan and they made good use of it.

WEEKS:

Yes. I remember that.

JOHNSON:

Yes. You know the facility because you were here in the community at that time. That was a classic example of how wrong you can be if you consider averages. This person had done a study in New York City and found out what the average family income was and found that there were several elite nursing homes that were able to charge X number of dollars per day. He compared New York City with Ann Arbor and found out the average family income was about the same. So he figured that he could build a nursing home in this area and do as well as the nursing homes in New York City. What he didn't reckon with was that the average in New York City was made up of people making $5 million a year and people making $5,000 a year. Whereas, in Ann Arbor, the average was made up of people making $30,000 a year and people making $15,000 a year. Although the average family income was the same, he didn't have those $5 million a year income people who could afford the cost of nursing home care that he was supposedly providing. Of course it was a very devastating thing because there were three or four doctors involved. It was a very unhappy situation, and I felt very sorry for them.

WEEKS:

Would you like to look down the corridors of time and see what you think is coming up in the nursing home, or any health care area?

JOHNSON:

This doctor that I had the argument with years ago on whether inspections should be qualitative or quantitative retired last year. He attended one of the nursing home association banquets and he said, "Johnson, aren't you about ready to hang 'em up too?"

I said, "Well, no. Not really." Mrs. Johnson and I had the opportunity

of going down and meeting with President Reagan a few weeks ago and he's still hitting the ball hard at age 75, and looks wonderful. I like what I'm doing so well that, God willing, I hope I can do it until I'm 80 years old. Although, I notice that I used to be known as that young fellow in the nursing home business and then that fellow in the nursing home business and I'm afraid that behind my back I may well be known as that old fellow in the nursing home business these days.

I still feel that this new inspection procedure is a step in the direction of qualitative evaluation of nursing home care. I am tremendously encouraged about these new insurance programs that are being put forth by all the major insurance companies that starting at age fifty a person can pay for nursing home care some time in their life time, when and if they need it, anywhere from one to six years. There are varying cost premiums. Now the later a person signs up for this, if they wait until they are seventy years old, the premiums I understand are $100 or $125 a month. But if they sign up when they are fifty, the premiums are less than $300 a year.

It's the person's own physician who decides that they need licensed nursing home care, and these programs that are being proposed today will pay up to $80 a day, all inclusive, for nursing home care for one to six years. Since the average length of stay is about two and a half years, this would meet most people's needs. This is not to say that that person who needed seven or eight years care wouldn't maybe eventually have to dip into their estate or be paid for by Medicaid, but if we can get enough people covered by this type of insurance program, that will more or less supplant the Medicaid program which says you have to spend everything that you've made down to just your homestead and perhaps a couple of thousand dollars before you qualify for

Medicaid. In some cases this leaves the surviving spouse with practically nothing to live on after people have been prudent and saved their money all the way through. Then three or four years of nursing home care and expensive hospital and medicine bills can just almost wipe out a husband and wife's plans for their retirement years.

So I'm extremely encouraged that Traveler's and Prudential and Banker's Life and quite a number of these -- I understand that eight programs are coming out in Michigan here now that are licensed in Michigan. So I think this will be a tremendous step in providing a safe haven for those people requiring nursing home care and still wanting to preserve their estate either for the family or for the surviving spouse.

I think that nursing homes are in the future to stay. I think that congregate living will serve some of the older people. This is an apartment project which provides two meals a day and sort of sheltered living, if it's in the northern climes people will not have to go out of the building, if there is a blizzard taking place. They will probably have a small grocery store where they can buy the makings for breakfast and have their dinner and their supper served to them within the building confines. They will be able to have transportation if they can no longer drive their automobiles. I see a great development in congregate living for older, retired people where there will be activities, dances, lectures, intellectual pursuits -- but everybody will not want that. Some retired people will still live in apartment buildings, such as I have. In the northern climate where it is difficult to get out on the ice and snow if you are eighty-five years old, even if you are well. I think there will be a lot of development of these congregate living facilities.

I look for a lot more competition among physicians. We know that there is supposedly now an overage of physicians, and I hope we can get our malpractice and liability insurance under control. I find that that is affecting the way that doctors practice medicine to a much larger extent than I like to see. It encourages doctors to practice by the book and not to try anything new or to use judgment to try to get something that will help an older person sometimes. They'll say, "This is all I can do. This is all I can prescribe." Sometimes even if it is a different colored pill with the same medication it's a kindly thing to do. Sometimes it's very helpful, even if it's a placebo.

I do find that with today's environment with malpractice insurance the best we could do in Michigan was a malpractice premium increase from $18,000 a year to $72,000 a year. Fortunately, I was able to buy a deductible malpractice and liability insurance from a division of the company I'm on the board of, National Medical Enterprises, so that I only went up $4,000 a year instead of something like $54,000 a year. This is a very serious situation. In some cases it is running as much as $4 a day of nursing home care is for malpractice and liability insurance.

I look for that to be ameliorated within one or two or three years. I look for the federal law to take effect. I read just this morning that they are talking about $250,000 limit for pain and suffering in malpractice suits which will be extremely helpful in holding people more responsible for their own actions. So I'm encouraged with what we'll see in the next decade in long-term care and acute care. But I see a lot of, in some cases, hospitals developing and owning their own long-term care facilities. I find that specialty hospitals are developing and will probably be used to a greater

extent. I find that there is a lot of new diagnostic equipment and machinery -- I recently had a proctoscopic examination with this new flexible proctoscope or whatever it is that they call it. Believe me, having this in lower GI tests with a complete physical, this is a tremendous thing. In fact, they have this thing that is seven feet long now and it's flexible and will follow the contour of the colon. In fact, I emulated the President, I had a fairly large polyp removed that wouldn't have been discovered with the old style proctoscope. So I am extremely encouraged.

Another area that I am very encouraged about is the improving dental care. We went the first eight or nine years without finding the first patient that had his own teeth. Now we find that seventy or eighty percent of the people that come in at least have a good share of their own teeth and they are able to chew their food and digest it much better. Although we have many challenges on the horizon, I think that we are developing a heritage, we are developing experiences, and I look forward optimistically to a lesser number of people percentage wise having to be in nursing homes. But for those people who have to have long-term chronic care, I look forward to them being more comfortable and more intellectually inspired.

The thing that has come on the horizon again the last few years is the living wills where in some cases -- we have always been put on the spot where we said we want to do everything we possibly can while there is still life in that body. You sometimes wonder whether you are doing people any favor when the quality of life has deteriorated to almost nothing. We do have these living wills today. However, I think they need to be more defined because the living wills indicate that, if I'm of a certain age, I want medication or treatment denied me. We've seen cases where a person was eighty or eighty-

five years old and was really having a pretty good quality of life even though in a nursing home. We've had cases where they would start to run a temperature and the doctor would refuse to prescribe an antibiotic. We are not quite sure that's what they mean in their living wills. That they ought not to have their life preserved if we have something at our disposal to do so. But I again, optimistically, think that will be worked out, and that suitable living wills will be implemented that will be a little more clearly defined to correct some of the confusion resulting from it now.

All in all, I am extremely happy that I changed careers for that third time. As you know, I purchased a radio station about two and a half years ago, and occasionally I get on there with our talk show host and am able to bring a little public enlightenment about the quality of health care and its direction, and answer a few questions. At this stage, I feel like I've been a part of history. I look forward to, hopefully, being a part of history for at least another ten or fifteen years.

WEEKS:

I'm sure you will.

Interview in Ann Arbor

June 27, 1986

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