St. John's Hospital

John Bringhurst and
Charles W. Hofer*

"You can go on making short-range moves here and there, but the time comes when you have to consider the long-range direction of the hospital. You need to determine where you are, what the community needs, and where you *should* be going." This was the thinking of Sister Macrina Ryan as she reflected on her decision to hire an outside consultant to assist in long-range planning for St. John's Hospital in October 1972.

Sister Macrina had been the administrator at St. John's for the previous 7 years. She received her undergraduate training in personnel after which she worked for 2 years in a Cheyenne hospital and 11 years at St. Joseph's Hospital in Denver. While at St. Joseph's she gained experience in both the business office and the personnel department. Before coming to St. John's, she had completed the Hospital Executive Development program offered by St. Louis University. After 6 years at St. John's, she was offered an opportunity for advancement to a larger hospital operated by the Sisterhood. She declined to apply for the position, though, because she needed more time to complete her work at St. John's.

Sister Macrina's administration at St. John's had been marked by several significant changes in both the physical plant and the medical services of the hospital. A number of important issues faced St. John's which required resolution by the end of 1972, however. In attempting to deal with them she felt the need for some independent, outside counsel. Therefore, after gaining the approval of the board of trustees in Leavenworth, Kansas, and discussing the matter with the president of the lay advisory board in Helena, she hired the Medical Planning Associates (henceforth referred to as MPA), a consulting firm based in Malibu, California, to make a comprehensive study of the hospital's capabilities and the health needs of the Helena community. MPA's contract also called for the development of a long-range plan for St. John's based on the results of these studies.

St. John's history

St. John's, which was organized in 1870 by the Sisters of Charity of Leavenworth, Kansas, was the first

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private hospital in the territory of Montana. It had its beginnings in a small frame building located in a tiny mining settlement which eventually became the capital of the state. In the early years of its existence, the hospital's patients were mostly miners, prospectors, and lumbermen. Soon charity patients from Lewis and Clark, Meagher, and Jefferson Counties were added to its patient load. In 1873, a small building behind the hospital became the first mental hospital in Montana. It offered care for psychiatric patients until its abandonment when the state established its own mental health institution in 1877. After the coming of the Northern Pacific Railroad in 1883, the original frame building became inadequate and was replaced by a larger brick and stone structure. This building was damaged beyond repair in the earthquakes of 1935. While a new building was being erected, St. John's utilized the facilities of the Montana Children's Home—now Shodair Hospital. The new unit, which was still the core of the hospital in 1972, was completed in 1939. Since then St. John's has expanded its facilities twice more. Specifically, a new cafeteria and kitchen were added in 1958, and in 1965 the hospital's north and south wings were completed. The north wing contained 10 medical-surgical private rooms, a labor and delivery unit, an x-ray department, and a general storeroom. The south wing consisted of a laundry, the boiler room, physical therapy, the dental room, and the chaplain's quarters. In addition, the south wing had rooms for 25 patients and also housed facilities for extended-care patients. (See Figure 1 for a layout of St. John's facilities in October 1972.)

In 1968, St. John's maternity department was closed temporarily to provide space for medical-surgical patients while the latter area was being refurbished. This renovation also involved conversion of the Sisters' living quarters into a medical records department and a modern coronary intensive-care unit. After a little more than a year without maternity facilities, during which time St. Peter's Community Hospital handled the maternity patient load in Helena, St. John's board of trustees decided not to reopen the department. The trustees believed that this action would eliminate "one of the most expensive examples of duplication and under-utilization of services in Helena."[1] More specifically, they felt their decision would reduce losses for both St. John's, which would be freed of a perennial deficit operation, and St. Peter's, which would gain maternity patients with little or no increase in overhead costs. Additional benefits to St. John's were expected to result from the use of the newly available rooms for additional medical and surgical bed space.

St. John's also established the first school of nursing in Montana. When the earthquakes of 1935 destroyed the school building, the hospital's nursing students were transferred to other schools to complete their training. The nursing school was reopened in 1940 and continued full-scale operations until 1965. At that time, because of financial losses incurred by the school and changing requirements in the field of nursing, the board of trustees decided to close the school. Nursing training at St. John's ceased in 1968 with the graduation of the class which had entered in 1965.

Hospitals and health services in Helena

The city of Helena, which had a population of approximately 26,000, was served by three hospitals in 1972. St. John's and the Shodair Crippled Chil-

[1] From a memorandum of November 26, 1969, from Sister Macrina to the medical staff.

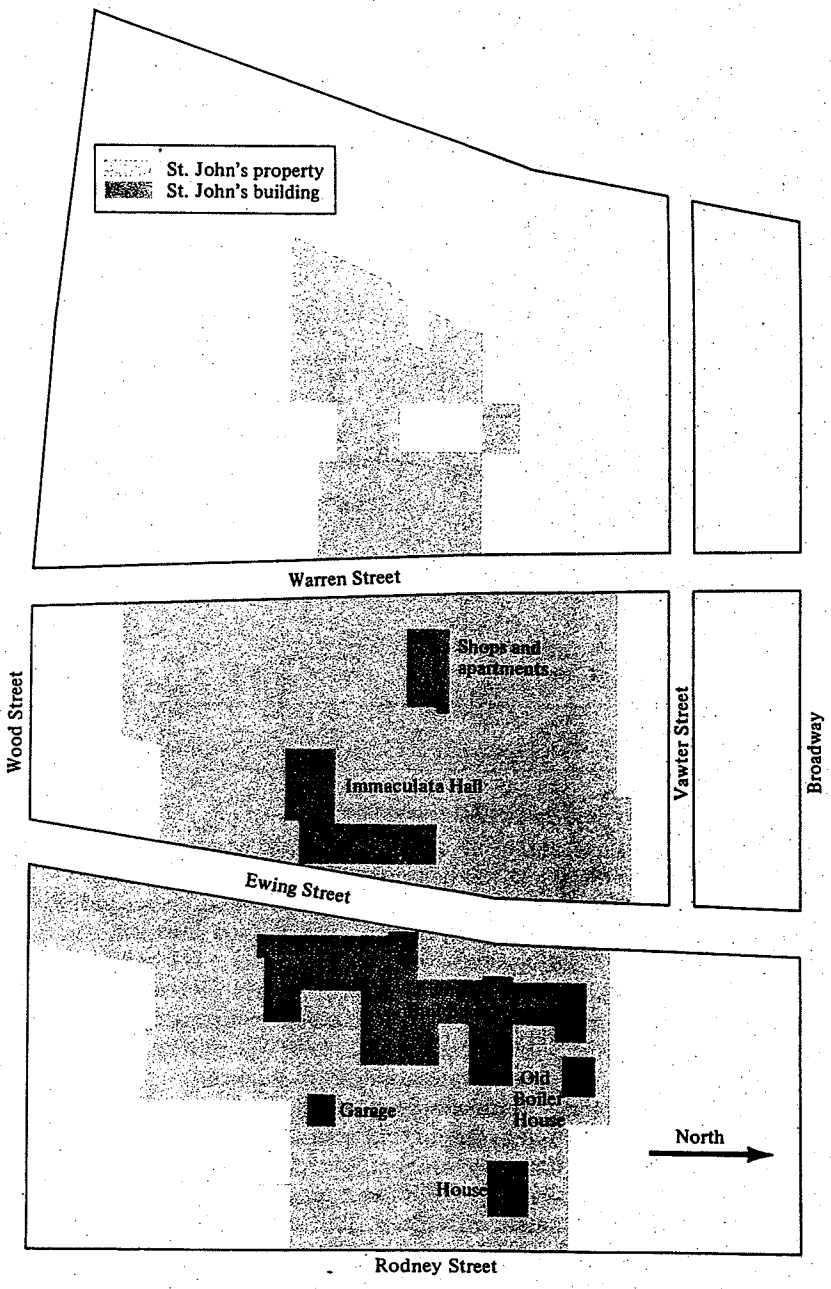

FIGURE 1 ■ Layout of St. John's Hospital.

dren's Hospital were located in the downtown area, and St. Peter's Community Hospital was on the extreme east side of town. In addition, a Veterans Administration Hospital was located at Fort Harrison, a military post about 6 miles west of Helena. However, it served only armed forces veterans, most of whom were not from the Helena area. (See Figure 2 for a map indicating the locations of the three Helena hospitals.)

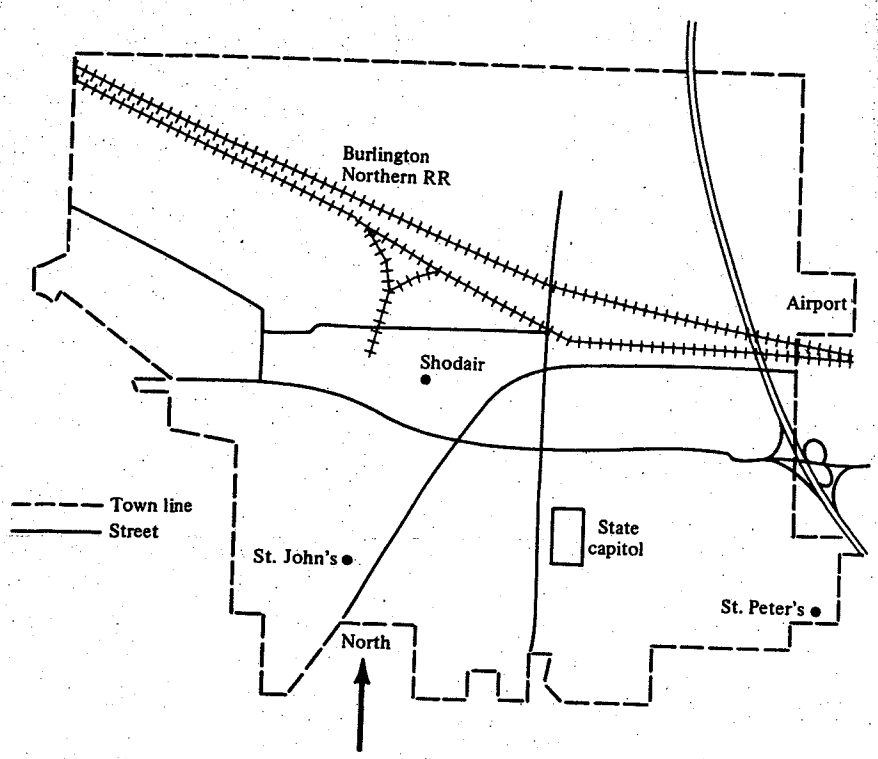

FIGURE 2 ■ Location of hospitals in Helena, Montana.

St. Peter's Community Hospital was established in 1887. It expanded to a new location in 1924 and in 1968 moved into a modern new facility at its present location. This facility had space for 111 beds, most of which were used for medical-surgical, pediatric, and maternity services. The completion of St. Peter's new building had reduced the utilization of St. John's, in the opinion of many St. John's administrators. Specifically, they pointed out that the average occupancy rate and the total number of ancillary services demanded at St. John's began to decline following the completion of St. Peter's new facility—a trend which continued through 1972. (See Figures 3, 4, and 5 for utilization statistics for St. John's.)

Shodair Crippled Children's Hospital was originally established as a residence for homeless children. The hospital, which was built as an addition to the home in 1937, was a focal point in the community during the polio epidemic of the fifties. With the widespread adoption of Salk and Sabin vaccines, however, Shodair's census declined to the point where its 45-bed capacity averaged less than 40 percent occupancy in the 1970s.

Although the 160 beds of the Veterans Administration Hospital were filled largely with patients from outside the community,[2] it nevertheless offered some competition to the other three Helena area hospitals and thus added to

[2] During the 1970s, approximately 20 percent of the VA Hospital's patients were from the Helena area.

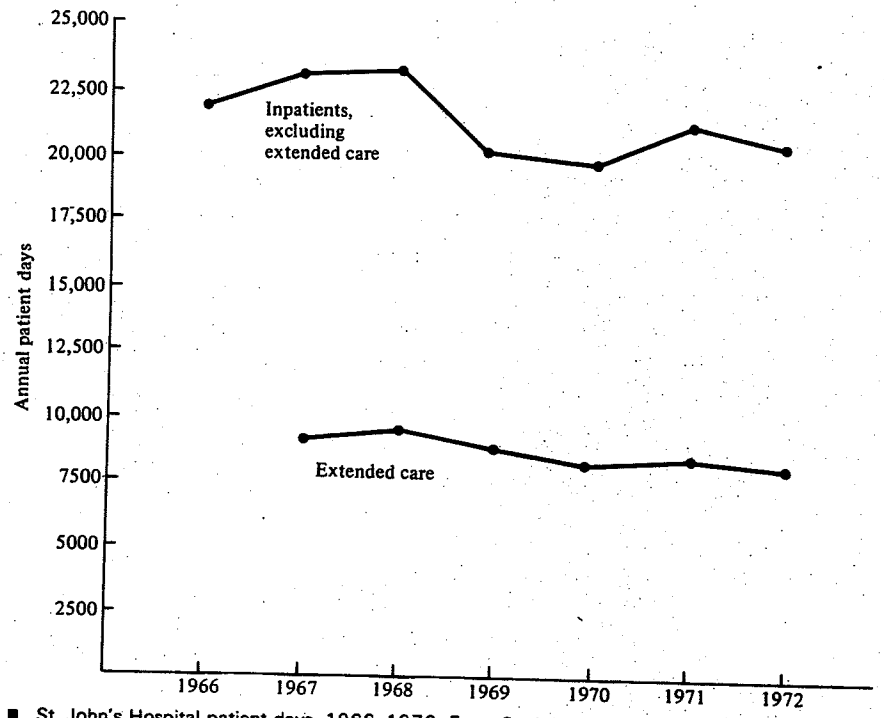

FIGURE 3 ■ St. John's Hospital patient days, 1966–1972. From St. John's Hospital records.

the surplus bed space problem which these hospitals faced in the 1970s. Specifically, with the exception of the VA Hospital, which often had an admissions waiting list, all the hospitals in the Helena area operated in dangerously low occupancy levels in the early 1970s. For instance, in 1971, St. John's average occupancy was 72 percent, St. Peter's average was 64 percent, and Shodair's was only 37 percent. Moreover, in 1972, St. John's average occupancy dropped to just under 58 percent while St. Peter's and Shodair's averages remained close to their 1971 levels. (See Table 1 for various operating statistics on all four hospitals in the greater Helena area.)

On a national basis, an occupancy rate of 80 to 90 percent was usually considered desirable in the early 1970s although most hospitals also tried to hold some beds open for emergency patients. Thus, by comparison with this standard, there were on average about 60 excess hospital beds in the greater Helena area in mid-1972. Because of this overbedding, considerable competition existed among the city's three private hospitals. The competition was keenest, however, between St. John's and St. Peter's because of the similar types of services offered by the two institutions. For instance, Sister Macrina observed: "If one hospital purchased a new piece of equipment, there was often pressure from physicians, patients, and personnel of the other hospital to purchase the same kind of equipment or something better." Helena's physicians were in a particularly strong position in respect to the city's hospitals because they could strongly affect a hospital's financial stability by referring their patients elsewhere. Such gambits enabled these physicians to exert considerable leverage on the policies of all three hospitals in the early 1970s.

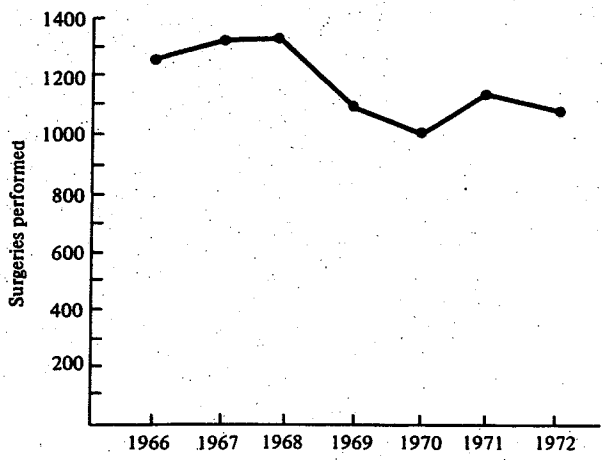

FIGURE 4 ■ Surgeries performed at St. John's Hospital. From St. John's Hospital records.

St. John's present situation

Competition from other hospitals was only one of the issues confronting Sister Macrina, however. In the spring of 1972, St. John's received the results of a fire and safety survey by the State Department of Health and Environmental Sciences. Among the deficiencies noted in the survey were some requiring extensive renovations of the main building to comply with new fire standards. For example, one of the required renovations was the installation of a fire warning and sprinkler system in the older portion of the building.[3] Although no exact estimates of the cost of all the required renovations had been made by the end of June, it appeared that these costs might well be greater than the value of the hospital sections which were affected.[4] Since the portion of the hospital which required renovation was 35 years old, Sister Macrina questioned the wisdom of making such extensive and expensive renovations. On the other hand, it was difficult to entertain any thoughts of building a separate new facility when about 40 percent of the existing building was less than 5 years old.

Another issue facing Sister Macrina was the question of whether to renovate St. John's emergency room, which was somewhat outdated and inconveniently located. Like most other hospitals across the country, St. John's had experienced a dramatic increase in demand for outpatient services in recent years. With industry forecasts predicting a continuation of this trend, Sister Macrina was considering the modification of the emergency room and the surgery department to facilitate an increased outpatient workload. To serve both an outpatient clinic and an emergency room, the existing emergency room would have to be extensively remodeled.[5] On the other hand, only minor

[3] The portion affected was one-third of the total floor space in St. John's main building. See Figure 1 for a layout of St. John's physical plant.

[4] One of the major reasons for the anticipated high cost of renovations was that St. John's facility had been designed to be earthquake proof when it was constructed in 1935.

[5] No estimates of the costs of a new emergency room had been made by October 1972.

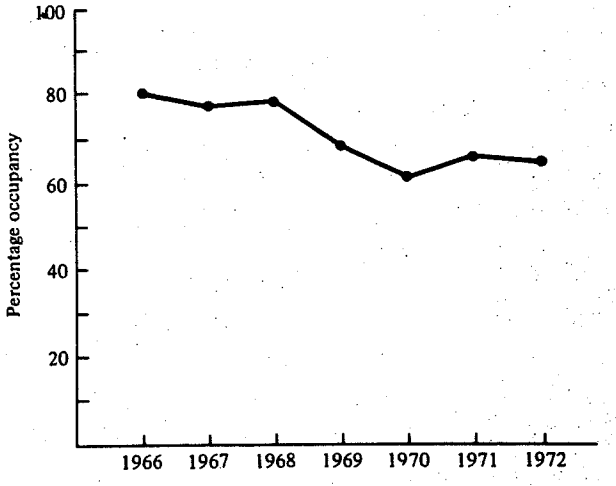

FIGURE 5 ■ Occupancy rates at St. John's Hospital. From St. John's Hospital records.

alterations would be required to develop the capability for outpatient surgery within the present surgery department.[6] The new requirement for fire protection safety complicated this type of expansionary planning, however, since both surgery and the emergency room were located in the older portion of the hospital.

Another decision facing Sister Macrina involved the sale of certain buildings

[6] No cost estimates for any of these options had been obtained by October 1972.

TABLE 1 ■ **UTILIZATION, EMPLOYMENT, AND PAYROLL DATA OF HELENA AREA HOSPITALS IN 1971 AND 1972**

	St. John's		St. Peter's		Shodair		Veterans Administration	
	1971	1972	1971	1972	1971	1972	1971	1972
Number of beds[a]	114	112	111	111	45	32	160	160
Admissions[b]	3064	2950	4147	4278	1119	1115	2240	2315
Average daily census[c]	82	65	71	72	15	13	139	139
Percentage occupancy[d]	71.9	57.5	64.0	64.9	36.6	40.6	86.9	86.9
Personnel[e]	219[f]	218[f]	224[f]	246[f]	77	80	242	250
Payroll expense (000)[g]	$1273[h]	$1322[h]	$1452	$1485	$331	$336	$2366	$2624
Total expense (000)[g]	$2010	$2259	$2684	$2822	$517	$773	$3501	$3956

[a] As of September 30, 197_. Does not include bassinets for newborn infants.
[b] Number of patients accepted for inpatient service during 12-month period ending September 30, 197_. Does not include newborn.
[c] Average number of inpatients each day during 12-month period ending September 30, 197_. Does not include newborn.
[d] Ratio of census to average number of beds maintained during 12-month period ending September 30, 197_.
[e] Excludes trainees, private nurses, and volunteers. Statistics stated as full-time equivalents.
[f] According to Sister Macrina, a possible explanation for St. John's having a lower ratio of personnel to patients than St. Peter's lay in the difference between the two hospitals' plants: St. John's had a compact, four-story building whereas St. Peter's had a rambling, two-level structure with larger distances between departments.
[g] For the fiscal year ending September 30, 197_.
[h] St. John's paid the Motherhouse a sum equal to the salaries that civilian workers would receive if they filled the Sisters' positions. These sums are included in the payroll expense totals for St. John's.
Note: September 30 does not coincide with the end of St. John's fiscal year.
Source: AHA *Guide to the Health Care Field,* 1972 and 1973 ed., The American Hospital Association.

and properties owned by the hospital. Specifically, the Model Cities and urban renewal programs of Helena had been negotiating with the hospital over the purchase of St. John's property west of Warren Street. While the city had appraised the property at $20,000, St. John's lay advisory board believed that it was worth twice that amount and was in the process of obtaining their own appraisal.

In addition, the hospital was considering the sale of Immaculata Hall, which was adjacent to the hospital. In recent years, this building had been used as a residence for the Sisters who served at St. John's, as a meeting hall for the hospital, and for storage. It had also been used to house student nurses up to 1968. Over the last decade, however, its occupancy had decreased to the point where the lay advisory board no longer felt it was economical for the hospital to keep the building.[7] The board considered $85,000 a fair price for the structure together with the former school of nursing[8] and the land immediately adjacent to both buildings. The board also believed that the price would rise to $125,000 if the rest of the block were included in the offer. By the end of October, they had been approached by two interested parties. Nonetheless, even though St. John's could use the cash generated by the sale of these assets, Sister Macrina felt consideration also had to be given to possible future expansion needs of St. John's before a final decision was reached.

Another issue which Sister Macrina discussed with the MPA consultants was the question of the services which should be offered at St. John's. This issue was especially important since one possible answer to the problem of competition in an overbedded community such as Helena would be for the different hospitals to specialize in one or more services. For instance, since there had never been enough demand for maternity services in the greater Helena community for two hospitals to efficiently operate obstetric departments, St. John's had closed its maternity service in 1968 and conceded the entire volume to St. Peter's as discussed earlier. Similarly, St. John's elected to close its special pediatric department in order to eliminate the duplication of services when Shodair Children's Hospital's expansion in 1969 enabled it to meet the community's needs for pediatric care. Furthermore, even though St. Peter's continued to operate its pediatric department, its 12-bed ward was generally less than 50 percent occupied and was reportedly operating at a small deficit. Sister Macrina felt that this was a good indication that St. John's should remain out of pediatric services.

The more important question in her opinion, though, was whether St. John's should eliminate other services in areas of duplication or expand their services in areas not adequately covered at present in Helena. For instance, in addition to its general medical-surgical services, St. John's Hospital operated a high-quality extended-care unit for long-term patients.[9] Although the price to the public for these extended-care services was almost double that of most nursing homes in the area, many residents of Helena apparently felt that the extra cost

[7] Including Sister Macrina, only seven Sisters were serving at St. John's in October 1972.

[8] The former school of nursing building was being used as apartments and shops in 1972, as indicated in Figure 1.

[9] Extended care was an intermediate stage for patients who could get along with less extensive nursing care than usually required in a hospital but were not yet independent enough for a nursing home. Consequently the cost for such a unit was below what hospitals would normally charge and greater than what nursing homes typically charged. A majority of St. John's extended-care cases came from Helena itself.

was justified by the quality of nursing care available. Moreover, Sister Macrina felt that the fact that the unit was always nearly full and had a sizable waiting list was further evidence that there was sufficient demand for such a unit.

The possibility of offering some completely new specialty beyond those presently offered by St. John's and the other hospitals in Helena was particularly appealing to Sister Macrina since such services might increase the draw of patients from areas outside Helena. For example, a specialized burn center might attract a large number of patients from the greater Northwest since the nearest existing burn center was in Austin, Texas, and that unit drew patients from the entire western half of the United States. Another possibility was the establishment of a special stroke ward as there were no other specialty units for stroke patients in Helena at the time. Although the demand for such a facility was difficult to estimate, there were enough stroke victims in the area that local hospital administrators occasionally discussed the possibility of such a unit among themselves. Still another alternative would be to combine a stroke ward with the present extended-care facility at St. John's to create a geriatric specialty hospital. Supporting this option was the degree to which St. John's was already involved in service to Medicare patients. Although no statistics had been gathered, it was believed by some of St. John's administrators that the older people of the community generally preferred St. John's Hospital to St. Peter's.

There were, of course, other ways in which St. John's might specialize, such as becoming a rehabilitation hospital or a self-care nursing facility, both of which had been mentioned by Helena health officials as areas requiring consideration. No studies of the demand for such facilities in Helena had ever been made, though. Moreover, any such alternative would have to be considered in light of the potential difficulty of bringing a specialty medical staff to this remote community in west central Montana. Thus, while some doctors in the Helena area believed that remoteness would not be a factor as long as the patient demand was there, others felt that the long, hard winters would be a deterrent to an influx of specialized physicians. In sum, one of the big questions for St. John's involved the kinds of services it should offer in order to best meet the needs of the community. (See Table 2 for a listing of the services offered by Helena's three private hospitals in 1972.)

The most drastic response to the problem of competition would be for St. John's to close its doors. Even though such an idea was unpalatable to a large number of the hospital employees and also to many people in the area, it was generally conceded that a 50-bed addition to St. Peter's Hospital could handle the present patient load at St. John's with the exception of the extended-care patients.[10] Furthermore, such a move might provide a significant reduction in cost to the community since ancillary services, such as the x-ray units, the laboratory, and surgery, were not being fully utilized at either hospital.[11] Thus, while the purpose of the MPA study was to assist in long-range planning for St. John's, Sister Macrina felt that the needs of the Helena community were probably the most important factor to be considered in the study. Conse-

[10] Construction costs per bed for new hospitals averaged between $20,000 and $30,000 in 1972.
[11] Both St. John's and St. Peter's were self-sufficient in laboratory services. Shodair, although smaller, was also adequate for all of the hospital's normal tests. The VA Hospital contracted with St. John's for some lab services, but these were also available and underutilized at St. Peter's.

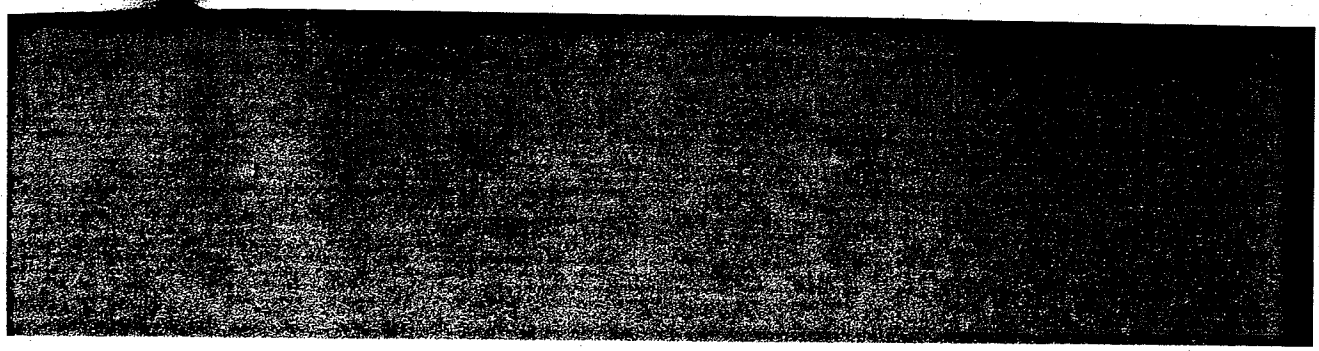

TABLE 2 ■ HOSPITAL SERVICES AVAILABLE IN HELENA (SEPTEMBER 1972)

Service[a]	St. John's	St. Peter's	Shodair	VA
Postoperative recovery room	Yes	Yes	Yes	Yes
Intensive-care unit	Yes	Yes	No	No
Pharmacy	Yes	Yes	Yes	Yes
X-ray therapy	No	Yes	No	No
Cobalt therapy	No	Yes	No	No
Radium therapy	No	Yes	No	No
Diagnostic radioisotope	No	Yes	No	No
Therapeutic radioisotope	No	Yes	No	No
Histopathology laboratory	Yes	Yes	No	Yes
Blood bank	Yes	Yes	No	Yes
Inhalation therapy	Yes	Yes	Yes	No
Extended-care unit	Yes	No	No	No
Inpatient renal dialysis	No	Yes	No	No
Outpatient renal dialysis	No	Yes	No	No
Physical therapy	Yes	Yes	Yes	Yes
Clinical psychologist	No	No	Yes	No
Outpatient department	No	No	No	Yes
Emergency department	Yes	Yes	Yes	Yes
Social work department	Yes	No	Yes	Yes
Genetic counseling	No	Yes	No	No
Inpatient abortions	No	Yes	No	No
Dental department	Yes	No	No	Yes
Speech therapy	Yes	No	Yes	No
Hospital auxiliary	Yes	No	Yes	No
Volunteer services	Yes	No	No	Yes

[a] Services are defined in the American Hospital Association's *Uniform Hospital Definition.*
Source: The AHA *Guide to the Health Care Field,* 1973.

quently, she believed the possibility of closing operations altogether had to be considered as a realistic alternative.

Financial and other considerations

In 1972, St. John's Hospital was considered to be financially sound. Like most nonprofit hospitals, the cost-revenue picture showed the hospital to be operating close to its break-even point. Since charitable contributions for St. John's, as well as for most other area hospitals, had declined to an insignificant level in recent years, operating losses in any particular year had to be balanced by gains in other years. During the past 3 years, St. John's had averaged an annual net loss of 0.18 percent on annual revenues which averaged $2.1 million.[12] (See Tables 3 and 4 for St. John's income statements and balance sheets.)

Many of the other factors which needed to be considered in any long-range plan were social, political, and economic in origin. One of the most important of these was the national health insurance legislation which was pending in Congress. Because of the many and varied packages which Congress was considering, it was extremely difficult to anticipate the scope, form, or type of national health insurance that might ultimately be adopted. Yet, because of the tremendous impact which any resulting legislation might have on the health care system, it was difficult to ignore the issue. For instance, an increase in the government's involvement in health care seemed sure to entail more

[12] According to figures compiled for the Internal Revenue Service.

TABLE 3 ■ ST. JOHN'S HOSPITAL INCOME STATEMENTS (1967–1972)

	1967	1968	1969	1970	1971	1972
Revenues						
Revenues from patients						
Daily patient care	$785,299	$879,177	$1,019,526	$1,090,527	$1,260,093	$1,290,043
Departmental services	598,258	691,037	759,408	797,573	938,959	1,077,428
Gross patient revenues	$1,383,557	$1,570,214	$1,778,934	$1,888,100	$2,199,052	$2,367,471
Deductions from gross revenues						
Provision for uncollectibles	$84,125	$63,461	$79,937	$87,984	$85,627	$57,314
Contractual discounts	67,640	32,078	16,479	23,835	89,353	79,400
Other adjustments[a]	21,806	10,534	4,637	2,298	504	0
Total deductions from gross revenues	$173,571	$106,073	$101,053	$114,117	$175,484	$136,714
Revenues from patients	$1,209,986	$1,464,141	$1,677,881	$1,773,983	$2,023,568	$2,230,757
Cafeteria and recovery of expenses	59,938	53,985	52,615	51,840	52,091	50,813
Grants	8,713	24,930	13,161	9,853		
Total operating revenues	$1,278,637	$1,543,056	$1,743,657	$1,835,676	$2,075,659	$2,281,570
Expenses						
Salaries and wages	$749,176	$996,192	$1,085,109	$1,197,130	$1,237,192	$1,321,761
Supplies and expenses	430,455	532,951	575,741	636,745	727,777	829,607
Depreciation	59,945	107,975	113,870	83,466	96,927	107,464
Total operating expenses	$1,239,576	$1,637,118	$1,774,720	$1,917,341	$2,061,896	$2,258,832
Net revenue from operations	$39,061	$(64,062)	$(30,063)	$(81,665)	$13,763	$22,738
Nonoperating revenue						
Interest income	0	4,679	4,970	18,552	6,871	7,927
Net revenues	$39,061	$(59,383)	$(25,093)	$(63,113)	$20,634	$30,665

[a] Discounts from St. John's standard rates resulted from contractual agreements with commercial insurers and nonprofit third-party payers and from differences between full costs and allowable costs for Medicare reimbursements. The treatment of such deductions was consistent with accepted hospital accounting procedures.
Source: St. John's Hospital annual audits, 1968–1972.

control over how federal funds were to be spent. Regardless of the form of any legislation adopted, one likely target for government control would be the area of hospital planning. Thus, it was quite possible that the future directions open to St. John's after the enactment of such legislation might be determined by some regional public planning agency rather than by the hospital. On the other hand, Sister Macrina felt she would have to make a decision about St. John's scope of operations within the next 6 months. Even if this were done before any legislation was passed, however, an unwise choice might restrict the amount of federal revenues the hospital could receive in the future.

Further complications were created by the federal government's wage-price freeze and subsequent Phase II requirements. St. John's had been in need of a small price increase to cover operating losses when price controls had been imposed in August 1972. Phase II, however, negated practically any plans for an increase in prices. This was particularly critical since extensive renovations of any buildings or expansion of any services would require far greater financial reserves than St. John's had available in October 1972.

Other variables which the MPA consultants would have to take into consideration in developing their recommendations were the demographic trends of the greater Helena area, possible changes in the region's ratio of population to hospital beds, and the availability of medical personnel in the community.

TABLE 4 ■ ST. JOHN'S HOSPITAL BALANCE SHEETS
Years ending May 31[a]

	1967	1968	1969	1970	1971	1972
Assets						
Cash	$73,561	$45,718	$6,148	$8,497	$52,852	$61,227
Accounts receivable from patients[b]	368,589	345,152	429,678	352,034	391,022	435,134
Receivable from third-party agencies	1,015	66,334	89,009	71,642	21,000	25,153
Inventories, at cost	35,839	43,854	51,670	51,625	54,721	65,479
Prepaid expenses	1,337	1,060	511	1,136	1,474	1,664
Total	$480,341	$502,118	$577,016	$484,934	$521,069	$588,657
Land, building, and equipment, less depreciation	$1,402,741	$1,517,091	$1,562,152	$1,616,529	$1,553,992	$1,475,660
Plant improvement and replacement funds:						
Cash	$98,414	$145,434	$65,345	$14,372	$21,460	$89,571
Certificates of deposit	0	0	0	0	100,000	102,547
Investments, at cost	112	112	112	88,000	0	0
Interest receivable	0	1,059	0	2,093	877	1,414
Total	$98,526	$146,605	$65,457	$104,465	$122,337	$193,532
Temporary fund cash	2,077	360	331	0	0	0
Total assets	$1,983,685	$2,166,174	$2,204,956	$2,205,928	$2,197,398	$2,257,849
Liabilities						
Portion due of note payable to Motherhouse	$0	$12,000	$18,000	$18,000	$41,800	$41,800
Accounts payable	36,519	51,569	25,981	36,569	38,989	53,304
Accrued payroll	33,088	14,745	19,600	24,760	29,475	39,233
Acrued Sister's salaries	0	0	12,286	12,286	0	0
Other accrued liabilities	10,355	3,616	6,726	38,425	22,338	19,727
Accrued interest	0	8,030	8,335	0	0	0
Medicare financing payable	18,000	15,000	15,000	46,994	44,298	49,811
Payable to third-party agencies	0	0	0	0	3,000	10,000
Retainage and construction costs payable	0	0	35,471	13,381	0	0
Total current liabilities	$97,962	$104,960	$141,399	$190,415	$179,900	$213,875
Deferred contractual adjustment[c]	$0	$30,506	$45,506	$59,506	$76,395	$90,000
Note payable to Motherhouse, less current portion	$515,658	$491,633	$483,633	$485,033	$438,720	$403,920
Fund balances:						
Operating fund	$216,442	$218,089	$281,025	$104,953	$150,524	$184,726
Plant fund	1,151,546	1,320,626	1,253,062	1,366,021	1,351,859	1,365,328
	$1,367,988	$1,538,715	$1,534,087	$1,470,974	$1,502,383	$1,550,054
Temporary fund:						
Due to operating fund	$1,015	$0	$0	$0	$0	$0
Fund balance	1,062	360	331	0	0	0
Total liabilities	$1,983,685	$2,166,174	$2,204,956	$2,205,928	$2,197,398	$2,257,849

[a] May 31 marked the end of the fiscal year for the eight hospitals and all schools, colleges, and other institutions operated by the Sisters of Charity of Leavenworth.
[b] Less allowance for uncollectibles and contractual discounts. These two items totaled $185,000 in 1967, $148,367 in 1968, $144,713 in 1969, $135,492 in 1970, $96,683 in 1971, and $160,000 in 1972.
[c] See note *a*, Table 3.
Source: St. John's Hospital annual audits, 1968–1972.

Overall, the population of Helena was projected to grow by 13 percent (1973)[13] to 32 percent (1970) between 1970 and 1980, depending on the assumptions made with respect to birth and death rates[14] and migration trends. Under the same assumptions, the population of Lewis and Clark county as a whole was forecast to grow by 19 percent (1973) to 27 percent (1970) during the same period. (See Tables 5 and 6 for more detailed demographic data for the greater Helena area.) The factor primarily responsible for the differences between the 1970 and 1973 forecasts was the rapid drop that occurred in average family size in the early 1970s. During this same interval, there were also some changes in national migration trends. Most demographers felt that Helena was not likely to benefit from these trends, however, because the poor rail and road transportation through the area did not encourage a buildup of industry in that part of the state, especially since other nearby

[13] The numbers within the parentheses refer to the date of the forecast.

[14] Both birth and death rates are, in turn, influenced by several other variables. Birth rates, for example, are dependent on the age distribution of the population, the net rate of family formation, the average family size, and the percentage of out-of-wedlock births. Death rates are primarily influenced by the age distribution of the population and the age-conditional mortality rates for the area in question.

TABLE 5 ■ POPULATION RECORDS AND PROJECTIONS, LEWIS AND CLARK COUNTY, MONTANA

	Actual				Projected	
	1960	1964	1968	1970	1975	1980
City of Helena	20,227	23,000	24,395	25,850	29,750	34,200
Rest of county	7,779	not available		8,014	none made	8,900
Total county	28,006	not available		33,864		43,100

Sources: 1960 and 1970 actual: U.S. Census.
1964 and 1968 actual: Lewis and Clark County records.
1975 and 1980 projections: 1970 Lewis and Clark County forecasts.

TABLE 6 ■ THE POPULATION AGE DISTRIBUTION FOR LEWIS AND CLARK COUNTY, MONTANA

	Actual				Projected	
	1960		1970		1980[a]	
Age	Male	Female	Male	Female	Male	Female
0–9	3,099	2,959	3,203	3,049	3,940	3,776
10–19	2,321	2,574	3,392	3,574	3,494	3,689
20–29	1,428	1,592	1,976	2,294	2,905	3,184
30–39	1,754	1,794	1,802	1,848	2,502	2,664
40–49	1,761	1,874	1,858	1,933	1,913	1,994
50–59	1,481	1,379	1,762	1,919	1,853	1,981
60–69	1,077	1,100	1,182	1,284	1,407	1,786
70–79	620	723	657	835	731	982
80 and over	184	276	260	453	350	515
Total	13,725	14,271	16,092	17,189	19,095	20,571

[a] Assumptions: Continued 1960–1970 migration trends.
Source: Information Systems Bureau, Department of Intergovernmental Relations, U.S. Government, 1973.

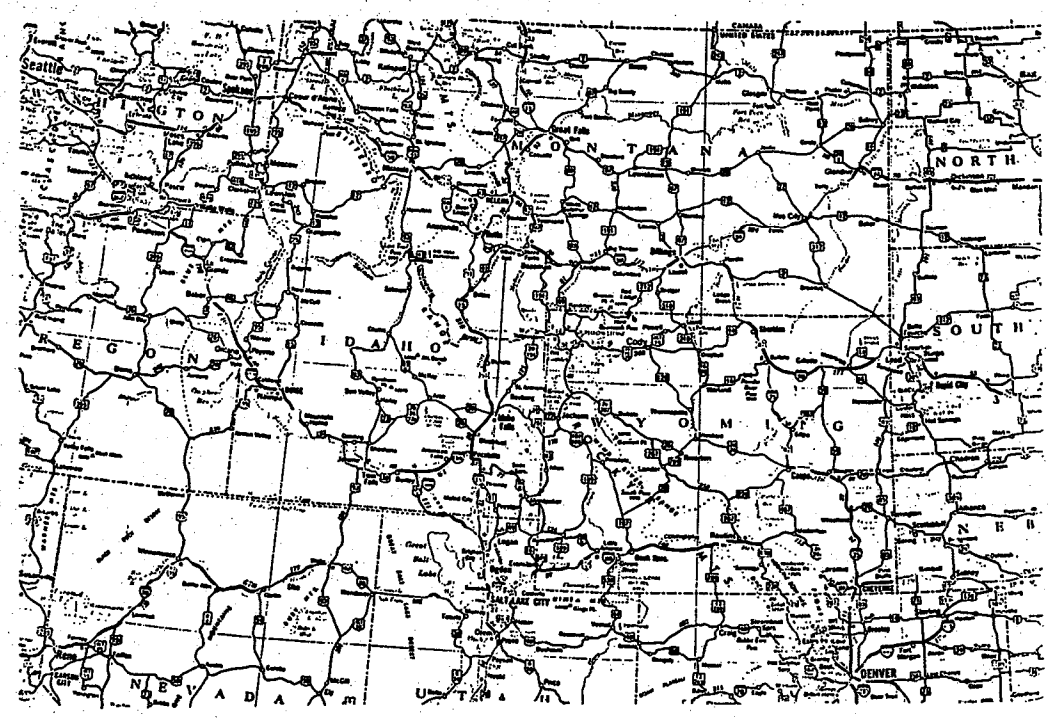

FIGURE 6 ■ The greater Pacific Northwest.

TABLE 7 ■ **BED-POPULATION RATIOS, BY STATE, 1950 AND 1960**
Beds per 1000 population

State area	1950	1960	State area	1950	1960
Alabama	1.9	2.5	Nebraska	4.0	3.9
Arizona	3.3	2.5	Nevada	4.1	3.3
Arkansas	1.8	2.7	New Hampshire	3.9	3.7
California	3.6	3.0	New Jersey	2.9	2.9
Colorado	3.7	3.8	New Mexico	2.7	2.6
Connecticut	3.3	3.4	New York	3.5	3.6
Delaware	3.1	2.9	North Carolina	2.5	2.8
D.C.-Maryland-Virginia	3.5	3.3	North Dakota	3.9	4.6
Florida	2.5	2.7	Ohio	3.1	3.3
Georgia	2.2	3.0	Oklahoma	3.0	3.6
Idaho	3.0	2.8	Oregon	3.5	3.1
Illinois	3.7	3.8	Pennsylvania	3.2	3.7
Indiana	3.2	3.3	Rhode Island	3.1	3.6
Iowa	3.9	3.7	South Carolina	2.7	3.2
Kansas	3.7	3.7	South Dakota	3.9	3.8
Kentucky	2.1	3.1	Tennessee	2.1	2.8
Louisiana	2.5	2.8	Texas	2.8	3.1
Maine	3.1	3.8	Utah	2.5	2.8
Massachusetts	3.9	3.7	Vermont	4.0	4.1
Michigan	2.7	3.1	Washington	3.4	3.2
Minnesota	3.9	4.0	West Virginia	2.7	4.0
Mississippi	1.7	2.6	Wisconsin	3.6	4.1
Missouri	3.1	3.6	Wyoming	3.4	4.1
Montana	4.0	4.3			

Source: American Hospital Association.

TABLE 8 ■ PHYSICIANS AND DENTISTS SERVING ON STAFFS OF HELENA HOSPITALS

	1964	1968	1971	1972
Physicians				
Age category				
30–39		10	9	11
40–49		19	20	20
50–59		10	9	9
60 and over		4	5	6
Classification				
Active	32	40	36	41
Courtesy	10	3	7	4
Inactive	0	0	3	0
Privileges				
Anesthesiology		2	2	2
Dermatology		0	1	1
Eye, ear, nose, and throat		1	2	2
General practice		19	15	12
General surgery		9	7	4
Internal medicine		5	4	5
Neurology		0	0	1
OB gynecology		2	2	2
Ophthalmology		1	3	4
Orthopedics		2	2	3
Pathology		1	1	3
Pediatrics		4	4	4
Radiology		2	3	4
Urology		0	1	1
Total physicians on hospital staffs	42	43	43	45
Dentists				
Age category				
30–39		6	6	2
40–49		4	4	3
50–59		1	0	3
60 and over		3	4	1
Classification				
Active	0	0	0	0
Courtesy	2	14	14	9
Inactive	0	0	0	0
Total dentists on hospital staffs	2	14	14	9
Total physicians and dentists on hospital staff	44	57	57	54

Source: St. John's Hospital records.

cities such as Great Falls and Bozeman had excellent transportation networks. (See Figure 6 for a map of the region.)

Under almost all sets of assumptions, though, the number of persons over 60 was forecast to increase at a rate more than 20 percent higher than that for the area's population as a whole. Thus, if past illness ratios and the medical procedures for dealing with them remained unchanged, the demand for geriatric services would increase by 23 percent or more by 1980.

On the other hand, the ratio of population to hospital beds for Helena in 1972 was substantially higher than the nationwide median of 3.5 beds per 1000 persons. The latter ratio could only be regarded as a "ball-park" figure, though, since it varied widely among different communities according to their

locations. For instance, Alabama had a ratio of 2.5/1000 in 1970 while North Dakota had a ratio of 4.6/1000 the same year. (See Table 7 for a listing by state for 1950 and 1960.) Among the factors which influenced it were the age and wealth of the area's population, the degree to which outpatient facilities were used, and the geographic characteristics of the area. In the latter regard, St. John's received some of its patients from the outlying areas of Lewis and Clark County, as well as approximately 13 percent of its case load from outside the county.[15]

In terms of availability of medical personnel, there was only a moderate increase in the number of physicians in the greater Helena area between 1964 and 1972, as is indicated in Table 8. There was, however, a noticeable trend away from general practice and general surgery toward more specialized fields of medicine. In addition, there was a general shortage of nursing personnel in the area—a condition which had been aggravated by the closing of St. John's nursing school in 1968.

A final, but important set of considerations in any decision on St. John's future were the goals of the Motherhouse of the Sisters of Charity. In the past, the policy of the Sisterhood had been to concentrate on providing general acute care through community-based hospitals in any community they entered. Once in a community, though, they adapted their facilities to the overall medical needs of the community insofar as those needs were unmet by other organizations and were within the financial resources of the Sisterhood. Given the range of services offered by St. Peter's and Shodair, Sister Macrina felt that the Motherhouse might not approve a plan for a major modification in St. John's mission unless she could demonstrate that such modifications were required to meet some aspects of the community's medical needs that St. Peter's or Shodair would not be able to provide, or that the costs of such modifications would be low, or that the necessary capital could be raised in the community or repaid relatively quickly.

As she described St. John's situation to the MPA consultants, Sister Macrina reflected on the fact that the factors influencing long-range planning at St. John's were numerous and difficult to access. Nonetheless, long-range objectives and policies would have to be made in order to give some direction to the hospital's future operations. Thus, the major question facing Sister Macrina and the MPA consultants was: "What should these objectives and policies be?"

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[15] In 1972, St. John's admissions were distributed among three geographic sources: 86.9 percent from Lewis and Clark County, 11.3 percent from adjoining counties, and 1.7 percent from other areas.