# Duplin Hospital Seeks Fiscal Cure

When a rural county hospital's low-income patients turn the hospital itself into a financial patient, voters and tax-payers face major decisions.

When the hospital is $700,000 behind in paying its bills, as Duplin General in Kenansville has been in recent months, taxpayers must decide how close the gap is between income and expenses.

Should they use county taxes, or raise fees to the patients who can pay, or turn the hospital over to a private for-profit firm?

Under the last option, the firm probably would need a county subsidy for patients who can't pay their full bills.

The problems facing Duplin General, an 80-bed facility serving one of the state's most rural counties, are typical of rural medical facilities, according to hospital and county officials.

The hospital is losing money because federal Medicare and Medicaid programs only pay about 70 percent of the hospital's charges. Patients under these programs make up two-thirds of its care, exactly opposite what county officials say should be.

W.J. Costin, chairman of the Duplin County Commissioners, said the patient payment mix should be about 30 percent Medicare and Medicaid and about 70 percent private insurance or payment schedules.

Duplin General now is in a serious bind because it has deviated from that formula.

"The government cheats on the payment of bills," said Dr. Corbett L. Quinn, of Magnolia, a longtime practitioner in Duplin County. He appears to have strong support from hospital and local government officials when he charges "the government lies when it says it funds Medicaid and Medicare."

"Quinn suggested levying a county tax, labeled as a hospital operating tax. Duplin County voters authorized a property tax of up to 8 cents per $100 for hospital operation when they approved the hospital in a 1952 referendum.

Costin said the county needs the hospital and won't allow it to close. The hospital's Board of Trustees will meet at 7 p.m. Thursday to discuss its financial problems.

"We've got to find something out by June 1," when the county plans its budget, Costin said. "They're (trustees) $700,000 behind in paying bills, although this varies month by month. They're having cash flow problems."

"We're getting hit at both ends," Costin said. "Besides having to make up the difference between billings and what we get, we have to send $308,700 to Raleigh this year as the county's share of the Medicaid program cost."

In the past five months, the hospital billed Medicare patients $106,188 — as much as allowed by current rules — and billed Medicare for the $982,117 balance of those patients' fees, hospital administrator Richard Harrell said. Of that balance, Medicare paid only $695,974, leaving the hospital with unpaid and uncollectable bills totaling $286,143.

Current government jargon calls that loss "contract adjustments."

Hospitals are barred by law from billing Medicare and Medicaid patients for the difference between charges and actual government payments. Some of the federally applied squeeze is designed to hold down hospital costs.

Hospital officials, however, maintain their costs far exceed what they can recover under these programs.

Hospital Board Chairman Ray Sanderson said Medicare and Medicaid reimbursements are about equal to the cost of a patient's care, but do not account for the patient's share of the hospital's total operating costs.

When all hospital costs are included, Harrell said, the actual cost of Medicare patients was $263.51 per day, of which patients paid $25.71 and Medicare $168.52, leaving $69.28 unpaid and uncollectable.

During the past hospital fiscal year — Oct. 1, 1981 to Sept. 30, 1982 — 50 percent of Duplin General's patients were on Medicare, a program for the elderly; 9 percent on Medicaid, designed to aid the poor; 12 percent under a mental health program using a similar reimbursement formula; and 29 percent on insurance or out-of-pocket payments. Eight percent of the hospital's billings ended up as bad debts, Harrell said.

Sanderson cited a recent "worst case scenario" in which Medicaid paid $252 and Blue Cross $18 towards a patient's $670 bill, leaving a loss of $382.

In a memorandum to county commissioners, Quinn predicted, "It will cost in the neighborhood of $1 million initially and about $500,000 annual maintenance (in public money) as long as the present formulas for state and federal participation remain in effect."

Quinn said his estimate of $1 million needed initially is an estimate of costs of immediate replacement for old equipment.

County Manager Ralph Cottle said county commissioners appropriated $1.931 million for the hospital in the last five years, an average of $380,000 per year, mostly for investment in the building and equipment. Cottle said this amounts to about 6 cents per $100 in the county's property tax rate.

Commissioner D. J. Fussell said, "Duplin General is not going to close. Closing it isn't even in my vocabulary."

Fussell suggested hiring a consultant on hospital financial affairs to advise the commissioners and hospital trustees on possible solutions. He and other commissioners have said they may have to alter their priorities to maintain the hospital, but they don't favor the last resort: raising county taxes.

**FIVE GENERATIONS** of the Andrew Herman Tyndall and Mary Davis Family of Pink Hill, are shown above. Seated, left to right, Baby Heather Smith, Mary Tyndall Howard. Standing, Patricia Howard Smith, Timothy Smith and Eunice Tyndall Howard.



## Attention Farmers

Attention all farmers who plan on raising peppers. According to Phil Denlinger, assistant Agricultural Extension agent, intent to import pepper plants from out of state must be reported to the Plant Protection section of the North Carolina Department of Agriculture. Notification forms can be picked up at the county Extension Service office in Kenansville.

This regulation requires anyone who intends to bring pepper plants from another state into North Carolina for commercial purposes to provide the Plant Protection section with the following information: importer's name and address, approximate number of plants to be imported, approximate date of importation and the name and address of the out-of-state source.

This action is prompted by the severe bacterial leaf spot problem encountered on peppers in 1982 which was largely traceable to infected transplants and seeds. Monitoring sources of imported pepper plants will be one way to help prevent a disease outbreak.

For more information and notification forms, contact Denlinger at the AES office in Kenansville.