

**STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
NEW HAMPSHIRE HOSPITAL**

**FINANCIAL AUDIT REPORT
FOR THE NINE MONTHS ENDED MARCH 31, 2019**



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To The Fiscal Committee Of The General Court:

We were engaged to audit the accompanying financial statement of the New Hampshire Hospital (Hospital) for the nine months ended March 31, 2019 and have issued our report thereon dated October 2, 2020.

This financial audit report presents information related to our audit in two sections; a management letter section and a financial section. The management letter section, prepared by the auditors, is a byproduct of the audit of the Hospital's financial statement. This section contains an auditor's report on internal control over financial reporting and on compliance and other matters, related audit findings, and a summary of the status of prior audit findings, originally reported in the audit report of New Hampshire Hospital for the nine months ended March 31, 2011.

The financial section of this report, with the exception of the independent auditor's report on the Hospital's financial statement, was prepared by the financial management of the Hospital, with assistance from the Department of Administrative Services, Bureau of Financial Reporting. In addition to the auditor's report, the financial section of the report includes the financial statement, notes to the financial statement, required supplementary information, and other supplementary information.

This report can be accessed in its entirety on-line at:

<http://www.gencourt.state.nh.us/LBA/AuditReports/financialreports.aspx>

Office of Legislative Budget Assistant

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October 2, 2020

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MANAGEMENT LETTER SECTION

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Abbreviations Used

ANSOS	Nurse Scheduling and Productivity Management System
Avatar	Patient Healthcare and Billing System
CBA	Collective Bargaining Agreement
DAS	Department of Administrative Services
DHHS	Department of Health and Human Services
DSH	Medicaid Disproportionate Share Revenue
DoIT	Department of Information Technology
HIPAA	Health Insurance Portability and Accountability Act
NHFirst	New Hampshire State Government Accounting and Financial Reporting System
NHH	New Hampshire Hospital

* No audit comments suggest legislative action may be required.

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Independent Auditor's Report On Internal Control Over Financial Reporting And On Compliance And Other Matters Based On An Audit Of Financial Statements Performed In Accordance With *Government Auditing Standards*

To The Fiscal Committee Of The General Court:

We were engaged to audit, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statement of the New Hampshire Hospital (Hospital) which comprises the Statement of Revenues and Expenditures – General and Capital Projects Funds for the nine months ended March 31, 2019, and the related notes to the financial statement thereon dated October 2, 2020. Our report disclaims an opinion on the Statement of Revenues and Expenditures – General Fund because we were unable to complete the audit of the Hospital's restricted revenues and the Hospital's share of the New Hampshire Department of Health and Human Services' Allocated Costs reported in the General Fund. Due to the effects of the COVID-19 pandemic, which became the sole focus of all the Hospital's staff, including finance, the Hospital's management informed us they would not be able to accommodate auditor requests in order to complete the audit in a timely manner.

Internal Control Over Financial Reporting

In connection with our engagement to audit the financial statement of the Hospital, we considered the Hospital's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statement, but not for the purpose of expressing an opinion on the effectiveness of the Hospital's internal control. Accordingly, we do not express an opinion on the effectiveness of the Hospital's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist that were not identified. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. We did identify certain deficiencies in internal control, described in Observations No. 1 through No. 17, that we considered to be significant deficiencies.

Compliance And Other Matters

In connection with our engagement to audit the financial statement of the Hospital, we performed tests of its compliance with certain provisions of laws, rules, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*. Additionally, if the scope of our audit work had been sufficient to enable us to express an opinion on the Statement of Revenues and Expenditures – General Fund, instances of noncompliance or other matters may have been identified and reported herein.

Hospital's Responses To Findings

The Hospital's responses to the findings identified in our audit are included with each reported finding. The Hospital's responses were not subjected to the auditing procedures applied in our engagement to audit the financial statement and, accordingly, we express no opinion on them.

Purpose Of This Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Hospital's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Hospital's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.



Office Of Legislative Budget Assistant

October 2, 2020

Internal Control Comments
Significant Deficiencies

Observation No. 1: Formal Risk Assessment Policies And Procedures Should Be Established

Observation:

The Hospital does not have a formal risk assessment process in place for its financial accounting and reporting functions, including an information technology security assessment. While management reports that the Hospital holds periodic manager meetings to discuss a multitude of issues, no policies and procedures exist requiring a regular on-going review of its financial operations for risks.

Risk assessment is the process of identifying, assessing, and responding to risks related to the achievement of the entity's objectives, and is one of the five generally accepted components of internal control. A prerequisite to an effective risk assessment is the establishment and recognition of objectives and the identification of risks that may put achieving those objectives in jeopardy.

An effective risk assessment process is the foundation for the development and implementation of controls intended to identify and eliminate, mitigate, or otherwise manage identified risks. A formal and well-planned risk assessment process increases the likelihood that the appropriate balance between the costs and benefits of controls can be understood and become the basis for controls put into operation. As risks change over time due to changes in processes and the environment, controls intended to mitigate risk may become inefficient and ineffective. Without an ongoing risk assessment process, the identification and response to risk often occurs in a reactive mode, after a risk had been realized and a loss incurred.

Periodic monitoring of Hospital processes and activities using a risk-based mindset promotes effective planning and assists in resource allocation decision-making.

Recommendation:

The Hospital should establish a formal and documented risk assessment process for recognizing, evaluating, and responding to risks that could affect its ability to achieve its financial accounting and reporting objectives. The process should include an IT security risk assessment to ensure the Hospital's information systems are adequately protected. Risks identified should be analyzed to determine whether current internal controls mitigate risk to a level desired by management or whether other actions are required in response to risks. Hospital employees with particular areas of expertise and knowledge of Hospital financial operations should participate in the review to ensure that details of operations that may not be obvious to management are appropriately considered. A continuous monitoring of Hospital processes and activities using a risk-based mindset will promote effective planning and assist in resource allocation decision-making.

Auditee Response:

We concur. The Hospital does not have a formal, comprehensive risk assessment in place relative to financial accounting and reporting. The Hospital will consult with its colleagues at DHHS, and should resources allow, we will conduct a comprehensive financial risk assessment of the Hospital, and develop policies whereby risk assessments are completed periodically.

It is important to note that, the Hospital does have policies in place relative to specific financial risks, such as identify theft and financial fraud, but these policies are relative to specific risks, and not a comprehensive risk assessment. Additionally, the Hospital follows policies as established by the Department of Administrative Services, and any findings in the annual CAFR regarding financial risk are addressed.

Although the Hospital does not conduct a comprehensive financial risk assessment, the Hospital has significant experience in operational risk assessment given the complex nature of Hospital services, and the myriad of regulatory bodies which oversee Hospital operations.

Observation No. 2: Internal Audit Function Should Be Established

Observation:

The Hospital does not currently have its own dedicated internal audit function to effectively monitor controls, identify risks, and ensure management objectives are being carried out as intended.

The Hospital is organizationally located within the Department of Health and Human Services (DHHS), and while the DHHS has a dedicated Internal Auditor, no internal audits of the Hospital have been performed in the past several years. The Hospital, as an entity with over 600 employees, several large contracts, many significant accounts, and numerous compliance requirements could benefit from having its own internal audit function.

According to the Institute of Internal Auditors, an effective internal audit function can help an organization “accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes.” The scope of responsibilities assigned to internal auditors can be broad and involve many topics such as an entity’s governance; risk management; evaluating management controls over the efficiency and effectiveness of operations; including safeguarding assets; assessing the reliability of financial and management reporting; and determining compliance with laws, rules, and policies. Internal auditing can also involve conducting fraud audits to identify fraudulent acts.

Many observations noted in this report may have been identified and addressed earlier had a dedicated internal audit function been in place.

Recommendation:

The Hospital should establish an internal audit function and work towards the implementation of standard internal audit industry practices. The internal audit function should include a formalized process, including the reporting of issues and challenges identified, and recommendations for improvement, to Hospital and DHHS management.

Auditee Response:

We concur. New Hampshire Hospital leadership has engaged with the DHHS Bureau of Improvement and Integrity about potential options for conducting internal financial audits moving forward. While creating an internal auditing function for the Hospital may be ideal, the Hospital cannot support creating and funding such a position given the current financial situation of the State, but certainly appreciates the merits of this observation.

Observation No. 3: Patient Services Revenues Reconciliation Policies And Procedures Should Be Improved

Observation:

The Hospital has not developed formal policies and procedures for performing periodic reconciliations of its patient services revenues to ensure revenues are posted accurately and that the reconciliations are performed timely, and appropriately reviewed.

Hospital patient services revenue receipts for board and care are initially recorded in the Hospital's electronic patient billing system, Avatar, and then posted to various revenue accounts in the State's accounting system, NHFirst. While the Hospital reported that reconciliations between the two systems were performed monthly, there was uncertainty regarding the details of the process, including who performed the reconciliations and when they were completed. Based on auditor inquiry as of June 4, 2019, the last reconciliation performed was for the month of January 2019.

Failure to develop and implement formal revenue reconciliation policies and procedures increases the risk that errors or fraud could occur and not be detected and corrected in a timely manner.

During the nine months ended March 31, 2019, the Hospital reported \$12 million in patient services revenues received from Medicaid, Medicare, private insurances, and patients.

Recommendation:

The Hospital should develop formal policies and procedures over its reconciliation process for patient services receipts. Periodic and timely reconciliations should be performed to ensure the posted receipts in each system agree. The Hospital should investigate and sufficiently understand causes for any significant variances. Reconciliations should be reviewed and approved by management to ensure timely and accurate performance.

Auditee Response:

We concur. We concur that policies and procedures should have been formally documented. The Hospital has formally documented policies and procedures over its reconciliation process for patient services receipts, which requires notification of the next level of management in the event that discrepancies are unresolvable, or are over 10 days old.

As the audit recognizes, New Hampshire Hospital had implemented a process to reconcile patient service receipts posted in its billing systems to state accounting systems on a monthly basis. Each month of the audit period prior to January 2019, the reconciliation was timely performed revealing no unresolvable or extended discrepancies. Additionally, the Hospital's billing systems are reconciled to the deposit reconciliation form (A-15) daily, and the A-15 is reconciled to state accounting systems (NH-First) daily. Given the lack of discrepancies in monthly reconciliations, primarily due to the daily reconciliations that are conducted, the Hospital decided to transition to quarterly reconciliations in January of 2019, however the March reconciliation was delayed as the observation noted. Moving forward, the Hospital will ensure reconciliations are completed in a timely fashion and that roles and responsibilities relative to reconciliations will be clear to all parties involved.

Observation No. 4: Policies And Procedures For Patient Billings And Collections Should Be Established

Observation:

The Hospital has not supported significant aspects of its patient billing and collection operations with formal controls, including documented management-approved policies and procedures.

Some Hospital employees responsible for patient billings have documented procedures for their assigned tasks, but employees have not benefited from management-approved policy and procedure guidance that would encourage accuracy, consistency, and compliance with management's objectives and directives.

To be effective, policies and procedures must be readily available to employees, employees must be trained in the application of the policies and procedures, and compliance with the policies and procedures must be monitored to ensure they remain in place and effective over time.

The absence of formal policies and procedures increases the risk of an unintended or inconsistent approach, including not billing all services provided, or receiving all revenues due, and potential disruption to continuity of operations if key employees leave Hospital service.

A similar comment was note in our prior audit report.

Recommendation:

The Hospital should establish formal billing and collections policies and procedures to support its significant accounting and financial reporting activities.

Policies and procedures should be approved by management and address processes and controls that support accounting and financial reporting activities and compliance with management's objectives and expectations. Approved policies and procedures should be effectively communicated to employees involved in the process, and employees should be appropriately trained. Additionally, Hospital management should establish a suitable monitoring control to ensure the policies and procedures continue to operate as intended and remain relevant.

Auditee Response:

We do not concur. The observation indicates that the Hospital lacks both policies and procedures related to patient billing and collections. In fact, procedures have been established and are aligned with New Hampshire Hospital policies, state law and federal regulations. All billing staff, including billing, patient financial services and utilization management, are provided procedural guidance in the form of hard copy and electronically. Staff are encouraged to access the online version of procedures as they are subject to continual changes to reflect updates applicable to specific contracts with guarantors (payers), the Centers for Medicare and Medicaid Services (CMS), and other authoritative bodies. Updates to policies and procedures are communicated to staff after review by supervisors and various levels of management.

The observation also recommends management-approved *policies* relative to how staff's efforts align to desired organizational outcomes. The Hospital agrees that aligning front-line work to desired outcomes is imperative, but disagrees that a written policy is the most appropriate tool to achieve this. As management objectives relative to healthcare account receivables are contextual due to variables outside the Hospital's control, documenting such expectations in a policy, and subsequently managing to such expectations, would be challenging. Instead, the Hospital has diligently worked to incorporate such practices into its daily culture, regularly works with Revenue Cycle Staff to build a shared-understanding of Revenue Cycle performance, and continuously strives to improve revenue capture for the State of New Hampshire. It is important to note that the Hospital's revenue cycle remained uninterrupted during a significant gap in CFO's, largely because controls have been built into the culture and management system of the Hospital.

LBA Rejoinder:

Documented procedures were provided to the auditors and consisted of written instructions on how to perform specific job tasks. This observation addresses the need to establish written policies and procedures to ensure management objectives are being met through the establishment of key control activities along with effective management reviews. The Hospital reports its key control activities have been incorporated into its daily organizational culture. The Hospital's informal approach presents significant risk that appropriate policies and procedures will not be in place to support and direct the Hospital's critical financial operations.

Observation No. 5: Accounts Receivable Policies And Procedures Should Be Improved

Observation:

The Hospital has not demonstrated that its methodology for estimating its accounts receivable, as documented in its accounts receivable policies and procedures, is a reasonable process approximating actual collection, and is in compliance with State policy.

While the Hospital has developed policies and procedures for estimating year-end accounts receivables for financial reporting to the Department of Administrative Services (DAS), the policy provides for a 90 day collectability period, rather than a 60 day collectability period in accordance with State accounting policy; and does not provide for effective tracking of subsequent collections to verify the accuracy of the estimate. The Hospital has not made effective use of its billing system, Avatar, by developing system reports that identify 60 days of subsequent period collections for patient services rendered during the financial reporting period, thus allowing the Hospital to effectively track and identify the precise receivable amount to compare to its estimates, and make and report corrections to the DAS if needed.

In compliance with U.S. Generally Accepted Accounting Principles (GAAP), the State's policy for revenue and accounts receivable recognition for governmental funds is to use the modified accrual basis of accounting. Modified accrual for governmental funds recognizes revenues as soon as they are both measurable and available. For this purpose, State policy is to recognize an accounts receivable, only if the revenue is to be collected within 60 days. To ensure the agency accounts receivable estimate is reasonable, State Policy requires agencies to track subsequent collections to evaluate the estimate.

Auditor review of patient billings collections for the 60 days following June 30, 2018 and March 31, 2019, noted the majority of collections related to services rendered in the prior period, therefore all amounts collected in the 60 day subsequent period appear to represent valid accounts receivables under the modified accrual basis of accounting.

Recommendation:

The Hospital should improve its policies and procedures for compiling and tracking its year-end accounts receivable. The Hospital's policies and procedures should include sufficient detail of discussion of methodologies, procedures, and sources of information to allow employees to perform the calculations and accrue an accounts receivable that represents a reasonable estimate of the amount to be collected in the measurement period. The Hospital should also develop Avatar system reports that appropriately track collections of year-end accounts receivable to allow for effective comparison and analysis to fine-tune the methodology, and make and report corrections to DAS, if needed.

Auditee Response:

We concur. The Hospital fully concurs that the Hospital should align its accounts receivable to reflect the Department of Administrative Services (DAS) Manual of Procedure's standard of

accounts receivables expected in the 60-day period following the fiscal year close. As a result of this observation New Hampshire Hospital changed its accounts receivable formulation during the FY 2020 close to align with the DAS Manual of Procedures.

Additionally, since the audit period, the Hospital has improved collections forecasting by reviewing uncollectible claims in accounts receivable and identifying and correcting issues in the application of collection percentages to our accounts receivable. The accuracy of this methodology proved to be quite accurate during the FY 2020 close, and will continue to be reviewed for further improvement. Healthcare account receivables are challenging to plan and forecast for, as they're subject to numerous variables that are outside of a hospital's control such as the tiering of insurances, issues in insurance carrier portals, and changes in insurance carrier policies.

In an effort to further improve the Hospital's forecasting abilities, as well as many other aspects of its accounts receivable, we have issued a Request for Proposal for a claims management system; an industry standard tool that assists in electronic aggregation, review, and submission of claims to insurance payment portals. By having a centralized tool for adjudicating claims, the Hospital will be better positioned to forecast accounts receivables in a given period.

Observation No. 6: Accountability For Contract Provided Staffing Should Be Improved

Observation:

The Hospital lacks appropriate timekeeping controls to ensure it is receiving contracted psychiatric related services in accordance with its contract.

The Department of Health and Human Services (DHHS) contracts with the Mary Hitchcock Memorial Hospital (Dartmouth-Hitchcock) on behalf of New Hampshire Hospital (Hospital) and six other DHHS service areas for physician, clinical and administrative services. According to the contract, Dartmouth-Hitchcock is to provide the Hospital with a Medical Director, Associate Medical Director, 11 psychiatrists, and other clinical and administrative staff amounting to a total of 37.5 full-time equivalent (FTE) positions.

The contract specifies "...the term "full-time" shall mean that each psychiatrist shall be required to account, through appropriate recordkeeping as specified by NHH, for a minimum of 40 hours per week, devoted to his or her duties and responsibilities, subject to the Contractor's normal and customary employee leave policies. Said minimum hours must be satisfied through hours devoted to clinical activities onsite at NHH."

During the nine months ended March 31, 2019, neither the Hospital nor the Department had established a system for tracking hours worked by Dartmouth-Hitchcock staff who provided services under the contract. The Hospital did not require Dartmouth-Hitchcock staff to prepare time and activity reports, sign-in, or otherwise track time worked on site at the Hospital.

While the Hospital reports it is confident that hours worked by Dartmouth-Hitchcock staff are being adhered to based upon management's observation of contract personnel and staffing

schedules, management was unable to provide the auditors with documentation to verify the Hospital was receiving the equivalent of 37.5 FTE positions as outlined in the contract.

During the nine months ended March 31, 2019, the Hospital expended approximately \$9 million for Dartmouth-Hitchcock staffing at New Hampshire Hospital.

A similar comment was noted in our prior audit report.

Recommendation:

The Hospital should improve accountability over its contracted staff to ensure it is receiving the services specified in the Dartmouth-Hitchcock contract. The Hospital should utilize existing contract provisions to implement controls sufficient to monitor performance. Timekeeping controls should be designed to provide management reasonable assurance that Dartmouth-Hitchcock staff are working their allotted times, and that those times are in accordance with the FTE's for the respective positions.

Auditee Response:

We concur. As tracking provider time in the form of a timecard, or relative to a 40-hour workweek, is a deviation from industry standard practices, the Hospital will revise this contract language in the next version of the contract. Disregarding short-term, temporary staffing services (commonly referred to as "locums"), industry practice is to track provider time at the full-time equivalent (FTE) level, which is consistent with the Hospital's current methodology.

Since the last LBA audit in 2011 which contained a similar finding, the Hospital has made significant improvements in its oversight of the Dartmouth-Hitchcock Provider Services Contract. The Hospital maintains a staffing schedule that complies with the contract provisions and provides assurance that scheduled times are being maintained; missing staff would be readily apparent as clinical activities involve inter-disciplinary teams. As an example, Provider staffing is reviewed every morning in a meeting comprising of all clinical, and many non-clinical leaders. If a contracted staff member is absent, coverage plans are articulated in this meeting to ensure that patient care is not impacted.

When contracted position vacancies last longer than 30 days, the Hospital has consistently executed a contract provision allowing for the reduction of invoices based on unfilled positions. In utilizing this provision, the Hospital saved \$394,221 in FY2020.

Observation No. 7: Expenditures For Contract Provided Staffing Services Should Be Limited To Hospital Operations

Observation:

The Hospital should limit expenditures for contract-provided staffing services to only those received by the Hospital.

During the nine months ended March 31, 2019, the Hospital paid Dartmouth-Hitchcock for contracted staffing services provided to the Department of Health and Human Services' Division of Behavioral Health and to Glencliff Home for the Elderly in the amounts of approximately \$327,000 and \$105,000, respectively.

Including the cost of services provided to other State entities in the Hospital's financial activity distorts the cost of operating the Hospital.

Recommendation:

The Hospital should ensure expenditures charged to the Hospital's appropriations represent only those associated with the Hospital's operations and activities.

Auditee Response:

We concur. This observation was resolved before the audit took place. Effective July 1, 2019, Glencliff Home and the Division of Behavioral Health had funds appropriated for their portion of the provider services contract, and subsequently paid for services received.

Observation No. 8: Ensure Cafeteria Employees Comply With Cash Handling Policies And Improve Accountability Controls

Observation:

The Hospital has not effectively monitored cashier adherence to a policy intended to maintain accountability over cash drawers. Additionally, the Hospital has not developed adequate controls to ensure that all cafeteria receipts are deposited.

The Hospital operates two cafeterias, one at the Hospital and one at the Department of Health and Human Services' Brown Building, known as Brown Café.

Hospital cafeteria cashiers post the receipt and return of cash drawers on a Cashier-Log & Drop Log (Log). A cafeteria supervisor also counts the cash drawer and posts the amount of cash collected in the Log. Both the cashier and supervisor are required to sign the Log to acknowledge the cash that was received for sales processed by the cashier.

A review of the Logs during the audit period identified the following:

- The Hospital was unable to locate the Logs for the period July 1, 2018 – October 6, 2019.
- 63 out of the 282, or 22%, of the Log postings for the period October 7, 2018 – March 31, 2019 were incomplete and missing, either cashier's or supervisor's signature, or both.
- The Brown Café did not complete any Logs during the audit period.

Daily the Hospital reconciles the cash drawers to individual register reports, and to cash deposited. However, a reconciliation is not periodically performed to compare the total sales and cash activity reported per cash register system reports to the cafeteria revenue posted to the State's accounting

system, to ensure that all revenues from all registers' activities were properly recorded and deposited. Additionally, employees at the Brown Café share cash drawers regularly.

Inconsistent monitoring of control compliance increases the risk that controls become ineffective due to complacency or noncompliance.

A similar comment was noted in our prior audit report.

Recommendation:

The Hospital should improve its monitoring of employee compliance with cash drawer accountability control activities to ensure controls continue to operate as management intends.

Controls over cash drawers for the Brown Café should be established to provide accountability. Cash drawers should not be shared amongst employees.

The Hospital should develop policies and procedures for reconciling cafeteria receipts per the cash register system report to revenue recorded in NHFirst. Discrepancies should be investigated and resolved in a timely manner. Reconciliations should also be documented and reviewed and approved by management.

Auditee Response:

We concur. New Food & Nutrition management was hired in FY19, resulting in cash management improvements.

While the audit was being performed, Hospital Finance and Food & Nutrition management met on a regular basis to review and refine procedures to ensure procedures and process were in compliance and staff were appropriately trained. Daily variances are logged into a tracking worksheet and reviewed quarterly to identify the need for refresher training and process review.

Additionally, New Hampshire Hospital's cafeteria now uses separate cash drawers to cover employee breaks and lunches. This process was implemented during the audit period. If there is a scenario where staffing is limited, the department has opted to close cafeteria services during staff breaks to eliminate the need for a second cashier.

Lastly, the lack of reconciliation between the cash register tapes, bank deposit slips, and state accounting system (NH-First) postings has been resolved. Daily deposits are processed through the Cashier's Office. The Cashier creates a deposit reconciliation form (A-15) based upon the source documents from the bank. A second employee enters the deposit summary information into NH-First. A third person, a supervisor or manager in New Hampshire Hospital finance, must approve the NH-First entry which requires comparison of deposit backup documents (register reports) to the bank deposit slips and then to the A-15. This process is performed at an appropriate supervisory/managerial level and acknowledged by the reconciler's initials and date of approval on the A-15. In addition to this reconciliation process, the Hospital will require register reports to

be printed from all registers daily, regardless of whether or not they are all used, to eliminate the risk of a register not being brought forth for reconciliation.

Observation No. 9: Formal Business Plan And Pricing Policy For Cafeteria Operations Should Be Established

Observation:

The Hospital has not established formal business, cost reporting, and pricing plans for its cafeteria operations. The cafeterias operate without formal stated purposes and goals, and without a management information system to track the operations' results and progress towards the achievement of management's intended goals and objectives.

The Hospital has cafeteria operations both within the Hospital and in the nearby Brown Building, headquarters of the Department of Health and Human Services (DHHS). The Hospital reports the objective of the cafeterias are to breakeven but has not defined a breakeven methodology or addressed this goal in a formal business plan.

The Hospital does not have an information system that accounts for labor and overhead cost for cafeteria services separately from patient food-services costs, making a determination and analysis of cafeteria costs problematic for the Hospital's cafeteria.

During the audit period, the Hospital reported sales of approximately \$278,000 and \$130,000 for the Hospital's cafeteria and Brown Building cafeteria, respectively. An analysis of the Brown Building cafeteria during the nine months ended March 31, 2019 indicated that approximately \$183,000 was expended on salaries and benefits, food, supplies and other items. As previously noted, costs for the Hospital's cafeteria are unknown.

Additionally, the Hospital does not have formal policies and procedures for developing pricing for the meals served at its cafeterias. According to the Hospital's chef, meal prices have historically been set at a 55% profit margin. Free meals have been provided to physicians to encourage them to accept on-call assignments.

A similar comment was noted in our prior audit report.

Recommendation:

The Hospital should establish a business plan for its cafeteria operations that describes the goals and objectives of offering cafeteria services and the plan for providing those services, including a determination of whether the cafeterias are to be self-funded or subsidized.

The Hospital should establish an accurate and timely management information system for its cafeteria operations, including cost reporting. The system should consider inputs such as food, labor, supplies, overhead, and other costs incurred in providing cafeteria services to employees and visitors, separately from its patient food-services costs.

The Hospital should establish formal pricing policies and procedures for its cafeteria services that consider all the costs of providing those services. Prices should be regularly reviewed and updated as necessary.

Auditee Response:

We concur. As previously stated, the Hospital had hired new Food & Nutrition management who are actively working to improve overall operations of the meal preparation and delivery process. Research is ongoing and steps have been taken to develop an accurate cost accounting methodology for pricing meals and food items. One of the first steps was to create a measurement system to separate patient meal costs from cafeteria costs. We anticipate having a cost accounting methodology prior to the close of FY21, which may come in the form of a recently issued RFP to secure a vendor to provide an integrated cost accounting, meal and menu tracking, and inventory system.

The practice of permitting free meals for physicians was a vestige of historical practices in the healthcare industry, and has been discontinued.

Observation No. 10: Timekeeping Process Should Be Improved And Redundancies Eliminated

Observation:

The timekeeping and payroll process for direct care, food services, and facilities employees is reliant upon the accuracy of manual calculations, transcription of time worked, and input into two different timekeeping systems, as well as manual biweekly timesheets; increasing the risk that payroll expenditures may not accurately reflect hours worked.

Management utilizes staffing reports from the ANSOS system (Nurse Scheduling and Productivity Management System) to communicate the weekly work schedule to direct care workers (nurses and mental health workers). The staffing reports, overtime forms, and ANSOS system are used by Hospital administrative staff employees to manually key hours into direct care employee timecards in the NHFirst Time Management System (TMS).

Part-time employees and full-time food services and facilities employees complete manual time sheets that log hours worked and leave time taken on a bi-weekly basis. The timesheets are used by Hospital administrative staff to manually key hours worked into employees' timecards in TMS.

In addition to the manual processes describe above, the DHHS Payroll Department manually calculates and inputs shift differentials, hazard pay, overtime premiums or longevity into TMS.

A similar comment was noted in our prior audit report.

Recommendation:

The Hospital should consider the feasibility of implementing an automated timekeeping system for direct care, food service and facilities employees that will automatically upload timekeeping information into TMS, similar to those used by other State agencies. An automated timekeeping system will help eliminate redundancy, improve accuracy, and decrease the risk of errors and fraud.

Auditee Response:

We concur. The Hospital previously attempted to contract with a timekeeping vendor used by other agencies, but the vendor was unable to meet the requirements of a healthcare facility. Subsequently, in 2018 the Department of Administrative Services had commenced a timekeeping project soliciting business requirements from all agencies. The Department of Health and Human Services, including New Hampshire Hospital, were in queue for this roll-out, but it is now our understanding that this endeavor has ended.

Should funding become available, The Hospital would welcome the opportunity to implement a timekeeping system.

Observation No. 11: Leave Taken On Holidays Should Be Properly Recorded

Observation:

Hospital employees scheduled to work on a paid holiday are permitted to submit leave requests not to work on the holiday, resulting in the payment of overtime contrary to the State's Collective Bargaining Agreement (CBA) and guidance provided by the Department of Administrative Services.

According to the 2018-2019 Collective Bargaining Agreement (CBA) Article 7.1.2.d., "There shall be no pyramiding or duplication of compensation by reason of overtime or holiday or other premium pay provisions of this Agreement."

Additionally, the Department of Administrative Services (DAS) provided State agency payroll supervisory staff with a *Holiday Pay – Scheduling and Time Entry Memo* dated April 24, 2016, which includes guidance on how to account for holiday pay. The memo recommended planning ahead and incorporating the holiday hours into the work schedule during the week that the holiday occurs, but was silent with respect to requesting leave or accounting for holiday pay when an employee is scheduled to work the holiday and calls in sick or requests leave after the schedule has been released.

During payroll testing, we noted an employee was paid annual leave on a State holiday resulting in the erroneous payment of \$216 in overtime since the leave hours were treated as overtime. In reviewing the Hospital's payroll expenditure population for the audit period, we noted this practice

is not isolated to one employee as other employees were also paid for leave time used on a State holiday.

Recommendation:

The Hospital should work with the DAS to develop and implement procedures to properly account for employees scheduled to work on a paid holiday to ensure employees are compensated in accordance with the CBA and State policy.

The DAS should establish in administrative rule or policy the process by which

- employees and supervisors should process and record requests and approvals of leave time used on a holiday
- agencies are to properly account for holiday pay as it relates to the approved and paid hours in the work week in which the actual holiday takes place.

Once established, it should be incorporated into agency payroll departments' policies and procedures and adequately communicated.

Auditee Response:

We concur. Corrective measures were taken while the audit was on-going. This finding was limited to "pool" staff, scheduled to work on an as needed part-time basis, whom traditionally worked second shift. In their initial creation, all pool positions were recoded to first shift, thus requiring an additional timecard entry to account for shift differentials. The Hospital believes this finding has been fully resolved.

Department of Administrative Services' Response:

DAS concurs. One of the primary roles of the statewide payroll office at DAS is to assist agencies in interpreting various complex payroll situations, such as pay for working on a State holiday, to ensure that employees are compensated in accordance with the CBA and State Personnel Policies. DAS concurs that agencies should have a documented procedure for employees and supervisors to process and record requests and approvals of leave. However, for DAS to establish a universal administrative rule or statewide policy would present significant challenges due to the varied operations at each agency, specifically as it pertains to characteristics of a twenty-four hour / seven-day operation that does not apply to all state agencies.

It is important to note that DAS was in full support of recent proposed legislation that would have clarified the DAS Department of Personnel's central policy making authority, however this initiative will be delayed to a future legislative session. Absent clarification of the law, DAS will continue to work with agencies to provide guidance to ensure their policies and procedures adequately address their specific operations, while maintaining compliance with the various collective bargaining agreements.

Within the next six months, DAS will work with the Hospital to review the agency's leave request and approval procedures, specifically as it relates to an employee taking leave after being

scheduled to work a holiday. DAS will ensure that the agency procedures include clear instruction in order to avoid inconsistency. In addition, DAS will inquire of other agencies that have similar holiday scheduling arrangements, to promote consistency across state agencies.

Observation No. 12: Weekend Pay Differential Should Be Paid As Negotiated

Observation:

The Hospital pays a weekend rate differential of \$1.50 per hour to all nursing staff employees even though not all nurses are eligible for this rate per the State's Collective Bargaining Agreement (CBA) covering Hospital employees.

According to Article 19.12.5 of the 2018 – 2019 CBA, "Institutional Weekend Differential: All full-time and part-time institutional employees who work on a shift which commences from 11:00:00 pm Friday night to 10:59:59 pm Sunday night shall receive a weekend differential of one dollar (\$1.00) per hour for all hours actually worked on that shift."

Per Article 19.12.6.c., "The differentials in effect on July 1, 2009 for full-time and part-time Licensed Practical Nurses and Registered Nurses working at New Hampshire Hospital in a direct care position shall remain in effect for those full-time and part-time Licensed Practical Nurses and Registered Nurses employed at New Hampshire Hospital in a direct care position on February 12, 2010." The effective hourly rate differential was \$1.50 on February 12, 2010.

During our testing of payroll expenditures for the nine months ended March 31, 2019 we noted the following:

- The Hospital commenced the weekend differential from 6:45 am Saturday morning to 6:44 am Monday morning, contrary to the timeframes specified in the CBA.
- Nursing weekend shift differentials expenditures totaled \$48,875 during the nine months ended March 31, 2019. The total weekend shift-differential overpayment paid to employees hired after the February 12, 2010 was approximately \$10,000.

A similar comment was noted in our prior audit report.

Recommendation:

The Hospital should pay the nursing staff weekend direct care shift differentials as negotiated in the Collective Bargaining Agreement. If management determines that the current payment of the nursing direct care weekend shift differential is necessary for the continued operations of the Hospital, then the Hospital should seek proper and formal authority to continue making payments in this manner.

Auditee Response:

We concur. Corrective measures were taken while the audit was on-going. This finding was limited to “pool” staff, scheduled to work on an as needed part-time basis, whom traditionally worked second shift. In their initial creation, all pool positions were recoded to first shift, thus requiring an additional timecard entry to account for shift differentials. The Hospital believes this finding has been fully resolved.

Department of Administrative Services’ Response:

Department of Administrative Services (DAS) concurs. While it appears that there was documented approval of the higher incremental rate many years ago, it does not appear that current authoritative documents, such as the CBA, have been updated to reflect this previous approval. As a result, DAS will work with the Hospital to research the appropriate mechanism to re-establish formal authority for the current pay rate, and the personnel to whom it applies.

Observation No. 13: Controls Over Pharmacy Operations Should Be Improved

Observation:

The Hospital does not have effective controls to accurately account for and track its pharmaceutical inventory of noncontrolled substances. Also, duties performed in the pharmacy are not effectively segregated.

The Hospital procured and began using its current pharmaceutical inventory system in December 2017. The Hospital has not relied upon the accuracy of inventory system to track activity and balances. It is not clear if the Hospital’s lack of confidence in the system is due to a lack of technical training, inherent limitations of the system, or combination thereof. The Hospital relies on the system to track issuances of pharmaceuticals to patients. The following weaknesses in the pharmaceutical inventory process were noted.

- The Hospital does not have a regular process to check inventory of noncontrolled substances for shrinkage to identify the drugs that potentially have been subject to loss or theft.
- User-access authority to adjust inventory in the system, including posting returns of unused drugs to the pharmacy, is not restricted. All pharmacy employees have unlimited access to the inventory system and can make changes to the inventory records without requiring documentation to support the propriety of the posted adjustment, or other management monitoring controls. Pharmacy staff regularly perform cycle-counts of pharmaceutical inventory and manually update balances to agree with physical quantity of products.
- The Hospital is unaware of a process for generating inventory system reports, such as posted adjustment activity or receipts scanned into inventory.
- Hospital pharmacy staff are not aware of a process for viewing or generating a report of historical orders received into the system. Upon receipt of product, the invoice that loads the receipt of the products into the system is scanned. In attempt to ensure that a sample of

purchased products were received into the system, auditors requested a receipt report that the Pharmacy was unable to generate.

- The Hospital does not perform a three-way match to ensure that the products ordered, invoiced, and received agree. Pharmacy Technicians use the invoices included with the shipments to document what was received.
- Pharmacy Technicians are primarily responsible for ordering, receiving, and authorizing payment for pharmaceuticals, and can perform all three of these functions independently resulting in a lack of segregation of duties that increases the likelihood of errors or irregularities occurring and not being detected.

During the nine months ended March 31, 2019, the Hospital purchased approximately \$1.1 million of pharmaceuticals.

A similar comment was noted in the prior audit reports with conditions in the current audit presenting no improvements. The Hospital has demonstrated a history of not effectively accounting for its pharmaceutical inventory of noncontrolled substances.

Recommendation:

The Hospital should improve controls over its pharmaceutical inventory of noncontrolled substances. The Hospital should perform a thorough review of the capabilities of the pharmaceutical inventory system to determine whether the perceived problems with the system are due to inherent system limitations, or the Hospital's operation of the system. If the system is determined to be capable of operating as intended, then the Hospital should take full advantage of the control opportunities available in the system. If it is determined the system is not operating as intended, then the Hospital should fix the system or determine the feasibility of replacing the system with a system that will effectively meet its needs.

The Hospital should ensure its pharmaceutical controls establish accountability for the pharmaceutical inventory upon receipt and maintain accountability for that inventory through subsequent issuance of the drugs. Pharmacy management should be aware of and review and monitor inventory adjustments.

Duties performed in the pharmacy consisting of ordering, receiving, and authorizing payments for the purchase of drugs should be effectively segregated or mitigating controls should be implemented.

User access in the inventory system should be effectively segregated and limited to personnel and functions necessary in the performance of assigned job duties.

Pharmacy personnel should complete receiving and inspection reports and compare the receipt of those goods to pharmaceutical orders to ensure that only ordered products are accepted and received into the inventory system.

Auditee Response:

We do not concur. New Hampshire Hospital follows industry standard pharmaceutical inventory practices, which are regulated by the DEA, and the Board of Pharmacy. Pharmacy inventory is highly complicated, and requires an in-depth understanding of pharmacy and hospital operations. To date, no concerns of drug diversion have been raised at New Hampshire Hospital, and the hospital is proud of the high-quality of service its inpatient pharmacy provides.

1. New Hampshire Hospital does not concur with the observation that the Hospital does not have a regular process to check inventory for shrinkage. The NH Board of Pharmacy is the regulatory body that governs the operations and performance of Pharmacies and Pharmacists within this state. Administrative Rule Ph 703.03, Controlled Drug Losses, requires *only* that Schedule II drugs (most tightly controlled) be subject to monthly perpetual inventory. The Hospital records perpetual inventory of all controlled substances, Schedules II-V and compares to physical inventory, keeping practices and policies in-line with regulatory requirements.

As an example, Ph 703.03 (d) permits for most controlled substances a loss of 15 dosage units or 2% of the monthly dispensing volume. Recent reports from New Hampshire Hospital indicate that during the 9 months from July 1, 2018 until March 31, 2019, all controlled substance daily dose units were accounted for either through the perpetual paper inventory or resolution of discrepancies, meaning the hospital had an effective loss of 0% during this 9-month period.
2. In respect to the creation and management of a perpetual inventory system for non-controlled substances, New Hampshire Hospital is not aware of any other hospital or pharmacy currently performing this practice. In outreach to other pharmacies and hospitals as a result of this finding, all respondents indicated they follow the same inventory management protocols that New Hampshire Hospital does. Respondents included a large-scale national pharmacy chain, a critical access hospital, two of the largest health-systems in New Hampshire, and another psychiatric hospital.
3. New Hampshire Hospital does not concur with the observation and/or premise that user-access to adjust pharmacy inventory *should* be restricted beyond how it is currently designed.
 - a. Pharmacists and Pharmacy Technicians are licensed individuals whom perform many functions throughout their daily work that could, and should, impact pharmacy inventory. It is impractical and inappropriate to reduce access to pharmacy inventory for licensed pharmacy staff.
 - b. Additionally, every Registered Nurse within the hospital also has the ability to adjust pharmacy inventories by means of administering or wasting medications; standard practices in all hospital settings. This brings the effective count of those who can adjust inventory in any hospital to hundreds of individuals. Recognizing that this makes inventory challenging to manage, the healthcare industry and its associated regulatory bodies require individuals with such access to be licensed and credentialed.
4. New Hampshire Hospital concurs in part with the observation that staff cannot run inventory reports. In reviewing this observation with the Hospital's Chief Pharmacist, she was able to generate several inventory reports, and will share this information with any Pharmacy staff that do not already know of such functions. Additionally, the Hospital is

- continually trying to improve reporting functions for RXConnect, the software connecting the Hospital's medical record to pharmacy dispensing machines.
5. Since this report was issued, the Hospital has adopted a three-way match methodology when receiving inventory.
 6. The Hospital has implemented changes based upon the audit recommendations that requires the Chief Pharmacist or designee to review and approve invoices. Due to limited staffing it is not cost effective to separate each phase of the ordering, receiving, and inventory entry cycle, however effort is always taken to minimize the risk of adverse outcomes as much as possible.
 7. To meet the observations expectations relative to inventory management and shrinkage control for non-controlled substances, The Hospital would have to increase pharmacy staffing at a cost that we believe would outweigh any potential benefit gained from shrinkage management.
 8. At no point in time has there been any evidence or concern that a member of the pharmacy staff has been concealing errors or fraud.

LBA Rejoinder:

The Hospital's response appears to agree in part with this observation and cites limited resources and a cost versus benefit analysis for some of the nonconurrence. However, mitigating management monitoring controls could be implemented at minimal cost to improve accountability over the pharmaceutical inventory of noncontrolled substances.

Observation No. 14: Controls Should Be Implemented To Review Workers' Compensation Billings

Observation:

The Hospital did not have a process for reviewing workers' compensation expenditures charged by the Department of Administrative Services (DAS) to Hospital accounts.

Monthly, the DAS processes workers' compensation payments on behalf of State agencies and records the expenditures in the respective agencies' accounts in the State accounting system, NHFirst. The Hospital neither received nor requested support from DAS for the \$838,000 of workers' compensation expenditures charged to the Hospital's account during the nine months ended March 31, 2019.

While a review of documentation supporting workers' compensation expenditures did not reveal any workers compensation claims unrelated to Hospital employees paid for by the Hospital during the audit period, it is possible errors could occur and not be detected timely due the lack of an effective management review process.

Recommendation:

The Hospital should develop policies and procedures for reviewing and monitoring workers' compensation expenditures recorded in the Hospital's accounts. The Hospital should regularly request and review sufficient support to reasonably ensure that the expenditures posted to the Hospital accounts are for Hospital employees and that the charges are accurate.

Auditee Response:

We concur. While the audit was ongoing, the Hospital worked with the Department of Administrative Services (DAS) to receive details of charges related to the worker's compensation amount charged to the Hospital. All charges were found to be valid for current and former employees. Review and reconciliation is now a standard process as charges are posted to the Hospital.

Observation No. 15: Hospital Security Memorandum Of Understanding And Invoicing Review Practices For Hospital Campus Security Should Be Updated And Documented

Observation:

The Hospital has not established formal policies and procedures over the review and payment of campus security services provided by the Department of Safety. In addition, the original memorandum of understanding (MOU) between the Department of Safety and the Department of Health and Human Services has not been updated since its inception in January 2005.

RSA 21-P:7-b authorizes the Commissioner of the Department of Safety to organize a State office complex police force for the purpose of patrolling the New Hampshire Hospital's buildings, roads, and grounds of the campus of the State office park south and providing for general security on campus.

RSA 21-P:7-c, II, requires that the commissioners of the Department of Health and Human Services and the Department of Safety enter into a MOU for the purposes of delineating the functions, duties, and responsibilities of the Department of Safety in regard to the provision of security and dispatch services to the New Hampshire Hospital.

During our review of the campus security expenditures process, we noted the following weaknesses in internal control:

- The Hospital receives monthly invoices from the Department of Safety for the cost of providing security and dispatch services. The monthly invoices are entered into a spreadsheet that is reviewed by accounts payable staff during monthly budget to actual comparisons. A comparison of the invoices to budgeted appropriations is performed to ensure billings do not exceed amounts budgeted. The Hospital has neither requested nor reviewed underlying support to ensure the accuracy and propriety of the invoices prior to payment.

- The MOU with the Department of Safety does not specify the scope of services to be provided, service requirements, agreed upon costs, or the invoicing procedures to be implemented. The Hospital receives little information to enable it to assess the effectiveness of campus security in meeting its expectations and security objectives.

Campus security expenditures totaled approximately \$1 million for the nine months ended March 31, 2019.

Recommendation:

The Hospital should implement an effective review and approval control prior to payment of campus security invoices. The control should include a review of underlying supporting documentation for the costs incurred to ensure payment is based on the actual costs of providing services, not budgeted amounts. If the Hospital determines certain provisions of the MOU no longer meet its needs, revisions should be made accordingly, and communicated to appropriate employees to ensure consistency in operation.

Auditee Response:

We concur. As a result of this audit, Hospital Leadership is currently reviewing the Memorandum of Understanding (MOU) and working with the Department of Safety (DOS) to ensure accuracy in service expectations and documentation.

Observation No. 16: User Access To Critical Information Systems Should Be Limited And Remain Current

Observation:

The Hospital does not consistently update and review the propriety of user-access authorities to mission critical information technology (IT) systems, Avatar and ANSOS.

According to the Hospital's Computer Systems policy and procedure, section III. F. "Department Directors are responsible for contacting the DHHS Support Center to set up new employees with computer systems identifying all computer functions to which the employee has access. Upon transfer or termination, the Department Directors is responsible for ensuring that the employee's access to all computer systems is removed. The Director of Information Systems shall be notified of all system user additions, deletions or transfers."

The Hospital provided a list of active user accounts to auditors on July 3, 2019 for its Avatar system used for patient billings, census, pharmacy, and patient health records. Auditors reviewed the listing with Hospital personnel and identified over 100 active user accounts consisting of terminated employees or contractors. Additionally, user-access is not effectively restricted to user needs for Avatar and ANSOS, application used for scheduling of direct care employees.

Inappropriate access to IT systems and data increases the risk that the systems and data could be misused resulting in errors, fraud, or possible violations of the confidentiality provisions of the Health Insurance Portability and Accountability Act.

While terminated employees or contractors may not have physical access to the Hospital's IT systems, other employees or contractors could use their access authorities to disguise accountability for inappropriate system activity.

A similar comment was noted in our prior audit report.

Recommendation:

The Hospital should routinely and regularly review and evaluate employee and contractor access to its critical IT systems. The Hospital should re-emphasize with Department Directors their responsibility to timely and accurately monitor and comply with the Department's policy of ensuring that all employees' and contractors' access levels remain current.

The Hospital should immediately act to ensure that all employee and contractor access levels are appropriately limited to the needs and responsibilities of the users. All terminated employees and contractors' user authorities should be deactivated immediately, and a review of those accounts should be performed to ensure no activity has occurred since their date of termination through the date of deactivation.

Auditee Response:

We concur. In review of the list of user-accounts provided to the LBA for the audit period, a significant portion of the 100+ accounts referenced were Medical Students and Residents who come to the hospital on varying rotations, but have no access to systems unless they are physically present at the Hospital. The Hospital is collaborating with its contractor to ensure accounts are created and terminated as students move through their clinical rotations. Additionally, the Hospital has adopted a monthly review process to ensure credentials are deactivated, and is reviewing its Human Resources (HR) protocols relative to termination to ensure Information Systems is notified when employees leave the organization.

It is important to note that upon notification of termination, staff and contractors are removed from the Active Directory disabling access to the building, Medical Records, and other systems. If Information Systems does not receive notification, a process is in place where after 90-days of no activity, access is suspended, and after 180-days, access is cancelled. Reactivation requires management approval. Additionally, systems cannot be accessed outside of the New Hampshire Hospital Network, preventing any unauthorized access by a previous employee. These measures represent significant failsafe's in the event that the Hospital's primary procedures are not followed, and significantly reduce the risk of any adverse outcomes arising from this observation.

Observation No. 17: Disaster Recovery Plan For Critical Information System Should Be In Place

Observation:

The Hospital does not have a current, comprehensive, and tested disaster recovery plan in place for its mission-critical information technology (IT) systems and assets.

The Hospital relies on IT for critical functions such as maintaining and tracking patient admissions, transfers, leaves, and discharges for patient care, security, and billing; patient banking; pharmacy control and administration; as well as scheduling employees to provide nursing and other health care to meet patient health and security needs. A current comprehensive, and tested IT disaster recovery plan is vital to ensuring the Hospital's important information systems and supported functions are and remain available in the event of a disaster.

Ongoing IT support is critical, especially in the event of crisis to the Hospital's operations, and for efficient communications. The Hospital and the Department of Information Technology (DoIT) share responsibility for IT support at the Hospital.

A similar comment was noted in our prior audit report.

Recommendation:

A current, comprehensive, and tested IT disaster recovery plan should be implemented for the Hospital's mission-critical IT systems and assets.

The Hospital should coordinate the development of such a plan with its IT resources including DoIT representatives. The plan must be documented and provided to all staff that have related responsibilities in the event of a disaster. The Hospital should periodically test the plan and ensure employees are aware of their responsibilities and are regularly trained in the proper operation of the plan.

Auditee Response:

We do not concur. Information system downtime for hospitals is regulated by the Joint Commission and Centers for Medicare and Medicaid Services. The Hospital has a downtime policy in place for critical systems, and has continuity of operation plans for its information technology. These plans include directions on how to handle various aspects of healthcare delivery without an electronic medical record, and how technological issues should be identified, communicated, and resolved. The Hospital regularly works to update and improve policies as aspects of IT and IS systems change, and recently included a Responsible, Accountable, Consulted, and Informed (RACI) Matrix in its Downtime plan.

It is also worth noting that the Hospital's medical record, and its associated systems, are now cloud-based, offering significant systems redundancy. This change occurred after the audit

period. Additionally, the hospital routinely executes planned and unplanned downtime events to ensure staff are prepared in the event of a true downtime.

LBA Rejoinder:

The Hospital has incorporated some aspects of a Disaster Recovery Plan into their policies and procedures but does not have a current and completed IT Disaster Recovery Plan. Additional elements of a comprehensive Disaster Recovery Plan may include personnel assigned to disaster teams with operating procedures and contact information; arrangement or consideration of a designated physical facility; a risk analysis identifying the critical applications, their exposure, and an assessment of the impact on the entity; and the arrangement of vendors to support needed hardware and software requirements.

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Current Status Of Prior Audit Findings

The following is a summary of the current status, as of October 2, 2020 of the observations contained in the financial audit of New Hampshire Hospital for the nine months ended March 31, 2011. That report can be accessed at, and printed from, the Office of Legislative Budget Assistant website: <http://www.gencourt.state.nh.us/LBA/AuditReports/financialreports.aspx>

	<u>Status</u>
<i>Internal Control Comments</i>	
<i>Material Weaknesses</i>	
1. Appropriate Controls Over Financial Operations Should Be Established <i>Establish effective internal controls for its financial operations.</i>	● ○
2. Effective System For Documenting Patients' Continuing Need For Psychiatric Hospital Level Care Should Be Implemented <i>Establish an appropriate system, including policies and procedures, for the regular medical-professional review and determination of medical eligibility of its patients for inpatient psychiatric hospital level of care.</i>	● ●
<i>Significant Deficiencies</i>	
3. Financial Oversight Of Psychiatric Services Contract Should Be Improved <i>Establish an appropriate system of record-keeping to account for the hours worked by contracted staff psychiatrists. (See Current Observation No. 6)</i>	● ○
4. Equipment Purchased Under The Dartmouth Medical School Services Contract Should Be Reviewed <i>Review the financial efficacy of using the psychiatric services contract to fund the purchase and servicing of NHH equipment.</i>	● ●
5. Pharmaceutical Inventory Controls Should Be Improved <i>Improve controls over its pharmaceutical inventory including a review of the capabilities of the pharmaceutical inventory system and accountability controls. (See Current Observation No. 13)</i>	○ ○
6. Pharmaceutical Contract Payments Should Be Monitored For Efficiency <i>Ensure responsible employees have a sufficient understanding of the pharmaceutical contract to allow NHH to take proper advantage of contract provisions. Establish policies and procedures for the periodic review of relevant information.</i>	● ○
7. Adherence With Cafeteria Accountability Controls Should Be Improved <i>Improve monitoring of employee compliance with cash drawer accountability controls. (See Current Observation No. 8)</i>	○ ○
8. Formal Pricing Policy For Cafeteria Operations Should Be Established <i>Establish a business plan, an accurate and timely management information system, and formal pricing policies and procedures for the cafeteria operations. (See Current Observation No. 9)</i>	○ ○
9. Controls Over Food Inventory Should Be Improved <i>Take reasonable steps to secure and better manage its food inventory.</i>	● ○
10. Accuracy Of Food Services Reports Should Be Improved	● ○

- Establish reasonable review procedures to promote the accuracy and completeness of reports used for management information and decision-making.*
11. Food Services Invoices Should Be Reconciled To Detail Support ● ●
Perform and document a reasonable review of all invoices prior to payment, and where appropriate, invoices should be reconciled and agreed to available support.
 12. Operation Of Motor Vehicle Repair Facility Should Be Reviewed ● ●
Review the business case for continuing to operate a motor vehicle repair facility.
 13. Risks In Gift Store Operations Should Be Mitigated ▲ ▲
Mitigate the risk resulting from the lack of segregation of duties in the gift store operation.
 14. Arrangement For Supplementing State Employee's Pay Should Be Reviewed ● ●
Review the appropriateness of pay arrangement with the Department of Administrative Service's Division of Personnel and the Department of Justice.
 15. Payroll Accuracy Should Be Improved ○ ○
Review payroll processes with the DHHS payroll office. (See Current Observation No. 10)
 16. Weekend Pay Differential Should Be Paid As Negotiated ○ ○
Determine if NHH has the authority to pay weekend differentials in excess of the differentials provided for in the CBA. (See Current Observation No. 12)
 17. Policies And Procedures Should Be Established For Billing Patient Accounts ● ○
Office of Reimbursements should establish policies and procedures for recovering the cost of NHH services. (See Current Observation No. 4)
 18. Continued Offering Of Outpatient Services Should Be Reviewed ● ●
Determine whether it is in the State's best interest for NHH to continue to provide outpatient services.
 19. Policies And Procedures For The Timely And Complete Collection Of Patient Services Revenues Should Be Established ● ○
Establish policies and procedures for the timely collection of patient services revenues. (See Current Observation No. 4)
 20. Additional Fringe Benefits Expenditures Should Be Processed As Budgeted ● ●
Process additional fringe benefits expenditures as budgeted and set patient services daily rate to recover those costs.
 21. Rate Setting For Transitional Housing Should Be Formalized ● ●
Formalize and document its rate-setting policies and procedures for Transitional Housing Services.
 22. Policies And Procedures For The Accrual Of Accounts Receivable Should Be Established ● ○

- Establish policies and procedures for compiling year-end accounts receivable estimates in accordance with State accounting policies. (See Current Observation No. 5)*
23. User Access To Critical Information Systems Should Remain Current ○ ○
Ensure there are appropriate controls in place to reasonably ensure user-access authorities remain current for all critical IT systems. (See Current Observation No. 16)
24. Disaster Recovery Plan For Critical Information Systems Should Be In Place ○ ○
A current, comprehensive, and tested IT disaster recovery plan should be in place for NHH's mission-critical IT systems and assets. (See Current Observation No. 17)
25. Payments For Non-Hospital Medical Services Should Be Limited To Provider's Usual And Customary Charge ● ●
Establish policies and procedures for the review of all medical service provider invoices for compliance with RSA 126-A:3 prior to payment.
26. Controls Over Preparation Of Medicare Cost Report Should Be Improved ● ●
Establish effective controls for accumulating and reporting complete and accurate Medicare Cost Report information.
27. Classification Of Accounts In Client Banking System Should Be Reviewed ▲ ▲
Review the accounts within the client banking system to ensure the accounts are reported in the proper classifications for the State's financial reporting purposes.
28. Use Of Client Banking System Should Be Reviewed ▲ ▲
The client banking system should not be used to process transactions that would be more appropriately accounted for in NHFirst or other financial systems.
29. Signatory Authority And List Of Authorities Should Be Current ▲ ▲
Establish policies and procedures to timely update signatory authorities and lists of authorities upon changes in employee status.

Federal Compliance Comments

30. Disproportionate Share Hospital Cost Recoupment Should Comply With Federal Rules ● ●
Review practice of not limiting its DSH claims to the otherwise unrecovered cost of inpatient hospital care provided to Medicaid patients and the uninsured.
31. Medicare Compliant Certifications Should Be Prepared ● ●
Establish an appropriate system, including policies and procedures compliant with requirements in 42 CFR 424.14, for physician recertification of patient eligibility for Medicare Part A-supported inpatient psychiatric hospital care.

State Compliance Comments

32. Patient Personal Fund Statements Should Be Issued At Least Quarterly ● ●
Provide personal fund statements to all patients at least quarterly.

33. Statutory Requirements For Reporting Certain Trust Funds Should Be Reviewed ▲ ▲
Perform the recordkeeping and reporting for the Catherine Fiske Legacy Fund and the Jacob Kimball Legacy Fund required by statute.

<u>Status Key</u>			<u>Count</u>
Fully Resolved	●	●	13
Remediation In Process (Action Beyond Meeting And Discussion)	●	○	8
Unresolved	○	○	7
Not Applicable In Current Audit	▲	▲	5

**STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
NEW HAMPSHIRE HOSPITAL**

**FINANCIAL STATEMENT
FOR THE NINE MONTHS ENDED MARCH 31, 2019**

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**STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
NEW HAMPSHIRE HOSPITAL**

**FINANCIAL STATEMENT
FOR THE NINE MONTHS ENDED MARCH 31, 2019**

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FINANCIAL SECTION



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Independent Auditor's Report

To The Fiscal Committee Of The General Court:

Report on the Financial Statement

We have audited the accompanying financial statement of the New Hampshire Department of Health and Human Services, New Hampshire Hospital (Hospital), the Statement of Revenues and Expenditures – Capital Projects Fund for the nine months ended March 31, 2019, and the related notes to the financial statement. We were engaged to audit the accompanying financial statement of the Hospital, the Statement of Revenues and Expenditures – General Fund for the nine months ended March 31, 2019. These collectively comprise the Hospital's basic financial statement.

Management's Responsibility for the Financial Statement

Management is responsible for the preparation and fair presentation of the financial statement in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on the financial statement based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statement is free from material misstatement. Because of the matter described in the Basis of Disclaimer of Opinion paragraph, we were unable to obtain sufficient appropriate audit evidence to provide a basis for an audit opinion on the Statement of Revenues and Expenditures – General Fund.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether

due to fraud or error. In making those risk assessments, the audit considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

Except for the matter described in the Basis for Disclaimer of Opinion paragraph, we believe the audit evidence we have obtained is sufficient and appropriate to provide a basis for our qualified audit opinion.

Basis for Disclaimer of Opinion on Statement of Revenues and Expenditures – General Fund for the Nine Months Ended March 31, 2019

Due to circumstances resulting from the progression of the COVID-19 pandemic, the Hospital's management, in its attempt to limit the risk of exposure, requested the auditors leave the premises before audit work could be completed. With the ongoing and continued effects of COVID-19, which became the sole focus of all the Hospital's staff, including finance, the Hospital's management subsequently informed us they would not be able to sufficiently accommodate auditor requests for timely access to staff, underlying accounting records, and other sufficient evidence needed for timely completion of the audit of the Hospital's restricted revenues and the New Hampshire Department of Health and Human Services' (DHHS) allocated expenditures reported in the Hospital's Statement of Revenues and Expenditures - General Fund.

Disclaimer of Opinion

Because of the significance of the matter described in the Basis for Disclaimer of Opinion paragraph, we were unable to obtain sufficient appropriate audit evidence to express an opinion on the results of operations for the Hospital's General Fund activity for the nine months ended March 31, 2019. Accordingly, we do not express an opinion on the Statement of Revenues and Expenditures – General Fund.

Basis for Qualified Opinion

As discussed in Note 1, the financial statement referred to above does not purport to, and does not, constitute a complete financial statement presentation of the Hospital in conformity with accounting principles generally accepted in the United States of America.

Qualified Opinion

In our opinion, except for the matter described in the Basis for Qualified Opinion paragraph, the Hospital's Statement of Revenues and Expenditures – Capital Projects Fund activity for the nine months ended March 31, 2019 presents fairly, in all material respects, the respective revenues and expenditures of the Hospital's portion of the State of New Hampshire's Capital Projects Fund for the nine months ended March 31, 2019 in accordance with accounting principles generally accepted in the United States of America.

Emphasis Of Matter

As discussed in Note 1, the financial statement referred to above reports certain financial activity of the Hospital. It does not purport to, and does not, present fairly the financial activity of the State of New Hampshire as of March 31, 2019 in conformity with accounting principles generally accepted in the United States of America. Our opinion on the Statement of Revenues and Expenditures – Capital Projects Fund is not modified with respect to this matter.

Other Matters

Other Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the financial statement of the Department of Health and Human Services, New Hampshire Hospital. The Schedule Of Budget And Disbursements – Capital Projects Fund on page 22 is presented for the purpose of additional analysis, although not part of the basic financial statement.

The Schedule Of Budget And Disbursements – Capital Projects Fund has not been subjected to the auditing procedures applied in the audit of the basic financial statement, and accordingly, we do not express an opinion or provide any assurance on it.

Other Reporting Required By Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued a report dated October 2, 2020 on our consideration of the New Hampshire Hospital's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, rules, regulations, contracts, and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Hospital's internal control over financial reporting and compliance.



Office Of Legislative Budget Assistant

October 2, 2020

State of New Hampshire
Department of Health and Human Services
New Hampshire Hospital
Statement of Revenues and Expenditures – Governmental Funds
For the Nine Months Ended March 31, 2019

<u>Revenues</u>	<u>General Fund</u>	<u>Capital Projects Fund</u>	<u>Total Governmental Funds</u>
Restricted Revenues			
Medicaid Disproportionate Share	\$ 18,708,841	\$ -0-	\$ 18,708,841
Medicare	4,464,408	-0-	4,464,408
Board - State Hospital - Adults	3,351,625	-0-	3,351,625
Medicaid	3,117,060	-0-	3,117,060
Board - State Hospital - Children	1,035,237	-0-	1,035,237
Trust Funds	609,399	-0-	609,399
Cafeteria Sales	406,679	-0-	406,679
Other	28,823	-0-	28,823
Children Services - SAU	25,920	-0-	25,920
Total Restricted Revenues	31,747,992	-0-	31,747,992
Total Revenues	31,747,992	-0-	31,747,992
Expenditures			
Salaries And Benefits	39,454,330	-0-	39,454,330
Contracted Psychiatric Services	9,723,909	-0-	9,723,909
DHHS Allocated Costs (Note 5)	5,650,491	68	5,650,559
Prescription Drugs	1,098,262	-0-	1,098,262
Security Services	1,003,865	-0-	1,003,865
Current Expenses	802,986	-0-	802,986
Food and Nutrition Services	704,081	-0-	704,081
Heat, Electricity, and Water	687,338	-0-	687,338
Trust Funds	609,399	-0-	609,399
Other	540,030	-0-	540,030
Medical Providers	515,192	-0-	515,192
Maintenance, Building and Grounds	345,020	-0-	345,020
Rents and Leases	203,530	-0-	203,530
Capital Expenditures	-0-	795,626	795,626
Total Expenditures	61,338,433	795,694	62,134,127
Excess (Deficiency) Of Revenues Over (Under) Expenditures	(29,590,441)	(795,694)	(30,386,135)
Other Financing Sources (Uses)			
Net Appropriations (Note 2)	29,590,441	795,694	30,386,135
Total Other Financing Sources (Uses)	29,590,441	795,694	30,386,135
Excess (Deficiency) Of Revenues And Other Financing Sources Over (Under) Expenditures And Other Financing Uses	\$ -0-	\$ -0-	\$ -0-

The notes to the financial statement are an integral part of this statement.

**State Of New Hampshire
Department of Health and Human Services
New Hampshire Hospital
Notes to the Statement of Revenues and Expenditures – Governmental Funds
For the Nine Months Ended March 31, 2019**

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The accompanying financial statement of the New Hampshire Department of Health and Human Services, New Hampshire Hospital (Hospital) has been prepared in accordance with accounting principles generally accepted in the United States of America (GAAP) and as prescribed by the Governmental Accounting Standards Board (GASB), which is the primary standard-setting body for establishing governmental accounting and financial reporting principles.

A. REPORTING ENTITY

The reporting entity of this audit and audit report is the New Hampshire Department of Health and Human Services, New Hampshire Hospital (Hospital) excluding the Hospital's trust funds, agency funds, and permanent funds. The New Hampshire Hospital (Hospital) is a department of the primary government of the State of New Hampshire.

The financial activity of the Hospital is accounted for and reported in the State's General Fund and Capital Projects Fund in the State of New Hampshire's Comprehensive Annual Financial Report (CAFR). Assets, liabilities, and fund balances are reported by fund for the State as a whole in the CAFR. The Hospital, as an organization of the primary government, accounts for only a small portion of the General Fund and Capital Projects Fund and those assets, liabilities, and fund balances as reported in the CAFR that are attributable to the Hospital cannot be determined. Accordingly, the accompanying General Fund and Capital Projects Fund financial statement is not intended to show and does not report the financial position or the fund balance of the Hospital in the General Fund or Capital Projects Fund.

B. FINANCIAL STATEMENT PRESENTATION

The State of New Hampshire and the Hospital use funds to report on their financial position and results of their operations. Fund accounting is designed to demonstrate legal compliance and to aid financial management by segregating transactions related to certain governmental functions or activities. A fund is a separate accounting entity with a self-balancing set of accounts. The Hospital reports its financial activity in the funds described below:

Governmental Fund Type:

General Fund: The General Fund is the State's primary operating fund and accounts for all financial transactions not specifically accounted for in any other fund. All revenues of governmental funds, other than certain designated revenues, are credited to the General Fund.

Capital Projects Fund: The Capital Projects Fund is used to account for certain capital improvement appropriations which are or will be primarily funded by State bonds, or notes, other than bonds or notes for highway or turnpike purposes, or by the application of certain federal matching grants.

C. REPORTING PERIOD

The State's and the Hospital's fiscal year is the 12 months ended June 30. The accompanying financial statement of the Department of Health and Human Services, New Hampshire Hospital, is for the nine months ended March 31, 2019.

D. MEASUREMENT FOCUS AND BASIS OF ACCOUNTING

Governmental fund financial statements are reported using the current financial resources measurement focus and the modified accrual basis of accounting. Revenues are recognized as soon as they are both measurable and available. Revenues are considered to be available when they are collectible within the current period or soon enough thereafter to pay liabilities of the current period. For this purpose, the State generally considers revenues to be available if they are collected within 60 days after year end. Receivables not expected to be collected within 60 days are offset by deferred inflows of resources. An exception to this policy is federal grant revenue, which generally is considered to be available if collection is expected within 12 months after year end. Taxes, grants, licenses and fees associated with the current fiscal period are all considered to be susceptible to accrual and so have been recognized as revenues of the current fiscal period when available.

Expenditures generally are recorded when a liability is incurred, as under accrual accounting. However, expenditures related to debt service and other long-term obligations including compensated absences, other post-employment benefits, pollution remediation obligations, and claims and judgments are recorded only when payment is due.

E. REVENUES AND EXPENDITURES

In the governmental fund financial statement, revenues are reported by source. For budgetary control purposes, revenues are further classified as either "unrestricted" (general purpose) or "restricted." Unrestricted revenues are credited directly to the General Fund or other fund balance upon recording in the State's accounting system. Pursuant to the State's operating budget, unrestricted revenues collected by an agency are not used as direct source of funding for agency operations but are available to fund any activity accounted for in the fund. The recording of unrestricted revenues has no effect on an agency's authorization to expend funds. The Hospital did not report any unrestricted revenues during the nine months ended March 31, 2019.

Unused restricted revenues at yearend are either lapsed or generally recorded as committed or assigned fund balance. When an expenditure/expense is incurred for purposes for which both restricted and unrestricted resources are available, it is the State's general policy to use restricted resources first. In the governmental funds, when expenditures are incurred for purposes for which unrestricted (committed, assigned, and unassigned) resources are available, and amounts in any of

these unrestricted classifications could be used, it is the State's general policy to spend committed resources first followed by assigned and unassigned resources, respectively.

In the governmental fund financial statements, expenditures are reported by function.

F. BUDGET CONTROL AND REPORTING

The statutes of the State of New Hampshire require the Governor to submit a biennial budget to the Legislature for adoption. This budget, which includes a separate budget for each year of the biennium, consists of three parts: Part I is the Governor's program for meeting all expenditure needs and estimating revenues. There is no constitutional or statutory requirement that the Governor propose, or the Legislature adopt, a budget that does not resort to borrowing. Part II is a detailed breakdown of the budget at the department level for appropriations to meet the expenditure needs of the government. Part III consists of draft appropriation bills for the appropriations made in the proposed budget.

The operating budget is prepared principally on a modified cash basis and adopted for the governmental funds, with the exception of the Capital Projects Fund, and certain proprietary funds. The Capital Projects Fund budget represents individual projects that extend over several fiscal years.

In addition to the enacted biennial operating budget, State departments may submit to the Legislature and Governor and Council, as required, supplemental budget requests necessary to meet expenditures during the current biennium. Appropriation transfers can be made within a department with the appropriate approvals; therefore, the legal level of budgetary control is generally at the expenditure class level within each accounting unit within each department.

Both the Executive and Legislative Branches of government maintain additional fiscal control procedures. The Executive Branch, represented by the Commissioner of the Department of Administrative Services, is directed to continually monitor the State's financial operations, needs, and resources, and to maintain an integrated financial accounting system. The Legislative Branch, represented by the Fiscal Committee, the Joint Legislative Capital Budget Overview Committee, and the Office of Legislative Budget Assistant, monitors compliance with the budget and the effectiveness of budgeted programs.

Unexpended balances of appropriations at year end will generally lapse to assigned or unassigned fund balance and be available for future appropriations unless they have been encumbered or legally defined as non-lapsing, which means the balances are reported as restricted, committed, or assigned fund balance. The balance of unexpended encumbrances is brought forward into the next fiscal year. Capital Projects Fund unencumbered appropriations lapse in two years unless extended or designated as non-lapsing by law.

Budget To Actual comparison and additional budgetary information are included as Required Supplementary Information.

G. USE OF ESTIMATES

The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the amounts reported in the basic financial statements and accompanying notes. Actual results could differ from those estimates.

2. OTHER FINANCING SOURCES

Net Appropriations reflect appropriations for expenditures in excess of restricted revenues. Net Appropriations are made from the fund balance of the respective Governmental Fund.

3. RISK MANAGEMENT AND INSURANCE

The State and Hospital are exposed to various risks of loss related to torts; theft of, damage to, and destruction of assets; errors and omissions; injuries to employees; employee health benefits; and natural disasters. The State generally retains the risk of loss except where the provisions of law require the purchase of commercial insurance or a risk assessment has indicated that commercial insurance is economical and beneficial for the State or the general public. In such instances, the State may elect to purchase commercial insurance. There are approximately 26 such commercial insurance programs in effect. These include, but are not exclusive to, state owned real property insurance, fleet automobile liability, inland marine insurance, foster parent liability, ski area liability for Cannon Mountain, data security and privacy cyber liability insurance, and a fidelity and faithful performance bond. In general, claims settled in the past three years under the insurance programs have not exceeded commercial insurance coverage. The State's exposure per claimant is limited by law to a total of \$475 thousand under RSA 541-B:14 and the State's current fleet policy coverage is \$250 thousand per claimant.

Claim liabilities not covered by commercial insurance are recorded by the State when it is probable that a loss has occurred and the amount of the loss can be reasonably estimated. Claim liabilities not covered by commercial insurance relate primarily to worker's compensation claims and health benefit claims.

4. EMPLOYEE BENEFIT PLANS

NEW HAMPSHIRE RETIREMENT SYSTEM

Plan Description: The New Hampshire Retirement System is the administrator of a cost-sharing multiple-employer Public Employee Retirement System ("NHRS") established in 1967 by RSA 100-A:2 and is qualified as a tax-exempt organization under Sections 401(a) and 501(a) of the Internal Revenue Code. NHRS is a contributory defined-benefit plan providing service, disability, death, and vested retirement benefits to members and beneficiaries. NHRS covers substantially all full-time State employees, public school teachers and administrators, permanent firefighters, and police officers within the State of New Hampshire. Full-time employees of political subdivisions, including counties, municipalities, and school districts, are also eligible to participate as a group if the governing body of the political subdivision has elected participation. NHRS is divided into two

membership groups. Group I consists of State and local employees and teachers. Group II consists of firefighters and police officers. All covered Hospital employees are members of Group I. All assets are in a single trust and are available to pay retirement benefits to its members and beneficiaries.

Group I members at age 60 (age 65 for members beginning service on or after July 1, 2011) qualify for a normal service retirement allowance based on years of creditable service and average final compensation (AFC). The yearly pension amount is $1/60$ (1.667%) of average final compensation, multiplied by years of creditable service ($1/66$ of AFC times creditable service for members beginning service on or after July 1, 2011). AFC is defined as the average of the three highest salary years for members vested as of January 1, 2012 and five years for members not vested as of January 1, 2012. At age 65, the yearly pension amount is recalculated at $1/66$ (1.515%) of AFC multiplied by years of creditable service.

Members in service with 10 or more years of creditable service who are between age 50 and 60 or members in service with at least 20 or more years of service, whose combination of age and service is 70 or more, are entitled to a retirement allowance with appropriate graduated reduction based on years of creditable service.

Group II members who are age 60, or members who are at least age 45 with a minimum of 20 years of creditable service (age 50 with a minimum of 25 years of creditable service or age 60 for members beginning service on or after July 1, 2011) can receive a retirement allowance at a rate of 2.5% of AFC for each year of service, not to exceed 40 years (2% of AFC times creditable service up to 42.5 years for members beginning service on or after July 1, 2011). A member who began service on or after July 1, 2011 shall not receive a service retirement allowance until attaining age 52.5, but may receive a reduced allowance after age 50 if the member has at least 25 years of creditable service. However, the allowance will be reduced by $1/4$ of one percent for each month prior to age 52.5 that the member receives the allowance.

Group II members hired prior to July 1, 2011 who have non-vested status as of January 1, 2012 are subject to graduated transition provisions for years of service required for regular service retirement, the minimum age for service retirement, and the multiplier used to calculate the retirement annuity, which shall be applicable on January 1, 2012.

Members of both groups may qualify for vested deferred allowances, disability allowances, and death benefit allowances subject to meeting various eligibility requirements. Benefits are based on AFC or earnable compensation, service, or both.

Pursuant to RSA 100-A:52, RSA 100-A:52-a and RSA 100-A:52-b, NHRS also provides a postretirement medical premium subsidy for Group I employees and teachers and Group II police officers and firefighters.

NHRS issues publicly available financial reports that can be obtained by writing to them at 54 Regional Drive, Concord, NH 03301-8507 or from their web site at <http://www.nhrs.org>.

Funding Policy: NHRS is financed by contributions from the members, the State and local employers, and investment earnings. By statute, Group I members contributed 7.0% of gross earnings. Group II firefighter members contributed 11.80% of gross earnings and Group II police officers contributed 11.55% of gross earnings. Employer contributions required to cover that amount of cost not met by the members' contributions are determined by a biennial actuarial valuation by the NHRS actuary using the entry age normal funding method and are expressed as a percentage of gross payroll. The State contributed 11.08% of gross payroll for Group I members, 27.79% of gross payroll for Group II firefighter members, and 25.33% of gross payroll for Group II police officer members.

The Hospital's required and actual contributions for the nine months ended March 31, 2019 were \$2,991,742, which included an amount for other postemployment benefits of \$263,470.

OTHER POSTEMPLOYMENT BENEFITS

The State also participates in two Other Post Employment Benefit (OPEB) plans - (1) New Hampshire Retirement System (NHRS) which is a cost sharing OPEB plan (medical subsidy portion of the pension trust) administered through a trust that meets the criteria in paragraph 4 of GASB 75 (Trusted OPEB Plan), and (2) State's single employer (primary government with component units) defined benefit OPEB plan which is not administered through a trust that meets the criteria in paragraph 4 of GASB 75 (Non Trusted OPEB Plan). The actuarial liabilities and expenses of the OPEB plans do not flow to the Division level financial statement.

General Information about the New Hampshire Retirement System Trusted OPEB Plan

Plan Description: Pursuant to RSA 100-A:52, RSA 100-A:52-a and RSA 100-A:52-b, NHRS administers a cost-sharing multiple employer defined benefit postemployment medical subsidy healthcare plan designated in statute by membership type. This plan has been previously defined as the Trusted OPEB plan but is also commonly referred to as "medical subsidy plan". The membership groups are Group II Police Officers and Firefighters and Group I State Employees.

NHRS issues publicly available financial reports that can be obtained by writing to them at 54 Regional Drive, Concord, NH 03301-8507 or from their web site at <http://www.nhrs.org>

Benefits Provided: The Trusted OPEB Plan provides a medical insurance subsidy to qualified retired members. The medical subsidy is a payment made by NHRS to the former employers or its members, or their insurance administrator, toward the cost of health insurance for a qualified retiree, spouse, and certifiably dependent children with a disability who is living in the household and being cared for by the retiree. Under specific conditions, the qualified beneficiaries of members who die while in service may also be eligible for the medical subsidy. The eligibility requirements for receiving Trusted OPEB Plan benefits differ for Group I and Group II members. Eligibility for the medical subsidy payment is determined by the relevant RSA's, however, the medical subsidy plan is closed to new entrants. The State is a recipient of these medical subsidy payments on behalf of its former employees.

Contributions: Pursuant to RSA 100-A:16, III, and the biennial actuarial valuation, funding for the medical subsidy payment is via the employer contribution rates set forth by NHRS. Employer contributions required to cover that amount of cost not met by the members' contributions are determined by a biennial actuarial valuation by the NHRS actuary using the entry age normal funding method and are expressed as a percentage of gross payroll. The State contributed 1.07% of gross payroll for Group I members, 4.10% of gross payroll for Group II firefighter members, and 4.10% of gross payroll for Group II police officer members. Employees are not required to contribute to the Trusted OPEB plan.

The State Legislature has the authority to establish, amend and discontinue the contribution requirements of the medical subsidy plan. Employer contributions made by the State to NHRS for the medical subsidy component amounted to \$263,470 for the nine months ended March 31, 2019.

General Information about the Non Trusted OPEB Plan

Plan Description: RSA 21-I:30 specifies that the State provide certain health care benefits for retired employees and their spouses through a single employer (primary government with component units) defined postemployment benefit plan, previously defined as the Non Trusted OPEB Plan. These benefits include group hospitalization, hospital medical care, surgical care, and other medical care. Substantially all of the State's employees who were hired on or before June 30, 2003 and have 10 years of service, may become eligible for these benefits if they reach normal retirement age while working for the State and receive their pensions on a periodic basis rather than a lump sum. During fiscal year 2004, legislation was passed that requires State Group I employees hired on or after July 1, 2003 to have 20 years of State service in order to qualify for health benefits. During fiscal year 2011, legislation was passed that requires Group II employees to have 20 years of State service to qualify for retiree health benefits. Additionally, during fiscal year 2012, legislation was passed requiring Group I employees hired after July 1, 2011 to have 25 years of State service and increased the normal retirement age for Group I and Group II employees hired after July 1, 2011. These and similar benefits for active employees and retirees are authorized by RSA 21-I:30 and provided through the Employee and Retiree Benefit Risk Management Fund, previously defined as the Fund, a single-employer group health fund, which is the State's self-insurance internal service fund implemented in October 2003 for active State employees and retirees. The Fund covers the cost of medical and prescription drug claims by charging actuarially developed working rates to State agencies for participating employees, retirees, and eligible spouses. An additional major source of funding for retiree benefits is from the NHRS medical subsidy payment described earlier.

5. DHHS ALLOCATED COSTS

All Department of Health and Human Services (DHHS) expenditures are used as a basis for the DHHS federally required, Public Assistance Cost Allocation Plan (PACAP) which allocates direct and indirect program and administrative costs to the benefitting program. The PACAP is used for preparing the required federal reports and filings for various federal programs.

Revenues are derived from allocated expenditures for New Hampshire Hospital (NHH). These expenditures are posted to the accounting unit incurring the cost.. Allocated costs are included in

the NHH Medicare Cost Report (MCR) in order to capture all costs required in Medicare Cost Reporting. Disproportionate Share Hospital (DSH) program and Medicare NHH revenues are computed on the costs reflected in the MCR in aggregation with data from other psychiatric hospitals to adjust the payment rates. As a result, allocated costs are reimbursed through DSH and Medicare.

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**Required Supplementary Information
Budgetary Reporting
(Unaudited)**

State of New Hampshire
 Department of Health and Human Services
 New Hampshire Hospital
 Budget To Actual Schedule – General Fund (Budgetary Basis) (Unaudited)
 For The Nine Months Ended March 31, 2019

	<u>Budgeted Amounts</u>		<u>Actual</u>	<u>Variance With</u>
	<u>Original</u>	<u>Final</u>	<u>(Budgetary Basis)</u>	<u>Final Budget</u> <u>Positive (Negative)</u>
Revenues				
Restricted Revenues				
Agency Income	\$ 26,301,786	\$ 26,887,842	\$ 11,117,061	\$ (15,770,781)
Federal Funds	15,854,535	16,422,355	20,803,430	4,381,075
Private Local Funds	260,752	270,752	562,685	291,933
Revolving Funds	-0-	-0-	20	20
Total Restricted Revenues	42,417,073	43,580,949	32,483,196	(11,097,753)
Total Revenues	42,417,073	43,580,949	32,483,196	(11,097,753)
Expenditures				
Salaries And Benefits	52,522,595	53,216,826	40,072,874	13,143,952
Contracted Psychiatric Services	12,797,534	13,729,734	9,278,199	4,451,535
Prescription Drugs	1,397,565	1,514,565	1,077,742	436,823
Transfers To Other State Agencies	1,393,845	1,298,845	756,453	542,392
Food and Nutrition Services	1,100,000	1,089,000	728,830	360,170
Medical Providers	870,960	670,960	500,154	170,806
Heat, Electricity, and Water	820,000	1,020,000	721,496	298,504
Maintenance, Building and Ground	743,000	743,000	372,729	370,271
Equipment	130,000	130,000	68,452	61,548
Current Expense	704,693	760,576	580,860	179,716
Trust Fund	260,752	270,752	615,624	(344,872)
Other	199,543	159,543	107,599	51,944
Equipment Lease	189,000	399,000	202,460	196,540
Indirect Cost	135,000	362,000	271,149	90,851
Information Technology	50,000	50,000	35,719	14,281
Employee Training	25,000	25,800	40,536	(14,736)
Travel	3,550	10,825	878	9,947
Total Expenditures	73,343,037	75,451,426	55,431,754	20,019,672
Excess (Deficiency) Of Revenues				
Over (Under) Expenditures	(30,925,964)	(31,870,477)	(22,948,558)	8,921,919
Other Financing Sources (Uses)				
Net Appropriations	30,925,964	31,870,477	22,948,558	(8,921,919)
Total Other Financing Sources (Uses)	30,925,964	31,870,477	22,948,558	(8,921,919)
Excess (Deficiency) Of Revenues And				
Other Financing Sources Over (Under)				
Expenditures And Other Financing Uses	\$ -0-	\$ -0-	\$ -0-	\$ -0-

The accompanying note is an integral part of this schedule.

Note To The Required Supplementary Information – Budgetary Reporting (Unaudited)

The Budget To Actual (Non-GAAP Budgetary Basis) Schedule depicts budgeted to actual expenditures at the Department level, which is the legal level of budgetary control for all governmental funds.

The comparison schedule presents the original and final appropriated budgets for fiscal year 2019, as well as the actual resource inflows and outflows stated on the budgetary basis.

The “original budget” and related estimated revenues represent the spending authority enacted into law by the appropriation bill (HB 144) as of June 30, 2017, with an effective date of July 1, 2017, and include balances and encumbrances carried forward from the prior year.

Generally accepted accounting principles (GAAP) require the final legal budget be reflected in the “final budget” column for those accounts included in the original budget. Therefore, updated revenue estimates available for appropriations as of March 31, 2019 rather than the amounts shown in the original budget are reported. The final appropriations budget represents the original budget (HB144), plus HB517 and supplemental appropriations, carry-forwards, approved transfers, and any executive order reductions for budgeted accounts.

When statements are presented at an interim date, a date other than June 30 fiscal year end, the variance reflects the difference between the twelve-month budget period amount and a partial year’s actual revenue and expenditures. Thus, for the nine month financial statement dated March 31, 2019, unfavorable revenue variances are expected. Similarly, favorable expenditure variances are expected as nine months of expenditures are compared to the anticipated expenditures of the twelve-month budget period.

Reconciliation Of Budgetary To GAAP

The State’s biennial budget is prepared on a basis other than GAAP. The “actual” results column of the Budget To Actual (Non-GAAP Budgetary Basis) schedule is presented on a “budgetary basis” under such standardized accounting methods and policies structured to provide a meaningful comparison to budget.

The major differences between the budgetary basis and the GAAP basis are:

1. Department of Health and Human Services Allocated Cost to New Hampshire Hospital (Hospital) are not budgeted in the Hospital’s budget but are included as costs on the Hospital’s financial statement.
2. Certain Medical Provider Costs for psychiatric services are included in the Hospital’s budget but are not included on the financial statement.
3. Expenditures (Budgetary) are recorded when cash is paid, rather than when the obligation is incurred (GAAP). Revenues (Budgetary) are based on cash received plus estimated revenues related to the budgetary expenditures. Additional revenue accruals are made on a GAAP basis only.
4. On a GAAP basis, major inter-agency and intra-agency transactions are eliminated in order to not double count revenues and expenditures.

The following schedule reconciles the differences between budgetary accounting methods and the GAAP basis accounting principles for the nine months ended March 31, 2019.

Reconciliation of Budgetary to GAAP

Excess/(Deficiency) of Revenues Over/(Under) Expenditures (Budgetary Basis)	\$ (22,948,558)
Adjustments and Reclassifications:	
To adjust DHHS Allocated Costs not included in the Hospital's Budget	(5,650,491)
To record Medical Provider Costs included in the Hospital's Budget, but not in the Hospital's financial statement	(553,151)
To record change in Accounts Payable and Accrued Payroll	296,963
To record change in Accounts Receivable	<u>(735,204)</u>
Excess/(Deficiency) of Revenues Over/(Under) Expenditures (GAAP Basis)	<u>\$ (29,590,441)</u>

**Other Supplementary Information
Budgetary Reporting
(Unaudited)**

**State of New Hampshire
Department of Health and Human Services, New Hampshire Hospital
Schedule of Budget and Disbursements - Capital Projects Fund (Budgetary Basis) (Unaudited)
For the Nine Months Ended March 31, 2019**

<u>Chapter Law, Program</u>	<u>Unaudited</u>				
	<u>Budget</u>	<u>Audit Period Disbursements</u>	<u>Prior Period Disbursements</u>	<u>Total Disbursements</u>	<u>Unexpended</u>
Chapter 253:1, VII, D, Laws of 2011					
APS Repairs/Renovations-Roof, Windows and Curtain Wall (Note 1)	\$ 3,675,000	\$ 555,519	\$ 2,873,874	\$ 3,429,393	\$ 245,607
Chapter 253:1, VII, H, Laws of 2011					
Electronic Health Record	335,000	-0-	299,544	299,544	35,456
Chapter 228:1, X, G, Laws of 2017					
NHH Air Handling System Upgrade	2,400,000	76,010	69,996	146,006	2,253,994
Chapter 195:1, VII, B, Laws of 2013					
APS Security and Safety Upgrades	500,000	-0-	492,757	492,757	7,243
Chapter 220:1, VII, D, Laws of 2015					
Replace Roof Over Auditorium at Howard Rec	230,000	-0-	191,555	191,555	38,445
Chapter 220:1, VII, F, Laws of 2015					
Chillers and Associated Components Replacement	2,800,000	157,220	1,508,438	1,665,658	1,134,342
Chapter 220:1, VII, J, Laws of 2015					
NHH Electronic Health Record Pharmacy and Scanning Module	465,517	-0-	360,101	360,101	105,416
Chapter 220:1, VII, K, Laws of 2015					
NHH Underground Fuel Line Replacement, Fuel Conversion	225,000	8,838	216,098	224,936	64
Chapter 220:1, VII, L, Laws of 2015					
NHH Renovation of Existing Space	984,400	65,655	890,192	955,847	28,553
Total Disbursements	11,614,917	863,242	6,902,555	7,765,797	3,849,120

The accompanying notes are an integral part of this schedule.

**Notes To The Supplementary Information – Budgetary Reporting (Unaudited)
For The Nine Months Ended March 31, 2019**

Note 1 – APS Repairs/Renovations-Roof, Windows, and Curtain Wall

This project was established by Chapter 253:1, VII-D, Laws of 2011 with an appropriation of \$4,050,000. Subsequent amendment reduced the appropriation by \$375,000 to \$3,675,000.

Note 2 – Capital Budget

Prior to May 2004, capital budget appropriations lapsed at the end of the biennium unless extended in the subsequent capital budget. Chapter 138, Laws of 2004 changed the two-year capital budget by establishing a six-year capital budget and amending sections of RSA 9. RSA 9:18 provides that all unexpended portions of the capital appropriations made by the six-year capital budget are to lapse at the end of six years from the date the appropriation took effect. However, legislative practice has been to continue extending the lapse dates for all approved projects through the subsequent biennium.

Note 3 – Differences Between Audit Period Disbursements On Budgetary Schedule And Financial Statement Expenditures

Capital Projects Fund disbursements are reported on a budgetary basis in the Schedule of Budget and Disbursements and are recorded when cash is paid, rather than when the obligation is incurred (GAAP), as reported in the Statement of Revenues and Expenditures – Governmental Funds.

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