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

# FINANCIAL AUDIT REPORT
# FOR THE NINE MONTHS ENDED
# MARCH 31, 2011

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

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* Audit comments suggest legislative action may be required.

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**STATE OF NEW HAMPSHIRE**
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## Reporting Entity And Scope

The reporting entity and scope of this audit and audit report is the financial operations of New Hampshire Hospital for the nine months ended March 31, 2011. New Hampshire Hospital is an organization of the New Hampshire Department of Health and Human Services, Division of Community Based Care Services.

The following report describes the financial operations of New Hampshire Hospital during the period under audit. Unless otherwise indicated, reference to NHH or the Hospital refers to the New Hampshire Hospital. Reference to the Department refers to the Department of Health and Human Services. Auditee responses were provided by NHH in coordination with the Department.

## Organization

New Hampshire Hospital's operations are under the direction of a Chief Executive Officer who reports to the Department's Associate Commissioner. The Associate Commissioner reports to the Department's Commissioner.

NHH was established in 1842 as the State's public hospital for the care and treatment of the mentally ill. NHH is located at 36 Clinton Street, Concord, New Hampshire. Facilities include the Acute Psychiatric Services (APS) building, the Anna Philbrook Center building, and eight community transitional housing units. During the nine months ended March 31, 2011, the APS building was NHH's primary care facility providing treatment to children, adolescents, adults, and elders with severe mental illness. The APS building also houses NHH's administrative offices. During the nine months ended March 31, 2011, the Anna Philbrook Center (APC) building was not used for patient care and patients previously cared for in the APC building were moved to the APC unit in the APS building.

At March 31, 2011, the Hospital employed 490 permanent full-time and 143 part-time employees, including 45 unclassified positions.

## Responsibilities

NHH is a State operated, publicly funded hospital providing a range of specialized inpatient psychiatric services to the people of New Hampshire.

NHH provides psychiatric care including acute treatment services for children, adolescents, adults, and elders with severe mental illness. NHH also provides management services for the transitional housing services program where individuals with limited community placement options can live in a residential setting with appropriate treatment. Most NHH patients are admitted to the NHH on an involuntary basis, as a result of having been found to be dangerous to

themselves or others. Some NHH patients are admitted on a voluntary basis. NHH also works with the community mental health center system in the continuum of care for patients at NHH.

At March 31, 2011, the APS patient capacity, excluding the APC unit, was 134 and the actual patient census was 122. The APC unit patient capacity was 24 and the actual patient census was 19. Transitional Housing resident capacity was 49 and actual resident census was 45. The average census for the nine months ended March 31, 2011 for the APS, APC unit, and Transitional Housing was 137, 16, and 42, respectively.

## Funding

NHH is funded primarily by appropriations from the General Fund. Financial activity of the Hospital is accounted for in the General, Permanent, and Agency Funds of the State of New Hampshire. A summary of NHH's General Fund revenues and expenditures for the nine months ended March 31, 2011 is shown in the following table.

**Summary Of Revenues And Expenditures**
**Nine Months Ended March 31, 2011**

| | General Fund |
|---|---|
| Total Revenues | $ 27,043,868 |
| Total Expenditures | 48,834,521 |
| **Excess (Deficiency) Of Revenues Over (Under) Expenditures** | **$ (21,790,653)** |

## Prior Audit

The most recent prior financial audit of New Hampshire Hospital was for the fiscal year ended June 30, 2003. The appendix to this report on page 65 contains a summary of the current status of the observations contained in that report. A copy of the prior audit report can be accessed on-line at www.gencourt.state.nh.us/LBA/auditreports.aspx.

## Audit Objectives And Scope

The primary objective of our audit was to express an opinion on the fairness of the presentation of the financial statements of the New Hampshire Hospital for the nine months ended March 31, 2011. As part of obtaining reasonable assurance about whether the financial statements are free of material misstatement, we considered the effectiveness of the internal controls in place at the Hospital and tested its compliance with certain provisions of applicable State and federal laws, rules, regulations, and contracts. Major accounts or areas subject to our examination included, but were not limited to, revenues and expenditures.

Our report on internal control over financial reporting and on compliance and other matters, the related observations and recommendations, our independent auditor's report, the financial statements, and supplementary information are contained in the report that follows.

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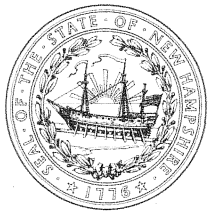

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**Auditor's Report On Internal Control Over Financial Reporting And On Compliance And Other Matters**

*To The Fiscal Committee Of The General Court:*

We were engaged to audit the accompanying financial statements of the New Hampshire Hospital as of and for the nine months ended March 31, 2011, as listed in the table of contents, and have issued our report thereon dated December 23, 2011 in which we disclaimed an opinion due to the lack of supporting revenue and agency fund records.

Internal Control Over Financial Reporting

As part of our consideration as to whether sufficient competent evidential matter existed to allow us to audit the Hospital's financial statements, we considered the Hospital's internal control over financial reporting as a basis for designing our auditing procedures for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Hospital's internal control over financial reporting. Accordingly we do not express an opinion on the effectiveness of the Hospital's internal control over financial reporting.

Our consideration of internal control over financial reporting was for the limited purpose described in the preceding paragraph and was not designed to identify all deficiencies in internal control over financial reporting that might be significant deficiencies or material weaknesses and therefore, there can be no assurance that all deficiencies, significant deficiencies, or material weaknesses have been identified. However, as discussed below, we identified certain deficiencies in internal control over financial reporting that we consider to be material weaknesses and other deficiencies that we consider to be significant deficiencies.

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 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 Hospital's financial statements will not be prevented, or detected and corrected on a timely basis. We consider the deficiencies described in Observations No. 1 and No. 2 to be material weaknesses.


TDD Access: Relay NH 1-800-735-2964

A *significant deficiency* is a deficiency or 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. We consider the deficiencies described in Observations No. 3 through No. 29 to be significant deficiencies.

Compliance And Other Matters

As part of obtaining reasonable assurance about whether the Hospital's financial statements are free of material misstatement, we performed tests of the Hospital's compliance with certain provisions of laws, rules, regulations, and contracts, 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 instances of noncompliance that are required to be reported under *Government Auditing Standards* and are described in Observations No. 30 and No. 31. We also noted immaterial instances of noncompliance which are described in Observations No. 32 and No. 33.

The Hospital's response is included with each observation in this report. We did not audit the Hospital's responses and, accordingly, we express no opinion on them.

This report is intended solely for the information and use of the management of the Hospital, others within the Department of Health and Human Services, and the Fiscal Committee of the General Court and is not intended to be and should not be used by anyone other than these specified parties.

Office of Legislative Budget Assistant

Office Of Legislative Budget Assistant

December 23, 2011

## Internal Control Comments
## Material Weaknesses

### Observation No. 1: Appropriate Controls Over Financial Operations Should Be Established

*Observation:*

NHH's weak control structure, evidenced by its lack of resolution of significant prior audit comments during the eight years since the last audit, places NHH's financial operations at increased risk.

The fiscal year 2003 NHH audit report included 43 audit comments, three of which were material weaknesses. The report also included an auditor's disclaimer of opinion on the financial statements, as NHH did not have sufficient systems in operation to adequately account for and report revenues from services provided to patients and residents.

This current audit report includes 33 audit comments, two of which are categorized as material weaknesses. Many of the audit comments in this current report are related to the same or similar conditions that resulted in comments in the prior report. The current report, like the prior report, includes an auditor's disclaimer of opinion on the financial statements, as NHH did not have sufficient systems in operation to adequately account for and report revenues from services provided to patients.

While NHH reports it has worked to address certain issues included in the prior audit report, as noted by the current audit comments, many of the root causes of the problems and issues in the 2003 report remained unresolved.

*Recommendation:*

NHH should establish effective internal controls for its financial operations. NHH should review its current control systems by control component including: 1) control environment, 2) risk assessment, 3) control activities, 4) information and communication, and 5) monitoring to ensure its controls are appropriate and balanced for its financial risks.

NHH should respond timely to significant audit comments. While in certain circumstances it may be appropriate for management to accept risk and not immediately change procedures in response to observed risk, that acceptance of risk should only be taken as a deliberate action based on proper cost benefit analysis and documented consideration of alternatives.

*Auditee Response:*

We concur in part. To the extent that this observation generally recommends that NHH have effective internal controls for its financial operations, we concur. The effort to improve on such controls is ongoing.

NHH began the effort to improve on such controls starting back during the spring of 2011 and has made the commitment to on-going review and improvements. DHHS made an organizational change and re-established the internal auditor reporting structure. While the LBA was still on-site NHH directed the Internal Auditor to follow up on the LBA concerns and once the initial findings came in from the LBA late July or early August, it was decided to develop an action plan to not only reinstitute the controls previously in place but to enhance them to guard against turnover, vacancies and to mitigate financial risk. In addition, the Internal Auditor was directed by NHH to create a list of the findings and define steps to immediately correct the finding, how those steps will be implemented, who will implement them and what will be performed on a regular basis to assure the controls are still in place. Every two weeks the Internal Auditor meets with NHH's CFO to review how each step is progressing and to correct impediments that might slow the progress.

NHH is currently undergoing a LEAN process as an organized effort to review and improve NHH billing, reimbursement and related items. One such item is to develop a Return on Billing Report to establish a consistent method to monitor and measure changes in the reimbursement rate and to design and create a financial scorecard to report by payor, the dollar amounts that were billed, paid, suspended, transferred and the remaining balance for a given date range. Other efforts identified include a review and revision of utilization management policies and improvements and better utilization of the AVATAR system.

We do not concur with the observation that the three material weakness observations from the 2003 audit were not resolved. In letters directed to the Governor, dated October 9, 2007 by DHHS and September 8, 2007 by DAS, the Governor was notified that action had been taken by NHH on each of the prior 43 observations. It was reported that 35 of the 43 were fully resolved and the remaining 8 were in process. Both DAS and NHH verified that by September 2007 all 3 material weaknesses in the 2003 audit regarding Controls Needing Improvement, Patient Billing Improvements and Controls over DSH, were resolved. However, since that time NHH has had significant turnover in essential staff, including 3 vacancies in the Business Office one of which was the Business Administrator III. While it is true that such controls have not been fully maintained, we do not concur with LBA's conclusion that NHH did not have sufficient systems in operation to account for and report revenues from services provided to patients and residents. NHH does have systems in place to account for and report revenues from services provided to patients. NHH recognizes that these systems can be improved and is, in fact working on such improvements.

NHH is well aware of and understands the operational and financial consequences of utilization review processes such as determination of a patients clinical status, calculating and recouping Medicaid Disproportionate Share Hospital program costs and the related significance of insured and uninsured patients.

**Observation No. 2: Effective System For Documenting Patients' Continuing Need For Psychiatric Hospital Level Care Should Be Implemented**

*Observation:*

During the nine months ended March 31, 2011, NHH did not have an effective system in place to clearly evidence the continued medical eligibility for psychiatric hospital level care for patients it identified as clinically decertified. As a result, the Hospital's identification of patients as being either clinically certified or decertified could not be relied upon to establish whether inpatient psychiatric hospital level care was the medically necessary level of patient care. It is a Medicaid precept that Medicaid only participates in costs for medically necessary care.

NHH's evaluation system for Medicare patients included a physician signed certification stamp in patients' medical records which identified and documented a regular review and determination of patient status. For non-Medicare patients, NHH operated a patient evaluation system outside of the NHH patient medical record system. This system regularly identified patients as clinically decertified, without changing the patients' level of care. NHH reported the decertification determination had various meanings to various people at NHH. Some NHH personnel believed the decertification meant the patient was medically decertified for NHH level of care. Others reportedly used the clinical decertification determination interchangeably with an administrative decertification, generally used to stop billing for provided services. Others were uncertain of its meaning. NHH also reported clinical evaluators used long-term care facility criteria instead of in-patient psychiatric hospital criteria when making clinical decertification determinations, further confusing the relevance of a clinical decertification determination.

Auditors requested a report of clinically decertified patient days of service for the nine months ended March 31, 2011. The report indicated NHH provided approximately 12,000 days of inpatient psychiatric hospital level care to patients identified by NHH's information system as clinically decertified. However, this report appeared to include data related to administrative decertifications as well as clinical decertifications. As such, the report could not be relied upon to identify patients who were truly decertified for the level of care being provided.

Because NHH's non-Medicare certification and decertification process did not clearly document a regular, medical-professional determination of patients' ongoing need for inpatient psychiatric hospital level care, and there was no other NHH documented process available for that purpose beyond a medical-professional review of individual patient records, we could not audit the eligibility and allowability of costs included in NHH's Disproportionate Share Hospital (DSH) revenues related to cost of care provided to patients identified by NHH as clinically decertified.

*Questioned costs:*

Federal participation in Medicaid DSH program costs for decertified patient days during the nine months ended March 31, 2011: Unable to determine.

*Recommendation:*

NHH should 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.

NHH should not include the cost for providing inpatient psychiatric hospital level of care to patients that do not have a medical necessity for that level of care in its DSH cost recovery calculations and revenue draws.

NHH should contact the Centers for Medicare and Medicaid Services to determine a resolution of the noted questioned costs.

*Auditee Response:*

We concur. NHH has, and continues to review and improve, systems for the regular medical professional review and determination of medical eligibility of its patients for inpatient psychiatric level of care, which include evaluation of patients for their need for active treatment. NHH's evaluation system that is the subject of this observation was not aligned with a medical professional review of the patients' medical needs and treatment contained in individual patient records. Accordingly, NHH is working to improve this process.

## Significant Deficiencies

### Observation No. 3: Financial Oversight Of Psychiatric Services Contract Should Be Improved

*Observation:*

NHH has not established appropriate policies and procedures requiring a reasonable review and approval of invoices from its contracted psychiatric services provider prior to making payment on those invoices. Historically, NHH has not requested or received support for the monthly invoice. Starting in January 2011 and subsequent to the auditor's request for detail supporting provider invoices, NHH requested the provider include detail for billed amounts.

The Department of Health and Human Services (Department) contracts with the Dartmouth Medical School (DMS) to provide NHH with a Medical Director and a staff of psychiatrists to be responsible for psychiatric evaluations, mental status examinations, clinical and laboratory testing, treatment orders, including psychopharmacology, emergency, and special treatment procedures, discharge orders, and necessary legal activities. DMS invoices NHH monthly pursuant to the contract. Provisions in the contract in effect during the nine months ended March 31, 2011 included direct costs for services plus an overhead markup of 26% over direct costs. During the nine months ended March 31, 2011, NHH paid approximately $500,000 per month for these services.

In practice, DMS staff assigned to NHH work as if they were salaried NHH employees. The contract requires psychiatrists to "work full time at the Hospital and shall limit their practice to treating Hospital patients only…psychiatrists serving under this contract may perform occasional outside practice duties, with the advanced written approval of the Medical Director and the Superintendent, but only if said duties do not, in the sole judgment of the Superintendent, interfere with the psychiatrists' duties at the Hospital." The contract further states: "the term "full-time" shall mean that each staff psychiatrist shall be required to account, through appropriate record-keeping as determined by the Hospital, for a minimum of 40 hours of work per week devoted to his or her duties and responsibilities, subject to Dartmouth's normal and customary benefits as to vacation, personal leave, and sick leave." We noted the following issues related to the psychiatric services contract:

1. During the nine months ended March 31, 2011, NHH had not established a system of record-keeping for hours worked by staff psychiatrists providing services under the contract. NHH did not require DMS staff to prepare time and activity reports, sign-in, or otherwise document attendance at NHH. According to NHH, the only way to establish whether any particular DMS staff was onsite on any given day would be to review patient records for indications of DMS staff contact. While NHH did require DMS staff to provide copies of approved Request for Leave forms, NHH did not require any additional timekeeping documenting time worked under the contract. DMS's invoices did not include details of professional services rendered and NHH made no additional efforts to ensure the billings reflected services received.

- During the nine months ended March 31, 2011, the Department's Surveillance and Utilization Recovery Unit (SURS), became aware that a Community Mental Health Center on five occasions billed the State's Medicaid program for the services of a psychiatrist when the psychiatrist's time was also being billed as working full-time providing services to NHH patients. After notification from SURS, NHH reviewed the billings with DMS. As a result of that review, the psychiatrist in question submitted leave slips covering 12 days and DMS agreed to implement a timekeeping system that would allow NHH to better track when DMS psychiatrists were performing their contractually obligated work. As of July 15, 2011, neither NHH nor DMS had put a timekeeping system in place for DMS psychiatrists.

2. A cursory review of support requested for four monthly DMS invoices revealed instances where the NHH should pursue further justification for the invoiced amounts prior to payment.

   - In one instance, DMS billed NHH for an individual who NHH could not identify. Upon further inquiry, it was determined the individual was providing services to another area of the Department under a separate section of the contract unrelated to NHH's operation. NHH paid DMS approximately $72,000 for the services of this individual during the nine months ended March 31, 2011, without recognizing that NHH had not received any services.
   - In one instance, NHH paid the $600 New York State medical license fee for one assigned DMS staff.
   - Other expenses paid by NHH included a number of $815 charges for personal DMS staff dues to professional organizations; cell phone costs; and travel expenses, including vehicle maintenance for a DMS vehicle used by DMS staff commuting to NHH. The provision of equipment such as cell phones and the payment of personal dues are expenditures generally incurred on the behalf of employees in an employer-employee relationship. Generally, these expenditures, as well as the payment of contractor vehicle expenses, are not incurred in an employer-contractor relationship.

   NHH also paid a 26% overhead charge in each of the above instances.

The DMS invoice received by NHH also includes costs for services provided by DMS to other Department entities, including the Division of Juvenile Justice (DJJ), the Division of Behavioral Health, and the Commissioner's Office. NHH processes these organizations' payments on the DMS invoice even though NHH does not have knowledge of whether the services billed to these organizations were received. In addition, errors made by NHH in processing these payments in the State accounting system (NHFirst) went undetected by those affected Department organizations for approximately 10 months. In May 2011, it was determined NHH erroneously cross-charged the DJJ and Commissioner's Office accounts.

A similar comment addressing time tracking and reporting for services provided under the contract was included in the prior audit report.

*Recommendation:*

NHH should improve its financial oversight of the DMS contract.

NHH should work with DMS to establish an appropriate system of record-keeping to account for the hours worked by DMS staff psychiatrists that would allow NHH to readily determine staff coverage for any and every day, including which staff was on-site providing services, and that the contracted level of services - 40 hours per week per staff member - is received.

NHH should require the detail support for each monthly invoice. NHH should review the support prior to approving the invoice for payment.

NHH should not process payments for Department organizations for which it does not have a basis to ensure that payments are appropriate and accurately applied. Invoices should be mailed to and paid by responsible offices. Invoices should be accompanied by sufficient support to allow those offices to accurately process payments.

*Auditee Response:*

We concur. NHH was in the process of introducing changes in contract oversight before the audit period recognizing the need for greater accountability on the part of both DHHS and DMS and continued to implement changes while the audit was in process. Since that time, greater control over time tracking has been implemented by using the same system DHHS uses for unclassified employees that require monthly accounting for time worked with the physician's signature as well as increased oversight regarding leave tracking.

As part of the contract in effect during the audit period as well as in the new contract going forward, it is agreed NHH would reimburse contracted physicians for professional development fees up to a set limit. Stipulated in the contract under this line item are dues to professional organizations, attendance at conferences as well as books and periodicals. Cell phones for the Chief Medical Officer and Associate Chief Medical Officer are in the contract as well. Stricter controls over vehicle maintenance of the two vehicles assigned for residents and students commuting from DMS have been instituted by having the vehicle identification numbers on file and cross-referencing repair invoices, assuring only service of those two vehicles are being charged to the contract.

Detailed backup received from DMS to support monthly invoices had been difficult to monitor in the past so the entire reporting system is being reconfigured. Future invoices will include detailed backup per contracted line item in a clear, orderly fashion with each expense identified to the physician or program being charged for. This new formatted invoicing will be distributed to each DHHS agency under the contract for verification before payment is approved.

**Observation No. 4: Equipment Purchased Under The Dartmouth Medical School Services Contract Should Be Reviewed**

*Observation:*

Equipment purchased through the Dartmouth Medical School (DMS) contract has been inconsistently identified as owned by either NHH or DMS. According to NHH, such equipment should be reported as NHH equipment.

In addition to professional services, the DMS contract includes budgets for certain administrative expenses, including equipment. While the contract indicates NHH will provide the contracted staff with offices and applicable equipment to perform their duties, the contract does not include provisions for the purchase of equipment, or its ownership. DMS bills NHH for the cost of equipment purchased through the contract, plus a 26% overhead markup, in its monthly contract billing. While no equipment was purchased during the nine months ended March 31, 2011, communications and x-ray equipment purchased prior to fiscal year 2011 was in use during the audit period. Similar equipment items, some with NHH equipment tags and some with DMS equipment tags, were serviced during the audit period and charged to NHH at cost plus 26%.

*Recommendation:*

NHH should review the financial efficacy of using the DMS contract to fund the purchase and servicing of NHH equipment. When appropriate, NHH should purchase necessary equipment directly and avoid incurring the 26% overhead burden contained in the contract. If NHH continues to purchase equipment using the DMS contract, NHH should properly identify and inventory the equipment upon receipt.

NHH should clarify ownership of equipment previously purchased through the DMS contract and amend the DMS contract to include provisions related to equipment purchases.

*Auditee Response:*

We concur. NHH will avoid using the contract to purchase equipment thus saving the 26% indirect cost.

**Observation No. 5: Pharmaceutical Inventory Controls Should Be Improved**

*Observation:*

During the nine months ended March 31, 2011, NHH did not have an operating pharmaceutical inventory system that accurately accounted for and tracked its pharmaceutical inventory.

NHH began using its current pharmaceutical inventory system in October 2004. While the system has a perpetual inventory function, the NHH pharmacy reports it has never been confident of the accuracy of that aspect of the system and, as a result, has not utilized the

perpetual inventory function for control or reporting purposes. NHH does rely on the system to track the receipts and issuances of pharmaceuticals.

- In accordance with State policy, NHH reports an annual physical inventory of pharmaceuticals. NHH determines the inventory balance by counting the quantity of each drug on hand at the inventory date and listing the counts on a spreadsheet by drug and unit cost to arrive at the total count and value of each pharmaceutical on hand on that date. While the annual count could be used to verify the accuracy of inventory that would be reported by the automated perpetual inventory system, NHH has not chosen to do so.
- The pharmacy does not have any regular process to check for inventory shrinkage. Because NHH does not use the perpetual inventory system or otherwise effectively roll-forward and compare physical counts of inventory to the inventory that should be on hand, based on purchases and usage, NHH cannot be certain that its pharmaceuticals are effectively controlled and safeguarded against loss or theft.
- User-access authority to make adjustments to the inventory system, including 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 posted adjustments or a subsequent review and approval for the change.
- The inventory system as currently configured can only record inventory items that are on a particular data listing, which is generally updated every 30 days. If the NHH orders a pharmaceutical that is not on the current listing, the pharmacy manually keeps track of the unlisted pharmaceutical until the listing is subsequently updated, at which point the pharmacy enters the information into the inventory system. The pharmacy reports it does not consistently complete this manual process accurately, due to resource limitations.
- While each pharmaceutical dosage and packaging quantity has a unique national drug code identifier (for example, there are separate identifiers for the 50, 100, and 500 count packages of 100 milligram aspirin tablets), NHH pools its pharmaceuticals by dosage for inventory and distribution purposes. NHH has identified this difference in practice as an example of why difficulties would exist if it were to utilize the perpetual inventory system for its pooled drugs.
- The pharmacy reports it is aware of discrepancies between the patient prescription fill orders on the system's order fill screen and the orders in the patient profiles in the inventory system. The pharmacy reports, in some instances, the fill orders do not timely reflect a change in dosage or may include both the old dosage and the new dosage amounts. It is unclear whether the untimely maintenance of dosage information contributes to inventory errors.
- The pharmacy does not conduct any procedures to ensure items received were actually ordered. One pharmacy technician is generally responsible for receiving pharmaceutical deliveries and invoices. The employee forwards a copy of the invoice and a Receiving and Inspection report to the business office for payment. No one in the pharmacy reviews the receiving report and invoice to determine that only ordered pharmaceuticals were delivered and accepted.

During the nine months ended March 31, 2011, the NHH purchased approximately $1.1 million of pharmaceuticals. During that 270 day period, the NHH served approximately 150 patients per day for an average pharmaceutical cost of $27 per patient day. In November 2010, NHH reported

that the average monthly pharmaceutical expenditures were $123,540. In January of 2011, NHH reported the estimated cost of inventory on hand was $175,000.

A similar comment was noted in the prior audit report. The condition has deteriorated since the original comment was issued.

*Recommendation:*

NHH should improve controls over its pharmaceutical inventory. NHH 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 NHH's operation of the system. If the system is capable of operating as intended, NHH should take full advantage of the control opportunities available in the system. If it is determined the system is not operating as intended, NHH should fix the system. Pending NHH's successful use of the perpetual inventory function of the system, the NHH should establish reasonable procedures to compare and reconcile the available periodic physical inventory counts and other inventory data to control for inventory shrinkage or other unexpected inventory variances.

NHH 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 review and approve all inventory adjustments.

Pharmacy personnel should compare receiving and inspection reports to pharmaceutical orders to ensure that only ordered products are accepted and purchased.

*Auditee Response:*

We concur. Subsequent to audit inquiry, a comprehensive investigation was initiated to determine the accuracy of the pharmaceutical inventory system and NHH's ability to correctly operate the system and correctly track inventory. This investigation demonstrated the perpetual inventory system could function properly with continued education efforts to pharmacy staff. The annual count will be used to verify inventory amounts reported by the perpetual inventory system.

**Observation No. 6: Pharmaceutical Contract Payments Should Be Monitored For Efficiency**

*Observation:*

During the nine months ended March 31, 2011, NHH did not have a sufficient understanding of its pharmaceutical contract to allow it to effectively manage the contract and perform the analysis necessary to take the best advantage of the contract's terms. During this period, NHH purchased approximately $1.1 million of pharmaceuticals.

The Department of Administrative Services (DAS), Bureau of Purchase and Property, arranged for the State to participate in a multistate alliance for the purchase of pharmaceuticals. The alliance's vendor provides a discount based on the member state's monthly purchases and selected payment option. Payment options include maintaining pre-paid balances of 30 days, 15 days, or 7 days of expected purchases and payments subsequent to invoicing, such as next day net and 90 day net. While the State is a single entity in determining the purchase volume discount, each participating State department is able to select a payment-term option. During the nine months ended March 31, 2011, NHH paid for pharmaceuticals using the 30-day pre-pay option. Neither NHH nor DAS was aware of any analysis performed to support the selection of the 30-day pre-pay option. While NHH employees were aware pharmaceutical purchases were subject to a pre-pay condition, no one at NHH was aware of how the 30-day option, which provides for a 2.54% discount, was selected or that other payment terms and discount options were available. In addition, no one at NHH was reviewing invoices to ensure that the invoice pricing accurately reflected the discount. In fact, inconsistent payments by NHH resulted in the vendor applying a reduced 2.17% discount for July 2010 and a further reduced 2.02% discount from August 2010 through March 2011. NHH was unaware the vendor decreased the applied discount during this period until our auditors brought it to their attention.

*Recommendation:*

NHH should ensure its responsible employees have a sufficient understanding of its pharmaceutical contract to allow it to take proper advantage of contract provisions. NHH should also establish policies and procedures for the periodic review of relevant information such as pharmaceutical usage, budgets, and input from the State Treasury regarding the State's cash flow position to take advantage of the most advantageous payment options for pharmaceuticals.

NHH should monitor its vendor payments to ensure it maintains the required balance for the expected discount.

*Auditee Response:*

We concur. As best as resources allow, a Business Office staff member will be assigned to monitor vendor payments and reference the contract to confirm proper discounts have been identified and verified. Once proper controls are in place, policies and procedures will be developed for a periodic review process to comply with this recommendation.

## Observation No. 7: Adherence With Cafeteria Accountability Controls Should Be Improved

*Observation:*

NHH cafeteria operations management has not effectively monitored cashier adherence to a policy intended to maintain accountability over cash drawers. Irregular monitoring of control compliance increases the risk that controls become ineffective due to complacency or non-compliance.

NHH cafeteria cashiers post the receipt and return of cash drawers on a *Cashier Drop Log* to provide accountability over cash drawers used to process cafeteria sales transactions. Information posted to the log includes the date, cashier's name, and times and balances of the drawer when the cashier accepts the cash drawer from the safe and returns the cash drawer to the safe.

For nine of 24 (38%) instances tested, cafeteria cashiers did not complete postings in the *Cashier Drop Log,* either not recording information related to acceptance or return of the drawer, or both. During our observation of the cafeteria operation, we also noted cashiers and supervisors occasionally shared access to the cash drawers during change of cashiers. Both of these situations reduce employee accountability for cash drawer activity and balances.

*Recommendation:*

NHH should improve its monitoring of employee compliance with cash drawer accountability control activities to ensure control objectives provide the intended results.

*Auditee Response:*

We concur. Controls were put in place while the audit team was on-site as soon as this was brought to management's attention. Immediate follow-up showed the problem was not corrected so continuing education of staff was put in place. A recent audit of the cash drawer controls for the months of August and September 2011 revealed 53 of 55 records were properly documented. The NHH Internal Auditor will continue to monitor this and all other cash activities within the Hospital.

**Observation No. 8: Formal Pricing Policy For Cafeteria Operations Should Be Established**

*Observation:*

NHH 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 sufficient to track the operation's alignment with and achievement of stated goals.

NHH operates a cafeteria in its Acute Psychiatric Services (APS) building and also operates a cafeteria in the nearby Brown Building, headquarters of the Department of Health and Human Services (Department). While not addressed by a formal business plan, NHH reports the objective of the APS cafeteria is to provide reasonably-priced and well-balanced meals to NHH employees and visitors, primarily so employees will remain on-site for meal breaks. NHH reports it has operated the Brown Building cafeteria since 2005 at the request of the Department Commissioner.

According to NHH, there is no current 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 NHH site. A NHH analysis of the Brown

Building cafeteria service indicates that cafeteria operated at an $82,000 loss for the nine months ended March 31, 2011.

NHH also does not have formal policies and procedures for pricing meals served at its cafeterias. According to NHH, meal prices have historically been set with a 42-45% margin over the cost of food ingredients. In practice, NHH reports it generally adjusts meal prices if it recognizes the cost of a primary ingredient has changed since the item was previously on the menu. In those instances, NHH may change the menu price to reflect the change in component cost; however, the NHH does not formally recalculate meal price to ensure the 42-45% margin is maintained.

A similar comment was noted in the prior audit report.

*Recommendation:*

NHH 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 the recognition of whether the cafeterias are to be self-funding or subsidized.

NHH should establish an accurate and timely management information system, including cost reporting, for its cafeteria operations that considers inputs of food, labor, supplies, overhead, and other costs incurred in providing cafeteria service to employees and visitors, separate from its patient food-services costs.

NHH should establish formal pricing policies and procedures for its cafeteria services that consider all costs of providing those services when setting meal prices.

*Auditee Response:*

We concur. NHH has been attempting to procure a reasonably priced software package to track all associated activity within the cafeteria operations, both APS and Brown Building locations. APS cafeteria staff will rotate between the main kitchen operation and the cafeteria several times within the course of shift depending on the volume of customers. At present, it is problematic to accurately track time spent by each employee between operations without some sort of automated time tracker system activated by the swipe of a card as staff constantly switch positions. Entrées served in the APS cafeteria are the same meals provided on the patient trays. The menu tracker system in place allows us to input the daily census and receive a printout of the volume of ingredients needed for that meal and we historically added a percentage to cover the cafeteria line. It is that percentage of the total food cost that is applied to cafeteria operations. NHH will work with our food vendor to develop a more formal set of standards to increase the accuracy of meal pricing.

Brown Building Cafeteria was established by utilizing existing APS staff to provide the service. It was understood the goal was to cover actual food and consumable supplies with a pricing structure to ensure that goal. NHH continues to cover those costs without factoring labor, as at any given time staff at Brown are needed back at APS to cover vacancies or short shifts. The Department will continue to monitor the viability of providing this operation to a small service

audience, the volume of which will not allow labor to be covered unless pricing is drastically increased. That will in turn result in lower traffic counts.

**Observation No. 9: Controls Over Food Inventory Should Be Improved**

*Observation:*

NHH does not fully secure or effectively manage its food inventory.

NHH stores its food inventory in two primary locations in the NHH building. A stock clerk located in one of the storage areas is responsible for maintaining custody of the food inventory, stocking the shelves with new inventory, issuing inventory to the kitchen, conducting physical inventory counts twice a week and at month end, and reporting the results of the counts to management. The counts during the week are used as a basis for ordering food and supplies and the monthly count is used for management reporting purposes.

NHH does not track the issuance of food inventory. When products are needed for meal preparation, kitchen personnel generally take the products needed from the storage area. There is no documentation of the issuance of the food and the storage areas are not locked, secured, or observed when the stock clerk is not on duty. There is also no comparison of the inventory activity reported by the stock clerk to the use of the inventory in meal preparation.

A significantly smaller inventory of food is also stored at the Brown Building for use in that cafeteria. The Brown Building cafeteria employees conduct a weekly count of inventory for ordering purposes; however, monthly counts are not conducted. NHH generally does not track, value, or report food inventory at the Brown Building.

At March 31, 2011, NHH reported the cost value of its food inventory on hand was approximately $29,000 and $3,000, respectively, for the NHH and Brown Building. During the nine months ended March 31, 2011, NHH purchased approximately $668,000 of food products.

A similar comment was noted in the prior audit report.

*Recommendation:*

NHH should take reasonable steps to secure and better manage its food inventory. The food storage areas should be locked to prevent unauthorized access when unattended and food removed from inventory should be logged. NHH should make periodic comparisons of food inventory issued and meals prepared to reasonably ensure the integrity of its food inventory. NHH should also work to reduce inventory levels to ensure rapid turnover.

*Auditee Response:*

We concur. Currently NHH has one stock clerk position that is also called on for other tasks in the course of any given day. Staff has been counseled to be more vigilant in securing the stock

room door when leaving the area. A bin slip system has been implemented for each stocked item and on-going staff training has begun. The NHH Internal Auditor will work with Dietary staff on proper controls over the food inventory.

**Observation No. 10: Accuracy Of Food Services Reports Should Be Improved**

*Observation:*

As noted in Observation No. 8, the NHH does not have formal cost accounting and reporting systems for its food services operations. Management information reports that were prepared during the nine months ended March 31, 2011 contained clerical errors that significantly misstated the cost of operating the NHH and Brown Building cafeterias.

NHH does prepare monthly budget to actual comparisons and operating statements that track and report the cost of food and controllables, such as cleaning supplies, plastic cups, and fees for other contracted costs. While the Brown Building's operating statement includes labor costs in determining a monthly profit or loss, the operating statement for the NHH cafeteria does not include labor costs.

The reports are used by food services personnel to support menu selection, quantity adjustments, and meal pricing decisions. NHH management also receives the reports for their review of the cafeteria operations.

A review of the NHH and Brown Building cafeteria budgets and operating statements revealed the reports were not clerically accurate. Auditors informed NHH of errors in the cafeteria operating statements in January 2011. NHH had not corrected the errors in the fiscal year 2011 operating statement it prepared six months later in July 2011. In another example of an error, the Brown Building cafeteria budget understated its fiscal year 2011 projected loss by almost $100,000.

*Recommendation:*

NHH should reconfirm with its employees the necessity to prepare and submit accurate reporting. Reasonable review procedures should be established to promote the accuracy and completeness of reports used for management information and decision-making.

Management information reports should be periodically reviewed and challenged to reasonably ensure that information on which decisions are based is complete, accurate, relevant, and reliable.

All recognized errors in management reports should be corrected timely.

*Auditee Response:*

We concur. Management information reports generated by a generic food service software program will be replaced with more detailed reporting once NHH upgrades the software as referenced in Observation No. 8. Report preparation duties will be reassigned when a vacant Supervisor position is filled. Other changes include more comprehensive training for rotated staff to ensure continuity of operations.

**Observation No. 11: Food Services Invoices Should Be Reconciled To Detail Support**

*Observation:*

NHH does not consistently review detail supporting its primary food and food services vendor's invoices prior to approving the invoices for payment.

Monthly, NHH's primary food and food services vendor sends an invoice and operating statement to NHH for payment. The invoice includes the total payments made by the vendor on the NHH's behalf to supplying vendors, plus fees associated with those purchases and related services. A NHH employee agrees the total amount on the primary vendor's invoice to the total amount on the supporting operating statement and approves the invoice for payment. The approver does not review available information to ensure the amount billed by the primary vendor accurately reflects the actual product purchased on behalf of, and received by, NHH.

During the nine months ended March 31, 2011, NHH paid the primary vendor approximately $587,000 for food and food related services. According to records of vendor deliveries, NHH formally received approximately $544,000 of these products and services. NHH could not explain the difference of approximately $43,000.

*Recommendation:*

NHH should perform and document a reasonable review of all invoices prior to payment, including invoices for food and food related services.

Where appropriate, invoices should be reconciled and agreed to available support. NHH should note and resolve any discrepancies between the detailed support and the invoice amount prior to making payment on the invoice.

*Auditee Response:*

We concur. NHH has a system of checks and balances in place but due to staff turnover and reductions in key areas, detailed review of all invoices had become overlooked. The NHH Internal Auditor will be working with Dietary and Accounts Payable staff to ensure existing procedures are adhered to. Furthermore, quarterly audits will be implemented to ensure compliance.

**Observation No. 12: Operation Of Motor Vehicle Repair Facility Should Be Reviewed**

*Observation:*

NHH operates a motor vehicle repair facility which provides maintenance and repair services to NHH's fleet of motor vehicles. The NHH repair facility also offers maintenance and repair services to other State agencies.

During the nine months ended March 31, 2011, approximately $324,000 of expenditures were posted to the accounting unit reporting the financial activity of the NHH repair facility. NHH reports revenues from NHH repair facility in an account with other user fee revenues, making an analysis of net operating costs of the repair facility problematic.

NHH's maintenance of a fleet of more than 40 motor vehicles and the operation of a motor vehicle repair facility appears beyond the needs of the psychiatric hospital and is likely a vestige from when the NHH was responsible for vehicles and equipment necessary for the maintenance of the entire NHH campus. The primary responsibility for the maintenance of the NHH campus, outside of the NHH and Transitional Housing buildings, currently rests with the Department of Administrative Services.

For fiscal year 2010, the Department of Administrative Services (DAS) reported NHH's fleet consisted of 46 vehicles including four medium duty trucks, 27 light duty trucks including passenger vans, two mobile equipment items and 13 passenger automobiles. DAS reported ten of the passenger automobiles and light duty trucks exceeded DAS's 9,219 mile break-even mileage for fiscal year 2010. Administrative Services reviewed the fleet and made a recommendation to the Fiscal Committee that the fleet be retained to serve the business needs of NHH.

*Recommendation:*

NHH should review with the Departments of Health and Human Services and Administrative Services the business case for continuing to operate a motor vehicle repair facility.

If NHH continues to operate the motor vehicle repair facility, NHH should report user fee revenues in a manner that would allow an analysis of net operating costs for the facility.

NHH should review the need for a fleet of more than 40 motor vehicles.

*Auditee Response:*

We concur. NHH will work with the Department of Administrative Services to review the most effective and efficient process for maintaining vehicles.

*Department of Administrative Services' Response:*

The Department of Administrative Services concurs with the LBA finding.

We concur that the Departments of Health and Human Services and Administrative Services should review in detail if it is feasible to continue to operate this repair facility. In order to complete the financial analysis the total cost of the repair facility must not be limited to payroll costs and must include but not be limited to capital and operating costs, equipment repairs, overhead, environmental costs, supplies, inventory, payroll, billing, benefits and indirect costs.

We recommend that a complete financial analysis be completed before any recommendations are made regarding the future of the NHH repair facility.

We concur that NHH should review the need for their fleet of 46 motor vehicles and Administrative Services would be glad to assist with that process.

**Observation No. 13: Risks In Gift Store Operations Should Be Mitigated**

*Observation:*

NHH's gift store has not taken advantage of certain available functions in its point of sale computer system to improve controls and available information on the gift store's financial activity.

NHH operates a gift store that sells small, gift-type items to patients, employees, and visitors. During the nine months ended March 31, 2011, the gift store generated approximately $30,000 in sales. The gift store uses revenues to purchase inventory for resale, with balances accumulating over $10,000 transferred to a rehabilitation account to purchase items to benefit patients. The financial operations of the gift store are accounted for in the NHH client banking system and are not reported or accounted for in the State's accounting system (NHFirst). The Gift Store is regularly staffed by one NHH employee, with the assistance of other NHH employees, and some patients.

The limited staffing level of the gift store makes an effective segregation of financial responsibilities problematic. The one employee has the authority to purchase and receive goods, adjust inventory records, set prices, and receive and record cash transactions without the benefit of an effective review and approval control process. The single employee is also responsible for the incompatible responsibilities of performing the annual inventory count of all products, inputting the counts into the retail inventory and sales system, comparing the counts to the perpetual inventory records, and adjusting the perpetual records to actual counts. The scope of this employee's responsibilities increases the risk that errors or fraud could occur and not be detected and corrected in a timely manner.

While the use of a controlled sales and inventory system could mitigate some of the risks facing gift store operations, the primary gift store employee and NHH management have not become

sufficiently knowledgeable and trained in the point-of-sale system to incorporate the available controls into daily operations. For example:

- Increases in inventory levels resulting from inventory purchases are "adjusted" instead of using the available order/purchase function in the point of sale system. Inventory adjustments are not reviewed by management and are not tracked and reported by the system.
- NHH mistakenly presumed the automated annual December 31 system closeout resulted in historical data being deleted. NHH was unaware historical data was simply moved to backup files and remained available for review purposes.
- While user names are set up in the system, individual passwords are not. Employees share a password to access the system, which increases the risks of unauthorized access and obscures accountability.

*Recommendation:*

NHH should take steps to mitigate the risk resulting from the lack of segregation of duties in the gift store operation.

To lessen the segregation of duties risk, NHH management should perform timely reviews of appropriate reports of financial operations that would allow it to have reasonable assurance the gift store is operating as intended.

To be most useful as a mitigating control, the point of sale system should be operated in a reasonably controlled manner, with secure username and password controls in place, all appropriate functions utilized, and adjustments limited and subject to close management review. To do so, NHH will need to become more knowledgeable of, and train its employees in, the proper use of the system.

*Auditee Response:*

We concur. The NHH Internal Auditor will be tasked with performing quarterly reviews to ensure appropriate reporting of financial operations. NHH will put controls in place to require designated Business Office staff to become more knowledgeable of, and train Gift Shop staff in the proper use of the system. Due to staffing constraints, there will continue to be a lack of segregation of duties in the operation.

**Observation No. 14: Arrangement For Supplementing State Employee's Pay Should Be Reviewed**

*Observation:*

During the nine months ended March 31, 2011, NHH had an arrangement with its medical services contractor whereby the contractor supplemented the pay of a State employee. Under the arrangement, the State employee, who had previously retired from the contractor's employment

as NHH's medical director, receives paychecks from both NHH and the contractor for the same hours of work performed at NHH.

During the nine months ended March 31, 2011, the contractor supplemented the now State employee's $68.27 per hour NHH rate of pay (unclassified group PP) with an additional $41.73 per hour, bringing the employee's total compensation for work at NHH to $110 per hour. The contractor billed the amount it paid to the State employee, plus an additional 26% overhead charge, to NHH in its monthly contract invoice.

During the nine months ended March 31, 2011, NHH and the contractor paid the employee approximately $106,000 and $64,000, respectively, for a total of approximately $170,000 for hours worked at NHH.

Having a contractor make payments to supplement a State employee's wages is highly unusual and raises concerns regarding the general appropriateness of the arrangement and the circumstances that cause it to be in place.

*Recommendation:*

NHH should review the appropriateness of this pay arrangement with the Department of Administrative Service's Division of Personnel and the Department of Justice.

*Auditee Response:*

We concur in part. This was a unique and isolated occurrence with the former Medical Director. The Medical Director was not a state employee but was working on a per diem basis as needed through the contractor. While NHH was experiencing a shortage of physicians at the time, the former medical director was asked to take on additional roles. As such, the pay under the contract was augmented by an hourly state rate. This practice of paying a person under contract with a supplemented state pay for the same hours worked is no longer being done.

*LBA Clarification:*

The auditee response indicates this was a unique and isolated occurrence. In fact, this type of pay arrangement was reportedly used in two prior instances in which State employees' pay was supplemented by the NHH contractor.

**Observation No. 15: Payroll Accuracy Should Be Improved**

*Observation:*

The number of relatively minor errors noted during payroll testing raise concerns as to the overall accuracy of NHH's payroll processes.

Audit tests noted four monetary errors (7%) in 54 employee biweekly paychecks tested. Errors in the tested paycheck amounts ranged from an overpayment of $160 to an underpayment of $115. While NHH's overall payroll amounts are materially correct, the impact of these types of pay errors on employees can be significant.

Audit tests also noted errors on eight (14%) of the 59 leave slips associated with the paychecks tested. These noted errors affected the leave accounts of five employees.

The errors appeared largely due to clerical mistakes in transposing pay event information from timekeeping systems and leave slips to the State's payroll system, GHRS. The Department of Health and Human Services' (Department) payroll office performs most of this data entry for NHH.

*Recommendation:*

NHH should review its payroll processes with the Department's payroll office. NHH should consider whether the translation between its timekeeping systems and GHRS could be automated, or otherwise improved, to lessen the likelihood of clerical errors in that process.

Pending any improvements in NHH's payroll processing that lessen the likelihood of these types of errors, the NHH should take additional steps to detect and correct payroll errors in a timely manner.

*Auditee Response:*

We concur. NHH has assigned administrative support to act as a liaison with the Department's payroll to mitigate leave slip errors. NHH has considered automated timekeeping systems in the past but has not received approval to pursue. It is our understanding a statewide initiative is under way to replace GHRS and a newly designed payroll and timekeeping system is part of that replacement. It would not be feasible to pursue other systems while this is being developed. Monetary errors as a result of factors other than leave slips are within the operational responsibility of the Department's payroll.

**Observation No. 16: Weekend Pay Differential Should Be Paid As Negotiated**

*Observation:*

NHH pays employees who work the second and third shifts on a Friday, as well as employees who work any shift commencing on Saturday and Sunday, a weekend pay differential even though the State's current collective bargaining agreement (CBA) covering NHH's employees provides for weekend differentials for only Saturday and Sunday shifts. NHH was unable to provide authorization for the payment of shift differentials on Fridays.

According to Article XIX 19.12.5 of the CBA, Institutional Weekend Differential, "All full-time and part-time institutional employees who work on a shift which commences on a Saturday or a

Sunday shall receive a weekend differential of one dollar ($1.00) per hour for all hours actually worked on that shift. [Nurses at the NHH during the nine months ended March 31, 2011 received a $1.50 per hour weekend differential pursuant to Article XIX 19.12.6(c) of the CBA.] This week-end differential is in addition to, but shall not be compounded by any other pay or premium pay provision of this Agreement."

According to NHH, the practice of paying weekend pay differentials for the second and third shifts on Fridays has been in place for a number of years and would likely be regarded as a long-standing practice requiring negotiation with employees to discontinue. NHH paid approximately $56,000 in shift differentials for employees working the second and third shifts on Fridays during the nine months ended March 31, 2011.

A similar comment was noted in the prior audit report.

*Recommendation:*

NHH should consult with legal counsel to determine if it has the authority to pay weekend differentials in excess of the differentials provided for in the CBA. If NHH determines it has the authority, it should document that authority and determine whether the continued payment is appropriate. If it determines no current authority exists for these payments and the payments are necessary for its continued operations, NHH should seek appropriate authority to continue making the payments.

*Auditee Response:*

We concur. As with this observation in the prior audit report, NHH will consult with the Department's legal counsel to determine the appropriateness of this practice.

**Observation No. 17: Policies And Procedures Should Be Established For Billing Patient Accounts**

*Observation:*

The Office of Reimbursements reports it has not established policies and procedures, including a description of the process, documentation requirements, and stated evaluation criteria to support its recovery of cost of services provided to NHH patients.

Pursuant to RSA 126-A:36, the costs of services provided by NHH may be recovered from the person receiving services and from certain close family members. RSA 126-A:34, I(b) directs the Department of Health and Human Services (Department), Office of Reimbursements, to investigate the ability of NHH patients and others to pay for such care, treatment, and maintenance and to recommend to the Department's Commissioner the amounts to be recovered. To support and help form a basis for this recommendation, RSA 126-A:38 requires persons legally chargeable for expenses pursuant to RSA 126-A:36 to file a financial statement within 60 days of an individual's admittance to a covered program.

Office of Reimbursements employees interview and obtain financial information from NHH patients and appropriate family members when individuals are first admitted to NHH. The employees determine whether any costs of services are recoverable from those responsible parties and make payment recommendations to recover those costs over a reasonable period of time. According to the Office of Reimbursements, employees perform this work without the benefit of formal policy and procedure guidance.

A similar comment was noted in the prior audit report.

*Recommendation:*

The Office of Reimbursements should establish policies and procedures for recovering the cost of NHH services. The policies and procedures should include specific criteria, define responsible employees, procedures to be performed, and information required to be gathered, documented, and evaluated.

*Auditee Response:*

We concur. The Office of Reimbursements (OOR) has policies and procedures, but they are not documented and are under review. OOR was transferred to the Office of Improvement & Integrity in the past few months. First priority was given to reviewing the very manual processes in use at the time. Many of these have now been automated. A new Supervisor with extensive experience in eligibility determining processes was moved into OOR and the policies and procedures referred to in the finding are being reviewed, modified, and documented.

**Observation No. 18: Continued Offering Of Outpatient Services Should Be Reviewed**

*Observation:*

NHH currently does not have policies and procedures to enable it to bill for services provided to patients on an outpatient basis. During the nine months ended March 31, 2011, NHH provided services to at least one individual on an outpatient basis; however, NHH did not bill for those services.

NHH's Billing Office reports it does not have a process in place to accumulate information related to the scope and instances of outpatient services provided by NHH or to determine the costs of those services to bill to responsible parties.

*Recommendation:*

NHH should determine whether it is in the State's best interest for NHH to provide outpatient services.

If NHH is to continue to provide outpatient services, NHH should establish policies and procedures and business processes that would allow it to accurately track, bill, collect, and report revenues from the outpatient services provided.

*Auditee Response:*

We concur. NHH will continue to explore outpatient services and will craft policies consistent with those services.

**Observation No. 19: Policies And Procedures For The Timely And Complete Collection Of Patient Services Revenues Should Be Established**

*Observation:*

NHH has not established policies and procedures to effectively and consistently pursue collections on amounts owed from responsible parties for services provided to patients.

NHH's Billing Department generates board and care bills or claims for services provided by the hospital to patients. The Billing Department typically receives notice if a payer such as private insurance, Medicare, or Medicaid denies responsibility for a billed claim and refuses to make payment. Depending on the nature of a payer's denial, either NHH's Quality Assurance Office or the Department of Health and Human Service's (Department) Office of Reimbursements becomes responsible for resolving the issues surrounding the denial. The Quality Assurance Office typically addresses issues related to administrative and clinical certification of patients and the Office of Reimbursements addresses requests from payers for refunds of previously paid claims.

Audit testing noted an instance where NHH issued a refund to an insurance company for a claim previously paid by the insurance company, prior to NHH determining the refund was appropriate. According to the Billing Department and a review of supporting documentation, an insurance company requested a refund of a previously paid claim on the basis the services NHH provided to its insured patient were not medically necessary, even though the patient was clinically certified as requiring NHH-level care during the billing period. According to the Billing Department, the Quality Assurance Office did not pursue resolution of the denied claim, apparently because NHH had discharged the patient prior to the insurance company's challenge of the claim. While the Office of Reimbursements contacted the insurance company in an attempt to resolve the refund request, the insurance company did not respond to the Office of Reimbursements' letter and referred its request for a refund to a collection agency. NHH subsequently issued the requested refund without further challenge.

*Recommendation:*

NHH should actively pursue all patient services revenue it is owed.

NHH should establish policies and procedures for the timely collection of patient services revenues. The policies and procedures should promote improved communications between NHH's Billing Department and Quality Assurance Office, and the Department's Office of Reimbursements and should formally assign responsibility for the resolution of denied and disputed claims.

*Auditee Response:*

We concur. NHH Billing Office, Quality Assurance, and Office of Reimbursement have policies and procedures, but they are not adequately documented or complete causing missed opportunities. NHH Billing Office, Quality Assurance, and Office of Reimbursement are currently in the process of establishing policies and procedures to document and pursue collections, and to follow up on payment denials. These procedures will ensure coordination between NHH Billing Office, Quality Assurance, and Office of Reimbursement to maximize revenues.

**Observation No. 20: Additional Fringe Benefits Expenditures Should Be Processed As Budgeted**

*Observation:*

During the nine months ended March 31, 2011, NHH did not expend any of its appropriations for additional fringe benefits, the expenditure class intended to support health care costs for future retirees. Amounts expended by NHH from this expenditure class in fiscal years 2009 and 2010 were reportedly unrelated to NHH's operations and funded shortfalls in the post retirement accounts of other Department of Health and Human Services bureaus.

Amounts expended by NHH in this account are recoverable by NHH through its patient services daily rate and its disproportionate share hospital (DSH) cost recovery.

NHH's fiscal year 2011 budget included approximately $248,000 for additional fringe benefit expenditures. During the nine months ended March 31, 2011, NHH did not expend any of the appropriated amount. While approximately $75,000 of the appropriated amount was transferred to other accounts, the $173,000 remaining appropriation lapsed to the General Fund at the close of fiscal year 2011.

As a result of not having paid additional fringe benefit costs to the Department of Administrative Services during this period and in prior years, NHH did not include additional fringe benefits as a recoverable cost on its Medicare Cost Reports used to calculate its board and care rates, and also used for Medicare and Medicaid settlements of provider payments to determine total costs of NHH's operations subject to DSH cost recovery.

*Recommendation:*

NHH should regularly process additional fringe benefits expenditures as budgeted. NHH should set its patient services daily rate to recover those costs and should include those costs in its Medicare Cost Reports and DSH revenue calculations.

*Auditee Response:*

We concur. NHH will be following up with the NH Department of Health and Human Services Cost Allocation and Finance Department to work on this issue. We anticipate having this policy in place for State fiscal year 2012.

**Observation No. 21: Rate Setting For Transitional Housing Should Be Formalized**

*Observation:*

NHH could not provide the source and basis for the rent, food, and non-clinical services rates charged to Transitional Housing Services (THS) residents during the nine months ended March 31, 2011. While spreadsheets NHH described as supporting the rates indicate the rate calculations were based on fiscal year 2009 financial information, NHH could not provide the source and support for the actual amounts used in the calculation. As a result, NHH could not demonstrate the reasonableness of the rates, what costs the rates are intended to recover, or their accuracy, including the use of the correct component costs.

The lack of a formally described and supported calculation increases the risk that rates will not be appropriate for their purposes, and that errors made in establishing rates will not be detected and corrected timely. Also, because the basis of the calculations is not clearly identified and understood, changes in operations, which should prompt recalculations of rates, may not be identified and responded to timely.

A similar comment was noted in the prior audit report.

*Recommendation:*

NHH should formalize and document its rate-setting policies and procedures for Transitional Housing Services. NHH should document its objectives in its rate setting, including costs to be recovered, methods for determining and approving rates, and requirements for periodically reviewing rates for continued appropriateness. Documentation supporting applied rates should be subject to review and approval to ensure components of costs are accurately determined and calculations are accurately computed.

*Auditee Response:*

We concur. The rate setting process for institutions operated by the Department is under review. Pursuant to RSA 126-A:34, the Office of Reimbursements (OOR) is responsible for recommending rate changes related to services provided at most institutions operated by the Department. The exceptions to this are Transitional Housing and the Sununu Center. This is done in cooperation with each of the institutions. During the past year, OOR was transferred to the Office of Improvement & Integrity and the rate setting process is being reviewed and modified. Transitional Housing Services will no longer be provided in the State operated facility beginning January 1, 2012. THS rates were based on calculations developed by the THS Director, effective December 2009. With one exception, costs incurred at that time already exceeded income and assistance received by THS clients. An increase in rates would likely have not resulted in more revenue for the program.

**Observation No. 22: Policies And Procedures For The Accrual Of Accounts Receivable Should Be Established**

*Observation:*

NHH has not shown that its methods for determining its unrestricted revenue accounts receivable effectively approximate those revenues that are owed and likely to be collected at fiscal year end. NHH also generally does not consider whether there is a need to accrue accounts receivable for its restricted revenue accounts.

NHH has not formalized its policies and procedures related to estimating and recording accounts receivable. NHH reports it has an informal policy of estimating fiscal year end accounts receivable as 125% of the period's average monthly revenue. NHH was unable to demonstrate the recalculation of the reported June 30, 2010 accounts receivable, apparently due to subsequent undocumented adjustments having been made to the calculated amounts. Any misstatement that may have occurred in the estimate of the June 30, 2010 accounts receivable affected the revenues of the nine months ended March 31, 2011.

In addition to the lack of formal policies and procedures related to accounts receivable, NHH has not calculated nor recorded accounts receivable related to Medicaid revenue for Transitional Housing Services.

A similar comment was noted in the prior audit report.

*Recommendation:*

NHH should establish policies and procedures for compiling year-end accounts receivable estimates in accordance with State accounting policies. NHH policies and procedures should include sufficient discussion of methodologies, procedures, and sources of information to allow employees to perform the calculations and accrue an accounts receivable balance that represents a reasonable estimate of the amount to be collected by NHH in the measurement period

discussed in State policy. Policies and procedures should include suitable controls to ascertain the estimates are documented accurately and in a consistent manner from year-to-year in accordance with State and NHH policy. A review of the subsequent collections of amounts accrued should be performed to ensure estimates were reasonable and methodologies remain sound.

*Auditee Response:*

We concur. In response to the comment that this was in the prior audit report, since that time there have been changes in the reporting structure of the Billing Office, who at the time of the prior audit reported to the Division of Behavioral Health. They now report to NHH, and are also working with billing software different from the previous audit.

NHH has for several years been using a method of reporting unrestricted revenue as 125% of the period's average monthly revenue as our best estimate of an Accounts Receivable balance at year-end. This method will be reviewed and a formal policy and procedure will be established to comply with the State policy to report an amount that is both measurable and available.

Regarding restricted revenue accounts, we consider this amount to be insignificant with the closing of our APC school program on June 30, 2010 and the closing of the Transitional Housing Services program on December 31, 2011. NHH will continue to record the Cafeteria revenue amount for year-end.

**Observation No. 23: User Access To Critical Information Systems Should Remain Current**

*Observation:*

NHH does not consistently update user-access authorities to mission critical information technology (IT) systems when NHH employees terminate employment.

The Department of Health and Human Services (DHHS) Technical Resource Utilization Policy, which is incorporated by means of reference into the NHH Computer Systems policy, states, "upon resignation or termination of a user, the immediate supervisor is responsible for ensuring that the departing employee's access to all DHHS IT resources and information is terminated within 3 days of their departure."

We tested the employment status for users of two significant NHH IT systems, the patient health information system and the pharmacy inventory information system, to review NHH's controls for making timely updates to its user-access authorities. We noted the following issues during testing of user-access authorities:

1. NHH uses the patient health information system to record patient information used in tracking and billing patient services and to account for patient money held by NHH. We obtained a list of users of the system and traced and agreed the users with administrator access to the listing of active NHH employees.

- At the date of testing, the administrative-level, user-access authorities for five former employees remained active in the patient health information system.

2. We also obtained a list of users of NHH's pharmacy inventory information system discussed in Observation No. 5. We traced and agreed all authorized users of that system to the listing of active NHH employees.

    - At the date of testing, the user-access authorities for two former employees remained active in the pharmacy inventory information system.

According to NHH, the accounts for these former employees remained active in the systems as a result of supervisors not notifying NHH IT of the change in employee status.

While terminated employees may not have physical access to systems, other employees could use terminated employees' access authorities to disguise accountability for inappropriate system activity, if passwords were known.

A similar comment was noted in the prior audit report.

*Recommendation:*

NHH should ensure there are appropriate controls in place to reasonably ensure user-access authorities remain current for all critical IT systems.

NHH should re-emphasize with supervisors their responsibility to timely and accurately monitor and comply with the Department's policy of updating access authorities for all changes in employment status, including the timely deletion of access authorities for terminating employees. NHH should confer with DHHS Human Resources personnel to determine whether their involvement in employee terminations could be expanded to ensure notices to delete IT authorities and permissions are made timely.

NHH should immediately act to correct any noted inappropriate user-access authorities to critical IT systems.

*Auditee Response:*

We concur. NHH immediately removed the authorizations for terminated employees and reinforced existing procedures to follow when an employee terminates. The NHH Internal Auditor will be performing quarterly audits of all terminated employees to ensure compliance with this observation as well as other tasks to be performed upon termination.

**Observation No. 24: Disaster Recovery Plan For Critical Information Systems Should Be In Place**

*Observation:*

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

NHH 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 NHH'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 NHH operations, and for efficient communications. NHH and the Department of Information Technology (DoIT) share responsibility for IT support at NHH. While NHH reported it assumed DoIT had a detailed disaster recovery plan for NHH, DoIT reported it did not have such a plan for NHH IT systems.
*Recommendation:*

A current, comprehensive, and tested IT disaster recovery plan should be in place for NHH's mission-critical IT systems and assets.

NHH 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. NHH 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 concur. NHH will coordinate the development of a disaster recovery plan with DHHS and DoIT and have been in contact with the Chief Information Officer of DHHS to commence the project. NHH has been operating with just one IT staff member but has received a vacant Program Specialist III position from another DHHS agency to provide much needed assistance. Responsibility for coordinating this effort will be assigned to the new position.

**Observation No. 25: Payments For Non-Hospital Medical Services Should Be Limited To Provider's Usual And Customary Charge**

*Observation:*

During the nine months ended March 31, 2011, NHH did not have controls in place to ensure it consistently paid the correct amount for non-hospital medical services provided to NHH patients outside of the NHH setting.

NHH periodically sends its patients to medical service providers outside of NHH for procedures that are not available at NHH. NHH generally pays for outside medical services provided to its patients.

NHH does not have procedures to reasonably ensure the amounts it pays to outside service providers are in accordance with RSA 126-A:3. Pursuant to the statute, no provider shall bill or charge NHH more than the provider's usual and customary charge, generally defined in statute as the lowest rates charged by the provider to any customer for those services.

If the outside provider is a hospital, NHH pays for the services at the applicable facility's Medicaid rate, as determined by the Department of Health and Human Services' Office of Medicaid Business and Policy (OMBP). If the outside provider is other than a hospital, NHH generally pays the invoiced amount without taking steps to reasonably ensure the invoiced amount is the usual and customary charge as defined by statute.

Two non-hospital medical services invoices were selected for testing in the random sample of nonpayroll expenditures. NHH paid each invoice at the billed amount without consideration as to whether the billed amount was the provider's usual and customary charge. Due to the overpayments noted in these two sample-selected test items, we selected and tested an additional eight non-hospital medical services invoices paid during the nine months ended March 31, 2011. For these 10 items, we compared the amount paid by NHH to the Medicare Healthcare Common Procedure Coding System (HCPCS) rate for the noted procedures. The Medicare HCPCS rate was used as a proxy for the usual and customary charge rate of the individual provider. By Medicaid regulations, the Medicaid rate is a provider's lowest charge rate. Therefore, under RSA 126-A:3 the Medicaid rate would be the usual and customary rate that NHH would be liable to pay (and that rate would be no more than the Medicare HCPCS rate). Overpayments were noted for each of the 10 payments tested with a summary of the results as follows:

| Amounts Paid | HCPCS Amount Owed | Amounts Overpaid | Percentage Overpaid |
|---|---|---|---|
| $16,360 | $3,451 | $12,909 | 78.9% |

NHH paid approximately $175,000 for non-hospital medical services during the nine months ended March 31, 2011.

A similar comment was noted in the prior audit report.

*Recommendation:*

NHH should establish policies and procedures for the review of all medical service provider invoices for compliance with RSA 126-A:3 prior to payment. NHH should work with the OMBP to develop and implement the necessary exchange of information that would provide NHH with data that would allow for an effective payment control procedure.

Once established, employees involved in the payment process will need to remain familiar with the policies and procedures and the need to periodically review and update them in response to changes in provider billing conditions and rates.

*Auditee Response:*

We concur. Given the complexities associated with providing medical treatment to those with mental illness, NHH will examine this issue to determine the best and most efficient way to obtain non-hospital medical services for patients who require such services outside of NHH. Despite the requirements of NH RSA 126-A:3 III, outside medical providers are under no obligation to accept NHH patients for non-emergency treatment. NHH must ensure that there is an adequate network of providers willing to provide such non-hospital medical treatment. NHH will make efforts to negotiate with providers to agree upon payment at the usual and customary rate consistent with State statute. Once established, staff will be trained on the procedures for determining and verifying the lowest rate to ensure continuity and accuracy. In addition, the NHH Internal Auditor will perform regular audits of invoices and payments to ensure compliance. In the event NHH is unable to negotiate rates that comport with the statute, NHH may need to seek alternatives that will allow for a continuum of care, including legislative changes.

**Observation No. 26: Controls Over Preparation Of Medicare Cost Report Should Be Improved**

*Observation:*

NHH's fiscal year 2009 *Medicare Cost Report* (MCR), used for fiscal year 2011 board and care rate setting, and the fiscal year 2010 MCR, used for fiscal year 2010 Disproportionate Share Hospital (DSH) cost calculations used to collect fiscal year 2011 revenue, contained inaccurate information. While the inaccurate information may not have had a significant effect on fiscal year 2009 or 2010 MCRs and the use of those MCRs, the fact that the reporting deficiencies were not recognized by NHH prior to submitting the MCRs indicates an ineffective review process.

Federal regulations require providers such as NHH to maintain sufficient financial records and statistical data to determine costs payable under the program and to annually report the costs on an MCR. NHH also uses the daily board and care rates set, using the MCRs, to charge insurance companies and self-pay patients for provided services.

The following errors were noted in NHH's fiscal year 2009 and 2010 *Medicare Cost Reports:*

- NHH could not support a bond schedule used in the calculation of adjustments to its expenses in the 2009 and 2010 MCR. NHH's subsequent inquiry to the State Treasury indicated the schedule is likely outdated and no longer represents an appropriate MCR cost element. NHH reported it would not include the bond schedule information in its fiscal year 2011 MCR.
- The 2009 MCR reflected a physician cost adjustment erroneously overstated by $312,000.
- The Centers for Medicare and Medicaid Services (CMS) made a $900,000 adjustment to NHH's fiscal year 2009 MCR. The adjustment reduced the amount owed to NHH. When the auditors inquired as to the nature of the adjustment, NHH reported it did not know but presumed the adjustment related to timing issues. According to CMS, the adjustment related to NHH not reporting Medicare's pass-through payments related to bad debt in the determination of total provider payments on the MCR. While CMS agreed its instructions for completing the MCR were not clear in this regard, it would have been prudent for NHH to inquire as to the basis of CMS' $900,000 adjustment to its MCR, both to consider whether the adjustment was appropriate and also to consider whether NHH needed to revise its MCR preparation process going forward.

Prior to the auditor's inquiry, NHH was unaware of these errors in its preparation of the MCRs.

Historically, one NHH employee has been responsible for completing the MCRs. This employee compiles information obtained from NHH, the Department of Health and Human Services (Department), and other sources for posting to the MCR.

A similar comment was noted in the prior audit report.

*Recommendation:*

NHH should establish effective controls for accumulating and reporting complete and accurate MCR information. Controls should include, but not be limited to, improving communication with other State organizations, including the Department and the State Treasury, to obtain current and accurate information relative to the cost of operating NHH. NHH should also ensure it provides its employees with the appropriate training, information, and resources to accurately prepare the MCR.

NHH should establish an effective review and approval control to promote the timely detection and correction of errors in the preparation of the MCR, review any subsequent CMS adjustments made to the MCR, and make any necessary changes to the MCR preparation process, as appropriate.

*Auditee Response:*

We concur. NHH agrees that it was not aware of the errors found on the MCR. The responsibility for the preparation of the MCR over the last several years has changed Divisions within the Department as well as by individuals within the agency. The documentation

supporting the bond for the original construction of the Acute Psychiatric Services building 20 years ago have not been found. NHH has consulted with the State agencies involved at the time to retrieve the documents with no success at this time.

NHH will be training another individual for backup for the preparation of this report. We will also continue to request attendance for any educational and training opportunities to ensure that the report is being prepared accurately. Previous requests for this specialized training, which are generally held out-of-state, have been denied due to funding issues.

**Observation No. 27: Classification Of Accounts In Client Banking System Should Be Reviewed**

*Observation:*

NHH maintains a client banking system that accounts for approximately 230 fiduciary and other NHH accounts at any given time. The balance and activity in the client banking system is held in, and transacted via, a checking account outside of the State's accounting system. NHH reports the financial activity in the banking system to the Department of Administrative Services (DAS) as a single agency fund for inclusion in the State's comprehensive annual financial report, even though the accounts in the banking system include private-purpose trust funds, permanent funds and likely other governmental funds, as well as agency funds. At March 31, 2011, the balance in the client banking system was approximately $174,000. Total receipts and disbursements processed through the checking account during the nine months ended March 31, 2011 were approximately $535,000 and $553,000, respectively.

The Governmental Accounting Standards Board in its *Codification of Governmental Accounting and Reporting Standards* (*GASB Codification*), section 1300.114, states, "*Agency funds* should be used to report resources held by the reporting government in a purely custodial capacity (assets equal liabilities). Agency funds typically involve only the receipt, temporary investment, and remittance of fiduciary resources to individuals, private organizations, or other governments."

Permanent funds are defined in *GASB Codification* section 1300.108 as "resources that are legally restricted to the extent that only earnings, and not principal, may be used for purposes that support the reporting government's programs – that is, for the benefit of the government or its citizenry."

*GASB Codification* section 1300.113 states, "*Private–purpose trust funds,* such as a fund used to report escheat property, should be used to report all other trust arrangements under which principal and income benefit individuals, private organizations, or other governments."

NHH reported that it was unaware that it should categorize and report the banking system accounts as permanent or other governmental funds, agency funds, or private-purpose trust funds.

Of the $174,000 March 31, 2011 balance in the client banking system, approximately $64,000 was properly classified as agency funds. The remaining balance consisted of approximately $50,000 of permanent funds, $20,000 of private-purpose trust funds, $9,000 of funds where the classification was unclear, and $31,000 of State General Funds.

*Recommendation:*

NHH should review the accounts within its client banking system with DAS to ensure the NHH can report the accounts in the proper classifications for the State's financial reporting purposes.

*Auditee Response:*

NHH concurs that it does report the balance in the client banking system as a single agency fund and has been doing so for many years.

NHH has requested and received from the LBA the detail that categorizes the $174,000 into the accounts as defined and will review the classifications. Once NHH reviews this list, we will seek guidance from the NH State Treasury Department and DAS. Once we get input from Treasury and DAS, this response should be completed.

**Observation No. 28: Use Of Client Banking System Should Be Reviewed**

*Observation:*

NHH and the Department of Health and Human Services (Department) have used NHH's client banking system checking account to process financial transactions that should be processed and recorded in the State's accounting system (NHFirst) or other accounts. The State Treasurer does not have signatory authority over this account.

1. In October 2010, NHH received a $10,000 grant from the New Hampshire Hospital Association for emergency preparedness. NHH deposited the funds in the client banking system. On December 8, 2010, NHH submitted a request to Governor and Council for approval "to accept and expend" the $10,000 grant. The Hospital requested that the funds be budgeted in NHFirst revenue and expenditure accounts. The request was approved and NHH's NHFirst revenue and expenditure budgets were increased to accommodate the additional funds.

   As of March 31, 2011, NHH had not transferred the grant funds to the NHFirst accounts nor had it deposited the money with the State Treasurer. NHH had spent approximately $2,500 of the grant funds directly out of the client banking system checking account.

2. During March 2011, NHH deposited an additional $7,000 from the New Hampshire Hospital Association into a client banking system account and expended $398 from that account prior to submitting a request to Governor and Council for authority to accept and expend those funds.

3. NHH allows the Department's Office of Reimbursement to use the client banking system to hold balances and process transactions related to its activities. During the nine months ended March 31, 2011, approximately $43,000 related to the Office of Reimbursement's activities was deposited into, and $54,000 was disbursed out of, the client banking system bank account. At March 31, 2011, the balance of Office of Reimbursement funds in the client banking system was approximately $23,000. Other than processing the transactions, NHH employees responsible for processing and approving transactions in the client banking system have no operational knowledge of, or provide effective fiscal control over, this financial activity. A similar comment was noted in the prior audit report.

The NHH client banking system and checking account were presumably established for the purpose of accepting, holding, and disbursing fiduciary monies of NHH. It is not clear if the account was also intended to be used to transact NHH business that should be accounted for in NHFirst, or to provide banking services for another section of the Department. It is also not clear if the controls over the NHH banking system are appropriate for those additional purposes.

*Recommendation:*

NHH should not use or allow others to use the client banking system for purposes unrelated to the client banking system's purpose. The client banking system should not be used to process transactions that would be more appropriately accounted for in NHFirst or other financial systems, especially if the use of the client banking system would not subject those transactions to State or other control activities that would be present in those other, more appropriate, financial systems.

The State Treasurer should be added as an authorized signatory on this checking account in the event direct access to the account or account information is ever needed.

*Auditee Response:*

Item No. 1, we concur. The lack of transferring the money from the Client Banking System (Avatar) to NH First was an oversight by NHH. We agree that this should have been done as soon as it was approved by Governor and Council. The amount was recorded in the correct fiscal year as it was transferred to NH First in June 2011.

Item No. 2, we concur. As of May 9, 2011, a request for Governor and Council approval was being developed but had not been submitted. Governor and Council approval to accept and expend $7,000 was approved on May 25, 2011. The amount of this grant was transferred to NH First in June, 2011.

Comment on both Items 1 and 2: NHH had been using the Avatar system as a holding account for these funds until Governor & Council approval was received to accept and expend. That process has been eliminated due to NHH requesting through the budget cycle that as of State fiscal year 2012, a revolving account be set up for these funds. Effective July 1, 2011 any grant money received will be deposited directly into NH First.

Item No. 3, we do not concur. NHH has had an agreement with the Office of Reimbursement, to utilize our client banking system for many years. NHH works closely with and has a unique relationship with this Office on several matters regarding clients (i.e., Transitional Housing Services, insurance, eligibility) and this arrangement of temporarily holding funds until estates are finalized has worked well.

We will seek direction from NH State Treasury Department as to adding them as an authorized signatory on this account.

**Observation No. 29: Signatory Authority And List Of Authorities Should Be Current**

*Observation:*

NHH has not been consistently timely in updating its authorized signature lists upon changes in employee status.

At March 31, 2011, two separate authorized signature lists were not current.

1. The authorized signature list for two NHH bank accounts each included two employees who had previously terminated employment. One of the signatories terminated NHH employment in 2009.

2. The list of employees having current NHH power of attorney filed with the Department of Administrative Services included two employees who both terminated NHH employment in 2009.

*Recommendation:*

NHH should establish policies and procedures to timely update signatory authorities and lists of authorities upon changes in employee status, and periodically review those lists to ensure the lists remain current.

As recommended in Observation No. 28, the State Treasurer should be added as an authorized signatory on the NHH bank accounts in the event direct access to the accounts and account information is ever needed.

*Auditee Response:*

We concur. The NHH Internal Auditor will be assigned to perform quarterly audits of all signatory lists to ensure accuracy and relevance. NHH will also consult with the State Treasurer to determine appropriateness in being added as an authorized signatory. If deemed appropriate, NH Department of Treasury will be added as an authorized signatory.

## Federal Compliance Comments

### Observation No. 30: Disproportionate Share Hospital Cost Recoupment Should Comply With Federal Rules

*Observation:*

NHH estimates $9.8 million of the federal Disproportionate Share Hospital (DSH) revenues it received during the nine months ended March 31, 2011 represented the recoupment of its costs for care provided to patients with some level of health insurance during that period.

Under Section 1923(g)(1)(A) of Title XIX of the Social Security Act (Act), a hospital's DSH payments may not exceed the costs incurred by that hospital in furnishing services during the year to Medicaid patients and individuals "who have no health insurance (or other source of third party coverage) for services provided during the year", less other Medicaid payments made to the hospital and payments made by the uninsured patients for those services (uncompensated care costs).

In a December 19, 2008 Final Rule reported at 42 Code of Federal Regulations (CFR) Parts 447 and 455, the Centers for Medicare and Medicaid Services (CMS) states "We have always read [Section 1923(g)(1)] to distinguish between care furnished to individuals who have health insurance or other coverage, and care furnished to those who do not. We have never read this language to be service-specific and we believe that such an interpretation would be inconsistent with the broad statutory references to insurance or other coverage."

NHH's recoupment through DSH of costs for care provided to patients with some level of health insurance appears noncompliant with CMS' 2008 explanation of federal Medicaid program rules.

*Questioned costs:*

Federal participation in Medicaid DSH Program for insured patients: $9.8 million.

*Recommendation:*

NHH should review its practice of not limiting its DSH claims to the otherwise unrecovered cost of inpatient hospital care provided to Medicaid patients and the uninsured.

NHH should contact CMS to determine a resolution of the noted questioned costs.

*Auditee Response:*

NHH does not concur with LBA audit finding 30 for the following reasons. LBA has questioned costs in the amount of $9.8 million in federal participation for Medicaid Disproportionate Share Hospital payments (DSH) for the 9 months ending March 2011. This observation is based upon an interpretation that is more harsh than the federal law and process supports. Further, LBA is

seeking to construct its own version of an audit of NHH DSH calculations for state Medicaid year 2011 without adhering to the scrupulously prescribed requirements required of the independent auditors under the federal DSH audit rules and is performing its audit three years in advance of the independent auditors' review which is not scheduled to be conducted until 2014. By doing so, LBA injects uncertainty and unreliability into a complex process strictly governed by federal requirements and protocols. This observation fails to consider relevant facts and law, including recent CMS communications which directly support DHHS position and which do not support LBA's conclusions.

Section1902 (a)(13)(A)(iv) of the Social Security Act, which was established in 1981, allows States to make Medicaid payment adjustments for hospitals that serve a disproportionate share of low-income patients with special needs. Section 1923 (g) of the Act provides specific guidance regarding hospital-specific DSH payments. Section 1923 (g) of the Act states that DSH payment for uncompensated costs shall not exceed the costs of furnishing hospital services to "individuals *who are either eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage)* ***for services provided during the year****..." (Emphasis added).*

Over time, CMS sought to standardize and provide more specific direction to the States regarding its expectations for the DSH program. In a State Medicaid Director Letter (SMDL) dated August 17, 1994, CMS clarified that the term "uninsured patients" included instances where there was no insurance for the specific services which an individual received.

"Uninsured patients One of the key provisions in the limit is the determination of which of a hospital's patients 'have no health insurance or source of third party payment for services provided'. A number of States have asked about the meaning of this provision, and whether it includes, for example, individuals with indemnity policies, or individuals whose policies contain day limits that are exhausted. HFCA believes it would be permissible for States to include in this definition individuals who do not possess health insurance which would apply to the service for which the individual sought treatment." (SMDL dated August 17, 1994, at pg 4.)

In 2003, against a national backdrop of questions and concerns about growth in the DSH program, Congress added an annual reporting and auditing requirement for each state's DSH program. However, Congress did not substantively change the definition or requirements relative to "uninsured" (Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003, adding Section 1923(j)(c) of the Act.).

To implement the MMA Act of 2003, CMS proposed rules in 2005, which were issued in a final form in 2008 (73 FR 77904-77952, December 19, 2008) codified at 42 CFR 455.304 and 42 CFR 447.299. The regulatory language was consistent with the statutory language that uninsured meant uninsured "for the services [individuals] received." Compare Section1902(a)(13)(A)(iv) with 42 CFR 455.304(d)(3), (4) and (6) ("Individuals with no third party coverage for the inpatient and outpatient hospital **services they received**"). It was only in a comment on the final DSH audit rule, related to bad debt arising from a lack of prior authorizations or from claims submitted too late as not being properly considered "uninsured" that CMS interpreted the phrase "who have health insurance" "to refer broadly to individuals who have creditable coverage

consistent with the definitions under 45 CFR parts 144 and 146" (73 Federal Register 77911). However, 45 CFR parts 144 and 146 were designed for a different purpose than the DSH audit rule. 45 CFR 144 and 146 were intended to address health insurance portability for group health plans. This is unlike the DSH audit rule, 42 CFR 447, which was for the purposes of calculating uncompensated care under DSH and which expressed this uninsured term in different language, "no health insurance (or other source of third party coverage) *for services provided during the year."* CMS's current interpretation of insured for purposes of calculating uncompensated care as relating only to the person and not to the services that person receives is inconsistent with the explicit language contained in Section1902 (a)(13)(A)(iv) of the Social Security Act, CMS's direction to State Medicaid Directors in the SMDL dated August 1994 and even with the plain language in the audit regulations themselves.

The independent NH DHHS DSH auditors, Clifton Gunderson, have reflected CMS's changing interpretation regarding how to construe the term "uninsured" for purposes DSH calculations. Their guidance from December 2010 to March 2011 reflected CMS emerging and narrower construction of the term as no longer being related to ***"services provided during the year,"*** (Section 1923 (g) of the Act), but instead as having the limited meaning of individuals lacking any "creditable coverage" (comment at 73 FR 77911). During the audit, DHHS pointed out to LBA that it understood that CMS was continuing to examine and reconsider its interpretation of 'uninsured" for purposes of DSH. During the audit and before the final findings were issued, on January 17, 2012, CMS issued a communication on proposed rulemaking that defines uninsured as having no insurance for the service provided. See CMS publication "CMS 42 CFR Part 447; Medicaid Program; Disproportionate Share Hospital Payments – Uninsured Definition; Proposed Rule."

CMS stated in that publication at page 12, "For purposes of defining uncompensated care costs for the Medicaid hospital-specific DSH limit, we believe that uncompensated costs of providing inpatient and outpatient hospital services to individuals who do not have coverage for those specific services should be considered costs for which there is no liable third party payer and thus eligible for Medicaid DSH payments."

NHH acknowledged that it must comply with the then current CMS interpretation of Section 1923(g)(1)(A) and 42 CFR 455.304 as CMS construed the term uninsured in its more limited form, while raising questions about the appropriateness of that interpretation. Accordingly, NHH had been actively engaged in making the necessary changes to conform with CMS's current interpretation and requirements.

CMS intended the implementation of the DSH audit rules, which includes a grace period for State Medicaid years 2005 through 2010, be used by States as a learning process. "Findings from Medicaid State plan years 2005 through 2010 will be used only for the purpose of determining prospective hospital specific eligible uncompensated care cost limits and associated DSH payments." 73 FR 77948.

Clifton Gunderson's first audit reports which covered years 2005, 2006 and 2007 were completed as recently as December 2010. Each December thereafter, a subsequent year is scheduled to be audited by the independent auditors. The Clifton Gunderson audits for years

2005 through 2010 are progressing effectively. Medicaid State plan rate year 2011, the first year in which DSH reimbursement could potentially result, has not yet been reviewed by the federal audit process. This will occur in the normal course of events in 2014. LBA will certainly have a full opportunity to scrutinize Clifton Gunderson's independent audit findings related to NHH DSH for Medicaid State plan rate year 2011 when that process is properly completed in 2014.

The DSH audit process for 2005 through 2010 is designed to allow hospitals and states to adjust to CMS's current requirements. This carefully designed federal process also allows CMS to review and adjust its interpretations in light of its national experience with the complexities in this area. DHHS has heard from several sources that CMS is reconsidering or reviewing its interpretation of the term "insured."

NHH raised concerns regarding CMS' restrictive interpretation in the context of responding to the Clifton Gunderson statewide DSH audit. NHH expressed its view that as a State owned and operated inpatient psychiatric facility, NHH provides mental health services to a higher percentage of individuals who have no source of third party coverage "for the services they received" when compared to general hospitals or special rehabilitation hospitals in New Hampshire. We point out this distinction because, during the audit period, NHH has relied on Section 1923(g)(1)(A) of the Social Security Act, which in describing uncompensated costs states in pertinent part *"...individuals who are either eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year..."* to allow NHH to include in its calculation of uncompensated costs those who may have **some** form of health insurance or other source of third party coverage, but who have no such insurance or coverage for the services they received at NHH.

As New Hampshire's only inpatient psychiatric facility and only public hospital, NHH delivers mental health services to patients who are civilly committed to NHH by New Hampshire courts for extended periods of time. Except for a small percentage of patients who have been voluntarily admitted, every patient at NHH has been determined by a court to be a danger to themselves or others. NHH must treat a patient's psychiatric needs before moving the patient to a less restrictive treatment environment. Mental health services as delivered by NHH very often are not covered by health insurance. Even in those limited instances where insurance does cover these services, the length of stay that is often necessary to stabilize, treat and then discharge a patient to a less restrictive setting is often longer than the insurance coverage or the patient has already exhausted a lifetime benefit for his or her inpatient psychiatric stay due to a serious and persistent mental illness.

Even as NH was communicating its concerns about the unintended and undermining impact on the DSH program that would arise from a narrow interpretation of the term uninsured, many other states were also communicating their serious concerns as well. CMS observed in recent proposed rulemaking communication: "After publication of the 2008 DSH final rule, numerous states, members of Congress, and related stakeholders expressed their concern that the 2008 DSH final rule definition of the uninsured deviated from prior guidance and would have a significant financial impact on States and hospitals. The proposed rule is designed to mitigate some of the unintended consequences . . . and to provide additional clarity on which costs can be considered uninsured costs for purposes of determining the hospital-specific limit." Id at 6.

CMS acknowledged in its communication that in an effort to adhere to an accurate representation of the broad statutory references to insurance and other coverage, its 2008 final DSH definition was not the same as the guidance provided to the States and providers in 1994. CMS proposed rulemaking at 5.

In light of the significant history with regard to DSH and meaning of "uninsured" for purposes of calculating uncompensated care, LBA's suggestion that NHH has been acting outside the established boundaries of law is not a proper conclusion. It is not grounded in the significant statutory and regulatory history that informs this issue. CMS' recent communication and proposed rulemaking not only makes this clear, it also provides direction with respect to the audited year, that NHH may properly include in its DSH calculation costs for individuals "who do not have coverage for those specific services." Id at pages 12 and 16.

"This interpretation and definition of 'uninsured' affords States and hospitals maximum flexibility permitted by statute in calculating the hospital-specific DSH limit. This proposed **clarification would be effective for DSH audits and reports submitted following the effective date of the rule**, thus avoiding any unintended and potentially significant financial impact resulting from the 2008 DSH final rule." Id at 16 (emphasis added). See also CMS proposed rulemaking at 13-14 ("for purposes of calculating the hospital-specific DSH limit as described in section 1923 (g) of the Act **effective for 2011.**")

NH DHHS does not concur with the dollar amounts that LBA has estimated to be questioned DSH payments. As expressed within, the interpretation of the term uninsured had been unsettled but for the audit year has been clarified to mean individuals who do not have insurance for the specific service. CMS has explicitly stated that its clarification is effective for audits submitted after the rule is effective and is effective for 2011. The NHH 2011 DSH program will be audited by Clifton Gunderson in 2014. Given this factual and legal context, LBA does not have a reasonable basis for questioned costs of $9.8 million related to the inclusion of uninsured costs for services for which the individual had no coverage at NHH during 2011.

Additionally, from a factual perspective, LBA did not properly analyze NHH data to form a reasonable basis of the questioned costs for the 9 months ending March 2011, even if the interpretation of "uninsured" was the one upon which it relies. To form a more accurate estimate, one would need to review the DSH payments actually claimed by NHH for the relevant periods and consider their aggregate impact for the Medicaid State plan rate year 2011. Accordingly, one would need to take into account, among other things, that DSH payments were not claimed for the quarter ending June 2011. It is also worth noting that DSH claims were adjusted for the quarter ending September 2011 based on CMS's current narrower interpretation of the term uninsured. Moreover, the federal audit rule establishes a grace period through Medicaid State plan rate year 2010, yet LBA appears to include a quarter from that grace period in its calculation of possible DSH reimbursement. This has led to an over inflated the risk of questioned costs for DSH even if the interpretation of "uninsured" were as described by LBA, which it is not the case.

For these reasons, DHHS respectfully disagrees and requests that LBA withdraw audit Finding #30.

*LBA Rejoinder:*

The Final Rule in question was published in the Federal Register approximately three years ago on December 19, 2008 and is one of several Medicaid Program rules and regulations against which we were required to audit NHH's compliance. NHH reports in its response that it "acknowledged that it must comply with the then current CMS interpretation of Section 1923(g)(1)(A) and 42 CFR 455.304 as CMS construed the term uninsured in its more limited form, while raising questions about the appropriateness of that interpretation. Accordingly, NHH had been actively engaged in making the necessary changes to conform with CMS's current interpretation and requirements." NHH acknowledges it was not in compliance with the rule, yet disagrees with the Observation.

NHH wrongly suggests the LBA is "seeking to construct its own version of an audit of NHH DSH calculations" under the December 19, 2008 final rule and that our interpretation of this rule is somehow "more harsh than the federal law and process supports." The LBA conducted an audit of the NHH, of which Medicaid revenue, including DSH, was a part. The DSH audit to which NHH refers is very different in purpose and scope than the LBA audit and the two should not be confused.

On January 18, 2012 CMS proposed a rule change which, if enacted, would define uninsured consistent with NHH's practice during the audit period and could make the above observation and recommendation moot. As this was only a proposed rule change at the time of this report, the LBA stands by its comment.

**Observation No 31: Medicare Compliant Certifications Should Be Prepared**

*Observation:*

NHH's process for certifying the results of regular, medical-professional evaluations and determinations of patients' medical status during the nine months ended March 31, 2011 did not fully comply with Medicare Program requirements intended to ensure that Medicare pays only for services of the type appropriate for Medicare coverage.

According to 42 CFR 424.14 (a), "Medicare Part A pays for inpatient care in a psychiatric hospital only if a physician certifies and recertifies the need for services consistent with the content of paragraphs (b) [initial certifications] or (c) [recertifications] of this section as appropriate."

In addition to other requirements of these recertifications, paragraph (c)(2) requires recertifications consistent with the statement:

> "(2) The hospital records show that the services furnished were –
>
> (i) Intensive treatment services;
> (ii) Admission and related services necessary for diagnostic study; or

(iii) Equivalent services."

While during the audit period NHH's patient certification procedures appeared to meet the content requirements for the initial certification of a Medicare patient, NHH's procedures for recertifying Medicare patients did not include a certification compliant with 42 CFR 424.14 (c)(2), as noted above.

*Questioned costs:*

Medicare revenues claimed for Medicare patient days subsequent to the 12th day of hospitalization during the nine months ended March 31, 2011: Unable to determine.

*Recommendation:*

NHH should 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.

NHH should contact the Centers for Medicare and Medicaid Services (CMS) to determine a resolution of the noted questioned costs.

*Auditee Response:*

We concur in part. While we concur that NHH's Medicare recertification stamp did not use the precise language contained in 42 CFR 424.14(c)(2), the recertification stamp did comply with 42 CFR 424.14(c)(2) as it was "consistent with" and "appropriate." Nevertheless, we are modifying the recertification stamp language to include the precise language referred to by LBA in order to eliminate possible confusion or questions.

NHH's recertification stamp, dated and signed by medical personnel, is affixed directly to the hospital medical record. It stated:

> *"The actively supervised inpatient psychiatric care furnished daily since the previous certification or recertification continues to be medically necessary and could reasonably be expected to improve the patient's condition."*

While it is true, as LBA has expressed that NHH did not use the words "hospital records show" in its recertification stamp, the recertification itself was stamped directly on the individual's hospital medical records that showed necessary inpatient psychiatric hospital services being furnished to the individual. In fact, in some instances not only was the signature of the medical professional on the doctors' progress notes the same person's signature as on the certification stating that the individual was receiving actively supervised inpatient care, but also it was on the very same page, directly above or below each other. Where the recertification was stamped directly on the individual's medical record, read in context it is clear that the medical professional was certifying

not only that the services were furnished but also that the hospital records to which it was stamped showed that these services were being furnished.

NHH believes it has complied with the recertification requirements of 42 CFR 424.14(c)(1) and (c)(3) and has properly recertified that inpatient psychiatric hospital services furnished to the individuals were and continued to be required for treatment that could reasonably be expected to improve the patient's condition and that "the patient continues to need, on a daily basis, active treatment furnished directly by or requiring the supervision of inpatient psychiatric care."

While NHH's recertification stamp did not use the exact words of 42 CFR 424.14 all that is required is that the language be consistent with and as appropriate with 42. CFR 424.14 and, taken as a whole, this was done.

DHHS does not believe that there are inappropriate claims to discuss with CMS.

*LBA Rejoinder:*

We do not agree with NHH's assertion that its certification stamp was compliant with 42 CFR 424.14 (c)(2), taken as a whole. That CFR requires a certification signed by a physician regarding the hospital's records. NHH's certification stamp makes no mention of hospital records.

In 42 CFR 424.14 (a), CMS explains the content requirement for certification and recertification statements for psychiatric hospitals "differ from those of other hospitals because the care furnished in psychiatric hospitals is often purely custodial and thus not covered under Medicare. The purpose of the statements, therefore, is to help ensure Medicare pays only for services of the type appropriate for Medicare coverage."

## State Compliance Comments

### Observation No. 32: Patient Personal Fund Statements Should Be Issued At Least Quarterly

*Observation:*

NHH is not in full compliance with the provisions of RSA 151:24, III, which require health facilities to provide patients or their personal representatives with a quarterly statement of the patients' funds and possessions held by the facility. While NHH reports it provides monthly statements to the Office of Public Guardian for those patients under their representation, it does not provide statements to other patients unless requested, contrary to RSA 151:24, III.

*Recommendation:*

NHH should provide personal fund statements to all patients at least quarterly.

*Auditee Response:*

We concur. NHH does not provide patients with quarterly statements but does make all parties aware of the availability of a statement upon request. Historically, NHH has found that the truly psychotic patient does not have the interest nor understanding of what is presented, often compounding an already confusing situation for the patient. Although not in full compliance with the provisions of the statute, interested parties are well informed of the availability of statements should they require one. NHH will consult with the DHHS legal department to consider a law change to reflect this.

### Observation No. 33: Statutory Requirements For Reporting Certain Trust Funds Should Be Reviewed

*Observation:*

NHH has not maintained the accounting nor performed the reporting required by RSA 11:4 for certain trust funds.

Pursuant to RSA 11:4, "The agencies designated to administer the Catherine Fiske Legacy for the benefit of the state hospital [and] the Jacob Kimball Legacy for the benefit of the state hospital... shall keep appropriate bookkeeping records, showing on an annual basis the amount of each trust fund and the profits and income allocable to each trust. A copy of such records shall be approved annually by the governor and council and filed with the state treasurer."

The State Treasurer has custody of approximately 50 NHH funds similar to, and including, the above mentioned funds with a total balance of approximately $5.9 million. Some of these funds date back to original gifts made to NHH in the 1850s. Each of these funds has a separate but

related purpose supporting NHH, its patients, and its activities. The balance in these accounts has accumulated over a number of years since the funds were established. Currently, there is no separate accounting of the balances in the individual funds maintained by either NHH or the State Treasurer. The combined balance in these funds is reported annually in the State's comprehensive annual financial report as NHH permanent funds.

Because neither NHH nor the State Treasurer maintains detailed bookkeeping records of individual fund activity, NHH can neither report the current balance or other records of the Catherine Fiske Legacy and Jacob Kimball Legacy donations to the Governor and Council nor file the records with the State Treasurer in accordance with the statute.

*Recommendation:*

NHH should perform the recordkeeping and reporting for the Catherine Fiske Legacy Fund and the Jacob Kimball Legacy Fund required by statute.

If NHH determines that the statutory recordkeeping and reporting requirement no longer benefits NHH and the State, NHH should request an appropriate statutory revision.

*Auditee Response:*

We concur in part. Because of the age of many of these funds, it would be a very challenging and time-consuming task to go back in time to the 1850s to recreate the individual fund activity. NHH will consult with NH Department of Treasury to determine what degree of statutory record keeping and reporting, if any, serves to benefit the State. NHH will, however, follow statute regarding these two funds and will work with Treasury to develop procedures to ensure compliance.

JEFFRY A. PATTISON
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# State of New Hampshire

OFFICE OF LEGISLATIVE BUDGET ASSISTANT
State House, Room 102
Concord, New Hampshire 03301

RICHARD J. MAHONEY, CPA
Director, Audit Division
(603) 271-2785

## Independent Auditor's Report

*To The Fiscal Committee Of The General Court:*

We were engaged to audit the accompanying financial statements of the New Hampshire Hospital as of and for the nine months ended March 31, 2011, as listed in the table of contents. These financial statements are the responsibility of the New Hampshire Hospital's management.

The New Hampshire Hospital does not have sufficient systems in operation to account for and report revenues from services provided to patients and residents or to report and account for its agency funds.

Since the New Hampshire Hospital did not have sufficient systems in place and we were not able to apply other auditing procedures to satisfy ourselves as to Hospital revenues and agency fund activity, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on these financial statements.

In accordance with *Government Auditing Standards,* we have also issued a report dated December 23, 2011 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* and should be considered in assessing the results of our work.

Office of Legislative Budget Assistant

Office Of Legislative Budget Assistant

December 23, 2011


TDD Access: Relay NH 1-800-735-2964

**STATE OF NEW HAMPSHIRE**
**NEW HAMPSHIRE HOSPITAL**

**STATEMENT OF REVENUES AND EXPENDITURES**
**GENERAL FUND - UNAUDITED**
**FOR THE NINE MONTHS ENDED MARCH 31, 2011**

| | |
|---|---|
| **Revenues** | |
| **Unrestricted Revenues** | |
| Medicare | $ 4,669,523 |
| Board-State Hospital | 2,475,191 |
| Medicaid-Children Services | 1,612,417 |
| **Total Unrestricted Revenues** | **8,757,131** |
| **Restricted Revenues** | |
| Medicaid Disproportionate Share | 16,396,205 |
| Board-Transitional Housing | 1,127,246 |
| Cafeteria Sales | 463,257 |
| Board-Children Services | 146,405 |
| User Fees And Other | 103,502 |
| Trust Funds | 50,122 |
| **Total Restricted Revenues** | **18,286,737** |
| **Total Revenues** | **27,043,868** |
| **Expenditures** | |
| Salaries And Benefits | 39,356,081 |
| Contracted Psychiatric Services | 4,496,850 |
| Prescription Drugs | 900,911 |
| Heat-Electricity-Water | 853,375 |
| Contracted Food And Nutrition Services | 671,161 |
| Current Expenses | 616,508 |
| Maintenance Building And Grounds | 519,853 |
| Security Services | 508,583 |
| Medical Providers | 505,533 |
| Other | 308,490 |
| Trust Funds | 97,176 |
| **Total Expenditures** | **48,834,521** |
| **Excess (Deficiency) Of Revenues Over (Under) Expenditures** | **(21,790,653)** |
| **Other Financing Sources (Uses)** | |
| Net Appropriations (Note 2) | 30,547,784 |
| **Total Other Financing Sources (Uses)** | **30,547,784** |
| **Excess (Deficiency) Of Revenues And Other Financing Sources Over (Under) Expenditures And Other Financing Uses** | **$ 8,757,131** |

The accompanying notes are an integral part of this financial statement.

# STATE OF NEW HAMPSHIRE
# NEW HAMPSHIRE HOSPITAL

## BALANCE SHEET
## PERMANENT FUNDS - UNAUDITED
## MARCH 31, 2011

| | |
|---|---|
| **Assets** | |
| Cash And Cash Equivalents | $ 293,503 |
| Investments | 5,590,985 |
| **Total Assets** | **5,884,488** |
| **Liabilities** | |
| Liabilities | **-0-** |
| **Fund Balance** | |
| Restricted | 5,884,488 |
| **Total Liabilities And Fund Balance** | **$ 5,884,488** |

The accompanying notes are an integral part of this financial statement.

## STATE OF NEW HAMPSHIRE
## NEW HAMPSHIRE HOSPITAL

## STATEMENT OF REVENUES, EXPENDITURES, AND CHANGES IN FUND BALANCE
## PERMANENT FUNDS - UNAUDITED
## FOR THE NINE MONTHS ENDED MARCH 31, 2011

| | |
|---|---|
| **Revenues** | |
| Interest And Dividends | $ 118,449 |
| Miscellaneous | 715,218 |
| **Total Revenues** | **833,667** |
| **Expenditures** | |
| Trustee Fees | 20,540 |
| Payments To Beneficiaries | 50,123 |
| **Total Expenditures** | **70,663** |
| **Excess (Deficiency) Of Revenues Over (Under) Expenditures** | **763,004** |
| Fund Balance July 1, 2010 | 5,121,484 |
| **Fund Balance March 31, 2011** | **$ 5,884,488** |

The accompanying notes are an integral part of this financial statement.

**STATE OF NEW HAMPSHIRE**
**NEW HAMPSHIRE HOSPITAL**

## STATEMENT OF CHANGES IN ASSETS AND LIABILITIES
## NEW HAMPSHIRE HOSPITAL PATIENT BANKING ACCOUNT
## AGENCY FUND - UNAUDITED
## FOR THE NINE MONTHS ENDED MARCH 31, 2011

| | Balance July 1, 2010 | Additions | Deletions | Balance March 31, 2011 |
|---|---|---|---|---|
| **Assets** | | | | |
| Cash And Cash Equivalents | $ 191,796 | $ 535,271 | $ 552,771 | $ 174,296 |
| **Total Assets** | **191,796** | **535,271** | **552,771** | **174,296** |
| **Liabilities** | | | | |
| Custodial Funds Payable | 191,796 | 535,271 | 552,771 | 174,296 |
| **Total Liabilities** | **$ 191,796** | **$ 535,271** | **$ 552,771** | **$ 174,296** |

The accompanying notes are an integral part of this financial statement.

STATE OF NEW HAMPSHIRE
NEW HAMPSHIRE HOSPITAL

NOTES TO THE FINANCIAL STATEMENTS -UNAUDITED
FOR THE NINE MONTHS ENDED MARCH 31, 2011

## NOTE 1 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The accompanying financial statements of the New Hampshire Hospital have 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. Financial Reporting Entity

New Hampshire Hospital (Hospital), a component of the New Hampshire Department of Health and Human Services, is an organization of the primary government of the State of New Hampshire (State). The accompanying financial statements report the financial activity of the Hospital.

The financial activities of the Hospital are accounted for and reported in the State's General, Permanent, and Agency Funds in the State'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 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 financial statement is not intended to show the financial position or fund balance of the Hospital in the General Fund.

### B. Financial Statement Presentation

The State and Hospital use funds to report on their financial position and the results of their operations. Fund accounting is designed to demonstrate legal compliance and to aid financial management by segregating transactions related to certain government 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 Types:

*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.

*Permanent Fund:* The Permanent Fund reports resources that are legally restricted to the extent that only earnings, and not principal, may be used for purposes that benefit the state or its citizenry.

Fiduciary Fund Types:

*Agency Fund:* An agency fund reports assets and liabilities for deposits and other investments entrusted to the State as an agent for others.

**C. 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 the liabilities of the current period. For this purpose, except for federal grants, the State generally considers revenues to be available if they are collected within 60 days of the end of the current fiscal period. Expenditures generally are recorded when a liability is incurred, as under accrual accounting. However, expenditures related to debt service, compensated absences, and claims and judgments are recorded only when payment is due.

Fiduciary fund financial statements are reported using the economic resources measurement focus and the accrual basis of accounting. Revenues are recorded when earned and expenses are recorded when a liability is incurred, regardless of the timing of related cash flows.

**D. Revenues And Expenditures**

In the governmental fund financial statements, revenues are reported by source. For budgetary control purposes, revenues are further classified as either "general purpose" or "restricted". General purpose revenues are available to fund any activity accounted for in the fund. Restricted revenues are, either by State law or by outside restriction (e.g., federal grants), available only for specified purposes. Unused restricted revenues at year end are recorded as reservations of fund balance. When both general purpose and restricted funds are available, it is the State's policy to use restricted revenues first. In the governmental fund financial statements, expenditures are reported by function.

**E. Budget Control And Reporting**

*General Budget Policies*

The statutes of the State 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 that 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. Since the Capital Projects Fund comprises appropriations for multi-year projects, it is not included in the budget and actual comparison schedules in the State CAFR. Fiduciary Funds are not budgeted.

In addition to the enacted biennial operating budget, the Governor may submit to the Legislature supplemental budget requests necessary to meet expenditures during the current biennium. Appropriation transfers can be made within a department without the approval of the Legislature; therefore, the legal level of budgetary control is at the departmental level.

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 lapse to undesignated 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 reservation of fund balance. Unexpended encumbrances are 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.

Contracts and purchasing commitments are recorded as encumbrances when the contract or purchase order is executed. Upon receipt of goods or services, the encumbrance is liquidated and the expenditure and liability are recorded. The Hospital's unliquidated encumbrance balance at March 31, 2011 in the General Fund was $5,240,514.

A Budget To Actual Schedule - General Fund is included as supplementary information.

## NOTE 2 - NET APPROPRIATIONS

Net appropriations reflect appropriations for expenditures in excess of restricted revenue.

## NOTE 3 - EMPLOYEE BENEFIT PLANS

*New Hampshire Retirement System*

The Hospital, as an organization of the State government, participates in the New Hampshire Retirement System (Plan). The Plan is a contributory defined-benefit plan and covers all full-time employees of the Hospital. The Plan qualifies as a tax-exempt organization under Sections 401 (a) and 501 (a) of the Internal Revenue Code. RSA 100-A established the Plan and the contribution requirements. The Plan, which is a cost-sharing, multiple-employer Public

Employees Retirement System (PERS), 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 assets are in a single trust and are available to pay retirement benefits to its members and beneficiaries.

Group I members at age 60 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 (1.67%) of AFC multiplied by years of creditable service. AFC is defined as the average of the three highest salary years. At age 65, the yearly pension amount is recalculated at 1/66 (1.5%) 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 at least 20 years of creditable service can receive a retirement allowance at a rate of 2.5% of AFC for each year of creditable service, not to exceed 40 years.

All covered Hospital employees are members of Group I.

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.

The Plan is financed by contributions from the members, the State and local employers, and investment earnings. During the nine months ended March 31, 2011, Group I members were required to contribute 5% of gross earnings, except for State employees hired after July 1, 2009, who contributed 7% of gross earnings. Group II members contributed 9.3% of gross earnings. The State funds 100% of the employer cost for all of the Hospital's employees enrolled in the Plan. The annual contribution required to cover any normal cost beyond the employee contribution is determined every two years based on the Plan's actuary.

The Hospital's payments for normal contributions for the nine months ended March 31, 2011 amounted 9.09% of the covered payroll for its Group I employees. The Hospital's normal contributions for the nine months ended March 31, 2011 were $2,693,918.

A special account was established by RSA 100-A:16, II (h) for additional benefits. During fiscal year 2007, legislation was passed that permits the transfer of assets into the special account for earnings in excess of 10.5% as long as the actuary determines the funded ratio of the retirement system to be at least 85%. If the funded ratio of the system is less than 85%, no assets will be transferred to the special account.

The New Hampshire Retirement System issues a publicly available financial report that may be obtained by writing to them at 54 Regional Drive, Concord, NH 03301 or from their web site at http://www.nhrs.org.

*Other Postemployment Benefits*

In addition to providing pension benefits, RSA 21-I:30 specifies that the State provide certain health care benefits for retired employees and their spouses within the limits of the funds appropriated at each legislative session. These benefits include group hospitalization, hospital medical care, and surgical 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 after July 1, 2003 to have 20 years of State service in order to qualify for health insurance benefits. These and similar benefits for active employees are authorized by RSA 21-I:30 and provided through the Employee and Retiree Benefit Risk Management Fund, which is the State's self-insurance fund implemented in October 2003 for active State employees and retirees. The State recognizes the cost of providing these benefits on a pay-as-you-go basis by paying actuarially determined contributions into the fund. The New Hampshire Retirement System's medical premium subsidy program for Group I and Group II employees also contributes to the fund. The Hospital's Medical Subsidy normal contribution rate for the nine months ended March 31, 2011 was 0.07% of the covered payroll for its Group I employees. The Hospital's contributions for the Medical Subsidy the nine months ended March 31, 2011 were $20,745.

The cost of the health benefits for the Hospital's retired employees and spouses is a budgeted amount paid from an appropriation made to the administrative organization of the New Hampshire Retirement System and is not included in the Hospital's financial statements.

The State Legislature currently plans to only partially fund (on a pay-as-you-go basis) the annual required contribution (ARC), an actuarially determined rate in accordance with the parameters of Governmental Accounting Standard Board (GASB) Statement No. 45. The ARC represents a level of funding that, if paid on an ongoing basis, is projected to cover normal cost each year and amortize any unfunded actuarial liabilities over a period not to exceed 30 years. The ARC and contributions are reported for the State as a whole and are not separately reported for the Hospital.

# STATE OF NEW HAMPSHIRE
# NEW HAMPSHIRE HOSPITAL
# BUDGET TO ACTUAL SCHEDULE - GENERAL FUND - UNAUDITED
# FOR THE NINE MONTHS ENDED MARCH 31, 2011

| Revenues | Fiscal Year 2011 Original Budget | Nine Months Ended 3/31/2011 Actual | Favorable (Unfavorable) Variance |
|---|---|---|---|
| **Unrestricted Revenues** | | | |
| Medicare | $ 7,179,000 | $ 4,669,523 | $ (2,509,477) |
| Board-State Hospital | 3,766,000 | 2,475,191 | (1,290,809) |
| Medicaid-Children Services | 1,772,000 | 1,612,417 | (159,583) |
| **Total Unrestricted Revenues** | **12,717,000** | **8,757,131** | **(3,959,869)** |
| **Restricted Revenues** | | | |
| Medicaid Disproportionate Share | 20,703,777 | 16,396,205 | (4,307,572) |
| Board-Transitional Housing | 1,217,112 | 1,127,246 | (89,866) |
| Cafeteria Sales | 700,462 | 463,257 | (237,205) |
| Board-Children Services | 643,845 | 146,405 | (497,440) |
| User Fees And Other | 88,415 | 103,502 | 15,087 |
| Trust Funds | 225,000 | 50,122 | (174,878) |
| **Total Restricted Revenues** | **23,578,611** | **18,286,737** | **(5,291,874)** |
| **Total Revenues** | **36,295,611** | **27,043,868** | **(9,251,743)** |
| **Expenditures** | | | |
| Salaries And Benefits | 59,223,409 | 39,356,081 | 19,867,328 |
| Contracts For Program Services (Note 2) | 8,366,910 | 5,246,412 | 3,120,498 |
| Prescription Drugs | 2,260,755 | 900,911 | 1,359,844 |
| Heat-Electricity-Water | 1,550,761 | 853,375 | 697,386 |
| Current Expenses | 1,280,490 | 616,508 | 663,982 |
| Maintenance Building And Grounds | 1,296,664 | 519,853 | 776,811 |
| Security Services | 944,764 | 508,583 | 436,181 |
| Medical Providers | 1,492,816 | 505,533 | 987,283 |
| Other | 470,955 | 230,089 | 240,866 |
| Trust Funds | 225,000 | 97,176 | 127,824 |
| **Total Expenditures** | **77,112,524** | **48,834,521** | **28,278,003** |
| **Excess (Deficiency) Of Revenues Over (Under) Expenditures** | **(40,816,913)** | **(21,790,653)** | **19,026,260** |
| **Other Financing Sources (Uses)** | | | |
| Net Appropriations (Note 3) | 53,533,913 | 30,547,784 | 22,986,129 |
| **Total Other Financing Sources (Uses)** | **53,533,913** | **30,547,784** | **22,986,129** |
| **Excess (Deficiency) Of Revenues And Other Financing Sources Over (Under) Expenditures And Other Financing Uses** | **$ 12,717,000** | **$ 8,757,131** | **$ (3,959,869)** |

The accompanying notes are an integral part of this schedule.

**Notes To The Budget To Actual Schedule - General Fund - Unaudited**
**For The Nine Months Ended March 31, 2011**

## Note 1 - General Budget Policies

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 annual budgets for each year of the biennium, consists of three parts: Part I is the Governor's program for meeting all expenditure needs as well as estimating revenues to be received. 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 and proprietary fund types with the exception of the Capital Projects Fund.

The New Hampshire biennial budget is composed of the initial operating budget, supplemented by additional appropriations. These additional appropriations and estimated revenues from various sources are authorized by Governor and Council action, annual session laws, and existing statutes which require appropriations under certain circumstances.

The budget, as reported in the Budget To Actual Schedule, reports the initial operating budget for fiscal year 2011 as passed by the Legislature in Chapter 143, Laws of 2009.

Budgetary control is at the department level. In accordance with RSA 9:16-a, notwithstanding any other provision of law, every department is authorized to transfer funds within and among all program appropriation units within said department, provided any transfer of $2,500 or more shall require approval of the Joint Legislative Fiscal Committee and the Governor and Council. Additional fiscal control procedures are maintained by both the Executive and Legislative Branches of government. The Executive Branch, represented by the Commissioner of the Department of Administrative Services, is directed to continually monitor the State's financial system. The Legislative Branch, represented by the Joint Legislative 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 lapse to undesignated fund balance and be available for future appropriations unless they have been encumbered or are legally defined as non-lapsing accounts.

*Variances - Favorable/(Unfavorable)*

The variance column on the Budget To Actual Schedule highlights differences between the original 12-month operating budget and the actual revenues and expenditures for the nine months ended March 31, 2011. Actual revenues exceeding budget or actual expenditures being less than

budget generate a favorable variance. Actual revenues being less than budget or actual expenditures exceeding budget cause an unfavorable variance.

Unfavorable variances are expected for revenues and favorable variances are expected for expenditures when comparing nine months of actual revenues and expenditures to an annual budget.

The excess of revenues and other financing sources over expenditures and other financing uses is the amount of unrestricted revenues budgeted to be collected by and actually collected by NHH. Unrestricted revenues are not available, without prior appropriation, to fund the operations of NHH.

**Note 2 - Contracts For Program Services**

The 2010 – 2011 Operating Budget combines Contracted Psychiatric Services, Contracted Food and Nutrition Services, and other Contracted Program Services in one budgeted expenditure line, Contracts for Program Services.

**Note 3 - Net Appropriations**

Net appropriations reflect appropriations for expenditures in excess of restricted revenue.

## APPENDIX - CURRENT STATUS OF PRIOR AUDIT FINDINGS

The following is a summary, as of March 31, 2011, of the current status of the observations contained in the financial and compliance audit report of New Hampshire Hospital for the fiscal year ended June 30, 2003. The prior audit report can be accessed on-line at http://www.gencourt.state.nh.us/LBA/AuditReports/FinancialReports/pdf/NHH_2003_full.pdf.

| | Status | | |
|---|---|---|---|
| ***Internal Control Comments*** | | | |
| *Material Weaknesses* | | | |
| 1. Control Environment Over Financial Operations Needs To Be Improved (*See Current Observation No. 1*) | ○ | ○ | ○ |
| 2. Patient Billing System Needs Improvement | ● | ● | ● |
| 3. Controls Should Be Improved Over The Calculation Of Disproportionate Share Revenues (*See Current Observations No. 2 and No. 30*) | ○ | ○ | ○ |
| *Other Reportable Conditions* | | | |
| Board And Care Revenue | | | |
| 4. Policies And Procedures Should Be Established For Billing Patient Accounts (*See Current Observation No. 17*) | ● | ○ | ○ |
| 5. Documented Policies And Procedures Should Be Established For Setting Board And Care Rates | ● | ○ | ○ |
| 6. Segregation Of Duties Should Be Established In The Processing Of Board And Care Invoices | ● | ● | ● |
| 7. Policies And Procedures For The Accrual Of Accounts Receivable Must Be Established (*See Current Observation No. 22*) | ● | ○ | ○ |
| 8. Charges For Transitional Housing Services Should Be Subject To Periodic Reviews (*See Current Observation No. 21*) | ○ | ○ | ○ |
| 9. Transitional Housing Billing Practices Should Be Reviewed | ▲ | ▲ | ▲ |
| 10. Controls Over Food Allowances For Transitional Housing Residents Should Be Improved | ● | ○ | ○ |
| 11. Income Of Residents In Federally Supported Housing Should Be Reviewed At Least Annually | ▲ | ▲ | ▲ |
| 12. Recovery Of Costs For Patients On Visitation Status At Transitional Housing Should Be Considered | ▲ | ▲ | ▲ |
| 13. Policies And Procedures Should Be Established For Recovery Of Costs Of Educational Services | ▲ | ▲ | ▲ |
| Payroll And Employee Relations | | | |
| 14. Effectiveness Of The Time And Attendance Recording Should Be Reviewed (*See Current Observation No. 15*) | ● | ○ | ○ |
| 15. Weekend Pay Differential Should Be Paid As Negotiated (*See Current Observation No. 16*) | ○ | ○ | ○ |
| 16. Policies For Payment Of Overtime Should Be Consistent And Documented | ▲ | ▲ | ▲ |
| 17. All Formal Agreements Between Employee And Employer Should Be Documented | ▲ | ▲ | ▲ |
| 18. Payment Of Temporary Salary Increases Should Be Made Only When Authorized | ● | ● | ● |
| 19. Propriety And Efficacy Of Having Employees Provide On-Call Medical | ● | ● | ● |

| | Status | | |
|---|---|---|---|
| Physician Services Through Medical Services Contract Should Be Considered | | | |
| 20. Necessity And Extent Of On-Call Coverage Should Be Reviewed | ● | ● | ● |
| Other Control Comments | | | |
| 21. Formal Fraud Prevention, Deterrence, And Detection Program Should Be Established | ● | ● | ○ |
| 22. Formal Fraud Reporting Policy Should Be Established | ● | ● | ● |
| 23. Controls Over Preparation Of Medicare Cost Report Should Be Improved (*See Current Observation No. 26*) | ○ | ○ | ○ |
| 24. Budgetary Controls Should Not Be Avoided | ▲ | ▲ | ▲ |
| 25. Controls Should Be Improved In The Pharmacy (*See Current Observation No. 5*) | ○ | ○ | ○ |
| 26. Policies And Procedures For Making Payments On Medical Services Bills Should Be Established (*See Current Observation No. 25*) | ○ | ○ | ○ |
| 27. Medical Services Should Be Documented According To The Contract Provisions (*See Current Observation No. 3*) | ○ | ○ | ○ |
| 28. Access To Computerized Applications And Data Should Be Restricted To That Necessary To Perform Job Functions (*See Current Observation No. 23*) | ● | ○ | ○ |
| 29. Controls Over The Receiving Of Purchased Supplies Should Be Improved | ● | ○ | ○ |
| 30. Use Of Numeric Document Controls Should Be Reviewed | ● | ● | ● |
| Hospital Trust Accounts | | | |
| 31. Controls Over Client Banking System Must Be Improved | ● | ● | ● |
| 32. Estate Monies Held For The Division Should Be Coordinated With The State Treasurer (*See Current Observation No. 28*) | ○ | ○ | ○ |
| 33. Controls Over Disbursements From The Investment Account Should Be Improved | ● | ● | ● |
| 34. Trust Fund Expenditures Should Benefit The Purpose Of The Trusts | ● | ● | ● |
| 35. Private-Purpose Trust Fund Accounts Should Be In The Custody Of The State Treasurer | ● | ● | ○ |
| 36. Controls Over Gift Store Operations Should Be Implemented (*See Current Observation No. 13*) | ● | ○ | ○ |
| Cafeteria Operations | | | |
| 37. Analysis Of Cafeteria Costs Should Include Costs For Labor And Overhead (*See Current Observation No. 8*) | ○ | ○ | ○ |
| 38. Cafeteria Meal Pricing Policies And Procedures Should Be Established (*See Current Observation No. 8*) | ○ | ○ | ○ |
| 39. Accountability Over Cafeteria Cash Register Receipts Should Be Improved (*See Current Observation No. 7*) | ● | ● | ○ |
| 40. Food Inventory Should Be Subject To An Inventory Control System (*See Current Observation No.9*) | ● | ○ | ○ |
| Property And Equipment | | | |
| 41. Effective And Efficient Controls Should Be Established For Long-Term Assets And Equipment | ● | ● | ● |
| 42. Responsibility For Power-Plant Building And Associated Equipment Should Be Established | ▲ | ▲ | ▲ |

| | Status | | |
|---|---|---|---|
| *Management Issues Comment* | | | |
| 43. NHH Should Review Continued Performance Of Building And Grounds Maintenance And Other Services Provided To Campus Buildings Operated By Other State Organizations | ▲ | ▲ | ▲ |

| Status Key | | | | Count |
|---|---|---|---|---|
| Fully Resolved | ● | ● | ● | 11 |
| Substantially Resolved | ● | ● | ○ | 3 |
| Partially Resolved | ● | ○ | ○ | 9 |
| Unresolved | ○ | ○ | ○ | 11 |
| Not Applicable In Current Audit | ▲ | ▲ | ▲ | 9 |

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