

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

**FINANCIAL AND COMPLIANCE
AUDIT REPORT
FOR THE FISCAL YEAR ENDED
JUNE 30, 2003**

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

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

Reporting Entity And Scope

The reporting entity and scope of this audit and audit report is the financial operations of the New Hampshire Hospital for the fiscal year ended June 30, 2003. The New Hampshire Hospital is a component of the New Hampshire Department of Health and Human Services, Division of Behavioral Health.

The following report describes the financial activity of the Hospital as it existed during the period under audit. Unless otherwise indicated, reference to the Hospital or NHH refers to the New Hampshire Hospital. Auditee responses, comments on observations, auditee corrective action plan statements, and date of anticipated completion were provided by the Hospital in coordination with the Division of Behavioral Health.

Organization

The Hospital is a component of the Division of Behavioral Health, a division of the Department of Health and Human Services. Hospital operations are under the direction of the Superintendent who reports to the Division Director. The Division Director reports to the Commissioner of the Department of Health and Human Services.

The Hospital was established in 1842 as the State's public hospital for the care and treatment of the mentally ill. The Hospital is located at 36 Clinton Street, Concord, NH. Facilities include the Acute Psychiatric Services building (APS), Anna Philbrook Center (APC), and eight community Transitional Housing units. The APS is the main Hospital building and is the primary care facility providing treatment and boarding primarily to adult patients. The APS building also houses the administrative offices of the Hospital. The APC facility is used for providing treatment and board to children and adolescents.

At June 30, 2003, the Hospital employed 791 permanent full-time and 101 part-time employees, including 18 unclassified positions.

Responsibilities

The Hospital's mission states, "The Hospital advocates for and provides psychiatric services, which support an individual's recovery toward an authentic sense of personal meaning and optimum health. Work is directed toward evaluating innovative treatment methods and sharing outcomes, which improve the mental health of individuals served."

The Hospital is a State-operated, publicly funded hospital providing a range of specialized diagnostic and therapeutic psychiatric services. The Hospital provides psychiatric and

neurological care in two program areas. The objective of both programs is the placement of all patients and residents into the community.

- The first area is acute treatment services for children, adolescents, and adults and elders with severe mental illness.
- The second program is transitional housing services where individuals with limited community placement options live in a residential setting with appropriate treatment.

At June 30, 2003 the APS patient capacity was 184 and actual patient census was 171. At the same point, APC patient capacity was 28 and actual patient census was 19. Transitional Housing resident capacity was 43 and actual residents numbered 39. The average census for fiscal year 2003 for the three facilities was 156, 16, and 34 for the APS, APC, and Transitional Housing, respectively.

Most of the Hospital's admissions are involuntary in nature with the patients found to be dangerous to themselves or others. Many of the remaining voluntary cases meet these criteria and recognize their need for treatment, agree to it and are admitted.

Funding

The Hospital is funded primarily by appropriations from the General Fund. Financial activity of the Hospital is accounted for in the General and Permanent Funds of the State of New Hampshire. A summary of the Hospital's General and Permanent Funds revenues and expenditures for the fiscal year ended June 30, 2003, is in the following table.

Summary Of Revenues And Expenditures

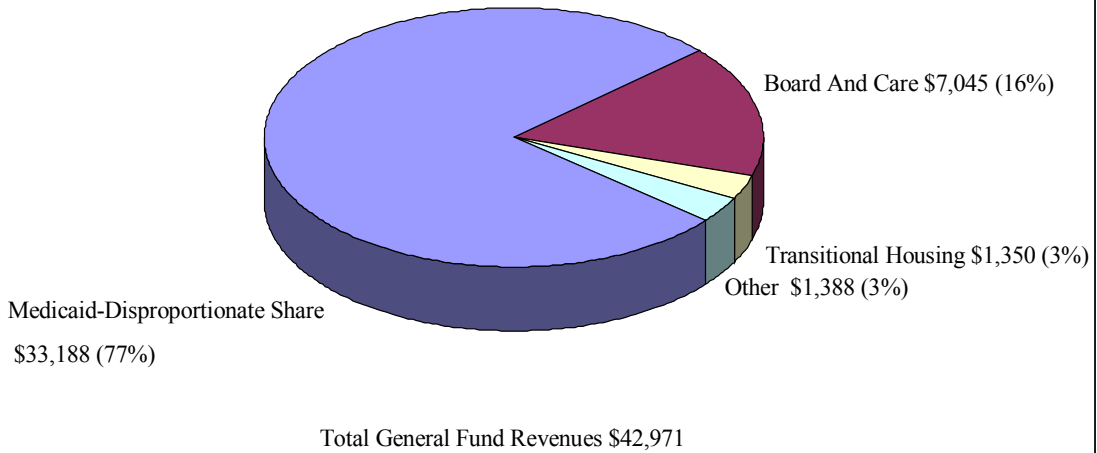
Fiscal Year Ended June 30, 2003

(expressed in thousands)

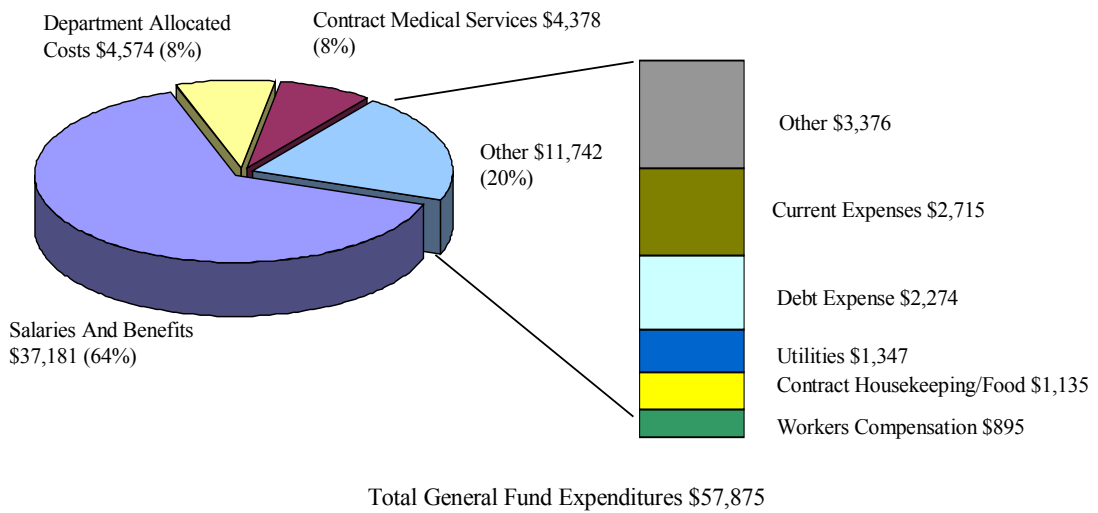
	<u>General Fund</u>	<u>Permanent Fund</u>	<u>Total Governmental Funds</u>
Total Revenues	\$ 42,971	\$ 169	\$ 43,140
Total Expenditures	<u>\$ 57,874</u>	<u>\$ 199</u>	<u>\$ 58,073</u>
Excess (Deficiency) Of Revenues Over (Under) Expenditures	<u>\$ (14,903)</u>	<u>\$ (30)</u>	<u>\$ (14,933)</u>

The graphs on page 3 illustrates the major components of the Hospital's revenues and expenditures in the General Fund.

NEW HAMPSHIRE HOSPITAL
 FISCAL YEAR 2003 - REVENUES BY TYPE
 GENERAL FUND
 (Amounts Expressed In Thousands)



NEW HAMPSHIRE HOSPITAL
 FISCAL YEAR 2003 - EXPENDITURES BY TYPE
 GENERAL FUND
 (Amounts Expressed In Thousands)



Prior Audit

The most recent prior financial and compliance audit of New Hampshire Hospital was for the eighteen months ended December 31, 1988. The appendix to this report on page 79 contains a summary of the current status of the observations contained in that prior audit report. Copies of the prior audit report can be obtained from the Office of Legislative Budget Assistant, Audit Division, 107 North Main Street, State House Room 102, Concord, NH 03301-4906.

Audit Objectives And Scope

The primary objective of our audit is to express an opinion on the fairness of the presentation of the financial statements of the New Hampshire Hospital for the fiscal year ended June 30, 2003. 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 the Hospital's compliance with certain provisions of applicable State laws, rules, and contracts. Major accounts or areas subject to our examination included, but were not limited to, the following:

- Revenues and receivables,
- Expenditures and payables,
- Real property and equipment,
- Inventory, and
- Fiduciary funds.

Our reports on compliance and on internal control over financial reporting, and on management issues, the related observations and recommendations, our independent auditor's report, and the financial statements of the Hospital are contained in the report that follows.

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

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 fiscal year ended June 30, 2003, as listed in the table of contents, and have issued our report thereon dated April 13, 2004, in which we disclaimed an opinion due to the lack of supporting revenue and agency fund records.

Compliance

As part of our consideration as to whether sufficient competent evidential matter existed to allow us to audit the New Hampshire Hospital's financial statements, we performed tests of its compliance with certain provisions of laws, rules, 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, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance that are required to be reported under *Government Auditing Standards*.

Internal Control Over Financial Reporting

In planning as to whether to perform our audit, we considered New Hampshire Hospital's control over financial reporting in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements and not to provide assurance on the internal control over financial reporting. However, we noted certain matters involving the internal control over financial reporting and its operation that we consider to be reportable conditions. Reportable conditions involve matters coming to our attention relating to significant deficiencies in the design or operation of the internal control over financial reporting that, in our judgment, could adversely affect the New Hampshire Hospital's ability to record, process, summarize, and report financial data consistent with the assertions of management in the financial statements. Reportable conditions are described in Observations No. 1 through No. 42 of this report.

A material weakness is a condition in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that misstatements

in amounts that would be material in relation to the financial statements being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. Our consideration of the internal control over financial reporting would not necessarily disclose all matters in the internal control that might be reportable conditions and, accordingly, would not necessarily disclose all reportable conditions that are also considered to be material weaknesses. However, of the reportable conditions described above, we consider the matters described in Observations No. 1 through No. 3 to be material weaknesses as described above.

This auditor's report on compliance and on internal control over financial reporting is intended solely for the information and use of the management of New Hampshire Hospital 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

April 13, 2004

Internal Control Comments
Material Weaknesses

Observation No. 1: Control Environment Over Financial Operations Needs To Be Improved

Observation:

The NHH's control environment during fiscal year 2003 did not function as a solid foundation for the other components of internal control including risk assessment, control activities, information and communication, and monitoring. The weak control environment contributed to the number and type of audit issues and concerns noted in NHH's operations and appears to be a significant causal factor in the NHH's limitations in reporting financial operations. Those limitations resulted in a limitation on the audit's scope and a disclaimer of audit opinion.

The control environment sets the tone of an organization, influencing the control consciousness of its people. It is the foundation for all other components of internal control, providing discipline and structure. Control environment factors include management's philosophy and operating style, the way management assigns authority and responsibility, and the way management organizes and develops its people. The control environment influences control activities, information and communication systems, and monitoring activities.

NHH's management exhibits a consciousness and concern for a strong control environment over the healthcare provided to its patients and residents; however, the control environment over the financial activities of the NHH was weak and a significant causal factor to the limitations in financial operations and reporting. These limitations affected the scope of our audit such that we were unable to complete our audit work and also contributed to a number of audit comments.

Examples of auditor concerns with the NHH's control environment included:

- As noted in Observation No. 2, the NHH system for the accounting and reporting of board and care revenues is inadequate and a source of errors. The NHH has not been provided with a reliable system for the accounting and reporting of revenues and no one at the NHH has been made responsible for monitoring and reviewing revenues.
- Policies and procedures directing the methodology and review of board and care and educational rates and Disproportionate Share Calculation are inadequate. There has been no effective monitoring and review of the Disproportionate Share Calculation as management does not have a complete understanding and one employee has become essentially singly responsible for the performance of the calculation.
- As noted in Observation No. 31, the NHH system used during fiscal year 2003 for accounting and reporting patient account money is inadequate. The system did not provide reporting that would allow effective monitoring and review of account activity.
- The NHH, on occasion during fiscal year 2003, bypassed budgetary controls, including transfer requests or other provisions for obtaining additional expenditure authority, and

charged expenditures to accounts with available appropriations, regardless of whether they were proper budgeted accounts for the expenditure class.

- Two significant positions in the NHH's control structure became vacant during fiscal year 2003. Both the Chief Finance Officer's and internal auditor's positions became vacant and remained unfilled during fiscal year 2003.

Recommendation:

The NHH should strengthen its control environment to promote effective internal controls and reduce the risks of errors and fraud in the NHH financial operations and reporting. Management must demonstrate to its employees an overall attitude and awareness of the importance of an effective financial control environment. NHH management should take the steps necessary to gain an understanding of all significant aspects of its operations and provide adequate resources and appropriately trained and skilled employees to perform those functions.

Auditee Response: We concur in part.

Actions to be Taken: Two of the examples cited relate to the billing functions performed by the Division of Behavioral Health. We concur that NHH management must work with the staff that is responsible for billing, collections, rate setting and establishing the Disproportionate Share Calculations, to improve the internal controls related to those functions. Discussions have already begun on corrective actions as noted in our responses to other findings.

With respect to the adequacy of resources related to controls over financial functions, the following actions have already or will be taken:

- a) Reclassified a vacant position, establishing a Business Administrator to assist in the financial area. As of March 7, 2005 the NHH has not received a waiver to recruit and fill this position.
- b) Continue to request waiver from the hiring freeze to fill the Chief Financial Officer position that has been vacant since July 2003.
- c) NHH will work within the budgetary controls and request proper authority to expend from budget accounts.
- d) NHH will work with the DHHS to request assistance in performing Internal Audits, to cover areas normally would have been performed by an Internal Auditor, which has been vacant since FY 2003 due to the hiring freeze and subsequently abolished.

Observation No. 2: Patient Billing System Needs Improvement

Observation:

The billing system used during fiscal year 2003 by the NHH and Division Of Behavioral Health (DBH) to track services provided to NHH patients and to bill for those services was inadequate to efficiently track patient days of service and ensure that billings for, and revenues from, those services were complete, accurate, and reported in the proper accounting period.

The billing system, while partially automated, required intensive manual intervention, multiple ledgers and spreadsheets, and suffered from the inefficiencies and errors that resulted from the use of an inadequate system. The effect of the limitations of this system was a substantial risk that earned revenues were not collected and recorded in the correct period. Limitations in the information available from the billing system contributed to repeated errors in the calculation of the Federal Medicaid program's Disproportionate Share payments to the NHH. In addition, management information available from the system including days of service, payment sources, and accounts receivable was limited.

Management is responsible for establishing and maintaining systems and controls that will, among other things, initiate, record, process, and report transactions consistent with management's assertions implicit in the financial statements including: existence; completeness; rights and obligations; valuation and allocation; and presentation and disclosure. The billing system in operation at the NHH and DBH during fiscal year 2003 did not allow management to meet that responsibility.

While the NHH and DBH were taking steps to update and improve its system during fiscal year 2003, the DBH was not confident that the updated system would allow the NHH to determine and report its board and care revenues in the proper accounting period.

Recommendation:

The NHH needs to make significant improvements to its billing system to allow for the accurate and timely reporting of its revenues and to provide reliable and timely management information to decision makers. While improved hardware, software, and programs will be part of the solution, the NHH and DBH will also need to redesign policies and procedures related to the tracking and billing for services provided to patients and clients of the NHH to ensure that the financial reporting needs of the NHH and DBH as well as the other programmatic needs of those organizations are addressed.

The NHH and DBH should request assistance from others with competencies in revenue recognition and financial reporting to ensure that any improvements made to its billing system provide for proper recognition of revenue and also for the accumulation of information necessary for periodic State financial reporting.

Auditee Response: We concur.

As noted in another area, in October of 2004 NHH converted to a new Billing System and is working with DBH to develop a work plan to review all aspects of the Billing Office. The first step is to complete the conversion of the old billing system to the new system.

The new system will start in the second quarter of the current fiscal year and the current system(s) will be phased out as current balances are collected.

As part of the new computer conversion we will review all functions and responsibilities of the Billing Office to improve all areas of billing including collections, tracking patient days, and management reporting.

Observation No. 3: Controls Should Be Improved Over The Calculation Of Disproportionate Share Revenues

Observation:

The NHH's calculation of disproportionate share revenues (DSH) for the fiscal year ended June 30, 2003 was not sufficiently documented to allow for a recalculation to arrive at the same result. The methodology was not adequately described and the data used in the calculation appeared erroneous.

The methodology for the NHH's DSH calculation during fiscal year 2003 was not documented in the NHH's policies and procedures, the Medicaid State Plan, law, or rule. The calculation was open to interpretation and prone to inconsistent application and error. Compounding the risks to the accuracy of the calculation was the lack of methodology documentation, the involved, if not complex, nature of the calculation, the multiple sources of information required for the calculation, and the NHH's reliance on one employee to perform the calculation with no effective review of the calculation. In fact, there were no effective controls in place during fiscal year 2003 designed to detect errors or frauds in the calculation's results in a timely manner.

The DSH calculation has been performed in a less than controlled environment. Errors in establishing data for the calculation repeatedly occurred during fiscal year 2003 including incorrect determinations of patients' dates of services allowing patients receiving services outside the measurement period to be included in the calculation and patient days to be improperly included more than once in the calculation. In addition, NHH personnel regarded the ledgers used for providing information used in the calculation to contain inaccurate information.

Subsequent to the fiscal year 2003 DSH calculation, the NHH adopted a relatively simpler DSH calculation method. However, the weaknesses in the relevant controls including a lack of segregation of duties, an ineffective review process, inaccurate source documents, and insufficient calculation documentation do not appear to have been addressed.

Recommendation:

Controls over the NHH's DSH should be improved.

- Controls should be implemented that allow for the timely detection of errors in the DSH calculation.
- Additional employees at the NHH should gain an understanding of the DSH calculation, including the methodology and systems used for gathering the underlying data used in performance of the calculation, to allow for an effective review and approval process over the results of the calculation.

- Formal policies and procedures should be established that document the DSH calculation methodology including systems and procedures used, employees' responsibilities, and controls to be in effect for assuring the complete and accurate calculation of DSH. The policy should include periodic reviews of procedures to identify changes in legislation/laws that may affect DSH.
- Systems supporting and providing data for the DSH calculation should be improved to provide complete and reliable information for use in the calculation.

Auditee Response: We concur.

Controls over the DSH calculation will be improved including mechanisms for the early detection of errors. In addition, additional employees will be trained to complete the DSH calculations.

Regarding policies and procedures:

Formal procedures and policies were written for preparing the DSH calculation. These procedures included: a definition of DSH, a brief history of the DSH calculation, the items needed to do the calculation, and step-by-step procedures to do the calculation. We will review these to ensure that they reflect the current methodologies and procedures.

NHH converted to a new hospital information system in October 2004. We recognized that the prior system, which has been used for over 15 years, has many flaws. We expect this will allow NHH to be able to generate more accurate data regarding the number of paid days and therefore eliminate the need to maintain Excel spreadsheets used for the DSH calculation. The old system will be phased out, as outstanding patient balances are resolved.

Internal Control Comments
Other Reportable Conditions

BOARD AND CARE REVENUE

Observation No. 4: Policies And Procedures Should Be Established For Billing Patient Accounts

Observation:

The Office of Reimbursements has not established formal policies and procedures to assist employees in recovering the cost of services provided to NHH patients, residents, and clients.

Per RSA 126-A:36, the costs of services provided by the NHH may be recovered from the person receiving services and from certain close family members. RSA 126-A:34 directs the Division of Behavioral Health, Office of Reimbursements to 1) investigate the ability of patients, residents, or clients of the NHH, and those legally chargeable for their support and maintenance to pay for such care, treatment, and maintenance and 2) recommend to the Commissioner of the Department of Health and Human Services the amounts to be recovered. To support and help form a basis for this recommendation, RSA 126-A:38 requires a financial statement to be filed by persons legally chargeable for expenses pursuant to RSA 126-A:36 within 60 days of an individual's admittance to a covered program.

Office of Reimbursements employees interview and obtain financial information from NHH patients, residents, clients, and when appropriate, family members when individuals are first admitted to covered facilities including the Acute Psychiatric Services (APS) Building, Anna Philbrook Center (APC), and transitional housing units. The employees determine whether any costs of services are recoverable from those responsible parties as established in RSA 126-A:34 and make payment recommendations to recover those costs over a reasonable period of time. The Office of Reimbursements has not established policies and procedures, including documentation requirements, to ensure that objectivity and consistency remain central to the decision-making process.

1. Payment recommendations are based on criteria established by the employees rather than standardized criteria set by management. The lack of policies and procedures with common evaluation criteria hampers the maintenance of objectivity and consistency in the decision process.
2. Not all payment recommendations in a sample reviewed were accompanied by documentation to support and provide an audit trail for the payment recommendations/decisions. For example, in one case reviewed, a \$200 personal allowance was not supported at the time of the payment recommendation/decision, even though the amount was unusual in comparison to other cases. In addition, we noted that a required financial statement was not obtained yet there was no documentation describing attempts to obtain such a statement. Hospital management indicated their inability to obtain a statement

was due to the patient's unwillingness to cooperate with the process. The file did not indicate the reason why a statement was not obtained or whether there was more than one attempt to obtain the financial statement.

3. Payment recommendations may be revised for relatively small, infrequent, or one-time changes in patient resources such as funds needed to be retained for a patient to purchase a winter coat for example. Frequent changes in this manual process compound the risk of errors in the board and care billings and the supporting spreadsheets/ledgers. The board and care bills generated from the process identify only the net amount due and do not provide details on the rate, days applied, amounts suspended, and net due. The lack of detail on the bills makes effective and efficient review of the bills by the NHH and the payors more difficult.
4. Some patients do not file the statutorily required "financial statement" timely. We also noted an instance where a financial statement was not sufficiently complete to allow determination of the individual's financial status.

Recommendation:

The Office of Reimbursements should establish policies and procedures for recovering the cost of NHH services, as provided for in statute. The policies and procedures should be sufficiently comprehensive to ensure a controlled and consistent approach to recovering costs. While objectivity and consistency must be a goal of the policies and procedures, they should respond to patients' unique circumstances yet ensure compliance with management objectives. The policies and procedures should include specific criteria, define responsible employees, procedures to be performed, and information required to be gathered and documented. Clear definitions, such as allowable resources, income, expenses, assets, liabilities, etc., will be critical to the fair application of these policies and procedures. The policies and procedures should also provide direction as to actions to be taken when circumstances beyond the control of the employee, such as the recalcitrance of a patient, do not allow standard procedures to be performed or completed.

Board and care bills should include sufficient detail to allow for proper review of the accuracy of the billed amounts.

Management will also need to establish monitoring controls to regularly determine that policies and procedures remain appropriate and are adhered to by employees performing the related functions.

Auditee Response: We concur in part.

RSA 126-A:34 I (b) instructs the Office of Reimbursements to investigate the ability of patients or those liable to pay for services received. As noted in the recommendation, this office has a duty to respond to patients' unique circumstances. Each admission is looked at individually and a determination is made based on the outcome of that individualized investigation.

DBH and NHH will work to develop the policies and procedures taking into account both the need for flexibility to respond to patients' unique circumstances, while at the same time ensuring compliance with management objectives

Observation No. 5: Documented Policies And Procedures Should Be Established For Setting Board And Care Rates

Observation:

Although there is a methodology described in the federally approved Medicaid State Plan (State Plan) for calculating the NHH's board and care rates, there are no written policies and procedures for setting the rates. The lack of written policies and procedures contributes to confusion and errors in the calculation of the rates.

RSA-126-A:43, I. requires the Commissioner of the Department of Health and Human Services to establish a uniform rate to cover the expenses of services provided to patients, residents, and clients of the NHH. The rate established for NHH patients is an all-inclusive rate for board and care services. The NHH's Transitional Housing rate consists of a rate for rent and services.

1. The daily board and care rates applied by the NHH do not necessarily cover the costs of services provided. The board and care rates calculated and applied by the NHH include consideration of a lapse amount, which has reportedly been used as an adjustment amount to cause the calculation to provide a rate that is acceptable to management. For fiscal year 2003, the lapse amount used in the rate setting calculation was \$4.5 million versus \$1 million in actual lapses. The use of the larger lapse amount in the calculation resulted in a lower board and care rate.
2. The State Plan provides that governmental psychiatric hospitals shall be paid per-diem rates for inpatient acute psychiatric services. The Plan provides the methodology for calculating the rate, including the use of 90% of projected patient days in the calculation. The Administrator performing the calculation was not aware of the methodology's inclusion in the State Plan, and was not aware of the 90% of projected patient days requirement and, as a consequence, that required adjustment was not used in calculating the fiscal year 2003 rate. According to the Administrator, the inclusion of the rate setting methodology in the State Plan was not intended and was done in error.
3. During fiscal year 2003, one employee was responsible for setting the board and care and education rates. The employee previously responsible for this calculation assisted this employee. No one independent of the board and care rate-setting process reviewed the board and care rates established for the NHH's Acute Psychiatric Services (APS) Building and Anna Philbrook Center (APC). Although the Commissioner of the Department approved the rates, the detail supporting the rates was not subject to review.

A review of the rate calculations for the APS Building and APC identified numerous errors in addition to those noted above, including the following.

- a) Some budget amounts used in the calculation were not supported.
- b) “Benefits” and “Other Costs” for APC were not segregated from APS costs, according to calculated percentages.
- c) A transposition error was made in posting one of the components of indirect costs on the Department-wide costs sheet.
- d) Depreciation for fixed assets was erroneously calculated. Depreciation for only half the year was taken for several items listed in the depreciation schedule.
- e) The depreciation amount for NHH fixed assets was not supported. The depreciation amount should have been taken from the depreciation schedule.
- f) Some depreciable fixed assets should have been excluded from the depreciation schedule (e.g. Thayer building).

The daily board and care rates charged for the APS and APC during the last half of fiscal year 2003 were \$647 and \$505, respectively. Had the above noted errors not occurred in the calculation, the daily board and care rates would have been \$770 and \$823 for APS and APC, respectively.

Recommendation:

Written policies and procedures should be established for setting board and care rates.

- The NHH should perform its rate calculation in accordance with the provisions of RSA 126-A:43, requiring that the rates cover costs of services provided.
- The NHH should adhere to the board and care rate setting methodology stated in the State Plan. If it is determined that the rate setting methodology was inadvertently input into the State Plan, then NHH should seek approval to remove such language.
- The NHH and the Division of Behavioral Health should develop effective internal controls over the board and care rate setting process. Someone independent of the rate setting process should perform a thorough review. Policies and procedures should be developed that clearly communicate the methodology and procedures. Calculations should be documented and supported.

Auditee Response:

We concur there are no written policies regarding the methodologies that should be used to set institutional rates, other than language in the Medicaid State Plan. The Division of Behavioral Health (DBH) and NHH will write policies and procedures for the rate calculation and include them in the Billing Manual.

The rate calculation will be designed to arrive at a Board and Care rate, which will cover the costs of services provided. DBH needs to study the issue of whether using budgeted less projected lapse or actual costs from the previous year will be the better method.

Observation point 2. We concur that the 90% occupancy rate, as outlined in the Medicaid State Plan, was not used in calculating the FY 2003 rates. This was due to the Medicaid State Plan not being changed to agree with the new rules and laws.

DBH has had a meeting with the Department's State Plan Specialist and, working with her, we have drafted new language for the Medicaid State Plan regarding rate setting.

Observation point 3. We concur that there is no independent review of the rate setting process outside of DBH. In the future DBH will explore the possibility of having other auditors within the Division of Community Based Services (BEAS Auditors) review the rate setting calculations before they are submitted to the Commissioner for his approval.

As stated above, DBH believes that the rate setting calculation is in accordance with the RSAs and DBH will work to have the rate setting process removed or rewritten in the Medicaid State Plan. DBH will explore having the Division's Internal Auditor, who is independent of the rate setting process; review the rate setting calculations in the future.

Observation No. 6: Segregation Of Duties Should Be Established In The Processing Of Board And Care Invoices

Observation:

The procedures used by the NHH and Division of Behavioral Health for billing for services do not provide for an adequate segregation of duties to minimize the potential for undetected errors and frauds.

NHH policies and procedures do not require an independent review of board and care invoices prior to their being submitted to patients or their responsible parties for payment. According to the Division of Behavioral Health, Office of Billings, as time allows, a review of board and care invoices is made to make sure invoices were properly calculated and submitted and while errors are often found during the review, the Office of Billings does not have the personnel or necessary resources to perform a review of each claim prior to submission.

Office of Billing employees are responsible for determining billing days for patients whose accounts are to be billed, preparing and submitting the claim, and recording charges and payments in the applicable spreadsheets/ledgers. During fiscal year 2003, the NHH did not have an automated and integrated billing system and the systems used by the NHH required significant manual involvement to prepare and issue bills for services provided. Accounting for charges and payments was also manual. The Office of Billings maintained a series of computerized spreadsheets organized by responsible payor type to track charges, payments, balances, and amounts that are determined to be uncollectible. Because the system was essentially a manual process with multiple inputs and conditions, it was prone to clerical-type errors and inconsistent application of policy.

Some payors like Medicare may take several months to pay claims and respond to one claim per patient at a time. Errors in billings can delay the collection of revenue related to that patient for all subsequent periods until the error gets resolved. Due to the complexities of the bills and manual processes, as noted above, errors are not unusual.

A similar lack of segregation of duties condition exists for the billing of education costs back to school districts.

Recommendation:

The NHH and Division of Behavioral Health should establish a segregation of duties over the preparation of board and care and education invoices to ensure that:

- bills submitted to payors are accurate,
- payments are made for the proper amount and applied to the correct period and account, and
- there is a proper accounting and reporting of revenues, etc.

Auditee Response: We concur.

We concur with the LBA findings regarding the Segregation of Duties in the Processing of Board and Care Invoices for the Billing Office of New Hampshire Hospital (NHH). We agree that the billing system is a complex manual system prone to clerical type errors.

In October of 2004 NHH converted to a new Billing System. NHH and the Division of Behavioral Health (DBH) are developing a work plan to review all aspects of the Billing Office. The first step is to complete the conversion of the old billing system to the new system. Once this step is complete and we are able to produce both electronic and paper claims we will then review the overall operations of the Billing Office including all activities, all reports, and all spreadsheets that are currently used by staff for billing and for reports to management.

DBH and NHH will then start the process of documenting all policies and procedures to update the current Policies and Procedure Manual to insure more accurate billing and training of staff to improve productivity. We will also examine the process of having bills reviewed for accuracy before they are mailed.

Observation No. 7: Policies And Procedures For The Accrual Of Accounts Receivable Must Be Established

Observation:

The methods used for determining NHH's unrestricted revenue accounts receivable at June 30, 2003 did not effectively estimate, evaluate, and analyze those amounts of revenue that were likely to be collected. The NHH did not consider whether there was a need to accrue accounts receivable for restricted revenue accounts.

Questionable methods used to estimate and accrue board and care accounts receivable for the NHH at June 30, 2003 included taking 1/12 of the total amount due from an account receivable aging report (presumably to estimate what would be collected in 30 days) without regard to the age and collectibility of the accounts and taking an average of the accounts receivable posted in

an account at June 30 for the prior three fiscal years. There was no subsequent evaluation performed to determine if the accruals were reasonable.

The State's policy provides "[a]ccounts receivable are amounts due to the State from private persons, organizations, other governments, or other state agencies for goods or services furnished by the State on or before June 30, 2003 and for which the State has not received payment by June 30, 2003. In order to be considered a receivable the amount must be measurable and available. Available generally means the amount will be received within 60 days." Division of Behavioral Health employees responsible for the calculations stated they were not aware of the State's accounting policies for recognizing accounts receivables.

Recommendation:

The NHH in conjunction with the Division of Behavioral Health 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 the NHH in the measurement period discussed in State policy. Included in the policies and procedures should be suitable controls to ascertain that the estimates are performed accurately and in a consistent manner from year-to-year that is also consistent with State and NHH policy. A review of the amounts accrued should be performed, once subsequent collection information is available, to determine whether estimates made were reasonable.

Auditee Response: We concur in part.

We concur that there are no written policies or procedures for compiling the year-end accounts receivable. Problems in receiving information from some patients also causes time delays in recognizing revenue.

The Division of Behavioral Health and NHH will, as part of a complete review of the Billing Office, create policies and procedures for estimating the amount of accounts receivables balances to be collected within 60 days. We will also incorporate a review policy to ascertain the accuracy of those estimates with an eye towards continuous improvement by making adjustments to the methodology. The new billing system will allow us to better track payments and the fiscal year to which they were earned, something the previous system did not allow.

Observation No. 8: Charges For Transitional Housing Services Should Be Subject To Periodic Reviews

Observation:

The NHH and Transitional Housing have not developed a methodology to support current charges for rent and services provided at Transitional Housing. The \$500 monthly fee charged to Transitional Housing residents was set in 1992 and has not changed since that time.

There is no documentation that supports the continued appropriateness of the \$500 monthly rent and services charge to Transitional Housing residents. No review of the monthly charge has been done since Transitional Housing was established in 1992. Reportedly, at that time, Transitional Housing canvassed the Mental Health Centers to determine what was the average charge for group homes and set Transitional Housing's rate accordingly.

Recommendation:

Periodic reviews of costs of services and fees charged to Transitional Housing residents should be performed to make sure fees remain appropriate.

The NHH and Transitional Housing should review the appropriateness of the current \$500 monthly charge for Transitional Housing residents. The charge should, as much as practical, reflect the cost of providing the services and be supported by documented analysis.

Auditee Response: We concur.

Action To Be Taken: In 1992 NHH/Transitional Housing Services did not have the technical means to develop a methodology to calculate current charges for rent and services provided at Transitional Housing. A current rate was calculated in December of 2004 based on the Medicare Cost report for the prior State Fiscal Year. The rate will be calculated annually thereafter and set each year after January 1st and recommendations will be made to the appropriate person as specified by statute.

Observation No. 9: Transitional Housing Billing Practices Should Be Reviewed

Observation:

The NHH's practices for billing for services provided to Transitional Housing residents appear to violate federal regulations for supported housing.

NHH patients who no longer meet the criteria for hospital-level care may transfer to NHH's Transitional Housing or other residential facilities. Residents of the Transitional Housing units are charged all or a portion of a \$500 monthly rate for rent and services, based on a payment recommendation set by the Division of Behavioral Health, Office of Reimbursements. Certain Transitional Housing facilities are supported by federal Housing and Urban Development (HUD)

grants and residents of those supported housing facilities must be charged for rent according to HUD regulations.

- The current practice of billing on a monthly basis does not comply with HUD regulations, which require billing on a daily basis. In addition, for those residents not in HUD supported facilities, billing monthly does not necessarily match charges to actual services provided as residents may transfer between NHH patient and Transitional Housing resident status midmonth, without an adjustment of the bill or postings of the subsequent revenue collections being made. If a patient returns to the NHH, the money paid by or on behalf of the resident/patient is applied to the institution the person was in for the greater part of the month. When a person leaves Transitional Housing and goes to the community and was at Transitional Housing for less than 15 days in the final month, the charges for the partial final month's rent and services are suspended to allow the leaving resident to use the money for start-up expenses in the community setting. Waiving rent for federally subsidized housing may not be allowed by federal regulations.
- The current practice of splitting the \$500 monthly charge for HUD supported residents between rent and services does not appear to comply with the rent limitations in HUD regulations. In practice, the calculation arbitrarily sets the rent portion of the charge at the amount allowed by HUD regulations and charges the remainder of the \$500 monthly rate as a service fee. When asked, Transitional Housing could not describe the additional services that were paid for by the service fee.

Recommendation:

The NHH and Transitional Housing should review and evaluate current payment recommendation and billing practices for patients and residents to ensure that the practices can be applied fairly and consistently to all individuals including those who are in transition between facilities in any given month.

As part of their review, the NHH and Transitional Housing should ensure that amounts charged for residents in subsidized housing are in compliance with federal regulations.

Policies and procedures should be established, clearly communicated, and monitored to ensure the costs for services are recovered as intended and laws, rules, and regulations are complied with.

Auditee Response: We concur in part.

Beginning in April of 2005 there will be a break out of the daily rate from services charged on the bill. This break out will be based on the daily rate as determined by the HUD rental calculation formulae for each individual. Policies will be developed to ensure the above practices are within all State and federal guidelines.

When a patient enters a HUD house, a rate calculation worksheet specified by HUD is done to compute their daily rent. The clerk who prepares the bills for rent uses these worksheets to determine the daily charge for rent based on the HUD subsidy. Services are then assessed based

on all other costs associated with the residential program not included in the operations portion of the HUD grant. The Billings Office must submit an annual report to HUD that illustrates how much of a subsidy HUD is paying for each resident based on the resident's income. These rate calculation sheets are updated annually or whenever a resident has a substantial change in income. Additional services paid for with the services fee, based on allocated costs, will be identified in the monthly bill. We will develop formal policies and procedures to reflect this practice, which is in compliance with HUD regulations.

Observation No. 10: Controls Over Food Allowances For Transitional Housing Residents Should Be Improved

Observation:

Money collected from Transitional Housing residents for food is not sufficiently controlled to ensure residents receive the full benefit of their contributions.

Money collected from residents as a contribution towards the cost of food is commingled and is not segregated and accounted for by individual resident. Money collected from Transitional Housing residents is combined with cashed food stamp benefits and provided as an allowance to residents responsible for food shopping, with assistance, for the housing units.

Transitional Housing maintains resident food money in an interest-bearing checking account in the NHH's banking system. Weekly, a Transitional Housing employee withdraws sufficient money to cover anticipated food purchases for the week. The withdrawal is recorded in the banking system and in a log. When money is subsequently given to residents or mental health workers to shop for food, the disbursement of money for shopping is also recorded in the log. Money that is not spent, remains in the Transitional Housing safe and is used for shopping during the following week.

The current procedures appear to allow food money collected from some residents to subsidize other residents that are not able to pay an equal or full contribution towards food. Transitional Housing procedures in effect during fiscal year 2003 did not ensure that resident contributions for food were properly safeguarded, remitted, and accounted for; that duties were properly segregated, that purchases of food were in agreement with money paid by residents; and that residents were not paying for food for other residents. No one monitored the accounting records, including the logsheet, to ensure that purchases were supported by proper receipt documentation. There were no procedures to reconcile the records of account activity maintained by the cashier's office and the account activity recorded in the Transitional Housing log.

Recommendation:

Policies and procedures should be established to ensure that monies contributed by residents for food are properly safeguarded and accounted for. Responsibilities for receiving, holding, and disbursing resident food contributions should be properly segregated. As much as practical, policies and procedures should ensure residents are paying for the food they consume and

residents are not required to pay for the food of residents with fewer resources. Accounting records, including logsheets and purchase receipts, should be periodically reviewed to make sure that purchases are supported. Periodic reconciliations of the records maintained by the cashier's office and the log maintained by the Transitional Housing employee should be performed to ensure that all resident food monies are properly accounted for.

Auditee Response: We concur in part.

Action To Be Taken: Transitional Housing Services (THS) will develop policies that are more specific and inclusive of the recommendations by April 30, 2005. There shall be requests to the DHHS for periodic reconciliation of the accounts by an outside auditor.

No one resident subsidizes another resident's food costs. Each resident contributes a monthly allocation for food of \$175.00. If a resident is without sufficient resources, he/she may apply for a food grant up to \$175.00. THS is authorized by the USDA to participate in the Food Stamp program for Communal Dining. As authorized representative, THS complies with the requirements for participation including returning of pro rata share of funds to a resident when unexpended.

Observation No. 11: Income Of Residents In Federally Supported Housing Should Be Reviewed At Least Annually

Observation:

Transitional Housing is not reviewing changes in resident income in federally supported housing as required by the federal Department of Housing and Urban Development (HUD) rent calculation guidelines.

Transitional Housing prepares a rent calculation worksheet that includes an adjusted income determination for each HUD resident. The *Rent Calculation Guidelines* indicate that a resident's income must be examined initially and reexamined at least annually, however, if there is a substantial change during the year an adjustment must be made to the rent payable to reflect the change in income. Per review of a HUD rent worksheet selected during the planning stage of the audit, we noted that the most recent *Payment Recommendation* for the respective resident was more than 12 months old. Per discussions with Transitional Housing personnel, there are no policies and procedures in place requiring an annual reexamination of residents' income and ability to pay rent and, generally, a resident's income and ability to pay rent may not be reexamined unless Transitional Housing is notified of a significant change in a resident's financial status.

Recommendation:

Residents' income for Transitional Housing residents in HUD supported facilities should be reexamined at least annually to remain in compliance with HUD requirements. Policies and

procedures should be established to assist Transitional Housing in performing the reviews in a timely manner.

Auditee Response: We concur.

Action To Be Taken: Policies shall be developed by April 30, 2005 that contain the language of the federal requirements. During the time period of the audit, annual calculation of rental payments was not available for review. As of February 23, 2004 policy change for maintaining annual calculation of rent was implemented and is available for auditor review. All residents' rental calculations are completed in July of each fiscal year regardless of change in income status.

Observation No. 12: Recovery Of Costs For Patients On Visitation Status At Transitional Housing Should Be Considered

Observation:

The NHH has not established policies and procedures to recover the cost of service provided during the period NHH residents are on visitation status at Transitional Housing.

Prior to discharge from the hospital, NHH patients who will be residing at the NHH's Transitional Housing units undergo a trial period during which they are observed and evaluated to determine if they will be successful in the new environment. During the trial or visitation period, patients reside at the Transitional Housing units and receive the same set of services as the rest of the residents in addition to a continuation of certain services at the Acute Psychiatric Services (APS) facility. However, the cost of providing services to these patients while in visitation status is not billed. The NHH census reports these patients as "on leave" from the APS facility and the Transitional Housing census reports the patients as on "visitation status." Both situations are currently classified as not billable by the NHH. While visitation status generally lasts a period of one week, during fiscal year 2003, one resident was listed as on visitation status for 30 days. During fiscal year 2003, there were 362 unbilled visiting days at Transitional Housing.

According to the head of Transitional Housing, because patients on visitation status have not been formally discharged from the APS facility, the NHH cannot bill costs related to the visitation to Medicaid, the main payer of clinical services provided to Transitional Housing residents. In addition, because the patients are on leave status at the APS, billings for the patient cannot occur through that facility. Because the visitation period is generally considered to be relatively short, the NHH has not seen it as a priority to establish a policy to recover the costs of services provided during the visitation period from other sources such as Social Security, Medicare, or other payers.

Recommendation:

The NHH should investigate whether opportunities exist for recovering the cost of services provided to patients on visitation status at Transitional Housing. If current Transitional Housing charges cannot be recovered, NHH should investigate whether it could establish fees to support services that it continues to provide while the patients are on visitation status.

Auditee Response: We concur.

We have explored opportunities for recovering the cost of services provided to patients on visitation status at Transitional Housing (THS) and determined there are no additional opportunities for recovering costs. Individuals that remain inpatients at NHH and go on visit at THS are not eligible for Medicaid until they are discharged from NHH and meet all other eligibility criteria. For billing either Medicare or Medicaid, federal law is clear that you cannot be an inpatient at two facilities at the same time.

If the patient is on visit to THS then they are not “physically located” in the Acute Psychiatric Services (APS) Unit and therefore NHH cannot bill Medicare or Medicaid for any services. If they are not absolutely discharged from the APS Unit, they are still considered an inpatient of NHH, therefore THS cannot bill for any services.

If a patient has any “Entitlement Income” (Social Security Administration, Veterans Administration, etc.), NHH bills the patient a partial rate less any personal allowance as long as the patient is at the APS for at least one day a month. The daily charge at NHH is over \$700; should any individual have a monthly income greater than this amount, the Office of Reimbursements reviews the account and determines what additional charges should be made. If the patient is discharged from NHH and admitted to THS, any entitlement money is used to cover the cost of food, rent & services at THS. Regardless of where the patient is located during the month, either NHH or THS keeps the patient’s entitlement money.

We do not believe establishing fees for support services at THS would generate any additional revenue for the State since the patient’s income has already been taken.

Observation No. 13: Policies And Procedures Should Be Established For Recovery Of Costs Of Educational Services

Observation:

Methods used by the NHH to recover the costs of providing educational services to residents are not well developed, documented, reviewed, or applied.

The NHH, through the Division of Behavioral Health, Office of Billings, charges responsible school districts the cost of providing educational services to Hospital residents between the ages of three and 21. RSA 126-A:39, directs the Hospital to recover up to the State’s average cost for an elementary school pupil, as determined by the State Board of Education. The amount charged

to a school district is determined by applying a daily rate to the number of days of educational services provided. The daily rate is calculated as the total amount budgeted to the Hospital for providing all educational services divided by the estimated number of student days. However, the rate actually applied in charging school districts is subjective, as the estimated number of educational service days used in calculating the daily rate is adjusted, according to the Office of Billings, to attain what is considered to be an acceptable rate. There are no policies and procedures regarding the methodology used for determining the rate or the review of the calculation.

While the statute allows for recovery of costs in excess of the amounts recovered from the school districts from other responsible parties including the resident, the resident's parents, and the resident's and parent's estates, the Hospital does not normally attempt recovery from these sources.

Recommendation:

The NHH should establish formal documented policies and procedures for recovering the costs of providing educational services to residents. The policies and procedures should address the calculation of rates charged to school districts and other responsible parties. The policies and procedures should address who to charge, how much to charge, and controls for waiving charges. The policies and procedures should include review and approval functions to ensure the recovery of costs occur as intended by management and statute.

The documentation of the policies and procedures should be sufficiently detailed to provide for their consistent and accurate application, regardless of the tenure of the employee assigned the responsibility.

Auditee Response: We concur.

Action To Be Taken: The NHH will establish formal documented policies and procedures for rates charged and fees collected for educational services provided at NHH. Although the current rate setting process, using the approved budget and estimated number of days has been used for many years, the process is not currently documented. NHH will establish written policies for rate setting for all services at NHH by April 30, 2005.

We do not concur that Division of Behavioral Health should establish policies and procedures that "address who to charge, how much to charge and controls for waiving charges". RSA 126-A:39 specifically states that the charges will be that of the average elementary cost per pupil. This maximum is set by the Department of Education not the Department of Health and Human Services, as noted in the LBA Finding. Although the Division of Behavioral Health sets the daily rate based on the approved budget and the projected total number school of days, the total charges for any student cannot exceed the maximum set by the Department of Education. This usually means that the maximum number of days that can be billed to the school district is approximately 40 school days. The RSA also states: "The liability of the school district for such expenses shall precede that of the persons, or estates named in RSA 126-A:37, which are hereby relieved of liability for such expenses to the extent of the school district's liability". It has been

the interpretation of the NHH lawyer that this statement places the liability of the educational cost on the school district and therefore these expenses are not recoverable from the minor's parents or guardians. By April 30, 2005 NHH will seek a second opinion to confirm our understanding of this RSA.

PAYROLL AND EMPLOYEE RELATIONS

Observation No. 14: Effectiveness Of The Time And Attendance Recording Should Be Reviewed

Observation:

NHH employee timekeeping procedures are inefficient and prone to error and ineffective use.

Daily, classified employees at NHH record their presence at work on attendance sheets generally located in common areas of the Hospital. According to NHH policies, each employee is to record time in at the beginning of a work shift and time out and total hours worked upon leaving at the end of a workday. Attendance sheets are used in conjunction with employee leave slips to establish biweekly hours worked and pay for employees.

A review of a number of attendance sheets indicated that NHH employees are not consistently completing the sheets in the manner intended by management. For example, while some employees appear to properly record the time they actually reported to and left their unit, others appear to record the time they are scheduled to start or quit working. Some employees appear to record both in and out time when they sign in. Some time-in postings appear to be the time the employee enters the Hospital building, perhaps to utilize the cafeteria prior to a work shift, and not necessarily when the employee actually reported for work. Some time in or out postings for multiple employees appear to be completed by the same hand, raising the question as to whether the employee was present at that time. Neither employees nor supervisors are required to sign the attendance sheet to attest to its accuracy. Compounding the accuracy issues raised by inconsistent use of the attendance sheets is the condition where NHH does not rigorously enforce the requirement for the timely submission of leave slips. The NHH's six payroll accounting clerks reportedly spend approximately 75% of their time performing recalculations of hours worked and transferring the information recorded on the attendance sheets to a bi-weekly timesheet, a redundant posting of attendance sheet information.

The lack of effective controls over recording employee hours worked increases the risk that payroll error or fraud could occur and not be detected by the employee or supervisor in a timely manner. In addition, because there is no apparent consistent application of the controls over the hours reported as worked, the NHH may be liable for employee hours worked that were not authorized but are documented in the attendance sheets.

Recommendation:

NHH should make each employee accountable for accurately recording the actual time worked. Supervisors should be required to review and approve the attendance record prior to the payroll being prepared. The time recording procedure should be clearly described and included in NHH policy manual and periodically reviewed with employees to ensure clear understanding by both employee and employer.

NHH should consider more effective and efficient time recording systems such as electronic scanning of the employee ID card, or an on-line attendance record system to promote a more controlled and accurate time accounting and to eliminate the redundant processing of time and attendance information.

While the NHH continues to use attendance sheets, the NHH should consider providing more secure locations for the attendance sheets to limit unauthorized access to the records and should consider requiring employees sign the sheets to attest to their accuracy.

Auditee Response: We concur in part.

Action To Be Taken: NHH will review our existing process and implement changes by developing a work plan. We would phase in any changes by June 30, 2005 using a pilot program, and adjust the plan as needed. We are looking at employees needing to sign in on daily attendance sheets, located in their individual work unit areas, with attendance sheets needing to reflect work hours (schedules) for each employee. We will determine whether it is feasible to have designated leave clerks in each work unit sign to the sign-in sheet's accuracy and submit to HR daily, along with the attached leave slips, which would serve as backup. If daily attendance sheets were to be developed for each work area, the time recording procedure will be included in the NHH policy manual. Advance notice would be provided to employees. There is currently no computer software available to state agencies for an on-line attendance system. Should one be adopted statewide, it would promote a more controlled and accurate time accounting and eliminate the redundant processing of time and attendance.

Observation No. 15: Weekend Pay Differential Should Be Paid As Negotiated

Observation:

The 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 *Collective Bargaining Agreement* provides for weekend differentials for only Saturday and Sunday shifts.

According to the *Collective Bargaining Agreement*, section 19.12.5, 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. 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 the 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. The NHH was unable to provide documentation supporting authorization for the payment of differentials for these shifts.

Recommendation:

The NHH should determine if it has the authority to pay weekend differentials in excess of the differentials provided for in the *Collective Bargaining Agreement*. If the NHH determines it has the authority, the NHH should document the authority and determine whether the continued payment is appropriate. If the NHH determines no current authority exists for these payments and the payments are necessary for the continued operations of the Hospital, the NHH should seek authority to continue making the payments.

Auditee Response: We concur in part.

Action To Be Taken: NHH had received approval from former Director of Personnel, to pay weekend differentials in excess of the differentials provided for in the Collective Bargaining Agreement (CBA). By April 1, 2004 NHH will request permission from the Division of Personnel to continue our current practice. We will stop the practice within 60 days should the Division of Personnel not concur.

Observation No. 16: Policies For Payment Of Overtime Should Be Consistent And Documented

Observation:

The NHH is inconsistent in its payment of overtime to employees who work full-time for other State organizations and also work part-time for the NHH.

Generally, employees who work part-time for the NHH and also work for another State organization are considered to work for two separate employers and the hours worked at each agency are not combined for overtime computation purposes. However, employees who work as full-time employees for the Department of Corrections, and also work part-time for the NHH, are paid premium pay for hours worked in excess of 40 hours during a pay period for both employers combined. Department of Health and Human Services employees who work full-time at other than the NHH location are also paid premium pay for part-time hours in excess of 40 hours per pay period for both the non-NHH and the NHH hours combined. Other non-Department employees are not paid premium pay by the NHH unless the NHH hours exceed 40 hours per week. While hours may be combined for premium pay purposes, the work at NHH is considered part-time work for a separate employer, for retirement contributions purposes, and neither the employer nor the employee makes contributions on the NHH pay.

Recommendation:

The NHH, in conjunction with the Department of Administrative Services Division of Personnel, should establish consistent policies and procedures for paying part-time employees who also work at other State organizations. If there are valid reasons to pay employees of other State organizations premium pay based on combined hours, the rationale for that action should be documented and consistently applied. Also, the rationale for not reporting and making contributions to the retirement system on the part-time payroll should be reviewed for propriety and if ratified for continued practice, should also be consistently applied and documented.

Auditee Response: We concur in part.

Action To Be Taken: A February 1991 memo from, Bureau of Employee Relations, Administrator, Bureau of Accounts, re: Overtime Rates/Joint Employment, is currently the basis for determining overtime pay. In the memo, we were advised that employment of an individual by two or more agencies with hours worked for each employer be computed and paid separately, and suggested that we not treat employment by two or more State agencies as employment by a single employer for overtime computation purposes. NHH concurs that consistent policies and procedures for paying part-time employees who work at other State agencies should be established. With the shortage of nurses, we are currently paying employees with registered nurse licensures from other State agencies premium pay based on combined hours. By April 1, 2005 the Hospital will request permission from the Division of Personnel to continue our current practice. We will stop the practice within 60 days should the Division of Personnel not concur.

Observation No. 17: All Formal Agreements Between Employee And Employer Should Be Documented

Observation:

NHH has established an alternative work schedule which allows its direct-care employees to work through one of two 15 minute paid breaks and end their workday in seven and three quarters hours and get paid for eight hours of work. While this alternative schedule is employed for all direct-care workers at the Hospital, it has not been made the formal schedule through the collective bargaining process and has not been made subject to other written agreements.

According to the NHH the current workday arrangement for direct care-employees is a long-standing practice, and the Human Resource Department is not aware of any documentation that the schedule was of mutual agreement. The lack of documentation of the mutual agreement impedes the clear understanding of employment contract by both employee and employer and it increases the risk of employee dissatisfaction, indolence, or labor dispute.

Recommendation:

NHH should document the basis for the alternative work schedule to ensure that it continues to meet the needs of the Hospital. If it is determined that it is advantageous to the Hospital and it is intended to be continued and applied to all direct-care employees, the schedule should be fully documented and considered for inclusion in the collective bargaining process.

Auditee Response: We concur.

Action To Be Taken: Effective January 2005, the Superintendent of NHH appointed a committee to review current schedules of direct care workers and to research and provide information by mid-April re: evidence-based practices at other acute psychiatric hospitals. Whatever schedule is adopted will either be consistent with the current Collective Bargaining Agreement or documented as an alternative work schedule to be considered for inclusion in the collective bargaining process.

Observation No. 18: Payment Of Temporary Salary Increases Should Be Made Only When Authorized

Observation:

During fiscal year 2003, Occupational Therapists at the NHH continued to receive a 13.5% temporary increase in their hourly pay rate, even though the authority for the temporary increase, first enacted in 1993, expired early in fiscal year 2002.

The NHH originally received approval for a temporary increase in hourly pay rate for Occupational Therapists on November 9, 1993. This approval, which was for a two-year period, was subsequently extended. Prior to its ultimate expiration on November 9, 2001, the NHH sought another extension through the Department of Administrative Services, Division of Personnel. However, the Division of Personnel never responded to the request and the approval expired without further action.

Recommendation:

The NHH should determine whether the circumstances requiring the payment of a salary enhancement to Occupational Therapists continue and the payment is warranted. If it is determined that the salary enhancement is recommended, proper approval should be sought.

Auditee Response: We concur.

Action To Be Taken: NHH recognizes that this was an oversight on our part and we will determine if the salary enhancement should be continued, based on a salary survey, and proper approval will be sought through the Division of Personnel and Governor and Council by June 30, 2005.

Observation No. 19: Propriety And Efficacy Of Having Employees Provide On-Call Medical Physician Services Through Medical Services Contract Should Be Considered

Observation:

Having NHH employees also provide contracted services blurs the employee-employer contractor relationships at the NHH and causes the NHH to pay additional overhead costs.

During fiscal year 2003, three NHH unclassified employee physicians were among a group of doctors that provided night and weekend on-call medical physician services to the NHH. These doctors worked as employees of the NHH's medical services contractor and were paid \$900 per week when covering on-call duties. The contractor charged these costs plus payroll taxes and a 26% indirect cost premium back to NHH through the medical services contract.

It is unclear whether the NHH medical services contractor's hiring of salaried State employees for the provision of medical on-call physician services is the most efficient and effective method to obtain these necessary services. While these services were not specifically included in the contract in effect during fiscal year 2003, the contract covering fiscal year 2004 did include a provision for the contractor to provide on-call medical doctors.

Recommendation:

1. The NHH should determine whether there are any employment-law considerations to having a contractor hire salaried State employees to provide contracted services to the NHH. The NHH may want to seek a review of the employee/employer/contractor relationship by a Department of Justice or other attorney familiar with employment law.
2. The NHH should also consider whether hiring employees through the medical services contract is an efficient method to obtain needed services.

Auditee Response: We concur in part.

1. We concur that, NHH is seeking legal council and review the employment-law to assure compliance and take action if needed.
2. We do not concur. NHH has reviewed its practice of hiring the on-call medical coverage through contract and has validated it as cost effective and provides a high level of professional care to our patients for the following reasons:
 - a) Best knowledge of patients at NHH.
 - b) Already familiar with acute situations and can respond with increased Hospital uses, decreased complications.
 - c) Familiar with NHH environment, mental issues and community facilities, and are able to interact with the local emergency room to screen patients' appropriateness for admission.

- d) Physicians don't want to work at night/ the present rate of \$900/120 hours of night and weekend coverage translates, to \$7.50/hour, far less than the \$25-50 per hour required on the open market.

Observation No. 20: Necessity And Extent Of On-Call Coverage Should Be Reviewed

Observation:

During fiscal year 2003 NHH paid \$169,000 to employees who performed on-call duties. It is not clear that the NHH managed its on-call coverage in the most efficient and effective manner.

In addition to medical doctors providing on-call coverage, the NHH has employees on call during evenings, weekends, and holidays to respond to situations that require administrative and professional decisions when such employees are not normally available. During fiscal year 2003, five unclassified and 18 classified employees covered these non-medical doctor on-call duties. Unclassified employees were not compensated and, in accordance with the *Collective Bargaining Agreement*, classified employees were compensated at 25% of their regular hourly pay rate when on call.

On call coverage was maintained nights, weekends, and holidays for the following functions during fiscal year 2003.

- NHH Executive Administration
- Pharmacy
- Engineering/Maintenance
- Transitional Housing Administrative
- Transitional Housing Clinical/Nursing

During fiscal year 2003, on-call pay was a substantial amount of some employees' income, ranging 6% to 56%, with an average of 18% of the regular salary for those classified employees providing on-call coverage.

The NHH has not maintained records to establish the frequency and nature of situations requiring contacting its on-call employees and the necessity of the timely involvement of those employees either through call back to work or other decision making. Anecdotal reports indicated that there had been relatively few situations where on-call employees were required to return to work or to make decisions that could not wait until regular work hours.

In December 2003, the Commissioner of the Department of Health and Human Services directed that the NHH reduce on-call coverage expenditures by 25%.

Recommendation:

The NHH should review its current on-call coverage practices to ensure that the coverage is necessary, efficient, and effective. The NHH should also consider whether options are available

that would ensure adequate on-call coverage yet minimize paying for unnecessary employee time.

Any review performed by the NHH should consider the actual utilization of on-call employees including frequency, urgency of the call, input resulting from the on-call employee's involvement with the situation, and possible alternatives that may have been employed had the on-call not been available. The NHH should also review whether better policies and procedures could alleviate the frequency of crisis situations and lessen the need for utilization of on-call employees.

Auditee Response: We concur in part.

NHH is responsible for a major portion of 106 acres of State Park South that includes buildings and roadways (including snow plowing) 24/7, 365 days a year. The Acute Care Psychiatric Services and Transitional Housing Program, both patient care providers, operate on a 24/7, 365 days a year. We have reviewed this issue a number of times to confirm we are providing only necessary coverage to insure the safety of patients, staff, and meeting the standards of Medicaid/Medicare and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Using an on-call system, in fact, saves the State a considerable amount of funds, by only paying 1 hour for every four hours on-call. The other more expensive option would be to have employees on site being paid the regular hourly rate or at the higher over-time rate. The practice used by NHH is a standard used by hospitals throughout the industry.

NHH on-call staff maintains logs to track the number of calls and the action taken during the on call period. The first is the Campus Police log that documents every call to the Executive on-call, Maintenance, and the Pharmacy. The second log is maintained by the Executive on Call containing vital information and notes regarding action taken on each incident. NHH will immediately instruct all other areas to begin to utilize the on-call log process including action taken and forwarded to the Superintendent's office weekly.

OTHER CONTROL COMMENTS

Observation No. 21: Formal Fraud Prevention, Deterrence, And Detection Program Should Be Established

Observation:

The NHH has not established a formal fraud prevention, deterrence, and detection program.

Fraud encompasses an array of irregularities and illegal acts characterized by intentional deception. Persons outside or inside the organization can perpetrate it for the benefit or to the detriment of the organization. Fraud runs the spectrum from minor employee theft and unproductive behavior to misappropriation of assets, fraudulent financial reporting, and intentional noncompliance with a law or rule leading to an undue benefit.

Management is responsible for assessing the risk of fraud and implementing measures to reduce the risks of fraud to an organization. Fraud assessment, prevention, deterrence, and detection are crucial to the controlled operations of an organization.

- Assessment is critical since risks can only be effectively managed if risks are identified. The risk of fraud can be reduced through a combination of prevention, deterrence, and detection measures.
- Prevention reduces opportunities. Preventative methods are typically part of the organization's internal control – tone at the top and control procedures. Management of an organization “sets the tone” for the whole organization by signaling that fraud will not be tolerated and establishing control procedures including, but not limited to, adequate segregation of duties and formal accounting policies and procedures intended to limit the opportunity for fraud.
- Deterrence consists of those actions taken to discourage the perpetration of fraud and limit the exposure if fraud does occur. The principal mechanism for deterring fraud is the establishment of effective controls that persuade employees that frauds will be detected and perpetrators punished. Management has the primary responsibility for establishing and maintaining these controls, which may include written codes of conduct that apply to all employees, periodic employee trainings, monitoring of employee compliance, and an effective fraud reporting mechanism.
- Detection consists of identifying indicators of fraud sufficient to warrant recommending an investigation. These indicators may arise as a result of controls established by management, tests conducted by internal auditors, and other sources both within and outside the entity. Detection can be difficult because fraud often involves concealment through falsification of documents or collusion among management, employees, or third parties. If fraud is detected, the organization should contact legal counsel. Legal counsel has the expertise to advise as to the extent of any necessary investigation.

Generally, prevention and deterrence measures are less costly in time and expense than fraud detection and investigation efforts.

Recommendation:

The NHH should perform a fraud risk assessment and develop and implement a formal fraud prevention, deterrence, and detection program to help limit the NHH's exposure to fraud and promote early detection of fraud that may occur. The NHH should take measures to foster a high degree of control consciousness among its employees and ensure that its employees understand that adhering to controls is a primary concern of management. Fraud risk assessment and the establishment of a prevention, deterrence, and detection program are critical activities for the NHH and the State.

Auditee Response: We concur.

Action To Be Taken: Once NHH receives the formal copy of the reporting policy against fraudulent or other wrongful acts from the Department of Administrative Services we will implement the procedures as defined.

Observation No. 22: Formal Fraud Reporting Policy Should Be Established

Observation:

The NHH has no formal fraud reporting policy. The lack of a written policy may delay the reporting of fraudulent activity.

Management is responsible for fraud deterrence and a fraud reporting policy supports that effort. The attributes of an effective fraud reporting policy include the following.

- Policy is in writing.
- Policy describes fraudulent activities and the actions required when fraud is suspected or detected.
- Policy is communicated to all employees.
- Management obtains written assurance from each employee that the policy and related reporting mechanism is understood.
- Employee training is provided.

The effectiveness of a fraud reporting policy is enhanced when employees have a clear understanding of fraud indicators and what constitutes a fraudulent act. It is important that the reporting procedure is non-threatening for the reporter and provides for the reasonable protection of all parties.

Recommendation:

The NHH should establish a formal fraud reporting policy and provide its employees with fraud awareness training. The NHH should take measures to ensure that the policy facilitates and encourages reporting and protects all parties involved.

Auditee Response: We concur.

Action To Be Taken: NHH will prepare a work plan by June 30, 2005 coordinated with the Department of Administrative Services and other agencies in development of this policy but given the complexity of the project we have difficulty committing the staff to a specific timetable when this can be completed.

Observation No. 23: Controls Over Preparation Of Medicare Cost Report Should Be Improved

Observation:

The fiscal year 2003 *Medicare Cost Report* prepared by the NHH and based on fiscal year 2002 cost experience contained incomplete and inaccurate information. While the missing and inaccurate information may not have had a significant effect on fiscal year 2003 NHH activity,

the fact that the reporting deficiencies were not recognized by the NHH prior to the reports submission indicates an ineffective review of the report.

The NHH is required to submit information to Medicare for the settlement of costs relating to health care services rendered to Medicare beneficiaries. Federal regulations require providers maintain sufficient financial records and statistical data for the proper determination of costs payable under the program and report costs on an annual basis. Costs reported on the *Medicare Cost Report* are also used by NHH for determining the settlement of costs for Disproportionate Share (DSH) payments to the NHH. To obtain the proper amount of reimbursement from Medicaid and Medicare for the services provided it is important to report correct information in the *Medicare Cost Report*.

While the *Medicare Cost Report* was not specifically audited, the following errors were noted in the NHH's preparation of the fiscal year 2003 report.

- In reviewing the compilation of capital-related costs for the *Medicare Cost Report* we noted:
 - Depreciation schedules, included building renovations and roof repairs at buildings that were not part of NHH's operations, overstating reported depreciation costs by \$93,558.
 - Depreciation expense for some capital items was calculated for only one half of a year even though the items had been in service for longer than a year and a full year of depreciation should have been calculated. Reported depreciation expense for these items was understated by \$68,710.
 - Interest expense on the *Report* was taken from original bond amortization schedules however much of the NHH debt has been subsequently refunded making the original interest expense generally overstated. No determination of misstatement for interest expense was performed relative to the reporting year 2002, however the effect of using the incorrect amortization schedules for fiscal year 2003 interest expense was to overstate the expense by approximately \$16,000.
- One Department-wide cost allocated to NHH, and included on the *Report*, was incorrectly input into a spreadsheet and resulted in a \$30,000 cost overstatement.

The errors in the depreciation schedules and the error in the spreadsheet for indirect cost went undetected by the NHH illustrating the fact that there was no effective review performed on data compiled for the *Report*. One Division of Behavioral Health employee has historically been responsible for understanding the requirements of and completing the *Medicare Cost Report* on behalf of the NHH. The preparation of the *Report* requires obtaining information from various NHH, Department, and other sources and compiling the information on various spreadsheets and schedules prior to completing the report. While during fiscal year 2003 the employee who had previously completed the *Report* began to train a NHH business office employee to assume the responsibility, there was no effective review process in place to verify the accuracy and completeness of the reporting.

Recommendation:

The NHH and its related State partners need to establish effective controls for accumulating and reporting complete and accurate information in its *Medicare Cost Report*. Controls should

include, but not be limited to, improving coordination efforts with other State organizations including the Department and the State Treasury to obtain current and accurate information relative to the cost of operating the NHH. An effective review process that includes segregation between the *Report* completion and approval responsibilities and provides for the timely detection and correction of errors must be established.

Auditee Response: We concur.

The preparation of the Medicare Cost Report does require information from several sources. Improvements will include:

- As part of the review process the Division of Behavioral Health (DBH)/NHH will explore having an auditor from another Bureau within the Division review the cost report and supporting documents for accuracy.
- DBH/NHH will contact the State Treasury Department each year prior to completion of the cost report to determine the proper amount of interest for NHH.

Observation No. 24: Budgetary Controls Should Not Be Avoided

Observation:

During fiscal year 2003, approximately \$570,000 of Department expenses were allocated to NHH organization and class accounts even though these expenses were not related to NHH operations. In addition, the NHH charged expenditures inconsistently to its accounts and accounting periods due to exhausting appropriations in some accounts. Examples of cross organization allocations include the following.

- Utility costs for buildings on the NHH campus are generally invoiced by building and not by the organizations housed in the buildings. When NHH receives a utility invoice, it generally charges the expenditures to the agencies or divisions operating in the building; however, all utility costs for the Thayer building were charged to NHH even though it was occupied by other non-NHH organizations. Also, heating and other utility bills that should have been charged to the Division of Behavioral Health (DBH) were charged to NHH accounts when the DBH depleted its budget before the fiscal year end.
- The NHH paid the salary and benefit costs of four DBH employees during fiscal year 2003. These employees' duties were not within the scope of NHH's operations.
- A small amount of DBH's maintenance and other expenditures were also charged to NHH during fiscal year 2003.

According to the NHH, crossover of utility, maintenance, and other costs occurred with the gradual turnover of buildings and responsibilities from the NHH to other divisions and agencies without sufficient clarification of associated responsibilities. Utility bills for Thayer building were charged to NHH during fiscal year 2003 but were not charged starting with fiscal year 2004. The Department's frequent reorganizations and restructuring also contributed to crossover of services and costs. According to the NHH, the use of separate job numbers for non-NHH

expenditures in the State's accounting system, NHIFS, properly excluded the non-NHH expenditures from the Disproportionate Share calculation and included the services provided by other State organizations to the NHH as indirect costs.

Examples of expenditure allocations contrary to budgeted amounts within the NHH organization include the following.

- Fiscal year 2003 utility expenditures for Transitional Housing were charged to NHH Facility when the Transitional Housing appropriations were exhausted.
- Fiscal year 2003 Outside Medical Services expenditures were charged to Current Expense when the Outside Medical Services appropriations were exhausted.
- Approximately \$22,000 of fiscal year 2003 expenditures were charged to fiscal year 2004 appropriations for a contracted vendor as the fiscal year 2003 appropriations were exhausted.

Recommendation:

Budgetary controls should not be avoided. Only expenditures budgeted to the NHH should be paid from NHH accounts. The expenditures of other State organizations should be charged to their appropriations. NHH appropriations should not be used to supplement the exhausted appropriations of other divisions. Instead, approvals for increasing appropriations through the use of transfers or supplemental appropriations should be requested.

Auditee Response: We concur.

NHH concurs that expenditures of other State organizations should not be charged to its appropriation and during the budget process will make appropriate adjustments. NHH will work diligently with the Department of Health and Human Services to ensure only hospital expenses are charged to its accounts.

Observation No. 25: Controls Should Be Improved In The Pharmacy

Observation:

A review of the NHH's pharmacy operations indicated opportunities for improving controls over the pharmaceutical inventory. For example:

- Controls are weak over unused drugs that are returned to the pharmacy. Returned drugs may or may not be accompanied by a doctor's return order or documentation. Additionally, when returned drugs are received at the Hospital's pharmacy, the drugs are temporarily stored in a bin with other returned drugs prior to being counted and put back into the perpetual inventory system. Allowing the returned drugs to remain in the temporary storage without restricting access to the bin breaks the chain of custody for the drugs and hampers the pharmacy in maintaining accountability for all drugs. The lack of supporting documentation for returned pharmaceuticals prevented the testing of these transactions.

- When inquiring about a variance between a physical count and a perpetual inventory system count, a limitation in the computerized pharmaceutical inventory system was discovered. When two or more transactions were input into the system for the same drug without having exited that function in the system, only the last transaction would be recorded. The earlier postings would not be recorded.
- Access to making adjustments to the perpetual inventory system is not restricted. All pharmacy employees have unlimited access to the perpetual inventory system and therefore can make changes in the perpetual inventory system with no review or approval of the change. This weakness is compounded by the pharmacy not documenting the circumstances requiring the adjustments.
- Investigations of discrepancies between the test count and the perpetual inventory records are not properly documented.
- Instructions for performing physical counts and reconciliations with the perpetual inventory system provided to employees performing the physical inventory could be improved.

During fiscal year 2003, \$1.3 million of pharmaceuticals were purchased by the NHH. At June 30, 2003, the NHH pharmacy reported that the cost value of pharmaceuticals on hand was \$175,000.

Recommendation:

The NHH pharmacy must improve controls over its pharmaceutical inventory. Controls should help ensure that all drugs brought into the pharmacy and disbursed from the pharmacy inventory are properly accounted for.

Policies and procedures should be established to secure drugs that are dispensed from the pharmacy but are not administered to a patient. Drugs returned to the pharmacy for restocking should be secured from loss or misuse.

Policies and procedures should be established to minimize limitations in the perpetual inventory system and to limit access to supervisory functions such as making adjustments.

Auditee Response: We concur.

Discontinued medications are returned to the pharmacy when a physician changes a medication order, an order is discontinued due to therapeutic failure, or a patient is discharged. The number of discontinued medications returned in one day could be in the hundreds.

Ninety-five percent of all medications dispensed from our pharmacy are in unit dose containers (each pill is individually packaged). We utilize this type of packaging because the law allows us to restock these medications. If we were to discard them the cost would amount to thousands of dollars per day. Restocking these medications is a practice hospitals use to keep the cost of pharmaceuticals within their budget.

The restocking process in our pharmacy has been tightened. We no longer place returned medications in a bin. A designated pharmacy personnel re-enters these returned medications into our inventory as they arrive back in the pharmacy.

We are presently installing new pharmacy software. Restriction will be placed on access to making adjustments to the physical inventory. All medications will be entered into the system by their National Drug Code (NDC code), which is unique to each medication. This will allow us to track any variances as well as reduce any human error, which might occur.

The present pharmacy system has its limitations. This newer software will be a vast improvement over the current software.

Policies and procedures will be established for access to the inventory function when the Mediware Software installation is complete and running.

Observation No. 26: Policies And Procedures For Making Payments On Medical Services Bills Should Be Established

Observation:

During and prior to fiscal year 2003, the NHH did not have sufficient controls in place to ensure that it paid the correct amount for outside medical services provided to NHH patients.

During fiscal year 2003, the NHH paid 65% of the amount billed by a local medical hospital providing services to NHH patients. The NHH paid 100% of the amount billed by other outside medical service providers. The NHH did not have a clear understanding of the source of the 65% rate adjustment nor did it not know why the rate was applied to the hospital and whether a similar rate adjustment should be applied to the bills of other medical providers.

According to RSA 126-A:3, "...no provider shall bill or charge the department more than the provider's usual and customary charge...." The statute defines this charge generally as the lowest charge, fee or rate accepted from any customer.

The NHH reportedly has historically used the 65% rate as the usual and customary charges from the local hospital without knowing the source of the rate or considering whether the rate was appropriate. The NHH has apparently not considered whether accepting and paying 100% of the non-hospital bills is also in compliance with statute.

NHH's current calculation method cannot ensure that payments made to the medical service providers are the usual and customary charge as provided for in statute. NHH may be paying more than the lowest charge, fee or rate, thereby in noncompliance with RSA 126-A:3.

In response to this observation, the NHH revised its payment rate to 53% of the billed amount, which was the then current Medicaid rate for the local hospital, and recovered \$112,000 in

overpayments. The NHH has not changed its practice of paying 100% of the billed amount from non-hospital medical service providers.

Recommendation:

The NHH should establish formal policies and procedures for making payments for medical services provided to NHH patients. Policies and procedures should include reviews and other controls to ensure that amounts paid are in accordance with RSA 126-A:3. The NHH should review the propriety of its current practice of paying 100% of the billed amount from non-hospital medical service providers to determine whether it is in compliance with the statute. Regular communications with medical service providers will be needed to ensure that the statute is complied with.

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

Auditee Response: We concur.

As indicated in the observation, upon discovery NHH revised its payment rate to the current Medicaid rate of the local hospital and received a refund for any over payment to that facility. NHH has obtained payment schedules of current rates from the Office of Medicaid Business and Policy and has distributed and reviewed it with employees involved in the payment process.

NHH is reviewing its current practice of paying 100% of the billed amount from non-hospital medical services providers to determine whether it is in compliance with the statute.

Observation No. 27: Medical Services Should Be Documented According To The Contract Provisions

Observation:

The NHH does not require the medical services contractor to comply with contract provisions requiring the documentation of staff hours worked.

According to the medical services contract, the Medical Director and each of the assigned clinical staff are required to account for 40 hours per week through appropriate recordkeeping. However, per Dartmouth Medical School Department of Psychiatry, neither the Director nor the clinicians keep the required time record. The monthly charge to NHH is based on one-twelfth of the annual salary of the assigned staff person. While the NHH reports that it is confident that the contracted medical staff are meeting or exceeding the 40 hour requirement, there is no documentation that NHH monitors the contractor to ensure compliance with contract provisions requiring appropriate recordkeeping to evidence hours worked.

Recommendation:

The NHH should require its medical services contractor to maintain the recordkeeping provided for in the contract. The NHH should periodically review the records to ensure that the contractor is performing according to the contract provisions.

If the NHH determines that the contract provisions are not required, the NHH should consider removing the requirements from subsequent contracts.

Auditee Response: We concur.

The Hospital accounts for the hours worked in two ways, first through a leave system that requires all leave time to be approved by the Medical Director.

The new five year contract starting July 1, 2003 and ending June 30, 2008 was changed to read:

“Full-Time” Defined. For purposes of this paragraph, 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 the Dartmouth’s normal and customary benefits as to vacation, personal leave, and sick leave.

Additionally, at the beginning of each quarter (four times per year) blank time study sheets are sent to each physician and psychologist that works at New Hampshire Hospital. They are asked to pick ten random days from each quarter to complete a time study in the following categories: Provider Services, Teaching & Supervision Interns & Residents, Non-Teaching Reimbursable Activities - Administrative Supervision - Nursing & Technical Staff - UR Review, Professional Services - Direct Patient Care, Non Reimbursable Teaching Medical Students, Writing for Journals. The time studies are tracked by Administration and then sent to the Business Administrator for tabulation.

On November 12, 2003, based on a request from the Commissioner of Department of Health and Human Services, we conducted a 100 percent sampling of our Dartmouth physicians’ scheduled hours for one week and found that they far exceeded the 40-hour requirement specified in the contract and averaged 47.8 worked hours per week. Based on these actions, we feel that the contract requirements are being fulfilled.

Observation No. 28: Access To Computerized Applications And Data Should Be Restricted To That Necessary To Perform Job Functions

Observation:

Employee access to computerized applications and data is not restricted to that necessary for the employee to perform his or her job functions.

All thirteen employees in the Human Resource (HR) Section have been granted computer edit access authority to input, change, or delete Hospital employee payroll data in the State's payroll system (GHRIS). Of these thirteen employees, five employees in the payroll section are responsible for processing payroll and as a matter of job function use their edit access authority in GHRIS daily. The other employees have either rarely or never have had occasion to access GHRIS and input or change employee data. According to HR management, the edit access authority is a necessity for all thirteen employees to guard against situations when unexpected payroll staff shortages could impact HR's ability to process the payroll.

Access to the Hospital's other computerized systems, including the State's accounting system (NHIFS), the Hospital's information system, and others, is similarly not restricted to those employees whose jobs require access.

Excess employee access to computerized applications and data increases the risk that the applications and data could be misused and abused resulting in error, fraud, and release of confidential employee and patient information. Compounding the risk of improper access is a weakness in GHRIS that allows an employee's pay rate to be changed without proper authority and with a low chance of detection.

Recommendation:

The NHH should review and evaluate employee access to its computerized systems. Access should be restricted to that necessary for the employee's job function. Excess access should not routinely be granted to employees in order to guard against potential and irregular emergencies or other staffing concerns. Employee access should be routinely and regularly reviewed and adjusted to reflect changes in employee responsibility and system design.

Auditee Response: We concur.

Action To Be Taken: NHH will review and evaluate computer access and restrict access to that necessary for the employees' job functions. Update/edit access should be limited to payroll and those needing to update PUD2 [Agency Position User Screen] in GHRIS.

Observation No. 29: Controls Over The Receiving Of Purchased Supplies Should Be Improved

Observation:

The NHH does not employ standard receiving and inspection procedures for the acceptance of all purchased goods. Certain food and nutrition and housekeeping invoices are paid without the NHH requiring documentation that the supplies have been received as invoiced.

When supplies are delivered to NHH's Food and Nutrition Services, the stock clerk generally signs the accompanying invoices or shipping documents to verify the receipt of goods. No inspection and receiving documents are prepared. The signed invoice is forwarded to the

program assistant for payment processing. However, some vendors send invoices directly to the program assistant, and the program assistant processes these invoices for payment without any verification that goods have been actually received. The program assistant also receives invoices for Environmental Services (Cleaning & Housekeeping) for paper and cleaning supplies. She processes these invoices for payments without verifying that goods were received as invoiced.

The State's *Manual of Procedure* (expired) requires the preparation of receiving and inspection reports to document the receipt of ordered supplies and merchandise.

Recommendation:

The NHH should establish formal and controlled procedures for receiving and inspecting delivered goods. The NHH should incorporate, as appropriate, procedures from the State's *Manual of Procedures* relative to receiving and inspection reports and modify those procedures as necessary to meet the needs of the NHH. As a general rule, the individual who actually accepts the delivery of the goods should prepare a record of the receipt, including quantity and description of the items received. This record should be dated and initialed to evidence the receipt and support the payment of the goods received.

Auditee Response: We concur.

Action To Be Taken: Our internal operating standards did not require a receiving/inspection report. Commencing November 1, 2004, the stock clerk will fill out the necessary receiving and inspection reports. These documents will be signed by the stock clerk and sent to department's office for filing. The department will photo copy the original invoices and attach them to the receiving/inspection report. Any discrepancies will be noted on the receiving/inspection report. The reports will be kept in the Director's/designee's office. Invoices received by the department will be verified with the department stock clerk. Counter signatures will be obtained. The Program Assistant no longer receives invoices for Environmental Services (Cleaning & Housekeeping). Environmental Services has implemented a receiving and billing system that complies with the state's manual of procedure.

Observation No. 30: Use Of Numeric Document Controls Should Be Reviewed

Observation:

The NHH does not utilize the document control numbers on the *Valuables Form* (W25) as a control against lost or misused documents. A W25 is used to record patient cash and other valuables when a patient is first admitted to the hospital.

Upon admittance, valuables on the person of a new patient are listed on a W25 and secured by the NHH against loss. While each W25 has a preprinted control number and the cashier's office issues the forms to the NHH patient admission sites in a controlled manner, the numeric control aspect of the form is not used as unit staff borrow forms from other units, patients may destroy

the forms, etc. The cashier's office confirmed it would not be aware if a W25 was lost or misused.

Numerically controlled documents imply control procedures requiring the accounting for all documents to ensure that all related activity has been identified and recorded.

Recommendation:

The NHH should review its policies and procedures surrounding its use of the W25. If NHH determines that the numeric control of the documents is important to the security of the patients' property, the NHH should take steps to suitably control the documents and require staff to adhere to those policies and procedures that would provide that control. If the NHH determines that the numeric control is not important, it should eliminate the requirement for the cashier's office to track the issuance of the documents.

Auditee Response: We concur in part.

In response to the auditor's recommendations, a review of NHH's policies and procedures surrounding the use of the W 25 was conducted. This review included, New Hampshire Hospital Policy, *Patient Valuables/Personal Belongings*, New Hampshire Hospital Nursing Department Standard *Admissions Planning*, and Financial Services.

The review confirmed that the document control numbers on the Valuables Record (Form W25) are not used to control against the loss or misuse of the forms themselves. The numbers are not important to the security of the patient's property, but they do provide a useful means for tracking patient valuables for cashier's personnel. They are not *issued* in a controlled manner. In order to facilitate timely listing and disposition of patient belongings and valuables, W25 forms are made available in each admission packet, and on patient care units.

The current process for controlling and tracking patient valuables begins at the time of admission, when patient belongings and valuables are listed on the W 25 form. The original form is filed in the patient record, and copies are sent to the cashier's office, along with valuables that are to be secured. The control number is logged in by the cashier's office upon receipt, and provides a means for the cashier's office to track both the completed forms and the disposition of the valuables.

HOSPITAL TRUST ACCOUNTS

Observation No. 31: Controls Over Client Banking System Must Be Improved

Observation:

The client banking system, used by the NHH during fiscal year 2003 for maintaining patient as well as other non-Hospital account monies, was incapable of producing financial reports or statements of aggregate account activity. While statements for individual accounts were readily

available, the system could not report a total of all activity processed through the system. To obtain this information would require running statements for each of the hundreds of accounts within the system and then summing the individual amounts reported. As a matter of practice, NHH management did not regularly receive or review any financial activity reports related to these accounts.

The NHH is custodian of patients' and others' monies, which it holds in a bank checking account. The NHH has no ownership interest in these monies and operates the account as a convenience primarily for the Hospital patients. From the State's perspective, this patient money is considered an agency fund of the Hospital and State. At June 30, 2003, the account contained approximately \$155,296. Because the bank checking account is also used as a general Hospital depository account and the client banking system has limitations, the total activity in the Hospital's agency accounts during fiscal year 2003 could not be reported by the Hospital.

The Department of Administrative Services (DAS) fiscal year 2003 *Annual Closing Review* directed agencies to prepare an *Exhibit D* form to report Trust and Agency Fund balances and activities for inclusion in the fiscal year 2003 Comprehensive Annual Financial Report (CAFR). Along with the *Exhibit D*, agencies were directed to provide supporting documentation such as bank statements and reconciliations, investment statements, and worksheets.

The NHH did not complete a fiscal year 2003 *Exhibit D* nor otherwise report to DAS the monies the Hospital held in its agency account. According to the Hospital's business office, the Hospital misunderstood the requirement to report these funds to the DAS.

Recommendation:

The NHH must improve controls, including systems, policies and procedures, for holding and reporting its patient and other non-Hospital account monies. In implementing its new client banking system, the Hospital should ensure that the new system provides for the reporting of relevant account information that will safeguard patient monies. Management should be provided with and review these periodic reports to ensure that patient and other monies are properly accounted for.

The NHH should report its agency fund balances and activities as required by the DAS in the *Annual Closing Review* process and include the required supporting documentation.

Auditee Response: We concur.

The NHH misunderstood the requirement to report these funds. The NHH reported its agency fund balances and activities to the DAS for SFY 2004.

A monthly financial report will be submitted to the Hospital's Executive Committee for review.

Observation No. 32: Estate Monies Held For The Division Should Be Coordinated With The State Treasurer

Observation:

The NHH allows its checking account to be used as a custodian account to hold monies from the estates of deceased and indigent Division of Behavioral Health clients. These clients may or may not have been patients of the NHH. As of June 30, 2003, the NHH held approximately \$36,000 in its checking account for the Division.

According to the Division, its Office of Reimbursements becomes the administrator of the estates of its indigent clients when no one else, such as a relative, accepts the responsibility. The Office of Reimbursements is under the assumption that a separate bank account for an individual estate account cannot be opened without a court order and estate money is deposited into the NHH's bank account, as a convenience, while awaiting final disposition upon an order of the probate court. The estate monies held in the NHH account are credited with interest while awaiting final disposition. According to the NHH, the NHH maintains a higher cash balance in the account than it otherwise would in order to accommodate unexpected requests for the payment of these estate monies.

The NHH checking account presumably was established for the purpose of accepting and holding revenues of the NHH and its patients. It is not clear that the account was also intended to provide custodial banking services to another section of the Division of Behavioral Health. It is also not clear whether the controls over the NHH account are appropriate for holding custodial accounts of non-patients.

Recommendation:

The NHH should consider requesting the Division deposit its custodial monies with another custodian. The NHH is not in the business of offering custodial services beyond its own needs and operating as a custodian in this manner opens the NHH to unnecessary responsibilities and risks.

The NHH should review the current uses of the NHH checking account with the State Treasury to ensure that the account is used as authorized.

Auditee Response: We concur.

The Division of Behavioral Health (DBH) will review with the State Treasurer the current use of the NHH checking account to hold monies from the estates of deceased and indigent DBH clients. Discussions are on going with Treasury and this issue will be addressed at a future date.

Observation No. 33: Controls Over Disbursements From The Investment Account Should Be Improved

Observation:

There is a lack of segregation of duties in NHH's accounting procedures over its Public Deposit Investment Pool (PDIP) investment account. The NHH Business Administrator is an authorized signer on the PDIP account as well as being responsible for reviewing the financial activity in the account. Only one authorized signer is required to initiate a transaction in the PDIP account (NHH's other operating account requires two authorized signers).

During the fiscal year ended June 30, 2003, \$35,000 was deposited into and \$100,000 was paid out of the NHH PDIP account. At June 30, the balance in the account was \$124,405.

The NHH business office reported it was unnecessary to perform a complete reconciliation of the account due to the low volume of the account activity. While the NHH reports that the daily balancing procedures performed between the business office and the cashier's office would detect any errors and/or missing funds, it is questionable whether the balancing procedures would detect funds withdrawn for a fictitious hospital use. The lack of independent reconciliations or reviews of the PDIP account activity increases the risk that errors or frauds that may occur in the account would not be detected in a timely manner.

Recommendation:

Controls over disbursements from the investment account should be improved. Duties should be segregated so that the authority for signing checks and the responsibility for reviewing account activity are properly segregated. An employee who is at an appropriate level of management and otherwise uninvolved in the operation of the account should be responsible for reconciling and or reviewing the account activity.

Auditee Response: We concur.

NHH has adjusted its PDIP investment account to require two authorized signers. A Financial Service's staff member uninvolved with the operation of the account will perform a review and reconciliation of PDIP's monthly statement. A monthly report of activity will be submitted to the Hospital's Executive Committee for review.

Observation No. 34: Trust Fund Expenditures Should Benefit The Purpose Of The Trusts

Observation:

Some fiscal year 2003 trust fund expenditures appeared to supplant NHH operating funds. It was not clear whether the expenditures were made in accordance with the underlying purposes of the trusts.

The NHH administers various trust funds generally intended to benefit Hospital residents and clients. While the trust objectives are generally broad and not restrictive, and some trusts established many years ago describe a hospital operation that existed at that earlier time and not current operations, the trusts commonly direct the funds be used for the benefit of the patients, clients, or other specific parties. The State Treasury is responsible for investing the funds at the direction of the NHH. The NHH Donations Committee is responsible for overseeing fund activities and the NHH department heads approve expenditures from the funds for goods and services. The total trust fund balance at June 30, 2003 was approximately \$5 million and during fiscal year 2003, approximately \$175,000 was expended from the funds.

During our testing of 17 trust fund expenditures, we noted six expenditures totaling \$26,000 that appeared to fund hospital operations which were only of indirect benefit to the Hospital's patients and clients. Expenditures that appeared to be operational in nature included purchases of mattresses, chain link fencing, a dishwasher, a defibrillator, lighting fixtures, and \$16,000 to pay a patient's board and care charge. Further inquiry noted that trust funds were also used to purchase two laundry washing machines, one dryer, \$5,000 of bedroom furniture, and two additional defibrillators and accessories for \$5,700. These expenditures appear to be for normal operations of the NHH and, at best, only indirectly benefited the patients and other clients.

Our 1988 audit report also noted a similar observation and it recommended the NHH consult with the Department of Justice to clarify, if necessary, the trusts and develop a clear set of policies and procedures governing the appropriate types of expenditures from the funds. While the NHH responded at the time that it would request clarification of the proper uses of the trusts from the Attorney General's Office, the NHH is not certain whether this was ever done.

Recommendation:

The NHH should review its policies and procedures regarding its administration of the trust funds. While the NHH needs to comply with explicit conditions placed by the trusts on the trust funds, it should also administer the trust funds in the spirit of fiduciary funds and not use the funds to supplant what should be NHH operating costs. If the NHH continues to have concern as to restrictions within the trusts or other legal concerns as to the proper uses of the trusts, the NHH should confer with the Department of Justice to clarify the appropriate uses of the funds.

The NHH should review whether its Donations Committee has sufficient direction and policy guidance to ensure that the trust funds are used as intended by or in the spirit of the trusts. In addition, periodic detail disbursement reporting should be provided to NHH management and to the Donations Committee to ensure that they are receiving sufficient and timely information to enable them to be confident that the expenditures from the funds are appropriate and as intended by the trusts and the NHH.

Auditee Response: We concur in part.

We concur. Quarterly reports for the NHH management will be reviewed for expansion of the report and recommendations.

We do not concur that trust funds were inappropriately used. It is believed the NHH administers the trust funds as intended by or in the spirit of the trusts. Each purchase noted above was reviewed by the Donation Committee and purchased appropriately. The Donation Committee determines trust fund purchases from the description of each group as authorized from the "Classification of New Hampshire State Hospital Trust Funds" by the Director, Register of Charitable Trusts, dated July 3, 1952 and amended September 11, 1952.

Observation No. 35: Private-Purpose Trust Fund Accounts Should Be In The Custody Of The State Treasurer

Observation:

The NHH maintains various accounts that meet the classification of private-purpose trust fund accounts. The aggregate balance in these accounts, held as part of its checking account balance, was approximately \$39,000 at June 30, 2003. RSA 11:1 requires that all trust funds left to and accepted by the State be kept separate from other funds and be in the custody of the State Treasurer and RSA 11:7 directs that all disbursements for trust fund purposes shall follow the laws, rules, and regulations applicable for disbursements of normal State operating and capital funds. Neither of these conditions is met by the NHH's current operation of these private-purpose trust fund accounts.

The NHH maintains various accounts within its client banking system that are not patients' monies but are funds intended to benefit the patients. These accounts are used for various purposes such as operating the gift store, including purchasing gift store inventory, and patient payroll and also for purposes benefiting the rehabilitation of patients, indigent patients or residents, and recreational and social events.

The balances and financial activity in these accounts have not been reported to the Department of Administrative Services, Bureau of Financial Reporting, contrary to State accounting policy, and hence their balances and financial activity have not been included in the State's Comprehensive Annual Financial Reports.

Recommendation:

The NHH should consult with the State Treasury to ensure that the NHH's policies and procedures for operating its checking account are adequate to properly secure the trust fund monies deposited in the account.

The NHH should consult with the Department of Administrative Services to ensure that disbursements from the accounts, as much as practicable, follow the laws, rules, and regulations appropriate for State funds and the accounts are properly reported for inclusion in the State's financial reports.

Auditee Response: We concur.

NHH has an on-going working relationship with State Treasury regarding the operating of its checking account, as well as Trust Fund accounts in general. State Treasury and NHH's Donation Committee meet quarterly to review and discuss issues and concerns relating to Trust Funds.

NHH has consulted with the Department of Administrative Services, Accounting Services and fulfilled its reporting requirement, Exhibit D, Funds Held by State Departments as Trustee, for State Fiscal Year 2004

Observation No. 36: Controls Over Gift Store Operations Should Be Implemented

Observation:

Lack of controls over the gift store operations present a significant risk that errors or frauds could occur and not be detected in a timely manner.

The NHH operates a gift store that sells cigarettes, phone cards, and small gift items to patients, employees, and visitors. During fiscal year 2003, the gift store generated \$13,000 to \$16,000 in sales per month. Gift store revenues are used to purchase inventory for resale with balances accumulating over \$3,000 transferred to the Rehabilitation Account to purchase items to benefit patient recovery. 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 (NHIFS).

The NHH has not implemented policies and procedures to ensure that the gift store operates in a controlled manner as intended by NHH management. For example:

- There is only minimal management oversight of store operations. There is no formal process for monitoring gift store operations. The gift store does not maintain inventory records or prepare financial reports providing information on sales including costs of sales, inventory, etc., that would enable management's review of store operations.
- The NHH does not have formal policies and procedures relative to store operations including purchasing and pricing.
- There is a lack of segregation of duties within the store operations. Two employees are responsible for purchasing, receiving, and pricing merchandise. The two employees also work at the gift store making sales, recording sales on the cash receipts ledger, and performing cash out procedures. The risk to controlled store operations resulting from a lack of segregation of duties over purchasing is further compounded by purchases of store inventory outside the State's purchasing control processes.

Recommendation:

The NHH should implement controls over its gift store operations. Controls should include policies and procedures that include segregation of incompatible responsibilities and proper

accounting for store inventory and operations. A critical component of the controls implemented must be a monitoring process to ensure NHH management that the controls remain adequate and functioning and the store is operating as intended.

Auditee Response: We concur in part.

A number of controls have been put into place to assure monitoring of merchandise in the gift shop. Merchandise most prone to theft is kept behind the counter, requiring assistance to the buyer, or it is kept close to the counter so gift shop staff can continually monitor expensive items. Two staff members are always available in the shop to monitor customers and they have developed techniques to monitor customers when the shop is busy. The gift shop currently does not have equipment that would allow the entering of inventory into the cash register. It is our opinion that the cost of purchasing new equipment that has an inventory function, and the additional staff time to complete an inventory would not offset losses.

Additional managerial oversight will be provided by the Director of Rehabilitation Services. It will be the Director's responsibility to review bills that are paid, check packing slips on new inventory and monitor deposit slips. In addition, criminal background checks will be performed on all new hires.

CAFETERIA OPERATIONS

Observation No. 37: Analysis Of Cafeteria Costs Should Include Costs For Labor And Overhead

Observation:

The NHH does not have a cost accounting and reporting system that adequately accumulates the costs of providing cafeteria services and allows management to monitor, analyze, and evaluate those costs of its operations.

The objective of the NHH Cafeteria Services is to provide a reasonably priced and well-balanced cafeteria menu to employees, volunteers, visitors, and patients. The majority of cafeteria users are employees. While management ensures cafeteria revenues recover the cost of food, management does not know whether revenues also cover the cost of labor and overhead associated with the cafeteria operation. No attempt has been made to estimate the total cost of providing cafeteria services.

Management reviews cafeteria revenues and cost of cafeteria food consumed monthly. The NHH's current accounting and reporting system combines cafeteria labor and overhead costs with the NHH's patient Food and Nutrition Services costs and does not make a separate accounting and reporting for the costs for the cafeteria operations. Management has not estimated these cafeteria costs or otherwise attempted to include these costs in the calculation of cafeteria meal prices.

Labor and overhead costs would appear to be substantial components of the costs of the cafeteria operation and by excluding these costs from the determination of meal prices, the NHH is underestimating the total cost of the Cafeteria Services and potentially is pricing cafeteria meals at a level that may not recover those costs.

Recommendation:

Management should expand its analysis of cafeteria costs and meal prices to include the cafeteria operations costs for labor and overhead. If the NHH's current accounting and reporting systems do not provide information on these costs, the NHH should devise methods to reasonably estimate and include the costs in the determinations of net costs of cafeteria operations and meal pricing.

Auditee Response: We concur.

The Food & Nutrition Department as matter of routine does not receive labor cost reports nor cost of heating & lighting. Prior to the State assuming responsibility for the management of the Food & Nutrition department the formula used was, food cost * 200% = sales price of food item in the cafeteria. The mark-up covered the cost of labor and overhead.

Action To Be Taken: The Department will initiate a labor cost estimate and overhead estimate. The labor portion will be determined by using the wages of cafeteria employees' times a benefit percentage to determine labor cost per hour. Overhead will be determined by square footage costs as determined by the maintenance department. These costs will then be taken into account when determining selling price in the cafeteria.

Observation No. 38: Cafeteria Meal Pricing Policies And Procedures Should Be Established

Observation:

The NHH cafeteria's policy (*Operational Standard*) in place during fiscal year 2003 was not clearly written with regards to meal discounts, appears inaccurately drafted, and is not followed by cafeteria employees.

The NHH's meal pricing policy provides for a 40% markup for employees and a 35% markup for visitors. The policy is unclear on what basis the markup should be applied. It also appears unreasonable that the policy would intend employees to pay more for meals than visitors. The policy was not adhered to during fiscal year 2003.

NHH meal pricing practices in place during fiscal year 2003 provided for charging discounted meal prices to employees and patients and full meal prices to visitors. Cashiers were not provided guidance on how to establish which customers are employees, visitors, and more importantly patients in an unobtrusive manner. In practice, cashiers do not attempt to verify employee/patient/visitor status and charge discount prices to all customers who are not clearly

wearing a visitor badge. Because not all visitors wear badges, it is understood that some visitors are provided a discounted meal price.

Recommendation:

The NHH should establish policies and procedures for pricing cafeteria meals that provide guidance for establishing meal prices and any discounts for meals purchased by favored groups of customers. The policies and procedures should be consistent with intended practice and helpful to employees intended to implement them.

Auditee Response: We concur.

The department will discontinue the old policy as cited. By April 30, 2005 the department will write a new policy that will use the cost of goods, cost of labor and overhead in determining the price to be charged in the cafeteria.

Observation No. 39: Accountability Over Cafeteria Cash Register Receipts Should Be Improved

Observation:

Accountability for overages and shortages processed through the NHH cafeteria cash register is not controlled, as the clerk processing the sales does not count the cash drawer prior to relinquishing control of the receipts to a second individual.

The cash drawer is counted and reconciled to the sales record by a supervisor. Because the clerk does not count the drawer prior to transferring the control of the drawer to a second person, the responsibility for any overages or shortages in the drawer cannot be definitively established.

Recommendation:

Accountability over cafeteria cash register receipts should be improved. The clerk processing sales should count the cash drawer prior to transferring the drawer to the supervisor for reconciliation. The clerk's count should be performed without access to the total amount of sales processed through the cash register.

Auditee Response: We concur.

In reviewing the department's standards on cash control, Operational Standard Policy Drawer Verification (2.3.17) requires the manager and register person to count the drawer prior to opening the drawer. Operational Standard Policy, Method for Counting A Cash Drawer At The End of The Shift (2.3.16) requires the manager take the cash, drawer and register readings to a secure place and count the money. We are complying with policy 2.3.16 but not 2.3.17. We have no policy addressing drawer verification and the end of shift for the register person.

Action To Be Taken: The department will enforce our policy and develop a new policy by April 30, 2005 to include counting the cash drawer at the end of the shift by the register person and manager.

Observation No. 40: Food Inventory Should Be Subject To An Inventory Control System

Observation:

The NHH does not maintain a perpetual inventory recordkeeping system for its food stores, which is required by the State's *Manual of Procedures* (expired). At June 30, 2003, the estimated value of food stores on hand at the NHH was approximately \$20,000.

When food is needed for meal preparation, supervisors (chefs) go into the food storage area and remove what is required. There is no documentation of the issuance of the food. The inventory record is updated only through the purchase record and the actual physical counts performed monthly. The stock clerk is responsible for the incompatible responsibilities of the custody of food products, conducting the physical counts, and reporting the counts to management. There is no formal monitoring process or formal documented analysis of food usage to allow for the efficient monitoring of food purchased by the NHH to ensure that it is used in an efficient manner and is not subject to loss or misuse.

The State's *Manual of Procedures* requires agencies to maintain perpetual inventory records for consumable supplies. The records required by the *Manual* include records of purchases, issuances, and ending balances reported in quantities and average costs. The NHH does not maintain these records. In addition, consumable inventories, such as the NHH's food inventory is required to be reported at each fiscal year end to the Department of Administrative Services for inclusion in the State's financial records and reports. The NHH has historically not reported its food inventory to the Department of Administrative Services reportedly due to lack of knowledge of the requirement.

Recommendation:

The NHH should improve its controls over its food inventory. The NHH should develop a reasonable inventory reporting system such as a perpetual system to allow for tracking and reporting the purchase and use of food products. Responsibilities over the custody and inventorying of the products should be reasonably segregated to promote the detection of errors or frauds that may occur in the food inventory process. The fiscal year end inventory balances should be reported to the Department of Administrative Services.

Auditee Response: We concur.

Although the NHH does not believe it incurred any misuse or loss of consumable food in the past year the department does recognize that this can occur given a different set of employees.

Action To Be Taken: The monthly ending inventory will be tallied and completed by the Chef III. The current stock room clerk will continue to take twice-weekly inventory of food stocks for ordering purposes. The stock room clerk began on October 1, 2004 to utilize the “Receiving and Inspection Report” for all orders sent by vendors to NH Hospital.

NHH will institute a perpetual inventory system for all meat/poultry/fish products. In addition, it will extend this system to dessert items of high value. To institute a complete perpetual inventory of every item the Food and Nutrition Services orders will not be of great benefit to NHH. It will take enormous amount of time and personnel to complete for small gains.

NHH instituted a bin system of inventory to satisfy the above action plan as of February 1, 2005. The director will then reconcile the inventory at the end of each month. A monthly usage report will be added to the department’s monthly report to the Superintendent or designee.

NHH submitted its year ending inventory level in quantity and value to Administrative Services at the end of FY 04.

PROPERTY AND EQUIPMENT

Observation No. 41: Effective and Efficient Controls Should Be Established For Long-Term Assets And Equipment

Observation:

The NHH accounting and reporting controls for its long-term property and equipment assets are not as robust as they should be.

- The NHH accounting records for real property assets are incomplete. The NHH could not provide complete documentation supporting the cost of its real property assets. In addition, the reporting responsibility between the NHH and the Division of Behavioral Health for some buildings on the NHH campus is unclear.
- A lack of segregation of duties negatively affects the controls intended by the annual physical inventory of equipment assets as employees performing the inventory also have access to the equipment records and are responsible for performing investigations for equipment identified as missing. The lack of segregation of duties could allow an employee to conceal an error or fraud without detection.
- The NHH has possession of a number of apparently antique pieces of artwork that are stored in its materials management warehouse. The NHH has not inventoried or reported these items on its asset reports, nor is it clear that the storage location of these items is secure against loss and environmental damage.

The State’s *Long-Term Assets Policy and Procedures Manual* directs agencies to establish an internal control structure over long-term assets that provides reasonable assurance of effective and efficient operations and reliable financial reporting. The major objective of the internal control over long-term assets is accountability. The policy goes on to state that “Agencies should

have procedures in place so that assets are adequately safeguarded from loss or theft, that adequate documentation is maintained to support the cost of the assets, proper approvals are used for acquisitions, physical inventories are taken annually, and proper segregation of duties exists.”

Recommendation:

Effective and efficient controls should be established over the accounting, reporting, and safeguarding of long-term assets and equipment.

- The reporting responsibilities for buildings on the NHH campus should be established and documentation maintained to support the reported costs of the buildings and other real property assets.
- Improved segregation of duties should be established to enhance the controls provided by the annual physical inventory of equipment.
- The NHH should review the conditions of its storage of artwork in the materials management warehouse to ensure the artwork is safeguarded against loss and environmental damage.

Auditee Response: We concur.

Though the Hospital could not provide complete documentation supporting the base cost of its real property as established by the State Fixed Assets Project Team in 1996, it has maintained documentation to support the reported costs of its buildings and other real property assets from 1996 to the present.

The NHH has revised its Physical Inventory Procedures to segregate duties of performing the physical inventory and that of equipment recording and investigating equipment identified as missing.

The NHH is reviewing the condition of the artwork currently stored at its warehouse and will work closely with other State agencies to surplus identified items appropriately. Remaining items will be added to the Hospital’s inventory and reported accordingly.

Observation No. 42: Responsibility For Power-Plant Building And Associated Equipment Should Be Established

Observation:

The responsibility for the NHH power-plant building appears to be shared between the NHH and the Division of Behavioral Health (DBH) with neither organization clear as to the extent of its responsibilities.

The NHH power-plant building is leased for operation to the Concord Steam Company pursuant to a contract between the NHH and the company. While the contract names the NHH as the owner and payments are made to and recorded by the NHH, the NHH reports that the DBH has taken over management of the lease.

Neither the NHH, DBH, nor reportedly, the Concord Steam Company know whether the steam-generating and other equipment in the power-plant building is the property of the State or of Concord Steam.

According to the lease agreement, “all alterations, additions and improvements to the premises shall, at the termination of this lease, be and remain in said premises and belong to the lessor [NHH] as a further consideration for this lease except that within six (6) months after the termination lessee may remove such boilers, fixtures, and equipment, not including replacements of equipment of lessor, which lessee installed in the premises and which can be removed without damage to the premises.”

Reportedly, much of the original steam generating equipment has been replaced, some of it several times, during the period that Concord Steam has operated the facility.

Recommendation:

The NHH should review the current status of the power-plant building and associated equipment with the DBH and the Concord Steam Company. The NHH and DBH should determine what State-owned equipment items, building improvements, and fixtures located in the power-plant building should be accounted for. The NHH and DBH should institute controls to ensure that all State-owned equipment, building improvements, and fixtures are identified, tracked, properly accounted for, and reported. The NHH and DBH should improve their communications with the Concord Steam Company to ensure that any future changes to the State-owned equipment items meeting the State’s definition of equipment are properly identified and controlled.

Auditee Response: We concur.

The Division of Behavioral Health (DBH) and New Hampshire Hospital (NHH) concur with the LBA findings and recommendations. DBH will seek to transfer responsibility for the NHH power-plant building to the Department of Administrative Services (DAS).

Since the 30-year lease was signed in 1980, the NHH Campus has been transformed into a State office park. Many of the buildings, which once housed NHH patients, are now office buildings occupied by State employees from many different State agencies such as the Departments of Corrections, Education and Labor. It is felt this campus is now becoming more of statewide responsibility than an NHH responsibility, and for this reason the steam generating plant should fall within the purview of the Department of Administrative Services. In addition, DAS has staff within its Division of Plant and Property Management who have the expertise to carry out the LBA's recommendations regarding the identification, tracking, reporting, and accounting for state-owned equipment items, and building improvements.

DBH and NHH will enter into discussions with Department of Administrative Services (DAS) staff to carry out this transfer of responsibility. DAS will be fully apprised of the LBA's findings and recommendations.

Auditor's Report On Management Issues

To The Fiscal Committee Of The General Court:

We were engaged to audit the accompanying financial statements of New Hampshire Hospital as of and for the fiscal year ended June 30, 2003, as listed in the table of contents, and have issued our report thereon dated April 13, 2004, which we disclaimed upon due to the lack of supporting revenue and agency fund records.

In planning as to whether to perform our audit of the financial statements of New Hampshire Hospital as of and for the fiscal year ended June 30, 2003, we noted certain issues related to the operation of New Hampshire Hospital that merit management consideration but do not meet the definition of a reportable condition as defined by the American Institute of Certified Public Accountants, and were not issues of noncompliance with laws or rules.

The issue that we believe is worthy of management consideration but does not meet the criteria of reportable conditions or noncompliance is included in Observation No. 43 of this report.

This auditor's report on management issues is intended solely for the information of the management of New Hampshire Hospital 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

April 13, 2004

Management Issues Comment

Observation No. 43: NHH Should Review Continued Performance Of Building And Grounds Maintenance And Other Services Provided To Campus Buildings Operated By Other State Organizations

Observation:

The NHH provides building and grounds maintenance for some of the buildings on the campus (State Office Park South) that are no longer part of NHH operations. The NHH also provides road maintenance for the entire campus, even though the campus is shared by multiple agencies. In addition, in accordance with RSA 135:41, NHH's Campus Police patrols the entire campus. All of these activities are charged to NHH's accounts with no contributions made by the other organizations benefiting from these services.

Recommendation:

The NHH in conjunction with the Departments of Health and Human Services and Administrative Services should review the options available to the NHH for obtaining assistance in providing these services or delegating the responsibilities to a more appropriate agency of State government. The NHH's current core competencies and structure does not make it the most appropriate organization to provide these services. Other organizations receiving the benefits of the services, at a minimum, should share in the costs of providing the services.

Auditee Response: We concur.

Action To Be Taken: NHH is reviewing with the Department of Health and Human Services the most cost effective and appropriate options of providing building and grounds maintenance for State Office Park South. Effective January 1, 2005, Campus Police was transferred to the Department of Safety. NHH and Department of Safety will work closely to ensure that NHH is only charged for cost directly applicable to the Hospital.

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 fiscal year ended June 30, 2003, 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.

April 13, 2004

Office Of Legislative Budget Assistant
Office Of Legislative Budget Assistant

**STATE OF NEW HAMPSHIRE
NEW HAMPSHIRE HOSPITAL**

**STATEMENT OF ACTIVITIES
FOR THE FISCAL YEAR ENDED JUNE 30, 2003**

		Program Revenues		
	<u>Expenses</u>	<u>Charges For Services</u>	<u>Operating Grants And Contributions</u>	Net (Expenses) Revenues And Change <u>In Net Assets</u>
<u>Governmental Activities</u>				
<i>General Government</i>				
Health And Social Services	\$ 57,101,683	\$ 9,652,322	\$ 215,309	\$ (47,234,052)
Total Governmental Activities	<u>\$ 57,101,683</u>	<u>\$ 9,652,322</u>	<u>\$ 215,309</u>	<u>(47,234,052)</u>
<u>General Revenues</u>				
Net Appropriations				48,163,861
Medicaid Disproportionate Share				33,188,351
Property Lease				<u>83,763</u>
Total General Revenues				<u>81,435,975</u>
Change In Net Assets				<u>\$ 34,201,923</u>

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

**STATE OF NEW HAMPSHIRE
NEW HAMPSHIRE HOSPITAL**

**COMBINED STATEMENT OF REVENUES AND EXPENDITURES
GOVERNMENTAL FUNDS
FOR THE FISCAL YEAR ENDED JUNE 30, 2003**

	General Fund	Permanent Fund	Total Governmental Funds
Revenues			
Medicaid-Disproportionate Share	\$ 33,188,351	\$ -0-	\$ 33,188,351
Board And Care	7,044,630	-0-	7,044,630
Transitional Housing	1,350,244	-0-	1,350,244
Services Provided To Other Agencies	489,027	-0-	489,027
Cafeteria Revenue	448,362	-0-	448,362
Children Services-Education	316,408	-0-	316,408
Dividends And Interest	-0-	191,649	191,649
Property Lease	83,763	-0-	83,763
Net (Decrease) In Fair Value Of Investment	-0-	(23,086)	(23,086)
Other (Grants/User Fees)	50,397	-0-	50,397
Total Revenues	<u>42,971,182</u>	<u>168,563</u>	<u>43,139,745</u>
Expenditures			
Acute Psychiatric Services	30,749,848	-0-	30,749,848
NHH Facility/Patient Services	14,804,842	-0-	14,804,842
Administration	8,374,968	-0-	8,374,968
Transitional Housing	3,930,873	-0-	3,930,873
Trust Disbursements	-0-	175,625	175,625
Trustee Fees	-0-	23,215	23,215
Adult Basic Education	13,988	-0-	13,988
Total Expenditures	<u>57,874,519</u>	<u>198,840</u>	<u>58,073,359</u>
Excess (Deficiency) Of Revenues			
Over (Under) Expenditures	<u>(14,903,337)</u>	<u>(30,277)</u>	<u>(14,933,614)</u>
Other Financing Sources (Uses)			
Net Appropriations	<u>48,163,861</u>	<u>-0-</u>	<u>48,163,861</u>
Total Other Financing Sources (Uses)	<u>48,163,861</u>	<u>-0-</u>	<u>48,163,861</u>
Excess (Deficiency) Of Revenues			
And Other Sources Over (Under)			
Expenditures And Other Sources (Uses)	<u>\$ 33,260,524</u>	<u>\$ (30,277)</u>	<u>\$ 33,230,247</u>

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

**STATE OF NEW HAMPSHIRE
NEW HAMPSHIRE HOSPITAL**

**RECONCILIATION OF THE STATEMENT OF REVENUES
AND EXPENDITURES GOVERNMENTAL FUNDS TO THE
STATEMENT OF ACTIVITIES
FOR THE FISCAL YEAR ENDED JUNE 30, 2003**

Excess (Deficiency) Of Revenues And Other Sources Over (Under) Expenditures And Other Sources (Uses)	\$ 33,230,247
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Amounts reported for governmental activities in the Statement of Activities are different because (see Note 1-C., also):

Governmental funds report capital outlays as expenditures. However, in the Statement of Activities, the cost of those assets is allocated over their estimated useful lives as depreciation expense. This is the amount by which capital outlays exceeded depreciation in the current period. (763,025)

Bond proceeds provide current financial resources to governmental funds, but issuing debt increases long-term liabilities in the Statement of Net Assets. Repayment of bond principal is an expenditure in the governmental funds, but the repayment reduces long-term liabilities in the Statement of Net Assets and therefore is not recognized as an expense in the Statement of Activities:

Bond Principal Repayments	<u>1,734,701</u>
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Change In Net Assets Of Governmental Activities	<u><u>\$ 34,201,923</u></u>
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The accompanying notes are an integral part of this financial statement.

**STATE OF NEW HAMPSHIRE
NEW HAMPSHIRE HOSPITAL**

**BALANCE SHEET
PERMANENT FUND
JUNE 30, 2003**

Assets

Cash And Cash Equivalents	\$ 10,150
Investments	<u>5,083,672</u>
Total Assets	<u><u>5,093,822</u></u>

Fund Balance

Reserved For Permanent Trust	<u>5,093,822</u>
Total Fund Balance	<u><u>\$ 5,093,822</u></u>

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

**STATE OF NEW HAMPSHIRE
NEW HAMPSHIRE HOSPITAL**

**NOTES TO THE FINANCIAL STATEMENTS
FOR THE FISCAL YEAR ENDED JUNE 30, 2003**

NOTE 1 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The financial statements of the New Hampshire Hospital have been prepared in conformity with generally accepted accounting principles (GAAP) as applied to governmental units. The Governmental Accounting Standards Board (GASB) is the accepted standard-setting body for establishing governmental accounting and financial reporting principles.

A. Financial Reporting Entity

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

The financial activity of New Hampshire Hospital is accounted for and reported in the State's General and Non-Major Governmental Funds in the State of New Hampshire's Comprehensive Annual Financial Report (CAFR). Assets, liabilities, and fund balances are reported by fund for the State as a whole in the CAFR. New Hampshire 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 New Hampshire Hospital cannot be determined. Accordingly, the accompanying financial statements are not intended to show the financial position or change in fund balances of New Hampshire Hospital in the General Fund.

B. Government-Wide And Fund Financial Statements

Government-Wide Financial Statements

The Statement of Activities reports information on all of the non-fiduciary activities of New Hampshire Hospital.

The Statement of Activities demonstrates the degree to which the direct expenses of a given function or segment are offset by program revenues. Direct expenses are those that are clearly identifiable with a specific function or segment. Program revenues include: 1) charges to customers or applicants who purchase, use, or directly benefit from goods, services, or privileges provided by a given function or segment and 2) grants and contributions that are restricted to meeting the operational or capital requirements of a particular function or segment. Certain indirect costs are included in program expenses reported for individual functions.

Fund Financial Statements

Separate financial statements are provided for governmental funds and fiduciary funds, even though fiduciary funds are excluded from the government-wide financial statements. The general fund and permanent fund are reported in the fund financial statements.

C. Measurement Focus And Basis Of Accounting

The government-wide 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.

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, the State generally considers non-grant revenues to be available if they are collected within 60 days of the end of the current fiscal period. Grant revenues that the State earns by incurring obligations are recognized in the same period the obligations are recognized. 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.

D. Financial Statement Presentation

The State of New Hampshire and New Hampshire 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. New Hampshire Hospital reports its financial activity in the funds described below:

Governmental Fund Types:

General Fund: The General Fund accounts for all financial transactions not specifically accounted for in any other fund. All revenues of governmental funds, other than certain designated revenues, are credited to the General Fund. Annual expenditures that are not allocated by law to other funds are charged to the General Fund.

Permanent Fund: The Permanent Fund accounts for 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.

E. Interfund And Intrafund Transactions

As a general rule, the effect of interfund and intrafund activity is eliminated from the government-wide statements, with the exception of activities between funds that are reported in different functional categories of governmental activities. Elimination of these activities would distort the direct costs and programs revenues for the functions concerned.

F. Revenues And Expenditures/Expenses

In the government-wide Statement of Activities, revenues and expenses are listed by activity type. Additionally, revenues are classified between program and general revenues. New Hampshire Hospital's program revenues include 1) charges for services provided and 2) operating grants and contributions. Resources not dedicated to a program, as well as resources that are internally dedicated, are reported as general revenues rather than program revenues.

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, available for only specified purposes. When both general purpose and restricted funds are available for use, it is the State's policy to use restricted resources first.

Other Financing Sources – these additions to governmental resources in the fund financial statements result from financing provided by net appropriations.

G. Capital Assets

Capital assets, which include property, plant, equipment, and infrastructure assets, are reported by the State in its government-wide financial statements. Such assets, whether purchased or constructed, are recorded at historical cost or estimated historical cost. Donated capital assets are recorded at estimated fair value at the date of donation. The Hospital's capital assets are reported in Note 3 on page 71.

Equipment is capitalized when the cost of the individual items exceed \$10,000 and all other capital assets are capitalized when the cost of individual items or projects exceed \$100,000. The costs of normal maintenance and repairs that do not add to the value of the asset or materially extend asset lives are not capitalized. Depreciation expense is recognized in the government-wide financial statements. Capital assets are depreciated using the straight-line method over the following useful lives:

Depreciation Useful Lives

Equipment	5 years
Computer Software	5 years
Building Improvements	20 years
Buildings	40 years
Infrastructure	50 years

H. Budget Control And Reporting

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 and estimating revenues. There is no constitutional or statutory requirement that the Governor proposes, or that the Legislature adopts, 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 Capital Projects Fund budget represents individual projects that extend over several fiscal years. During fiscal year 2003, the Hospital had only minimal financial activity in the Capital Projects Fund. Fiduciary fund types are not budgeted.

In addition to the enacted biennial operating budget, the Governor may submit to the Legislature supplemental budget requests 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 department 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 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 legally defined as non-lapsing, which means the balances are reported as reservation of fund balance.

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 General Fund unliquidated encumbrance balance at June 30, 2003 was \$1,812,154.

A Budget To Actual (Non-GAAP Budgetary Basis) Schedule - General Fund is included as Required Supplementary Information.

NOTE 2 - CASH AND INVESTMENTS

Deposits

The following statutory requirements and Treasury Department policies have been adopted to minimize risk associated with deposits.

RSA 6:7 establishes the policy the State Treasurer must adhere to when depositing public monies. The statute restricts deposits to national banks, trust companies, and savings banks within the United States that have a branch in the State of New Hampshire. In addition, all depositories used by the State must be approved at least annually by the Governor and Executive Council.

RSA 6:11 establishes depositing procedures and procedures for making payment to State Treasury accounts. All accounts opened by departments of the State require State Treasury concurrence.

RSA 6-B:2 requires the State Treasurer to submit quarterly financial reports to the Governor and Executive Council, the Commissioner of the Department of Administrative Services, and the Legislative Fiscal Committee.

The Treasury Department examines the financial condition of its depositories at least quarterly. The State Treasurer is not required to collateralize bank deposits.

The bank balance and carrying amount of New Hampshire Hospital’s demand deposits at June 30, 2003 are shown in the following table. The principle difference between bank balance and carrying amount is outstanding checks which have not cleared the bank as of June 30, 2003.

	<u>Bank Balance</u>			<u>Total Carrying Amount</u>
	FDIC			
	<u>Insured</u>	<u>Uninsured</u>	<u>Total</u>	
Demand Deposits	\$ -0-	\$ 236,146	\$ 236,146	\$ 28,426
Total Deposits	\$ -0-	\$ 236,146	\$ 236,146	\$ 28,426

Investments

The State Treasurer, under the authority of RSA 11:1, acts as custodian of the New Hampshire Hospital’s trust fund investments. In accordance with RSA 11:5, all trust funds in the custody of the Treasurer are invested and reinvested in legal instruments allowable under RSA 6:8. New Hampshire Hospital notifies the Treasurer, at least biennially, of the investment objectives of New Hampshire Hospital’s fiduciary funds.

Investments are categorized into these three categories of credit risk:

- (1) Insured registered, or securities held by the government or its agent in the Hospital's name.
- (2) Uninsured and unregistered, with securities held by the counterparty's trust department or agent in the Hospital's name.
- (3) Uninsured and unregistered, with securities held by the counterparty, or by its trust department or agent, but not in the Hospital's name.

The following table presents the investments of the New Hampshire Hospital as of June 30, 2003 categorized by credit risk.

Investments:	Categories			Fair
	1	2	3	Value
Stocks And Bonds	<u>\$ -0-</u>	<u>\$ -0-</u>	<u>\$3,650,097</u>	\$ 3,650,097
Uncategorized:				
Money Market Funds				435,400
U.S. Government Obligations				714,111
Mutual Funds				<u>408,474</u>
Total Investments				<u>\$5,208,082</u>

NOTE 3 - CAPITAL ASSETS AND OTHER EQUIPMENT

In addition to capital assets, New Hampshire Hospital also accounts for equipment and other assets with an original cost between \$100 and \$10,000. While only capital assets are reported on the Department's financial statements, State policies require departments to inventory all assets with an original cost of \$100 or more and a useful life of greater than one year for accountability purposes.

Capital asset and other equipment activity for the fiscal year ended June 30, 2003 was as follows.

	Balance July 1, 2002	Additions	Deletions	Balance June 30, 2003
Capital Assets Not Being Depreciated:				
Land And Land Improvements	\$ 471,211	\$ -0-	\$ -0-	\$ 471,211
Total Capital Assets Not Being Depreciated	<u>471,211</u>	<u>-0-</u>	<u>-0-</u>	<u>471,211</u>
Other Capital Assets:				
Building And Building Improvements	30,390,385	-0-	-0-	30,390,385
Capital Equipment	1,082,093	36,922	15,000	1,104,015
Total Other Capital Assets	<u>31,472,478</u>	<u>36,922</u>	<u>15,000</u>	<u>31,494,400</u>
Less Accumulated Depreciation For:				
Building And Building Improvements	12,437,226	697,592	-0-	13,134,818
Land Improvements	51,890	17,297	-0-	69,187
Capital Equipment	868,154	85,058	-0-	953,212
Total Accumulated Depreciation	<u>13,357,270</u>	<u>799,947</u>	<u>-0-</u>	<u>14,157,217</u>
Other Capital Assets, Net	<u>18,115,208</u>	<u>(763,025)</u>	<u>15,000</u>	<u>17,337,183</u>
Capital Assets, Net	<u>18,586,419</u>	<u>(763,025)</u>	<u>15,000</u>	<u>17,808,394</u>
Equipment With Original Cost Between \$100 And \$10,000	<u>3,150,246</u>	<u>63,017</u>	<u>123,959</u>	<u>3,089,304</u>
Net Capital Assets And Other Equipment	<u>\$ 21,736,665</u>	<u>\$ (700,008)</u>	<u>\$ 138,959</u>	<u>\$ 20,897,698</u>

NOTE 4 - EMPLOYEE BENEFIT PLANS

New Hampshire Retirement System

New Hampshire 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 substantially all full-time employees of the NHH. 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 all members.

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 ten or more years of creditable service who are between ages 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 New Hampshire 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 fiscal year ended June 30, 2003, Group I and II members were required to contribute 5% and 9.3%, respectively, 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.

New Hampshire Hospital's payments for normal contribution costs for the fiscal year ended June 30, 2003 amounted to 4.14% of the covered payroll for its Group I employees. The NHH's normal contributions for the fiscal year ended June 30, 2003 were \$1,118,769.

A special account was established by RSA 100-A:16, II (h) for additional benefits. The account is credited with all the earnings of the account assets in the account plus the earnings of the remaining assets of the plan in excess of the assumed rate of return plus ½ of 1%.

The New Hampshire Retirement System issues a publicly available financial report that may be obtained by writing to them at 4 Chenell Drive, Concord, NH 03301-8509 or from their web site at <http://www.state.nh.us/retirement>.

Post-Employment Health Care Benefits

In addition to providing pension benefits, RSA 21-I:30 specifies that the State provide certain health care insurance benefits for retired employees. These benefits include group hospitalization, hospital medical care, and surgical care. Substantially all of the State's employees 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 2003, 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 an insurance company whose premiums are based on the benefits paid during the year. The State recognizes the cost of providing these benefits by paying the entire annual insurance premium with a portion of the cost offset by the New Hampshire Retirement System's medical premium subsidy program for Group I and Group II employees.

During the fiscal year ended June 30, 2003, the State paid for the cost of health insurance premiums for New Hampshire Hospital's retired employees and spouses on a pay-as-you-go

basis. The cost of the health insurance for New Hampshire 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. Accordingly, the cost of health insurance benefits for retired New Hampshire Hospital employees and spouses is not included in the Hospital's financial statements.

NOTE 5 – GENERAL LONG-TERM DEBT

Various capital projects, such as Acute Psychiatric Services building construction and renovations, fire safety improvements for the Anna Philbrook Center, parking lot improvements, and acquisition of laundry equipment have been financed by issuance of general obligation bonds through State Treasury. Disbursements for the payment of principal and interest are budgeted and paid for by State Treasury. The following is a summary of the changes in long-term liability for these bonds related to New Hampshire Hospital during fiscal year 2003:

<u>Governmental Activities</u>	Beginning			Ending
	<u>Balance</u>	<u>Increases</u>	<u>Decreases</u>	<u>Balance</u>
General Obligation Bonds Payable	\$ 12,449,332	\$ -0-	\$(1,761,967)	\$ 10,687,365
Total Governmental	<u>\$ 12,449,332</u>	<u>\$ -0-</u>	<u>\$(1,761,967)</u>	<u>\$ 10,687,365</u>

Bonds issued are backed by the full faith and credit of the State. Interest rates on these bonds range from 3.0% to 7.2%. The annual maturities are as follows:

<u>Payable June 30,</u>	<u>Principal</u>	<u>Interest</u>	<u>Total</u>
2004	\$ 1,128,851	\$ 477,947	\$ 1,606,798
2005	1,198,256	497,051	1,695,307
2006	1,122,212	432,015	1,554,227
2007	1,063,032	426,458	1,489,490
2008	1,037,060	423,198	1,460,258
Thereafter	<u>5,137,954</u>	<u>1,843,674</u>	<u>6,981,628</u>
Total	<u>\$ 10,687,365</u>	<u>\$ 4,100,343</u>	<u>\$ 14,787,708</u>

**STATE OF NEW HAMPSHIRE
NEW HAMPSHIRE HOSPITAL**

**BUDGET TO ACTUAL (NON-GAAP BUDGETARY BASIS) SCHEDULE
GENERAL FUND
FOR THE FISCAL YEAR ENDED JUNE 30, 2003**

	<u>Budgeted Amount</u>		<u>Actual Budgetary Basis</u>	<u>Variance With Final Budget</u>
	<u>Original</u>	<u>Final</u>		<u>Positive (Negative)</u>
<u>Revenues</u>				
Medicaid-Disproportionate Share	\$ 26,800,000	\$ 26,800,000	\$ 33,188,351	\$ 6,388,351
Board And Care	6,656,810	6,656,810	7,044,630	387,820
Transitional Housing	735,451	1,210,678	1,350,244	139,566
Services Provided To Other Agencies	492,950	489,027	489,027	-0-
Cafeteria Revenue	-0-	324,000	340,421	16,421
Children Services-Education	370,000	276,237	316,408	40,171
Property Lease	83,763	83,763	76,783	(6,980)
Other (Grants/User Fees)	45,171	43,553	50,397	6,844
Total Revenues	<u>35,184,145</u>	<u>35,884,068</u>	<u>42,856,261</u>	<u>6,972,193</u>
<u>Expenditures</u>				
General Government And Capital Outlays	<u>51,934,030</u>	<u>51,734,378</u>	<u>51,254,857</u>	<u>479,521</u>
Total Expenditures	<u>51,934,030</u>	<u>51,734,378</u>	<u>51,254,857</u>	<u>479,521</u>
Excess (Deficiency) Of Revenues				
Over (Under) Expenditures	<u>\$ (16,749,885)</u>	<u>\$ (15,850,310)</u>	<u>\$ (8,398,596)</u>	<u>\$ 7,451,714</u>

The accompanying note is an integral part of this schedule.

Note To The Required Supplementary Information - Budgetary Reporting

The Hospital's biennial budget is prepared principally on a modified cash basis and adopted for governmental and proprietary funds. The "actual" results column of the Budget To Actual Schedule is presented on a "budgetary basis" to provide a meaningful comparison to budget.

The 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. For reporting purposes, the original budget is equal to the initial operating budget plus any balances brought forward, additional appropriations, and other legally authorized legislative and executive changes made before the beginning of the fiscal year. The final budgeted amount includes the original budget plus supplemental appropriation warrants and transfers made throughout the fiscal year.

The variance column on the Budget To Actual Schedule highlights differences between the final budget and actual revenue and expenditures. For revenue, these variances are caused by actual revenue exceeding budget, generating a favorable variance, or actual being less than budget, generating an unfavorable variance. For expenditures, a favorable variance results from actual expenditures being less than the amount budgeted for the fiscal year, and unfavorable variances represent actual expenditures for the reporting period exceeding the amounts budgeted for the fiscal year.

Budgetary vs. GAAP basis

Because the budget is prepared on a budgetary basis and not in accordance with generally accepted accounting principles (GAAP) there are differences in the revenue and expenditures amounts reported in the Statement of Revenues and Expenditures and the Budget To Actual Schedule.

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

1. Expenditures are recorded when cash is paid or committed (budgetary), rather than when the obligation is incurred (GAAP). In addition, revenue based on these accruals is adjusted on a GAAP basis only.
2. On a GAAP basis, major inter-agency and intra-agency transactions are eliminated in order to not double count revenues and expenditures.

The following schedule reconciles the differences between budgetary accounting methods and the GAAP basis accounting principles for the fiscal year ended June 30, 2003.

RECONCILIATION OF BUDGETARY TO GAAP

Excess (Deficiency) Of Revenues Over (Under) Expenditures (Budgetary Basis)	\$ (8,398,596)
Adjustments And Reclassifications:	
To Record The Effect Of Encumbrances	544,498
To Record Net Accounts Receivable	228,688
To Record Net Accounts Payable	(201,814)
To Record Net Accrued Salaries And Benefits	(243,298)
To Record Cost Of Operations Paid By Other Orgaizations	<u>(6,832,815)</u>
Net Adjustments And Reclassifications	<u>(6,504,741)</u>
Excess (Deficiency) Of Revenues Over (Under) Expenditures (GAAP)	<u>\$ (14,903,337)</u>

**STATE OF NEW HAMPSHIRE
NEW HAMPSHIRE HOSPITAL**

**SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS
FOR THE FISCAL YEAR ENDED JUNE 30, 2003**

<u>Federal Catalog Number</u>	<u>Federal Grantor <i>Federal Program Title</i></u>	<u>Expenditures</u>	<u>Pass Thru Percent</u>
14.235	U.S. Department of Housing and Urban Development <i>Supportive Housing Program-Shelter Plus Care</i>	\$ 236,866 <u>\$ 236,866</u>	0%

**APPENDIX
CURRENT STATUS OF PRIOR AUDIT FINDINGS**

The following is a summary, as of April 13, 2004, of the current status of the observations and other issues and concerns contained in the audit report of New Hampshire Hospital for the eighteen months ended December 31, 1988. A copy of the prior report can be obtained from the Office of Legislative Budget Assistant, Audit Division, 107 North Main Street, State House Room 102, Concord, NH 03301-4906.

	<u>Status</u>		
<i>Internal Control Comments</i>			
<i>Material Weaknesses</i>			
1. Land And Building Costs Not Documented (<i>See Current Observation No. 41</i>)	●	○	○
2. Equipment Inventory Control (<i>See Current Observation Nos. 41 and 42</i>)	●	○	○
<i>Other Reportable Conditions</i>			
3. Consumable Inventories – Dietary (<i>See Current Observation No. 40</i>)	○	○	○
4. Consumable Inventories – Pharmacy (<i>See Current Observation No. 25</i>)	○	○	○
5. Consumable Inventories – Gasoline	●	●	○
6. Patient Checking Account Balance	●	●	○
7. Patient Account Interest Income	●	●	●
8. Balances Brought Forward Improperly	●	●	●
9. Direct-Care Differential	●	●	●
10. Internal Audit (<i>See Current Observation No. 1</i>)	●	○	○
<i>State Compliance Comments</i>			
11. Questionable Use Of Trust Funds (<i>See Current Observation No. 34</i>)	○	○	○
12. No Records Of Private Car Mileage	●	●	●
13. Motor Vehicle Records	●	●	●

Status Key

Fully Resolved	●	●	●
Substantially Resolved	●	●	○
Partially Resolved	●	○	○
Unresolved	○	○	○

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