

STATE OF CONNECTICUT

**AUDITORS' REPORT
UNIVERSITY OF CONNECTICUT
HEALTH CENTER
FOR THE FISCAL YEARS ENDED
JUNE 30, 2001, 2002, 2003 AND 2004**

AUDITORS OF PUBLIC ACCOUNTS
KEVIN P. JOHNSTON ♦ ROBERT G. JAEKLE

Table of Contents

INTRODUCTION	1
COMMENTS	1
FOREWORD:	1
Recent Legislation:	5
RÉSUMÉ OF OPERATIONS:	5
PROGRAM EVALUATION:	12
Dental School Tuition and Fee Charges:	12
Class	13
In-State Enrollment	13
Total Enrollment	13
CONDITION OF RECORDS	16
Documentation of Procurement Actions:	16
Finance Corporation Procurement:	16
Execution of Contracts:	18
Access Control:	20
EDP Disaster Recovery:	21
Equipment Inventory:	23
Compensatory Time:	24
Faculty Time and Attendance Reports:	25
Termination Payments:	26
Other Audits:	27
RECOMMENDATIONS	30
INDEPENDENT AUDITORS' CERTIFICATION	35
CONCLUSION	37

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AUDITORS OF PUBLIC ACCOUNTS

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July 5, 2006

AUDITORS' REPORT UNIVERSITY OF CONNECTICUT HEALTH CENTER FOR THE FISCAL YEARS ENDED JUNE 30, 2001, 2002, 2003 AND 2004

We have made an examination of the financial records of the University of Connecticut Health Center (Health Center) for the fiscal years ended June 30, 2001, 2002, 2003 and 2004. The University of Connecticut (University) and the Health Center are component units of the University of Connecticut system, which includes the University, the Health Center, the University of Connecticut Foundation, Inc. (Foundation) and the University of Connecticut Law School Foundation, Inc. (Law School Foundation). This report on that examination consists of the Comments, Recommendations and Certification that follow.

Financial statement presentation and auditing are done on a Statewide Single Audit basis to include all State agencies. This audit has been limited to assessing the Health Center's compliance with certain provisions of financial related laws, regulations and contracts, and evaluating the Health Center's internal control structure policies and procedures established to ensure such compliance.

COMMENTS

FOREWORD:

The Health Center operates generally under the provisions of Title 10a, Chapter 185, where applicable, Chapter 185b, Part III, and Chapter 187c of the General Statutes. Together, the University and the Health Center are a constituent unit of the State system of public higher education under the central authority of the Board of Governors of Higher Education. The Health Center is governed by a Board of Trustees of the University of Connecticut, consisting of 19 members appointed or elected under the provisions of Section 10a-103 of the General Statutes.

Auditors of Public Accounts

This Board, subject to Statewide policy and guidelines established by the Board of Governors of Higher Education, makes rules for the government of the Health Center and sets policies for administration of the Health Center pursuant to duties set forth in Section 10a-104 of the General Statutes. The members of the Board of Trustees as of June 30, 2004, were:

Ex officio members:

John G. Rowland, Governor
Bruce J. Gresczyk, Commissioner of Agriculture (Acting)
Betty J. Sternberg, Commissioner of Education

Appointed by the Governor:

John W. Rowe, M.D., New York, New York, Chair
Louise M. Bailey, West Hartford, Secretary
James F. Abromaitis, Unionville
William R. Berkley, Greenwich
Michael H. Cicchetti, Litchfield
Linda P. Gatling, Southington
Lenworth M. Jacobs, M.D., West Hartford
Michael J. Martinez, East Lyme
Denis J. Nayden, Wilton
David W. O'Leary, Waterbury
Thomas D. Ritter, Hartford
Richard Treibick, Greenwich

Elected by alumni:

Philip P. Barry, Storrs
Andrea Dennis-LaVigne, Simsbury

Elected by students:

Michael J. Nichols, Cromwell
Richard Twilley, Hartford

June 30, 2000, marked the completion of the term of Alyssa O. Benedict of Willington. Christopher J. Albanese of Gales Ferry succeeded her. His term ended June 30, 2002; Richard Twilley of Hartford succeeded him, effective July 1, 2002. John R. Downey of Redding resigned in April 2001; David W. O'Leary of Waterbury was appointed to serve the remainder of his term.

Roger A. Gelfenbien of Wethersfield completed his term effective June 30, 2003. Thomas D. Ritter of Hartford succeeded him. John W. Rowe, M.D., of New York, who succeeded Claire R. Leonardi of Harwington, replaced him as Chair. Though Claire R. Leonardi resigned from the Board of Trustees, she continues to serve on the newly created Board of Directors for the Health Center.

James M. Donich of Colchester and Irving R. Saslow of Hamden completed their terms effective June 30, 2001. They were succeeded by Christopher S. Hattayer of Storrs and Denis J. Nayden of Wilton, respectively. Christopher S. Hattayer completed his term effective June 30, 2003; Michael J. Nichols of Cromwell succeeded him effective July 1, 2003. Louise S. Berry of

Danielson completed her term effective August 31, 2001. Philip P. Barry of Storrs succeeded her effective September 1, 2001.

Shirley Ferris served as Commissioner of Agriculture until she was succeeded by Bruce J. Gresczyk in March 2003. Theodore S. Sergi served as Commissioner of Education during the first part of the audited period; he was succeeded by Betty J. Sternberg in November 2003.

Public Act 01-173, Section 35, effective July 1, 2001 (codified as Subsection (c) to Section 10a-104 of the General Statutes), authorized the Board of Trustees of the University of Connecticut to create a Board of Directors for the governance of the Health Center and delegate such duties and authority as it deems necessary and appropriate to said board of directors. On July 24, 2001, the Board amended the *Laws, By-Laws and Rules of the University of Connecticut* to provide for the creation of a 17 (increased to 18 after the end of the audited period by the addition of the Commissioner of the Department of Public Health) member Board of Directors.

The Board of Directors was established in 2001-2002, though it did not hold its first meeting until September 9, 2002. The members of the Board of Directors as of June 30, 2004, were:

Ex officio members:

Philip E. Austin, President, University of Connecticut
Marc Ryan, Secretary, Office of Policy and Management

Appointed by the Governor:

Thomas J. Devers, M.D., New Britain
David B. Friend, M.D., Weston, Massachusetts
Jay L. Haberland, Simsbury

Appointed by the Chair of the Board of Trustees:

Claire R. Leonardi, Chair, Harwinton
James F. Abromaitis, Unionville
Lenworth M. Jacobs, M.D., West Hartford

Members at Large:

Gerald N. Burrow, Hamden
Bruce Chudwick, Farmington
Aldrage B. Cooper, Skillman, New Jersey
A. Jon Goldberg, West Hartford
Nancy J. Hutson, Stonington
Paul H. Johnson, Guilford
Gerard J. Lawrence, M.D., Lyme
David P. Marks, West Hartford
Robert T. Samuels, West Hartford

John W. Rowe, M.D., of New York served on the Board of Directors until he replaced Roger A. Gelfenbien of Wethersfield as Chair of the Board of Trustees. Gerald N. Burrow of Hamden succeeded him. Michael R. Meacham of Coventry also served on the Board during the audited period; Jay L. Haberland of Simsbury succeeded him.

Pursuant to Section 10a-108 of the General Statutes, the Board of Trustees of the University of Connecticut are to appoint a president of the University and the Health Center to be the chief executive and administrative officer of the University and the Health Center and of the Board of Trustees. Philip E. Austin served as president during the audited period.

The Health Center's Farmington complex houses the John Dempsey Hospital, the School of Medicine, the School of Dental Medicine, and related research laboratories. Additionally, the Schools of Medicine and Dental Medicine provide health care to the public, through the UConn Medical Group and the University Dentists, in facilities located at the Farmington campus and in neighboring towns.

The University of Connecticut Health Center Finance Corporation (Finance Corporation), a body politic and corporate, constituting a public instrumentality and political subdivision of the State, operates generally under the provisions of Title 10a, Chapter 187c of the General Statutes. The Finance Corporation exists to provide operational flexibility with respect to hospital operations, including the clinical operations of the Schools of Medicine and Dental Medicine.

The Finance Corporation is empowered to acquire, maintain and dispose of hospital facilities and to make and enter into contracts, leases, joint ventures and other agreements; it acts as a procurement vehicle for the clinical operations of the Health Center. The Hospital Insurance Fund (otherwise known as the John Dempsey Hospital Malpractice Fund), which accounts for a self-insurance program covering claims arising from health care services, is administered by the Finance Corporation in accordance with Section 10a-256 of the General Statutes. Additionally, Section 10a-258 of the General Statutes gives the Finance Corporation the authority to determine which hospital accounts receivable shall be treated as uncollectible.

The Finance Corporation acts as an agent for the Health Center. In the past, it operated on a "pass-through" basis; it did not accumulate any significant assets or liabilities. However, construction of the Health Center's new Medical Arts and Research Building, initiated during the audited period, was handled through the Finance Corporation. The building is an asset of the Finance Corporation and the associated debt a liability. Similarly, subsequent to the audited period, the Health Center's acquisition of the facility located at 16 Munson Road was handled through the Finance Corporation.

The Finance Corporation is administered by a Board of Directors, consisting of five members appointed under the provisions of Section 10a-253 of the General Statutes. The members of the Board of Directors as of June 30, 2004, were:

Ex officio members:

Phillip E. Austin, Ph.D., President

Peter J. Deckers, M.D., Executive Vice President for Health Affairs

Mark S. Ryan, Secretary of the Office of Policy and Management

Appointed by the Governor:

John W. Rowe, M.D., of New York, New York, Chair

James F. Abromaitis, Unionville

Further, Gale Mattison was designated to represent the Secretary of the Office of Policy and Management as an alternate. Benson Cohn formerly served in this capacity.

Roger A. Gelfenbien of Wethersfield completed his term effective June 30, 2003. John W. Rowe, M.D., of New York, succeeded him as Chair. Claire R. Leonardi of Harwinton served on the Board until she resigned from the Board of Trustees (per Section 10a-253, members of the Finance Corporation's Board of Directors are to be University trustees). James F. Abromaitis of Unionville succeeded her. Leslie S. Cutler, D.D.S., Ph.D., stepped down as Chancellor and Provost for Health Affairs when his appointment expired on June 30, 2000. Peter J. Deckers, M.D, succeeded him.

Recent Legislation:

During the period under review, and thereafter, legislation was passed by the General Assembly affecting the Health Center. The most noteworthy items are presented below.

- Public Act 01-141, Section 11, effective July 1, 2001, increased the authorization for the endowment matching grant program for the fiscal years ending June 30, 2006 and 2007, from \$5,000,000 per year to \$10,000,000 per year, and extended the program through the fiscal year ended June 30, 2014, with \$15,000,000 per year authorized for the additional period.
- Public Act 01-173, Section 35, effective July 1, 2001, authorized the Board of Trustees of the University of Connecticut to create a Board of Directors for the governance of the Health Center and delegate such duties and authority as it deems necessary and appropriate to said board of directors.
- Public Act 02-3 of the May 9 Special Session authorized 1.3 billion dollars in new bond funds for the University of Connecticut and expanded the UConn 2000 capital improvement program, effective July 1, 2002. Over \$300 million was earmarked for infrastructure improvements at the UConn Health Center.

RÉSUMÉ OF OPERATIONS:

Over the last decade and more, changes in the statutes governing the State's constituent institutions of higher education gave the Health Center greater autonomy and flexibility. The most significant changes were effectuated by Public Act 91-256, effective July 1, 1991; subsequent legislation increased the degree of independence granted the institutions.

This independence is most notable with respect to procurement actions. Institutions of higher education may, under Section 10a-151b of the General Statutes, purchase equipment, supplies and services and lease personal property without review and approval by the State Comptroller, the Department of Administrative Services or the Department of Information Technology. Further, they are not subject to the restrictions concerning personal service agreements codified under Sections 4-212 through 4-219, although, as a compensating measure, personal service agreements executed by the institutions of higher education must satisfy the same requirements generally applicable to other procurement actions.

Under Section 3-25 of the General Statutes, higher education institutions may, subject to the approval of the Comptroller, pay most non-payroll expenditures (those funded from the proceeds of State bond issuances being an exception) directly, instead of through the State Comptroller. The Health Center began issuing checks directly to vendors in August 1993. The checks are drawn on a “zero balance” checking account controlled by the State Treasurer. Under the approved procedures, funds are advanced from the Health Center’s civil list funds to the Treasurer’s cash management account. The Treasurer transfers funds from the cash management account to the “zero balance” checking account on a daily basis, as needed to cover checks that have cleared.

The Health Center also enjoys a significant degree of autonomy with respect to personnel matters. Section 10a-108 of the General Statutes grants the Board of Trustees the authority to employ professional employees and establish the terms and conditions of employment. Section 10a-154b allows institutions of higher education to establish positions and approve the filling of all position vacancies within the limits of available funds.

Public Act 95-230, known as “The University of Connecticut 2000 Act,” authorized a massive infrastructure improvement program to be managed by the University, effective June 7, 1995. Although subsection (c) of Section 7 of Public Act 95-230 provides that the securities issued to fund this program are to be issued as general obligations of the University, it also provides that the debt service on these securities is to be financed, for the most part, from the resources of the General Fund. However, as they are not considered to be a “state bond issue” as referred to in Section 3-25 of the General Statutes, the University is able to make payments related to the program directly, rather than process them through the State Comptroller.

The Health Center did not participate in this program when it was first established. However, when Public Act 02-3 of the May 9 Special Session authorized 1.3 billion dollars in new bond funds for the University, over \$300 million was earmarked for infrastructure improvements at the UConn Health Center.

Subdivision (1) of subsection (b) of Section 9 of Public Act 95-230 established a permanent endowment fund, the net earnings on the principal of which are to be dedicated and made available for endowed professorships, scholarships and programmatic enhancements. To encourage donations, subparagraph (A) of subdivision (2) of subsection (b) of Section 9 of the Act provided for State matching funds for eligible donations deposited into the fund, limiting the total amount matched to \$10,000,000 in any one year and to \$20,000,000 in the aggregate. It specified that the match, which was to be financed from the General Fund, would be paid into the fund during the fiscal years ending June 30, 1998, 1999 and 2000.

The amount paid was to be equal to the endowment fund eligible gifts received for the calendar year ending the preceding December thirty-first. If funds were not budgeted for this purpose, bonds were authorized to be issued to finance the match. The authority for such issuances was limited to \$10,000,000 in any one fiscal year and \$20,000,000 in the aggregate.

Effective July 1, 1997, Section 7 of Public Act 97-293 extended this endowment matching grant program through the fiscal year ending June 30, 2007, and increased the cumulative authorization for the State matching amount to \$72,500,000. Section 8 of the Act reduced the

State match to a one to two ratio (one State dollar for two private dollars) for donations involving a written commitment made on or after July 1, 1997. Section 1 of the Act specified that the program be administered by the Department of Higher Education and established the Higher Education State Matching Grant Fund to facilitate the process. Effective July 1, 2001, Section 11 of Public Act 01-141 increased the authorization for the fiscal years ending June 30, 2006 and 2007, from \$5,000,000 per year to \$10,000,000 per year, and extended the program through the fiscal year ended June 30, 2014, with \$15,000,000 per year authorized for the additional period.

Effective July 1, 1998, Section 28 of Public Act 98-252 authorized the deposit of State matching funds in “the university or in a foundation operating pursuant to Sections 4-37e and 4-37f consistent with the deposit of endowment fund eligible gifts.” This provision was made to clarify the issue of whether State matching funds could become foundation assets or must be deemed assets of the associated constituent unit of higher education.

Statistics compiled by the University’s registrar showed the following enrollments in the Health Center’s credit programs during the audited period.

Student Status	Fall 2000	Fall 2001	Fall 2002	Fall 2003
Medicine - Students	324	316	311	312
Medicine – Residents	525	570	590	609
Dental – Students	160	155	158	161
Dental - Residents	98	111	93	91
Totals	1107	1152	1152	1173

Under the provisions of Section 10a-105, subsection (a), of the General Statutes, fees for tuition were fixed by the University’s Board of Trustees. The following summary shows annual tuition charges during the audited period.

Student Status	2000-2001			2001-2002		
	In-State	Out-of-State	Regional	In-State	Out-of-State	Regional
School of Medicine	\$9,655	\$21,960	\$14,480	\$10,040	\$22,840	\$15,060
School of Dental Medicine	8,385	21,490	12,580	8,385	21,490	12,580

Student Status	2002-2003			2003-2004		
	In-State	Out-of-State	Regional	In-State	Out-of-State	Regional
School of Medicine	\$10,440	\$23,750	\$15,660	\$12,000	\$27,300	\$18,000
School of Dental Medicine	8,385	21,490	12,580	9,643	24,714	14,647

During the audited period, the State Comptroller accounted for Health Center operations in:

- General Fund appropriation accounts.
- The University of Connecticut Health Center Operating Fund (Section 10a-105 of the General Statutes).
- The University of Connecticut Health Center Research Fund (Section 10a-130 of the General Statutes).
- The University Bond Liquidation Fund (Special Act 67-276, Section 26, and others - used for both the University and the Health Center).
- The University Health Center Hospital Fund (Section 10a-127 of the General Statutes).
- The John Dempsey Hospital Malpractice Fund (Section 10a-256 of the General Statutes).
- Accounts established in capital project and special revenue funds for appropriations financed primarily with bond proceeds.

Though the Finance Corporation maintains a separate accounting system, in the past virtually all of its activity and balances were mirrored in the University of Connecticut Health Center Operating and Hospital Funds. However, this changed with the recent construction of the Health Center's new Medical Arts and Research Building and the acquisition of the facility located at 16 Munson Road. These buildings are assets of the Finance Corporation and the associated debt a liability.

There were two activity funds associated with the Health Center, the Health Center Student Activity Fund and the Uncas-on-Thames Welfare Fund. Neither of these funds was included in the State Comptroller's accounting system at the beginning of the audited period; the Uncas-on-Thames Welfare Fund was closed and its assets transferred into a University of Connecticut Health Center Operating Fund restricted account October 26, 2001. The financial effect of these activity funds was negligible.

During the first year of the audited period, the accounting system of the Health Center reflected the accounting model in general use by colleges and universities, per the American Institute of Certified Public Accountants' industry audit guide Audits of Colleges and Universities. Under this model, the Health Center maintained separate fund groups for current unrestricted, current restricted, hospital, endowment and similar, loan and plant funds.

The Health Center implemented Governmental Accounting Standards Board (GASB) Statement No. 33, *Accounting and Financial Reporting for Non-exchange Transactions*, during the fiscal year ended June 30, 2001. Statement No. 33 requires recipients of government-mandated and voluntary non-exchange transactions to recognize revenue when all applicable eligibility requirements are met for these transactions. As a result, the Health Center's restricted fund balance at June 30, 2000, previously reported as \$13,446,178, was restated as \$15,946,178. The net effect of implementing Statement No. 33 was to decrease restricted revenues for the year by \$839,228.

Additionally, beginning with the fiscal year 2002, GASB Statements Nos. 34, *Basic Financial Statements—and Management's Discussion and Analysis—for State and Local Governments*, and 35, *Basic Financial Statements—and Management's Discussion and*

Analysis—for Public Colleges and Universities—an amendment of GASB Statement No. 34, require recognition of depreciation on buildings, non-structural improvements and equipment. The Health Center chose to adopt this provision in the fiscal year ended June 30, 2001, as allowed by GASB Statement No. 8. Accordingly, the Health Center's plant funds fund balance at June 30, 2000, previously reported as \$370,210,520, was restated as \$162,762,856.

Health Center financial statements were adjusted as necessary and incorporated in the State's Comprehensive Annual Financial Report. The financial balances and activity of the John Dempsey Hospital were included as an enterprise fund; the remaining financial balances and activity of the Health Center were combined with those of the State's other institutions of higher education and shown using the discrete presentation format.

The Health Center implemented GASB Statements Nos. 34 and 35 during the fiscal year ended June 30, 2001. The format of the Health Center's financial statements changed drastically as a result of this implementation. Previously, the institution presented a balance sheet, statement of changes in fund balance and statement of current funds revenues, expenditures and other changes, with separate columns for each fund group. GASB Statements Nos. 34 and 35 require a statement of net assets, a statement of revenues, expenses and changes in net assets and a statement of cash flows.

Also, prior to this implementation, restricted current funds received before revenue recognition criteria were met were treated as assets of the institution. Per GASB Statements Nos. 34 and 35, such amounts are to be classified as deferred revenues until the applicable revenue recognition criteria are met. Therefore, the Health Center's fund balance (exclusive of John Dempsey Hospital) at June 30, 2001, previously reported as \$164,696,188, was restated as \$153,025,778. The net effect of this change in accounting principles was to increase revenues for the year by \$1,759,881.

Health Center financial statements continued to be adjusted as necessary and incorporated in the State's Comprehensive Annual Financial Report. Beginning with the fiscal year ended June 30, 2002, the financial balances and activity of the Health Center, including that of the John Dempsey Hospital, were combined with those of the State's other institutions of higher education and included as an enterprise fund.

The John Dempsey Hospital was shown separately in the Health Center's financial statements for the fiscal years ended June 30, 2002 and 2003. Beginning with the fiscal year ended June 30, 2004, the Health Center elected to use a single column format. However, consolidating statements of net assets and of revenues, expenses and changes in net assets were presented as supplementary information.

The Health Center' fund balance decreased by \$5,324,150 from \$220,912,526 as of June 30, 2000, as restated to comply with GASB Statement No. 33 and to recognize depreciation on buildings, non-structural improvements and equipment, to \$215,588,376 as of June 30, 2001. The latter balance was restated to \$203,917,966 in the following year to reflect the change in the treatment of funds received before revenue recognition criteria were met mandated by GASB Statements Nos. 34 and 35.

The Health Center's net assets balance increased by \$17,821,336 from \$203,917,966 as of June 30, 2001, as restated, to \$221,739,302 as of June 30, 2002. It increased again by \$4,026,842 to \$225,766,144 as of June 30, 2003, and then by \$4,802,866 to \$230,569,010 as of June 30, 2004.

Health Center employment grew slightly during the audited period. Health Center position summaries show that filled positions aggregated 3,761, 3,975, 3,931 and 4,074 as of June 30, 2001, 2002, 2003 and 2004, respectively.

During the audited period, patient revenues were the Health Center's largest source of revenue. Patient revenues, as reflected in the Health Center's financial statements, aggregated \$206,358,479, \$288,842,328, \$304,887,089 and \$319,777,310 for the fiscal years ended June 30, 2001, 2002, 2003 and 2004, respectively. The amount for the fiscal year ended June 30, 2004, is net of eliminations of internal transactions between the primary institution and the John Dempsey Hospital; the amounts shown for the first three fiscal years are not. Such internal revenues aggregated \$5,288,297 for the fiscal year ended June 30, 2004.

John Dempsey Hospital patient revenues were the largest single component of Patient revenues. Such revenues totaled \$94,358,929, \$144,876,889, \$166,118,025 and \$184,578,641 for the fiscal years ended June 30, 2001, 2002, 2003 and 2004, respectively. Other operations that generated significant patient revenues were the Correctional Managed Healthcare Program and the UConn Medical Group.

Under the Correctional Managed Healthcare Program, the Health Center entered into an agreement, effective August 11, 1997, with the Department of Correction to provide medical care to the inmates incarcerated at the State's correctional facilities. Medical personnel at the correctional facilities, formerly paid through the Department of Correction, were transferred to the Health Center's payroll. The agreement called for the Health Center to provide comprehensive medical, mental health and dental services and medical support services such as laboratory, pharmacy and radiology to Department of Correction inmates at a capitated, or fixed, cost. However, as currently implemented, the program functions on a cost reimbursement basis.

Patient revenues generated by the program, as reflected in the Health Center's financial statements, were \$65,550,681, \$79,643,880, \$79,230,044 and \$77,511,992 for the fiscal years ended June 30, 2001, 2002, 2003 and 2004, respectively. These amounts did not include in-kind fringe benefit support, which was classified as General Fund operating support.

In the fiscal year ended June 30, 2002, the Health Center recorded a receivable from the General Fund in the amount of unfunded program expenditures to recognize the fact that the program was functioning on a cost reimbursement basis. In previous years, the cumulative program deficit was reflected in the Health Center's financial statements. The amount recorded as of June 30, 2002, was \$7,912,822; this practice continued in subsequent years.

While the program is managed by the Health Center, the Commissioner of the Department of Correction retains the authority for the care and custody of inmates and has responsibility for the supervision and direction of all institutions, facilities and activities of the Department. The purpose of the program is to enlist the services of the Health Center to carry out the responsibility of the Commissioner for the provision and management of comprehensive medical

care.

The UConn Medical Group functions similarly to a private group practice. Faculty clinicians provide patient services and receive incentive payments based on fees earned. Patient service revenues, as reflected in the Health Center's financial statements, totaled, \$44,828,520, \$62,312,917, \$57,777,132 and \$59,968,287 for the fiscal years ended June 30, 2001, 2002, 2003 and 2004, respectively. A portion of the increase noted in the fiscal year ended June 30, 2002, and the subsequent decrease, reflected changes in the classification of certain receipts, rather than actual changes in operations. UConn Medical Group revenues classified as contract and other operating revenues totaled \$8,733,133, \$708,829, \$5,127,134 and \$3,795,040 for the fiscal years ended June 30, 2001, 2002, 2003 and 2004, respectively.

Additionally, beginning in the fiscal year ended June 30, 2003, certain transactions between the UConn Medical Group and the John Dempsey Hospital were identified and eliminated from the financial statements. Such transactions aggregated \$2,968,864 and \$3,074,179 for the fiscal years ended June 30, 2003 and 2004, respectively.

Other significant sources of revenue included State General Fund operating support, restricted grants and payments for the services of interns and residents. State General Fund operating support, as reflected in the Health Center's financial statements, totaled \$112,486,860, \$117,964,237, \$115,445,236 and \$119,067,925 for the fiscal years ended June 30, 2001, 2002, 2003 and 2004, respectively. These amounts included budgeted appropriations, in-kind fringe benefit support associated with those budgeted appropriations and in-kind fringe benefit support associated with the Correctional Managed Healthcare Program.

Restricted grant revenues, as reflected in the Health Center's financial statements totaled \$46,469,167, \$66,887,106, \$80,802,988 and \$88,876,629 for the fiscal years ended June 30, 2001, 2002, 2003 and 2004, respectively, exclusive of recoveries of facilities and administrative costs. Federal grants comprised the largest part of these revenues.

Under the Residency Training Program, interns and residents appointed to local health care organizations are paid through the Capital Area Health Consortium. The Health Center reimburses the Capital Area Health Consortium for the personnel service costs incurred and is, in turn, reimbursed by the participating organizations. Program revenues, as reflected in the Health Center's financial statements, aggregated \$29,898,306, \$32,066,698, \$35,226,855 and \$28,587,851 for the fiscal years ended June 30, 2001, 2002, 2003 and 2004, respectively. The amount for the fiscal year ended June 30, 2004 is net of eliminations of internal transactions between the primary institution and the John Dempsey Hospital; the amounts shown for the first three fiscal years are not. Such internal revenues aggregated \$8,647,962 for the fiscal year ended June 30, 2004.

The Health Center did not hold significant endowment and similar funds balances during the audited period, as it has been the Health Center's longstanding practice to deposit funds raised with the University of Connecticut Foundation, Inc. The Foundation provides support for the University and the Health Center. Its financial statements reflect balances and transactions associated with both entities, not with just the Health Center. A summary of the Foundation's assets, liabilities, support and revenue and expenses, as per those audited financial statements, follows:

	Foundation			
	Fiscal Year Ended			
	<u>June 30, 2001</u>	<u>June 30, 2002</u>	<u>June 30, 2003</u>	<u>June 30, 2004</u>
Assets	\$251,095,000	\$244,375,000	\$257,491,000	\$311,273,000
Liabilities	14,266,000	15,815,000	15,521,000	13,622,000
Net Assets	236,829,000	228,560,000	241,970,000	297,651,000
Support and Revenue	18,448,000	24,904,000	48,438,000	88,730,000
Expenses and Transfers	30,397,000	33,173,000	35,028,000	33,049,000

PROGRAM EVALUATION:

Section 2-90 of the General Statutes authorizes the Auditors of Public Accounts to conduct a program evaluation as part of their routine audits of public and quasi-public agencies. In our report on the fiscal year ended June 30, 1998, we noted that the Health Center’s Dental School enrolls a relatively high portion of out-of-State students. As virtually all Dental School students benefit substantially from State subsidization of the program, we recommended increased emphasis on the recruitment of State residents.

Responding to our recommendation, the Health Center stated that the State subsidy allowed the Dental School to “attract the best caliber students from all over the country thereby maintaining the highest quality classes in the country and graduating the best dentists.” Further, that “many of those who have gained in-State status remain in Connecticut helping to fill the Dental School’s obligation of providing the best possible dental care for the citizens of Connecticut.”

However, did not find any indication that the Legislature provided this subsidy for the purpose of increasing the number of dentists practicing in Connecticut. To the contrary, it appeared that the Legislature’s intent was to, as set forth in Section 10a-102 of the General Statutes, facilitate “the education of youth whose parents are citizens of this state” in order to “promote the liberal and practical education of the industrial classes.” We continued to feel that in-State students should be the primary beneficiaries of subsidization of academic programs from the General Fund resources of the State and that current practice is not consistent with this idea. Therefore, we repeated our recommendation in our next report, which covered the fiscal years ended June 30, 1999, and 2000.

During our current review, we noted that, in spite of efforts to increase in-State enrollment, it remained essentially static. Therefore, we are now recommending that the Health Center prepare a cost/benefit analysis documenting the value of the dental program to the State.

Dental School Tuition and Fee Charges:

Criteria: Section 10a-105 of the General Statutes gives the Board of Trustees of the University of Connecticut the authority to fix tuition and fees at the Health Center, subject to the provisions of Sections 10a-8 and 10a-126. Tuition and fees for Dental School

students for the 2003-2004 fiscal year were fixed at \$14,108 for in-State students, \$19,202 for out-of-State students participating in the New England Regional Student Program and \$29,449 for other out-of-State students. The substantially higher rates established for out-of-State students are an acknowledgment that in-State students should be the primary beneficiaries of subsidization of academic programs from the General Fund resources of the State. Further, as noted above, Section 10a-102 of the General Statutes indicates that the University's, and by extension the Health Center's, reason for existing is to provide for "the education of youth whose parents are citizens of this state" in order to "promote the liberal and practical education of the industrial classes."

Part II of Chapter 185 of the General Statutes sets forth criteria for the determination of student status. Generally, emancipated persons are entitled to classification as in-State students for tuition purposes after residing in the State for a period of one year. Most Dental School students entering the institution from other states apply for and are granted in-State status after their first year in the program.

Condition:

In our report on the fiscal years ended June 30, 1999, and 2000, we recommended that the Health Center Dental School increase its efforts to recruit State residents. In responding to this recommendation, the Health Center identified the recruitment of "CT residents with high academic qualifications for its future entering classes" as an institutional goal. Further, that "The School of Dental Medicine (SDM) continues to strive to improve its student recruitment approach to attract more Connecticut residents with an enhanced emphasis on recruitment of underrepresented minority (URM) and/or students from low income (LI) families."

In spite of these efforts, in-State enrollment remains essentially static. The following table shows the makeup of recent classes (by year of graduation) in their first year of enrollment.

Class	In-State Enrollment	Total Enrollment	In-State Percentage
2002	17	48	35%
2003	21	44	48%
2004	12	32	38%
2005	9	44	20%
2006	22	46	48%
2007	14	40	35%
2008	17	44	39%

- Effect:* The majority of the students benefiting from the General Fund subsidization of the dental program are not State residents when they enter the program. However, the program may provide other valuable benefits to the State in addition to furthering “the education of youth whose parents are citizens of this state.”
- Cause:* There may not be a sufficient number of qualified State residents interested in the program.
- Recommendation:* The Health Center Dental School should prepare a cost/benefit analysis documenting the value of the dental program to the State. (See Recommendation 1.)
- Agency Response:* “Relative to the “condition” cited, i.e. the concern that 38% in-state enrollment in 2004 is low, this assessment is made with no context. This is not a low percentage given national and state statistics. First, the number of Connecticut residents applying to any US dental school/year is only approximately 40 to 50 per year. Second, though Connecticut residents who apply to the SDM are given strong preference over non resident applicants, the fact that our dental students take the same robust basic science curriculum as our medical students requires that applicants must have exceptionally high ability in the sciences compared to dental students accepted to most other US dental schools. The UConn Health Center is keenly aware of its mission to provide remarkable care for Connecticut through research and education. We are committed to providing educational opportunity for Connecticut’s sons and daughters, just as we are committed to ensuring that we provide educated health professionals to serve Connecticut’s citizens. To use a model that measures only the number of 1st year students who are Connecticut residents upon application misses a critical component of our mission. There is also great value to Connecticut in attracting highly talented out-of-state students because many of them remain here post-graduation. When one examines the age and educational background of Connecticut dentists, the data show that the UConn School of Dental Medicine has produced fully one-half of the dentists practicing in our State today. Current data from our Alumni Office indicate that 48% of our Dental School graduates stay in Connecticut to work, to improve the health status of our citizens, and to pay taxes. This is an outcome also worthy of General Fund investment. That said, the SDM, in partnership with the Storrs campus, has recently developed two important initiatives to address the goal of more qualified Connecticut dental school applicants to the SDM. The first initiative is a combined program that leads to the awarding of an undergraduate BA/BS degree from UConn and a DMD from the UConn SDM. The program allows for provisional acceptance to the SDM at the time of admission to the undergraduate program

and now has 16 participants. The second initiative is the Pre-Dental Society, which provides students interested in dentistry the opportunity to participate in a range of activities that will enhance their interest and assist them in becoming excellent dental school applicants. After its first year, the organization now has over 70 members, the majority of whom are Connecticut residents. The SDM has successfully addressed the underrepresented minority enrollment issue cited in the report as a “condition”. Through several initiatives, the SDM has dramatically increased the percentage of URM students in the classes of 2008 (20%) and 2009 (at least 27% and could be as high as 34%). The URM % improvement in the Class of 2008 was cited nationally in a Robert Wood Johnson Foundation Report as one of the top three most improved for dental schools in the nation (the SDM had averaged 7% URM/class in the previous 7 years).”

CONDITION OF RECORDS

Our review of the financial records of the Health Center disclosed certain areas requiring attention, as discussed in this section of the report.

Documentation of Procurement Actions:

Criteria: Procurement actions by a public entity should be carefully documented to provide accountability. Documentation created during the process, and maintained on file, should clearly show who evaluated the bids or proposals submitted, their conclusions and the basis for those conclusions. Selection committees should prepare minutes of all meetings held and formally vote on all critical issues.

It is vital that the process actually followed be documented. For example, assigning weighted numerical scores to various criteria and summing the results can be helpful in evaluating alternatives. However, it is not appropriate for all procurement actions and such analyses should not be prepared “after-the-fact” to justify a decision already made based on less easily quantifiable criteria.

Condition: We found standard procurement actions processed through the Purchasing Department to be generally well documented. However, we found the documentation on file for certain unusual procurement actions to be inadequate. Health Center personnel had to reconstruct documentation for critical aspects of the processes.

Effect: Inadequate documentation reduces accountability.

Cause: It was not clear to us why the procurement actions were not adequately documented.

Recommendation: The Health Center should thoroughly document all procurement actions. (See Recommendation 2.)

Agency response: “The agency agrees and management will prepare minutes to all meetings that are held for the purposes of planning applicable procurement activities.”

Finance Corporation Procurement:

Criteria: Purchasing policies and procedures should be designed to encourage a strong element of competition. Free market forces, acting in an open and competitive environment, are vital to an efficient and cost effective procurement process.

Open and public solicitation and consideration of bids or proposals should be standard practice. If, in emergencies or because of the nature of the procurement action, this is not practical or cost effective, deviations from standard practice should be clearly described and communicated to those exercising oversight authority.

Condition:

The Finance Corporation policies and procedures for purchasing and contracting describe “Open or Competitive Bidding” as “any impartial process whereby hospital facilities type A, hospital facilities type B, joint ventures or shared service agreements which are to be contracted for by the corporation are evaluated.” They go on to state that “This process may include solicitations to bid, pre-qualification of bidders, review of written proposals, pre-bid meetings, oral presentations, sealed bids, negotiation or any combination thereof.”

Further, the policies and procedures describe “procurement without any formal process of advertising, pre-qualification or review of written proposals” as “Sole Source.” This term, in common usage, is reserved for situations where no alternatives exist; the Health Center uses it for Finance Corporation purchases where no alternatives are considered.

Finance Corporation procurement actions may involve a significant degree of competition. However, they often do not involve public advertising of requests for bids or proposals and may lack other key elements of a fully competitive selection process.

Effect:

This could result in higher costs through reduced competition or, potentially, create the impression that contract steering has occurred.

Cause:

The policies and procedures for purchasing and contracting were designed for maximum flexibility. They describe certain key elements of a fully competitive selection process as optional. These elements should be considered requirements - absent clear justification for their omission.

Recommendation:

Finance Corporation policies and procedures for purchasing and contracting should be revised to provide for open and public solicitation and consideration of bids or proposals as standard practice. They should require that any deviations from standard practice, and the reasons therefore, be clearly communicated to the Corporation’s Board of Directors and documented in the minutes. (See Recommendation 3.)

Agency Response: “The current policies and procedures for purchasing and contracting of the Finance Corporation were established and follow the guidelines set forth in Section 10a-250 et seq. of the Connecticut General Statutes. Current policies and procedures provide for competitive bidding, which is used extensively. In addition, the Board of Directors approves all contracts and purchases over \$250,000. This provides for a much greater level of review and approval than the policy for all other University transactions; the overall University threshold for Board approval is \$500,000. The clinical operation also achieves significant savings by participating in a huge national cooperative called Novation, the University Health System Consortium’s purchasing organization that includes 200 hospitals and 2,600 affiliates. The group’s buying power achieves better pricing on drugs and supplies than individual bidding ever could hope to. In fact, the pharmaceutical pricing is so favorable that the Office of Policy and Management has designated the Health Center as the entity to purchase pharmaceuticals for all State agencies. Finally, specific medical needs may dictate the use of the sole source mechanism. It is precisely for this reason that the Finance Corporation was created.”

Auditors’ Concluding Comments:

We believe that our recommendation would increase accountability without significantly affecting flexibility. We are not taking the position that the Finance Corporation must follow an open competitive process with respect to all procurement actions; we are recommending that any instances where an open competitive process is not followed be communicated to the Corporation’s Board of Directors and that the justification for this deviation be clearly documented in the minutes.

Execution of Contracts:

Criteria: Contractors should not be authorized to begin work prior to execution of a contract. Formal written agreements establishing rights and responsibilities are a safeguard for all parties involved.

Condition: We reviewed 75 personal service agreements issued by the Health Center during the period from July 1, 2001 through June 30, 2004. Fifty were issued directly by the Health Center; 25 of the 50 were research related. The remaining 25 were issued through the Finance Corporation. The purpose of our review was to determine if contractors were allowed to begin working prior to execution of a contract. We defined execution as the signing of the contract by both the Health Center and the contractor.

Nine of the 25 research related agreements were amendments of existing contracts; one was voided. All of the remaining 15 were

signed after the start date. Delays ranged from 24 to 223 days; the average lag time was 103 days. Twenty-one of the other 25 agreements issued directly by the Health Center were signed after the start date. Delays ranged from 5 to 1,083 days; the average lag time was 148 days. Twenty-four of the 25 contracts issued through the Finance Corporation were signed after the start date. Delays ranged from four to 416 days; the average lag time was 82 days.

In our prior report, we noted that 24 of 24 agreements issued directly by the Health Center and 25 of 28 agreements issued through the Finance Corporation were signed after the start date; average lag times were 300 and 69 days, respectively. Though the situation has improved somewhat, delays continue to be unacceptable.

Effect: Unforeseen liabilities may be incurred if work is started on a project before all of the key terms have been agreed to and the contract has been signed, especially if disagreements arise regarding the nature or quality of the work involved.

Cause: Those responsible for initiating the process did not allow sufficient lead-time. The magnitude of the time lags involved indicates that, in at least some instances, initiation of the process may have been delayed until the need to process payments to contractors became apparent (payments are not processed until a contract is in place).

Recommendation: The Health Center should not authorize contractors to begin work prior to the execution of a contract. (See Recommendation 4.)

Agency Response: “Management agrees and is considering a revised review process as part of its efforts to correct this problem. UCHC has and continues to communicate to departments the policies necessary to prepare and circulate documents to develop a personal services contract that would be sent to prospective contractors for their signature prior to execution. Our procedures on our website also indicate that we will not prepare the necessary paperwork for a personal services contract that has a retrospective effective date or an effective date that cannot be met prior to the contract’s full execution. It also states that no contracted service may begin prior to a fully executed contract. As stated above improvements are being made and in no cases were any payments made to contractors until such time as the agreement was executed.

A more detailed response will be submitted once we have a further discussion and breakdown the four year test sample by Fiscal Year. This will enable the agency to formulate a new and effective policy.”

Access Control:

Criteria: Staff should be given access to automated processing systems only to the extent they need it to perform their assigned functions. In order to preserve adequate segregation of duties, no single individual should have control over all phases of a transaction.

Condition: We found that:

- Certain accountants were given virtually unlimited access to accounting, purchasing and accounts payable functions.
- Several former employees still had system access.
- Responsibility for maintaining access control templates was assigned to departmental personnel instead of Information Technology.

Additionally, during our prior audit we noted that administrators familiar with assigned staff and their access needs did not regularly review data access templates and recommended that such a review be instituted. During our current audit, we found that an attempt had been made to institute a review, but that it had not been successful.

Effect: Allowing any unnecessary access to critical systems has the potential to weaken internal control.

Cause: Some employees' access rights were not terminated when they left because it was initially assumed that they would be reemployed. Current procedures call for a one-time notification by Human Resources when regular employees terminate; there is no regular comparison of those given access with the roster of current employees.

It is our understanding that the Health Center attempted to institute a regular review of data access templates, but the system-generated reports were difficult for administrators to review.

We were told that the accountants had been given full access to multiple functions in order to allow them to fill in for other employees as needed.

Information Technology was responsible for maintaining access control templates in the past. Responsibility was transferred to departmental personnel because Information Technology was not processing requested changes quickly enough.

Recommendation: Access to critical automated processing systems should be limited as necessary to provide for adequate segregation of duties and

should only be provided to those that currently need such access. (See Recommendation 5.)

Agency Response: “Management agrees with the above recommendation. We will immediately set up new procedures to ensure access is terminated when an employee separates from the Health Center. In addition we will review the attempt that was made for the administrative review of employee access and make necessary adjustments to ensure an access review is completed.”

EDP Disaster Recovery:

Criteria: An institution that relies on data processing for vital business functions needs to have a current, written disaster recovery plan in place. The disaster recovery plan should be detailed enough so that it can be implemented even if key data center staff members are absent.

Critical data should be backed up at a remote location. Secure local backups provide for quick recovery from system outages, and may seem sufficient to deal with anticipated problems. Supplementary offsite backups provide an extra layer of security for unforeseen emergencies.

Data processing equipment should be protected against electrical surges by installing surge protection devices at the main panel (service entrance), branch panel and at the equipment level.

Condition: We conducted a high level review of the Health Center’s provisions for EDP disaster recovery in February 2005. We found that, though the Health Center was taking steps to update its disaster recover strategy to address recent operational changes, the institution did not have an updated, comprehensive, written disaster recovery plan on file. We also noted that the Health Center was not maintaining offsite backups of critical data – instead relying on maintaining multiple on-site copies of data in separate buildings.

The Health Center maintains two data centers. At the time of our review, both were protected at the equipment level, one had limited protection at the main panel and neither had protection at the branch panel.

Effect: The lack of a detailed written plan increases the Health Center’s potential vulnerability to EDP related problems. The lack of a written plan providing clear direction could hamper efforts to restore services, especially if key personnel are absent. At the time

of our review, this vulnerability was aggravated by the fact that the institution's strategy for dealing with EDP outages was in flux.

The lack of offsite backup reduces the institution's ability to respond to unexpected problems. Less than optimal surge protection increases the potential for damage from electrical surges.

Cause:

It was our impression that Health Center EDP personnel were taking a proactive role with respect to improving the institution's approach to disaster recovery. However, the need to thoroughly document the process was not given sufficient priority.

We believe that administrators decided it was unlikely that all onsite copies of critical data would be damaged. Similarly, the risk of damage from electrical surges was considered low.

Recommendation:

The Health Center should maintain a current, comprehensive written disaster recovery plan that provides for offsite backup of critical data and should upgrade data center surge protection. (See Recommendation 6.)

Agency Response:

"At the time of the audit, we were re-writing and updating our Disaster Recovery documentation. We currently have an updated, comprehensive, written Disaster Recovery plan.

UHC has contracted with Sungard (formerly Comdisco) for Disaster Recovery (DR) services since 1998. The current contract runs through April, 2006. Recovery procedures are presently maintained by IT for recovery efforts at Sungard.

To take advantage of the newest disaster recovery methods, the IT Department has developed a Disaster Recovery room, located in the basement of the Health Center's ARB. This DR room was designed to emulate the environmentally controlled alternate power supplied setup of our current Data Center. If power is lost, the UPS in the DR room will automatically switch on to maintain back-up power until the systems automatically are transferred to the generator power supply, which can run for 41 days.

Nightly backups are maintained in one of the two locations, the Data Center in the ASB or in the vault, located in Room AG073D of the Academic Building. At present, we feel that this is an adequate storage method, however we will evaluate the cost-benefit of contracting with a third party for off-site tape storage.

Regarding electrical protection for the Data Center, the main panel has no transient protection, however the protection provided by the

UPS is sufficient. The Liebert Precision Power Center units within the Data Center have built in protection. For the Disaster Recovery Room, Facilities Management has agreed to correct the improperly installed protection at the main panel. At the branch panel, protection is provided by the UPS.”

Auditors’ Concluding Comments:

We believe that it would be prudent to store a copy of critical data off-site. Though the current method may seem adequate in light of known risks, off-site storage would provide additional assurance with respect to unforeseen problems.

Equipment Inventory:

Criteria:

Equipment inventory records need to be accurate as to existence, value and location in order to provide adequate control and accountability and for reporting purposes.

Condition:

The Health Center’s inventory control has improved significantly in recent years, as evidenced by the results of our annual test basis physical inventories. However, in our most recent review, we were unable to verify the existence of seven of the 120 items tested and noted significant valuation errors.

Additionally, 96 of the 113 items verified had static locations (the other 17 items were regularly moved or intangible in nature). Thirty-six of those 96 items were not found at the location shown in the system.

Effect:

Errors are accumulating in the Health Center’s inventory records. If corrective action is not taken, they could have a material effect on some aspects of agency operations.

Cause:

The inventory control unit told us that they conduct a comprehensive, ongoing physical inventory. However, we noted that inventory control system records indicated that only a small fraction of the equipment inventory was being physically inventoried each year. At this point, it appears likely that inventory system records are not being updated properly due to a software incompatibility. This would affect the accuracy of the records as far as existence and location are concerned. The Health Center is reviewing the discrepancy and plans to take corrective action.

Equipment is not being tagged when it is delivered to the Health Center campus. Instead, inventory control unit personnel tag equipment on site after it has been put into service. This is inefficient and can cause errors.

The Health Center has not been reconciling equipment expenditures to changes in the aggregate value of capitalized equipment per the inventory listing. This increases the probability that valuation errors will occur and not be detected.

Currently, the Health Center uses bar coded equipment tags. Use of RFID (radio frequency identification tags) would improve scanning speed and allow for more frequent physical inventories.

Recommendation: The Health Center should: tag equipment when it is delivered to the Health Center Campus, reconcile equipment expenditures to the aggregate change in equipment inventory valuation, and consider using RFID tags instead of bar coded tags. (See Recommendation 7.)

Agency Response: “Management agrees with the above recommendation. A working group that includes members from Finance and Materials Management meet bi weekly to discuss these issues. During FY 2006 they will focus on:

- Investigating items that can be tagged at the receiving doc to ensure they are tagged before they are delivered to departments.
- Evaluating current staff to assign equipment reconciliations.
- Currently obtaining information on the cost and feasibility of using RFID tags.”

Compensatory Time:

Criteria: Compensatory time is intended to provide management with a useful tool for dealing with relatively short term workload fluctuations. The existence of large balances that are not used in a timely fashion may be indicative of staffing problems.

Additionally, the Fair Labor Standards Act (FLSA) sets certain maximum accrual limits for compensatory time earned in lieu of overtime (as defined under FLSA, i.e., overtime earned by actually physically working in excess of 40 hours per week).

Condition: We noted that some Health Center employees had accumulated large compensatory time balances. Further, the number of employees with large accumulations appears to be increasing. In our prior review, we found that 15 employees had balances of 400 hours or more as of March 27, 2002. In our current review, we found that 31 employees had balances of 400 hours or more as of June 17, 2005. One employee had accumulated more than 911 hours.

- Effect:* Large compensatory time balances that are increasing over time may be indicative of staffing problems.
- Cause:* The accumulation of large compensatory time balances may reflect staffing problems.
- Recommendation:* The Health Center should improve control over compensatory time by addressing the accumulation of large balances. (See Recommendation 8.)
- Agency Response:* “Of the 31 employees over the threshold of 400 hours of compensatory time, 6 are in the job classes that require pay out of time accrued beyond 240 hours. Payroll has amended biweekly audit reports to better capture and monitors this information in order to pay the employees. The remaining individuals have accrued compensatory time in accordance with bargaining unit contract, and do not fall under the FLSA threshold as required for the other job classes. These compensatory balances may represent staffing issues that individual departments need to address. HR will distribute reports for these areas and assist departments in addressing this issue.”

Faculty Time and Attendance Reports:

- Criteria:* Centralization of time and attendance recordkeeping improves control and enhances accountability.
- Condition:* Non-faculty Health Center employees submit time and attendance reports to the Payroll Department on a biweekly basis. As has been discussed in prior audit reports, though many faculty members accumulate compensated absences (vacation), most of those faculty members do not submit any report of attendance or leave to the Payroll Department. The official records of faculty vacation balances are “calendars” submitted to the Dean’s offices on an annual basis.

The degree of control exercised in this area by employing departments varies. Some apparently place the responsibility for maintaining leave records solely on the faculty members themselves, requiring them to complete and submit “calendars” on an annual basis. When a faculty member retires, the appropriate Dean’s office informs the Personnel Department of the faculty member’s accumulated balance. After reviewing a faculty member’s vacation leave record, the Human Resources Department then directs the Payroll Department to pay the faculty member for the unused time. We have been informed that this procedure would apply even to those faculty members that do

regularly submit time and attendance reports to the Payroll Department. The “calendars” are considered the official records for these employees, not the centralized time and attendance records.

Effect: The lack of a uniform control structure mandating regular reporting of time and attendance for recording in a centralized recordkeeping system lessens the assurance the Health Center can have that amounts paid are correct. Additionally, as “calendars” are submitted on a calendar year basis, the Health Center’s liability for faculty members’ compensated absences at fiscal year end must be based on an estimate of accumulated balances.

Cause: The Health Center has historically accounted for faculty members’ compensated absences in this manner.

Recommendation: The Health Center should require all employees that accumulate compensated absences to submit biweekly attendance reports to the Payroll Department. (See Recommendation 9.)

Agency Response: “A change in the current process for tracking compensated absences is not recommended at this time. The Health Center will continue to collect this data through the Dean’s offices where they are recorded and sent to payroll for payment.”

Auditors’ Concluding Comments:

Our review indicates that requiring all employees that accumulate compensated absences to regularly report the use of leave time in a consistent manner would yield significant benefits in terms of internal control, accountability and accuracy in reporting. We do not see any reason to continue with the current patchwork system; the Agency’s response does not cite any obstacles to converting.

Termination Payments:

Criteria: Semiannual longevity lump-sum payments are made on the last regular pay day in April and October of each year. Retiring employees are entitled to a prorated payment based on the proportion of the six-month period served prior to the effective date of their retirement. Retiring employees are also entitled to compensation for accrued sick leave at the rate of one-fourth of such employee's salary up to a maximum payment equivalent to sixty days' pay.

Condition: As part of our Health Center payroll testing we reviewed a sample of 25 terminations. We found that six employees had been overpaid a total of \$15,319 and six employees had been underpaid a total of \$1,002. The agency was aware of the largest

overpayment, \$11,057 in amount, but had not detected the other errors.

Effect: Terminated employees were paid incorrectly.

Cause: An early retirement incentive program resulted in significant turnover in the Health Center's payroll department. It appeared to us that the errors were due to confusion on the part of inexperienced employees.

Resolution: The Health Center recalculated all termination payments made since January 2004, made supplementary payments as necessary and initiated efforts to collect overpayments.

Agency Response: "A procedure for calculating termination payments has been written and employees have been trained. The payroll department is currently collecting overpayments to the employees that have been notified."

Other Audits:

The John Dempsey Hospital, the Finance Corporation and the UConn Medical Group were audited by public accounting firms during the audited period. Combined management letters were issued each year communicating the recommendations developed as a result of their audits. The letter for the fiscal year ended June 30, 2002, was only issued in draft form. They recommended the following:

Fiscal year ended June 30, 2001:

1. Implement a contract management system to improve control over medical receivables.
2. Improve access control over clinical automated data processing systems.
3. Consider the costs and related benefits of expanding the resources and function of the Internal Audit department.
4. Assign responsibility for Office of Health Care Access (OHCA) filings to a single individual.
5. Reconcile daily charges per the pharmacy application to the billing system.
6. Continue to move towards compliance with the Health Insurance Portability and Accountability Act of 1996.
7. Improve control over the medical supplies inventory.
8. Improve control over patient receivables.

Fiscal year ended June 30, 2002:

1. Post dental clinic receipts to the detailed accounts receivable records in a timely manner.
2. Put in place an official policy addressing the pricing of the medical supplies inventory.
3. Use the same system for financial reporting and OHCA filings.

4. Improve access control over clinical automated data processing systems.
5. Develop comprehensive change control guidelines addressing changes/enhancements in automated data processing systems.
6. Continue to move towards compliance with the Health Insurance Portability and Accountability Act of 1996.
7. Go forward with the planned implementation of a new pharmacy system; ensure that the system has adequate controls and provides individual security reports.
8. Improve control over changes to the vendor master file.

Fiscal year ended June 30, 2003:

1. Post dental clinic receipts to the detailed accounts receivable records in a timely manner.
2. Consider utilizing an inventory tracking system to maintain inventory prices for specific medical supply items.
3. Consider utilizing a property, plant and equipment tracking system that automatically feeds the accounting system and initiates capitalization at the time of purchase rather than at the end of the reporting period.
4. Stop using unassigned/generic access ids.
5. Assign responsibility for the internal audit and compliance function left vacant during the year.
6. Concentrate resources to reduce the time lag between patient discharge and final billing.
7. Consider developing a control over the accuracy of manual entry of charges to the hospital billing system.

Fiscal year ended June 30, 2004:

1. Post hospital receipts to the detailed accounts receivable records in a timely manner.
2. Post dental clinic receipts to the detailed accounts receivable records in a timely manner, review the adequacy of the new dental clinic billing and collection system and consistently follow policies and procedures regarding the authorization of dental patient charts.
3. Consider utilizing an inventory tracking system to maintain inventory prices for specific medical supply items and applying the policies and procedures developed for the hospital to all departments.
4. Improve control over access to the VMS operating system.
5. Ensure that information technology policies and procedures under development provide for adequate access controls and adequate testing of changes/enhancements in automated data processing systems.
6. Assign responsibility for the vacant internal audit and compliance function.
7. Resolve reconciliation issues related to the implementation of the State's new accounting system (CORE-CT).
8. Consider certain changes in the methodology and assumptions underlying the Health Center's malpractice liability calculation.
9. Consider redeveloping a control over the accuracy of the manual entry of charges to the hospital billing system.
10. Improve documentation supporting manual journal entries.

11. Consider validating pharmacy charges, currently reviewed only for reasonableness, to the contractual provisions.

RECOMMENDATIONS

Status of Prior Audit Recommendations:

In our previous report on our audit examination of the Health Center, we presented nine recommendations pertaining to Health Center operations. The following is a summary of those recommendations and the actions taken thereon:

- Increase efforts to recruit State residents into the Dental School – this recommendation has been restated and repeated. (See Recommendation 1.)
- Execute contracts before authorizing contractors to begin work – this recommendation has been repeated. (See Recommendation 4.)
- Obtain Board of Directors’ approval, when required, before issuing contracts through the Finance Corporation – we did not note a reoccurrence of this problem during our current review.
- Solicit competitive proposals in the manner legally mandated by Section 10a-151b of the General Statutes when contracting for professional services – we did not note a reoccurrence of this problem during our current review.
- Have administrators familiar with assigned staff and their access needs regularly review access control templates established for automated data processing systems – this recommendation has been incorporated in a more comprehensive recommendation addressing access control. (See Recommendation 5.)
- Transfer the General Fund appropriation into the operating fund to eliminate inefficiencies resulting for the maintenance of separate General Fund accounts – this recommendation has not been repeated, as it is incompatible with new accountability requirements established by the Office of Policy and Management.
- Have changes to the payroll reviewed and signed off on by a supervisory level Human Resources staff member – we noted improvement during the audited period.
- Prepare an overall summary reconciliation of the amount expended for equipment to the change in the aggregate value of capitalized equipment per the inventory control listing – this recommendation has been incorporated in a more comprehensive recommendation addressing inventory control. (See Recommendation 7.)
- Improve practices and recordkeeping related to compensated absences – this recommendation was split into two recommendations and repeated. (See Recommendations 8 and 9.)

Current Audit Recommendations:

- 1. The Health Center Dental School should prepare a cost/benefit analysis documenting the value of the dental program to the State.**

Comment:

Section 10a-102 of the General Statutes indicates that the University's, and by extension the Health Center's, reason for existing is to provide for "the education of youth whose parents are citizens of this state" by "promoting the liberal and practical education of the industrial classes." The majority of the students benefiting from the General Fund subsidization of the dental program are not State residents when they enter the program. However, the program may provide other valuable benefits to the State.

- 2. The Health Center should thoroughly document all procurement actions.**

Comment:

We found standard procurement actions processed through the Purchasing Department to be generally well documented. However, we found the documentation on file for certain unusual procurement actions to be inadequate. Health Center personnel had to reconstruct documentation for critical aspects of the processes.

- 3. Finance Corporation policies and procedures for purchasing and contracting should be revised to provide for open and public solicitation and consideration of bids or proposals as standard practice.**

Comment:

The policies and procedures for purchasing and contracting were designed for maximum flexibility. They describe certain key elements of a fully competitive selection process as optional. These elements should be considered requirements – absent clear justification for their omission. Any deviations from standard practice, and the reasons therefore, should be clearly communicated to the Corporation's Board of Directors and documented in the minutes.

- 4. The Health Center should not authorize contractors to begin work prior to execution of a contract.**

Comment:

We reviewed 75 personal service agreements issued by the Health Center during the period from July 1, 2001 through June 30, 2004. Fifty were issued directly by the Health Center; 25 of the 50 were research related. The remaining 25 were issued through the Finance Corporation.

Fifteen of the 25 research related agreements were signed after the start date. Delays ranged from 24 to 223 days; the average lag time was 103 days. Twenty-one of the other 25 agreements issued directly by the Health Center were signed after the start date. Delays ranged from 5 to 1,083 days; the average lag time was 148 days. Twenty-four of the 25 contracts issued through the Finance Corporation were signed after the start date. Delays ranged from four to 416 days; the average lag time was 82 days.

5. Access to critical automated processing systems should be limited as necessary to provide for adequate segregation of duties and should only be provided to those that currently need such access.

Comment:

We found that:

- Certain accountants were given virtually unlimited access to accounting, purchasing and accounts payable functions.
- Several former employees still had system access.
- Responsibility for maintaining access control templates was assigned to departmental personnel instead of Information Technology.

Additionally, during our prior audit we noted that administrators familiar with assigned staff and their access needs did not regularly review data access templates and recommended that such a review be instituted. During our current audit, we found that an attempt had been made to institute a review, but that it had not been successful.

6. The Health Center should maintain a current, comprehensive written disaster recovery plan that provides for offsite backup of critical data and should upgrade data center surge protection.

Comment:

We conducted a high level review of the Health Center's provisions for EDP disaster recovery in February 2005. We found that, though the Health Center was taking steps to update its disaster recovery strategy to address recent operational changes, the institution did not have an updated, comprehensive, written disaster recovery plan on file. We also noted that the Health Center was not maintaining offsite backups of critical data – instead relying on maintaining multiple on-site copies of data in separate buildings.

The Health Center maintains two data centers. At the time of our review, both were protected at the equipment level, one had limited protection at the main panel and neither had protection at the branch panel.

- 7. The Health Center should: tag equipment when it is delivered to the Health Center Campus, reconcile equipment expenditures to the aggregate change in equipment inventory valuation, and consider using RFID tags instead of bar coded tags.**

Comment:

Equipment is not being tagged when it is delivered to the Health Center campus. Instead, inventory control unit personnel tag equipment on site after it has been put into service. This is inefficient and can cause errors.

The Health Center has not been reconciling equipment expenditures to changes in the aggregate value of capitalized equipment per the inventory listing. This increases the probability that valuation errors will occur and not be detected.

Currently, the Health Center uses bar coded equipment tags. Use of RFID (radio frequency identification tags) would improve scanning speed and allow for more frequent physical inventories.

- 8. The Health Center should improve control over compensatory time by addressing the accumulation of large balances.**

Comment:

We noted that some Health Center employees had accumulated large compensatory time balances. Further, the number of employees with large accumulations appears to be increasing. In our prior review, we found that 15 employees had balances of 400 hours or more as of March 27, 2002. In our current review, we found that 31 employees had balances of 400 hours or more as of June 17, 2005. One employee had accumulated more than 911 hours.

- 9. The Health Center should require all employees that accumulate compensated absences to submit biweekly attendance reports to the Payroll Department.**

Comment:

The official records of faculty vacation balances are “calendars” submitted to the Dean’s offices on an annual basis. The degree of control exercised in this area by employing departments varies. Some apparently place the responsibility for maintaining leave records solely on the faculty members themselves; requiring them to complete and submit “calendars” on an annual basis. The “calendars” are considered the official records for these employees, not the centralized time and attendance records.

The lack of a uniform control structure mandating regular reporting of time and attendance for recording in a centralized recordkeeping system lessens the assurance the Health Center can have that amounts paid are correct. Additionally, as “calendars” are submitted on a calendar year basis, the Health Center’s liability for faculty members’

compensated absences at fiscal year end must be based on an estimate of accumulated balances.

INDEPENDENT AUDITORS' CERTIFICATION

As required by Section 2-90 of the General Statutes we have audited the books and accounts of the University of Connecticut Health Center (Health Center) for the fiscal years ended June 30, 2001, 2002, 2003 and 2004. This audit was primarily limited to performing tests of the Health Center's compliance with certain provisions of laws, regulations, contracts and grants, and to understanding and evaluating the effectiveness of the Health Center's internal control policies and procedures for ensuring that (1) the provisions of certain laws, regulations, contracts and grants applicable to the Health Center are complied with, (2) the financial transactions of the Health Center are properly recorded, processed, summarized and reported on consistent with management's authorization, and (3) the assets of the Health Center are safeguarded against loss or unauthorized use. The financial statement audits of the Health Center for the fiscal years ended June 30, 2001, 2002, 2003 and 2004, are reported upon separately and are included as a part of our Statewide Single Audit of the State of Connecticut for those fiscal years.

We conducted our audit in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the Health Center complied in all material or significant respects with the provisions of certain laws, regulations, contracts and grants and to obtain a sufficient understanding of the internal control to plan the audit and determine the nature, timing and extent of tests to be performed during the conduct of the audit.

Compliance:

Compliance with the requirements of laws, regulations, contracts and grants applicable to the Health Center is the responsibility of the Health Center's management.

As part of obtaining reasonable assurance about whether the Health Center complied with laws, regulations, contracts and grants, noncompliance with which could result in significant unauthorized, illegal, irregular or unsafe transactions or could have a direct and material effect on the results of the Health Center's financial operations for the fiscal years ended June 30, 2001, 2002, 2003 and 2004, we performed tests of its compliance with certain provisions of the laws, regulations, contracts and grants. However, an opinion on compliance with these provisions was not an objective of our audit, and accordingly, we do not express such an opinion.

The results of our tests disclosed no instances of noncompliance that are required to be reported under *Government Auditing Standards*. However, we noted certain immaterial or less than significant instances of noncompliance, which are described in the accompanying "Condition of Records" and "Recommendations" sections of this report.

Internal Control over Financial Operations, Safeguarding of Assets and Compliance:

The management of the Health Center is responsible for establishing and maintaining effective internal control over its financial operations, safeguarding of assets, and compliance with the requirements of laws, regulations, contracts and grants applicable to the Health Center. In planning and performing our audit, we considered the Health Center's internal control over its

financial operations, safeguarding of assets, and compliance with requirements that could have a material or significant effect on the Health Center's financial operations in order to determine our auditing procedures for the purpose of evaluating the Health Center's financial operations, safeguarding of assets, and compliance with certain provisions of laws, regulations, contracts and grants, and not to provide assurance on the internal control over those control objectives.

However, we noted certain matters involving the internal control over the Health Center's financial operations, safeguarding of assets, and/or compliance 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 internal control over the Health Center's financial operations, safeguarding of assets, and/or compliance that, in our judgment, could adversely affect the Health Center's ability to properly record, process, summarize and report financial data consistent with management's authorization, safeguard assets, and/or comply with certain provisions of laws, regulations, contracts, and grants. We believe the following findings represent reportable conditions: inadequate documentation of procurement actions, overly flexible Finance Corporation policies and procedures for purchasing and contracting, authorizing contractors to begin work before execution of contracts, inappropriate access to critical automated processing systems, the lack of a current disaster recovery plan, deficiencies in equipment inventory control procedures, and a decentralized recordkeeping system for faculty compensated absences.

A material or significant 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 noncompliance with certain provisions of laws, regulations, contracts, and grants or the requirements to safeguard assets that would be material in relation to the Health Center's financial operations or noncompliance which could result in significant unauthorized, illegal, irregular or unsafe transactions to the Health Center 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 the Health Center's financial operations and over compliance 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 a material or significant weaknesses. However, of the reportable conditions described above, we believe the following reportable conditions to be material or significant weaknesses: inadequate documentation of procurement actions and authorizing contractors to begin work before execution of contracts.

This report is intended for the information of the Governor, the State Comptroller, the Appropriations Committee of the General Assembly and the Legislative Committee on Program Review and Investigations. However, this report is a matter of public record and its distribution is not limited.

CONCLUSION

We wish to express our appreciation to the staff of the Health Center for the cooperation and courtesies extended to our representatives during this examination.

James K. Carroll
Principal Auditor

Approved:

Kevin P. Johnston
Auditor of Public Accounts

Robert G. Jaekle
Auditor of Public Accounts