### Joint Audit & Compliance Committee
#### Agenda

**10:00 am – 10:45 am – Executive Session**
**10:45 am – 12:00 pm - Public Meeting**

<table>
<thead>
<tr>
<th>Issue</th>
<th>Proposed Action</th>
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<tr>
<td>Executive Session to discuss:</td>
<td></td>
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<tr>
<td>• C.G.S. 1-200(6)(E) – A discussion of any matter which would result in the disclosure of public records or the information contained therein pertaining to preliminary drafts or notes that the public agency has determined the public’s interest in withholding outweighs the public’s interest in disclosure. [1-210(b)(1)]</td>
<td>Approval</td>
<td>None</td>
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<tr>
<td>• C.G.S. 1-200(6)(E) - A discussion of any matter which would result in the disclosure of public records or the information contained therein pertaining to strategy and negotiations with respect to pending claims regarding Recovery Audit Contractor (RAC) Audits. [1-210(b)(4)]</td>
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<tr>
<td>• C.G.S. 1-200(6)(E) - A discussion of any matter which would result in the disclosure of public records or the information contained therein pertaining to communications privileged by the attorney-client relationship. [1-210(b)(10)]</td>
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<td>• C.G.S. 1-200(6)(c) – Matters concerning standards, processes and codes not available to the public the disclosure of which would compromise the security of integrity of information technology systems.</td>
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<tr>
<td>Opportunity for Public Comment</td>
<td>Approval</td>
<td>None</td>
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<tr>
<td>Minutes of the September 12, 2014 JACC Meeting</td>
<td>Approval</td>
<td>1</td>
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<tr>
<td>Storrs &amp; UConn Health Significant Compliance Activities</td>
<td>Update</td>
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<td>Clery Act – Storrs and UConn Health</td>
<td>Update</td>
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<tr>
<td>HIPAA Policies – Storrs</td>
<td>Approval</td>
<td>3</td>
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<tr>
<td>Significant Audit Activities</td>
<td>Update</td>
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<tr>
<td>• Status of Audit Assignments (Storrs &amp; UConn Health)</td>
<td>Update</td>
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<tr>
<td>• Audit Follow-up Activity</td>
<td>Update</td>
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</table>
Joint Audit & Compliance Committee

Agenda

10:00 am – 10:45 am – Executive Session
10:45 am – 12:00 pm - Public Meeting

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<tr>
<th>Issue</th>
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<td>External Engagements</td>
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<tr>
<td>- Annual Agreed-Upon Procedures performed on the Statements of Revenues &amp; Expenses of the UConn’s Athletics Program - BKD</td>
<td>Update Presentation (sent under separate cover)</td>
<td>5</td>
</tr>
<tr>
<td>- Audited financial statements performed on the UConn Health John Dempsey Hospital, University Medical Group, &amp; Finance Corporation – Marcum</td>
<td>Presentation</td>
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<tr>
<td>2015 JACC Meeting Schedule</td>
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<td>Information/Educational Items</td>
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<td>• Compliance Newsletter – UConn Health and Storrs</td>
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<td>• Current Issues in Compliance – September and October 2014</td>
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<td>• JACC Agenda Forecast</td>
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<td>Conclusion of Full Meeting</td>
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<tr>
<td>Information Session with OACE’s Chief Audit &amp; Compliance Officer and Direct Reports</td>
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The next meeting of the JACC will be held on Tuesday, February 10, 2015 at 10:00 am
Rome Commons Ballroom, Storrs

Individual Responsibility, Institutional Success
The meeting of the Joint Audit and Compliance Committee (JACC) was called to order at 10:10 a.m. by Trustee Nayden.

ON A MOTION made by Trustee Nayden and seconded by Director Holt, THE JACC VOTED to go into executive session to discuss:

- C.G.S. 1-200(6)(E) – A discussion of any matter which would result in the disclosure of public records or the information contained therein pertaining to preliminary drafts or notes that the public agency has determined the public’s interest in withholding outweighs the public’s interest in disclosure. [1-210(b)(1)]
- C.G.S. 1-200(6)(E) - A discussion of any matter which would result in the disclosure of public records or the information contained therein pertaining to strategy and negotiations with respect to pending claims regarding Recovery Audit Contractor (RAC) Audits. [1-210(b)(4)]
- C.G.S. 1-200(6)(E) - A discussion of any matter which would result in the disclosure of public records or the information contained therein pertaining to or communications privileged by the attorney-client relationship. [1-210(b)(10)]
- C.G.S. 1-200(6)(c) – Matters concerning standards, processes and codes not available to the public the disclosure of which would compromise the security of integrity of information technology systems.


The Executive Session ended at 11:17 a.m. and the JACC returned to open session at 11:19 a.m.

There were no public comments.

Tab 1 – Minutes of the Meeting

ON A MOTION made by Trustee Nayden and seconded by Director Archambault, the minutes of the May 20, 2014 meeting were approved.
TAB 2 - Storrs & UConn Health Significant Compliance Activities
K. Fearney and I. Mauriello updated the committee on significant compliance activities.

A. Cretors and P. McCarthy presented the committee with an update on NCAA Compliance activities as well as various topics impacting the NCAA.

TAB 3 – Significant Audit Activities
C. Chiaputti provided the JACC with an update on the status of audit assignments (Storrs and UConn Health). OACE completed thirteen audits and had twenty audits ongoing during this reporting period.

The JACC accepted twelve audits this period as follows:
- Library Business Process
- Tuition Fees/Student Accounts Receivable/Financial Aid
- Faculty Consulting – FY13
- Federal Grants – Cost Sharing
- Overtime Payments – Public Safety
- Kronos System
- American Disability Act (ADA) Program Review
- Clery Act Compliance
- Real Estate Center, School of Business
- Meaningful Use – Hospital
- Medicare Enrollment – Provider Data
- McMahon Dining Hall Renovation

The committee was provided with the status of OACE’s follow-up Activities.

TAB 4 – Audit Plans – Storrs & UConn Health for FY15

ON A MOTION made by Trustee Cantor and seconded by Trustee Kruger, the FY 14 Audit Plans were approved.

TAB 5 – Compliance Plans – Storrs & UConn Health for FY15

ON A MOTION made by Trustee Cantor and seconded by Trustee Kruger, the FY 14 Compliance Plans were approved.
Tab 6 - Auditors of Public Accounts


TAB 7 - External Engagements

C. Chiaputti provided the JACC with a brief update on the status of external audit projects.

On A MOTION made by Trustee Nayden and seconded by Trustee Borges, the JACC approved the hiring of McGladrey for audit services of UConn 2000 Construction Projects and Expenditures.

On A MOTION made by Trustee Nayden and seconded by Trustee Holt, the JACC approved the hiring of BKD for the Statement of Revenues and Expenses of the University of Connecticut’s Athletic Program.

TAB 8 – Informational / Educational Items

The committee was provided with:

• Article – “Internal Control – Integrated Framework” published by the Committee of Sponsoring Organizations of the Treadway Commission, May 2013
• Compliance Newsletter – UConn Health and Storrs
• JACC Agenda Forecast

There was no further business.

On A MOTION made by Trustee Nayden and seconded by Director Archambault, the meeting was adjourned at 12:05 p.m.

Respectfully submitted,

Angela Marsh

Angela Marsh
TAB 2
• **University HIPAA Policies Update** - As noted briefly at the last JACC meeting, the draft UConn HIPAA Privacy & Security Practices Manual was approved by the President’s Cabinet on September 10, 2014. The Manual contains all HIPAA Privacy, Data Security and Breach Management policies, notices and forms that apply to the HIPAA-Covered Components of the University. It was agreed that the policies contained therein should be reviewed and approved by the Board of Trustees.

• **Comprehensive HIPAA Training** - New, comprehensive HIPAA privacy and data security modules have been rolled out as of October 1, 2014 to provide required training to all individuals considered to be part of the University’s HIPAA hybrid.

• **University Code of Conduct** - Based on recommendations of the Something’s Happening Committee, OACE distributed over 400 Code of Conduct booklets to University employees with limited access to computers. All other employees were provided with a link to the electronic version of the Code, with a reminder about the civility requirements of the policy.

• **Policy of the Week** – Recent policies and procedures include: University Guide to the State Code of Ethics, Reporting of Necessary Expenses, University Code of Conduct and the Working Alone Policy.
Joint Audit & Compliance Committee
Significant Compliance Activities

UConn Health

- **Electronic Monitoring of Access to Patient Medical Records** – A Request For Proposals was re-posted to implement an electronic monitoring technology since previous efforts have been unsuccessful. The Privacy Office has implemented a clinical manager monitoring program of electronic access to patient records in the meantime. Results of the first monitors under this program are due at the end of the year.

- **Open Payments** – Industry payments information was publically posted on 9/30/14. Physicians, Dentists and John Dempsey Hospital have reviewed the information provided by industry via the CMS website. Faculty have been sent informative messages with links to the CMS website to encourage review of the data. UConn Health has also responded to external audiences to answer questions about the data.

- **Overpayment refunds** –
  - Critical Care Billing in the Surgical Global Period
  - Fine Needle Aspiration billing – error in modifier use

- **Department of Health & Human Services, Office of Inspector General Work Plan** – The 2014 Plan was reviewed by the Compliance Office and discussions were held with stakeholders on key components. Stakeholder responses were obtained regarding oversight of risk areas. The 2015 Plan was posted by OIG in October. Process for review of the new Plan is underway.

- **Documentation and Coding HelpLine Email** – A helpline email was launched by the Documentation and Coding Program in collaboration with UMG Administration. The purpose of the email is to assist clinical providers with any questions regarding their documentation and coding of services, so they are accurate and appropriate. The email is managed by the Office’s certified coding staff.

- **AVP for Research Compliance** – Dr. Wesley Byerly has been hired and will start in late December 2014. He holds a Doctor of Pharmacy degree from the University of North Carolina at Chapel Hill and has many years experience in the field of research administration and compliance. Wesley comes to UConn Health after serving as the system-wide Compliance Officer for Research at the University of Texas System where his responsibilities included oversight of a comprehensive program to promote integrity and compliance throughout all research and sponsored programs for the fifteen institutions of the University of Texas.
TAB 3
# UConn HIPAA Privacy & Security Practices Manual

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<td>Nayden Rehabilitation Clinic Form</td>
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<td>Information Technology Resource Management</td>
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<td>Data Security- Risk Management</td>
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HIPAA Hybrid Designation

Policy Statement

This policy designates the University of Connecticut as a Hybrid Entity under the Health Insurance Portability and Accountability Act (HIPAA) and identifies its health care components subject to HIPAA’s privacy and security provisions.

Scope and Distribution

The policies and procedures in the **UConn HIPAA Privacy & Security Practices Manual** apply to those clinics, units, departments, faculty and/or staff identified below as health care components of the University (collectively referred to as “HIPAA-Covered Components” throughout this *Manual*).

Definitions

These terms have the following meaning:

“Covered Entity” means one or more of the following:

- A health plan;
- A health care clearinghouse; or
- A health care provider who transmits protected health information in electronic form in connection with a HIPAA covered transaction.

“HIPAA-Covered Component” means a component or combination of components of the University designated as part of its HIPAA hybrid. The component or combination of components includes any persons or offices of the covered entity that:

- performs the functions of a covered entity;
- engages in activities that would make it a business associate of the covered entity if both were separate legal entities;
- would meet the definition of a covered entity if it were a separate entity; or
- units, departments, faculty and/or staff who serve as a business associate of a covered entity other than the University of Connecticut.

“Hybrid Entity” means a single legal entity that is also a covered entity whose business activities include both covered and non-covered functions and that designates its health care components. The University of Connecticut’s primary functions are education and research, not health care. However, because the University does have offices, departments or units that engage in HIPAA covered functions and function as HIPAA-Covered Components, the University of Connecticut is designated as a Hybrid Entity.

Effective: 8/2014
### HIPAA Hybrid Designation

#### Designated UConn HIPAA-Covered Components

The following are designated as HIPAA-Covered Components of the University of Connecticut:

<table>
<thead>
<tr>
<th>Department or Unit</th>
<th>Function</th>
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<tbody>
<tr>
<td><strong>Clinics</strong></td>
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<tr>
<td>Speech &amp; Hearing Clinic (CLAS)</td>
<td>Covered Component</td>
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<tr>
<td>Nayden Rehabilitation Clinic (AHNR)</td>
<td>Covered Component</td>
</tr>
<tr>
<td><strong>First Responders</strong></td>
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<tr>
<td>UConn Fire Department</td>
<td>Covered Component</td>
</tr>
<tr>
<td>Student Health Services—non-student records</td>
<td>The provision of health care services to UConn students is covered by FERPA, rather than HIPAA. However, to the extent that SHS begins treating non-students or accessing non-student record, they would be covered by HIPAA.</td>
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<tr>
<td><strong>Individual Faculty/Staff</strong></td>
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<tr>
<td>Various Academic Department and Units</td>
<td>Business Associate of a non-UConn Covered Entity, or of one of the University’s Covered Components</td>
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<tr>
<td><strong>Administrative Support Staff/Internal UConn Resources</strong></td>
<td>Individual members of the offices listed provide support or advice to the covered components or business associates listed in this chart and who may access or have access to PHI are covered by HIPAA.</td>
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<tr>
<td>Compliance Office staff (OACE), particularly the University’s Privacy Officer</td>
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<td>Internal Audit (OACE)</td>
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<tr>
<td>Information Security Office staff (UITS), particularly the Chief</td>
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1. Note that the University of Connecticut Health Center (UCHC) is considered a separate agency for HIPAA purposes. UCHC maintains its own HIPAA structure, policies, procedures and forms.

2. As of October 1, 2014.

Effective: 8/2014
## HIPAA Hybrid Designation

<table>
<thead>
<tr>
<th>Information Security Officer</th>
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<tr>
<td>Office of General Counsel attorneys</td>
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<tr>
<td>UITS staff</td>
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<tr>
<td>Academic IT staff who provide IT support to the covered components or business associates listed in this chart (Academic Schools/Departments)</td>
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<tr>
<td>Accounts Payable/Receivable staff who may deal with billing or collections related to the provision of health care related services.</td>
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<tr>
<td>Office of Research Compliance/Institutional Review Board (IRB) staff who may need to assess, review or be provided access to PHI to investigate research misconduct where a HIPAA Research Waiver may not apply.</td>
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Effective: 8/2014

Introduction

The University of Connecticut is committed to compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its related regulations.

Scope

Except where otherwise specified, the policies and procedures specified in this HIPAA Privacy & Security Practices Manual apply to those clinics, units, departments, faculty and/or staff identified as HIPAA-Covered Components in the HIPAA Hybrid Designation section of the Manual.

The policies and procedures described in this Manual replace all previous HIPAA Privacy & Security policies of the University of Connecticut and/or its various components, clinics, offices and departments.

1. The University has assigned the role of University’s HIPAA Privacy Officer to the Assistant Director of Compliance in the Office of Audit, Compliance & Ethics to serve as a privacy official who is responsible for the overall guidance, monitoring and maintenance of the privacy policies and procedures for University.

2. The University has assigned the role of University’s HIPAA Security Officer to the Chief Information Security Officer (CISO) in UITS to serve as a security official that is responsible for overall guidance, monitoring and maintenance of the security policies and procedures for the University.

3. Each of the University’s HIPAA-Covered Components shall designate and maintain a contact person or office who will serve as an internal privacy contact (“privacy liaison”) for the individual unit, who is responsible for receiving complaints and who is able to provide further information about matters covered by the Notice of Privacy Practices (the “NPP”).

4. Each of the University’s HIPAA-Covered Components shall designate and maintain a contact person or office who will serve as an internal data security contact (“security liaison”) for the individual unit, who is responsible for monitoring and/or overseeing the Component’s compliance with the HIPAA Security Rule and for reporting compliance related security incidents and/or breaches to the University’s Security Officer.

5. Each of the HIPAA-Covered Components of the University will make the University’s HIPAA Privacy and Security policies and procedures available

Effective: 8/2014
through a Notice of Privacy Practices (NPP). The NPP shall be provided to clients/patients (hereinafter “Individuals”) as follows:

- The NPP will be distributed and/or made available to directly to Individuals receiving services from the HIPAA-covered component,
- A copy of the NPP will be posted in the main reception area of the unit, and/or
- A link to the NPP will located on the HIPAA-covered component’s web page.

6. The HIPAA-Covered Components will train all employees, faculty, staff, students and volunteers (collectively, “members” of the HIPAA-Covered Components) who may have access to protected health information (PHI) on the policies and procedures that have been implemented to protect PHI. The training may be customized as appropriate for the different roles filled by the members listed above in a given HIPAA-Covered Component.

7. The HIPAA-Covered Components will implement appropriate administrative, technical, and physical safeguards to protect the security and privacy of protected health information.

8. The HIPAA-Covered Components will provide a process for Individuals to make complaints concerning the HIPAA-Covered Components privacy policies and procedures.

9. If staff members of the HIPAA-Covered Components fail to comply with the University’s security and privacy policies and procedures or the requirements of the Health Insurance Portability and Accountability Act (HIPAA), the HIPAA-Covered Components will use the disciplinary procedures currently defined at the University of Connecticut to apply appropriate sanctions.

10. The HIPAA-Covered Components will not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any Individual or other person who exercises any right or process established by HIPAA.

11. The HIPAA-Covered Components will not require Individuals to waive their rights to make a complaint to the Secretary of the Department of Health and Human Services. The HIPAA-Covered Components will also not require Individuals to waive their rights to make a complaint as a condition of the provision of treatment, payment, or eligibility for benefits.

12. The HIPAA-Covered Components will implement unit-level procedures that are designed to implement the policies set forth in this *HIPAA Privacy & Security Practices Manual* and the standards, implementation specifications and other requirements of HIPAA. The procedures will be reasonably designed to ensure
compliance, taking into account the types of activities that are performed by the HIPAA-Covered Components.

13. The University will change its policies and procedures as necessary and appropriate to respond to changes that may be made to the standards, requirements, and implementation specifications of HIPAA.

14. The University and its HIPAA-Covered Components will maintain policies and procedures in written or electronic form, maintain copies of communications that are required to be in writing, and retain the documentation for a minimum of six (6) years from the date of its creation or the date when it last was in effect, whichever is later.

**Business Associates**

The University will document an agreement that defines the privacy and security rules that apply to the relationship between its HIPAA-Covered Components and each Business Associate. These agreements will conform to the requirements of HIPAA and its related regulations.

**Individual Rights**

The University of Connecticut, in accordance with state and federal law, will allow Individuals to access and inspect or obtain a copy of his/her protected health information (PHI) for long as the HIPAA-Covered Components maintain the PHI. The University’s HIPAA-Covered Components shall at a minimum maintain such records in accordance with retention schedules required by law and regulation, and as established by the Office of the Public Records Administrator for the State of Connecticut.

The HIPAA-Covered Components will allow an Individual to request amendment of PHI or a record about him/her for as long as the HIPAA-Covered Components maintain the information.

The HIPAA-Covered Components will accept and consider a request from an Individual to restrict the use and disclosure of PHI that is created and maintained by the HIPAA-Covered Components in accordance with HIPAA and its related regulations and the policies set forth in this Manual.

The HIPAA-Covered Components will permit an Individual to request that confidential communication of PHI be delivered to alternative locations or by alternative means. The HIPAA-Covered Components will accommodate reasonable requests for alternative communications in accordance with HIPAA and its related regulations and the policies set forth in this Manual.
The HIPAA-Covered Components will provide an accounting of disclosures of PHI made by the HIPAA-Covered Components in the six (6) years prior to the date on which the accounting is requested except for disclosures not required by law. The accounting will be provided within 60 days of receipt of the request, which may be extended as necessary where permitted by law.

**Use and Disclosure**

The University of Connecticut will limit its use and disclosure of PHI as required by law. The University believes that an Individual has the right to manage how PHI is being used and disclosed. Except where permitted or required by law, the University will only use and disclose PHI with people involved in the care of a patient, for payment of services, and for general health care operations.

The University’s HIPAA-Covered Components are permitted to use or disclose PHI as follows:

1. To the Individual
2. To authorized personal representatives of an Individual;
3. To carry out treatment, payment or health care operations;
4. In compliance with an authorization to use or disclose PHI;
5. As required by law, public health activities, health oversight, law enforcement purposes, judicial and administrative proceedings;
6. As required to support reviews or investigations conducted by the Secretary of the U.S. Department of Health and Human Services or other delegated organization;
7. As allowed by law, for the purpose of the legal defense of the University; and
8. As permitted for marketing, fundraising, and underwriting activities that the University may perform.

The University HIPAA-Covered Components will disclose PHI in accordance with the consent, authorization, or other legal permissions from an Individual.

For certain types of use and disclosure of PHI, the University’s HIPAA-Covered Components will inform an Individual in advance of the use or disclosure and give the individual an opportunity to prohibit or restrict the use or disclosure.

For other types of use and disclosure of PHI, the University and/or its HIPAA-Covered Components may make the disclosure as allowed by law without informing an Individual in advance of the use or disclosure or giving the Individual an opportunity to prohibit or restrict the use or disclosure. The list of these types of activities include disclosures for the sole purposes of:

1. Public Health Activities
2. Health Oversight Activities
3. Victims of Abuse, Neglect, or Domestic Violence
4. Judicial and Administrative Proceedings
5. Law Enforcement Activities
6. Decedents
7. Threats to Health or Safety
8. Research
9. Workers’ Compensation Activities

The University and/or its HIPAA-Covered Components may use or disclose PHI without authorization when information that would allow identification of the Individual has been removed in a HIPAA-compliant manner.

**Minimum Necessary**

When disclosing PHI to other organizations, the University’s HIPAA-Covered Components will provide only the PHI that is necessary for the organization to accomplish the intended use of the data. When receiving PHI from other organizations, the University’s HIPAA-Covered Components will rely on those external entities to provide only the information needed to satisfy their needs.
Glossary of Terms & Definitions

As used in this HIPAA Privacy & Security Practices Manual, the following terms have the following meanings. Terms that are not specifically defined throughout this Manual shall have the same meaning as those terms are defined by HIPAA or relevant State law, whichever provides the greater protection for the Individual.

**Alternative Communication** – In the context of HIPAA rules, an “alternative communication” is a communication from a covered entity to an Individual served by that covered entity that differs in some way from the “standard” communication. The difference may be the timing (e.g. an off-shift telephone call), the method (e.g. e-mail rather than U.S. mail), or destination (e.g. a different address).

**Authorization** – Permission granted by the Individual or the Individual’s legally authorized representative to use or disclose protected health information in accordance with uses and disclosures permitted or required by the Privacy Rule and/or State law.

**Business Associate** – A person or organization that performs a function or activity on behalf of a covered entity, but is not part of the covered entity’s workforce. A business associate can be a covered entity in its own right.

**Business Continuity Plan**: A Business Continuity Plan (BCP) is a written set of instructions focused on how to sustain mission/business processes during and after a disruption. See NIST sp 800-34.

**Clearinghouse** - For HIPAA, an organization that translates health care transactions to or from a standard format.

**Code Set** - Any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes. A code set includes the codes and the descriptors of the codes.

**Contracted Provider** – As a special case of a business associate, a contracted provider is a provider that offers health services on behalf of another provider. For example, a hospital may have a contract for a separate organization for provision of all radiology services.

**Consent** - Permission granted by the Individual or the Individual’s legally authorized representative to use or disclose protected health information for purposes of treatment, payment, or health care operations.

**Covered Entity** – Means a person or organization that falls into any of the following groups:

1. A health plan.
2. A health care clearinghouse.

**Covered Transaction** - Any of the set of electronic healthcare transactions specified by HIPAA regulations. The list includes transactions for health insurance claims, health insurance claim status, health insurance claim payment and remittance, health plan eligibility, referral certification and authorization, health plan enrollment, health plan premium payments.

**Disaster Recovery Plan**: A Disaster Recovery Plan (DRP) is an information system-focused plan designed to restore operability of the target system, application, or computer facility infrastructure at an alternate site after an emergency. See NIST sp 800-34.

**Disclosure** - The release, transfer, provision of access to, or divulging in any other manner of protected health information outside the entity holding the information.

**Discovery Request** – A request from one attorney to opposing counsel for copies of information relevant to a legal case that is being considered.
Designated Record Set - A group of records maintained by or for a covered entity that includes the medical records and billing records about Individuals maintained by or for a covered health care provider; the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or used, in whole or in part, by or for the covered entity to make decisions about Individuals.

Healthcare Operations - Means any of the named activities of the covered entity to the extent that:
- The activities are related to covered functions, and any of the following activities of an organized health care arrangement in which the covered entity participates
- Conducting quality assessment and improvement activities
- Reviewing the competence or qualifications of health care professionals

Health Plan – Means an individual or group plan that provides or pays the cost of medical care.

HIPAA - The Health Insurance Portability and Accountability Act of 1996, as amended from time to time, along with the supporting published regulations. The law is intended to provide for portability of health insurance, reduce fraud and waste in the healthcare system, and simplify the administration of health insurance.

Hybrid Entity – Refers to a covered entity whose primary function does not meet HIPAA definitions of a covered entity but does have functions that are covered. UConn is a Hybrid Entity.

Individual – The person who is the subject of protected health information. It includes, but is not limited to, patients and clients of the University’s HIPAA-Covered Components.

Member – Faculty, staff, students, and volunteers as well as affiliates of the HIPAA-covered components.

Payment - The activities undertaken by either a health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan; or a covered health care provider or health plan to obtain or provide reimbursement for the provision of health care.

Protected Health Information (PHI) - Individually identifiable health information that is or has been electronically maintained or electronically transmitted by a covered entity, as well as such information when it takes any other form that is:
- Created or received by a health care provider, health plan, employer, or health care clearinghouse; and
- Relates to the past, present, or future physical or mental health or condition of an Individual, the provision of health care to an Individual, or the past, present, or future payment for the provision of health care to an Individual.

Provider – Means a provider of health care services as defined in the HIPAA regulations. Generally this is any person or organization that furnishes, bills, or is paid for health care in the normal course of business.

Transaction - The exchange of information between two parties to carry out financial or administrative activities related to health care.

Treatment - Means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to an Individual; or the referral of an Individual for health care from one health care provider to another.

Unique Health Identifiers – Refers the set of identification fields specified in the HIPAA regulations. Under HIPAA, the formats and rules for creating and controlling identifiers for health plans, employers, health care providers, and Individuals will be standardized.

Use - Means the sharing, employment, application, utilization, examination, or analysis of protected health information within an entity that maintains such information.
Policy: The University of Connecticut will comply with all administrative requirements of the Health Insurance Portability and Accountability Act.

Rationale: To maintain compliance with Title 45 CFR Part 164.530, Administrative Requirements.

I. General Procedures:

1. The University has assigned the role of University’s HIPAA Privacy Officer to the Assistant Director of Compliance in the Office of Audit, Compliance & Ethics to serve as a privacy official who is responsible for the overall guidance, monitoring and maintenance of the privacy policies and procedures for University.

2. The University has assigned the role of University’s HIPAA Security Officer to the Chief Information Security Officer (CISO) in UITS to serve as a security official that is responsible for overall guidance, monitoring and maintenance of the security policies and procedures for the University.

3. Each of the University’s HIPAA-Covered Components shall designate and maintain a contact person who will serve as an internal privacy contact (“privacy liaison”) for the individual unit, who is responsible for receiving complaints and who is able to provide further information about matters covered by the Notice of Privacy Practices (the “NPP”).

4. Each of the University’s HIPAA-Covered Components shall designate and maintain a contact person or office who will serve as an internal data security contact (“security liaison”) for the individual unit, who is responsible for monitoring and/or overseeing the Component’s compliance with the HIPAA Security Rule and for reporting compliance related security incidents and/or breaches to the University’s Security Officer.

5. Each of the HIPAA-Covered Components of the University will make the University’s HIPAA Privacy and Security policies and procedures available through a Notice of Privacy Practices (NPP). The NPP shall be provided to clients/patients (hereinafter “Individuals”) as follows:

   - The NPP will be distributed and/or made available to directly to Individuals receiving services from the HIPAA-covered component,
   - A copy of the NPP will be posted in the main reception area of the unit, and
   - A link to the NPP will be located on the HIPAA-covered component’s web page.
Training:

6. The University will train all persons covered by the requirements set forth in this Manual on all relevant policies and procedures that have been implemented to protect and secure PHI. The training will be customized as appropriate for the different roles filled by faculty, staff, students, and volunteers as well as affiliates of the HIPAA-covered component (hereinafter “members”) who may have access to PHI.

7. The University will provide training that meets the following requirements:
   a. To each new member of the HIPAA-Covered Component within a reasonable period of time after the person joins the Component;
   b. To each member of the HIPAA-Covered Component who has changed job functions and is impacted differently by the privacy policies and procedures;
   c. To each member of the HIPAA-Covered Component whose functions are affected by a change in the HIPAA regulations; and
   d. To each member of the HIPAA-Covered Component whose functions are affected by a material change in the policies or procedures.

8. The University will also provide refresher training to all members on an annual basis.

9. The HIPAA-Covered Component will document that the training has been provided, in either written or electronic format, and retain the documentation for a minimum of six (6) years.

Safeguards:

10. The University will have in place appropriate administrative, technical, and physical safeguards to protect the privacy and ensure the data security of PHI.

11. The University will reasonably safeguard PHI from any intentional or unintentional use or disclosure that is in violation of the standards, implementation specifications or other requirements of HIPAA.

Complaints:

12. Each HIPAA-Covered Component will provide a process for Individuals to make complaints concerning the University’s policies and procedures or its compliance with such policies and procedures.

13. As part of the process, each HIPAA-Covered Component shall ensure that all complaints and suspected and/or actual security incidents are reported to the University’s Privacy Officer and Security Officer.
14. The HIPAA-covered Component will document all complaints received, and their disposition, if any, in written or electronic form. These documents must be retained for a minimum of six (6) years.

Sanctions:

15. If members of its workforce fail to comply with the privacy policies and procedures of the University or the requirements the HIPAA and/or the University will use the disciplinary procedures currently defined at the University to apply appropriate sanctions.

16. Any member of the HIPAA-Covered Component that becomes aware of a violation or deviation from the University’s Privacy policies and procedures should notify the HIPAA-covered component’s privacy liaison as soon as possible.

17. Any member of the HIPAA-Covered Component that becomes aware of a security incident, an actual or potential breach or a violation or deviation from the University’s Security policies and procedures should notify the HIPAA-Covered Component’s security liaison as soon as possible.

18. Sanctions may include, but are not limited to:
   a. Counseling
   b. Oral Warning
   c. Written Warning
   d. Suspension
   e. Termination

19. Disciplinary sanctions and appeals are handled in accordance with applicable procedures, depending on the type of workforce member being disciplined, for example:
   a. If the individual accused of the violation belongs to a collective bargaining union, involvement by the Office of Faculty & Staff Labor Relations (OFSLR) and union representation may be necessary to protect the rights of the member
   b. If the person accused of the breach is a faculty member, the process will be as outlined under applicable by-laws

20. Reporting a violation in bad faith or for malicious reasons may be interpreted as a misuse of the reporting mechanism(s) and may result in disciplinary action.

21. As outlined in Part 164.502(j) of the HIPAA Privacy regulations, a disclosure that is made by a member of the HIPAA-Covered Component’s workforce is not subject to sanction if the disclosure is part of a “whistleblower” action. To meet this condition, the disclosure must be made to a health oversight agency or public health authority authorized to investigate HIPAA privacy violations or to an
attorney retained to determine the legal options of the person making the disclosure.

22. If the HIPAA-Covered Component becomes aware of a use or disclosure of PHI that violates its privacy policies and procedures, the HIPAA-Covered Component shall work to mitigate, to the extent practicable, any harmful effect of the violation.

Refraining From Intimidating or Retaliatory Acts:

23. The University will not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against:
   a. Any Individual for the exercise of any right under, or for participation in any process established by the Health Insurance Portability and Accountability Act, including the filing of a complaint;
   b. Any Individual for:
      i. Filing of a complaint with the Secretary under subpart C of part 160 of Title 45 of the Code of Federal Regulations;
      ii. Testifying, assisting, or participating in an investigation, compliance review, proceeding, or hearing under Part C of Title XI; or
      iii. Opposing any act or practice believed to be unlawful, provided the person has a good faith belief that the practice is unlawful, and the manner of the opposition is reasonable and does not involve a disclosure of protected health information.

Waiver of Rights:

24. The University will not require Individuals to waive their rights to make a complaint to the Secretary of Department of Health and Human Services. The University will also not require Individuals to waive their rights to make a complaint as a condition of the provision of treatment, payment, or eligibility for benefits.

Policies and Procedures

25. The University’s policies and procedures are designed to comply with the standards, implementation specifications or other requirements of the Health Insurance Portability and Accountability Act of 1996. Applicable policies and procedures are reasonably designed to ensure compliance, taking into account the types of activities related PHI that are performed by the University’s HIPAA-Covered Components.

Changes to Policies or Procedures.

26. The University will change its policies and procedures as necessary and appropriate to respond to changes that may be made to the standards,
requirements, and implementation specifications of the Health Insurance
Portability and Accountability Act of 1996.

27. When the University changes a privacy or data security practice that is described
in the Notice of Privacy Practices (NPP) and makes corresponding changes to its
policies and procedures, it may make the changes effective for protected health
information that it created or received prior to the effective date of the NPP
revision.

28. When the University changes a privacy or data security practice that is described
in the NPP and makes corresponding changes to its policies and procedures, it will
provide a copy of the revised NPP to Individuals on their next visit to the HIPAA-
Covered Component. The revised NPP will be posted in the University’s HIPAA-
Covered Component units and available through the HIPAA-Covered
Component’s web pages.

Documentation:

29. The University shall:
   • Maintain its HIPAA privacy and security policies and procedures in
     written or electronic form;
   • Maintain a written or an electronic copy as documentation if a
     communication, action, activity, or designation is required to be in
     writing; and
   • Retain the documentation for a minimum of six (6) years from the date
     of its creation or the date when it last was in effect, whichever is later.
NOTICE OF PRIVACY PRACTICES

Policy: The University of Connecticut will describe the ways that it uses and discloses the protected health information (PHI) that it collects and maintains.

Rationale: To maintain compliance with Title 45 CFR Part 164.520, Notice of Privacy Practices.

I. General Procedures:

1. The University will maintain a single Notice of Privacy Practices (NPP) that applies to and for its HIPAA-Covered Components. Faculty, staff, departments or units that function as Business Associates of entities other than UConn’s HIPAA-Covered Components shall follow the Privacy Practices established or dictated by the other entity as described in the relevant Business Associate Agreements covering that relationship.

2. The University shall promptly revise the NPP and ensure that the University’s HIPAA-Covered Components distribute the NPP whenever there is a material change to the uses or disclosures, the Individual’s rights, the University’s legal duties, or other privacy or data security practices stated in the NPP. Except when required by law, a material change to any term of the NPP may not be implemented earlier than the effective date of the NPP in which the change is reflected.

3. The HIPAA-Covered Components shall post a copy of the NPP in a clear and prominent location.

4. The HIPAA-Covered Components shall provide access to a copy of the NPP on their websites.

5. The HIPAA-Covered Components shall provide and/or make available a copy of the NPP to each Individual no later than the date of first service delivery. If the Individual is an inmate of a correctional institution, the HIPAA-Covered Component will not provide a copy of the NPP.

6. The HIPAA-Covered Components shall provide updated NPP to Individuals when any material changes are made to the NPP by the University.

7. The University will maintain copies of each version of the NPP for a minimum of six (6) years after it is issued.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

POLICY:

We understand that information about your health and program is personal. We are committed to protecting health information about you. When you register as a client or patient with one of the University’s HIPAA-Covered Components, we create a record of care and services you will receive from the University. We use this record to provide you with quality services and to comply with certain legal requirements. This notice applies to all of the information maintained by the University’s HIPAA-Covered Components about services or care provided to you. Other providers of service outside of the University of Connecticut may have different policies or notices regarding the information they maintain about your health.

Protected health information (PHI) is any information that describes your health condition or health care that you may have received. This notice explains the ways that the University of Connecticut may use and disclose the PHI that we create, collect or maintain in accordance with HIPAA. We also describe your rights and certain obligations we have regarding the use and disclosure of your PHI. The University of Connecticut is considered to be a Hybrid Entity for HIPAA purposes. This means that the University as a whole is not covered by the requirements of HIPAA. Rather, certain individual units or clinics within the University, such as the one from whom you are receiving this notice, are covered by the requirements of HIPAA. Those units and clinics covered by the requirements of HIPAA, and thereby the contents of this notice, are called the University’s HIPAA-Covered Components. Each HIPAA-Covered Component serves as a separate unit and will not share your PHI between them, except where permitted or required by law, without your permission.

Please be advised that if you are a student at the University of Connecticut, your records may be subject to the federal Family Educational Rights and Privacy Act (FERPA) and/or certain privacy laws of the State of Connecticut, rather than HIPAA. If FERPA applies and/or state law, a different set of standards may dictate both your rights and the
obligations of the University with regard to your health-related records. Please refer to the University’s FERPA policy, or contact the University’s Privacy Officer at (860) 486-5256 for more information.

HIPAA requires us to:
- Make sure that any of your PHI is kept private;
- Give you this notice of our legal duties and privacy policy practices with respect to your PHI;
- Notify you of a breach of your PHI, if such breach occurs; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

The following categories describe different ways that we use and disclose your PHI. For each category we will explain what we mean and give some examples. We will not list every use or disclosure in the examples. However, all of the ways we are permitted to use and disclose PHI will fall within one of the categories.

We May Use and Disclose Your Protected Health Information For:

1. **Treatment:** We may use your PHI to provide you with services. We may disclose information about you to our staff and students who work to provide you with services.

   For example:
   - The staff may need to know that you are taking a certain medication or have a medical condition that may affect your care, program or treatment.
   - We may disclose your PHI to health providers who are involved in taking care of you.
   - We may disclose your PHI to people such as family members or others who take part in your care, program or treatment.

   If we are permitted to do so, we may also disclose or allow electronic access to your PHI to a health care provider you designate for follow-up care, care coordination, discharge planning and for other treatment purposes.

2. **Payment:** We may use and disclose your PHI so the cost of the services you receive can be billed to health plans or to you.

   For example:
   - We may provide information to a vendor who acts as our billing agent.

3. **Health Care Operations:** We may use and disclose your PHI for University operations. These uses and disclosures are necessary to operate our HIPAA-
Covered Components and improve the quality of services.

For example:

- We may use your PHI to review our programs and services and to evaluate the performance of our staff or the performance of a contracted provider.
- We may combine health information about many individuals to decide what changes in service might be needed.
- We may also use combined information to evaluate how we are managing changes in resources or services.

4. **Business Associates**: There may be some services provided by our business associates, such as a billing service, transcription service, legal counsel or accounting consultant. We may disclose your PHI to our business associate so that they can perform the job we have asked them to do. To protect your information, we require our business associates to enter into a written contract that obligates them to appropriately safeguard your information.

5. **Appointment Reminders**: We may use or disclose your PHI to remind you about appointments for services or treatments.

6. **Service Alternatives**: We may use or disclose your PHI to inform you about or recommend possible service or program alternatives that may be of interest to you.

7. **Individuals Involved in Your Support or Payment for Your Support**: We may disclose your PHI to a family member, friend, or staff member who is involved in your care, program or treatment. We may also give information to someone who helps pay for your care, program or treatment.

8. **Fundraising and Marketing**: We do not use PHI in fundraising or marketing activities.

9. **Research**: Under certain circumstances, we may use and disclose your PHI for research purposes.

   For example, a research project may involve comparing the progress of all individuals involved in a certain type of treatment program compared to those in a different program.
All research projects are subject to a special approval process. This process evaluates a proposed research project and its use of health information. Before we use or disclose health information for research, the project will have been approved through the University of Connecticut’s research approval process. We will ask for your permission if the researcher will have access to your name, address or other information that reveals who you are.

10. **Education**: Under certain circumstances, we may use and disclose your PHI for educational purposes.

Some of the services provided by the University’s HIPAA-Covered Components are delivered by students in the University of Connecticut’s programs. These students work under the supervision of licensed practitioners. These students have full access to your care, treatment or service history unless the individual has placed restrictions on that access.

In some of our programs, University of Connecticut students observe clinical activities in order to complete portions of program requirements. You have the right to that the care, treatment or services you receive be excluded from observations.

11. **As Required by Law**: We will disclose your PHI when required to do so by federal, state or local law.

12. **To Avert a Serious Threat to Health or Safety**: We may use and disclose your PHI when necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

13. **Workers' Compensation**: We may disclose your PHI for workers’ compensation or similar programs. These programs provide benefits for work related injuries or illness.

14. **Public Health Risk**: We may disclose your PHI for public health activities. These activities include the following:
   - To prevent or control disease, injury or disability;
   - To report births and deaths;
   - To report abuse or neglect;
   - To report reactions to medications or problems with products;
   - To notify people of recalls of products they may be using;

Notice Privacy Practices.Doc
• To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
• To notify the appropriate government authority if we believe a person has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

15. **Health Oversight Activities:** We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

16. **Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process. We will disclose the information only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

17. **Law Enforcement:** We may disclose health information if asked to do so by law enforcement officials:
   - In response to a court order, subpoena, warrant, summons or similar process;
   - To identify or locate a suspect, fugitive, material witness, or missing person;
   - About the victim of a crime if, under limited circumstances, we are unable to obtain the person’s agreement;
   - About a death we believe may be the result of criminal conduct;
   - About criminal conduct within one of our programs; and
   - In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

18. **Coroners, Medical Examiners and Funeral Directors:** We may disclose health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also disclose health information about individuals to funeral directors, as necessary, to carry out their duties.
19. **National Security and Intelligence Activities**: We may disclose your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

20. **Protective Services for the President of the United States and Others**: We may disclose your PHI to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state; or to conduct special investigations.

21. **Inmates**: If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose health information about you to the correctional institution or law enforcement official.

   This disclosure would be necessary:
   (1) for the institution to provide you with health care
   (2) to protect your health and safety or the health and safety of others; or
   (3) for the safety and security of the correctional institution.

22. **Sale of Protected health information**: Except when permitted by law, we will not sell your protected health information unless we receive a signed authorization from you.

**YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU**

You have the following rights regarding health information we maintain about you:

**Right to Inspect and Copy**: You have the right to inspect and copy health information that may be used to make decisions about your services. Usually, this includes health and billing records but does not include psychotherapy notes.

To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing to the HIPAA-Covered Component Director. You also have the right to obtain an electronic copy of any of your protected health information that we maintain in electronic format. You have the right to receive a copy of your PHI in the electronic format you request. If you request a copy of the information, we will charge a fee of 65¢ per page for copying, plus the costs of mailing or other supplies associated with your request.

We may deny your request to inspect and copy information, in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another person, chosen by the HIPAA-Covered Component, will review your request and the denial. We will comply with the outcome of the review.
Right to Request Transmission of Your Protected Health Information in Electronic Format: You may direct us to transmit an electronic copy of your protected health information that we maintain in electronic format to an individual or entity you designate. To request the transmission of your electronic health information, you must submit the request in writing to the HIPAA-Covered Component’s Director.

Right to Amend: If you feel that health information we have about you is incorrect or incomplete; you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the University’s HIPAA-Covered Component.

To request an amendment, your request must be made in writing and submitted to the HIPAA-Covered Component’s Director. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information kept by or for the HIPAA-Covered Component;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures the HIPAA-Covered Component made of your PHI.

To request this list or accounting of disclosures, you must submit your request in writing to the HIPAA-Covered Component’s Director. Your request must state a time period, which may not be longer than six (6) years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, or electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the cost of providing the list.

We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

We are not required to account for all disclosures, including disclosures for treatment, payment or health care operations. However, effective January 1, 2014, where required by law, when you request a list of disclosure of PHI that is maintained in an electronic health record, the accounting will be for three (3) years prior to the date of the request,
and will include disclosures made for the purposes of treatment, payment and health care operations in addition to those disclosures listed in the University’s policy regarding accounting of disclosures. To request this list of disclosures, you must submit your request in writing to the HIPAA-Covered Component’s Director.

Please note that, at times, companies we work with (called “business associates”) may have access to your protected health information. When you request an accounting of disclosures from the University, we may provide you with the accounting of disclosures made by our business associates or the names and contact information of our business associates, so that you may then contact them directly for an accounting of disclosures.

**Right to Request Restrictions:** You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or for the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We are not required to agree to these types of requests; however, if we do agree, we will comply with your request unless the disclosure is needed to provide you emergency treatment.

You may restrict the disclosure of your PHI to a health plan (other than Medicaid or other federal health care program that requires the University to submit information) and the University must agree to your request (unless we are prohibited by law from doing so), if the restriction is for purposes of payment or other health care operations (but not treatment) and if you paid out of pocket, in full, for the item or service to which the protected health information pertains. If those two conditions are not met, we are not required to agree to your requested restriction. To request restrictions of disclosure to a health plan, you must make your restriction request known at the time of service and complete and sign our restriction form.

Either you or the University may terminate any restriction on the disclosure of your PHI by notifying the other party in writing of the termination. The termination of the restriction will apply only to use and/or disclosure of PHI after the termination date.

**Right to Request Confidential Communications:** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the HIPAA-Covered Component’s Director. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
Right to a Paper Copy of this Notice: You have a right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice. You may obtain a copy of this Notice on any of the University’s HIPAA-Covered Components’ websites. You may obtain a paper copy of this Notice at any of the University's HIPAA-Covered Component offices from whom you receive care.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in our facilities and/or on our websites. The Notice will contain the effective date of the Notice on the first page. In addition, each time you receive new services from us, we will offer you a copy of the current Notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the HIPAA-Covered Component’s Director, the University’s Privacy Officer in the University’s Office of Audit, Compliance & Ethics (OACE), or with the Secretary of the U.S. Department of Health and Human Services (DHHS) Office of Civil Rights (OCR).

- For instructions on filing a complaint within the HIPAA-Covered Component from whom you receive care, contact the Component’s Director:
  - Speech & Hearing Clinic: (860) 486-2629
  - Nayden Rehabilitation Clinic: (860) 486-8080
  - UConn Fire Department/EMS: (860) 486-0010

- Complaints made to the University Privacy Officer/OACE can be made anonymously through the Reportline:
  - Website: https://uconncares.alertline.com/gcs/welcome
  - Reportline phone number: (888) 685-2637

Alternatively, complainants or individuals with concerns may contact the University’s Privacy Officer directly:

University Privacy Officer
Office of Audit, Compliance & Ethics
University of Connecticut
9 Walters Avenue, Unit 5084
Storrs, CT 06269-5084

Phone: (860) 486-5256
To file a complaint with DHHS OCR, you must file in writing (electronic or paper), within 180 days of when you knew or should have known of the problem. Send written complaints to:

DHHS Regional Manager for Region I, Office for Civil Rights
U.S. Department of Health & Human Services Government Center
J.F. Kennedy Federal Building – Room 1875
Boston, Massachusetts 02203

You may file electronic complaints with the DHHS OCR via their web portal or via email. Instructions can be found on their website.

*You will not be penalized for filing a complaint.*

**OTHER USES OF HEALTH INFORMATION**

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us written permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the services that we provided you.

**CONTACTS FOR FURTHER INFORMATION**

If you have any questions about this notice please contact the Director of the HIPAA-Covered Component from whom you receive care, or the University’s Privacy Officer.
**Business Associate Agreements**

**Policy:** The University of Connecticut will document an agreement that defines the privacy and data security rules that apply to the relationship between its HIPAA-Covered Components and each Business Associate.

**Rationale:** To maintain compliance with Title 45 CFR Part 164.504e, Business Associate Agreements.

**I. General Procedures:**

1. The HIPAA-Covered Components of the University will ensure continued privacy and data security protections of health information are in place by entering into a written agreement with any Business Associate to which it sends PHI. The HIPAA-Covered Components will investigate complaints or other information that provide substantial and credible evidence of privacy and/or data security violations by a Business Associate. If a HIPAA-Covered Component becomes aware of a material privacy or data security breach by and/or at a Business Associate, the HIPAA-Covered Component will take reasonable steps to correct the breach or terminate the relationship with the Business Associate.

2. In situations where the University and/or one of its HIPAA-Covered Components is serving as the Covered Entity, or as a Business Associate of a third party who is further subcontracting work that requires access to the PHI of the third party covered entity, the University will initiate and enter into a Business Associate Agreement (BAA). As a State Agency, the University is required to utilize appropriate BAA language created by the Office of the Attorney General. The HIPAA-Covered Components will utilize the language mandated by the Office of the Attorney General in drafting and implementing any required BAA’s with third parties who serve as their Business Associates to the University.
Health Insurance Portability and Accountability Act of 1996.

(a) If the Contactor is a Business Associate under the requirements of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), as noted in this Contract, the Contactor must comply with all terms and conditions of this Section of the Contract. If the Contactor is not a Business Associate under HIPAA, this Section of the Contract does not apply to the Contactor for this Contract.

(b) The Contactor is required to safeguard the use, publication and disclosure of information on all applicants for, and all clients who receive, services under the Contract in accordance with all applicable federal and state law regarding confidentiality, which includes but is not limited to HIPAA, more specifically with the Privacy and Security Rules at 45 C.F.R. part 160 and part 164, subparts A, C, and E; and

(c) The State of Connecticut Agency named on page 1 of this Contract (“Agency”) is a “covered entity” as that term is defined in 45 C.F.R. § 160.103; and

(d) The Contactor is a “business associate” of the Agency, as that term is defined in 45 C.F.R. § 160.103; and

(e) The Contactor and the Agency agree to the following in order to secure compliance with the HIPAA, the requirements of Subtitle D of the Health Information Technology for Economic and Clinical Health Act (Pub. L. 111-5, §§ 13400 to 13423) (“HITECH Act”), and more specifically with the Privacy and Security Rules at 45 C.F.R. part 160 and part 164, subparts A, C, D and E (collectively referred to herein as the “HIPAA Standards”).

(f) Definitions.

(1) “Breach” shall have the same meaning as the term is defined in section 45 C.F.R. 164.402 and shall also include any use or disclosure of PHI that violates the HIPAA Standards.

(2) “Business Associate” shall mean the Contactor.

(3) “Covered Entity” shall mean the Agency of the State of Connecticut named on page 1 of this Contract.
(4) “Designated Record Set” shall have the same meaning as the term “designated record set” in 45 C.F.R. § 164.501.

(5) “Electronic Health Record” shall have the same meaning as the term is defined in section 13400 of the HITECH Act (42 U.S.C. §17921(5).

(6) “Individual” shall have the same meaning as the term “individual” in 45 C.F.R. § 160.103 and shall include a person who qualifies as a personal representative as defined in 45 C.F.R. § 164.502(g).

(7) “Privacy Rule” shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. part 160 and part 164, subparts A and E.

(8) “Protected Health Information” or “PHI” shall have the same meaning as the term “protected health information” in 45 C.F.R. § 160.103, and includes electronic PHI, as defined in 45 C.F.R. 160.103, limited to information created, maintained, transmitted or received by the Business Associate from or on behalf of the Covered Entity or from another Business Associate of the Covered Entity.

(9) “Required by Law” shall have the same meaning as the term “required by law” in 45 C.F.R. § 164.103.

(10) “Secretary” shall mean the Secretary of the Department of Health and Human Services or his designee.

(11) “More stringent” shall have the same meaning as the term “more stringent” in 45 C.F.R. § 160.202.

(12) “This Section of the Contract” refers to the HIPAA Provisions stated herein, in their entirety.

(13) “Security Incident” shall have the same meaning as the term “security incident” in 45 C.F.R. § 164.304.

(14) “Security Rule” shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. part 160 and part 164, subpart A and C.

(15) “Unsecured protected health information” shall have the same meaning as the term as defined in 45 C.F.R. 164.402.

(g) Obligations and Activities of Business Associates.
(1) Business Associate agrees not to use or disclose PHI other than as permitted or required by this Section of the Contract or as Required by Law.

(2) Business Associate agrees to use and maintain appropriate safeguards and comply with applicable HIPAA Standards with respect to all PHI and to prevent use or disclosure of PHI other than as provided for in this Section of the Contract and in accordance with HIPAA standards.

(3) Business Associate agrees to use administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Covered Entity.

(4) Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to the Business Associate of a use or disclosure of PHI by Business Associate in violation of this Section of the Contract.

(5) Business Associate agrees to report to Covered Entity any use or disclosure of PHI not provided for by this Section of the Contract or any security incident of which it becomes aware.

(6) Business Associate agrees, in accordance with 45 C.F.R. 502(e)(1)(ii) and 164.308(d)(2), if applicable, to ensure that any subcontractors that create, receive, maintain or transmit protected health information on behalf of the Business Associate, agree to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information;

(7) Business Associate agrees to provide access (including inspection, obtaining a copy or both), at the request of the Covered Entity, and in the time and manner designated by the Covered Entity, to PHI in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 C.F.R. § 164.524. Business Associate shall not charge any fees greater than the lesser of the amount charged by the Covered Entity to an Individual for such records; the amount permitted by state law; or the Business Associate’s actual cost of postage, labor and supplies for complying with the request.

(8) Business Associate agrees to make any amendments to PHI in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 C.F.R. § 164.526 at the request of the Covered Entity, and in the time and manner designated by the Covered Entity.
(9) Business Associate agrees to make internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received from, or created, maintained, transmitted or received by, Business Associate on behalf of Covered Entity, available to Covered Entity or to the Secretary in a time and manner agreed to by the parties or designated by the Secretary, for purposes of the Secretary investigating or determining Covered Entity’s compliance with the HIPAA Standards.

(10) Business Associate agrees to document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528 and section 13405 of the HITECH Act (42 U.S.C. § 17935) and any regulations promulgated thereunder.

(11) Business Associate agrees to provide to Covered Entity, in a time and manner designated by the Covered Entity, information collected in accordance with subsection (g)(10) of this Section of the Contract, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528 and section 13405 of the HITECH Act (42 U.S.C. § 17935) and any regulations promulgated thereunder. Business Associate agrees at the Covered Entity’s direction to provide an accounting of disclosures of PHI directly to an individual in accordance with 45 C.F.R. § 164.528 and section 13405 of the HITECH Act (42 U.S.C. § 17935) and any regulations promulgated thereunder.

(12) Business Associate agrees to comply with any state or federal law that is more stringent than the Privacy Rule.

(13) Business Associate agrees to comply with the requirements of the HITECH Act relating to privacy and security that are applicable to the Covered Entity and with the requirements of 45 C.F.R. §§ 164.504(e), 164.308, 164.310, 164.312, and 164.316.

(14) In the event that an individual requests that the Business Associate

(A) restrict disclosures of PHI;
(B) provide an accounting of disclosures of the individual’s PHI;
(C) provide a copy of the individual’s PHI in an electronic health record; or
(D) amend PHI in the individual’s designated record set
the Business Associate agrees to notify the Covered Entity, in writing, within five business days of the request.

(15) Business Associate agrees that it shall not, and shall ensure that its subcontractors do not, directly or indirectly, receive any remuneration in exchange for PHI of an Individual without

(A) the written approval of the Covered Entity, unless receipt of remuneration in exchange for PHI is expressly authorized by this Contract and

(B) the valid authorization of the individual, except for the purposes provided under section 13405(d)(2) of the HITECH Act, (42 U.S.C. § 17935(d)(2)) and in any accompanying regulations


(A) The Business Associate agrees that, following the discovery by the Business Associate or by a subcontractor of the Business Associate of any use or disclosure not provided for by this Section of the Contract, any breach of unsecured protected health information, or any Security Incident, it shall notify the Covered Entity of such breach in accordance with 45 C.F.R. part 164, subpart D, and this Section of the Contract.

(B) Such notification shall be provided by the Business Associate to the Covered Entity without unreasonable delay, and in no case later than 30 days after the breach is discovered by the Business Associate, or a subcontractor of the Business Associate, except as otherwise instructed in writing by a law enforcement official pursuant to 45 C.F.R. 164.412. A breach is considered discovered as of the first day on which it is, or reasonably should have been, known to the Business Associate or its subcontractor. The notification shall include the identification and last known address, phone number and email address of each individual (or the next of kin of the individual if the individual is deceased) whose unsecured protected health information has been, or is reasonably believed by the Business Associate to have been, accessed, acquired, or disclosed during such breach.

(C) The Business Associate agrees to include in the notification to the Covered Entity at least the following information:

1. A description of what happened, including the date of the breach; the date of the discovery of the breach;
the unauthorized person, if known, who used the PHI or to whom it was disclosed; and whether the PHI was actually acquired or viewed.

2. A description of the types of unsecured protected health information that were involved in the breach (such as full name, Social Security number, date of birth, home address, account number, or disability code).

3. The steps the Business Associate recommends that Individual(s) take to protect themselves from potential harm resulting from the breach.

4. A detailed description of what the Business Associate is doing or has done to investigate the breach, to mitigate losses, and to protect against any further breaches.

5. Whether a law enforcement official has advised the Business Associate, either verbally or in writing, that he or she has determined that notification or notice to Individuals or the posting required under 45 C.F.R. 164.412 would impede a criminal investigation or cause damage to national security and, if so, contact information for said official.

(D) If directed by the Covered Entity, the Business Associate agrees to conduct a risk assessment using at least the information in subparagraphs 1 to 4, inclusive, of (g)(16)(C) of this Section and determine whether, in its opinion, there is a low probability that the PHI has been compromised. Such recommendation shall be transmitted to the Covered Entity within 20 business days of the Business Associate’s notification to the Covered Entity.

(E) If the Covered Entity determines that there has been a breach, as defined in 45 C.F.R. 164.402, by the Business Associate or a subcontractor of the Business Associate, the Business Associate, if directed by the Covered Entity, shall provide all notifications required by 45 C.F.R. 164.404 and 45 C.F.R. 164.406.

(F) Business Associate agrees to provide appropriate staffing and have established procedures to ensure that individuals informed of a breach have the opportunity to ask questions and contact the Business Associate for additional information regarding the breach. Such procedures shall include a toll-
free telephone number, an e-mail address, a posting on its Web site and a postal address. Business Associate agrees to include in the notification of a breach by the Business Associate to the Covered Entity, a written description of the procedures that have been established to meet these requirements. Costs of such contact procedures will be borne by the Contractor.

(G) Business Associate agrees that, in the event of a breach, it has the burden to demonstrate that it has complied with all notifications requirements set forth above, including evidence demonstrating the necessity of a delay in notification to the Covered Entity.

(h) Permitted Uses and Disclosure by Business Associate.

(1) General Use and Disclosure Provisions. Except as otherwise limited in this Section of the Contract, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in this Contract, provided that such use or disclosure would not violate the HIPAA Standards if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

(2) Specific Use and Disclosure Provisions

(A) Except as otherwise limited in this Section of the Contract, Business Associate may use PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate.

(B) Except as otherwise limited in this Section of the Contract, Business Associate may disclose PHI for the proper management and administration of Business Associate, provided that disclosures are Required by Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

(C) Except as otherwise limited in this Section of the Contract, Business Associate may use PHI to provide Data Aggregation services to Covered Entity as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B).
(i) Obligations of Covered Entity.

(1) Covered Entity shall notify Business Associate of any limitations in its notice of privacy practices of Covered Entity, in accordance with 45 C.F.R. § 164.520, or to the extent that such limitation may affect Business Associate’s use or disclosure of PHI.

(2) Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by Individual(s) to use or disclose PHI, to the extent that such changes may affect Business Associate’s use or disclosure of PHI.

(3) Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect Business Associate’s use or disclosure of PHI.

(j) Permissible Requests by Covered Entity. Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the HIPAA Standards if done by the Covered Entity, except that Business Associate may use and disclose PHI for data aggregation, and management and administrative activities of Business Associate, as permitted under this Section of the Contract.

(k) Term and Termination.

(1) Term. The Term of this Section of the Contract shall be effective as of the date the Contract is effective and shall terminate when the information collected in accordance with provision (g)(10) of this Section of the Contract is provided to the Covered Entity and all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this Section.

(2) Termination for Cause. Upon Covered Entity’s knowledge of a material breach by Business Associate, Covered Entity shall either:

(A) Provide an opportunity for Business Associate to cure the breach or end the violation and terminate the Contract if Business Associate does not cure the breach or end the violation within the time specified by the Covered Entity; or

(B) Immediately terminate the Contract if Business Associate has breached a material term of this Section of the Contract and cure is not possible; or
(C) If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

(3) Effect of Termination.

(A) Except as provided in (k)(2) of this Section of the Contract, upon termination of this Contract, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created, maintained, or received by Business Associate on behalf of Covered Entity. Business Associate shall also provide the information collected in accordance with section (g)(10) of this Section of the Contract to the Covered Entity within ten business days of the notice of termination. This section shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.

(B) In the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon documentation by Business Associate that return or destruction of PHI is infeasible, Business Associate shall extend the protections of this Section of the Contract to such PHI and limit further uses and disclosures of PHI to those purposes that make return or destruction infeasible, for as long as Business Associate maintains such PHI. Infeasibility of the return or destruction of PHI includes, but is not limited to, requirements under state or federal law that the Business Associate maintains or preserves the PHI or copies thereof.

(l) Miscellaneous Sections.

(1) Regulatory References. A reference in this Section of the Contract to a section in the Privacy Rule means the section as in effect or as amended.

(2) Amendment. The Parties agree to take such action as is necessary to amend this Section of the Contract from time to time as is necessary for Covered Entity to comply with requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

(3) Survival. The respective rights and obligations of Business Associate shall survive the termination of this Contract.
(4) Effect on Contract. Except as specifically required to implement the purposes of this Section of the Contract, all other terms of the Contract shall remain in force and effect.

(5) Construction. This Section of the Contract shall be construed as broadly as necessary to implement and comply with the Privacy Standard. Any ambiguity in this Section of the Contract shall be resolved in favor of a meaning that complies, and is consistent with, the Privacy Standard.

(6) Disclaimer. Covered Entity makes no warranty or representation that compliance with this Section of the Contract will be adequate or satisfactory for Business Associate’s own purposes. Covered Entity shall not be liable to Business Associate for any claim, civil or criminal penalty, loss or damage related to or arising from the unauthorized use or disclosure of PHI by Business Associate or any of its officers, directors, employees, contractors or agents, or any third party to whom Business Associate has disclosed PHI contrary to the sections of this Contract or applicable law. Business Associate is solely responsible for all decisions made, and actions taken, by Business Associate regarding the safeguarding, use and disclosure of PHI within its possession, custody or control.

(7) Indemnification. The Business Associate shall indemnify and hold the Covered Entity harmless from and against any and all claims, liabilities, judgments, fines, assessments, penalties, awards and any statutory damages that may be imposed or assessed pursuant to HIPAA, as amended or the HITECH Act, including, without limitation, attorney’s fees, expert witness fees, costs of investigation, litigation or dispute resolution, and costs awarded thereunder, relating to or arising out of any violation by the Business Associate and its agents, including subcontractors, of any obligation of Business Associate and its agents, including subcontractors, under this Section of the Contract, under HIPAA, the HITECH Act, and the HIPAA Standards.
ACCESS OF INDIVIDUALS TO PROTECTED HEALTH INFORMATION

Policy:
The University of Connecticut, in accordance with state and federal laws, will give an individual the right to access and inspect or obtain a copy of his/her protected health information (PHI) for as long as the University maintains the PHI. The Individual’s health and/or billing record is the property of the University and may not be removed from the University’s control except by court order. This policy will ensure the Individual’s right to obtain paper or electronic copies of his/her PHI. Individuals and/or their authorized representatives have the right to request copies of their health and billing record information and may request to receive this information in either paper or electronic format. Electronic format is only available for records that are maintained electronically and will be released in a format of the Individual’s choosing or a machine readable electronic format as agreed upon by the client and the University.

Rationale:
To maintain compliance with Title 45 CFR Part 164.524, Access of Individuals to Protected Health Information.

I. General Procedures:

1. The University will permit an Individual to request access to inspect or to obtain a copy of the protected health information about the Individual that is maintained in a designated record set. The University will require Individuals to make requests for access in writing to the appropriate HIPAA-Covered Component and will inform Individuals of that requirement.

2. The University will act on a request for access no later than 30 days after receipt of the request as follows:
   a. If the University grants the request, in whole or in part, it will inform the Individual of the acceptance of the request and provide the access requested;
   b. If the University denies the request, in whole or in part, it will provide the Individual with a written denial. If the request for access is for PHI that is not maintained or accessible to the University, the University will inform the Individual that the requested information cannot be provided.

3. PHI that may not be accessed, copied, released or inspected due to state and federal law include:
   a. Psychotherapy notes recorded by a mental health professional, in any medium, and maintained separately from the rest of the patient’s medical record. Psychotherapy notes document or analyze conversation during a private, joint, family or group counseling session. By definition psychotherapy notes do not include medication records, counseling start and stop times, treatment records, results of clinical tests, diagnoses, functional status, symptoms, prognosis and progress and notes maintained with the Individual’s regular health record.
b. Information subject to Clinical Laboratory Improvement Amendments of 1988 (CLIA). Labs that are subject to CLIA must not grant Individuals access to test results if CLIA bans them from doing so. Research labs that are exempt from CLIA may also deny Individuals access to health information.

c. Information compiled in reasonable anticipation of or for use in a civil, criminal or administrative action or proceeding or pending litigation. Incident reports generated when a medical error occurs are not included in the designated record set and thus requests to copy this information by the Individual or their authorized representative will be denied.

4. If the University does not maintain the PHI that is the subject of the Individual’s request for access, and the University knows where the requested information is maintained, the University will inform the Individual where to direct the request for access.

5. If the University provides an Individual with access, in whole or in part, to PHI, the University will:

   a. Provide access as requested by an Individual, including inspection or obtaining a copy, or both, of the PHI about them in designated record sets. If the same PHI that is the subject of a request for access is maintained in more than one designated record set or at more than one location, the University need only produce the PHI once in response to the request for access.

   b. Provide the Individual with access to the PHI in the form and format requested by the Individual, if it is readily producible in such form and format; or, if not, in a readable hard copy form or such other form and format as agreed to by the HIPAA-Covered Component and the Individual. If the PHI that is the subject of a request for access is maintained in one or more designated record sets electronically and if the Individual requests an electronic copy of such information, the HIPAA-Covered Component shall provide the Individual with access to the PHI in the electronic form and format requested by the Individual, if it is readily producible in such form and format; or, if not, in a readable electronic form and format as agreed to by the HIPAA-Covered Component and the Individual. Provide the Individual with a summary of the PHI requested, in lieu of providing access to the PHI or may provide an explanation of PHI to which access has been provided, if:

      i. The Individual agrees in advance to such a summary or explanation; and

      ii. The Individual agrees in advance to the fees imposed, if any, by the University for such summary or explanation.

   c. Provide the access as requested by the Individual in a timely manner, including arranging with the Individual for a convenient time and place to
inspect or obtain a copy of the PHI, or mailing the copy of the PHI at the Individual’s request.

**Fees**

6. If the Individual and/or the Individual’s authorized representative requests a copy of his/her PHI or agrees to a summary or explanation of such information, the University may charge .65¢ per page for paper records that are copied for the Individual and/or authorized representative’s use. For requests in electronic format, charges are based on the format agreed to between the Individual and the University and at no time shall exceed reasonable cost-based fees as defined by the HITECH Rule.

**Unreviewable Grounds for Denial:**

7. The University may deny an Individual access without providing the Individual with an opportunity for review if:
   a. The University, acting under the direction of a correctional institution, has denied, in whole or in part, an inmate’s request to obtain a copy of PHI and the University believes that obtaining the PHI would jeopardize the health, safety, security, custody, or rehabilitation of the Individual or of other inmates, or the safety of any officer, employee, or other person at the correctional institution or responsible for transporting the inmate;
   b. An Individual has agreed to the denial of access when consenting to participate in research that includes treatment and the University has informed the Individual that the right of access may be reinstated upon completion of the research;
   c. The PHI is held in records that are subject to the Privacy Act of 1974 (5 U.S.C. § 552a) and the denial of an Individual’s access to PHI meets the requirements described in that law;
   d. The PHI was obtained from someone other than the University under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.

**Reviewable Grounds for Denial:**

8. The University may deny an Individual access, provided that the Individual is given a right to have such denials reviewed, in the following circumstances:
   a. A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the Individual or another person;
   b. The PHI makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or
c. The request for access is made by the Individual’s authorized representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such authorized representative is reasonably likely to cause substantial harm to the Individual or another person.

9. If access has been denied, an Individual has the right to have the denial reviewed by a licensed health care professional who is designated by the University to act as a reviewing official and who did not participate in the original decision to deny access. The University will provide or deny access in accordance with the determination of the reviewing official.

10. If the University has denied access to all or part of the PHI it maintains, the University will:
   a. Give the Individual access to any PHI that has not been denied;
   b. Provide a timely, written denial to the Individual. The denial must be in plain language and contain:
      i. The basis for the denial;
      ii. A description of how the Individual may exercise his/her right to have the denial reviewed by a licensed healthcare professional designed by the University; and
      iii. A description of how the Individual may complain to the University’s Privacy Officer in the Office of Audit, Compliance & Ethics, or to the Secretary of Department of Health and Human Services. The description must include the name, or title, and telephone number of the contact person or office designated to receive these complaints.

11. If the Individual has requested a review of a denial, the University must designate a licensed health care professional, who was not directly involved in the denial to review the decision to deny access. The University must promptly refer a request for review to such designated reviewing official. The designated reviewing official must determine, within a reasonable period of time, whether or not to deny the access. The University must promptly provide a written notice to the Individual of the determination of the designated reviewing official and take other action as required.

12. The University must document and retain the following for a minimum of six (6) years:
   a. The designated record sets that are subject to access by Individuals; and
   b. The titles of the people at the University who are responsible for receiving and processing requests for access by Individuals.
AMENDMENT OF PROTECTED HEALTH INFORMATION

Policy: The University of Connecticut will allow an individual to request amendment of protected health information (PHI) or a record about them for as long as the University maintains the information.

Rationale: To maintain compliance with Title 45 CFR Part 164.526, Amendment of Protected Health Information.

I. General Procedures:

1. The University will consider requests for amending PHI that is created and maintained by its HIPAA-Covered Components.

2. The Individual requesting the amendment must submit the request in writing and provide the reasons for requesting the amendment.

3. The University will normally act on the request within 60 days. If the University is unable to act on the request within 60 days, the University may extend the time by 30 days. If this extension is needed, the University will send a written statement to the Individual who requested the amendment. This statement will provide the reasons for the extension and the expected date for completion.

4. If the University has accepted the amendment, in whole or in part, the University will make a reasonable effort to inform other parties that the information has been amended. Persons who may receive this notification of amendment are:
   a. Persons identified by the Individual as having received his/her PHI and who may need the amendment; or
   b. Persons, including Business Associates of the University, who have previously received the Individual’s PHI and who have relied on the information for the Individual’s benefit.

5. If the University grants the requested amendment, in whole or in part, the University will:
   a. Make the amendment where appropriate;
   b. Inform the Individual that the amendment has been accepted; and
   c. Notify the Individual that the University has or will notify persons who had been given the original information.
6. A request for amendment will automatically be denied if it is subject to any of the following:

a. The PHI was not created by the University, unless the individual provides a reasonable basis to believe that the person or organization that created the PHI is no longer available to act on the requested amendment;
b. It is not part of record created or maintained by the University;
c. It is information compiled in reasonable anticipation, or for use in, a civil, criminal, or administrative action or proceeding;
d. If the information is subject to the Clinical Laboratory Improvement Amendments of 1988 (Title 42 CFR Part 493.3(a)(2));
e. If the PHI was gathered in the course of research and the Individual agreed to denial of access until the completion of research;
f. If PHI was obtained from someone other than an employee of the University under a promise of confidentiality and the University believes this may reveal the source of the information;
g. If a licensed healthcare professional has determined, in the exercise of professional judgment, that the request is reasonably likely to endanger the life or physical safety of the Individual or another person;
h. If the PHI makes reference to another person, and a licensed healthcare professional has determined, in the exercise of professional judgment that the request is reasonably likely to cause substantial harm to that other person;
i. If the request is made by an authorized representative the Individual has assigned, and a licensed healthcare professional has determined, in the exercise of professional judgment, that provision of access to such personal representative is reasonably likely to cause substantial harm to the Individual or another person;
j. If the University is acting under the direction of a correctional institution, the University will deny an inmate’s request to obtain a copy of PHI; or
k. The University will deny the request for the amendment, if it has determined that the PHI is accurate and complete.

Denied Request for Amendment

7. If the University has denied an amendment, in whole or in part, then the following actions will occur:

a. The Individual will be given a timely written denial that will explain why the request was denied;
b. The University will grant the Individual’s request to the information requested, except for what was denied; and
c. The University will inform the Individual of any rights for a review of the denial and a description of how to make a complaint to the HIPAA-Covered Component Director, the University’s Privacy Officer in the
Office of Audit, Compliance & Ethics or the Secretary of the U.S. Department of Health and Human Services.

d. The University will also include in written notice of the denial, the HIPAA-Covered Component Director’s contact’s name, title, and telephone number for more information to address or file a complaint with the HIPAA-Covered Component, or with the University’s Privacy Officer.

8. If the Individual disagrees with the denial of amendment, then:
   a. The Individual may provide a written statement disagreeing with the denial of all or part of a request and the basis of such disagreement.
   b. The Individual has the right to have the denial reviewed. The University will provide a licensed healthcare professional, who did not participate in the original denial to review the new request for review of the denial.
   c. The University will provide a written notice to the Individual of the review findings and other actions, if any required, taken by the University.
   d. The University may prepare a written rebuttal to the Individual’s statement of disagreement. Whenever such a rebuttal is prepared, the University will provide the Individual with a copy.

9. The University will document the record or PHI that is the subject of the disputed amendment and append or otherwise link the Individual’s request for an amendment, the University’s denial of the request, the Individual’s statement of disagreement, if any, and the University’s rebuttal if any. The University will also document the titles or offices responsive for the receipt and processing of requests for amendment. Such documentation will be retained for a minimum of six (6) years from the date the individual made the request to amend.
REQUEST FOR RESTRICTION FOR PROTECTED HEALTH INFORMATION

Policy: The University of Connecticut must permit an Individual to request restrictions on the use or disclosure of protected health information (PHI) to carry out treatment, payment or health care operations. It is not necessary for the University to agree to a requested restriction except as outlined below.

Rationale: To maintain compliance with Title 45 CFR Part 164.522, Rights to request privacy protection for PHI.

I. For Restrictions on Disclosures of PHI to Health Plans:

A. When Granting the Restriction is Required:

The University must permit an Individual to request restrictions on the use or disclosure of PHI (except for covered services for patients covered by Medicaid) when:

1. The disclosure is to the Individual’s health plan for purposes of carrying out payment or health care operations and

2. The PHI pertains solely to healthcare items or services for which the University is paid out-of-pocket in full.

B. Process for Allowing Patient Request:

1. In order to make a request to restrict access to PHI, at the time of service to which the restriction will apply, the Individual will be required to sign the Request: Restrict Disclosure to Health Plan/Termination Form. Signature on this Form documents the Individual’s request for restriction on disclosure of PHI or billing information to his/her health plan for specific services or items, and holds the Individual financially responsible for payment of all charges for those services or items.

2. Payment out of pocket, in full, of the estimated total charges for the restricted services or items must be made at the time of service in order for the University to accept the restriction.

3. Should the Individual not have the funds to pay in full at the time of service, or only an estimated amount is known at the time of service, follow-up collection action will be made by or on behalf of the University to collect from the patient the amount owed on the restricted service.
4. Should failure to collect payment in full occur, the University reserves the right to terminate the agreement pursuant to the procedure outlined in this policy below under the Process for Termination of Restrictions section.

5. The applicable billing offices will assure that no insurance billing takes place for those specific services designated as restricted on the Request: Restrict Disclosure to Health Plan/Termination Form. Services on the same day that have not been restricted will be billed according to regular processes.

6. The original signed Request: Restrict Disclosure to Health Plan/ Termination Form will be maintained in the Individual’s file.

C. Process for Termination of Restrictions:

1. Documentation of the termination is completed on the original Request: Restrict Disclosure to Health Plan/ Termination Form, regardless of whether it is initiated by the Individual or the University.

   a) The original completed Request: Restrict Disclosure to Health Plan/ Termination Form must be obtained from the HIPAA-Covered Component.

   b) The Individual may terminate his/her request for a restriction by signing the Termination section of the original Request: Restrict Disclosure to Health Plan/ Termination Form.

   c) The University may terminate the restriction if after 30 days the Individual fails to pay for the requested restricted services in full. The Individual will be informed via certified letter that the agreement will be terminated effective 30 days from the date of the letter.

2. The effective date of the termination will be as follows:

   a) Termination by the Individual: the date of the Individual’s signature on the Termination section of the Form, OR

   b) Termination by the University: 30 days from the date of the certified termination letter.

3. The University will then update all necessary systems and files to reflect the termination of the agreement. Any prior payment made by
the Individual on the restricted service will be refunded to the Individual and/or moved to other self-pay balances that may exist for that Individual.

II. Request for Restrictions on Disclosure of PHI Other Than to a Health Plan:

A. Permissible Restrictions on Disclosure

1. The University will permit an Individual to request restrictions to the use and disclosure of PHI about the Individual. The University requires Individuals to make requests for restrictions in writing and will inform Individuals of that requirement.

2. When the University agrees to an Individual’s request for restriction of the use and disclosure of PHI about that Individual, the University will not use or disclose PHI in violation of this restriction. If the Individual who requested the restriction is in need of emergency treatment and the restricted PHI is needed to provide the emergency treatment, then the University may nevertheless disclose such information to a health care provider to provide the treatment. The University will request that the agency to which PHI is released does not further use or disclose the information provided.

3. The University may terminate its agreement to a restriction if:
   a) The Individual agrees to or requests the termination in writing;
   b) The Individual orally agrees to the termination and the oral agreement is documented and;
   c) The University informs the Individual it is terminating the agreement and the termination is effective with respect to PHI created or received after the Individual is informed.

4. The University will document restrictions and terminations of restriction that are requested.
REQUEST: RESTRICT DISCLOSURE TO HEALTH PLAN/ TERMINATION

- I request that [INSERT HIPAA-COVERED COMPONENT NAME] not disclose my protected health information (PHI) to my health plan.
- I have read the Patients Right to Restrict Protected Health Information to Health Plan informational letter.
- The records of the restricted services/items listed below will not be released or billed to my health plans for the purposes of payment or health care operations.
- I am financially responsible for these restricted services/items and expect to pay out-of-pocket, in full, at the time of service in order for [INSERT HIPAA-COVERED COMPONENT NAME] to accept this restriction request.

Print Patient Name: _______________________________________________________

Print Patient Address: _______________________________________________________

Requested restriction:

Date of Care: __/__/___ (mm/dd/yyyy) Provider of Care: _________________________

Service/ Item to be restricted: _______________________________________________

Total Charge Amount (or estimated amount): $_____________________

(I understand that I am responsible for full charges when finalized)

Signed by: ___________________________ Date: __/__/___ Time: __: ___ □am □pm

□ Patient   □ Parent/Guardian/Conservator □ Representative (specify): _______________________

Obtained by: ___________________________ Date: __/__/___ Time: __: ___ □am □pm

Termination of Restriction: Sign only if terminating requested restriction above.

You may terminate this restriction by signing the Termination of Restriction below. The [INSERT HIPAA-COVERED COMPONENT NAME] may terminate this restriction by notifying you in writing if you fail to pay in full.

Signed by: ___________________________ Date: __/__/___ Time: __: ___ □am □pm

□ Patient   □ Parent/Guardian/Conservator □ Representative (specify): _______________________

Obtained by: ___________________________ Date: __/__/___ Time: __: ___ □am □pm
REQUEST FOR ALTERNATIVE COMMUNICATION OF PROTECTED HEALTH INFORMATION

Policy: The University of Connecticut will permit an Individual to request that confidential communication of protected health information (PHI) be delivered to alternative locations or by alternative means. The University will accommodate reasonable requests for alternative communications.

Rationale: To maintain compliance with Title 45 CFR Part 164.522 (b), Confidential Communication Requirement.

I. General Provisions:

1. Individuals may request to receive correspondence from (including billing statements) at an address other than their home address.

2. Individuals may request to receive telephone calls at a number other than their home number.

3. HIPAA-Covered Component members may not require an explanation for the Individual’s request.

4. The request that confidential communications be delivered by alternative means or to alternative locations must be made in writing to the HIPAA-Covered Component Director.

5. Individuals will be informed by the HIPAA-Covered Component member entering the alternate information into the HIPAA-Covered Component’s records that the alternative address and/or telephone number will be used for ALL communications between the HIPAA-Covered Component and the Individual.

6. Only the Individual or the Individual’s legally authorized representative with proof of legal representation may request the change to the Individual’s contact information with the HIPAA-Covered Component.

Reference: §164.522 (b) Health Insurance Portability and Accountability Act of 1996
ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

Policy: The University of Connecticut will provide an accounting of disclosures of protected health information (PHI) made by its HIPAA-Covered Components in the six (6) years prior to the date on which the accounting is requested except for disclosures not required by law.

Rationale: To maintain compliance with Title 45 CFR Part 164.528, Accounting of Disclosures of Protected Health Information.

I. General Procedures:

1. The University will provide an accounting of disclosures of PHI made by the University up to six (6) years prior to the date on which the accounting is requested.

2. A request for an accounting of disclosures must be made in writing. It must be signed by the Individual described by the PHI or the Individual’s legally authorized representative. The request should identify the Individual using identifiers from the list shown below:
   a. Name,
   b. Address,
   c. Telephone number,
   d. Clinic/Patient ID number or other client identification number,
   e. Other identifiers, if applicable, for example: maiden name, date of birth, or dates of care.

   The University will normally act on the request within 60 days. If the University is unable to act on the request within 60, the University may extend the time by 30 days. If this extension is needed, the University will send a written statement to the Individual requesting the accounting. This statement will provide the reasons for the extension and the expected date for completion.

3. When preparing an accounting of disclosures, the University will not include disclosures that were made:
   a. For carrying out treatment, payment and health care operations, unless required by law.

   Note: Where required by law, when you request a list of disclosure of PHI that is maintained in an electronic health record, the accounting will be for three (3) years prior to the date of the request, and will include disclosures made for the purposes of treatment, payment and health care operations in addition to those disclosures listed in the University’s policy regarding accounting of disclosures. To request this list of disclosures, you must submit your request in writing to the HIPAA-Covered Component’s Director.
b. To the individual about their PHI;
c. In response to valid authorizations for disclosure;
d. Of data that cannot be associated with a specific individual;
e. For the facility’s directory or to persons involved in the individual’s care;
f. For national security or intelligence purposes;
g. To correctional institutions or law enforcement officials;
h. That occurred prior to the compliance date of HIPAA (April 14, 2003).

Note that the University will not disclose PHI that is not part of the Individual’s record, that is embedded in psychotherapy notes, or that was collected and held in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. No accounting from the University will reference PHI from these sources.

4. For each disclosure included in the Accounting, the University will note:
   a. The date of the disclosure;
   b. The name of the entity or person who received the PHI and, if known, the address of such entity or person;
   c. A brief description of the PHI disclosed; or
   d. A brief statement of the purpose of disclosure or a copy of their authorization.

5. The University will provide the first accounting requested by an Individual within a 12-month period at no charge. If that Individual requests a second accounting within 12 months, the University may charge a cost-based fee for the accounting. The University will inform the Individual if there will be a charge for the accounting and allow the Individual to withdraw the request prior to incurring charges.

6. The University will retain a copy of the request and a copy of the documentation provided to the Individual that includes the title of the person or office responsible for receiving and processing the request for a minimum of six (6) years.
USE and DISCLOSURE OF PROTECTED HEALTH INFORMATION – FUNDRAISING, MARKETING AND SALE

Policy: The University of Connecticut typically does not and will not use protected health information (PHI) for fundraising or marketing purposes. Nor does or will the University typically engage in the sale of PHI. Should the University determine that it is appropriate to do any of these activities, the University will follow all requirements for such activities under HIPAA.

Rationale: To comply with applicable HIPAA requirements when implementing and conducting fundraising, marketing and similar activities.

A. Fundraising

1. The University does not currently, use PHI for fundraising purposes.

   • If the University expects to start fundraising activities, it will not use or disclose PHI for fundraising purposes, unless the use is included in the Notice of Privacy Practices.

   • If the University expects to start fundraising activities, it will describe how to opt out for receiving future fundraising communications in all fundraising materials it sends.

   • If the University expects to start fundraising activities, it will make reasonable effort to ensure that Individuals who decide to opt out are not sent such communications.

B. Marketing

Currently the University does not engage in marketing-related activities. However, should the University begin to do so, a signed authorization will be required for the use or disclosure of PHI for a purpose that encourages the Individual to purchase or use a product or service except for certain limited circumstances such as when the marketing communication is face-to-face or when marketing includes the distribution of a promotional gift of nominal value provided by the University.

C. Sale of PHI

The University will not sell any Individual’s PHI unless the University has received a signed authorization specifying permission from the Individual to do so.
Reference:
§164.514 (f) Health Insurance Portability and Accountability Act of 1996
§164.514(f)(1)(i – vi) as amended by the HITECH Rule 1/25/13
MINIMUM NECESSARY DISCLOSURE OF PHI

Policy: When disclosing protected health information (PHI) to other organizations, the University of Connecticut will provide only the PHI that is necessary for the organization to accomplish the intended use of the data. When receiving PHI from other organizations, the University will rely on those to provide only the information needed to satisfy the University’s needs with regard to that information.

Rationale: To maintain compliance with Title 45 CFR Parts 164.502(b) and 164.514(d), Minimum Necessary Requirements and to provide guidance to members of the University’s HIPAA-Covered Components, directing them how to limit the release of PHI to the minimum necessary to accomplish the intended purpose of any use, disclosure, or request for PHI.

POLICY STATEMENT:

The University will make reasonable efforts to limit use and/or disclosure PHI, or when requesting PHI from another covered entity, limit the scope of the request to the minimum necessary to accomplish the purpose of the use or disclosure or request.

This policy will not apply to:

- Uses by or disclosures to or requests by a health care provider for treatment/care purposes
- Disclosures made to the Individual described by or in the PHI
- Disclosures that are authorized by the Individual described by the PHI
- Uses and disclosures required for compliance with the standardized HIPAA transactions
- To disclosures that are made using “limited datasets” or data that have been “de-identified” so that they can no longer be directly associated with the Individual described by the PHI.
- Disclosures to the U.S. Department of Health and Human Services (DHHS) regarding complaints related to privacy and security
- Other uses or disclosures that are required by law.

A. General Procedures:

1. The University will identify the functional roles of University employees, student, volunteers, affiliates and contractors who work in and/or with the University’s HIPAA-Covered Components and determine the access to PHI that is appropriate for persons working in those roles.

2. The University will make reasonable efforts to limit access to the PHI that is needed to work in each of those roles.
3. The University will take reasonable precautions to make sure that PHI is not overheard or inadvertently provided to bystanders.

4. For any routine or recurring PHI disclosures, the University will limit the disclosures to the minimum amount necessary to achieve the purpose of the disclosure.

5. For all other disclosures, the University will review the requests for disclosure and limit the data provided to the amount that is the minimum necessary to achieve the intended purpose of the disclosure.

B. Minimum Necessary Use of PHI

1. Directors of the University’s HIPAA-Covered Components shall identify members:
   - who need access to PHI to carry out their duties
   - by category or categories of PHI to which access is needed
   - any conditions appropriate to such access

2. Reasonable efforts shall be made to limit members’ access to that which is needed to carry out their duties.

3. Computerized PHI shall be password protected (sharing of passwords is prohibited) and members utilizing computers to access PHI must follow all the directives in the University’s HIPAA Security and other relevant University Security Policies.

C. Acting Upon Request for Disclosure

1. In the following situations, HIPAA-Covered Component members may rely on a person’s requested disclosure as the minimum necessary for the stated purpose in order to disclose the Individual’s PHI:
   - To public officials as required by other laws (if the official represents that the request is for minimum necessary information)
   - To provided information to another health care provider
   - To a professional staff member of the HIPAA-Covered Component or a business associate of the HIPAA-Covered Component in order to provide professional services to the University (if this person represents that the request is for the minimum necessary information)
   - To a person requesting information for research purposes if representations are made by the researcher that comply with IRB requirements under University policy.
2. For disclosures of PHI that the University provides on a routine and recurring basis, the HIPAA-Covered Components involved shall have standard protocols which are followed that limit the PHI disclosed to the minimum necessary.

D. Making Requests

1. HIPAA-Covered Component members must limit any request for PHI to that which is reasonably necessary to accomplish the purposes of the request when asking another health care provider for PHI.

2. For requests for PHI that the University makes on a routine and recurring basis, the HIPAA-Covered Components involved shall have standard protocols which are followed that limit the PHI requested to the minimum necessary.

E. Members of the University’s HIPAA-Covered Components may not use, disclose or request an Individual’s entire record except when the entire record is specifically justified or the amount needed to accomplish the purpose of the use, disclosure or request.

F. In some circumstances minimum necessary information cannot be determined by the University, but by some other entity such as in the case of federally mandated transactions, when an Individual authorizes use or disclosure of more than the minimum necessary, or in the case of judicial warrant, court orders or subpoenas.

G. Whenever possible, the University will determine some method of limiting the information that is used or disclosed. This may involve the use of de-identified data, use of a limited data set, or only granting access to certain parts of the PHI for online viewing, or copying only pertinent parts of the record for disclosure.

H. Each HIPAA-Covered Component will monitor and audit disclosures of PHI periodically to ensure that the minimum necessary data is released appropriately.

I. If it is determined that an access, use or disclosure of PHI does not comply with the minimum necessary standard for the particular access, use or disclosure, this must be reported to the University’s Privacy Officer and/or Security Officer for breach evaluation.

Reference: § 164.514 Health Insurance Portability and Accountability Act of 1996 and as amended by HITECH as of 1/25/13
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Policy: The University of Connecticut will disclose protected health information (PHI) in accordance with the consent, authorization, or other legal permissions from an Individual.

Rationale: To maintain compliance with Title 45 CFR Part 164.506 and 508, Consent and Authorization.

The University may not use or disclose PHI without a valid authorization unless such use and disclosure is otherwise permitted or required under the privacy standard or as required by law.

I. General Procedures:

The University routinely provides Individuals with copies of treatment or summary of care reports at the time of service so that Individuals can disclose the information as they choose. If Individuals provide authorization to the University, the University will disclose information on behalf of the Individuals to other parties.

All requests for review or release of PHI from persons or organizations not associated with a HIPAA-Covered Component must be made in writing and directed to the HIPAA-Covered Component’s Director.

The University will not normally collect a general consent for use and disclosure of PHI. The University will normally require an authorization for any use or disclosure that is outside the scope of Treatment, Payment, or Health Care Operations for the University.

II. Legal Authorizations

A. A legal authorization to release PHI must be in writing, written in plain language and signed by the Individual or his/her legally authorized representative in order for PHI to be released. Use or disclosure to authorized individuals/agencies must be consistent with the authorization.

B. A valid authorization must contain the following core elements/information:
   • Individual’s full name
   • The name of person or class of persons authorized to make the use or disclosure of the PHI
• Description of the information to be used or disclosed (i.e. specific date of service, clinic visit, services provided, etc.)

• Identification of person/agency to whom the University is authorized to make the requested use or disclosure (i.e. name, address).

• Form and format requested:
  If the Individual is requesting records for personal use, the Individual must specify whether he/she prefers to receive copies in paper format or electronic format. Only records maintained electronically will be released in electronic format. The Individual may specify the type of electronic format he/she prefers to receive. The University will comply to the extent possible, with requests for electronic formats selected by the Individual and will work with the Individual to provide the records in a machine readable electronic format as agreed upon by the Individual and the University.

• Description of the purpose for the use or disclosure

• The authorization’s expiration date or expiration event that relates to the Individual or to the purpose or use of the requested disclosure and no longer protected

• A statement of the Individual’s right to revoke the authorization in writing and how this can be done

• A statement that information used/disclosed under the authorization may be subject to re-disclosure by the recipient

• The signature of the Individual or Individual’s authorized representative and date of signature

• A description and or copy of legal paperwork of the representative’s authority to sign (if applicable)

• In addition, it is desirable to have the Individual’s date of birth and address to further correctly identify the Individual

• A statement that treatment, payment, enrollment and eligibility for benefits cannot be conditioned on whether the Individual signs the authorization.

III. Invalid/Defective Authorizations

A. An authorization to use/disclose PHI is not valid if any of the following circumstances are present:

a. The expiration date has passed or the expiration event is known by the University to have occurred

b. The authorization has not been filled out completely with respect to the required core elements
c. The authorization is known to have been revoked in writing

d. Any material information in the authorization is known by the University to be false

B. Defective authorizations will be returned to the requestor with an explanation as to why the authorization will not be honored.

IV. **Revocation of Authorization**

A. Each HIPAA-Covered Component shall provide a means by which an Individual may revoke their authorization for release of PHI.

B. An Individual has the right to revoke an authorization at any time by means of a written revocation, except to the extent that the University has already used or released information while the authorization was still valid.

C. Written revocation must be to the HIPAA-Covered Component Director. The University may not be able to prevent mailings or use of that information that was disclosed prior to the revocation.

D. Upon receipt of the request to revoke authorization, the University will stop the processing of information for use or disclosure to the greatest extent practical (with the exception of information for treatment, payment or health care operations). The University shall not be required to call back any information previously released under a valid authorization.

V. **Documentation of Authorization**

A. Each HIPAA-Covered Component shall document and retain the original or an electronic version of all authorizations for release of PHI on file.

B. Each HIPAA-Covered Component shall keep all revoked authorizations on file along with documentation of any action taken based on the revocation of authorization.

C. A copy of the signed authorization shall be given to the Individual.

VI. **Prohibition on Conditioning Authorizations:**

A. The University’s HIPAA-Covered Components may not condition the provision of treatment, payment, and enrollment in a health plan, or eligibility for benefits on the provision of an authorization, except:

1. The University may condition the provision of research related treatment on provision of an authorization
2. The University may condition the provision of healthcare that is solely for the purpose of creating PHI for disclosure to a third party on acquisition of an authorization to allow such disclosure.

GENERAL PROCEDURES REGARDING AUTHORIZATIONS:

I. Signatures on Authorizations

A. An Individual is required to sign a valid authorization for the release of his/her PHI, except when that information is used for treatment, payment, or health care operations.

B. Circumstances when authorization is required include but are not limited to:
   1. When the Individual has initiated the authorization because he/she wants the University to disclose PHI to a third party
   2. For marketing of health and non-health items and service
   3. For disclosure to a health plan or provider for the purpose of making eligibility or enrollment determinations prior to the Individual’s enrollment in the plan
   4. When disclosing information to an employer for use in employment determinations

C. The University will not disclose PHI to a requestor without first verifying the identity of the requestor and the authority of the requestor to receive the information.

D. Authorizations must be signed by:
   1. The Individual whose PHI is to be released.
   2. If the Individual is deceased, authorization to use or disclose PHI must be signed by the executor or administrator of the deceased’s estate. If an executor of the estate does not exist, the immediate next of kin (in relationship order of spouse, adult child, parent, adult sibling, grandparent) may sign the authorization to release PHI.
   3. If the Individual is a minor age under 18, the parent or legal guardian must sign the authorization for use or disclosure of PHI. If the guardian is not the parent, legal guardianship is required.
   4. Emancipated minors do not require the consent of the parent or guardian. They must supply court documents to prove status of emancipation.
   5. Psychiatric records of minors aged 16-17 require both the minor’s and the parent’s/guardian’s signature on the authorization. If the minor Individual aged 16-17 signs for permission to treat, they are the only person who can authorize the use or disclosure of those records.
   6. Records of minors involving venereal disease, drug abuse, or pregnancy/contraception require the minor’s authorization only.
   7. If the Individual is between 0-18 and is in the custody of the State, required authorization from the Department of Children and Youth
Services and a court certificate of removal from parents is required. If custody is retained by the parents, they are the only individuals who can authorize use or disclosure of the records.

8. If an Individual under the age of 18 is deceased, the parent’s/guardian’s authorization is sufficient (a court certificate is not required).

9. A stepparent may not authorize the release for minor’s records unless the child was adopted. If the child was adopted by the stepparent, proof is required.

10. If a minor is living in a foster home, the foster parent is not necessarily the legal guardian. The University requires proof of guardianship in this case.

11. In the case of divorce, either parent may authorize release of the child’s records. If the parent has lost their parental rights, they are not entitled to authorize use or disclosure of PHI.

12. Authorization to release PHI for HIV/AIDS must be signed by the "protected individual."

E. If the University has obtained an authorization (on the “Authorization to Release Health Information” form) from an Individual and receives any other conflicting authorizations or legal written permission from the Individual for a disclosure of PHI, the University will resolve the conflict by:
   a. Relying on the authorization with the most recent date; or
   b. In the absence of dated authorizations, relying on the most restrictive of the authorizations; or
   c. Contacting the Individual to seek clarification of the preference.

F. The authorization form supplied by the University will include statements indicating that:
   a. An Individual may revoke the authorization;
   b. PHI that is used or disclosed according to an authorization may be subject to re-disclosure by the recipient and no longer protected by Title 45 CFR Parts 160 and 164;
   c. The University will not condition treatment, payment, enrollment in a health plan, or eligibility for benefits on the Individual providing authorization;
   d. The Individual may inspect or copy information to be used or disclosed;
   e. The Individual may refuse to sign the authorization; and
   f. If use or disclosure of the information will result in direct or indirect payment to the University from a third party, a statement saying that such payment will result.
II. **Specific Procedures:**

1. When an authorization is received,
   a. The administrative staff will verify that the authorization:
      i. Is in writing. They may be written on the form provided by the University’s HIPAA-Covered Component (“Authorization to Release Health Information”) or they may be letters that includes the same information.
      ii. Covers only the uses and disclosures and only the PHI stipulated in the authorization;
      iii. Has an expiration date or event;
      iv. States the purpose for which the information may be used or disclosed;
      v. Specifies the recipient of the information;
      vi. Specifies the University as the institution releasing the information;
      vii. Is signed by the patient or legal representative of the patient (and if signed by the legal representative, contain a description of the representative’s authority to act for the patient);
      viii. Is dated after the date of care or service; and
      ix. Is not older than six (6) months.
   b. The administrative staff will then
      i. Place a copy of the authorization in the Individual’s file;
      ii. Provide the Individual with a copy of the authorization;
      iii. Disclose the information as authorized.

2. When a request to revoke an authorization is received,
   a. The administrative staff will verify that the request for revoking authorization:
      i. Is in writing;
      ii. Clearly identifies the authorization to be revoked or states that all current authorizations are to be revoked;
      iii. Is signed by the Individual or the Individual’s legally authorized representative(and if signed by the legal representative, contain a description of the representative’s authority to act for the Individual);
      iv. Is dated after the authorization(s) to be revoked.

References:
- §164.508 Health Insurance Portability & Accountability Act of 1996
- HITECH Rule Section 13405(e) as outlined 1/25/13 in § 164.524 (c) (2) (i)
Authorization to Obtain and/or Disclose Health Information Form

1.) I hereby authorize the UCONN Fire Department to disclose and/or obtain my individually identifiable health information as described here to the person/organization named below. I understand that this authorization is voluntary and that it may include information relating to AIDS, HIV infection, behavioral health services / psychiatric care, treatment for alcohol and/or drug abuse.

<table>
<thead>
<tr>
<th>PATIENT’S NAME:</th>
<th>DATE OF BIRTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS:</td>
<td>EMAIL:</td>
</tr>
<tr>
<td>CITY:</td>
<td>STATE:</td>
</tr>
<tr>
<td>PHONE #:</td>
<td>FAX #:</td>
</tr>
</tbody>
</table>

2.) Date of Service:__________

3.) Town of Service:___________________

4.) Address of Service:_________________ 

5.) Information to be disclosed  □  or to be obtained□
   □ Patient Care Report(s)   □ Dispatch Records   □ Verbal Discussion of Patient Care
   □ Other (Please Specify):-

6.) Please **DO NOT** release the following information:

7.) I am requesting that this information be disclosed □  or obtained □ for the purpose of (i.e. Legal reasons, continued care, insurance, another medical opinion, Worker’s compensation, research, personal use, Social Security): ________________

8.) Name of the person(s) / organization(s) to whom the disclosure is to be made □  or to whom the information is to be released to □. If the disclosure is made to or released to more than one person/organization for the same purpose, more than one entry may be made below.

<table>
<thead>
<tr>
<th>PERSON/ORGANIZATION #1 - NAME</th>
<th>PHONE #</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS</td>
<td></td>
</tr>
<tr>
<td>FAX #</td>
<td></td>
</tr>
<tr>
<td>CITY</td>
<td>STATE</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PERSON/ORGANIZATION #2 - NAME</th>
<th>PHONE #</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS</td>
<td></td>
</tr>
<tr>
<td>FAX #</td>
<td></td>
</tr>
<tr>
<td>CITY</td>
<td>STATE</td>
</tr>
</tbody>
</table>
8.) Method to disclose or obtain information (Check all that apply):

- [ ] Facsimile to: [ ] Person/Organization #1 [ ] Person/Organization #2
- [ ] US Mail to: [ ] Person/Organization #1 [ ] Person/Organization #2
- [ ] Email to: [ ] Person/Organization #1 [ ] Person/Organization #2
- [ ] To be picked up by (Name and relationship to patient of individual authorized to pick up record(s) being released from the facility):

9.) I understand this authorization may be revoked in writing to the Chief of Department at any time, except to the extent that action has already been taken in reliance on this authorization. This authorization shall automatically expire 6 months from the date of signature unless otherwise specified in the space provided here. DATE OF EXPIRATION:

10.) I understand that I may inspect and copy the information to be used and disclosed under this authorization and that I may receive a copy of this signed authorization form. There may be a fee associated with copying, not to exceed what Connecticut State law authorizes.

11.) UCONN Fire Department, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

12.) In cases where UCONN Fire Department is requested by a third party to create health information solely for the purpose of sharing that information with the party that requested it, I understand that I must sign this authorization.

13.) Notice to Recipients: As the recipient of this information, you may use this information only for the stated purpose. You may disclose this information to another party ONLY:

- [ ] With written authorization from the patient or his or her legal representative
- [ ] As required or authorized by state and / or federal law; or
- [ ] If urgently needed for the patient’s continued care.

If this disclosure contains information relating to HIV, behavioral health, alcohol or drug abuse education, training, treatment, rehabilitation, or research, the following shall apply: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (Title 42 CFR Part 2) and Connecticut General Statutes (Ch. 368x) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

14.) Notice to Individual Requesting the Disclosure:

Your signature below indicates that you understand that if the organization authorized to receive the information is not a health care provider or health plan, and the information disclosed is NOT protected by Title 42 CFR Part 2 and Ch. 368x, then the released information may no longer be protected by the HIPAA Federal Privacy Regulations.

Printed Name of Patient:____________________________________________
Signature of Patient or Legal Representative:____________________________________________ Date:____________________

Printed name of Legal Representative *:_____________________________ Relationship to patient:________________________
(* A copy of the personal representative's legal authority to act on behalf of the patient must be attached.)

Signature of Individual Picking up Record:____________________________ Relationship to patient:_________________________

For Department Use Only

<table>
<thead>
<tr>
<th>Date</th>
<th>Check identification</th>
<th>Charges:</th>
<th>Copy of Authorization was provided to patient</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Processed by (UCONN Fire Representative):____________________________ Date:____________________
AAG Approval:____________________________ Date:____________________

Form Version 1.1 Date: 5/1/2012
AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ___________________________ Date of Birth: ___________________________

I request and authorize Nayden Rehabilitation Clinic to release healthcare information of the patient named above to:

Name: ________________________________________________________________

Address: ____________________________________________________________________________

City: __________ State: _______ Zip Code: __________

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: __________________________

☐ All healthcare information

☐ Other: ______________________________________________________________________________

☐ Yes  ☐ No I authorize the release of my entire medical record, to the person(s)/entity listed above. I understand that the person(s)/entity listed above will be notified that I must give specific written permission before disclosure of results to anyone.

Patient Signature: ___________________________ Date Signed: ___________________________
This authorization regarding the use and/or disclosure of your protected health information is required under Federal laws.

I hereby authorize the University of Connecticut Speech & Hearing Clinic to use and/or disclose my individually identifiable health information as described below. I understand that this authorization is voluntary and that it may include information relating to AIDS, HIV infection, behavioral health services/psychiatric care, treatment for alcohol and/or drug abuse. I understand that, if the organization authorized to receive the information is not a health plan or healthcare provider; the released information may no longer be protected by Federal privacy regulations. I understand that I need not sign this authorization to ensure treatment and that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules.

I understand that:

- I may see and copy the information, in my medical record, in accordance with policies of the Speech & Hearing Clinic and that there may be a fee associated with copying.
- this authorization may be revoked, in writing, at any time, except to the extent that action has already been taken in reliance on this authorization.
- if I have questions about the disclosure of my health information, I may contact the Director of the University of Connecticut Speech & Hearing Clinic.

I give permission for you to communicate with the following individuals and to provide written information at my request. Your referring physician is recommended. Additional names may be added on the reverse side.

1. Name: _____________________________________________ Relationship: ________________________________
   Address: ___________________________________________________________________________________
   E-Mail Address: _______________________________ Phone 1: __________________ Phone 2: ____________________

2. Name: _____________________________________________ Relationship: ________________________________
   Address: ___________________________________________________________________________________
   E-Mail Address: _______________________________ Phone 1: __________________ Phone 2: ____________________

I hereby certify that I have read the provisions set forth in this authorization and I understand and agree to its terms. This agreement will be in effect for one year from date of signature.

Client’s Signature (if 18 & older) __________________________ Date __________________________

Parent/Guardian/Representative Signature __________________________ Date __________________________

Relationship to Patient ___________________________________________________________________________

The Clinic, its employees, officers, and staff are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

7/2012; Revised 9/11/12
3. Name: _____________________________________________ Relationship: ______________________________
   Address: ___________________________________________________________________________________
   E-Mail Address: __________________________ Phone 1: __________________ Phone 2: _________________
   Signature________________________________________ Date ______________________

4. Name: _____________________________________________ Relationship: ______________________________
   Address: ___________________________________________________________________________________
   E-Mail Address: __________________________ Phone 1: __________________ Phone 2: _________________
   Signature________________________________________ Date ______________________

5. Name: _____________________________________________ Relationship: ______________________________
   Address: ___________________________________________________________________________________
   E-Mail Address: __________________________ Phone 1: __________________ Phone 2: _________________
   Signature________________________________________ Date ______________________

6. Name: _____________________________________________ Relationship: ______________________________
   Address: ___________________________________________________________________________________
   E-Mail Address: __________________________ Phone 1: __________________ Phone 2: _________________
   Signature________________________________________ Date ______________________
USE and DISCLOSURE OF PROTECTED HEALTH INFORMATION – OPPORTUNITY TO AGREE OR OBJECT

Policy: For certain types of use and disclosure of protected health information (PHI), the University will inform an Individual in advance of the use or disclosure and give the Individual an opportunity to prohibit or restrict the use or disclosure.

Rationale: To maintain compliance with Title 45 CFR Part 164.510, Opportunity to Agree or Object.

I. General Provisions:

1. The University does not maintain a directory of its clients or patients since there are no in-patient services available at the University.

2. The University may use or disclose PHI to notify, or assist in the notification of (including identifying or locating), a family member, a personal representative of the Individual, or another person responsible for the care of the Individual of the Individual’s location, general condition, or death.

II. Specific Procedures:

1. Procedure to disclose PHI to a family member or a personal representative of an Individual.
   a. If the Individual is present, and has the capacity to make health care decisions, a member of the HIPAA-Covered Component’s staff will:
      i. Inform the Individual of the need for the disclosure,
      ii. Provide the Individual an opportunity to object or agree to the disclosure or reasonably infer from the circumstances that the Individual does not object.
      iii. Note the agreement or objection in the Individual’s file.
      iv. If agreement, make the disclosure and note the information disclosed in the Individual’s file.
   b. If the Individual is not present or does not have the capacity to agree or object to the use or disclosure, a member of the HIPAA-Covered Component’s staff will:
      i. Exercise professional judgment to determine whether the disclosure is in the best interests of the Individual.
      ii. Note the inferred agreement or objection in the Individual’s file.
      iii. If agreement, make the disclosure and note the information disclosed in the Individual’s file.
USE and DISCLOSURE OF PROTECTED HEALTH INFORMATION – WHERE OPPORTUNITY TO AGREE OR OBJECT IS NOT REQUIRED

Policy: For certain types of use and disclosure of protected health information (PHI), the University of Connecticut may make the disclosure without informing an Individual in advance of the use or disclosure or giving the Individual an opportunity to prohibit or restrict the use or disclosure.

Rationale: To maintain compliance with Title 45 CFR Part 164.512, Disclosure Without Authorization.

I. General Provisions:

For Public Health Activities

1. The University may disclose PHI without de-identification if it will be used for public health activities and purposes by:
   - A public health authority that is authorized to receive PHI for the purpose of preventing or controlling disease, injury, or disability. This includes but is not limited to the reporting of disease, injury, vital events (birth, death, etc.) and the conduct of public health surveillance;
   - A public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect;
   - A person responsible for tracking the quality, safety, or effectiveness of products or activities regulated by the Food and Drug Administration;
   - A person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if the University or a public health authority is authorized by law to notify such person;
   - An employer, if the Individual is a member of that employer’s workforce and the PHI will be used to determine whether the Individual has a work-related illness or injury.

For Victims of Abuse, Neglect, or Domestic Violence

2. The University may disclose PHI about an individual:
   - That the University reasonably believes to be a victim of abuse, neglect, or domestic violence to a government authority, including a social service or protective services agency, authorized to receive
reports of abuse, neglect, or domestic violence. If the University makes this disclosure, the University may inform the Individual that such a report has been made, but will not if:

a) the University believes informing the Individual would place the Individual at risk of serious harm; or

b) The University would be informing a personal representative, and reasonably believes the personal representative is responsible for the abuse, neglect, or other injury.

- As required by law including laws that require the reporting of certain types of wounds or other physical injuries, or

- In compliance with and as limited by the relevant requirements of:
  - A court order or court-ordered warrant, or a subpoena or summons issued by a judicial officer;
  - A grand jury subpoena; or
  - An administrative request, including an administrative subpoena or summons, a civil or an authorized investigative demand, or similar process authorized under law, provided that:
    - The information sought is relevant and material to a legitimate law enforcement inquiry;
    - The request is specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought; and
    - De-identified information could not reasonably be used.

For Health Oversight Activities

3. The University may disclose PHI to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight.

For Judicial and Administrative Proceedings

4. The University may disclose PHI in the course of any judicial or administrative proceeding:
   - In response to an order of a court or administrative tribunal, provided that the University discloses only the PHI expressly authorized by such order; or
In response to a subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court or administrative tribunal, if the University receives satisfactory assurance from the party seeking the information:

- That reasonable efforts have been made to ensure that the Individual who is the subject of the PHI has been given notice of the request; or
- That reasonable efforts have been made to secure a protective order that prohibits use of the PHI for any purpose other than the litigation and requires that the PHI be returned or destroyed at the end of the proceedings.

If the University receives documentation demonstrating that:

- The party requesting the PHI of an Individual has made a good faith attempt to provide written notice of the request to the Individual (or, if the Individual’s location is unknown, to mail a notice to the Individual’s last known address);
- The notice includes sufficient information, in the opinion of the Director, about the litigation or proceeding for which the PHI is requested to permit the Individual to raise an objection to the court; and
- The time for the Individual to raise objections to the court or administrative tribunal has elapsed, and:
  - No objections were filed; or
  - All objections filed by the Individual have been resolved by the court and the PHI disclosures being sought are consistent with such resolution.
- The parties to the dispute have agreed to an order that protects the PHI and have presented it to the court with jurisdiction over the dispute.

For Law Enforcement Activities

5. The University may disclose PHI in response to a law enforcement official’s request for such information for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person. The University will disclose only the following information (if it is available):

- Name and address;
- Date and place of birth;
- Social security number;
- Type of injury;
- Date and time of treatment;
Other information that is less commonly kept by the University:

- ABO blood type and rh factor;
- Date and time of death; and
- Description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars, and tattoos.

6. The University may disclose PHI in response to a law enforcement official’s request for such information about an Individual who is a victim or is suspected to be a victim of a crime other than disclosures for public health activities or victims of abuse, neglect or domestic violence, if:
   - The Individual agrees to the disclosure; or
   - The University is unable to obtain the Individual’s agreement because of incapacity or other emergency circumstance, provided that:
     - The law enforcement official states that such information is needed to determine whether a violation of law by a person other than the victim has occurred, and such information is not intended to be used against the victim;
     - The law enforcement official states that waiting until the Individual is able to agree to the disclosure would materially and adversely affect immediate law enforcement activity that depends upon the disclosure; and
     - The disclosure is in the best interests of the individual as determined by the University.

7. The University will disclose PHI about an Individual who has died to a law enforcement official for the purpose of alerting law enforcement of the death of the Individual if the University has a suspicion that such death may have resulted from criminal conduct.

8. The University will disclose PHI to a law enforcement official when the University believes that the PHI constitutes evidence of criminal conduct that occurred on the premises of the University.

9. The University may disclose PHI to a law enforcement official if such disclosure appears necessary to alert law enforcement to:
   - The commission and nature of a crime;
   - The location of such crime or of the victim(s) of such crime; and
   - The identity, description, and location of the perpetrator of such crime.
For Decedents

10. The University will disclose PHI to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law.

11. The University may disclose PHI to funeral directors, as necessary to carry out their duties with respect to the decedent. If necessary for funeral directors to carry out their duties, the University may disclose the PHI prior to, and in reasonable anticipation of, the Individual’s death.

For Threats to Health or Safety

12. The University is permitted to use and disclose PHI, if the University believes the use or disclosure:
   - Is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and
   - Is made to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat; or
   - Is necessary for law enforcement authorities to identify or apprehend an individual.

13. The University is not permitted to use or disclosure the PHI, if the information is learned by the University:
   - In the course of treatment, counseling, or therapy to affect the propensity to commit the criminal conduct that is the basis for the disclosure; or
   - Through a request by the Individual to initiate or to be referred for the treatment, counseling, or therapy.

For Research

14. The University may use or disclose PHI for research, provided that the University adheres to University policies and procedures regarding use of human subjects data for research purposes. These policies are developed and monitored by the University’s Institutional Review Board (IRB). The IRB applies the set of federal regulations, state laws, and other University policies that pertain to data used in human subjects research at the University of Connecticut. Additional information is available at the IRB’s web site (www.irb.uconn.edu).

For Workers’ Compensation Activities

15. The University may use or disclose PHI as necessary to comply with laws related to workers’ compensation or similar programs that provide benefits for work-related injuries or illness.
For Specialized Government Functions

16. The University may disclose PHI as necessary for Individuals who are members of the U.S. Armed Forces when that information is needed to assure proper execution of military missions.

17. The University may use or disclose PHI as necessary to authorized federal officials for the conduct of national security activities that are authorized by the National Security Act.

18. The University may use or disclose PHI as necessary to authorized federal officials for the provision of protective services to the President of the United States or other heads of state as authorized by law.
USE and DISCLOSURE OF PROTECTED HEALTH INFORMATION – DE-IDENTIFICATION

Policy: The University is permitted to use PHI that has been de-identified under certain circumstances. De-identified information is defined as information that has been stripped of any personalization so that it cannot be linked to any Individual or be re-identified.

Rationale: To maintain compliance with Title 45 CFR Part 164.514 and define what is not considered individually identifiable health information.

I. General Provisions:
   A. De-Identification of PHI

   1. The University will determine PHI is not individually identifiable health information if:
      a. A person with appropriate experience with statistics and methods for recognizing that information is not individually identifiable finds that the risk is very small that the information could be used to identify an Individual who is described by the information and documents the methods and results of the analysis that justify such determination; or
      b. The following identifiers of the Individual or of relatives, employers, or household members of the Individual, are removed:
         1) Name;
         2) Address (including street address, city, county, zip code). The initial three digits of a zip code may be used if, according to the current publicly available data from the Bureau of Census: 1) the area formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and 2) the initial three digits of a zip code for a region containing 20,000 or fewer people is changed to 000;
         3) All elements of dates (except year) for dates directly related to an individual (birth date, admission date, discharge date, date of death), and all ages over 89 and all elements of dates (including year) indicative of such age, except that ages and elements may be aggregated into a single category of age 90 or older;
         4) Telephone and fax numbers;
         5) Electronic mail addresses;
         6) Social security numbers;
         7) Medical record numbers;
         8) Health plan beneficiary numbers;
9) Account numbers (bank, retirement, credit card, etc);
10) Certificate/license numbers;
11) Vehicle identifiers and serial numbers, including license plates;
12) Device identifiers and serial numbers;
13) Web Universal Resource Locators (URL);
14) Internet Protocol (IP) address numbers;
15) Biometric identifiers including finger prints and voice prints;
16) Full face photographic images and comparable images; and
17) Any other unique identifying number, characteristic or code, unless assigned by the University and provided that the code is not derived from or related to information about the individual and is not otherwise capable of being translated to identifiable information and the University does not disclose the mechanism for re-identification or use the code for any other purpose; and

c. The University does not have actual knowledge that the information could be used alone or in combination with other information to identify an Individual who is the subject of the information.

B. Uses and Disclosures of de-identified PHI:

1. Uses and disclosures to create de-identified information:

   The University may use PHI to create de-identified information or disclose PHI only to a business associate who creates de-identified information, whether or not the de-identified data is to be used by the University.

2. Uses and disclosures of de-identified information:

   Health information that meets the standard above is considered de-identified, and is not subject to the policy on use and disclosure of PHI, provided that:

   i. Disclosure of a code or other means of record identification designed to enable coded or otherwise de-identified information to be re-identified constitutes disclosure of PHI; and

   ii. If de-identified data is re-identified, the University may use or disclose such re-identified information only as permitted or required by the policy on use and disclosure of PHI.
Reference: §164.502(d), §164.514(a-c), Health Insurance Portability and Accountability Act of 1996
USE and DISCLOSURE OF PROTECTED HEALTH INFORMATION – LIMITED DATA SETS

Policy: The University is permitted to use or disclose PHI as a limited data-set for purposes of public health, research, and health care operations if the University enters into a Data Use Agreement with the recipient. Limited data-set use and disclosure must be limited to that reasonably necessary to achieve the purpose of the disclosure per minimum necessary guidelines.

Rationale: To comply with applicable HIPAA regulation regarding limited data sets.

I. LIMITED DATA-SET CREATION

A. A limited data-set must remove all direct identifiers of the Individual or of relatives, employers, or household members of the Individual, as follows:

- name;
- social security number;
- postal address, other than town or city, state and zip code;
- e-mail address;
- telephone and fax numbers;
- certificate/license numbers;
- vehicle identifiers and serial numbers, including license plate numbers;
- URLs and IP addresses;
- full face photos and any other comparable images;
- health record numbers, patient numbers, health plan beneficiary numbers, and other account numbers;
- device identifiers and serial numbers; and
- biometric identifiers, including finger and voice prints.

B. A limited data-set may include the following (potentially identifying) information:

- treatment and/or service dates;
- birth or death dates;
- age (including 90 and over) expressed in years, months, days or hours;
- five-digit zip code or any other geographic subdivision, such as state, county, city
- precinct, and their equivalent geocodes (except street address);
- gender;
- race; and
- treatment information.

II. DATA USE AGREEMENT

19-Use and Disclosure-Limited Data Sets.doc
Effective 4/2003; Revised & Implemented as separate policy 8/2014
The University must condition the disclosure of the limited data-set on execution of a “Data Use Agreement” with the recipient of the limited data-set. A Data Use Agreement between the University and the recipient must:

a. establish the permitted uses and disclosures of the limited data-set by the recipient, consistent with the purposes of research, public health, or health care operations;
b. limit who can use or receive the data; and
c. provide that the recipient will:
   • not use or further disclose the information other than as permitted by the Data Use Agreement or as otherwise required by law;
   • use appropriate physical, technical and administrative safeguards to prevent use or disclosure of the limited data-set other than as provided for in the Data Use Agreement;
   • report to the University any use or disclosure of the information not provided for by the Data Use Agreement of which it becomes aware;
   • ensure that any agents, including a subcontractor, to whom it provides the limited data-set agrees to the same restrictions and conditions that apply to the limited data-set recipient with respect to such information;
   • not identify the information or contact the individuals; and
   • not use or further disclose the information in a manner that would violate HIPAA requirements.

The University may use PHI to create limited data sets or disclose PHI to a business associate for such purpose whether or not the limited data set is used by the University.

III. COMPLIANCE

Any material breach, pattern of activity or violation of the Data Use Agreement by the recipient must be reported to the University’s Privacy Officer in the Office of Audit, Compliance and Ethics (OACE). The University will then take reasonable steps to cure the breach or end the violation, as applicable. If such steps are unsuccessful the University will:

a. discontinue disclosure of PHI to the recipient; and
b. report the problem to the Secretary of Health and Human Services.
Reference: §164.514 (e)(f) Health Insurance Portability and Accountability Act of 1996 and as amended by HITECH on 1/25/13
Policy: It is the policy of the University of Connecticut to make all efforts to prevent data breaches of protected health information (PHI), and to properly report and respond to breaches when they occur.

Rationale: The University’s policies regarding the privacy and security of PHI reflect its commitment to protecting the confidentiality of Individual health records, account information, clinical information from management information systems, confidential conversations, and any other sensitive material as a result of doing business in our HIPAA-Covered Components and beyond. While a commitment to privacy and security of PHI is an expectation, there remains a possibility that an inappropriate or unintended disclosure of PHI may result in a data breach. This policy will determine the procedure to mitigate all breaches, both willful violations and unintended actions, consistent with guidance described by the HIPAA and HITECH rules.

POLICY STATEMENT:

1. PHI is confidential and must be treated with respect and care by any person with access to this information. Any violation or breach of confidentiality by members of the University’s HIPAA-Covered Components is subject to formal discipline up to and including termination as set forth in this policy. Policy guidelines shall be observed by the entire organization, and sanctions applied fairly and consistently to all persons in violation of the policies.

2. This policy covers the following:

   A) Definition of breach
   B) Required reporting process for breaches
   C) Investigation process followed
   D) Disciplinary sanctions and appeals
   E) The University’s duty to mitigate damages created by breaches
   F) Documentation requirements of these processes
   G) Other Examples

A. Breach Defined

A “Breach” means unauthorized acquisition, access, use or disclosure of PHI in a manner not permitted by the HIPAA privacy rule, which compromises the security or privacy of that information
“Access” means the ability to read, write, modify or communicate data in any form or otherwise use any system resource

“Breach” does not mean:

- Unintentional acquisition or use in good faith within the course and scope of employment by someone authorized to access PHI and the information is not further used or disclosed in a way that is inconsistent with the requirements of the HIPAA Privacy or Security Rule, or

- Inadvertent disclosure by an authorized person to another authorized person within the same Covered Entity or Business Associate and the information is not further used or disclosed in a way that is inconsistent with the requirements of the HIPAA Privacy or Security Rule, or

- A disclosure of PHI where a Covered Entity or Business Associate has a good faith belief that an unauthorized person who receives the information would not reasonably have been able to retain such information.

- Examples of a Breach (this is not an all-inclusive list):
  - Authorized user accesses a patient’s information without a functional “need to know”
  - Release of patient information to an outside party for any unauthorized purpose – examples may include releases to the media, to relatives or friends of a patient, or sale of PHI
  - Electronic hacking or theft of patient file or database
  - “Dumpster diving” and finds PHI
  - Unauthorized user using another authorized person’s ID/password to access patient information
  - Unauthorized access to PHI, paper or electronic, that is neither protected by encryption nor properly destroyed.

Other examples of violations of privacy and security of PHI are included at the end of this Policy. It is important to note that some violations may rise to the level of breach as defined by the HITECH Law.

**B. Initial Reporting Responsibilities:**

1. Anyone who is aware of or suspects a violation of privacy/security policy or a breach of patient/client information is required to report it immediately to:

   - The HIPAA-Covered Component Director
BREACH PREVENTION AND RESPONSE: REPORTING REQUIREMENTS, SANCTIONS & MITIGATION

- Department Head or Manager of the area in which the individual works
- Assistant or Associate Dean or Dean of Appropriate School

Reports of suspected breaches and/or security incidents may also be made to:

- The University’s Privacy Officer, or
- The University’s Chief Information Security Officer (CISO), or
- The confidential REPORTLINE at 1-888-685-2637

These individuals shall immediately perform an initial review utilizing the “Suspected Breach Analysis Form.”

Supervisors/managers and/or the University Privacy Officer/CISO shall start from the presumption that the security incident and/or suspected breach that has been identified constitutes a reportable breach under the HIPAA/HITECH Act unless they are able to demonstrate and document that there is a low probability that the PHI has been compromised. The supervisors/managers and/or the University Privacy Officer/CISO shall conduct the following risk assessment by assessing for specific factors and document the result on the “Suspected Breach Analysis Form:”

i. To whom the information was impermissibly disclosed;
ii. Whether the information was actually accessed or viewed;
iii. The potential ability of the recipient to identify the subjects of the data; and
iv. Whether the recipient took appropriate mitigating action.

Once the initial review by the above supervisor/manager has been completed and documented, the supervisor/manager shall immediately submit the completed “Suspected Breach Analysis Form” to the University’s Privacy Officer. The University’s Privacy Officer shall maintain copies of the “Suspected Breach Analysis Forms” for a minimum of six (6) years from the date of the form.

2. **Bad Faith Reports:** Reporting a violation or breach in bad faith or for malicious reasons may be interpreted as a misuse of the reporting mechanism(s) and may result in disciplinary action.
C. Investigations of Reported Breaches:

1. All reported violations, suspected breach violations and security incidents will be assessed by the University’s Privacy Officer and/or CISO and may be escalated to the attention of the University’s Security Breach Team where appropriate.

2. When applicable, the Security Breach Team will invoke the Security Breach Protocol which outlines the necessary steps to take in the event that any confidential or restricted data is compromised.
   a. This Protocol includes assembling key University stakeholders and is also used to review the contents of completed “Suspected Breach Analysis Forms,” the investigation into the matter completed by the University Privacy Office, CISO and/or relevant staff, and the risk assessment completed as part of that review and as identified under the HIPAA/HITECH regulations, as amended.

3. Information pertaining to investigations of breaches will only be shared with those who have a need to know. Confidentiality of all participants in the reported situation shall be maintained to the extent reasonably possible throughout any resulting investigation. The University’s Privacy Officer, CISO and relevant staff will conduct the necessary and appropriate investigation commensurate with the level of breach and the specific facts. This investigation may include, but is not limited to, interviewing the individuals involved, interviewing other individuals, obtaining specific facts surrounding the violation/breach and reviewing pertinent documentation.

D. Disciplinary Sanctions and Appeals:

1. When a violation/breach is verified, existing University procedures for disciplinary action shall be utilized; For example:
   a. If the individual responsible for the violation/breach belongs to a collective bargaining union, the Office of Faculty & Staff Labor Relations (OFSLR) and union representation will be involved.

   b. If the individual responsible for the violation/breach is a faculty member or non-faculty professional, the process followed will be as outlined under applicable by-laws.

2. Sanctions may include, but are not limited to:
BREACH PREVENTION AND RESPONSE: REPORTING REQUIREMENTS, SANCTIONS & MITIGATION

- Counseling
- Oral Warning
- Written Warning
- Suspension
- Termination

3. Disciplinary sanctions and appeals are handled in accordance with applicable University procedures, depending on the type of workforce member being disciplined.

4. If the individual responsible for the violation/breach is a Business Associate, the University will take reasonable corrective steps in accordance with the Business Associate Agreement signed between the University and the Business Associate. The University reserves the right to terminate contracts if it becomes clear that the business partner cannot be relied upon to maintain the privacy/security of information we provide to them.

E. Duty to Mitigate:

1. The University maintains this policy for mitigating to a practical extent, harmful or injurious effects of unauthorized access, use or disclosure of all forms of protected health information (paper, electronic, or oral). The Security Breach Team makes a recommendation to the appropriate department head for corrective action.

2. The University Privacy Officer, CISO and/or Security Breach Team shall be prepared to contact law enforcement, regulatory, accreditation, and licensure bodies as necessary, appropriate and/or required by law in order to properly report and mitigate policy and or law violations.

F. Notification of Breach

Where the risk analysis leads the University to the determination that a reportable breach has occurred, the University will follow appropriate and applicable notification standards.

1. Notification to Individuals

a. Where appropriate and/or required, the University shall notify each Individual whose unsecured PHI has been, or is reasonably believed by the University to have been accessed, acquired, used, or disclosed as a result
of a breach. The University will provide the required notification without unreasonable delay and in accordance with timelines required by law.

b. The required notification shall be written in plain language and shall include, to the extent possible and/or permitted by law:

(1) A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known;

(2) A description of the types of unsecured PHI that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);

(3) Steps Individuals should take to protect themselves from potential harm resulting from the breach;

(4) A brief description of what the University has done/is doing to investigate the breach, to mitigate harm to Individuals, and to protect against any further breaches; and

(5) Contact procedures for Individuals to ask questions or learn additional information.

c. The required notification to Individuals shall be provided in the following form:

(1) Written notification by first-class mail to the Individual at the last known address of the Individual or, if the Individual agrees to electronic notice and such agreement has not been withdrawn, by electronic mail. The notification may be provided in one or more mailings as information is available.

(2) If the University knows the Individual is deceased and has the address of the next of kin or authorized representative of the Individual, written notification by first-class mail to either the next of kin or authorized representative of the Individual. The notification may be provided in one or more mailings as information is available.

(3) In the case in which there is insufficient or out-of-date contact information that precludes written notification to the Individual, a substitute form of notice reasonably calculated to reach the individual shall be provided. Substitute notice need not be provided in the case in which there is insufficient or out-of-date contact information that precludes written notification to the next of kin or authorized representative of the Individual. Substitute notice must consist of all of the following:
2. Notification to the Media

For a breach of unsecured PHI involving more than 500 residents of a State or jurisdiction, the University will notify prominent media outlets serving the State or jurisdiction within the timeline required by law. The required notification shall be written in plain language and shall include, to the extent possible:

(1) A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known;

(2) A description of the types of unsecured PHI that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);

(3) Steps individuals should take to protect themselves from potential harm resulting from the breach;

(4) A brief description of what the University is doing to investigate the breach, to mitigate harm to Individuals, and to protect against any further breaches; and

(5) Contact procedures for Individuals to ask questions or learn additional information.

3. Notification to the Secretary of DHHS

A University will, in accordance with the breach notification requirement of the HIPAA/HITECH Act, notify the Secretary of the U.S. Department of Health and Human Services (DHHS) of breach.
For breaches of unsecured PHI involving 500 or more Individuals, the University shall provide notification to the Secretary contemporaneously with the notice provided to Individuals and in the manner specified on the HHS Web site.

For breaches of unsecured PHI involving less than 500 Individuals, the University shall maintain a log and/or other documentation of such breaches and, not later than 60 days after the end of each calendar year, provide the notification to the Secretary for breaches occurring during the preceding calendar year, in the manner specified on the HHS Web site.

4. Law Enforcement Delay

If a law enforcement official states informs the University that a required notification, notice, or posting would impede a criminal investigation or cause damage to national security, the University will:

(1) If the statement is in writing and specifies the time for which a delay is required, delay such notification, notice, or posting for the time period specified by the official; or

(2) If the statement is made orally, document the statement, including the identity of the official making the statement, and delay the notification, notice, or posting temporarily and no longer than 30 days from the date of the oral statement, unless a written statement as described in paragraph (1) is submitted during that time.

5. Notification to Consumer Reporting Agencies

If the University discovers a breach of security of electronic PHI that requires notification to more than 1,000 persons at a single time, the University will also notify, without unreasonable delay, consumer reporting agencies that compile and maintain files on consumers on a nationwide basis, as defined in 15 U.S.C. sec. 1681a(p). Notification shall include the date of the breach, an estimate of the number of persons affected by the breach, if known, and the actual or anticipated date that persons were or will be notified of the breach.

6. Notification to State Regulators

The University will also provide notice to appropriate state regulators where required by law.
G. Documentation and Tracking of Breaches:

1. Documentation regarding reported privacy and/or security breaches shall be maintained by the HIPAA-Covered Component, University Privacy Officer and CISO, and provided to University Management and/or the Security Breach Team where appropriate.

2. “Suspected Breach Analysis Forms” shall be maintained by the University’s Privacy Officer and the HIPAA-Covered Component for a minimum of six (6) years from the data of the form.

3. All information documenting the process required under HIPAA Privacy and Security and HITECH law regarding the violation or breach will be retained for a minimum of six (6) years by the University’s Privacy Officer and/or the CISO.

4. Violations that meet the definition of breach under the HIPAA/HITECH Act as amended shall be reported as required to the Department of Health and Human Services Office of Civil Rights.

II. Other Examples of Privacy and Security Incidents:

Other examples of violations of privacy and security of PHI are included below. All privacy and security incidents should be evaluated thoroughly to determine whether a breach has occurred. (This is not an all-inclusive list.):

- Persons discussing PHI in any public area where those who have no need to know the information can overhear.
- Someone leaves paper copy of any Individual’s health information in a public area.
- Unauthorized access to health records areas and health records.
- Someone leaves a computer unattended in a publically accessible area with health record information unsecured.
- Failure to log off computer terminal.
- For purposes unrelated to job duties:
  - Someone improperly acquires, accesses, uses, reviews and/or discloses records of any Individual or requests another person do so.
  - Someone acquires, accesses, reviews and/or discloses a patient/client’s record for the intent of giving or selling information outside of the University.
  - Someone improperly acquires, accesses, uses, reviews and/or discloses confidential information of another member of the University.
workforce who is also an Individual receiving services from the HIPAA-Covered Component.

- Stealing or sharing passwords or not reporting a known lost password.
- Introduction of viruses, worms, Trojan horses, or other malicious software into the organization’s computer systems.
- Unauthorized access to networks, computer systems, or facilities/equipment rooms housing the computer systems.
- Unauthorized destruction/changing of ePHI.
- Improperly discarding PHI (not physically destroying it) whether paper or electronic media.
- Loss or theft of any Mobile Computing Device with PHI that is discoverable and not properly protected/encrypted.
Breach Notification Risk Assessment

Use the following general framework to conduct the required risk assessment to determine whether the breach notification requirements of the HIPAA/HITECH Act apply.

1. Who are the unauthorized person(s) who used the PHI or to whom was the disclosure made?
   a. Is the individual who accessed/used/disclosed the PHI a member of our HIPAA Hybrid or our Business Associate?
      | Level | Description                                                                 |
      |-------|------------------------------------------------------------------------------|
      | Lo    | Yes, and otherwise authorized to access the PHI                              |
      | Lo    | Yes, but not otherwise authorized to access the PHI                           |
      | Med   | No                                                                            |
   b. Who is the individual who received the disclosed PHI a member of our HIPAA Hybrid or our Business Associate?
      | Level | Description                                                                 |
      |-------|------------------------------------------------------------------------------|
      | N/A   | No known disclosure                                                          |
      | Lo    | Yes, a member of our HIPAA hybrid or our BA                                  |
      | Lo    | No, not a member of the hybrid or a BA, but still a CE or BA subject to HIPAA |
      | Med   | An individual that is not bound by HIPAA and outside of UConn                |

2. What unique identifiers were disclosed?
   a. Limited Data Set
      | Level | Description                                                                 |
      |-------|------------------------------------------------------------------------------|
      | N/A   | Not a Limited Data Set; skip to 2.b.                                         |
      | Lo    | 16 HIPAA defined identifiers removed and also either no DOB or no zip code   |
      | Lo    | 16 HIPAA defined identifiers removed and age or zip codes do not create identifiable populations |
      | Med   | 16 HIPAA defined identifiers removed, but title, ages, or zip codes make reidentification possible |
   b. Unique Identifiers
      | Level | Description                                                                 |
      |-------|------------------------------------------------------------------------------|
      | N/A   | No Direct Identifiers were disclosed                                        |
      | Lo    | Full name or partial name, but no other unique identifiers                  |
      | Med   | Name with phone number or address but no SSN or other unique identifiers    |
      | Med   | Full name with DOB but no other unique identifiers                          |
      | HI    | SSN, credit card, driver's license, bank account numbers with first initial or first name and last name with or without other direct identifiers (presuming data unencrypted or transmitted with an encryption key) |
**Breach Notification Risk Assessment**

**c. Type of services provided**

<table>
<thead>
<tr>
<th>Level</th>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>0</td>
<td>No information regarding services or care was disclosed</td>
</tr>
<tr>
<td>Lo</td>
<td>1</td>
<td>Identified as an Individual (aka-patient/client)</td>
</tr>
<tr>
<td>Med</td>
<td>2</td>
<td>Reason for receiving care; diagnosis or treatment; or test results</td>
</tr>
<tr>
<td>Hi</td>
<td>3</td>
<td>Highly sensitive information such as treatment revealed by location or a condition that might result in employment discrimination, reputational harm or specific violation of state law (e.g. HIV, Cancer, Substance Abuse, genetic disorders)</td>
</tr>
</tbody>
</table>

**3a. What is the likelihood the PHI on a lost or stolen device was actually acquired or viewed?**

<table>
<thead>
<tr>
<th>Level</th>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>0</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Lo</td>
<td>1</td>
<td>Device retrieved before it was accessed - confirmed by ISO</td>
</tr>
<tr>
<td>Med</td>
<td>2</td>
<td>Device retrieved before it was accessed - not able to be confirmed by ISO</td>
</tr>
<tr>
<td>Hi</td>
<td>3</td>
<td>Device not retrieved and not confirmed to be encrypted</td>
</tr>
</tbody>
</table>

**4a. Was the risk of compromise to the PHI Mitigated (e.g. lost, stolen, faxed, or mailed, or accessed without authorization)?**

<table>
<thead>
<tr>
<th>Level</th>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lo</td>
<td>0</td>
<td>Information is returned without seal on envelope being broken and/or before being accessed &amp; viewed</td>
</tr>
<tr>
<td>Med</td>
<td>1</td>
<td>PHI is obtained by or disclosed to a member of UCONN Hybrid or BA who does not know the Individual and who provides assurance the information has been returned and/or destroyed</td>
</tr>
<tr>
<td>Med</td>
<td>2</td>
<td>PHI is obtained by or disclosed to someone outside the UCONN Hybrid or UCONN BA who does not know the Individual and returns the information with no indication of further use or disclosure of the information</td>
</tr>
<tr>
<td>Hi</td>
<td>3</td>
<td>PHI is disclosed to a to someone outside the UCONN Hybrid or UCONN BA who does not know the Individual and who will not or cannot return the information</td>
</tr>
<tr>
<td>Hi</td>
<td>4</td>
<td>PHI is obtained by or disclosed to someone who may know of the Individual and who is reasonably believed to have accessed the information with or without further disclosure</td>
</tr>
</tbody>
</table>
# Risk Assessment Scoring Grid

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 b</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 b</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 c</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 a</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**KEY:**

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 8</td>
<td>Low probability that the PHI has been compromised (notification not required)</td>
</tr>
<tr>
<td>8 - 9</td>
<td>Medium probability the PHI has been compromised (notification may be required; TBD by Security Breach Team based upon facts of specific event)</td>
</tr>
<tr>
<td>10 or more</td>
<td>High probability the PHI has been compromised (notification will generally be required unless an exception is determined based upon specific facts of the event)</td>
</tr>
</tbody>
</table>

2. **b. HI**
   - Automatically triggers notification under CT State law if the data is unencrypted

2. **c. HI**
   - May trigger mandatory notification under State law(s) depending upon the information disclosed and to whom
Suspected Security Incident Analysis Form

Please utilize this form to document your review of a suspected breach and/or data security incident, and to assist the University in its risk analysis required to determine whether the incident constitutes a reportable breach under the HIPAA/HITECH rules.

<table>
<thead>
<tr>
<th>Location of Incident</th>
<th>Date of Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of individuals impacted (if known)</td>
<td>Date of Report</td>
</tr>
<tr>
<td>Point of Contact (Reporter/Complainant)</td>
<td>Phone #/Email</td>
</tr>
</tbody>
</table>

Summary of What Occurred: (use additional pages if necessary)
**Initial Review Questions:**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the University the Covered Entity or the Business Associate for the PHI suspected to have been compromised? If we are the BA, who is the CE?</td>
<td></td>
</tr>
<tr>
<td>What specific data is involved?</td>
<td></td>
</tr>
<tr>
<td>How many records are involved? How many Individuals (i.e., patients/clients)? Do we know the last known address for these Individuals or for their authorized representatives?</td>
<td></td>
</tr>
<tr>
<td>Was the PHI accessed, used or disclosed in a manner not permitted by HIPAA and/or University policy? If so, how?</td>
<td></td>
</tr>
<tr>
<td>Was the PHI secure? By what method(s)?</td>
<td></td>
</tr>
<tr>
<td>Do any of these 3 exceptions apply?</td>
<td></td>
</tr>
<tr>
<td>1. Unintentional access within the University’s HIPAA-Covered Components or to a Business Associate by a person with appropriate access rights and no further use or disclosure occurred?</td>
<td></td>
</tr>
<tr>
<td>2. Inadvertent disclosure to another individual within the University’s HIPAA-Covered Components or to a Business Associate where no further use or disclosure occurred?</td>
<td></td>
</tr>
<tr>
<td>3. An unintentional access or inadvertent disclosure where there is reasonable belief that the information would not or could not have been retained by the recipient?</td>
<td></td>
</tr>
</tbody>
</table>
**Risk Assessment Related Questions:**

1. Who disclosed the information?

2. Who received the information?

3. What information was actually transmitted? Accessed? Used?

4. If the data was on a lost or stolen device, what is the chance that the data was actually acquired or viewed? Was the data encrypted or otherwise protected? By what method(s)?

5. Has the risk of compromised be mitigated? If so, how?

**Additional relevant information to consider:**

_____________________________________                            ________________________________
Name                                                                                                  Signature

_____________________________________                            ________________________________
Department                                                                                        Date

20-Suspected Breach Analysis Form
Implemented 9/2013, Updated 5/2014
Data Security Breach Protocol

This protocol is intended to assist University administration and staff in the event that University data is compromised.

University data is defined as: Items of information that are collected, maintained, and utilized by the University for the purpose of carrying out institutional business subject to or limited by any overriding contractual or statutory regulations. University data may be stored in any number of formats, including but not limited to electronic, paper, graphics, photographs, video, audio or metadata.

Breach Response Process:

1. A potential or actual compromise of University data or of a system containing University data is uncovered by or reported to a University office or department.

2. The potential or actual incident should be reported to Chief Information Security Office (CISO) in UITS or the Privacy Officer in OACE, immediately.

3. The Privacy Officer and CISO will coordinate as appropriate to collect information regarding the compromise and determine the appropriate course(s) of action to investigate the compromise.

4. If it is determined that University electronic devices (e.g., computers, mobile devices) or paper records have been stolen or otherwise have gone missing, the Privacy Officer and/or CISO will report the loss to the University Police.

5. The Privacy Officer and/or CISO will coordinate with appropriate University departments for investigation, containment, preservation, forensics and/or protection of sensitive data. As part of this process, the Privacy Officer and/or CISO will determine what sensitive and/or personal data may have been compromised.

6. As information becomes available over the course of the investigation, the CISO and/or Privacy Officer will determine whether it appears that sensitive personal information may have been exposed and/or breached.

7. If the CISO and Privacy Officer reasonably believe that a breach may have occurred, the CISO and Privacy Officer will contact the Office of the
General Counsel to discuss the actual or potential breach, legal obligations and proactive strategies.

8. If it is determined in conjunction with the Office of the General Counsel that a data breach has occurred, the Privacy Officer and CISO will contact members of the Security Breach Team (SBT) described below to discuss available information, and to begin troubleshooting how to handle the breach.

9. The SBT is comprised of the following standing members:

    • CISO
    • Privacy Officer
    • General Counsel
    • Chief of Staff
    • Deputy Chief of Staff
    • University Communications
    • Dean, Director or Department Head of the area where the breach is determined to have occurred

Other members of the University community will be asked to collaborate or participate where appropriate.

10. Once enough information about the situation is known and/or the extent of the breach has been determined, the Privacy Officer and CISO will collaborate with the Office of the General Counsel and appropriate members of the SBT to determine who needs to be notified about the breach, how individuals impacted by the breach should be notified and what, if any, services should be offered to the individuals impacted by the data breach to help protect themselves from potential or actual identity theft. As part of this analysis, the Privacy Officer will coordinate with the Office of the General Counsel to review applicable state (CT and any other applicable state) and federal privacy, data security and breach notification laws, standards and best practices.

11. The SBT will then formulate a plan of action to comply with applicable requirements of such laws, standards and best practices.

12. If it is determined that notification and credit monitoring protection is appropriate and/or required, the Privacy Officer will engage the
University’s designated vendor to provide notification and credit monitoring services on the University’s behalf. Unless an exception is determined to be appropriate by the SBT, the office or department responsible for the data that was lost or breached shall be responsible for the costs associated with remediating the breach, including but not limited to notification and credit monitoring services.

13. Where required by state and or federal law, the Privacy Officer will coordinate with the appropriate members of the SBT to ensure that the required state entities, federal government entities and/or credit bureaus (e.g., attorneys general, other state agencies, FTC, DHHS) are notified of the breach and who has been impacted as well as the University’s course of action related to managing the breach.

14. Where appropriate, the Privacy Officer, CISO and/or Office of the General Counsel will contact the Connecticut Office of the Attorney General (through the AG’s Privacy Taskforce), the Governor’s Office and/or any other appropriate State Officials to inform them about the breach.

15. Where necessary or appropriate, the SBT will expeditiously collaborate to develop press releases and letters to affected individuals (by email and/or U.S. post).

16. Where appropriate, the CISO will coordinate with University Communication to create web page(s) with information regarding the breach and how individuals can take steps to protect themselves.

17. The SBT will also designate a single point of contact to address questions/concerns of individuals concerned about the breach. The SBT may decide to set up special toll-free number phone line for individuals to call with questions/concerns where required and/or appropriate. The Privacy Officer will ensure that appropriate offices (i.e., University switchboard, University Communications, Office of the President, office who lost or who is responsible for the data that has been compromised) are made aware of the single point of contact to whom questions/concerns should be directed.

18. In the course of managing and remediating the breach, as expeditiously as possible:

- The Privacy Officer will work with Purchasing and the office or department responsible for the costs of remediating the breach to process necessary paperwork to engage the University’s
designated vendor to provide notification and/or credit monitoring services.

- The Privacy Officer will work with the vendor to process any appropriate paperwork (i.e., SOW, PO, etc.) to engage the vendor’s services.

- The Privacy Officer will work with appropriate University staff, the Office of the General Counsel and the vendor to draft notification letters and where appropriate, FAQ’s regarding the incident.

- The Privacy Officer and/or CISO will work with appropriate University staff to collect the names and last known addresses of individual who will need to be notified.

- Notification letters will be sent to impacted individuals or organizations via First Class Mail, email and/or other methods required by law.

- Press releases will be finalized and issued by University Communications where appropriate. The main University website(s), faculty/staff webpage student information webpage will include link to press releases.

- A special website containing information regarding the breach, how to get more information, and how to protect one’s credit will be posted as appropriate by University Communications and/or the UITS Information Security Office.

19. A mechanism for logging calls and/or inquiries received, as well as responses and/or assistance given, shall be created and implemented.

20. Once proper notifications have been sent and posted and the matter has been contained and handled, debriefing meeting(s) should be held with all of the individuals involved in the breach investigation, management and remediation. Additional follow-up activities should occur as appropriate.
HIPAA Privacy and Data Security Training

Policy: It is the policy of the University of Connecticut to ensure that members of its HIPAA-hybrid and all of those otherwise covered by the *UConn HIPAA Privacy & Security Practices Manual* receive appropriate training regarding the privacy, data security and breach provisions of HIPAA.

Rationale: The purpose of this policy is to identify the mechanism by which appropriate University faculty, staff, students, volunteers and affiliates receives education and training, both initial and ongoing, on HIPAA regulations and University organizational policies related to privacy and security of protected health information (PHI).

POLICY:

1. All persons covered by the provisions of this *UConn HIPAA Privacy & Security Practices Manual* and as outlined in the HIPAA Hybrid Designation Policy shall be trained on the HIPAA privacy, security and breach regulations, including University policies and applicable procedures.

2. Training content shall be selected and implemented by the HIPAA-Covered Components Directors in conjunction with the Chief Information Security Officer (CISO) and the University’s Privacy Officer.

3. The HIPAA-Covered Components shall be responsible for ensuring that all members of their unit complete the training in a timely manner.

4. New employees who are required to complete the training will do so during standard orientation period, and shall complete the training prior to being granted access to PHI.

5. Current employee whose role changes to include access to PHI shall complete the training prior to being granted access to PHI.

6. Thereafter, annual refresher training shall be provided to all individuals covered by the provisions of the *UConn HIPAA Privacy & Security Practices Manual*.

7. In addition to the initial and refresher trainings, when significant changes in policy and/or procedure occur, the affected workforce will be trained as soon as possible after the changes.

8. Training completion shall be documented in written or electronic form and retained for a minimum of six (6) years.

Reference: §164.530 (b) Health Insurance Portability and Accountability Act of 1996
§164.308 (a)(5)(i) Health Insurance Portability and Accountability Act of 1996
ACCEPTABLE USE OF INFORMATION TECHNOLOGY RESOURCES

Policy: Information Technology resources of the University’s HIPAA-Covered Components shall only be used in accordance with the University’s Acceptable Use policies.

Rationale: In accordance with 45 CFR Part 160 and Part 164, Subparts A and C, Covered Entities and Business Associates must adopt measures to protect against any reasonably anticipated threats or hazards to the security or integrity of electronic Patient Health Information (ePHI).

POLICY STATEMENT:

The purpose of this policy is to provide direction with regard to the use of University-owned IT equipment and software including, but not limited to, workstations, mobile computing devices, electronic communication systems and network and other business applications.

The intent of this policy is to provide information concerning appropriate and inappropriate use of University IT resources.

1. Usage of University Systems

University systems are provided at University expense and are to be used solely to conduct University business.

The University shall provide controls to help ensure system usage is in accordance with each Member’s job duties and responsibilities.

2. Ownership of Messages, Data and Documents

Information created, sent, received, accessed, or stored in support of University business processes is the property of the University.

3. User Responsibilities

Members shall not tamper with or disable any security controls.

Members may use only authorized credentials supplied to the individual to access and use University systems.

Members learning of or reasonably suspecting any violation of a University HIPAA Security policy shall immediately report to their manager, or designee, and to the Security Liaison.

Members are required to physically secure mobile computing devices in an appropriate manner whenever devices are not under direct control and monitoring by the assigned individual.
Members are to immediately report lost or stolen IT Resources to their manager, or
designee, and to the Security Liaison in accordance with the University’s HIPAA
Breach Prevention and Response Policy.

4. **Misuse of State Systems**

Any use inconsistent with the University’s *Acceptable Use, Information Technology*
Policy is prohibited.

5. **Compliance**

IT resources shall be protected from misuse including, but not limited to, theft,
unauthorized access, fraudulent manipulation and alteration of data, attempts to
circumvent security controls, and any activity that could compromise the confidentiality,
integrity or availability of data.

Any Member who violates any University HIPAA policies or underlying standards and
procedures may be subject to discipline in accordance with University procedures.

6. **Implementation**

HIPAA-Covered Components are responsible for developing and disseminating
procedures and standards governing the implementation of this policy. Such standards
and procedures are therefore considered an extension of this policy and compliance is
required thereto.

HIPAA-Covered Components are responsible for ensuring compliance with this policy.

HIPAA-Covered Components are responsible for making this policy available for
review; obtaining a signed acknowledgment of understanding from each user; and
keeping a copy of the signed acknowledgement on file.

Monitoring and oversight of the HIPAA Acceptable Use of IT Resources is the
responsibility of each HIPAA-Covered Component’s Security Liaison.

Reference: 45 CFR Part 160 and Part 164, Subparts A and C; P.A. 11-48 Sec. 14
BUSINESS CONTINUITY PLANNING
& INFORMATION TECHNOLOGY
DISASTER RECOVERY

Policy: The purpose of this policy is to address the minimum features that must be documented and implementable in plans that are developed for emergency situations.

Rationale: To comply with 45 CFR 164.308 to ensure that plans are developed to respond to emergency or similar occurrences.

POLICY STATEMENT:

The HIPAA Security rule requires that HIPAA Covered Entities create, implement and test contingency plans to respond to allow for business continuity and disaster recovery of data and systems in emergency or similar situations.

Each HIPAA Covered Component shall create and implement a contingency plan to deal with emergency situations. A contingency plan is the most appropriate approach to protect availability, integrity and security of data during negative events that may occur outside of the organization’s control. Five standard contingency planning components are identified within the HIPAA Security Rule:

1. Data Backup Plan – 45 CFR 164.308 (a) (7) (ii) (A) requires Covered Entities to establish and implement procedures to create and maintain retrievable exact copies of electronic protected health information.

2. Disaster Recovery Plan – 45 CFR 164.308 (a) (7) (ii) (B) requires Covered Entities to establish (and implement as needed) procedures to restore any loss of data.

3. Emergency Mode Operation Plan – 45 CFR 164.308(a) (7) (ii) (C) requires Covered Entities to establish (and implement as needed) procedures to enable continuation of critical business processes for protection of the security of electronic protected health information (ePHI) while operating in emergency mode.

4. Testing and Revision Procedures – 45 CFR 164.308(a) (7) (ii) (D) requires Covered Entities to implement procedures for periodic testing and revision of contingency plans.

5. Applications and Data Criticality Analysis– 45 CFR 164.308 (a) (7) (ii) (E) requires Covered Entities to assess the relative criticality of specific applications and data in support of other contingency plan components.
Implementation

A Contingency Plan is a written set of instructions focused on how to sustain mission/business processes during and after a disruption.

Each HIPAA-Covered Component shall develop a Contingency Plan for responding to an emergency or other occurrence (for example, fire, vandalism, system failure and natural disaster) that damages IT resources that contain ePHI.

The Contingency Plan shall include the following components:

1. An application and data criticality analysis shall be developed, documented and maintained to assess the relative criticality of specific applications and data in support of the contingency plan components.

2. Facility access procedures shall be developed, documented and maintained for access to support recovery efforts.

3. Contingency plan testing and revision procedures shall be developed, documented and periodically executed for verifying recovery capabilities.

4. A data backup plan shall be established, documented and implemented to create and maintain retrievable exact copies of ePHI.

5. Emergency access procedures shall be established, documented and implemented for the retrieval of ePHI during an emergency.

6. A disaster recovery plan shall be established, documented, implemented and tested to restore any loss of data in the event of a disaster.

7. An emergency mode operations plan shall be developed, documented and implemented to protect ePHI during emergency operations of business processes.

Reference: 45 CFR 164.308
Policy: The University shall maintain policies and procedures to protect confidential electronic data from improper alteration or destruction. This includes mechanisms to ensure that confidential electronic data have not been altered or destroyed in an unauthorized manner.

Rationale: To comply with 45 CFR 164.312.

POLICY STATEMENT:

The purpose of this policy is to provide direction with regard to data authentication and physical safeguards that should be implemented to secure ePHI.

Data Authentication

1. Authentication and authorization is required for any resource that has access to, or contains, ePHI.

2. Authentication controls shall minimally include a unique user logon and password combination.

3. The University’s Information Security Office shall maintain standards for transmitting data securely.

4. Confidential electronic data shall be encrypted while stored on electronic resources.

5. Confidential electronic data shall be encrypted while in transit across a network.

6. Mail messages containing confidential electronic data shall be encrypted while in transit across a network.

7. All other confidential electronic data transmissions, e.g. client/server connections, shall be encrypted.
Physical Safeguards

1. Electronic resources with access to or containing ePHI shall be secured using physical safeguards for protection from unauthorized access.

2. Screen locks shall be activated on electronic resources.

3. Virus protection shall be installed and activated on all electronic resources containing confidential electronic data where available.

Reference: 45 C.F.R. § 164.312(c) (1)
45 C.F.R. § 164.312(c) (2)
45 C.F.R. §164.308(3) (i)
45 C.F.R. §164.308(4) (i)
45 C.F.R. §164.312(d)
45 C.F.R. §164.312 (a) (1)
45 C.F.R. §164.312 (a) (2)
HIPAA FACILITY SECURITY POLICY

Policy: HIPAA Covered Components shall comply with the HIPAA Security Rule requirements pertaining to limiting physical access to a facility’s electronic protected health information (ePHI) and the facility or facilities in which they are housed, while ensuring that authorized access is allowed.

Rationale: To comply with 45 CFR 164.310 regarding physical safeguards.

POLICY STATEMENT:

Each HIPAA-Covered Component shall ensure that physical safeguards have been implemented to secure their facilities. Physical safeguards include controls, policies, and procedures to protect a covered entity's electronic information systems and related buildings and equipment from natural and environmental hazards, and unauthorized intrusion.

Implementation

1. Each HIPAA-Covered Component shall implement a facility security plan to safeguard the facility and the equipment therein from unauthorized physical access, tampering, and theft.

2. Each HIPAA-Covered Component shall maintain a facility security plan for all locations that store and/or access ePHI.

3. Each HIPAA-Covered Component must manage access for visitors.

4. Each HIPAA-Covered Component shall control and validate all persons’ access to facilities based on the individual’s role or function.

5. Each HIPAA-Covered Component Director shall establish authorization for access to facilities and equipment.

6. Each HIPAA-Covered Component shall maintain documentation regarding authorization to access facilities and equipment by its members.

Reference: 45 C.F.R. § 164.310(a)
DATA SECURITY: INCIDENT RESPONSE

Policy: HIPAA Covered-Components shall create and implement an incident response process to respond to suspected and actual data security incidents.

Rationale: To ensure that suspected and actual security incidents are properly assessed and mitigated.

POLICY STATEMENT:

Each HIPAA-Covered Component shall create and implement an Incident Response process to respond to security incidents. A security incident is any attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

Compliance

Each HIPAA-Covered Component shall utilize the Information Security Office’s Incident Response Procedures and the Suspected Security Incident Analysis Form (located at security.uconn.edu) incorporating:

- incident response training;
- incident response testing and exercises;
- incident handling, incident monitoring, incident reporting;
- incident response assistance and
- incident response
Policy: The University shall implement appropriate safeguards to ensure that only necessary access to information technology is permitted utilizing appropriate access controls.

Rationale: To comply with 45 CFR secs.164.308(a), 164.312(a)(1), 164.312(d).

POLICY STATEMENT:

Under the HIPAA Security Rule, the University must adopt measures to protect against any reasonably anticipated threats or hazards to the security or integrity of electronic Protected Health Information (ePHI). One method for doing so is by implementing appropriate access controls to ensure that only those who are supposed to have access to ePHI have such access.

Each HIPAA-Covered Component shall ensure that the following best practices are met with regard to access controls:

1. Members of each HIPAA-Covered Component shall be responsible for maintaining the security of their own passwords and login identification.

2. All supervisors shall be responsible for making appropriate and timely requests for activation and deactivation of user accounts for their Workforce Members.

3. All Members shall be responsible for reporting any observed breaches as outlined in the Breach Prevention and Response Policy.

4. Workforce Members must be vetted prior to being granted access to IT resources that store, process, have access to, and/or transmit ePHI.

5. Workforce Member access to IT resources shall be audited and re-evaluated annually or upon a job change.

Implementation

1. Each HIPAA-Covered Component shall develop a process to determine appropriate levels of authorization to access ePHI. The process shall meet the following requirements:

   • Access rights shall be granted based on business requirements.
   • Access rights shall not exceed the minimum necessary for a Member’s assigned duties.
• Access rights shall be authorized and documented by the HIPAA-Covered Components Director or authorized Member.
• Access rights shall be reviewed annually or as job duties change.

Each HIPAA-Covered Component shall ensure that the following:

1. Modifications of Member access to IT resources shall be authorized and processed.

2. Security configurations shall be maintained on IT resources to restrict access to ePHI to only those Members or software programs that have been granted access in accordance with this Policy.

3. Members shall be assigned unique user identifiers (or login names) for the purposes of authenticating to IT resources.

4. Members shall not share assigned unique system identifiers (or login names) with any other person, except for authorized support purposes.

5. Members shall not share assigned passwords with any other person.

6. Anonymous access, including the use of guest and public accounts, is prohibited.

7. Member access to IT resources shall be terminated when access is no longer necessary or when determined by management.

8. The Member’s manager, or manager designee, shall be responsible for making appropriate and timely requests for IT resource account deactivation.

9. The Member’s manager, or manager designee, shall request IT resource account deactivation immediately if termination is due to cause or sanction.

10. The Member’s manager, or manager designee, shall request IT resource account deactivation within 3 business days if termination is due to normal separation of duties.

11. A formal IT resource access termination process shall be used and shall include documentation and verification.

Reference: 45 CFR 164.308(a)
45 CFR 164.312(a)(1)
45 CFR 164.312(d)
INFORMATION TECHNOLOGY AUDIT & ACCOUNTABILITY

Policy: The University shall create and implement procedures to regularly review records of information system activity, such as audit logs, access reports and security incident tracking reports.

Rationale: The Information Technology Audit and Accountability Policy addresses requirements to implement procedures to regularly review records of information system activity.

POLICY STATEMENT:

The purpose of this policy is to comply with federal regulation requirements to perform system activity review. Audits and logging enable identification of risk-impacting changes to organizational information systems and the environments in which the systems operate. This activity verifies that planned risk responses are implemented and information security requirements derived from and traceable to organizational missions/business functions, federal legislation, directives, regulations, policies, standards, and guidelines are satisfied.

Compliance

1. This policy applies to all forms of ePHI.
2. IT resources that store, access or transmit ePHI shall electronically log activity into a central location and conform to standards established by the Information Security Office.
3. Logging shall include system, application, database, and file activity whenever available or deemed necessary.
4. Logging shall include creation, access, modification and deletion activity.
5. Log data shall be retained electronically in accordance with State of Connecticut retention schedules.
6. HIPAA-Covered Components are responsible for developing and implementing procedures for logging activity.
7. IT resources and log files shall be periodically examined for access control discrepancies, breaches and policy violations.
8. System activity review cycles shall include review of audit logs, access reports and security incident tracking reports, and shall occur at least once per month.

**Implementation**

1. HIPAA-Covered Components are responsible for developing process for review of collected audit logs

2. HIPAA-Covered Components should utilize any published University of Connecticut Information Security Office standards for log collection.

Reference: 45 CFR 164.308
Policy: The University shall ensure that requirements regarding the receipt and movement of hardware and electronic media that contain protected health information (ePHI) in/out and within of a facility are met.

Rationale: To comply with 45 CFR 160.103, an effective IT resource management process allows the organization to track physical and virtual assets and provide management with a picture of what, where and how assets are being used.

POLICY STATEMENT:

Each HIPAA-Covered Component shall establish procedures to ensure that it tracks and documents the movement of hardware and electronic media that has access to or may contain ePHI.

1. There shall be a record of the movements of IT resources and the designated individual(s) responsible.

2. The movement of IT resources shall be authorized and logged by the HIPAA-Covered Component prior to the IT resources entering or leaving a facility.

3. The HIPAA-Covered Component shall be accountable for IT resources while in transit between facilities.

4. IT resources shall be authorized for use and access within a facility by the HIPAA-Covered Component’s Director.

5. IT resources shall be properly disposed of when no longer used.

6. ePHI shall be removed from IT resources and electronic media before the resources are made available for reuse.

Reference: 45 CFR 160.103

Additional Resource: http://itpolicy.uconn.edu/policydocs/datawipe.html
DATA SECURITY: RISK MANAGEMENT

Policy: The University shall ensure that it meets requirements in the HIPAA Security rule regarding the assessment and mitigation of potential risks and vulnerabilities to electronic data security related to protected health information (PHI).

Rationale: To comply with 45 CFR 164.308

POLICY STATEMENT:

The purpose of the policy is to comply with state and federal requirements pertaining to the assessment of potential risks and vulnerabilities; the reduction of such risks and vulnerabilities; the evaluation of the University’s compliance with HIPAA Security requirements; and the University’s IT security policies and procedures.

Agency Responsibilities

The HIPAA-Covered Component shall implement a Risk Management Framework. Risk Assessment standards shall be reviewed annually. Policies and procedures shall be updated as necessary to ensure that state and federal required control capabilities are maintained.

Compliance and Implementation

1. Data Classification shall be implemented to ensure that each HIPAA-Covered Component, on an as-required basis as follows:

   - Categorizes information and their information systems in accordance with applicable federal laws and University Policy
   - Documents the security categorization results (including supporting rationale) in the organization’s security plan for information systems.

2. Each HIPAA-Covered Component shall implement a Risk Assessment methodology. The HIPAA-Covered Component shall:

   - Conduct a risk assessment. This methodology will include the likelihood and magnitude of harm resulting from the unauthorized access, use, disclosure, disruption, modification, or destruction of the information system and the information it processes, stores, or transmits.
   - Document risk assessment results
• Review risk assessment results
• Remediate identified risks

3. Each HIPAA-Covered Component shall conduct appropriate system vulnerability scanning. They will:

• Periodically scan for vulnerabilities in HIPAA-Covered Component information system
• Analyze vulnerability scan reports and results from security control assessments
• Remediate vulnerabilities in accordance with an organizational assessment of associated risk.

Reference: 45 CFR 164.308
TAB 4
## Joint Audit & Compliance Committee

### Status of Audit Assignments

<table>
<thead>
<tr>
<th>Audit Project</th>
<th>Storrs Or UConn Health (UH)</th>
<th>Planning</th>
<th>Fieldwork</th>
<th>Pre-Draft/Draft Report</th>
<th>Final Draft Report Issued</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environmental Health &amp; Safety (Lab Safety)</td>
<td>Storrs</td>
<td></td>
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<td>Federal Grants – Cost Sharing</td>
<td>UH</td>
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<td>Emergency Preparedness</td>
<td>Storrs</td>
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<td>Law School Foundation</td>
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<td>1st Change Order Monitoring Review</td>
<td>Storrs</td>
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<td>UConn Foundation – FY 14</td>
<td>Storrs</td>
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<td>Overtime Payments – Public Safety</td>
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<td>Center for Laboratory Animal Care (CLAC) Renovations</td>
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<td>Pharmacy Charge Capture</td>
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<td>Meaningful Use – Eligible Professionals</td>
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<td>NCAA Compliance</td>
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<td>Stem Cell – FY 14</td>
<td>Storrs &amp; UH</td>
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<td>Server Implementation and Security</td>
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<td>Cash Handling</td>
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<td>HIM – Patient Record Management</td>
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<td>Project Commissioning / Closeout Process</td>
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<td>Audit Project</td>
<td>Storrs or UConn Health (UH)</td>
<td>Planning</td>
<td>Fieldwork</td>
<td>Pre-Draft/Draft Report</td>
<td>Final Draft Report Issued</td>
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<td>Student Health Services</td>
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<th>Special Projects/Consulting/Follow-up</th>
<th>Storrs or UConn Health</th>
<th>Planning</th>
<th>Fieldwork</th>
<th>Review Pre-draft</th>
<th>Project Complete</th>
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<td>Physics</td>
<td>Storrs</td>
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<td>Speech &amp; Hearing Project</td>
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<td>School of Nursing</td>
<td>Storrs</td>
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<tr>
<td>OVPR Special Project</td>
<td>Storrs</td>
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</table>
Open Overdue Items by Audit - Based on Original Due Date

Audit Name

Number of Open Overdue Items
Implemented

High: 3
Medium: 31
Low: 39

Open OverDue Items by Risk Level

High: 18
Medium: 114
Low: 63
Low

Meaningful reportable issue for client consideration that in the Auditor’s judgment should be communicated in writing. The finding results in minimal exposure to the University or UConn Health and has little or no impact on the University’s or UConn Health’s compliance with laws and regulations. The issues related to this control weakness will typically not lead to a material error.

Medium

Significant exposure to the area under review within the scope of the audit. The finding results in the potential violation of laws and regulations and should be addressed as a priority to ensure compliance with University’s or UConn Health’s policies and procedures. The significance of the potential errors related to this control weakness makes it important to correct.

High

Significant exposure to the University or UConn Health that could include systemic University or UConn Health wide exposure. The finding could result in a significant violation of laws and regulations and should be viewed as a highest priority which the University or UConn Health must address immediately.
TAB 5
### The Office of Audit, Compliance & Ethics

#### Status of External Audit Projects

<table>
<thead>
<tr>
<th>Vendor</th>
<th>Area</th>
<th>Scope</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>BKD</td>
<td>Storrs Athletics</td>
<td>NCAA agreed upon procedures performed on all revenues, expenses, and capital expenditures for or on behalf of the University’s Athletics Program for FY2014.</td>
<td>OACE received approval to hire BKD for the FY2014 AUP at the September 12, 2014 JACC meeting. Engagement is underway and report will be presented to the JACC at the December 2, 2014 meeting.</td>
</tr>
<tr>
<td>McGladrey</td>
<td>Storrs, Regionals &amp; UConn Health</td>
<td>Audit of UCONN 2000 named projects substantially completed during FY2014, deferred maintenance projects with designated budgets substantially completed in FY2014 and agreed upon procedures performed on total UCONN 2000 expenditures (named projects, deferred maintenance and equipment) for FY2014.</td>
<td>OACE received approval to hire McGladrey for the FY2014 audit at the September 12, 2014 JACC meeting. Engagement is underway.</td>
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<tr>
<td>Marcum, LLP</td>
<td>UConn Health</td>
<td>Audits of the John Dempsey Hospital and Dental Clinics (Clinical Programs Fund), including the OHCA filings, UConn Medical Group (UMG) and the University of Connecticut Health Center Finance Corporation for FY2014.</td>
<td>Engagement is underway. Report will be presented to the JACC at the December 2, 2014 meeting.</td>
</tr>
</tbody>
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2014 AUDIT RESULTS
Prepared for:

The University of Connecticut Health Center:
John Dempsey Hospital
UConn Medical Group
Finance Corporation
December 2, 2014

Joint Audit and Compliance Committee of
University of Connecticut & University of Connecticut Health Center

We are pleased to meet with you to discuss the results of our audits of the 2014 financial statements of the University of Connecticut Health Center John Dempsey Hospital (the Hospital or JDH); University of Connecticut Health Center UConn Medical Group (UMG); and University of Connecticut Health Center Finance Corporation (Finance Corporation), collectively the Organization. We have issued unmodified audit opinions on the aforementioned financial statements as of June 30, 2014 and for the year then ended which are included herein.

This report summarizes our findings related to the significant areas of audit focus and the communications to audit committees that are required by our professional standards.

We appreciate the opportunity to provide audit services to the University of Connecticut Health Center. Please contact Chris Jackson at (860) 760-0630 or chris.jackson@marcumllp.com with any questions or comments.

Very truly yours,

Marcum LLP
**Areas of Audit Focus**

The following summarizes the audit results and our observations related to the higher risk audit areas:

<table>
<thead>
<tr>
<th>Emphasis Area</th>
<th>Audit Results and Observations</th>
</tr>
</thead>
</table>
| Accounts receivable allowances for contractual discounts and bad debts | The Hospital and UMG estimated the net realizable value of accounts receivable as of June 30, 2014 by calculating and applying separate contractual allowance and bad debt percentages by financial class and aging bucket.  

We performed extensive procedures to test the Hospital’s and UMG’s allowance calculations, including independent procedures to ensure that the allowances recorded were appropriate and the discount percentages used were accurate.  

We tested the Hospital’s and UMG’s revenue systems including the underlying system generated reports utilized by management in the determination of Hospital’s and UMG’s accounts receivable allowances.  

We performed a combined hindsight analysis of the allowances for doubtful accounts and contractual adjustments recorded in the prior year, noting that they were fairly stated on a combined basis in the prior year for both the Hospital and UMG.  

Based on our procedures, we have concluded that the Hospital’s and UMG’s allowances for contractual adjustments and bad debts were fairly stated as of June 30, 2014. |
| Amounts due to third party payors                 | We have tested the relevant inputs to the Hospital’s third party payor settlement calculations and reviewed management’s third party reserving methodology. We have concluded that the third party reserves were reasonable as of June 30, 2014 based on the exposures that existed. |
### Emphasis Area

**Revenue recognition related to the Health Information Technology for Economic and Clinical Health Act (HITECH) incentive funds**

UMG recognized HITECH incentive payment revenue of $1,571,000 in 2014. The Hospital did not recognize any HITECH incentive payments in 2014.

Marcum audited management’s documentation of compliance with the meaningful use criteria required to receive this reimbursement and tested the recognition of revenue without exception. UMG’s attestation of compliance with the meaningful use criteria is subject to audit by the federal government.

---

### Professional liability exposure and other legal matters

The University of Connecticut Health Center (Health Center) provides malpractice insurance coverage to the Hospital and UMG on an occurrence basis. The Hospital and UMG are charged an annual malpractice premium for such coverage.

The Hospital and UMG are not responsible for claim settlements in excess of the annual premiums charged by the Health Center, however, operational subsidies from the State of Connecticut or the Health Center may be affected by the performance of the malpractice program.

We obtained legal representation letters from the attorneys representing the Hospital, and UMG. Based on the legal letter responses received, there were no specific contingencies that were required to be recorded or disclosed in the audited financial statements. The relevant facts related to the Health Center’s malpractice program and trust fund have been disclosed in the audited financial statements.

---

### Construction of Outpatient Pavilion

UCHCFC Circle Road Corporation (Circle Road Corporation), a subsidiary of Finance Corporation, continued to administer the construction contract to build the Outpatient Pavilion.

We performed procedures to test a sample of the $79 million of construction costs incurred during 2014. We also tested the draws on its construction mortgage with TIAA to fund this project.
Areas of Audit Focus

The following summarizes the audit results and our observations related to the higher risk audit areas:

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<td>In connection with the June 30, 2014 financial statement audits, Marcum utilized specialists from our Information Technology Audit Group to perform a general controls review over the Hospital’s, UMG’s, and Finance Corporation’s logical access and program change controls. Reference is made to our management letter related to our one recommendation to improve the Hospital’s information technology controls.</td>
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<td>Future clinical system support</td>
<td>With the upcoming acquisition of Siemens Health Services by Cerner Corporation, there is a risk that the Hospital’s Siemens’ clinical system will no longer be supported within a two year period based on our discussions with management. As a result, the Hospital should begin the process of searching for a replacement clinical system. It will take a significant period of time and level of effort to select the new system, install it and test the functionality of the system. The Hospital should not run the risk of operating a clinical system that is no longer supported by its vendor.</td>
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<td>Disposition of Dental Clinics</td>
<td>The Health Center realigned the Dental Clinics by removing them from the Hospital’s operating unit and aligning them with the institution’s other dental practices. The change was made by transferring all assets and liabilities included in the Hospital’s financial statements to the Health Center. In accordance with GASB 69, during the year ended June 30, 2014, the Hospital recognized a loss of $3.9 million on the disposal of its Dental Clinics as a special item. In the prior year ended June 30, 2013, the Dental Clinics comprised net patient service revenues of $7.5 million and total operating expenses of $10.5 million. We ensured that this transaction was appropriately recorded and disclosed in the Hospital’s audited financial statements.</td>
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</tr>
</thead>
</table>
| Financial viability | During the year ended June 30, 2014, the Hospital had an operating loss of approximately $18 million prior to receiving a transfer of approximately $13 million from the Health Center. UMG had an operating loss of approximately $38 million prior to receiving a transfer of approximately $39 million from the Health Center.  
We obtained representations from Health Center management that the Health Center is committed to continue to provide financial support to Finance Corporation, the Hospital and UMG in the form of working capital advances or net asset transfers through June 30, 2015 in amounts that will be sufficient for these entities to continue to meet their cash flow requirements. |
| Unrecorded liabilities | We performed a search for unrecorded liabilities and other procedures to detect understated liabilities. Based on these procedures, we noted a minor amount of interest expense ($54,000) that was not accrued by Finance Corporation. In addition, interest in the amount of $323,000 was not accrued by Finance Corporation related to the loan for the construction of the Outpatient Pavilion which was offset by an unrecorded asset of the same amount representing the capitalization of interest on the project. |

**REQUIRED COMMUNICATIONS**

The following communications are required by our professional standards:

**OUR RESPONSIBILITIES UNDER AUDITING STANDARDS**

Our engagement letter and our audit reports define our responsibilities. As described by professional standards, our responsibility is to plan and perform our audits in accordance with auditing standards generally accepted in the United States to obtain reasonable, rather than absolute, assurance that the financial statements are free of material misstatement.
OUR RESPONSIBILITIES UNDER AUDITING STANDARDS (CONTINUED)

Management’s Discussion and Analysis has been presented to supplement the basic financial statements. Such information is required by the Governmental Accounting Standards Board. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management’s responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audits of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

ACCOUNTING POLICIES AND DISCLOSURES

Management is responsible for the selection and use of appropriate accounting policies. The Organization’s significant accounting policies are disclosed in Note 1 to the audited financial statements. The financial statement disclosures are neutral, consistent, and clear.

During the year ended June 30, 2014, the Hospital adopted GASB No. 69, Government Combinations and Disposals of Government Operations, in connection with the transfer of its Dental Clinics to the Health Center on July 1, 2013 which is further described in the preceding Areas of Audit Focus section.

In addition, disclosures have been updated in the Hospital’s and UMG’s financial statements related to the upcoming changes in the coding requirements to implement the tenth revision of International Classification of Diseases (ICD-10) which is required to be completed by October 1, 2015. The Hospital and UMG may experience delays in reimbursement while the payors from which they seek reimbursement make the transition to ICD-10. If the Hospital and UMG fail to implement the new coding system by the deadline, the Hospital and UMG will not be paid for services provided.

ACCOUNTING ESTIMATES

Accounting estimates are an integral part of the financial statements prepared by management and are based on management’s knowledge and experience about past and current events and assumptions about future events. The most sensitive estimates included in the financial statements relate to contractual allowances, the allowances for doubtful accounts, and third party reserves. Please refer to the preceding Areas of Audit Focus section for our analysis of these estimates.
AUDIT ADJUSTMENTS

An audit adjustment is a correction to the financial statements that was not detected by employees in the normal course of performing their duties or that was detected by employees subsequent to year end, but not recorded until the following year.

There were no audit adjustments that were recorded by the Hospital, UMG or Finance Corporation.

Unrecorded Audit Differences

The following unrecorded audit differences were detected for Finance Corporation. These differences had the impact of overstating Finance Corporation’s net position by $54,000 as of June 30, 2014.

<table>
<thead>
<tr>
<th>Description of Error</th>
<th>(Decrease) Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understatement of accrued interest expense payable as of 6/30/14 related to the debt on the Medical Arts &amp; Research Building (MARB)</td>
<td>$(54,000)</td>
</tr>
<tr>
<td>Understatement of accrued interest payable as of 6/30/14 related to the Outpatient Pavilion debt</td>
<td>(323,000)</td>
</tr>
<tr>
<td>Understatement of capitalized interest as of 6/30/14</td>
<td>323,000</td>
</tr>
<tr>
<td>Total overstatement of net position as of 6/30/14</td>
<td>(54,000)</td>
</tr>
<tr>
<td>Turnaround effect of the prior year understatement of accrued MARB interest payable on 2014 net income</td>
<td>58,000</td>
</tr>
<tr>
<td>Understatement of 2014 net income after turnaround</td>
<td>$ 4,000</td>
</tr>
</tbody>
</table>

DISAGREEMENTS WITH MANAGEMENT

Professional standards define a disagreement with management as a difference of opinion on any matter of accounting principles or practices, financial statement disclosure, auditing scope or procedures, which if not resolved to the auditors’ satisfaction would have caused the auditor to refer to the subject matter of the disagreement in connection with the auditors’ report. (Preliminary differences of opinion that are based on incomplete facts are not disagreements if the differences are resolved by obtaining more complete factual information). There were no disagreements with management related to auditing, accounting or disclosure matters.
Management Consultations with Other Independent Accountants

In some cases, management may decide to consult with other accountants about auditing or accounting matters, similar to obtaining a “second opinion”. If such consultation involves the application of an accounting principle to the financial statements or a determination of the type of auditors’ opinion that may be expressed on those statements, our professional standards require the consulting accountant to communicate with us to determine that the consulting accountant has all the relevant facts. Management has advised us that at times they consult with the State of Connecticut Auditors on certain accounting matters and other events as they arise during the year.

Management Representations

We have requested certain representations from management that are included in the management representation letter dated October 22, 2014.

Issues Discussed Prior to Our Retention as Independent Auditors

We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition to our retention as auditors. Further, there were no significant changes to our planned audit approach or areas of audit emphasis. In addition, there was no significant change to our estimates of planning materiality that were initially developed during the planning phase of the audits.

Significant Difficulties Encountered in Performing the Audits

Management and others within the Organization cooperated with our requests. We encountered no significant difficulties in dealing with management in performing our audits.

Fraud and Violations of Laws and Regulations

Those charged with governance should be adequately informed of fraud or violations of laws and regulations coming to the auditors’ attention during the course of the audits.

There was no fraud or violations of laws and regulations noted.
INTERNAL CONTROL

In planning and performing our audits of the financial statements of the Hospital, UMG and Finance Corporation, collectively the Organization, as of and for the year ended June 30, 2014, in accordance with auditing standards generally accepted in the United States of America, we considered the Organization’s internal control over financial reporting (internal control) as a basis for designing audit procedures that were appropriate in the circumstances for the purpose of expressing our opinions on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Organization’s internal control. Accordingly, we do not express an opinion on the effectiveness of the Organization’s internal control.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A material weakness is a deficiency, or combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity’s financial statements will not be prevented, or detected and corrected, on a timely basis.

Our consideration of internal control was for the limited purpose described in the first paragraph in this section above and was not designed to identify all deficiencies in internal control that might be material weaknesses. Given these limitations during our audits, we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

INDEPENDENCE CONFIRMATION

As required by professional standards, we communicate at least annually with you regarding all relationships between Marcum LLP and its related entities (the Firm) and the Hospital, UMG and Finance Corporation that, in our professional judgment, may reasonably be thought to bear on our independence. We are not aware of any relationships between the Firm and the Organization that, in our professional judgment, may reasonably be thought to bear on our independence.

We hereby confirm that we are independent accountants with respect to the Organization, within the meaning of the published rules and regulations of the American Institute of Certified Public Accountants and the State of Connecticut Board of Public Accountancy.
Joint Audit and Compliance Committee of  
University of Connecticut & University of Connecticut Health Center

In planning and performing our audits of the financial statements of the University of Connecticut Health Center John Dempsey Hospital (21002 Fund) (the Hospital) and the University of Connecticut Health Center UConn Medical Group (UConn Medical Group), collectively the Organization, as of and for the year ended June 30, 2014, in accordance with auditing standards generally accepted in the United States of America, we considered the Organization’s internal control over financial reporting (internal control) as a basis for designing audit procedures that were appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Organization’s internal control. Accordingly, we do not express an opinion on the effectiveness of the Organization’s internal control.

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During our audits, we became aware of certain matters that represent opportunities for the Organization to strengthen its internal controls and follow best practices. The pages which follow summarize our comments and suggestions regarding these matters.

This communication is intended solely for the information and use of the Joint Audit and Compliance Committee, the Board of Directors, management, and others within the Organization and is not intended to be and should not be used by anyone other than these specified parties.

Marcum LLP

Hartford, CT
October 22, 2014


**FIXED ASSETS**

During the performance of our fixed asset testing procedures, we noted improvement in the controls over fixed assets, but certain opportunities to enhance these controls continued to exist in 2014. In particular, the process to capitalize fixed assets in a timely manner could be improved and formal written policies and procedures over the fixed asset capitalization process should be established.

In our testing of fixed asset additions, there were instances where the asset’s supporting documentation included invoice dates from prior years. Delays in reconciling and capitalizing fixed assets can result in the failure to properly segregate capitalizable and non-capitalizable costs as well as the improper delay of depreciation expenses.

It is recommended that management seek to improve its capitalization processes by implementing formal written policies and procedures surrounding the capitalization of fixed assets, including the timely capitalization of fixed assets, capitalization thresholds, and the reconciliation process.

*Management’s Response:*

Management agrees with the comments above. The fixed assets area has undergone improvements in the controls over the last year. To continue this improvement, we are currently evaluating the capitalization process to promote a more timely capitalization of assets purchased and projects undertaken.

Based on results of this procedural review, we will work on updating the existing policies and procedures.

We expect the procedural review of the procurement to capitalization process to be accomplished by June 30, 2015.

**TIMELY REMOVAL OF TERMINATED EMPLOYEES FROM INFORMATION TECHNOLOGY SYSTEMS**

We tested the process to remove terminated employees from the Organization’s information technology (IT) systems which included reading the work order request tickets that were submitted for a sample of terminated employees. Based on the procedures performed, we identified delays in the removal of certain employees from the Organization’s systems. Management indicated that the delays in removing these employees resulted from lags in the time that the terminations were reported to the IT Department. In our sample of ten terminated employees, the requests for termination were not submitted for three of these employees until at least one week after their termination dates.

It is imperative to ensure that all terminated employees have their user access disabled or deleted in a timely manner in order to prevent unauthorized access from occurring. With user accounts remaining enabled after termination, there is a risk that terminated employees could perform malicious acts within the system or access protected health information.
It is recommended that the Organization’s department managers be informed of the need for user terminations to be reported to the IT Department in a timely manner to ensure that unauthorized access does not occur. There should also be a process established for the Payroll/Human Resource Department to notify the IT Department immediately once an employee has been terminated or if possible to provide advance notice of such termination. These procedures will help to ensure that access is restricted for terminated employees in a timely manner.

Management’s Response:

Management agrees that delays in the notification of separations can cause the potential for improper system access. Management has identified two basic causes for this condition. The first is individual departments and/or access grantors failing to notify the system account administrator. The second is the overall failure of the department to notify Human Resources.

The first condition is governed under existing UConn Health policy 2011_03 which calls upon the authorized approver to evaluate when access should be revoked either due to job change or employee status change. The IT department periodically circulates reminders on the importance of these duties to the UConn Health community and has recirculated this reminder this October.

UConn Health also employs automated notifications from Human Resources to Information Technology about new hires and terminations entered into the Human Resources system. The turnaround time for this process is generally 24 hours. However, where departments have not submitted the proper paperwork to Human Resources the process is delayed and can result in improper access gaps.

Human Resources is currently working on an initiative to streamline the existing separation procedures to make it easier for departments to communicate required information more timely.

We are expecting to complete this work by June 30, 2015.
UNIVERSITY OF CONNECTICUT HEALTH CENTER
JOHN DEMPSEY HOSPITAL (21002 FUND)

FINANCIAL STATEMENTS
(With Management’s Discussion and Analysis)

JUNE 30, 2014 AND 2013
Management’s Discussion and Analysis .......................................................... 1-6

Independent Auditors’ Report........................................................................... 7-8

Financial Statements

  Statements of Net Position.............................................................................. 9-10
  Statements of Revenues, Expenses, and Changes in Net Position ................. 11
  Statements of Cash Flows............................................................................. 12-13

Notes to Financial Statements.......................................................................... 14-30
The following discussion and analysis provides an overview of the financial position and activities of the University of Connecticut Health Center John Dempsey Hospital (21002 Fund) (the Hospital) as of and for the years ended June 30, 2014, 2013 and 2012. This discussion has been prepared by management and should be read in conjunction with the financial statements and the notes thereto, which follow this section.

Through the Hospital (a licensed acute care hospital with a certified 234 general acute care beds, 180 staffed), the University of Connecticut Health Center (UConn Health) provides specialized and routine inpatient and outpatient services. The Hospital also provides comprehensive healthcare services for Connecticut’s incarcerated inmates through a contract with the Correctional Managed Health Care (CMHC) program. The Hospital has long been regarded as the premier facility in the region for high-risk maternity services. It is also recognized for its cardiovascular program (interventional cardiology and surgery), cancer, musculoskeletal, and behavioral mental health services which include geriatric as well as locked inpatient psychiatric units, ambulatory partial hospitalization, and outpatient treatment programs. Additionally, the Hospital is home to the only Emergency Department in Connecticut’s fast-growing Farmington Valley.

**OVERVIEW OF THE FINANCIAL STATEMENTS**

This annual report consists of management’s discussion and analysis and the financial statements. The basic financial statements (statements of net position, statements of revenues, expenses, and changes in net position, and statements of cash flows) present the financial position of the Hospital at June 30, 2014 and 2013, and the results of its operations and its financial activities for the years then ended. These financial statements report information about the Hospital using accounting methods similar to those used by private-sector companies. The statements of net position include all of the Hospital’s assets and liabilities. The statements of revenues, expenses, and changes in net position reflects the year’s activities on the accrual basis of accounting, i.e., when services are provided or obligations are incurred, not necessarily when cash is received or paid. These financial statements report the Hospital’s net position and how they have changed. Net position (the difference between assets and liabilities) is one way to measure financial health or position. The statements of cash flows provide relevant information about each year’s cash receipts and cash payments and classifies them as to operating, investing, and capital and related financing activities.

**FINANCIAL HIGHLIGHTS**

Hospital discharges of 8,566 represent an increase of 79 cases from 2013. Outpatient visits increased by 8,896, or 2.7%, from the prior year. These changes are indicative of the general healthcare trend towards outpatient treatment.
The Hospital finished the year with an operating loss of $17.9 million compared to an operating loss of $4 million in the prior year. These losses were offset by net non-operating revenues of $414,000 and $505,000 in fiscal year 2014 and 2013, respectively. The Hospital also received net transfers from UConn Health of $13.0 million and $15.2 million in 2014 and 2013, respectively. Total net position decreased $8.3 million in fiscal 2014, but increased $11.6 million in fiscal 2013. Current year transfers were made up primarily of $8.9 million in fringe benefit recoveries related to support services paid against the institution's general fund allotment and $4.1 million transferred by UConn Health to cover operating deficiencies and fund strategic initiatives. Dental Clinics’ assets were transferred back to UConn Health as described in note 10 of the accompanying statements. The Hospital’s financial position at June 30, 2014, included assets of approximately $128.7 million and liabilities of approximately $57.4 million. Net position, which represents the residual interest in the Hospital’s assets after liabilities are deducted, decreased $8.3 million to approximately $71.4 million.

Changes in net position represent the activity of the Hospital, resulting from revenues, expenses, gains, and losses, and are summarized for the years ended June 30, 2014, 2013, and 2012, including other changes in net position, as follows:

<table>
<thead>
<tr>
<th></th>
<th>2014 (in thousands)</th>
<th>2013 (in thousands)</th>
<th>2012 (in thousands)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary of assets, liabilities and net position at June 30:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current assets</td>
<td>$ 67,324</td>
<td>$ 54,535</td>
<td>$ 48,212</td>
</tr>
<tr>
<td>Other assets</td>
<td>9,702</td>
<td>17,341</td>
<td>9,619</td>
</tr>
<tr>
<td>Capital assets, net</td>
<td>51,704</td>
<td>55,790</td>
<td>57,918</td>
</tr>
<tr>
<td>Total assets</td>
<td>$ 128,730</td>
<td>$ 127,666</td>
<td>$ 115,749</td>
</tr>
<tr>
<td>Current liabilities</td>
<td>$ 48,824</td>
<td>$ 39,272</td>
<td>$ 39,467</td>
</tr>
<tr>
<td>Accrued compensated absences, noncurrent portion</td>
<td>8,551</td>
<td>8,720</td>
<td>8,241</td>
</tr>
<tr>
<td>Total liabilities</td>
<td>57,375</td>
<td>47,992</td>
<td>47,708</td>
</tr>
<tr>
<td>Net investment in capital assets</td>
<td>51,704</td>
<td>55,790</td>
<td>57,031</td>
</tr>
<tr>
<td>Unrestricted</td>
<td>19,651</td>
<td>23,884</td>
<td>11,010</td>
</tr>
<tr>
<td>Total net position</td>
<td>71,355</td>
<td>79,674</td>
<td>68,041</td>
</tr>
<tr>
<td>Total liabilities and net position</td>
<td>$ 128,730</td>
<td>$ 127,666</td>
<td>$ 115,749</td>
</tr>
</tbody>
</table>
UNIVERSITY OF CONNECTICUT HEALTH CENTER
JOHN DEMPSEY HOSPITAL (21002 FUND)

MANAGEMENT’S DISCUSSION AND ANALYSIS

FINANCIAL HIGHLIGHTS (CONTINUED)

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2013</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(in thousands)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Summary of revenues, expenses and transfers for the year ended June 30:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating revenues</td>
<td>$308,713</td>
<td>$305,047</td>
<td>$289,410</td>
</tr>
<tr>
<td>Operating expenses</td>
<td>$(326,572)</td>
<td>$(309,097)</td>
<td>$(297,905)</td>
</tr>
<tr>
<td>Operating loss</td>
<td>$(17,859)</td>
<td>$(4,050)</td>
<td>$(8,495)</td>
</tr>
<tr>
<td>Nonoperating revenue, net</td>
<td>414</td>
<td>505</td>
<td>436</td>
</tr>
<tr>
<td>Loss before loss on disposal of Dental Clinics and transfers</td>
<td>$(17,445)</td>
<td>$(3,545)</td>
<td>$(8,059)</td>
</tr>
<tr>
<td>Loss on disposal of Dental Clinics</td>
<td>$(3,850)</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Net transfers</td>
<td>12,976</td>
<td>15,178</td>
<td>8,064</td>
</tr>
<tr>
<td>(Decrease) Increase in net position</td>
<td>$(8,319)</td>
<td>$11,633</td>
<td>$5</td>
</tr>
</tbody>
</table>

CAPITAL ASSETS

At June 30, 2014, the Hospital had property, plant, and equipment of $190.9 million before accumulated depreciation compared to $209.5 million at June 30, 2013, as shown in the table below:

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2013</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(in thousands)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Land</td>
<td>$183</td>
<td>$183</td>
<td>$183</td>
</tr>
<tr>
<td>Construction in progress</td>
<td>11,802</td>
<td>12,905</td>
<td>13,022</td>
</tr>
<tr>
<td>Buildings</td>
<td>93,653</td>
<td>102,066</td>
<td>100,179</td>
</tr>
<tr>
<td>Equipment</td>
<td>71,502</td>
<td>80,614</td>
<td>78,007</td>
</tr>
<tr>
<td>Capital leases</td>
<td>13,776</td>
<td>13,776</td>
<td>13,776</td>
</tr>
<tr>
<td>Total Property, Plant and Equipment</td>
<td>$190,916</td>
<td>$209,544</td>
<td>$205,167</td>
</tr>
</tbody>
</table>

For fiscal 2015 all UConn Health capital requests will be considered for funding on an individual basis. Capital requests will be considered by the senior executive committee of UConn Health. More detailed information about the Hospital’s plant and equipment is presented in note 6 to the financial statements.
STATEMENTS OF CASH FLOWS

The statements of cash flows provide additional information about the Hospital’s financial results by reporting the major sources and uses of cash. A summary of the statements of cash flows for the years ended June 30, 2014, 2013, and 2012 is as follows:

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2013</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>(in thousands)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash received from operations</td>
<td>$304,520</td>
<td>$291,619</td>
<td>$284,076</td>
</tr>
<tr>
<td>Cash expended for operations</td>
<td>(315,683)</td>
<td>(297,422)</td>
<td>(284,098)</td>
</tr>
<tr>
<td>Net cash used in operations</td>
<td>(11,163)</td>
<td>(5,803)</td>
<td>(22)</td>
</tr>
<tr>
<td>Net cash used in investing activities</td>
<td>(7,781)</td>
<td>(7,415)</td>
<td>(11,811)</td>
</tr>
<tr>
<td>Net cash provided by noncapital financing activities</td>
<td>18,944</td>
<td>14,109</td>
<td>13,340</td>
</tr>
<tr>
<td>Net cash used in capital and related financing activities</td>
<td>--</td>
<td>(891)</td>
<td>(1,507)</td>
</tr>
<tr>
<td>Net change in cash</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

SIGNIFICANT VARIANCES IN FINANCIAL STATEMENTS

In this section, the Hospital explains the reasons for those financial statement items with significant variances relating to fiscal 2014 amounts compared to fiscal 2013.

SUMMARY OF ASSETS AND LIABILITIES

Changes in assets included the following:

Cash – decreased from June 30, 2013 to June 30, 2014 by approximately $6 million, to a net overdraft position of $18.8 million. Decreases in cash were driven by operating losses.

Contract and other receivables – increased from June 30, 2013 to June 30, 2014 by approximately $2.3 million. The increase was driven by the contract between the Hospital and CT Children’s whereby CT Children’s pays the Hospital for costs associated with its administration of the Neonatal Intensive Care Unit (NICU).
SUMMARY OF ASSETS AND LIABILITIES (CONTINUED)

Changes in liabilities included the following:

Due to third-party payors – increased from June 30, 2013 to June 30, 2014 by approximately $1.8 million or 65.5%. The change is related to estimated and actual settlements. These amounts are the result of management’s analysis of outstanding Medicare and Medicaid cost reports and other potential settlement of claims with HMOs.

Due to UConn Health Malpractice Fund – an accrual for malpractice insurance was established for the Hospital in fiscal year 2014 for approximately $1.6 million. The balance represents the allocation of 2014 premiums for malpractice coverage owed to the UConn Health’s malpractice fund.

SUMMARY OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION

Operating revenue – increased from June 30, 2013 to June 30, 2014 by approximately $3.6 million or 1.2%. Net patient revenue went up $5.3 million or 1.9%. In fiscal year 2013, the Hospital reported approximately $2.1 million in contract and other revenue from meaningful use. There were no meaningful use payments recognized in fiscal year 2014.

Operating expenses – increased from June 30, 2013 to June 30, 2014 by approximately $17.5 million or 5.7% due to salary and fringe increases, including those embedded in internal contractual support. Fringe benefit rates, set by the State of Connecticut, increased approximately 9.8% in 2014.

Transfers from UConn Health – decreased from June 30, 2013 to June 30, 2014 by approximately $2.2 million. In the current year, the Hospital received approximately $4.0 million to cover operating deficiencies and fund strategic initiatives whereas in 2013, approximately $10.2 million was received. In the current year, the Hospital received transfers of $8.9 million related to fringe benefit recoveries for support services paid by the general fund compared to $4.9 million in fiscal year 2013.

FISCAL 2015 OUTLOOK

As we look forward to fiscal year 2015, the Hospital’s focus is on maintaining outstanding clinical care and sufficient volumes in a rapidly evolving market. Healthcare reform continues to bring changes in the ways that the Hospital serves the community while the Bioscience Connecticut initiative is changing the scope of our treatment facilities at the same time.

Average daily census and Hospital discharges finished below budget in 2014 while outpatient equivalents were higher than budget reflecting an overall shift in the market toward outpatient services. Management is continuing to focus on achieving inpatient volume via clinically focused advertising campaigns ahead of the opening of the new Hospital in 2016.
BIOSCIENCE CONNECTICUT

The construction work related to the Bioscience Connecticut initiative continues at a rapid pace. The first phase of the research lab renovations in the Main Building is completed, scientists have moved in and research is being conducted in the newly renovated space. These new research labs are the first programmatic space completed under the Bioscience CT program. In addition, two of three planned parking garages opened in 2013. The UConn Health Outpatient Pavilion (formerly named the Ambulatory Care Center) Project, the new Hospital Tower, the Main Building lab renovation area, and the Jackson Lab Building are all very active construction sites.

CONTACTING THE HOSPITAL’S FINANCIAL MANAGEMENT

This financial report provides the reader with a general overview of the Hospital’s finances and operations. If you have questions about this report or need additional financial information, please contact the Office of Chief Financial Officer, University of Connecticut Health Center, Farmington, Connecticut 06030-3800.
INDEPENDENT AUDITORS’ REPORT

Joint Audit and Compliance Committee
University of Connecticut Health Center

Report on the Financial Statements

We have audited the accompanying financial statements of the University of Connecticut Health Center, John Dempsey Hospital (21002 Fund) (the Hospital), an enterprise fund of the State of Connecticut, as of and for the years ended June 30, 2014 and 2013, and the related notes to the financial statements, which collectively comprise the Hospital’s basic financial statements as listed in the table of contents.

Management’s Responsibility for the Financial Statements

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

Auditors’ Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors’ judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity’s preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity’s internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.
Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the University of Connecticut Health Center, John Dempsey Hospital (21002 Fund) as of June 30, 2014 and 2013, and the results of its operations and changes in net position, and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the required supplementary information, such as Management’s Discussion and Analysis on pages 1 through 6, be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management’s responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audits of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Marcus LLP

Hartford, CT
October 22, 2014
The accompanying notes are an integral part of these financial statements.
### Liabilities and Net Position

#### Current Liabilities

<table>
<thead>
<tr>
<th>Description</th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash overdraft</td>
<td>$18,819,807</td>
<td>$12,799,970</td>
</tr>
<tr>
<td>Accounts payable and accrued expenses</td>
<td>9,737,077</td>
<td>9,877,274</td>
</tr>
<tr>
<td>Accrued payroll</td>
<td>4,973,857</td>
<td>4,917,699</td>
</tr>
<tr>
<td>Due to UConn Health Malpractice Fund</td>
<td>1,564,057</td>
<td>--</td>
</tr>
<tr>
<td>Due to State of Connecticut</td>
<td>2,705,656</td>
<td>2,384,290</td>
</tr>
<tr>
<td>Due to third-party payors</td>
<td>4,491,574</td>
<td>2,713,960</td>
</tr>
<tr>
<td>Accrued compensated absences, current portion (note 7)</td>
<td>6,532,440</td>
<td>6,578,332</td>
</tr>
</tbody>
</table>

**Total Current Liabilities**

<table>
<thead>
<tr>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>48,824,468</td>
<td>39,271,525</td>
</tr>
</tbody>
</table>

#### Noncurrent Liabilities

<table>
<thead>
<tr>
<th>Description</th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accrued compensated absences, net of current portion (note 7)</td>
<td>8,550,544</td>
<td>8,720,114</td>
</tr>
</tbody>
</table>

**Total Noncurrent Liabilities**

<table>
<thead>
<tr>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>8,550,544</td>
<td>8,720,114</td>
</tr>
</tbody>
</table>

**Total Liabilities**

<table>
<thead>
<tr>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>57,375,012</td>
<td>47,991,639</td>
</tr>
</tbody>
</table>

#### Net Position

<table>
<thead>
<tr>
<th>Description</th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net investment in capital assets</td>
<td>51,704,091</td>
<td>55,790,244</td>
</tr>
<tr>
<td>Unrestricted</td>
<td>19,650,938</td>
<td>23,884,354</td>
</tr>
</tbody>
</table>

**Total Net Position**

<table>
<thead>
<tr>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>71,355,029</td>
<td>79,674,598</td>
</tr>
</tbody>
</table>

**Total Liabilities and Net Position**

<table>
<thead>
<tr>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>$128,730,041</td>
<td>$127,666,237</td>
</tr>
</tbody>
</table>

*The accompanying notes are an integral part of these financial statements.*
UNIVERSITY OF CONNECTICUT HEALTH CENTER
JOHN DEMPSEY HOSPITAL (21002 FUND)

STATEMENTS OF REVENUES, EXPENSES,
AND CHANGES IN NET POSITION

FOR THE YEARS ENDED JUNE 30, 2014 AND 2013

The accompanying notes are an integral part of these financial statements.
UNIVERSITY OF CONNECTICUT HEALTH CENTER
JOHN DEMPSEY HOSPITAL (21002 FUND)

STATEMENTS OF CASH FLOWS

FOR THE YEARS ENDED JUNE 30, 2014 AND 2013

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash Flows from Operating Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash received from patients and third-party payors</td>
<td>$285,308,590</td>
<td>$277,941,059</td>
</tr>
<tr>
<td>Cash received from contract and other revenue</td>
<td>$19,210,912</td>
<td>$13,677,643</td>
</tr>
<tr>
<td>Cash paid to employees for salaries and fringe benefits</td>
<td>$(160,952,664)</td>
<td>$(162,498,227)</td>
</tr>
<tr>
<td>Cash paid for other than personal services</td>
<td>$(154,730,344)</td>
<td>$(134,923,807)</td>
</tr>
<tr>
<td><strong>Net Cash Used in Operating Activities</strong></td>
<td>$(11,163,506)</td>
<td>$(5,803,332)</td>
</tr>
</tbody>
</table>

| **Cash Flows from Investing Activities** |               |               |
| Additions to property and equipment | $(7,780,938)  | $(7,414,840)  |
| **Net Cash Used in Investing Activities** | $(7,780,938)  | $(7,414,840)  |

| **Cash Flows from Noncapital Financing Activities** |               |               |
| Gifts received | 550,000       | 550,000       |
| Transfer of Dental Clinics' cash | $(601,740)  | --            |
| Transfer from UConn Health | $12,976,347  | $15,178,047  |
| Advance provided to Finance Corporation | --            | $(7,721,102) |
| Net draw downs on cash overdraft | $6,019,837   | $6,101,840   |
| **Net Cash Provided by Noncapital Financing Activities** | $18,944,444  | $14,108,785  |

| **Cash Flows from Capital and Related Financing Activities** |               |               |
| Interest paid | --            | $(3,533)      |
| Repayment of long-term debt and capital leases | --            | $(887,080)    |
| **Net Cash Used in Capital and Related Financing Activities** | --            | $(890,613)    |

| **Net Change in Cash** | $--           | $--           |

*The accompanying notes are an integral part of these financial statements.*
Reconciliation of Operating Loss to Net Cash

<table>
<thead>
<tr>
<th>Used in Operating Activities</th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating loss</td>
<td>$ (17,859,461)</td>
<td>$ (4,049,405)</td>
</tr>
<tr>
<td>Adjustments to reconcile operating loss to net cash used in operating activities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>8,906,755</td>
<td>9,500,967</td>
</tr>
<tr>
<td>Changes in operating assets and liabilities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient accounts receivable, net</td>
<td>(3,226,614)</td>
<td>554,788</td>
</tr>
<tr>
<td>Due from UConn Health agencies</td>
<td>10,980</td>
<td>3,500,000</td>
</tr>
<tr>
<td>Inventory</td>
<td>349,889</td>
<td>(647,507)</td>
</tr>
<tr>
<td>Contract and other receivables</td>
<td>(2,744,678)</td>
<td>(9,956,831)</td>
</tr>
<tr>
<td>Prepaid expenses</td>
<td>(895,562)</td>
<td>226,892</td>
</tr>
<tr>
<td>Other assets</td>
<td>(67,011)</td>
<td>(999)</td>
</tr>
<tr>
<td>Due to third-party payors</td>
<td>1,777,614</td>
<td>(4,026,611)</td>
</tr>
<tr>
<td>Accounts payable and accrued expenses</td>
<td>420,083</td>
<td>(2,491,817)</td>
</tr>
<tr>
<td>Due to State of Connecticut</td>
<td>399,670</td>
<td>386,069</td>
</tr>
<tr>
<td>Due to UConn Health Malpractice Fund</td>
<td>1,564,057</td>
<td>--</td>
</tr>
<tr>
<td>Accrued payroll</td>
<td>243,234</td>
<td>354,997</td>
</tr>
<tr>
<td>Accrued compensated absences</td>
<td>(42,462)</td>
<td>846,125</td>
</tr>
</tbody>
</table>

Net Cash Used in Operating Activities

<table>
<thead>
<tr>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ (11,163,506)</td>
<td>$ (5,803,332)</td>
</tr>
</tbody>
</table>

In connection with the transfer of the Dental Clinics to UConn Health, certain assets and liabilities were transferred to UConn Health. Reference is made to Note 10.

The accompanying notes are an integral part of these financial statements.
NOTE 1 - DESCRIPTION OF REPORTING ENTITY AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

REPORTING ENTITY

The financial statements include those asset, liability, revenue, and expense accounts reflected in the accounting records of the John Dempsey Hospital (the Hospital), which are primarily accounted for in the 21002 Fund of the University of Connecticut Health Center (UConn Health). There are 21 members of the Board of Trustees of the University of Connecticut. Five serve as ex officio, voting members by virtue of other positions: The Governor is President of the Board, the Commissioners of Agriculture, Education, and Economic and Community Development are Board members, and the Chair of UConn Health’s Board of Directors is a member. Two Board members are elected by alumni for four-year terms (and may be re-elected once, in succession). One undergraduate student is elected by undergraduates for a two-year term. One graduate or professional student is elected by graduate and professional students for a two-year term. Twelve members are appointed by the Governor, subject to confirmation by the General Assembly, for six-year terms, and may be reappointed without limit.

There are 18 members of the University of Connecticut Health Center Board of Directors. Three serve as ex officio voting members and serve concurrently with their positions: The Commissioner of Public Health, The Secretary or a designated under-secretary of the Office of Policy and Management, and the President of the University. All other terms are for three years and include: three members appointed by the Governor, three members appointed by the chair of the Board of Trustees (two of which must be members of the Board of Trustees and last who serves as the chair of the Board of Directors), and 9 at-large members appointed by the Board of Directors itself.

The Hospital is an enterprise fund of the State of Connecticut (the State) and is therefore generally exempt from federal income taxes under Section 115 of the Internal Revenue Code of 1986.

The University of Connecticut Health Center Finance Corporation (Finance Corporation) was established pursuant to Public Act No 87-458. The purpose of the Finance Corporation is to provide greater flexibility for the Hospital and to promote the more efficient provision of health care services. As such, the Finance Corporation has been empowered to purchase supplies and equipment, acquire facilities, approve write-offs of Hospital accounts receivable, process malpractice claims on behalf of the Hospital and UConn Health beginning in 2011, as well as negotiate joint ventures, shared service, and other agreements for the benefit of the Hospital.
NOTE 1 – DESCRIPTION OF REPORTING ENTITY AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

BASIS OF PRESENTATION

The Hospital’s financial statements are prepared in accordance with all relevant Governmental Accounting Standards Board (GASB) pronouncements. GASB No. 20, Accounting and Financial Reporting for Proprietary Funds and Other Governmental Entities That Use Proprietary Fund Accounting, states that proprietary activities may elect to apply the provisions of Financial Accounting Standards Board (FASB) pronouncements issued after November 30, 1989 that do not conflict with or contradict GASB pronouncements. UConn Health has not made this election. The Hospital implemented GASB No. 62, Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements, which directly incorporated into GASB’s authoritative literature certain pronouncement issues by FASB on or before November 30, 1989.


The Hospital also adopted GASB Statement No. 38, Certain Financial Statement Note Disclosures, as of July 1, 2001. These GASB pronouncements established financial reporting standards for state and local governmental entities, including net position presentation, certain classifications of revenues and expenses and management’s discussion and analysis.

During the year ended June 30, 2014, the Hospital adopted GASB No. 69, Government Combinations and Disposals of Government Operations, in connection with the transfer of its Dental Clinics to UConn Health on July 1, 2013. See note 10.

PROPRIETARY FUND ACCOUNTING

The Hospital utilizes the proprietary fund method of accounting whereby revenues and expenses are recognized on the accrual basis. All revenues and expenses are subject to accrual.
NOTE 1 – DESCRIPTION OF REPORTING ENTITY AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

USE OF ESTIMATES

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingencies at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates. Financial statement areas where management applies the use of estimates consist primarily of the allowance for uncollectible accounts, contractual allowances, and third-party reimbursement reserves.

CASH AND CASH OVERDRAFT

Cash includes cash in banks. Cash overdraft positions, which occur when total outstanding issued checks exceed available cash balances at the end of each reporting period, are presented as a liability within the statements of net position. See note 2 for discussion regarding the Hospital’s available borrowing.

ACCOUNTS RECEIVABLE AND NET PATIENT SERVICE REVENUES

Net patient service revenues are reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Settlements are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods, as final settlements are determined.

The amount of the allowance for uncollectible accounts is based upon management’s assessment of historical and expected net collections, business and economic conditions, trends in Medicare and Medicaid health care coverage and other collection indicators. See note 4 for additional information relative to third-party payor programs.

CONTRACT AND OTHER REVENUES

Contract and other revenues primarily consist of services provided to area hospitals under the terms of contractual agreements. Revenue is recorded on the accrual basis of accounting in the period the related services are rendered.
NOTE 1 – DESCRIPTION OF REPORTING ENTITY AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

INVENTORY

Inventory, with the exception of pharmaceuticals, is recorded at cost, being determined by the first-in, first-out (FIFO) method. Pharmaceuticals are valued at market which approximates cost due to high turnover rates. Short-term or minor supplies are expensed as incurred.

CAPITAL ASSETS

Property and equipment acquisitions are recorded at cost. Betterments and major renewals are capitalized, and maintenance and repairs are expensed as incurred.

Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method. Buildings have an estimated useful life of 5 to 50 years and equipment has an estimated useful life of 2 to 25 years. Assets acquired under capital leases and leasehold improvements are depreciated no longer than the lease term. Construction in progress is capitalized as costs are incurred during the construction phase and depreciation will begin once the assets are placed in service.

RETIREMENT PLANS AND OTHER POST EMPLOYMENT BENEFITS

Eligible Hospital employees, as defined, may participate in the following State retirement plans: the State Retirement System Tier I, Tier II, Tier Iia, ARP Hybrid and the Teachers’ Retirement System defined benefit plans; and the Alternate Retirement Plan which is a defined contribution plan. These plans are funded by contributions from the State as well as payroll deductions from employees, except for the Tier II Plan, which is noncontributory.

In addition, eligible employees may participate in a State defined contribution deferred compensation plan, which is funded by payroll deductions from employees.

The State is statutorily responsible for the pension benefits of Hospital employees who participate in the aforementioned defined benefit plans; therefore, no liability for pension benefits is recorded in the Hospital’s financial statements. The State is required to contribute at an actuarially determined rate, which may be reduced by an act of the State legislature. These plans do not issue stand-alone financial reports. Summary information on the plans is publicly available in the State of Connecticut’s Comprehensive Annual Financial Report. Information is not available from the State specifically allocating pension benefits, plan assets, obligations, and expenses applicable to employees of the Hospital. Additional information on salary and fringe costs is presented in note 8.
NOTE 1 – DESCRIPTION OF REPORTING ENTITY AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

**RETIREMENT PLANS AND OTHER POST EMPLOYMENT BENEFITS (CONTINUED)**

In 2008, the State implemented Government Accounting Standards Board Statement No. 45, *Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions*. The State provides post retirement health care and life insurance benefits to eligible UConn Health employees, including those of the Hospital, in accordance with Sections 5-257(d) and 5-259(a) of the Connecticut General Statutes. Upon retirement, liability for retirement and other benefits rests with the State. Therefore, the liability is reported by the State and not recognized in the financial statements of the Hospital. When employees retire, the State pays up to 100% of their health care insurance premium cost (including the cost of dependent coverage). The State finances the cost of post retirement health care and life insurance benefits on a pay-as-you-go basis through an appropriation in the General Fund.

**COMPENSATED ABSENCES**

The Hospital’s employees earn vacation, personal, compensatory and sick time at varying rates depending on their collective bargaining units. Employees may accumulate sick leave up to a specified maximum. Employees are not paid for accumulated sick leave if they leave before retirement. However, employees who retire from the Hospital may convert accumulated sick leave to termination payments at varying rates, depending on the employee’s contract. Amounts recorded on the statements of net position are based on historical experience. All other compensated absences are accrued at 100% of their balance. Compensated absences have been allocated between current and noncurrent based on historical information.

**THIRD-PARTY PAYORS**

Laws governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. Each year as the Office of Inspector General’s (OIG) work plan changes, new areas of scrutiny surface. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in any given period.
INDEPENDENT AUDITORS’ REPORT

Joint Audit and Compliance Committee
University of Connecticut Health Center

Report on the Financial Statements

We have audited the accompanying financial statements of the University of Connecticut Health Center, John Dempsey Hospital (21002 Fund) (the Hospital), an enterprise fund of the State of Connecticut, as of and for the years ended June 30, 2014 and 2013, and the related notes to the financial statements, which collectively comprise the Hospital’s basic financial statements as listed in the table of contents.

Management’s Responsibility for the Financial Statements

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

Auditors’ Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors’ judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity’s preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity’s internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.
Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the University of Connecticut Health Center, John Dempsey Hospital (21002 Fund) as of June 30, 2014 and 2013, and the results of its operations and changes in net position, and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the required supplementary information, such as Management’s Discussion and Analysis on pages 1 through 6, be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management’s responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audits of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Marcum LLP

Hartford, CT
October 22, 2014
UNIVERSITY OF CONNECTICUT HEALTH CENTER  
JOHN DEMPSEY HOSPITAL (21002 FUND)  
STATEMENTS OF NET POSITION  
JUNE 30, 2014 AND 2013

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Current Assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient accounts receivable, net of estimated uncollectibles of $19,303,000 and $20,341,000 at June 30, 2014 and 2013, respectively</td>
<td>$ 33,443,105</td>
<td>$ 30,976,682</td>
</tr>
<tr>
<td>Inventory</td>
<td>7,660,191</td>
<td>8,234,194</td>
</tr>
<tr>
<td>Contract and other receivables</td>
<td>14,318,504</td>
<td>12,027,621</td>
</tr>
<tr>
<td>Due from Finance Corporation, current portion</td>
<td>7,710,122</td>
<td>--</td>
</tr>
<tr>
<td>Prepaid expenses</td>
<td>4,191,603</td>
<td>3,296,041</td>
</tr>
<tr>
<td><strong>Total Current Assets</strong></td>
<td><strong>67,323,525</strong></td>
<td><strong>54,534,538</strong></td>
</tr>
<tr>
<td><strong>Noncurrent Assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other assets</td>
<td>666,641</td>
<td>599,630</td>
</tr>
<tr>
<td>Due from Finance Corporation, noncurrent portion</td>
<td>9,035,784</td>
<td>16,741,825</td>
</tr>
<tr>
<td>Capital assets, net (note 6)</td>
<td>51,704,091</td>
<td>55,790,244</td>
</tr>
<tr>
<td><strong>Total Noncurrent Assets</strong></td>
<td><strong>61,406,516</strong></td>
<td><strong>73,131,699</strong></td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td>$ 128,730,041</td>
<td>$ 127,666,237</td>
</tr>
</tbody>
</table>

The accompanying notes are an integral part of these financial statements.
UNIVERSITY OF CONNECTICUT HEALTH CENTER  
JOHN DEMPSEY HOSPITAL (21002 FUND)  
STATEMENTS OF NET POSITION (CONTINUED)  
JUNE 30, 2014 AND 2013

Liabilities and Net Position

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash overdraft</td>
<td>$ 18,819,807</td>
<td>$ 12,799,970</td>
</tr>
<tr>
<td>Accounts payable and accrued expenses</td>
<td>9,737,077</td>
<td>9,877,274</td>
</tr>
<tr>
<td>Accrued payroll</td>
<td>4,973,857</td>
<td>4,917,699</td>
</tr>
<tr>
<td>Due to UConn Health Malpractice Fund</td>
<td>1,564,057</td>
<td>--</td>
</tr>
<tr>
<td>Due to State of Connecticut</td>
<td>2,705,656</td>
<td>2,384,290</td>
</tr>
<tr>
<td>Due to third-party payors</td>
<td>4,491,574</td>
<td>2,713,960</td>
</tr>
<tr>
<td>Accrued compensated absences, current portion (note 7)</td>
<td>6,532,440</td>
<td>6,578,332</td>
</tr>
<tr>
<td><strong>Total Current Liabilities</strong></td>
<td>48,824,468</td>
<td>39,271,525</td>
</tr>
<tr>
<td><strong>Noncurrent Liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accrued compensated absences, net of current portion (note 7)</td>
<td>8,550,544</td>
<td>8,720,114</td>
</tr>
<tr>
<td><strong>Total Noncurrent Liabilities</strong></td>
<td>8,550,544</td>
<td>8,720,114</td>
</tr>
<tr>
<td><strong>Total Liabilities</strong></td>
<td>57,375,012</td>
<td>47,991,639</td>
</tr>
<tr>
<td><strong>Net Position</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net investment in capital assets</td>
<td>51,704,091</td>
<td>55,790,244</td>
</tr>
<tr>
<td>Unrestricted</td>
<td>19,650,938</td>
<td>23,884,354</td>
</tr>
<tr>
<td><strong>Total Net Position</strong></td>
<td>71,355,029</td>
<td>79,674,598</td>
</tr>
<tr>
<td><strong>Total Liabilities and Net Position</strong></td>
<td>$ 128,730,041</td>
<td>$ 127,666,237</td>
</tr>
</tbody>
</table>

The accompanying notes are an integral part of these financial statements.
UNIVERSITY OF CONNECTICUT HEALTH CENTER  
JOHN DEMPESEY HOSPITAL (21002 FUND) 

STATEMENTS OF REVENUES, EXPENSES,  
AND CHANGES IN NET POSITION  

FOR THE YEARS ENDED JUNE 30, 2014 AND 2013

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Operating Revenues</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net patient service revenues (note 4)</td>
<td>$286,757,590</td>
<td>$281,412,882</td>
</tr>
<tr>
<td>Contract and other revenues</td>
<td>21,955,590</td>
<td>23,634,474</td>
</tr>
<tr>
<td><strong>Total Operating Revenues</strong></td>
<td>308,713,180</td>
<td>305,047,356</td>
</tr>
<tr>
<td><strong>Operating Expenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>104,623,208</td>
<td>110,136,856</td>
</tr>
<tr>
<td>Fringe benefits</td>
<td>55,729,014</td>
<td>50,774,180</td>
</tr>
<tr>
<td>Medical/dental house staff</td>
<td>20,183,070</td>
<td>14,241,190</td>
</tr>
<tr>
<td>Medical contractual support</td>
<td>5,199,144</td>
<td>4,174,725</td>
</tr>
<tr>
<td>Internal contractual support</td>
<td>31,562,557</td>
<td>22,954,922</td>
</tr>
<tr>
<td>Outside agency per diems</td>
<td>1,361,771</td>
<td>1,102,893</td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>8,906,755</td>
<td>9,500,967</td>
</tr>
<tr>
<td>Pharmaceutical/medical supplies</td>
<td>54,445,527</td>
<td>51,007,924</td>
</tr>
<tr>
<td>Utilities</td>
<td>2,129,221</td>
<td>1,985,750</td>
</tr>
<tr>
<td>Outside and other purchased services</td>
<td>28,620,860</td>
<td>27,004,937</td>
</tr>
<tr>
<td>Insurance</td>
<td>3,444,465</td>
<td>4,022,353</td>
</tr>
<tr>
<td>Repairs and maintenance</td>
<td>7,039,298</td>
<td>7,671,014</td>
</tr>
<tr>
<td>Other expenses</td>
<td>3,327,751</td>
<td>4,519,050</td>
</tr>
<tr>
<td><strong>Total Operating Expenses</strong></td>
<td>326,572,641</td>
<td>309,096,761</td>
</tr>
<tr>
<td><strong>Operating Loss</strong></td>
<td>(17,859,461)</td>
<td>(4,049,405)</td>
</tr>
<tr>
<td><strong>Nonoperating Revenues (Expenses)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gift income</td>
<td>550,000</td>
<td>550,000</td>
</tr>
<tr>
<td>Loss on disposals</td>
<td>(136,094)</td>
<td>(41,916)</td>
</tr>
<tr>
<td>Interest expense</td>
<td>--</td>
<td>(3,533)</td>
</tr>
<tr>
<td><strong>Net Nonoperating Revenues</strong></td>
<td>413,906</td>
<td>504,551</td>
</tr>
<tr>
<td><strong>Loss before Loss on Disposal of Dental Clinics and Transfers</strong></td>
<td>(17,445,555)</td>
<td>(3,544,854)</td>
</tr>
<tr>
<td><strong>Loss on Disposal of Dental Clinics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfers from UConn Health - Unrestricted (note 8)</td>
<td>(3,850,361)</td>
<td>--</td>
</tr>
<tr>
<td>(Decrease) Increase in Net Position</td>
<td>(8,319,569)</td>
<td>11,633,193</td>
</tr>
<tr>
<td>Net Position - Beginning</td>
<td>79,674,598</td>
<td>68,041,405</td>
</tr>
<tr>
<td>Net Position - End</td>
<td>$71,355,029</td>
<td>$79,674,598</td>
</tr>
</tbody>
</table>

*The accompanying notes are an integral part of these financial statements.*
UNIVERSITY OF CONNECTICUT HEALTH CENTER
JOHN DEMPSEY HOSPITAL (21002 FUND)

STATEMENTS OF CASH FLOWS

FOR THE YEARS ENDED JUNE 30, 2014 AND 2013

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash Flows from Operating Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash received from patients and third-party payors</td>
<td>$ 285,308,590</td>
<td>$ 277,941,059</td>
</tr>
<tr>
<td>Cash received from contract and other revenue</td>
<td>19,210,912</td>
<td>13,677,643</td>
</tr>
<tr>
<td>Cash paid to employees for salaries and fringe benefits</td>
<td>(160,952,664)</td>
<td>(162,498,227)</td>
</tr>
<tr>
<td>Cash paid for other than personal services</td>
<td>(154,730,344)</td>
<td>(134,923,807)</td>
</tr>
<tr>
<td><strong>Net Cash Used in Operating Activities</strong></td>
<td>(11,163,506)</td>
<td>(5,803,332)</td>
</tr>
<tr>
<td><strong>Cash Flows from Investing Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additions to property and equipment</td>
<td>(7,780,938)</td>
<td>(7,414,840)</td>
</tr>
<tr>
<td><strong>Net Cash Used in Investing Activities</strong></td>
<td>(7,780,938)</td>
<td>(7,414,840)</td>
</tr>
<tr>
<td><strong>Cash Flows from Noncapital Financing Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gifts received</td>
<td>550,000</td>
<td>550,000</td>
</tr>
<tr>
<td>Transfer of Dental Clinics’ cash</td>
<td>(601,740)</td>
<td>--</td>
</tr>
<tr>
<td>Transfer from UConn Health</td>
<td>12,976,347</td>
<td>15,178,047</td>
</tr>
<tr>
<td>Advance provided to Finance Corporation</td>
<td>--</td>
<td>(7,721,102)</td>
</tr>
<tr>
<td>Net draw downs on cash overdraft</td>
<td>6,019,837</td>
<td>6,101,840</td>
</tr>
<tr>
<td><strong>Net Cash Provided by Noncapital Financing Activities</strong></td>
<td>18,944,444</td>
<td>14,108,785</td>
</tr>
<tr>
<td><strong>Cash Flows from Capital and Related Financing Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest paid</td>
<td>--</td>
<td>(3,533)</td>
</tr>
<tr>
<td>Repayment of long-term debt and capital leases</td>
<td>--</td>
<td>(887,080)</td>
</tr>
<tr>
<td><strong>Net Cash Used in Capital and Related Financing Activities</strong></td>
<td>--</td>
<td>(890,613)</td>
</tr>
<tr>
<td><strong>Net Change in Cash</strong></td>
<td>$ --</td>
<td>$ --</td>
</tr>
</tbody>
</table>

The accompanying notes are an integral part of these financial statements.
Reconciliation of Operating Loss to Net Cash

### Used in Operating Activities

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating loss</td>
<td>$(17,859,461)</td>
<td>$(4,049,405)</td>
</tr>
<tr>
<td>Adjustments to reconcile operating loss to net cash used in operating activities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>8,906,755</td>
<td>9,500,967</td>
</tr>
<tr>
<td>Changes in operating assets and liabilities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient accounts receivable, net</td>
<td>(3,226,614)</td>
<td>554,788</td>
</tr>
<tr>
<td>Due from UConn Health agencies</td>
<td>10,980</td>
<td>3,500,000</td>
</tr>
<tr>
<td>Inventory</td>
<td>349,889</td>
<td>(647,507)</td>
</tr>
<tr>
<td>Contract and other receivables</td>
<td>(2,744,678)</td>
<td>(9,956,831)</td>
</tr>
<tr>
<td>Prepaid expenses</td>
<td>(895,562)</td>
<td>226,892</td>
</tr>
<tr>
<td>Other assets</td>
<td>(67,011)</td>
<td>(999)</td>
</tr>
<tr>
<td>Due to third-party payors</td>
<td>1,777,614</td>
<td>(4,026,611)</td>
</tr>
<tr>
<td>Accounts payable and accrued expenses</td>
<td>420,083</td>
<td>(2,491,817)</td>
</tr>
<tr>
<td>Due to State of Connecticut</td>
<td>399,670</td>
<td>386,069</td>
</tr>
<tr>
<td>Due to UConn Health Malpractice Fund</td>
<td>1,564,057</td>
<td>--</td>
</tr>
<tr>
<td>Accrued payroll</td>
<td>243,234</td>
<td>354,997</td>
</tr>
<tr>
<td>Accrued compensated absences</td>
<td>(42,462)</td>
<td>846,125</td>
</tr>
</tbody>
</table>

### Net Cash Used in Operating Activities

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$(11,163,506)</td>
<td>$(5,803,332)</td>
</tr>
</tbody>
</table>

In connection with the transfer of the Dental Clinics to UConn Health, certain assets and liabilities were transferred to UConn Health. Reference is made to Note 10.

*The accompanying notes are an integral part of these financial statements.*
NOTE 1 - DESCRIPTION OF REPORTING ENTITY AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

REPORTING ENTITY

The financial statements include those asset, liability, revenue, and expense accounts reflected in the accounting records of the John Dempsey Hospital (the Hospital), which are primarily accounted for in the 21002 Fund of the University of Connecticut Health Center (UConn Health). There are 21 members of the Board of Trustees of the University of Connecticut. Five serve as ex officio, voting members by virtue of other positions: The Governor is President of the Board, the Commissioners of Agriculture, Education, and Economic and Community Development are Board members, and the Chair of UConn Health’s Board of Directors is a member. Two Board members are elected by alumni for four-year terms (and may be re-elected once, in succession). One undergraduate student is elected by undergraduates for a two-year term. One graduate or professional student is elected by graduate and professional students for a two-year term. Twelve members are appointed by the Governor, subject to confirmation by the General Assembly, for six-year terms, and may be reappointed without limit.

There are 18 members of the University of Connecticut Health Center Board of Directors. Three serve as ex officio voting members and serve concurrently with their positions: The Commissioner of Public Health, The Secretary or a designated under-secretary of the Office of Policy and Management, and the President of the University. All other terms are for three years and include: three members appointed by the Governor, three members appointed by the chair of the Board of Trustees (two of which must be members of the Board of Trustees and last who serves as the chair of the Board of Directors), and 9 at-large members appointed by the Board of Directors itself.

The Hospital is an enterprise fund of the State of Connecticut (the State) and is therefore generally exempt from federal income taxes under Section 115 of the Internal Revenue Code of 1986.

The University of Connecticut Health Center Finance Corporation (Finance Corporation) was established pursuant to Public Act No 87-458. The purpose of the Finance Corporation is to provide greater flexibility for the Hospital and to promote the more efficient provision of health care services. As such, the Finance Corporation has been empowered to purchase supplies and equipment, acquire facilities, approve write-offs of Hospital accounts receivable, process malpractice claims on behalf of the Hospital and UConn Health beginning in 2011, as well as negotiate joint ventures, shared service, and other agreements for the benefit of the Hospital.
NOTE 1 – DESCRIPTION OF REPORTING ENTITY AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

BASIS OF PRESENTATION

The Hospital’s financial statements are prepared in accordance with all relevant Governmental Accounting Standards Board (GASB) pronouncements. GASB No. 20, Accounting and Financial Reporting for Proprietary Funds and Other Governmental Entities That Use Proprietary Fund Accounting, states that proprietary activities may elect to apply the provisions of Financial Accounting Standards Board (FASB) pronouncements issued after November 30, 1989 that do not conflict with or contradict GASB pronouncements. UConn Health has not made this election. The Hospital implemented GASB No. 62, Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements, which directly incorporated into GASB’s authoritative literature certain pronouncement issues by FASB on or before November 30, 1989.


The Hospital also adopted GASB Statement No. 38, Certain Financial Statement Note Disclosures, as of July 1, 2001. These GASB pronouncements established financial reporting standards for state and local governmental entities, including net position presentation, certain classifications of revenues and expenses and management’s discussion and analysis.

During the year ended June 30, 2014, the Hospital adopted GASB No. 69, Government Combinations and Disposals of Government Operations, in connection with the transfer of its Dental Clinics to UConn Health on July 1, 2013. See note 10.

PROPRIETARY FUND ACCOUNTING

The Hospital utilizes the proprietary fund method of accounting whereby revenues and expenses are recognized on the accrual basis. All revenues and expenses are subject to accrual.
NOTE 1 – DESCRIPTION OF REPORTING ENTITY AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

USE OF ESTIMATES

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingencies at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates. Financial statement areas where management applies the use of estimates consist primarily of the allowance for uncollectible accounts, contractual allowances, and third-party reimbursement reserves.

CASH AND CASH OVERDRAFT

Cash includes cash in banks. Cash overdraft positions, which occur when total outstanding issued checks exceed available cash balances at the end of each reporting period, are presented as a liability within the statements of net position. See note 2 for discussion regarding the Hospital’s available borrowing.

ACCOUNTS RECEIVABLE AND NET PATIENT SERVICE REVENUES

Net patient service revenues are reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Settlements are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods, as final settlements are determined.

The amount of the allowance for uncollectible accounts is based upon management’s assessment of historical and expected net collections, business and economic conditions, trends in Medicare and Medicaid health care coverage and other collection indicators. See note 4 for additional information relative to third-party payor programs.

CONTRACT AND OTHER REVENUES

Contract and other revenues primarily consist of services provided to area hospitals under the terms of contractual agreements. Revenue is recorded on the accrual basis of accounting in the period the related services are rendered.
NOTE 1 – DESCRIPTION OF REPORTING ENTITY AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

INVENTORY

Inventory, with the exception of pharmaceuticals, is recorded at cost, being determined by the first-in, first-out (FIFO) method. Pharmaceuticals are valued at market which approximates cost due to high turnover rates. Short-term or minor supplies are expensed as incurred.

CAPITAL ASSETS

Property and equipment acquisitions are recorded at cost. Betterments and major renewals are capitalized, and maintenance and repairs are expensed as incurred.

Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method. Buildings have an estimated useful life of 5 to 50 years and equipment has an estimated useful life of 2 to 25 years. Assets acquired under capital leases and leasehold improvements are depreciated no longer than the lease term. Construction in progress is capitalized as costs are incurred during the construction phase and depreciation will begin once the assets are placed in service.

RETIREMENT PLANS AND OTHER POST EMPLOYMENT BENEFITS

Eligible Hospital employees, as defined, may participate in the following State retirement plans: the State Retirement System Tier I, Tier II, Tier IIA, ARP Hybrid and the Teachers’ Retirement System defined benefit plans; and the Alternate Retirement Plan which is a defined contribution plan. These plans are funded by contributions from the State as well as payroll deductions from employees, except for the Tier II Plan, which is noncontributory.

In addition, eligible employees may participate in a State defined contribution deferred compensation plan, which is funded by payroll deductions from employees.

The State is statutorily responsible for the pension benefits of Hospital employees who participate in the aforementioned defined benefit plans; therefore, no liability for pension benefits is recorded in the Hospital’s financial statements. The State is required to contribute at an actuarially determined rate, which may be reduced by an act of the State legislature. These plans do not issue stand-alone financial reports. Summary information on the plans is publicly available in the State of Connecticut’s Comprehensive Annual Financial Report. Information is not available from the State specifically allocating pension benefits, plan assets, obligations, and expenses applicable to employees of the Hospital. Additional information on salary and fringe costs is presented in note 8.
RETIREMENT PLANS AND OTHER POST EMPLOYMENT BENEFITS (CONTINUED)

In 2008, the State implemented Government Accounting Standards Board Statement No. 45, Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions. The State provides post retirement health care and life insurance benefits to eligible UConn Health employees, including those of the Hospital, in accordance with Sections 5-257(d) and 5-259(a) of the Connecticut General Statutes. Upon retirement, liability for retirement and other benefits rests with the State. Therefore, the liability is reported by the State and not recognized in the financial statements of the Hospital. When employees retire, the State pays up to 100% of their health care insurance premium cost (including the cost of dependent coverage). The State finances the cost of post retirement health care and life insurance benefits on a pay-as-you-go basis through an appropriation in the General Fund.

COMPENSATED ABSENCES

The Hospital’s employees earn vacation, personal, compensatory and sick time at varying rates depending on their collective bargaining units. Employees may accumulate sick leave up to a specified maximum. Employees are not paid for accumulated sick leave if they leave before retirement. However, employees who retire from the Hospital may convert accumulated sick leave to termination payments at varying rates, depending on the employee’s contract. Amounts recorded on the statements of net position are based on historical experience. All other compensated absences are accrued at 100% of their balance. Compensated absences have been allocated between current and noncurrent based on historical information.

THIRD-PARTY PAYORS

Laws governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. Each year as the Office of Inspector General’s (OIG) work plan changes, new areas of scrutiny surface. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in any given period.
NOTE 1 – DESCRIPTION OF REPORTING ENTITY AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

MEDICAL MALPRACTICE

Health care providers and support staff of the Hospital are fully protected by State Statutes from any claim for damage or injury, not wanton, reckless or malicious, caused in the discharge of their duties or within the scope of their employment (statutory immunity). Any claims paid for actions brought against the State as permitted by waiver of statutory immunity have been charged against UConn Health’s malpractice self-insurance fund. UConn Health retains a qualified actuary to assist with calculating and determining the appropriate annual malpractice reserve. UConn Health allocates an annual malpractice premium to the Hospital, designed to reflect an estimate of the current year’s cash claims to be processed. For the years ended June 30, 2014 and 2013, such premiums were $3,128,114 and $3,672,492, respectively. These premiums are included in insurance expense in the Hospital’s statements of revenues, expenses, and changes in net position. The due to UConn Health Malpractice Fund reported on the June 30, 2014 statement of net position represented premiums payable for occurrence based coverage through June 30, 2014.

NET POSITION

Net position is classified in two components. Net investment in capital assets consists of capital assets net of accumulated depreciation and reduced by the current balances outstanding of any borrowings (less amounts held in trust) used to finance the purchase or construction of those assets. All other assets less liabilities are classified as unrestricted.

REGULATORY MATTERS

The Hospital is required to file semi-annual and annual operating information with the State’s Office of Health Care Access (OHCA) and is required to file annual cost reports with Medicare and Medicaid.

RECLASSIFICATIONS

Certain 2013 amounts have been reclassified to conform to the current year presentation.
NOTE 2 - HYPOTHECATION

In accordance with State Statute, the Hospital can borrow from the State up to 90% of its net patient receivables, contract and other receivables to fund operations. As of June 30, 2014 and 2013, the Hospital had drawn down $18,819,807 and $12,799,970, respectively. As of June 30, 2014 and 2013, the Hospital has available $24,165,640 and $25,903,903, respectively, under the State Statute.

NOTE 3 - CHARITY CARE

The Hospital maintains records to identify and monitor the level of charity care it provides. These records include the amount of charges forgone for services and supplies furnished under its charity care policy, the estimated cost of those services and supplies, and equivalent service statistics. During 2014 and 2013, the Hospital provided charity care services of $629,512 and $801,071, respectively. The cost of these services was $320,939 and $415,547, respectively. No net patient service revenue was recorded for these services and expenses associated with these services were included in operating expenses.

NOTE 4 - NET PATIENT SERVICE REVENUES

The Hospital provides health care services primarily to residents of the region. Revenues from the Medicare program accounted for approximately 45% and 43% of the Hospital’s net patient service revenues for the years ended June 30, 2014 and 2013, respectively. Revenues from the Medicaid program accounted for approximately 31% and 30% of the Hospital’s net patient service revenues for the years ended June 30, 2014 and 2013, respectively. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The Hospital believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrong doing. While no such regulatory inquiries are outstanding, compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from the Medicare and Medicaid programs. Changes in the Medicare and Medicaid programs and the reduction of funding levels could have an adverse impact on the Hospital.

Patient accounts receivable included approximately 36% and 30% due from Medicare and approximately 16% and 9% due from Medicaid at June 30, 2014 and 2013, respectively.
NOTE 4 - NET PATIENT SERVICE REVENUES (CONTINUED)

Patient service revenues reported net of allowances for the years ended June 30, were:

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross patient service revenues</td>
<td>$649,596,982</td>
<td>$581,954,466</td>
</tr>
<tr>
<td>Less contractual allowances</td>
<td>(357,461,826)</td>
<td>(297,190,471)</td>
</tr>
<tr>
<td>Less provision for bad debt</td>
<td>(5,377,566)</td>
<td>(3,351,113)</td>
</tr>
<tr>
<td>Net patient service revenues</td>
<td>$286,757,590</td>
<td>$281,412,882</td>
</tr>
</tbody>
</table>

The Hospital has agreements with third-party payors that provide for payments to the Hospital at amounts different from its established rates. As such, gross patient revenues are reduced by contractual allowances.

A summary of the payment arrangements with major third-party payors follows:

**MEDICARE**

Inpatient acute care services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge. These rates vary according to a patient classification system which are based on clinical, diagnostic, and other factors. The Hospital’s classification of patients under the Medicare program and the appropriateness of their admission are subject to an independent review by a peer review organization under contract with the Hospital. Services to Medicare beneficiaries are paid based on a prospective payment system (PPS) based on the classification of each case into a Diagnostic-Related Group (DRG). Inpatient psychiatric services are also reimbursed via a PPS system established for inpatient psychiatric patients based on pre-determined hospital specific per diems. The Hospital is reimbursed for Direct Graduate Medical Education and Medicare Bad Debts at an interim rate with final settlement determined after submission of annual cost reports by the Hospital and audits thereof by the Medicare fiscal intermediary. The Hospital’s Medicare cost reports have been audited by the Medicare fiscal intermediary through fiscal year 2011 with the exception of fiscal year 2006 which remains open.
NOTE 4 – NET PATIENT SERVICE REVENUES (CONTINUED)

MEDICAID

Inpatient services rendered to Medicaid program beneficiaries are reimbursed, in part, under the Tax Equity and Fiscal Responsibility Act (TEFRA) reimbursement methodology which provides for a cost-based reimbursement subject to a maximum target rate amount per discharge with the exception of individuals who are eligible for care under the state managed Medicaid program where reimbursement is based on contracts with other managed care companies. The Hospital is reimbursed at an interim rate with final settlement determined after submission of annual cost reports by the Hospital and audits thereof by the Medicaid fiscal intermediary.

Outpatient services rendered to patients are reimbursed based on the cost of services provided except for individuals in the managed Medicaid program where reimbursement is based on contracts as described above. The Hospital’s Medicaid cost reports have been audited by the Medicaid fiscal intermediary through 1997. Unaudited cost reports have been submitted as requested by Department of Social Services (DSS) through fiscal year 2012.

COMMERCIAL INSURANCE AND MANAGED CARE

The Hospital has agreements with certain commercial insurance carriers and Health Maintenance Organizations (HMOs) to provide medical services to subscribing participants. In addition, the HMOs make fee-for-service payments to the Hospital for certain covered services based upon discounted fee schedules.

ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS

The Hospital’s estimation of the allowance for uncollectible accounts is based primarily upon the type and age of the patient accounts receivable and the effectiveness of the Hospital’s collection efforts. The Hospital’s policy is to reserve a portion of all self-pay receivables, including amounts due from the uninsured and amounts related to co-payments and deductibles, as these charges are recorded. On a monthly basis, the Hospital reviews its accounts receivable balances, the effectiveness of the Hospital’s reserve policies and various analytics to support the basis for its estimates. These efforts primarily consist of reviewing the following:

- Revenue and volume trends by payor, particularly the self-pay components
- Changes in the aging and payor mix of accounts receivable, including increased focus on accounts due from the uninsured and accounts that represent co-payments and deductibles due from patients
- Various allowance coverage statistics
NOTE 4 – NET PATIENT SERVICE REVENUES (CONTINUED)

ALLOWANCE FORUNCOLLECTIBLE ACCOUNTS (CONTINUED)

The Hospital regularly performs hindsight procedures to evaluate historical write-off and collection experience throughout the year to assist in determining the reasonableness of its process for estimating the allowance for uncollectible accounts.

ICD-10 IMPLEMENTATION

The Hospital is subject to the administrative simplification provisions of HIPAA which require the use of uniform electronic data transmission standards for health care claims and payment transactions submitted or received electronically.

In January 2009, the Centers for Medicare and Medicaid Services (CMS) published its tenth revision of International Statistical Classification of Diseases and Related Health Problems (ICD-10) and related changes to the formats used for certain electronic transactions. ICD-10 contains significantly more diagnostic and procedural codes than the existing ICD-9 coding system, and as a result, the coding for the services provided in the Hospital and its clinics will require much greater specificity.

While HIPAA originally required implementation of ICD-10 to be achieved by October 1, 2013, CMS extended this deadline to October 1, 2015.

Implementation of ICD-10 will require a significant investment in technology and training. The Hospital may experience delays in reimbursement while the Hospital and the payors from which it seeks reimbursement make the transition to ICD-10. If the Hospital fails to implement the new coding system by the deadline, the Hospital will not be paid for services. Management is not able to reasonably estimate the overall financial impact of the Hospital’s transition to ICD-10.

NOTE 5 – ELECTRONIC HEALTH RECORD REIMBURSEMENT

The Health Information Technology for Economic and Clinical Health Act (the HITECH Act) was enacted into law on February 17, 2009 as part of the American Recovery and Reinvestment Act of 2009 (ARRA). The HITECH Act includes provisions designed to increase the use of electronic health records by health professionals and hospitals. Beginning with federal fiscal year 2011 and extending through federal fiscal year 2016, eligible providers participating in the Medicare and Medicaid programs are eligible for reimbursement incentives based on successfully demonstrating meaningful use of certified Electronic Health Record (EHR) technology. Conversely, those providers that do not successfully demonstrate meaningful use of EHR technology are subject to reductions in reimbursements beginning in fiscal year 2016.
NOTE 5 – ELECTRONIC HEALTH RECORD REIMBURSEMENT (CONTINUED)

The Medicaid EHR incentive program provides annual incentive payments to eligible professionals and hospitals for efforts to adopt, implement, and meaningfully use certified EHR technology.

The Hospital utilizes a grant accounting model to recognize EHR incentive revenues. EHR incentive revenues are recognized ratably over the relevant cost report period to determine the amount of the reimbursement.

EHR incentive payment revenue totaling $2,487,000 for the year ended June 30, 2013, is included in contract and other revenues in the accompanying statement of revenues, expenses, and changes in net position. There was no EHR incentive payment revenue recognized by the Hospital for the year ended June 30, 2014. The Hospital’s attestation of compliance with the meaningful use criteria is subject to audit by the federal government. Additionally, Medicare EHR incentive payments received are subject to retrospective adjustment upon final settlement of the applicable cost report from which payments were calculated.

A receivable of $556,340 was recorded for the Medicaid portion of the program as of June 30, 2013 and was included in contract and other receivables on the 2013 statement of net position. There were no receivables recorded for this program as of June 30, 2014.

NOTE 6 – CAPITAL ASSETS, NET

Capital assets at June 30 consist of the following:

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land</td>
<td>$ 183,137</td>
<td>$ 183,137</td>
</tr>
<tr>
<td>Construction in progress (estimated cost to complete $3.5 million)</td>
<td>11,801,640</td>
<td>12,904,730</td>
</tr>
<tr>
<td>Buildings</td>
<td>93,653,262</td>
<td>102,066,199</td>
</tr>
<tr>
<td>Equipment</td>
<td>71,501,502</td>
<td>80,613,427</td>
</tr>
<tr>
<td>Capital leases</td>
<td>13,776,275</td>
<td>13,776,275</td>
</tr>
<tr>
<td></td>
<td>190,915,816</td>
<td>209,543,768</td>
</tr>
<tr>
<td>Less accumulated depreciation and amortization</td>
<td>139,211,725</td>
<td>153,753,524</td>
</tr>
<tr>
<td>Capital assets, net</td>
<td>$ 51,704,091</td>
<td>$ 55,790,244</td>
</tr>
</tbody>
</table>
NOTE 6 – CAPITAL ASSETS, NET (CONTINUED)

Plant and equipment activity for the years ended June 30, 2014 and 2013 was as follows:

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>Additions</th>
<th>Deductions</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land</td>
<td>$183,137</td>
<td>-- $</td>
<td>-- $</td>
<td>$183,137</td>
</tr>
<tr>
<td>Construction in progress</td>
<td>12,904,730</td>
<td>6,276,980</td>
<td>(7,380,070)</td>
<td>11,801,640</td>
</tr>
<tr>
<td>Buildings</td>
<td>102,066,199</td>
<td>2,592,870</td>
<td>(11,005,807)</td>
<td>93,653,262</td>
</tr>
<tr>
<td>Equipment</td>
<td>80,613,427</td>
<td>5,572,553</td>
<td>(14,684,478)</td>
<td>71,501,502</td>
</tr>
<tr>
<td>Capital leases</td>
<td>13,776,275</td>
<td>--</td>
<td>--</td>
<td>13,776,275</td>
</tr>
<tr>
<td></td>
<td><strong>209,543,768</strong></td>
<td><strong>14,442,403</strong></td>
<td><strong>(33,070,355)</strong></td>
<td><strong>190,915,816</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>Additions</th>
<th>Deductions</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land</td>
<td>$183,137</td>
<td>-- $</td>
<td>-- $</td>
<td>$183,137</td>
</tr>
<tr>
<td>Construction in progress</td>
<td>13,022,370</td>
<td>8,998,328</td>
<td>(9,115,968)</td>
<td>12,904,730</td>
</tr>
<tr>
<td>Buildings</td>
<td>100,179,050</td>
<td>1,904,107</td>
<td>(16,958)</td>
<td>102,066,199</td>
</tr>
<tr>
<td>Equipment</td>
<td>78,006,552</td>
<td>5,628,373</td>
<td>(3,021,498)</td>
<td>80,613,427</td>
</tr>
<tr>
<td>Capital leases</td>
<td>13,776,275</td>
<td>--</td>
<td>--</td>
<td>13,776,275</td>
</tr>
<tr>
<td></td>
<td><strong>205,167,384</strong></td>
<td><strong>16,530,808</strong></td>
<td><strong>(12,154,424)</strong></td>
<td><strong>209,543,768</strong></td>
</tr>
</tbody>
</table>

Related information on accumulated depreciation and amortization for the years ended June 30, 2014 and 2013 was as follows:

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>Additions</th>
<th>Deductions</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buildings</td>
<td>$79,493,841</td>
<td>$2,342,805</td>
<td>$(9,396,471)</td>
<td>$72,440,175</td>
</tr>
<tr>
<td>Equipment</td>
<td>61,024,680</td>
<td>6,135,645</td>
<td>(14,052,083)</td>
<td>53,108,242</td>
</tr>
<tr>
<td>Capital leases</td>
<td>13,235,003</td>
<td>428,305</td>
<td>--</td>
<td>13,663,308</td>
</tr>
<tr>
<td></td>
<td><strong>153,753,524</strong></td>
<td><strong>8,906,755</strong></td>
<td><strong>(23,448,554)</strong></td>
<td><strong>139,211,725</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>Additions</th>
<th>Deductions</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buildings</td>
<td>$76,768,082</td>
<td>$2,739,885</td>
<td>$(14,126)</td>
<td>$79,493,841</td>
</tr>
<tr>
<td>Equipment</td>
<td>57,674,317</td>
<td>6,332,777</td>
<td>(2,982,414)</td>
<td>61,024,680</td>
</tr>
<tr>
<td>Capital leases</td>
<td>12,806,698</td>
<td>428,305</td>
<td>--</td>
<td>13,235,003</td>
</tr>
<tr>
<td></td>
<td><strong>147,249,097</strong></td>
<td><strong>9,500,967</strong></td>
<td><strong>(2,996,540)</strong></td>
<td><strong>153,753,524</strong></td>
</tr>
</tbody>
</table>
NOTE 6 – CAPITAL ASSETS, NET (CONTINUED)

Fiscal 2014 deductions include deductions associated with the transfer of assets to UConn Health. Specifically, $13,150,174 of capital assets as well as their associated accumulated depreciation of $10,325,932 were transferred as of July 1, 2014.

NOTE 7 – LONG-TERM LIABILITIES

Long-term liability activity for the years ended June 30, 2014 and 2013 was as follows:

<table>
<thead>
<tr>
<th></th>
<th>June 30, 2013</th>
<th>June 30, 2014</th>
<th>Amounts due within 1 year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Balance</td>
<td>Additions</td>
<td>Deductions</td>
</tr>
<tr>
<td>Accrued compensated</td>
<td>$15,298,446</td>
<td>$11,727,346</td>
<td>($11,942,808)</td>
</tr>
<tr>
<td>absences</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>$15,298,446</td>
<td>$11,727,346</td>
<td>($11,942,808)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>June 30, 2012</th>
<th>June 30, 2013</th>
<th>Amounts due within 1 year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Balance</td>
<td>Additions</td>
<td>Deductions</td>
</tr>
<tr>
<td>Accrued compensated</td>
<td>$14,452,321</td>
<td>$12,185,784</td>
<td>($11,339,659)</td>
</tr>
<tr>
<td>absences</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital leases</td>
<td>471,882</td>
<td>--</td>
<td>(471,882)</td>
</tr>
<tr>
<td>Long-term debt</td>
<td>415,198</td>
<td>--</td>
<td>(415,198)</td>
</tr>
<tr>
<td>Total</td>
<td>$15,339,401</td>
<td>$12,185,784</td>
<td>($12,226,739)</td>
</tr>
</tbody>
</table>

The Hospital participates in operating lease agreements under UConn Health for which its departments are allocated expenses based on square footage occupied. Rent expense was $3,614,343 and $3,498,769 in 2014 and 2013, respectively.

Upon completion of the Outpatient Pavilion (formerly the Ambulatory Care Center), scheduled for April of 2015, the Hospital will lease space in the new facility. The amount of rent expense that will be charged to the Hospital, UConn Medical Group, and other tenants of the Outpatient Pavilion will be approximately $3.5 million in fiscal year 2015 and approximately $14 million annually thereafter for the remainder of the lease term, which expires in March 2040. Refer to note 8 for additional details regarding advances made by the Hospital to construct the Outpatient Pavilion.
NOTE 7 – LONG-TERM LIABILITIES (CONTINUED)

The following is a schedule by year of existing future minimum lease payments under non-cancellable operating leases as of June 30, 2014, including space in the Outpatient Pavilion through the lease term with the Finance Corporation that expires in March 2040:

<table>
<thead>
<tr>
<th>Year ending June 30</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>$4,461,173</td>
</tr>
<tr>
<td>2016</td>
<td>8,026,864</td>
</tr>
<tr>
<td>2017</td>
<td>7,951,297</td>
</tr>
<tr>
<td>2018</td>
<td>7,650,587</td>
</tr>
<tr>
<td>2019</td>
<td>7,649,829</td>
</tr>
<tr>
<td>Thereafter</td>
<td>108,238,335</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$143,978,085</strong></td>
</tr>
</tbody>
</table>

NOTE 8 – RELATED PARTY TRANSACTIONS

The expenses reported in the statements of revenues, expenses, and changes in net position do not include undetermined amounts for salaries, services, and expenses provided to and received from UConn Health and other state agencies. Complete allocations have not been made for salaries and other services incurred by the Hospital on behalf of other UConn Health entities. In addition, certain activities accounted for in the 21002 Fund are periodically evaluated and transferred to/from other funds depending on the overall objectives of UConn Health.

The Hospital is party to an agreement with UConn Health whereby the salaries of certain administrative employees are reimbursed by the Hospital. The non-clinical support services provided to the Hospital from UConn Health have been reported in the financial statements as part of the internal contractual support expense.

UConn Health transferred $8.9 million and $4.9 million in 2014 and 2013, respectively, related to fringe benefit recoveries for support services paid by the general fund. During the year ended June 30, 2013 $22,000 was transferred to fund capital projects. No amounts were transferred to fund capital projects during the year ended June 30, 2014.

The Hospital transferred all Dental Clinic assets and liabilities to UConn Health as of July 1, 2013. See note 10 for additional information.
NOTE 8 – RELATED PARTY TRANSACTIONS (CONTINUED)

In 2014 and 2013, $4.0 million and $10.2 million, respectively, were transferred to the Hospital from UConn Health’s operating fund for budgeted operating support. These transfers are included in transfers in the statements of revenues, expenses and changes in net position.

As more fully described in note 9, UConn Health charges the Hospital with an annual premium for medical malpractice costs which is determined annually by UConn Health. The Hospital is not liable beyond the annual premium, but may have future operational subsidies affected by the performance of the malpractice fund.

As described in Note 1, the Hospital participates in certain State retirement plans. The State charges the Hospital for these and other fringe benefits. During the years ended June 30, 2014 and 2013, the Hospital incurred $55,729,014 and $50,774,180, respectively, for employee fringe benefits. Related salary costs were $104,623,208 and $110,136,856, respectively. The amounts due to the State related to the fringe benefit programs as of June 30, 2014 and 2013 are included in the statements of net position.

Contributions to the State for an assessment of postemployment benefits other than pension benefits are also included in fringe benefits expense. The related accrued postemployment benefit liability is a liability of the State.

The Hospital provides medical services to Correctional Managed Health Care patients under a UConn Health contract with the State of Connecticut’s Department of Correction (CTDOC). The Hospital provides inpatient and outpatient care to Correctional Managed Health Care patients at Medicaid rates. The Hospital also provides certain other services under capitated contracts whereby Correctional Managed Healthcare pays a set amount per year for services regardless of volume. The Hospital recorded revenues of $2,224,745 and $2,235,786 for fiscal 2014 and 2013, respectively, and included these revenues in net patient services revenue in the statements of revenues, expenses, and changes in net position.

As described in Note 1, Finance Corporation performs critical services on behalf of the Hospital. These services include the acquisition, construction, and maintenance of clinical space such as the new Outpatient Pavilion building. Total amounts advanced to the Finance Corporation were $16,745,906 and $16,741,825 at June 30, 2014 and 2013, respectively. The Hospital has received a financial guarantee from UConn Health that it will provide the funding required for Finance Corporation to repay the $16.7 million of advances if required. Amounts advanced for construction of the Outpatient Pavilion are expected to be returned at the completion of construction in fiscal 2015.
NOTE 9 – REPORTING OF THE MALPRACTICE FUND

UConn Health is self-insured with respect to medical malpractice risks. Estimated losses from asserted and unasserted claims identified under UConn Health’s incident reporting system and an estimate of incurred but not reported claims are accrued based on actuarially determined estimates that incorporate UConn Health’s past experience as well as other considerations, including the nature of each claim or incident and relevant trend factors. The Hospital provides timely incident reporting to UConn Health to assist UConn Health in maintaining appropriate reserve balances.

To the extent that claims for cases exceed current year premiums charged by UConn Health, UConn Health may petition the State to make up the difference. The Hospital is not responsible for amounts beyond the annual premium allocated by UConn Health. However, operational subsidies from the State and/or UConn Health may be affected by the performance of UConn Health’s malpractice program. At June 30, 2014 and 2013, UConn Health’s Malpractice Fund had actuarial reserves of approximately $21.9 million and $19.9 million and assets of approximately $9.9 million and $8.4 million as of June 30, 2014 and 2013, respectively.

NOTE 10 – TRANSFER OF DENTAL CLINICS TO UCONN HEALTH

On July 1, 2013, UConn Health realigned the Dental Clinics by removing them from the Hospital’s operating unit and aligning them with the institution’s other dental practices. The change was made by transferring all assets and liabilities included in the Hospital’s financial statements to UConn Health. In accordance with GASB 69, during the year ended June 30, 2014, the Hospital recognized a loss of $3,850,361 on the disposal of its Dental Clinics as a special item. The Dental Clinics comprised net patient service revenues of $7,531,254 and total operating expenses of $10,476,216 that were included in the 2013 statement of revenues, expenses and changes in position.
NOTE 10 – TRANSFER OF DENTAL CLINICS TO UCONN HEALTH (CONTINUED)

The effect of the transfer of the Dental Clinics’ assets and liabilities on July 1, 2013 is summarized in the table below.

<table>
<thead>
<tr>
<th>Description</th>
<th>June 30, 2013 Balances in the Statement of Net Position</th>
<th>Dental Account Transfers on July 1, 2013</th>
<th>Balances Net of Dental Transfers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient accounts receivable, net</td>
<td>$30,976,682</td>
<td>(760,191) $</td>
<td>30,216,491 $</td>
</tr>
<tr>
<td>Inventory</td>
<td>8,234,194</td>
<td>(224,114)</td>
<td>8,010,080 $</td>
</tr>
<tr>
<td>Contract and other receivables</td>
<td>12,027,621</td>
<td>(453,795)</td>
<td>11,573,826 $</td>
</tr>
<tr>
<td>Due from Finance Corporation, noncurrent portion</td>
<td>16,741,825</td>
<td>15,061</td>
<td>16,756,886 $</td>
</tr>
<tr>
<td>Capital assets, net</td>
<td>55,790,244</td>
<td>(2,824,242)</td>
<td>52,966,002 $</td>
</tr>
<tr>
<td>Total assets impacted by the transfer</td>
<td>$123,770,566</td>
<td>(4,247,281) $</td>
<td>$119,523,285 $</td>
</tr>
<tr>
<td>Cash overdraft</td>
<td>$12,799,970</td>
<td>601,740 $</td>
<td>13,401,710 $</td>
</tr>
<tr>
<td>Accounts payable and accrued expenses</td>
<td>9,877,274</td>
<td>(560,280)</td>
<td>9,316,994 $</td>
</tr>
<tr>
<td>Accrued payroll</td>
<td>4,917,699</td>
<td>(187,076)</td>
<td>4,730,623 $</td>
</tr>
<tr>
<td>Due to State of Connecticut</td>
<td>2,384,290</td>
<td>(78,304)</td>
<td>2,305,986 $</td>
</tr>
<tr>
<td>Accrued compensated absences, current portion</td>
<td>6,578,332</td>
<td>(74,390)</td>
<td>6,503,942 $</td>
</tr>
<tr>
<td>Accrued compensated absences, net of current portion</td>
<td>8,720,114</td>
<td>(98,610)</td>
<td>8,621,504 $</td>
</tr>
<tr>
<td>Total liabilities impacted by the transfer</td>
<td>$45,277,679</td>
<td>(396,920) $</td>
<td>$44,880,759 $</td>
</tr>
</tbody>
</table>

NOTE 11 – SUBSEQUENT EVENTS

The Hospital has evaluated subsequent events through October 22, 2014, which represents the date the financial statements were available to be issued and noted no subsequent events that would have impacted the Hospital’s financial statements.
The following discussion and analysis provides an overview of the financial position and activities of the University of Connecticut Health Center UConn Medical Group (UConn Medical Group or UMG) as of and for the years ended June 30, 2014, 2013 and 2012. UConn Medical Group is operated as a separate, identifiable unit (included in the 12018 fund) of The University of Connecticut Health Center (UConn Health). The 12018 fund represents the operating fund for all the entities that comprise UConn Health. UConn Medical Group has access to the funds available in the 12018 fund to fund their operations.

This discussion has been prepared by management and should be read in conjunction with the financial statements and the notes thereto, which follow this section.

UConn Medical Group’s clinical operations are modeled, in part, on private group practices and include approximately 386 providers practicing in a wide variety of specialties. The UConn Medical Group operation is an essential element for the education and training of medical students that enables the School of Medicine to accomplish its mission. Medical students, for example, learn diagnosis and treatment by training side-by-side with faculty clinicians as these doctors see patients. Funds transferred from UConn Health support this educational mission.

**Financial Highlights**

The UConn Medical Group’s financial position at June 30, 2014, consisted of assets of $40.3 million and liabilities of $15.2 million. Net position, which represents the residual interest in the UConn Medical Group’s assets after liabilities are deducted, increased approximately $1.4 million in fiscal 2014 to $25.1 million from $23.7 million at June 30, 2013.

Fiscal year 2014 total operating revenue increased 9.2% or approximately $8.3 million. Overall, operational results were unfavorable to prior year, with the loss from operations increasing approximately $10.1 million.

The unfavorable changes in operational results were driven largely by increases in physician expenses. Faculty salaries and fringe benefits increased approximately $16.8 million over the prior year. Increases were attributable to faculty recruitment and retention strategies thereby increasing UMG’s physician count. These costs were supported in part by non-operating transfers to fund salary and fringe benefits. The amount of support realized in the current year increased approximately $7.8 million from fiscal year 2013 to fiscal year 2014. Non-operating transfers from UConn Health allowed UMG to recognize an overall increase in net position in the current fiscal year.
FINANCIAL HIGHLIGHTS (CONTINUED)

Changes in net position represent the operating and non-operating activity of the UConn Medical Group. Account balances are summarized as follows:

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2013</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(in thousands)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Summary of assets, liabilities and net position at June 30:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current assets</td>
<td>$ 13,047</td>
<td>$ 13,798</td>
<td>$ 13,756</td>
</tr>
<tr>
<td>Other assets</td>
<td>4,061</td>
<td>4,072</td>
<td>4,131</td>
</tr>
<tr>
<td>Capital assets, net</td>
<td>23,159</td>
<td>18,321</td>
<td>15,413</td>
</tr>
<tr>
<td>Total assets</td>
<td>$ 40,267</td>
<td>$ 36,191</td>
<td>$ 33,300</td>
</tr>
<tr>
<td>Current liabilities</td>
<td>$ 11,491</td>
<td>$ 9,252</td>
<td>$ 9,938</td>
</tr>
<tr>
<td>Accrued compensated absences, noncurrent portion</td>
<td>3,708</td>
<td>3,225</td>
<td>3,016</td>
</tr>
<tr>
<td>Total liabilities</td>
<td>15,199</td>
<td>12,477</td>
<td>12,954</td>
</tr>
<tr>
<td>Net investment in capital assets</td>
<td>23,159</td>
<td>18,321</td>
<td>15,413</td>
</tr>
<tr>
<td>Unrestricted net assets</td>
<td>1,909</td>
<td>5,393</td>
<td>4,933</td>
</tr>
<tr>
<td>Total net position</td>
<td>25,068</td>
<td>23,714</td>
<td>20,346</td>
</tr>
<tr>
<td>Total liabilities and net position</td>
<td>$ 40,267</td>
<td>$ 36,191</td>
<td>$ 33,300</td>
</tr>
</tbody>
</table>

**Summary of revenues, expenses and transfers for the year ended June 30:**

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2013</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating revenues</td>
<td>$ 99,304</td>
<td>$ 90,975</td>
<td>$ 87,761</td>
</tr>
<tr>
<td>Operating expenses</td>
<td>137,094</td>
<td>118,633</td>
<td>106,663</td>
</tr>
<tr>
<td>Loss from operations</td>
<td>(37,790)</td>
<td>(27,658)</td>
<td>(18,902)</td>
</tr>
<tr>
<td>Nonoperating revenues (expenses), net</td>
<td>71</td>
<td>(239)</td>
<td>--</td>
</tr>
<tr>
<td>Net loss</td>
<td>(37,719)</td>
<td>(27,897)</td>
<td>(18,902)</td>
</tr>
<tr>
<td>Transfers, net</td>
<td>39,073</td>
<td>31,265</td>
<td>23,074</td>
</tr>
<tr>
<td>Increase in net position</td>
<td>$ 1,354</td>
<td>$ 3,368</td>
<td>$ 4,172</td>
</tr>
</tbody>
</table>
OVERVIEW OF THE FINANCIAL STATEMENTS

This annual report consists of management’s discussion and analysis and the financial statements. The basic financial statements (statements of net position, statements of revenues, expenses, and changes in net position, and statements of cash flows) present the financial position of the UConn Medical Group at June 30, 2014 and 2013, and the results of its operations and its financial activities for the years then ended. These statements report information about the UConn Medical Group using accounting methods similar to those used by private-sector companies. The statements of net position include all of the UConn Medical Group’s assets and liabilities. The statements of revenues, expenses, and changes in net position reflect the years’ activities on the accrual basis of accounting, i.e., when services are provided or obligations are incurred, not when cash is received or paid. These statements report the UConn Medical Group’s net position and how it has changed. Net position (the difference between assets and liabilities) is one way to measure financial health or position. The statements of cash flows provide relevant information about each year’s cash receipts and cash payments and classify them as to operating, noncapital financing, and capital and related financing activities. The financial statements include notes that explain information in the financial statements and provide more detailed data.

SIGNIFICANT VARIANCES IN THE FINANCIAL STATEMENTS

In this section, UConn Medical Group explains the reasons for those financial statement items with significant variances relating to fiscal 2014 amounts compared to fiscal 2013.

SUMMARY OF ASSETS AND LIABILITIES

Changes in assets are comprised of the following:

Patient accounts receivable – increased approximately $608,000 or 6.6% from June 30, 2013 to June 30, 2014. This increase was driven by increases in net patient revenues.

Prepaid Expenses – increased approximately $106,000 from June 30, 2013 to June 30, 2014. The increases related to advance payments related to new advertising campaigns for the upcoming year.

Due from Finance Corporation – UMG had a $4.1 million receivable from Finance Corporation at June 30, 2014 and 2013. Finance Corporation enters into certain transactions on behalf of UMG. Due to and due from balance changes arise from timing differences between Finance Corporation services and cash draws to support those services.
SUMMARY OF ASSETS AND LIABILITIES (CONTINUED)

Changes in liabilities are comprised of the following:

Accounts payable and accrued expenses – increased approximately $600,000 from June 30, 2013 to June 30, 2014. Accounts payable balances increased approximately $404,000 and accrued expenses increased approximately $189,000 due to the timing of payment of vendor balances this year versus the prior year.

Accrued payroll – increased approximately $1.1 million from June 30, 2013 to June 30, 2014. Accrued payroll and compensated absences balances fluctuate in relation to the number of employees, salaries, and length of remaining unpaid periods in relation to each fiscal year end.

Due to UConn Health Malpractice Fund – an accrual for malpractice insurance was established for UMG and Women’s Health in fiscal year 2014 for approximately $175,000. The balance represents the allocation of premiums for malpractice coverage owed to the UConn Health’s malpractice trust fund.

SUMMARY OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION

Operating revenues – increased from June 30, 2013 to June 30, 2014 by approximately $8.3 million or 9.2%. Net patient revenues increased $6.2 million or 8.2% from prior year, mostly attributed to recruiting of new physicians in fiscal year 2014, and an increase in relative value units (RVU’s). There was an increase in other revenues in fiscal year 2014 of $2.2 million, including a $1.1 million increase related to EHR revenue and approximately $400,000 increase in contractual revenues.

Operating expenses – increased from June 30, 2013 to June 30, 2014 by approximately $18.5 million or 15.6%. This increase was mostly due to an increase in salary and fringe expense of approximately $16.8 million for fiscal year 2014. Other notable increases included approximately $538,000 in depreciation expense associated with the capitalization of the NextGen EHR project.

Salaries and Fringe Benefits – increased from June 30, 2013 to June 30, 2014 by approximately $16.8 million or 18.8%. This increase was due to increases to salaries and fringe benefits driven by physician recruiting and retention strategies as well as fringe benefit rate increases passed down by the State of Connecticut (State).

Outside Agency Per Diems – decreased from June 30, 2013 to June 30, 2014 by approximately $742,000, which is due to the UMG Anesthesia contract. During fiscal year 2014, the Anesthesia Department was sufficiently staffed with Nurse Anesthetists and therefore, there was a decreased need for per diem support.
SUMMARY OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION (CONTINUED)

Pharmaceutical/Medical Supplies – increased from June 30, 2013 to June 30, 2014 by approximately $597,000 due to purchases of higher priced vaccines and other pharmaceuticals in the areas of Infectious Disease, Bone Osteo, Orthopedics, and Rheumatology.

Depreciation and Amortization - increased from June 30, 2013 to June 30, 2014 by approximately $538,000. This increase was mostly due to the capitalization of the NextGen project in May 2014. The NextGen system will be depreciated over the next 5 years.

SUMMARY OF CASH FLOWS

The statements of cash flows provide additional information about the UConn Medical Group’s financial results by reporting the major sources and uses of cash. A summary of the statements of cash flows for the years ended June 30, 2014, 2013 and 2012 is as follows:

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2013</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash received from operations</td>
<td>$98,674</td>
<td>$93,160</td>
<td>$89,947</td>
</tr>
<tr>
<td>Cash expended for operations</td>
<td>(132,237)</td>
<td>(116,348)</td>
<td>(109,372)</td>
</tr>
<tr>
<td>Net cash used in operations</td>
<td>(33,563)</td>
<td>(23,188)</td>
<td>(19,425)</td>
</tr>
<tr>
<td>Net cash provided by noncapital financing activities</td>
<td>39,179</td>
<td>30,241</td>
<td>22,680</td>
</tr>
<tr>
<td>Net cash used in capital and related financing activities</td>
<td>(7,009)</td>
<td>(4,745)</td>
<td>(3,255)</td>
</tr>
<tr>
<td>Net change in cash</td>
<td>(1,393)</td>
<td>2,308</td>
<td>--</td>
</tr>
<tr>
<td>Cash - Beginning of year</td>
<td>2,308</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Cash - End of year</td>
<td>$915</td>
<td>$2,308</td>
<td>$--</td>
</tr>
</tbody>
</table>

CAPITAL ACTIVITIES

At June 30, 2014, UConn Medical Group had plant and equipment, net of accumulated depreciation, of $23.2 million. For fiscal 2015, all UConn Health capital requests will be considered for funding on an individual basis by the senior executive committee of UConn Health.

More detailed information about the UConn Medical Group’s capital assets activities are presented in note 5 of the financial statements.
Fiscal Year 2015 Outlook

As we look forward to fiscal year 2015, UMG’s main concerns continue to be volume and cost control. Using RVU’s as a measure of productivity, UMG RVU’s increased 5% in 2014. Net revenue gains were outpaced by increases in salary and fringe benefits during the year leading to an increase in the total operating loss. Volume will remain a focus with management using clinically focused advertising campaigns, strategic acquisitions, and faculty recruiting efforts in core areas such as surgery, orthopedics, and dermatology to increase volumes in a competitive marketplace.

UMG will be challenged in the upcoming year with the continued impact of on campus construction on access to UMG’s on-campus facilities. In addition, collective bargaining increases previously agreed to by the State will continue into fiscal 2015 and will unfavorably impact UMG’s operating results. UMG will also be impacted by the effects of the implementation of national healthcare reform and changes in the US and global economic environments. Management will continue to monitor these factors over the upcoming year.

Bioscience Connecticut

The construction work related to the Bioscience Connecticut initiative continues at a rapid pace. The first phase of the research lab renovations in the Main Building is completed, scientists have moved in and research is being conducted in the newly renovated space. These new research labs are the first programmatic space completed under the Bioscience CT program. In addition, two of the three planned parking garages opened in 2013. The UConn Health Outpatient Pavilion (formerly named the Ambulatory Care Center) Project, the Hospital Tower, the Main Building lab renovation area, and the Jackson Lab Building are all very active construction sites.

Contacting UConn Medical Group’s Financial Management

This financial report provides the reader with a general overview of the UConn Medical Group’s finances and operations. If you have questions about this report or need additional financial information, please contact the Office of the Chief Financial Officer, University of Connecticut Health Center, Farmington, Connecticut 06030-3800.
INDEPENDENT AUDITORS’ REPORT

Joint Audit and Compliance Committee
University of Connecticut Health Center

Report on the Financial Statements

We have audited the accompanying financial statements of the University of Connecticut Health Center, UConn Medical Group (UConn Medical Group or Company), a component unit of the State of Connecticut, as of and for the years ended June 30, 2014 and 2013, and the related the notes to financial statements, which collectively comprise UConn Medical Group’s basic financial statements as listed in the table of contents.

Management’s Responsibility for the Financial Statements

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

Auditors’ Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors’ judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity’s preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity’s internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.
Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the University of Connecticut Health Center, UConn Medical Group as of June 30, 2014 and 2013, and the results of its operations and changes in net position, and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the required supplementary information, such as Management’s Discussion and Analysis on pages 1 through 6, be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management’s responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audits of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Marcum LLP

Hartford, CT
October 22, 2014
<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Current Assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash</td>
<td>$ 915,018</td>
<td>$ 2,308,367</td>
</tr>
<tr>
<td>Patient accounts receivable, net of estimated uncollectibles of $3,347,000 and $3,606,000 at June 30, 2014 and 2013, respectively</td>
<td>9,870,175</td>
<td>9,262,623</td>
</tr>
<tr>
<td>Inventory</td>
<td>154,664</td>
<td>248,484</td>
</tr>
<tr>
<td>Contract and other receivables</td>
<td>1,949,476</td>
<td>1,926,486</td>
</tr>
<tr>
<td>Prepaid expenses</td>
<td>157,328</td>
<td>51,769</td>
</tr>
<tr>
<td><strong>Total Current Assets</strong></td>
<td>13,046,661</td>
<td>13,797,729</td>
</tr>
<tr>
<td><strong>Noncurrent Assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Due from Finance Corporation (note 7)</td>
<td>4,061,366</td>
<td>4,072,346</td>
</tr>
<tr>
<td>Capital assets, net (note 5)</td>
<td>23,158,681</td>
<td>18,320,938</td>
</tr>
<tr>
<td><strong>Total Noncurrent Assets</strong></td>
<td>27,220,047</td>
<td>22,393,284</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td>$ 40,266,708</td>
<td>$ 36,191,013</td>
</tr>
</tbody>
</table>
UNIVERSITY OF CONNECTICUT HEALTH CENTER
UCONN MEDICAL GROUP

STATEMENTS OF NET POSITION (CONTINUED)

JUNE 30, 2014 AND 2013

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liabilities and Net Position</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Current Liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts payable and accrued expenses</td>
<td>$ 3,060,558</td>
<td>$ 2,461,038</td>
</tr>
<tr>
<td>Accrued payroll</td>
<td>5,422,396</td>
<td>4,357,944</td>
</tr>
<tr>
<td>Due to UConn Health Malpractice Fund</td>
<td>175,330</td>
<td>--</td>
</tr>
<tr>
<td>Accrued compensated absences, current portion (note 6)</td>
<td>2,832,595</td>
<td>2,432,974</td>
</tr>
<tr>
<td><strong>Total Current Liabilities</strong></td>
<td>11,490,879</td>
<td>9,251,956</td>
</tr>
<tr>
<td><strong>Noncurrent Liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accrued compensated absences, noncurrent portion (note 6)</td>
<td>3,707,684</td>
<td>3,225,106</td>
</tr>
<tr>
<td><strong>Total Noncurrent Liabilities</strong></td>
<td>3,707,684</td>
<td>3,225,106</td>
</tr>
<tr>
<td><strong>Total Liabilities</strong></td>
<td>15,198,563</td>
<td>12,477,062</td>
</tr>
<tr>
<td><strong>Net Position</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net investment in capital assets</td>
<td>23,158,681</td>
<td>18,320,938</td>
</tr>
<tr>
<td>Unrestricted</td>
<td>1,909,464</td>
<td>5,393,013</td>
</tr>
<tr>
<td><strong>Total Net Position</strong></td>
<td>25,068,145</td>
<td>23,713,951</td>
</tr>
<tr>
<td><strong>Total Liabilities and Net Position</strong></td>
<td>$ 40,266,708</td>
<td>$ 36,191,013</td>
</tr>
</tbody>
</table>

The accompanying notes are an integral part of these financial statements.
UNIVERSITY OF CONNECTICUT HEALTH CENTER  
UCONN MEDICAL GROUP  

STATEMENTS OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION  
FOR THE YEARS ENDED JUNE 30, 2014 AND 2013

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating Revenues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net patient service revenues (note 2)</td>
<td>$80,845,644</td>
<td>$74,686,883</td>
</tr>
<tr>
<td>Contract and other revenues</td>
<td>18,458,518</td>
<td>16,287,635</td>
</tr>
<tr>
<td>Total Operating Revenues</td>
<td>99,304,162</td>
<td>90,974,518</td>
</tr>
<tr>
<td>Operating Expenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>74,464,137</td>
<td>65,666,662</td>
</tr>
<tr>
<td>Fringe benefits</td>
<td>32,151,628</td>
<td>24,116,873</td>
</tr>
<tr>
<td>Medical contractual support</td>
<td>7,204,790</td>
<td>7,006,864</td>
</tr>
<tr>
<td>Internal contractual support</td>
<td>4,804,599</td>
<td>3,549,780</td>
</tr>
<tr>
<td>Outside agency per diems</td>
<td>219,505</td>
<td>961,854</td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>2,136,109</td>
<td>1,597,708</td>
</tr>
<tr>
<td>Pharmaceutical/medical supplies</td>
<td>4,248,589</td>
<td>3,651,466</td>
</tr>
<tr>
<td>Utilities</td>
<td>223,147</td>
<td>188,772</td>
</tr>
<tr>
<td>Outside and other purchased services</td>
<td>9,011,998</td>
<td>9,044,118</td>
</tr>
<tr>
<td>Insurance</td>
<td>428,771</td>
<td>498,589</td>
</tr>
<tr>
<td>Repairs and maintenance</td>
<td>734,653</td>
<td>635,133</td>
</tr>
<tr>
<td>Other expenses</td>
<td>1,465,860</td>
<td>1,715,296</td>
</tr>
<tr>
<td>Total Operating Expenses</td>
<td>137,093,786</td>
<td>118,633,115</td>
</tr>
<tr>
<td>Operating Loss</td>
<td>(37,789,624)</td>
<td>(27,658,597)</td>
</tr>
<tr>
<td>Nonoperating Revenues (Expenses)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reimbursement from UConn Foundation</td>
<td>105,759</td>
<td>--</td>
</tr>
<tr>
<td>Loss on disposals</td>
<td>(35,018)</td>
<td>(238,921)</td>
</tr>
<tr>
<td>Net Nonoperating Revenues (Expenses)</td>
<td>70,741</td>
<td>(238,921)</td>
</tr>
<tr>
<td>Loss before Transfers</td>
<td>(37,718,883)</td>
<td>(27,897,518)</td>
</tr>
<tr>
<td>Net transfers from</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UConn Health - Unrestricted (note 7)</td>
<td>39,073,077</td>
<td>31,265,199</td>
</tr>
<tr>
<td>Increase in Net Position</td>
<td>1,354,194</td>
<td>3,367,681</td>
</tr>
<tr>
<td>Net Position - Beginning</td>
<td>23,713,951</td>
<td>20,346,270</td>
</tr>
<tr>
<td>Net Position - End</td>
<td>$25,068,145</td>
<td>$23,713,951</td>
</tr>
</tbody>
</table>

The accompanying notes are an integral part of these financial statements.
# University of Connecticut Health Center
## UConn Medical Group
### Statements of Cash Flows
#### For the Years Ended June 30, 2014 and 2013

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash Flows from Operating Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash received from patients and third-party payors</td>
<td>$ 80,238,092</td>
<td>$ 77,014,119</td>
</tr>
<tr>
<td>Cash received from contract and other revenues</td>
<td>18,435,528</td>
<td>16,145,801</td>
</tr>
<tr>
<td>Cash paid to employees for personal services and fringe benefits</td>
<td>(104,669,114)</td>
<td>(88,719,705)</td>
</tr>
<tr>
<td>Cash paid for other than personal services</td>
<td>(27,567,821)</td>
<td>(27,628,369)</td>
</tr>
<tr>
<td><strong>Net Cash Used in Operating Activities</strong></td>
<td>(33,563,315)</td>
<td>(23,188,154)</td>
</tr>
</tbody>
</table>

| **Cash Flows from Noncapital Financing Activities**             |            |            |
| Reimbursement from UConn Foundation                           | 105,759    | --         |
| Net transfers from UConn Health's unrestricted net assets to support operations | 39,073,077  | 31,265,199  |
| Net repayments on cash overdraft                               | --         | (1,023,801) |
| **Net Cash Provided by Noncapital Financing Activities**       | 39,178,836 | 30,241,398 |

| **Cash Flows from Capital and Related Financing Activities**    |            |            |
| Purchases of capital assets                                    | (7,008,870) | (4,744,877) |
| **Net Cash Used in Capital and Related Financing Activities**  | (7,008,870) | (4,744,877) |

| **Net Change in Cash**                                         | (1,393,349) | 2,308,367  |
| **Cash - Beginning**                                           | 2,308,367   | --         |
| **Cash - End**                                                 | $ 915,018   | $ 2,308,367 |

*The accompanying notes are an integral part of these financial statements.*
Reconciliation of Operating Loss to Net Cash Used in Operating Activities

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating loss</td>
<td>$ (37,789,624)</td>
<td>$ (27,658,597)</td>
</tr>
<tr>
<td>Adjustments to reconcile operating loss to net cash used in operating activities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>2,136,109</td>
<td>1,597,708</td>
</tr>
<tr>
<td>Changes in operating assets and liabilities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient accounts receivable</td>
<td>(607,552)</td>
<td>2,327,236</td>
</tr>
<tr>
<td>Inventory</td>
<td>93,820</td>
<td>29,574</td>
</tr>
<tr>
<td>Contract and other receivables</td>
<td>(22,990)</td>
<td>(141,834)</td>
</tr>
<tr>
<td>Prepaid expenses</td>
<td>(105,559)</td>
<td>52,081</td>
</tr>
<tr>
<td>Due from Finance Corporation</td>
<td>10,980</td>
<td>58,573</td>
</tr>
<tr>
<td>Accounts payable and accrued expenses</td>
<td>599,520</td>
<td>(516,725)</td>
</tr>
<tr>
<td>Due to UConn Health Malpractice Fund</td>
<td>175,330</td>
<td>--</td>
</tr>
<tr>
<td>Accrued payroll</td>
<td>1,064,452</td>
<td>697,239</td>
</tr>
<tr>
<td>Accrued compensated absences</td>
<td>882,199</td>
<td>366,591</td>
</tr>
</tbody>
</table>

Net Cash Used in Operating Activities  $ (33,563,315) $ (23,188,154)

The accompanying notes are an integral part of these financial statements.
NOTE 1 - DESCRIPTION OF REPORTING ENTITY AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

REPORTING ENTITY

The University of Connecticut Health Center UConn Medical Group (UConn Medical Group or UMG) clinical operations are modeled, in part, on private group practices and include approximately 386 providers practicing in a wide variety of specialties.

The financial statements include those asset, liability, revenue, and expense accounts reflected in the accounting records of UConn Medical Group, which is operated as a separate, identifiable unit (included in the 12018 fund) of the University of Connecticut Health Center (UConn Health). The 12018 fund represents the operating fund for all the entities that comprise UConn Health. UConn Medical Group has unlimited access to the funds available in the 12018 fund to fund their operations. The Governor of the State of Connecticut (the State) appoints the Board of Trustees of the University of Connecticut whose chairman then appoints the Board of Directors, which oversees UConn Health, including UConn Medical Group. Reference is made to note 7 for related party transactions.

UConn Medical Group is a component unit of the State and is therefore generally exempt from federal income taxes under Section 115 of the Internal Revenue Code of 1986.

BASIS OF PRESENTATION

UConn Medical Group’s financial statements are prepared in accordance with all relevant Governmental Accounting Standards Board (GASB) pronouncements. GASB No. 20, Accounting and Financial Reporting for Proprietary Funds and Other Governmental Entities that Use Proprietary Fund Accounting, states that proprietary activities may elect to apply the provisions of Financial Accounting Standards Board (FASB) pronouncements issued after November 30, 1989 that do not conflict with or contradict GASB pronouncements. UConn Health has not made this election. UMG implemented GASB No. 62, Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements, which directly incorporated into GASB’s authoritative literature certain pronouncements issued by FASB on or before November 30, 1989.

NOTE 1 - DESCRIPTION OF REPORTING ENTITY AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

**BASIS OF PRESENTATION (CONTINUED)**

UMG also adopted GASB Statement No. 38, *Certain Financial Statement Note Disclosures*, as of July 1, 2001. These GASB pronouncements established financial reporting standards for state and local governmental entities, including net position presentation, certain classifications of revenues and expenses and management’s discussion and analysis.

**USE OF ESTIMATES**

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingencies at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates. Financial statement areas where management applies the use of estimates consist primarily of contractual allowances and the allowance for uncollectible accounts.

**PROPRIETARY FUND ACCOUNTING**

UConn Medical Group utilizes the proprietary fund method of accounting whereby revenues and expenses are recognized on the accrual basis. All revenue and expenses are subject to accrual.

**ACCOUNTS RECEIVABLE AND NET PATIENT SERVICE REVENUES**

Patient accounts receivable and net patient service revenues are recorded at the estimated net realizable amounts from patients when patient services are performed.

The amount of the allowance for uncollectible accounts is based upon management’s assessment of historical and expected net collections, business and economic conditions, trends in Medicare and Medicaid health care coverage and other collection indicators. See note 2 for additional information relative to third-party payor programs.

**CAPITAL ASSETS**

Property and equipment acquisitions are recorded at cost. Betterments and major renewals are capitalized and maintenance and repairs are expensed as incurred.
NOTE 1 - DESCRIPTION OF REPORTING ENTITY AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

CAPITAL ASSETS (CONTINUED)

Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method. Buildings have an estimated useful life of 5 to 50 years and equipment has an estimated useful life of 2 to 25 years. Leasehold improvements are depreciated over the expected life of the assets, but no longer than the lease term. Construction in progress is capitalized as costs are incurred during the construction phase and depreciation will begin once the assets are placed in service.

INVENTORY

Inventory is recorded at cost, being determined by the first-in, first-out (FIFO) method. Short-term or minor supplies are expensed as incurred.

CASH

Cash balances are included in a pooled cash account with the cash balances of the other entities included in the 12018 fund. See note 8 for discussion regarding UConn Medical Group’s available borrowing.

RETIREMENT PLANS AND POST EMPLOYMENT BENEFITS

Eligible employees of UMG, as defined, may participate in the following State retirement plans: the State Retirement System Tier I, Tier II, Tier IIa, the Teachers’ Retirement System defined benefit plans and the Alternate Retirement Plan which is a defined contribution plan. These plans are funded by contributions from the State as well as payroll deductions from employees, except for the Tier II Plan, which is noncontributory.

In addition, eligible employees may participate in a State defined contribution deferred compensation plan, which is funded by payroll deductions from employees.

The State is statutorily responsible for the pension benefits of UMG employees who participate in the aforementioned defined benefit plans; therefore, no liability for pension benefits is recorded in UMG’s financial statements. The State is required to contribute at an actuarially determined rate, which may be reduced by an act of the State legislature. These plans do not issue stand-alone financial reports. Summary information on the plans is publicly available in the State of Connecticut’s Comprehensive Annual Financial Report. Information is not available from the State specifically allocating pension benefits, plan assets, obligations, and expenses applicable to employees of UConn Health. Additional information on salary and fringe costs is presented in note 7.
NOTE 1 - DESCRIPTION OF REPORTING ENTITY AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

RETIREMENT PLANS AND POST EMPLOYMENT BENEFITS (CONTINUED)

In 2008, the State implemented Government Accounting Standards Board Statement No. 45, *Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions*. The State provides post retirement health care and life insurance benefits to eligible Health Center employees, including those of UConn Medical Group, in accordance with Sections 5-257(d) and 5-259(a) of the Connecticut General Statutes. Upon retirement, liability for retirement and other benefits rests with the State. Therefore, the liability is reported by the State and not included in these financial statements of UConn Medical Group. When employees retire, the State pays up to 100% of their health care insurance premium cost (including the cost of dependent coverage). The State finances the cost of post retirement health care and life insurance benefits on a pay-as-you-go basis through an appropriation in the General Fund.

COMPENSATED ABSENCES

UMG’s employees earn vacation, personal, compensatory and sick time at varying rates depending on their collective bargaining units. Employees may accumulate sick leave up to a specified maximum. Employees are not paid for accumulated sick leave if they leave before retirement. However, employees who retire from UMG may convert accumulated sick leave to termination payments at varying rates, depending on the employee’s contract. Amounts recorded on the statements of net position are based on historical experience. All other compensated absences are accrued at 100% of their balance. Compensated absences have been allocated between current and noncurrent based on historical information.

THIRD-PARTY PAYORS

Laws governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. Each year as the Office of Inspector General’s (OIG) work plan changes, new areas of scrutiny surface. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in any given period.
NOTE 1 - DESCRIPTION OF REPORTING ENTITY AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

MEDICAL MALPRACTICE

The physicians and all of the health care providers and support staff of UConn Medical Group are fully protected by State Statutes from any claim for damage or injury, not wanton, reckless or malicious, caused in the discharge of their duties or within the scope of their employment (statutory immunity). Any claims paid for actions brought against the State as permitted by waiver of statutory immunity have been paid against UConn Health’s malpractice self-insurance fund. UConn Health allocates an annual malpractice premium to UConn Medical Group, designed to reflect an estimate for the current year’s cash claims to be processed. For the years ended June 30, 2014 and 2013, such premiums were approximately $294,000 and $345,000, respectively. These premiums are included in insurance expense in UMG’s statements of revenues, expenses, and changes in net position.

The due to UConn Health Malpractice Fund reported on the June 30, 2014 statement of net position represented premiums payable for occurrence based coverage through June 30, 2014.

NET POSITION

Net position is classified in two components. Net investment in capital assets consists of capital assets net of accumulated depreciation and reduced by the current balances of any outstanding borrowings (less amounts held in trust) used to finance the purchase or construction of those assets. All other assets less liabilities are classified as unrestricted.

RECLASSIFICATIONS

Certain 2013 amounts have been reclassified to conform to the current year presentation.

NOTE 2 - PATIENT SERVICE REVENUES

UConn Medical Group provides health care services primarily to residents of the region. Revenues from the Medicare program accounted for approximately 30% and 27% of UConn Medical Group’s net patient service revenues for the years ended June 30, 2014 and 2013, respectively. Revenues from the Medicaid program accounted for approximately 14% and 11% of UConn Medical Group’s net patient service revenues for the years ended June 30, 2014 and 2013, respectively. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. UConn Medical Group believes that it is
NOTE 2 - PATIENT SERVICE REVENUES (CONTINUED)

in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no such regulatory inquiries are outstanding, compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from the Medicare and Medicaid programs. Changes in the Medicare and Medicaid programs and the reduction of funding levels could have an adverse impact on UConn Medical Group.

Patient accounts receivable included approximately 13% and 17% due from Medicaid and approximately 28% and 24% due from Medicare at June 30, 2014 and 2013, respectively.

Patient service revenues reported net of allowances for the years ended June 30 were:

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross patient service revenues</td>
<td>$ 212,622,959</td>
<td>$ 200,839,802</td>
</tr>
<tr>
<td>Less contractual allowances</td>
<td>(130,503,071)</td>
<td>(124,763,416)</td>
</tr>
<tr>
<td>Less provision for bad debt</td>
<td>(1,274,244)</td>
<td>(1,389,503)</td>
</tr>
<tr>
<td>Net patient service revenue</td>
<td>$ 80,845,644</td>
<td>$ 74,686,883</td>
</tr>
</tbody>
</table>

UConn Medical Group has agreements with certain third-party payors that provide for payments to UConn Medical Group at amounts different from established billing rates. A summary of these agreements are as follows:

**MEDICARE**

All services provided to traditional Medicare participants are reimbursed based on the resource-based relative value system (RBRVS). Various third-party payors, with the approval of the Centers for Medicare and Medicaid Services (CMS), provide Medicare managed care programs to its members, which reimburse UConn Medical Group based on their own fee schedules.

**MEDICAID**

Services are reimbursed based on Medicaid fee schedules except for various third-party payors who provide Medicaid managed care programs under the supervision of the State of Connecticut Department of Social Services. These third-parties reimburse UMG based upon their own individual fee schedules.
NOTE 2 - PATIENT SERVICE REVENUES (CONTINUED)

BLUE CROSS HOSPITAL-BASED PROVIDERS

Hospital-based practices, including radiology, are reimbursed based on the Blue Cross Hospital Based Providers (HBP) fee schedule.

BLUE SHIELD

Physicians are reimbursed according to Blue Shield’s published fee schedule.

MANAGED CARE

UConn Medical Group has entered into contracts with managed care companies. The basis for payment under these arrangements is primarily agreed-upon fee schedules with limited capitated contracts for primary care services.

ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS

UMG’s estimation of the allowance for uncollectible accounts is based primarily upon the type and age of the patient accounts receivable and the effectiveness of UMG’s collection efforts. UMG’s policy is to reserve a portion of all self-pay receivables, including amounts due from the uninsured and amounts related to co-payments and deductibles, as these charges are recorded. On a monthly basis, UMG reviews its accounts receivable balances, the effectiveness of UMG’s reserve policies and various analytics to support the basis for its estimates. These efforts primarily consist of reviewing the following:

- Revenue and volume trends by payor, particularly the self-pay components
- Changes in the aging and payor mix of accounts receivable, including increased focus on accounts due from the uninsured and accounts that represent co-payments and deductibles due from patients
- Various allowance coverage statistics

UMG regularly performs hindsight procedures to evaluate historical write-off and collection experience throughout the year to assist in determining the reasonableness of its process for estimating the allowance for uncollectible accounts.

ICD-10 IMPLEMENTATION

UMG is subject to the administrative simplification provisions of HIPAA which require the use of uniform electronic data transmission standards for health care claims and payment transactions submitted or received electronically.
NOTE 2 - PATIENT SERVICE REVENUES (CONTINUED)

In January 2009, the Centers for Medicare and Medicaid Services published its tenth revision of International Statistical Classification of Diseases and Related Health Problems (ICD-10) and related changes to the formats used for certain electronic transactions. ICD-10 contains significantly more diagnostic and procedural codes than the existing ICD-9 coding system, and as a result, the coding for the services provided by UMG will require much greater specificity.

While HIPAA originally required implementation of ICD-10 to be achieved by October 1, 2013, CMS extended this deadline to October 1, 2015.

Implementation of ICD-10 will require a significant investment in technology and training. UMG may experience delays in reimbursement while UMG and the payors from which it seeks reimbursement make the transition to ICD-10. If UMG fails to implement the new coding system by the deadline, UMG will not be paid for services. Management is not able to reasonably estimate the overall financial impact of UMG’s transition to ICD-10.

NOTE 3 - CONTRACT AND OTHER REVENUES

UConn Medical Group enters into contracts with external entities including hospitals, retirement homes and schools to provide physician services. UConn Medical Group also provides physician services to entities within UConn Health, including the School of Medicine, John Dempsey Hospital and Correctional Managed Health Care. Revenue related to these services is included in patient care revenues when relating to patient visits. Other miscellaneous revenues including revenues related to the performance of administrative duties at UConn Health are included in contract and other revenues in the statements of revenues, expenses, and changes in net position. Contract and other revenues are recorded when the services are rendered.

NOTE 4 – ELECTRONIC HEALTH RECORD REIMBURSEMENT

The Health Information Technology for Economic and Clinical Health Act (the HITECH Act) was enacted into law on February 17, 2009 as part of the American Recovery and Reinvestment Act of 2009 (ARRA). The HITECH Act includes provisions designed to increase the use of electronic health records by health professionals. Beginning with federal fiscal year 2011 and extending through federal fiscal year 2016, eligible physicians participating in the Medicare and Medicaid programs are eligible for reimbursement incentives based on successfully demonstrating meaningful use of certified Electronic Health Record (EHR) technology. Conversely, those physicians that do not successfully demonstrate
NOTE 4 – ELECTRONIC HEALTH RECORD REIMBURSEMENT (CONTINUED)

meaningful use of EHR technology are subject to reductions in reimbursements beginning in fiscal year 2016. The Medicaid EHR incentive program provides annual incentive payments to eligible professionals for efforts to adopt, implement, and meaningfully use certified EHR technology. UMG utilizes a grant accounting model to recognize EHR incentive revenues. EHR incentive revenues are recognized ratably over the relevant period to determine the amount of reimbursement. EHR incentive payment revenue totaling approximately $1,571,000 and $450,000 for the years ended June 30, 2014 and 2013, respectively, is included in contract and other revenues in the accompanying statements of revenues, expenses and changes in net position. UMG’s attestation of compliance with the meaningful use criteria is subject to audit by the federal government.

As of June 30, 2014 and 2013 receivables of approximately $166,000 and $56,000, respectively, were recorded for the Medicare portion of the program in contract and other receivables.

NOTE 5 - CAPITAL ASSETS, NET

Property and equipment at June 30, consist of the following:

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land</td>
<td>$ 89,132</td>
<td>$ 89,132</td>
</tr>
<tr>
<td>Construction in progress (estimated cost to complete $750,000)</td>
<td>4,629,334</td>
<td>11,151,628</td>
</tr>
<tr>
<td>Buildings and leasehold improvements</td>
<td>10,263,411</td>
<td>9,863,444</td>
</tr>
<tr>
<td>Equipment</td>
<td>24,455,255</td>
<td>13,311,781</td>
</tr>
<tr>
<td></td>
<td>39,437,132</td>
<td>34,415,985</td>
</tr>
<tr>
<td>Less accumulated depreciation</td>
<td>16,278,451</td>
<td>16,095,047</td>
</tr>
<tr>
<td>Property and equipment, net</td>
<td>$ 23,158,681</td>
<td>$ 18,320,938</td>
</tr>
</tbody>
</table>
NOTE 5 - CAPITAL ASSETS, NET (CONTINUED)

Property and equipment activity for the years ended June 30, 2014 and 2013 was as follows:

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>Additions</th>
<th>Deductions</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land</td>
<td>$89,132</td>
<td>--</td>
<td>$</td>
<td>$89,132</td>
</tr>
<tr>
<td>Construction in progress</td>
<td>11,151,628</td>
<td>6,504,766</td>
<td>(13,027,060)</td>
<td>4,629,334</td>
</tr>
<tr>
<td>Buildings and</td>
<td>10,016,069</td>
<td>965,151</td>
<td>(1,117,776)</td>
<td>9,863,444</td>
</tr>
<tr>
<td>leasehold improvements</td>
<td>13,311,781</td>
<td>13,131,197</td>
<td>(1,987,723)</td>
<td>24,455,255</td>
</tr>
<tr>
<td>Equipment</td>
<td>6,449,839</td>
<td>1,799,068</td>
<td>(848,860)</td>
<td>7,399,047</td>
</tr>
<tr>
<td>$34,415,985</td>
<td>$20,035,930</td>
<td>$ (15,014,783)</td>
<td>$39,437,132</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>Additions</th>
<th>Deductions</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land</td>
<td>$89,132</td>
<td>--</td>
<td>$</td>
<td>$89,132</td>
</tr>
<tr>
<td>Construction in progress</td>
<td>9,170,970</td>
<td>5,501,894</td>
<td>(3,521,236)</td>
<td>11,151,628</td>
</tr>
<tr>
<td>Buildings and</td>
<td>10,016,069</td>
<td>965,151</td>
<td>(1,117,776)</td>
<td>9,863,444</td>
</tr>
<tr>
<td>leasehold improvements</td>
<td>12,361,573</td>
<td>1,799,068</td>
<td>(848,860)</td>
<td>13,311,781</td>
</tr>
<tr>
<td>Equipment</td>
<td>13,311,781</td>
<td>1,799,068</td>
<td>(848,860)</td>
<td>13,311,781</td>
</tr>
<tr>
<td>$31,637,744</td>
<td>$8,266,113</td>
<td>$ (5,487,872)</td>
<td>$34,415,985</td>
<td></td>
</tr>
</tbody>
</table>
NOTE 5 - CAPITAL ASSETS, NET (CONTINUED)

Related information on accumulated depreciation for the years ended June 30, 2014 and 2013 was as follows:

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>Additions</th>
<th>Deductions</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buildings and</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>leasehold improvements</td>
<td>$6,753,172</td>
<td>$368,402</td>
<td>$</td>
<td>-- $7,121,574</td>
</tr>
<tr>
<td>Equipment</td>
<td>$9,341,875</td>
<td>1,767,707</td>
<td>(1,952,705)</td>
<td>$9,156,877</td>
</tr>
<tr>
<td></td>
<td>$16,095,047</td>
<td>$2,136,109</td>
<td>(1,952,705)</td>
<td>$16,278,451</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>Additions</th>
<th>Deductions</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buildings and</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>leasehold improvements</td>
<td>$7,292,299</td>
<td>$345,591</td>
<td>(884,718)</td>
<td>$6,753,172</td>
</tr>
<tr>
<td>Equipment</td>
<td>$8,932,755</td>
<td>1,252,117</td>
<td>(842,997)</td>
<td>$9,341,875</td>
</tr>
<tr>
<td></td>
<td>$16,225,054</td>
<td>$1,597,708</td>
<td>(1,727,715)</td>
<td>$16,095,047</td>
</tr>
</tbody>
</table>

NOTE 6 - LONG-TERM LIABILITIES

Long-term liability activity for the years ended June 30, 2014 and 2013 was as follows:

<table>
<thead>
<tr>
<th></th>
<th>June 30, 2013</th>
<th>Additions</th>
<th>Deductions</th>
<th>June 30, 2014</th>
<th>Amounts due within 1 year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accrued compensated</td>
<td>$5,658,080</td>
<td>$4,787,658</td>
<td>($3,905,459)</td>
<td>$6,540,279</td>
<td>$2,832,595</td>
</tr>
<tr>
<td>absences</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>June 30, 2012</th>
<th>Additions</th>
<th>Deductions</th>
<th>June 30, 2013</th>
<th>Amounts due within 1 year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accrued compensated</td>
<td>$5,291,489</td>
<td>$4,009,236</td>
<td>($3,642,645)</td>
<td>$5,658,080</td>
<td>$2,432,974</td>
</tr>
<tr>
<td>absences</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
NOTE 6 - LONG-TERM LIABILITIES (CONTINUED)

UConn Medical Group leases certain office space under operating leases. Total rental expense for the years ended June 30, 2014 and 2013 was $3,925,659 and $3,601,380, respectively. Rental expense paid to UConn Health for the years ended June 30, 2014 and 2013 was $1,940,685 and $2,235,697, respectively.

Upon completion of the UConn Health Outpatient Pavilion (formerly the Ambulatory Care Center), scheduled for April of 2015, UMG will lease space in the new facility. Refer to note 7 for additional information. The amount of rent expense that will be charged to UConn Medical Group, John Dempsey Hospital and other tenants of the UConn Health Outpatient Pavilion will be approximately $3.5 million in fiscal year 2015 and approximately $14 million annually thereafter for the remainder of the lease term.

The following is a schedule by year of existing future minimum lease payments under non-cancelable operating leases as of June 30, 2014, including space in the Outpatient Pavilion through the lease term with Finance Corporation that expires in March of 2040.

<table>
<thead>
<tr>
<th>Year ending June 30</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>$4,880,508</td>
</tr>
<tr>
<td>2016</td>
<td>11,172,629</td>
</tr>
<tr>
<td>2017</td>
<td>11,164,256</td>
</tr>
<tr>
<td>2018</td>
<td>10,998,051</td>
</tr>
<tr>
<td>2019</td>
<td>11,034,057</td>
</tr>
<tr>
<td>Thereafter</td>
<td>184,446,900</td>
</tr>
<tr>
<td></td>
<td><strong>$233,696,401</strong></td>
</tr>
</tbody>
</table>

NOTE 7 - RELATED PARTY TRANSACTIONS

The operations reported in the accompanying statements of revenues, expenses, and changes in net position do not include undetermined amounts for salaries, services, and expenses provided to and received from UConn Health and other state agencies, other than certain School of Medicine faculty-related personnel expenses which have been allocated to UConn Medical Group based upon State funding and an estimated amount for UConn Health administrative services. Reference is made to note 1 related to medical malpractice costs paid to UConn Health.
NOTE 7 - RELATED PARTY TRANSACTIONS (CONTINUED)

UConn Medical Group is party to an agreement with UConn Health whereby the salaries of certain employees are reimbursed by UConn Health operations. The reimbursed expenses are accounted for as a transfer from the UConn Health under the heading “Net Transfers from UConn Health”. Unrestricted assets of $17,215,396 and $11,464,642 were transferred from UConn Health in 2014 and 2013, respectively. This agreement is expected to continue indefinitely into the future. UConn Health also allocates working capital based on organizational need throughout the year on an as needed basis. UConn Health transferred $21,857,681 and $19,800,557 to UConn Medical Group in 2014 and 2013, respectively. As a result, the total transfers from UConn Health were $39,073,077 and $31,265,199 for 2014 and 2013, respectively.

As described in note 1, UConn Medical Group participates in certain State of Connecticut retirement and fringe benefit plans. During the years ended June 30, 2014 and 2013, UConn Medical Group expensed $32,151,628 and $24,116,873, respectively, for employee fringe benefits including contributions to the State employee retirement funds. Related salary costs were $74,464,137 and $65,666,662, respectively.

Contributions to the State for an assessment of postemployment benefits other than pension benefits are included in fringe benefits expense. The related accrued postemployment benefit liability is a liability of the State.

Patient care revenues and other revenues include approximately $10,375,000 and $10,095,000 in 2014 and 2013, respectively, of professional service revenues arising under contracts with UConn Health, John Dempsey Hospital, and other State agencies.

Effective July 1, 1987, the University of Connecticut Health Center Finance Corporation (Finance Corporation) was established pursuant to Public Act No. 87-458. The purpose of the Finance Corporation is to provide greater flexibility for UConn Medical Group and other UConn Health units to promote the more efficient provision of health care services. As such, the Finance Corporation has been empowered to enter into purchase agreements, acquire facilities, approve write-offs of patient accounts receivable as well as negotiate joint ventures, shared service, and other agreements for the benefit of UConn Medical Group.

UConn Medical Group’s receivable from the Finance Corporation was $4,061,366 and $4,072,346 as of June 30, 2014 and 2013, respectively. The Finance Corporation enters into certain transactions on behalf of the UConn Medical Group and funds these transactions by drawing cash from UMG. The balance due/receivable between these entities will fluctuate based on timing of expenditures and funding transactions. UConn Health has guaranteed the repayment of the $4,061,366 of advances made to the Finance Corporation if the Finance Corporation is unable to make the repayments.
NOTE 7 - RELATED PARTY TRANSACTIONS (CONTINUED)

The Finance Corporation is currently constructing UConn Health’s new Outpatient Pavilion which will serve as the permanent location for several UMG specialty practices. As stated in note 6, the Outpatient Pavilion construction is scheduled for completion in April of 2015. Upon completion of the construction, UMG will lease space from the Finance Corporation thereby facilitating the repayment of the Finance Corporation’s mortgage.

UConn Medical Group provided faculty to UConn Health in the form of administrative and other support. As a result of these efforts, UConn Health reimbursed UMG for physician salaries during the years 2014 and 2013. The amounts received totaled approximately $4.9 million and $4.7 million respectively, and were recorded as contract and other revenue in the statements of revenues, expenses, and changes in net position.

NOTE 8 - HYPOTHECATION

UConn Medical Group has an arrangement with the State whereby it can borrow up to 70% of its net patient and contract and other receivables, if the 12018 fund has an overall negative balance, to continue to fund operations. As of June 30, 2014 and June 30, 2013, UConn Medical Group had a positive cash position of $915,018 and $2,308,367, respectively. Management believes internal and external sources of cash, including the ability to receive additional transfers from UConn Health, will be sufficient to fund activities.

NOTE 9 - SUBSEQUENT EVENTS

UConn Medical Group has evaluated subsequent events through October 22, 2014 which represents the date the financial statements were available to be issued and noted no subsequent events that would have impacted UConn Medical Group’s financial statements.
UNIVERSITY OF CONNECTICUT HEALTH CENTER
FINANCE CORPORATION

CONSOLIDATED FINANCIAL STATEMENTS
AND SUPPLEMENTARY INFORMATION
(With Management’s Discussion and Analysis)

JUNE 30, 2014 AND 2013
UNIVERSITY OF CONNECTICUT HEALTH CENTER
FINANCE CORPORATION

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The following discussion and analysis provides an overview of the consolidated financial position and activities of the University of Connecticut Health Center Finance Corporation and Subsidiaries (Finance Corporation) as of and for the years ended June 30, 2014, 2013 and 2012. This discussion has been prepared by management and should be read in conjunction with the consolidated financial statements and the notes thereto, which follow this section.

**FINANCIAL HIGHLIGHTS**

Finance Corporation’s financial position at June 30, 2014, 2013 and 2012, included assets of $209,260,739, $95,442,149, and $36,597,833, respectively, and liabilities of $201,534,296, $89,212,254, and $31,703,451, respectively. The value of both the assets and liabilities is attributable mainly to the Finance Corporation’s maintaining the real estate and related financing on the Medical Arts and Research Building (MARB), 16 Munson Road, and the ongoing construction of the new Outpatient Pavilion (OP) previously called the Ambulatory Care Center (ACC). Changes in net position represent the operating activity of the Finance Corporation, primarily composed of rental revenues and expenses related to the MARB and Munson Road properties and are summarized below for the years ended June 30, 2014, 2013 and 2012:

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2013</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current assets</td>
<td>$ 62,905,039</td>
<td>$ 27,702,139</td>
<td>$ 4,796,689</td>
</tr>
<tr>
<td>Other assets</td>
<td>--</td>
<td>15,700</td>
<td>15,700</td>
</tr>
<tr>
<td>Capital assets, net</td>
<td>146,355,700</td>
<td>67,724,310</td>
<td>31,785,444</td>
</tr>
<tr>
<td>Total assets</td>
<td>$ 209,260,739</td>
<td>$ 95,442,149</td>
<td>$ 36,597,833</td>
</tr>
<tr>
<td>Current liabilities</td>
<td>$ 22,542,504</td>
<td>$ 6,516,820</td>
<td>$ 2,216,649</td>
</tr>
<tr>
<td>Long-term liabilities</td>
<td>178,991,792</td>
<td>82,695,434</td>
<td>29,486,802</td>
</tr>
<tr>
<td>Total liabilities</td>
<td>$ 201,534,296</td>
<td>$ 89,212,254</td>
<td>$ 31,703,451</td>
</tr>
<tr>
<td>Net investment in capital assets</td>
<td>$ 22,575,023</td>
<td>$ 22,243,699</td>
<td>$ 14,504,537</td>
</tr>
<tr>
<td>Unrestricted (deficit)</td>
<td>(14,848,580)</td>
<td>(16,013,804)</td>
<td>(9,610,155)</td>
</tr>
<tr>
<td>Total net position</td>
<td>7,726,443</td>
<td>6,229,895</td>
<td>4,894,382</td>
</tr>
<tr>
<td>Total liabilities and net position</td>
<td>$ 209,260,739</td>
<td>$ 95,442,149</td>
<td>$ 36,597,833</td>
</tr>
</tbody>
</table>
Summary of revenues, expenses and transfers for the year ended June 30:

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2013</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating revenues</td>
<td>$3,340,230</td>
<td>$3,340,230</td>
<td>$3,038,345</td>
</tr>
<tr>
<td>Operating expenses</td>
<td>(1,837,639)</td>
<td>(1,998,674)</td>
<td>(1,817,485)</td>
</tr>
<tr>
<td>Nonoperating (expenses)</td>
<td>(6,043)</td>
<td>(6,043)</td>
<td>(5,539)</td>
</tr>
<tr>
<td>Increase in net position</td>
<td>$1,496,548</td>
<td>$1,335,513</td>
<td>$1,215,321</td>
</tr>
</tbody>
</table>

**OVERVIEW OF THE FINANCIAL STATEMENTS**

This annual report consists of management’s discussion and analysis and the consolidated financial statements. The basic financial statements (consolidated statements of net position, consolidated statements of revenues, expenses, and changes in net position, and consolidated statements of cash flows) present the financial position of the Finance Corporation at June 30, 2014 and 2013, respectively and the results of its operations and financial activities for the years then ended. These statements report information about the Finance Corporation using accounting methods similar to those used by private-sector companies. The consolidated statements of net position include all of the Finance Corporation’s assets and liabilities. The consolidated statements of revenues, expenses, and changes in net position reflect the years’ activities on the accrual basis of accounting, i.e., when services are provided or obligations are incurred, not necessarily when cash is received or paid. These consolidated statements report the Finance Corporation’s net position and how they have changed. Net position (the difference between assets and liabilities) is one way to measure financial health or position. The consolidated statements of cash flows provide relevant information about each year’s cash receipts and cash payments and classify them as to operating, investing, and capital and related financing activities. The consolidated financial statements include notes that explain information in the consolidated financial statements and provide more detailed data.

**CAPITAL AND DEBT RELATED ACTIVITIES**

In the current year, the Finance Corporation continued to facilitate the University of Connecticut Health Center’s (UConn Health) efforts to increase patient facility space on campus by facilitating the financing of the Outpatient Pavilion through a mortgage with Teachers Insurance and Annuity Association of America (TIAA) and its facilitator, Wells Fargo. The full mortgage is for $203 million of which $152.7 million has been advanced for construction as of June 30, 2014.

As of June 30, 2014 costs of $117.1 million associated with the construction of the Outpatient Pavilion have been recorded as Construction in Progress and are included in capital assets, net, on the consolidated statement of net position. The estimated cost to complete the Outpatient Pavilion is $85.9 million. Mortgage payments associated with the construction of the Outpatient Pavilion.
Pavilion are expected to be recovered by Finance Corporation through scheduled lease payments made by UConn Health entities that will occupy space in the new building.

The Finance Corporation continues to own and rent both the MARB and Munson Road properties to UConn Health and will begin leasing Outpatient Pavilion space upon its completion in 2015. As of June 30, 2014 and 2013, the Finance Corporation had made all regularly scheduled payments on the MARB’s secured mortgage thereby reducing the amount of secured mortgage principal debt on the MARB by $1,007,480 and $945,746, respectively.

SUBSIDIARIES

The Finance Corporation’s UCHCFC Munson Road Corporation (MRC) ceased transactions effective June 30, 2013. The MRC was dissolved in the current fiscal year with balances combined into the Finance Corporation. The MRC had served as the vehicle for the loan supporting the purchase of the property at 16 Munson Road. After the completion of loan payments the MRC held no further purpose and therefore was dissolved.

The Finance Corporation is currently the sole member and parent to the UCHCFC Circle Road Corporation (Circle Road Corporation). As with the MRC, the Circle Road Corporation’s primary purpose is to serve as the financing vehicle for the construction of the Outpatient Pavilion. The Circle Road Corporation is a 501(c) 3 entity.

FISCAL YEAR 2015 OUTLOOK

The Finance Corporation was created by statute in recognition of the University of Connecticut Health Center’s (UConn Health) need to implement decisions rapidly in order to provide excellent care in a competitive health care environment with a special focus on the need for rapid and smoother processes in the areas of purchasing, leasing, construction, and through joint ventures with other organizations.

The economic position of the Finance Corporation is closely tied to that of the UConn Health’s clinical entities serviced by the Finance Corporation.

The Finance Corporation assists UConn Health by facilitating the acquisition of clinical space. The Finance Corporation has previously served as the vehicle to acquire both the MARB and 16 Munson Road properties. The Finance Corporation will continue to serve as owner/leaseholder of these properties in 2015.

If you have questions about this report or need additional financial information, please contact the Office of the Chief Financial Officer, University of Connecticut Health Center, Farmington, Connecticut 06030-3800.
INDEPENDENT AUDITORS’ REPORT

Joint Audit and Compliance Committee  
University of Connecticut Health Center Finance Corporation

Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of the University of Connecticut Health Center Finance Corporation (Finance Corporation or Company), a component unit of the State of Connecticut, as of and for the years ended June 30, 2014 and 2013, and the related notes to the consolidated financial statements, which collectively comprise Finance Corporation’s basic consolidated financial statement as listed in the table of contents.

Management’s Responsibility for the Consolidated Financial Statements

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

Auditors’ Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors’ judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity’s preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity’s internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.
Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the University of Connecticut Health Center Finance Corporation as of June 30, 2014 and 2013, and the results of their operations and changes in net position, and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the required supplementary information, such as Management’s Discussion and Analysis on pages 1 through 3, be presented to supplement the basic consolidated financial statements. Such information, although not a part of the basic consolidated financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic consolidated financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management’s responses to our inquiries, the basic consolidated financial statements, and other knowledge we obtained during our audits of the basic consolidated financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements that collectively comprise the University of Connecticut Health Center Finance Corporation’s basic consolidated financial statements. The consolidating information in Schedules 1 and 2 is presented for purposes of additional analysis and is not a required part of the basic consolidated financial statements.

The consolidating information in Schedules 1 and 2 is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the basic consolidated financial statements. Such information has been subjected to the auditing procedures applied in the audit of the basic consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic consolidated financial statements or to the basic consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the 2014 consolidating information in Schedules 1 and 2 is fairly stated, in all material respects, in relation to the basic consolidated financial statements as a whole.

Hartford, CT
October 22, 2014
The accompanying notes are an integral part of these consolidated financial statements.
UNIVERSITY OF CONNECTICUT HEALTH CENTER
FINANCE CORPORATION

CONSOLIDATED STATEMENTS OF NET POSITION (CONTINUED)

JUNE 30, 2014 AND 2013

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liabilities and Net Position</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Current Liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts payable and accrued expenses</td>
<td>$11,649,486</td>
<td>$4,183,625</td>
</tr>
<tr>
<td>Due to UConn Health - Malpractice fund</td>
<td>297,152</td>
<td>745,155</td>
</tr>
<tr>
<td>Due to Correctional Managed Health Care</td>
<td>286,807</td>
<td>286,807</td>
</tr>
<tr>
<td>Due to Central Administrative Services</td>
<td>462,707</td>
<td>287,134</td>
</tr>
<tr>
<td>Due to John Dempsey Hospital, current portion</td>
<td>7,710,122</td>
<td>--</td>
</tr>
<tr>
<td>Advances for construction</td>
<td>6,619</td>
<td>6,619</td>
</tr>
<tr>
<td>Loans payable, current portion</td>
<td>2,129,611</td>
<td>1,007,480</td>
</tr>
<tr>
<td><strong>Total Current Liabilities</strong></td>
<td>22,542,504</td>
<td>6,516,820</td>
</tr>
<tr>
<td><strong>Long-Term Liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Due to John Dempsey Hospital</td>
<td>9,035,784</td>
<td>16,741,825</td>
</tr>
<tr>
<td>Loans payable, net of current portion</td>
<td>165,894,642</td>
<td>61,881,263</td>
</tr>
<tr>
<td>Due to UConn Medical Group</td>
<td>4,061,366</td>
<td>4,072,346</td>
</tr>
<tr>
<td><strong>Total Long-Term Liabilities</strong></td>
<td>178,991,792</td>
<td>82,695,434</td>
</tr>
<tr>
<td><strong>Total Liabilities</strong></td>
<td>201,534,296</td>
<td>89,212,254</td>
</tr>
<tr>
<td><strong>Net Position</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net investment in capital assets</td>
<td>22,575,023</td>
<td>22,243,699</td>
</tr>
<tr>
<td>Unrestricted (deficit)</td>
<td>(14,848,580)</td>
<td>(16,013,804)</td>
</tr>
<tr>
<td><strong>Total Net Position</strong></td>
<td>7,726,443</td>
<td>6,229,895</td>
</tr>
<tr>
<td><strong>Total Liabilities and Net Position</strong></td>
<td>$209,260,739</td>
<td>$95,442,149</td>
</tr>
</tbody>
</table>

*The accompanying notes are an integral part of these consolidated financial statements.*
UNIVERSITY OF CONNECTICUT HEALTH CENTER
FINANCE CORPORATION

CONSOLIDATED STATEMENTS OF REVENUES, EXPENSES, AND CHANGES
IN NET POSITION

FOR THE YEARS ENDED JUNE 30, 2014 AND 2013

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Operating Revenues</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rental and other income</td>
<td>$3,340,230</td>
<td>$3,340,230</td>
</tr>
<tr>
<td><strong>Total Operating Revenues</strong></td>
<td>3,340,230</td>
<td>3,340,230</td>
</tr>
<tr>
<td><strong>Operating Expenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional services</td>
<td>25,100</td>
<td>17,060</td>
</tr>
<tr>
<td>Interest expense</td>
<td>1,006,708</td>
<td>1,068,441</td>
</tr>
<tr>
<td>Depreciation</td>
<td>753,300</td>
<td>753,300</td>
</tr>
<tr>
<td>Other</td>
<td>52,531</td>
<td>159,873</td>
</tr>
<tr>
<td><strong>Total Operating Expenses</strong></td>
<td>1,837,639</td>
<td>1,998,674</td>
</tr>
<tr>
<td><strong>Operating Income</strong></td>
<td>1,502,591</td>
<td>1,341,556</td>
</tr>
<tr>
<td><strong>Nonoperating (Expenses)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loan servicing fees</td>
<td>(6,043)</td>
<td>(6,043)</td>
</tr>
<tr>
<td><strong>Total Nonoperating (Expenses)</strong></td>
<td>(6,043)</td>
<td>(6,043)</td>
</tr>
<tr>
<td><strong>Increase in Net Position</strong></td>
<td>1,496,548</td>
<td>1,335,513</td>
</tr>
<tr>
<td><strong>Net Position - Beginning</strong></td>
<td>6,229,895</td>
<td>4,894,382</td>
</tr>
<tr>
<td><strong>Net Position - End</strong></td>
<td>$7,726,443</td>
<td>$6,229,895</td>
</tr>
</tbody>
</table>

The accompanying notes are an integral part of these consolidated financial statements.
UNIVERSITY OF CONNECTICUT HEALTH CENTER
FINANCE CORPORATION

CONSOLIDATED STATEMENTS OF CASH FLOWS

FOR THE YEARS ENDED JUNE 30, 2014 AND 2013

<table>
<thead>
<tr>
<th>Cash Flows from Operating Activities</th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash paid to suppliers, contractors and others</td>
<td>$(1,030,204)</td>
<td>$(1,288,123)</td>
</tr>
<tr>
<td>Cash received for rental income, service charges and other income</td>
<td>$3,340,230</td>
<td>$4,239,083</td>
</tr>
<tr>
<td>Cash paid for administrative expenses</td>
<td>$(27,859)</td>
<td>$(29,995)</td>
</tr>
<tr>
<td><strong>Net Cash Provided by Operating Activities</strong></td>
<td><strong>$2,282,167</strong></td>
<td><strong>$2,920,965</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cash Flows from Investing Activities</th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purchase of capital assets</td>
<td>$(71,775,792)</td>
<td>$(32,242,565)</td>
</tr>
<tr>
<td><strong>Net Cash Used in Investing Activities</strong></td>
<td><strong>$(71,775,792)</strong></td>
<td><strong>$(32,242,565)</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cash Flows from Capital Financing Activities</th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash received from John Dempsey Hospital in support of Outpatient Pavilion construction</td>
<td>--</td>
<td>7,721,102</td>
</tr>
<tr>
<td>Loan proceeds</td>
<td>$71,678,623</td>
<td>$24,694,736</td>
</tr>
<tr>
<td>Repayments of capital debt</td>
<td>$(1,007,480)</td>
<td>$(945,746)</td>
</tr>
<tr>
<td>Loan servicing fees</td>
<td>$(6,043)</td>
<td>$(6,043)</td>
</tr>
<tr>
<td><strong>Net Cash Provided by Capital Financing Activities</strong></td>
<td><strong>$70,665,100</strong></td>
<td><strong>$31,464,049</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Net Increase in Cash</th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net Increase in Cash</strong></td>
<td><strong>$1,171,475</strong></td>
<td><strong>$2,142,449</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cash - Beginning</th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash - Beginning</strong></td>
<td><strong>$5,098,138</strong></td>
<td><strong>$2,955,689</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cash - End</th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash - End</strong></td>
<td><strong>$6,269,613</strong></td>
<td><strong>$5,098,138</strong></td>
</tr>
</tbody>
</table>

*The accompanying notes are an integral part of these consolidated financial statements.*
Reconciliation of Operating Income to Net Cash
Provided by Operating Activities

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating income</td>
<td>$1,502,591</td>
<td>$1,341,556</td>
</tr>
<tr>
<td>Depreciation</td>
<td>753,300</td>
<td>753,300</td>
</tr>
<tr>
<td>Changes in operating assets and liabilities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assets limited to use</td>
<td>15,700</td>
<td>--</td>
</tr>
<tr>
<td>Due from other funds</td>
<td>--</td>
<td>898,853</td>
</tr>
<tr>
<td>Due to Central Administrative Services</td>
<td>7,467</td>
<td>--</td>
</tr>
<tr>
<td>Accounts payable and accrued expenses, excluding payables for capital assets</td>
<td>25,069</td>
<td>(14,172)</td>
</tr>
<tr>
<td>Due to John Dempsey Hospital</td>
<td>(10,980)</td>
<td>--</td>
</tr>
<tr>
<td>Due to UConn Medical Group</td>
<td>(10,980)</td>
<td>(58,572)</td>
</tr>
<tr>
<td><strong>Net Cash Provided by Operating Activities</strong></td>
<td><strong>$2,282,167</strong></td>
<td><strong>$2,920,965</strong></td>
</tr>
</tbody>
</table>

Schedule of Non-Cash Financing Transactions
Change in mortgage proceeds held by Trustee in construction escrow account

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$34,464,367</td>
<td>$21,858,846</td>
</tr>
</tbody>
</table>

As of June 30, 2014 and 2013, the Finance Corporation had construction invoices payable of $12,079,637 and $4,162,467, respectively, that were included in accounts payable, accrued expenses and due to Central Administrative Services. In fiscal year 2013, $287,134 of the increase in capital assets was provided by payments made by Central Administrative Services on behalf of the Finance Corporation.

*The accompanying notes are an integral part of these consolidated financial statements.*
NOTE 1 - DESCRIPTION OF REPORTING ENTITY AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

REPORTING ENTITY

Effective July 1, 1987, the University of Connecticut Health Center Finance Corporation (Finance Corporation or Company) was established pursuant to Public Act No. 87-458. The purpose of the Finance Corporation is to provide greater flexibility for John Dempsey Hospital (21002 Fund) (the Hospital), UConn Medical Group, University Dentists, and Correctional Managed Health Care (CMHC) (collectively the entities) and to promote the more efficient provision of health care services. As such, the Finance Corporation has been empowered to purchase supplies and equipment, acquire facilities, approve write-offs of accounts receivable, in addition to negotiate joint ventures, shared service, and other agreements for all of the entities, as well as process malpractice claims on behalf of University of Connecticut Health Center (UConn Health), the Hospital, UConn Medical Group, and University Dentists.

The Finance Corporation is administered by a board of directors currently consisting of the President of the University of Connecticut, the Secretary of the Office of Policy and Management for the State of Connecticut, a member of the Board of Directors of the University of Connecticut Health Center, the Executive Vice President for Health Affairs, and the Chairman of the Board of Trustees for the University of Connecticut who is appointed by the governor of the State of Connecticut. The governor appoints one of these members as Chairman of the Board of the University of Connecticut Health Center Finance Corporation.

The UCHCFC Munson Road Corporation, a subsidiary of the Finance Corporation, was formed pursuant to Section 10a-254 of the Connecticut General Statutes by the University of Connecticut Health Center Finance Corporation (its sole member). This subsidiary corporation ceased operations at the end of fiscal 2013 and was dissolved during fiscal 2014. Balances were consolidated with the Finance Corporation as part of the dissolution.
REPORTING ENTITY (CONTINUED)

The UCHCFC Circle Road Corporation (Circle Road Corporation), a subsidiary of the Finance Corporation, was formed pursuant to Section 10a-254 of the Connecticut General Statutes by the University of Connecticut Health Center Finance Corporation (its sole member). This subsidiary corporation is administered by a board of directors elected on an annual basis by the sole member’s board of directors or appointed by the Governor of the State of Connecticut, as prescribed in the bylaws of the Circle Road Corporation. The number of directors shall be not less than three or more than ten, and 50% shall be members of the board of directors of the sole member or appointed by the Governor. At least one of these directors must be an Independent Director. There are four members of the subsidiary corporation’s board of directors and five members of the sole member’s board of directors.

The expenses reported in the consolidated statements of revenues, expenses, and changes in net position do not include undetermined amounts for salaries, services, and expenses provided to and received from UConn Health and other Connecticut State agencies.

The Finance Corporation is a component unit of the State of Connecticut and is therefore generally exempt from federal income taxes under Section 115 of the Internal Revenue Code of 1986.

BASIS OF PRESENTATION

The Finance Corporation’s consolidated financial statements are prepared in accordance with all relevant Governmental Accounting Standards Board (GASB) pronouncements. GASB No. 20, Accounting and Financial Reporting for Proprietary Funds and Other Governmental Entities That Use Proprietary Fund Accounting, states that proprietary activities may elect to apply the provisions of Financial Accounting Standards Board (FASB) pronouncements issued after November 30, 1989 that do not conflict with or contradict GASB pronouncements. UConn Health has not made this election. The Finance Corporation implemented GASB No. 62, Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements, which directly incorporated into GASB’s authoritative literature certain pronouncements issued by FASB on or before November 30, 1989.

The Finance Corporation has adopted Governmental Accounting Standards Board Statement No. 34, Basic Financial Statements – and Management’s Discussion and Analysis – for State and Local Governments, as amended by GASB Statements No. 35, Basic Financial Statements – and Management’s Discussion and Analysis – for Public Colleges and
NOTE 1 - DESCRIPTION OF REPORTING ENTITY AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

BASIS OF PRESENTATION (CONTINUED)


The Finance Corporation also adopted GASB Statement No. 38, Certain Financial Statement Note Disclosures, as of July 1, 2001. These GASB pronouncements established financial reporting standards for state and local governmental entities, including net position presentation, certain classifications of revenues and expenses and management’s discussion and analysis.

USE OF ESTIMATES

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingencies at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

RECLASSIFICATIONS

Certain 2013 amounts have been reclassified to conform to the current year presentation.

PROPRIETARY FUND ACCOUNTING

The Finance Corporation utilizes the proprietary fund method of accounting whereby revenues and expenses are recognized on the accrual basis.

CASH

Cash includes cash in banks.

RENTAL INCOME

Rental income is recognized on a time basis over the rental period by reference to the lease agreements.
NOTE 1 - DESCRIPTION OF REPORTING ENTITY AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

MALPRACTICE FUND

The malpractice fund includes investments held on behalf of UConn Health and is offset by due to UConn Health on the consolidated statements of net position. The funds are invested in the State of Connecticut Short-Term Investment Fund. The cost of these funds approximates market value. The Finance Corporation is responsible for the timely payment of malpractice fund claims. Therefore, it holds an amount estimated to be the current portion due for the malpractice fund liabilities in its account. The claim liability is reflected on UConn Health’s financial statements.

CAPITAL ASSETS

Property and equipment acquisitions are recorded at cost. Betterments and major renewals are capitalized, and maintenance and repairs are expensed as incurred.

Depreciation is provided over the estimated useful life of each class of depreciable assets and is computed using the straight-line method. Buildings have an estimated useful life of 5 to 50 years and equipment has an estimated useful life of 2 to 25 years. Assets acquired under capital leases and leasehold improvements are depreciated no longer than the lease term. Construction in progress is capitalized as costs are incurred during the construction phase and depreciation will begin once the assets are placed in service.

NONCURRENT ASSETS LIMITED AS TO USE

Noncurrent assets limited as to use consisted of funds in escrow for the Medical Arts and Research Building (MARB) and the Munson Road Property. These amounts were held either in money market funds or in certificates of deposits.

CONSTRUCTION ESCROW ACCOUNT

The construction escrow account represents amounts advanced from Teachers Insurance and Annuity Association of America (TIAA) to Wells Fargo Bank Northwest, N.A. (Trustee) for the financing of the Outpatient Pavilion (formerly the Ambulatory Care Center) construction project. Such amounts have not yet been drawn down by the Finance Corporation for construction expenses. Refer to Note 4 for additional information related to the debt.
NOTE 1 - DESCRIPTION OF REPORTING ENTITY AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

ADVANCES FOR CONSTRUCTION

Advances for construction in the amount of $6,619 as of June 30, 2014 and 2013, represent the unused portion of bond proceeds that were received in March 1993 by the Finance Corporation which are to be used for the Farm Hollow Building renovations.

NET POSITION

Net position is classified in two components. Net investment in capital assets consists of capital assets net of accumulated depreciation and reduced by the current net balances of any outstanding borrowings (less amounts held in trust) used to finance the purchase or construction of those assets. All other assets less liabilities are classified as unrestricted.

NOTE 2 - DUE FROM (TO) RELATED PARTIES

As of June 30, 2014 and 2013, the Finance Corporation had the following amounts due from (to) related parties:

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Due from State of Connecticut</td>
<td>$</td>
<td>6,198</td>
</tr>
<tr>
<td>Due from Education Clinics</td>
<td>15,061</td>
<td>--</td>
</tr>
<tr>
<td>Due to UConn Medical Group</td>
<td>(4,061,366)</td>
<td>(4,072,346)</td>
</tr>
<tr>
<td>Due to Correctional Managed Health Care</td>
<td>(286,807)</td>
<td>(286,807)</td>
</tr>
<tr>
<td>Due to John Dempsey Hospital</td>
<td>(16,745,906)</td>
<td>(16,741,825)</td>
</tr>
<tr>
<td>Due to UConn Health Center - Malpractice fund</td>
<td>(297,152)</td>
<td>(745,155)</td>
</tr>
<tr>
<td>Due to Central Administrative Services</td>
<td>(462,707)</td>
<td>(287,134)</td>
</tr>
</tbody>
</table>
NOTE 3 - CAPITAL ASSETS

Capital assets as of June 30, 2014 and 2013 consisted of the following:

<table>
<thead>
<tr>
<th>Description</th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>MARB building</td>
<td>$23,873,966</td>
<td>$23,873,966</td>
</tr>
<tr>
<td>UCHCFC Munson Road Corp. land</td>
<td>6,058,136</td>
<td>6,058,136</td>
</tr>
<tr>
<td>UCHCFC Munson Road Corp. building</td>
<td>5,302,201</td>
<td>5,302,201</td>
</tr>
<tr>
<td>16 Munson Road land</td>
<td>534,948</td>
<td>534,948</td>
</tr>
<tr>
<td>16 Munson Road building</td>
<td>554,703</td>
<td>554,703</td>
</tr>
<tr>
<td>Construction in progress (estimated costs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>to complete - $85.9 million)</td>
<td>117,126,591</td>
<td>37,741,901</td>
</tr>
<tr>
<td>Office equipment</td>
<td>20,998</td>
<td>20,998</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>153,471,543</strong></td>
<td><strong>74,086,853</strong></td>
</tr>
<tr>
<td>Less accumulated depreciation</td>
<td>7,115,843</td>
<td>6,362,543</td>
</tr>
<tr>
<td></td>
<td><strong>146,355,700</strong></td>
<td><strong>67,724,310</strong></td>
</tr>
</tbody>
</table>

**Capital assets, net**
NOTE 3 - CAPITAL ASSETS (CONTINUED)

Capital assets and depreciation activity for the years ended June 30, 2014 and 2013 was as follows:

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>Additions</th>
<th>Deductions</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>MARB building</td>
<td>$ 23,873,966</td>
<td>$</td>
<td>$</td>
<td>$ 23,873,966</td>
</tr>
<tr>
<td>UCHCFC Munson Road</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>land</td>
<td>6,058,136</td>
<td></td>
<td></td>
<td>6,058,136</td>
</tr>
<tr>
<td>UCHCFC Munson Road</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>building</td>
<td>5,302,201</td>
<td></td>
<td></td>
<td>5,302,201</td>
</tr>
<tr>
<td>16 Munson Road land</td>
<td>534,948</td>
<td></td>
<td></td>
<td>534,948</td>
</tr>
<tr>
<td>16 Munson Road building</td>
<td>554,703</td>
<td></td>
<td></td>
<td>554,703</td>
</tr>
<tr>
<td>Office equipment</td>
<td>20,998</td>
<td></td>
<td></td>
<td>20,998</td>
</tr>
<tr>
<td>Construction in progress</td>
<td>37,741,901</td>
<td>79,384,690</td>
<td></td>
<td>117,126,591</td>
</tr>
<tr>
<td>Less depreciation -</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>buildings</td>
<td>(6,341,545)</td>
<td>(753,300)</td>
<td></td>
<td>(7,094,845)</td>
</tr>
<tr>
<td>Less depreciation -</td>
<td>(20,998)</td>
<td></td>
<td></td>
<td>(20,998)</td>
</tr>
<tr>
<td>Office equipment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$ 67,724,310</td>
<td>$ 78,631,390</td>
<td>$</td>
<td>$ 146,355,700</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>Additions</th>
<th>Deductions</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>MARB building</td>
<td>$ 23,873,966</td>
<td>$</td>
<td>$</td>
<td>$ 23,873,966</td>
</tr>
<tr>
<td>UCHCFC Munson Road</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corp. land</td>
<td>6,058,136</td>
<td></td>
<td></td>
<td>6,058,136</td>
</tr>
<tr>
<td>UCHCFC Munson Road</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corp. building</td>
<td>5,302,201</td>
<td></td>
<td></td>
<td>5,302,201</td>
</tr>
<tr>
<td>16 Munson Road land</td>
<td>534,948</td>
<td></td>
<td></td>
<td>534,948</td>
</tr>
<tr>
<td>16 Munson Road building</td>
<td>554,703</td>
<td></td>
<td></td>
<td>554,703</td>
</tr>
<tr>
<td>Office equipment</td>
<td>20,998</td>
<td></td>
<td></td>
<td>20,998</td>
</tr>
<tr>
<td>Construction in progress</td>
<td>1,049,735</td>
<td>36,692,166</td>
<td></td>
<td>37,741,901</td>
</tr>
<tr>
<td>Less depreciation -</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>buildings</td>
<td>(5,588,245)</td>
<td>(753,300)</td>
<td></td>
<td>(6,341,545)</td>
</tr>
<tr>
<td>Less depreciation -</td>
<td>(20,998)</td>
<td></td>
<td></td>
<td>(20,998)</td>
</tr>
<tr>
<td>Office equipment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$ 31,785,444</td>
<td>$ 35,938,866</td>
<td>$</td>
<td>$ 67,724,310</td>
</tr>
</tbody>
</table>

The Finance Corporation capitalized interest expense of $4,992,813 and $794,486 during the years ended June 30, 2014 and 2013, respectively.
NOTE 4 – LONG-TERM LIABILITIES

During 2004, the Finance Corporation entered into a loan agreement with Capital Lease Funding to finance the construction of the MARB. During 2013, the Finance Corporation through its subsidiary, the Circle Road Corporation, entered into a mortgage with TIAA for the construction of the Outpatient Pavilion. Activity related to these loans was as follows:

<table>
<thead>
<tr>
<th></th>
<th>June 30, 2013 Balance</th>
<th>Additions</th>
<th>Deductions</th>
<th>June 30, 2014 Balance</th>
<th>Amounts due within 1 year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secured mortgage -</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital Lease Funding</td>
<td>$16,335,161</td>
<td>$</td>
<td>$ (1,007,480)</td>
<td>$15,327,681</td>
<td>$1,073,243</td>
</tr>
<tr>
<td>TIAA</td>
<td>46,553,582</td>
<td>106,142,990</td>
<td>--</td>
<td>152,696,572</td>
<td>1,056,368</td>
</tr>
<tr>
<td></td>
<td>$62,888,743</td>
<td>$106,142,990</td>
<td>$ (1,007,480)</td>
<td>$168,024,253</td>
<td>$2,129,611</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>June 30, 2012 Balance</th>
<th>Additions</th>
<th>Deductions</th>
<th>June 30, 2013 Balance</th>
<th>Amounts due within 1 year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secured mortgage -</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital Lease Funding</td>
<td>$17,280,907</td>
<td>$</td>
<td>$ (945,746)</td>
<td>$16,335,161</td>
<td>$1,007,480</td>
</tr>
<tr>
<td>TIAA</td>
<td></td>
<td>$46,553,582</td>
<td>--</td>
<td>$46,553,582</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>$17,280,907</td>
<td>$46,553,582</td>
<td>$ (945,746)</td>
<td>$62,888,743</td>
<td>$1,007,480</td>
</tr>
</tbody>
</table>
NOTE 4 – LONG-TERM LIABILITIES (CONTINUED)

Long-term debt obligations as of June 30 consisted of the following:

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secured mortgage - Capital Lease Funding, principal and interest payments began January 2004 and continue until November 2024, with interest at 6.34%</td>
<td>$ 15,327,681</td>
<td>$ 16,335,161</td>
</tr>
<tr>
<td>Secured mortgage - TIAA, 25 year, 4.809% coupon. Total mortgage commitment is $203 million which will be advanced in full by January 15, 2015. Amounts reported are advanced amounts as of June 30, 2014. Interest only payments will be made until April 2015 and principal payments will begin on April 15, 2015 and will continue until March 15, 2040.</td>
<td>$ 152,696,572</td>
<td>$ 46,553,582</td>
</tr>
<tr>
<td></td>
<td>$ 168,024,253</td>
<td>$ 62,888,743</td>
</tr>
</tbody>
</table>

Aggregate maturities of long-term debt including the future advances to be received on the total TIAA mortgage commitment of $203 million are as follows:

<table>
<thead>
<tr>
<th>Year ending June 30,</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>$ 2,129,611</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>5,497,829</td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>5,786,546</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>6,090,659</td>
<td></td>
</tr>
<tr>
<td>2019</td>
<td>6,411,004</td>
<td></td>
</tr>
<tr>
<td>Thereafter</td>
<td>192,412,032</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$ 218,327,681</td>
<td></td>
</tr>
</tbody>
</table>

The Finance Corporation made interest payments of $5,999,521 and $1,862,927, respectively, during 2014 and 2013.
NOTE 5 – RELATED PARTY TRANSACTIONS

The Finance Corporation enters into transactions for the benefit of UConn Health entities. In 2006, the Finance Corporation entered into transactions resulting in the acquisition of the MARB and Munson Road properties. The Finance Corporation leases these buildings to entities from UConn Health thereby supporting the associated mortgage payments.

The Circle Road Corporation has a similar agreement, a lease with UConn Health, designed to facilitate the monthly debt service payments on its mortgage with TIAA. Beginning in 2015, the Circle Road Corporation will charge rent to UConn Health’s clinical enterprises, including the Hospital and UConn Medical Group. The amounts to be allocated to each of UConn Heath’s internal business units will be determined based on the square footage.

Revenue under these agreements over the next five years and thereafter is estimated to be as follows:

<table>
<thead>
<tr>
<th>Year ending June 30,</th>
<th>Outpatient Pavilion</th>
<th>MARB</th>
<th>Munson Road</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>$3,492,713</td>
<td>$2,020,230</td>
<td>$1,320,000</td>
</tr>
<tr>
<td>2016</td>
<td>13,970,852</td>
<td>2,020,230</td>
<td>1,320,000</td>
</tr>
<tr>
<td>2017</td>
<td>13,970,852</td>
<td>2,020,230</td>
<td>1,320,000</td>
</tr>
<tr>
<td>2018</td>
<td>13,970,852</td>
<td>2,020,230</td>
<td>1,320,000</td>
</tr>
<tr>
<td>2019</td>
<td>13,970,852</td>
<td>2,020,230</td>
<td>1,320,000</td>
</tr>
<tr>
<td>Thereafter</td>
<td>289,895,176</td>
<td>4,213,781</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>$349,271,297</td>
<td>$14,314,931</td>
<td>$6,600,000</td>
</tr>
</tbody>
</table>

During the year ended June 30, 2013, the Hospital provided advances to the Finance Corporation in the amount of $7,721,102 which were used to facilitate the construction of the Outpatient Pavilion. In 2014, the Hospital did not provide such advances to the Finance Corporation. Advances are non-interest bearing and are scheduled to be repaid to the Hospital upon completion of the project in 2015.

NOTE 6 – SUBSEQUENT EVENTS

Finance Corporation has evaluated subsequent events through October 22, 2014, which represents the date the financial statements were available to be issued. There were no subsequent events requiring recognition or disclosure in the financial statements.
<table>
<thead>
<tr>
<th>University of Connecticut Health Center Finance Corporation</th>
<th>UCHFC Circle Road Corp.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current Assets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash</td>
<td>$ 15,113,831</td>
<td>$ (8,844,218)</td>
</tr>
<tr>
<td>Malpractice fund</td>
<td>297,152</td>
<td>--</td>
</tr>
<tr>
<td>Due from Education Clinics</td>
<td>15,061</td>
<td>--</td>
</tr>
<tr>
<td>Construction escrow account</td>
<td>--</td>
<td>56,323,213</td>
</tr>
<tr>
<td>Total Current Assets</td>
<td>15,426,044</td>
<td>47,478,995</td>
</tr>
<tr>
<td>Noncurrent Assets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital assets, net</td>
<td>29,229,110</td>
<td>117,126,590</td>
</tr>
<tr>
<td>Total Noncurrent Assets</td>
<td>29,229,110</td>
<td>117,126,590</td>
</tr>
<tr>
<td>Total Assets</td>
<td>$ 44,655,154</td>
<td>$ 164,605,585</td>
</tr>
</tbody>
</table>

See independent auditors’ report.
## SCHEDULE I – CONSOLIDATING STATEMENT OF NET POSITION
(CONTINUED)

### JUNE 30, 2014

<table>
<thead>
<tr>
<th>Liabilities and Net Position</th>
<th>University of Connecticut Health Center Finance Corporation</th>
<th>UCHCFC Circle Road Corp.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Liabilities</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts payable and accrued expenses</td>
<td>$ 25,120</td>
<td>$ 11,624,366</td>
<td>$ 11,649,486</td>
</tr>
<tr>
<td>Due to UConn Health – Malpractice fund</td>
<td>297,152</td>
<td>--</td>
<td>297,152</td>
</tr>
<tr>
<td>Due to Correctional Managed Health Care</td>
<td>286,807</td>
<td>--</td>
<td>286,807</td>
</tr>
<tr>
<td>Due to Central Administrative Services</td>
<td>--</td>
<td>462,707</td>
<td>462,707</td>
</tr>
<tr>
<td>Due to John Dempsey Hospital, current portion</td>
<td>7,710,122</td>
<td>--</td>
<td>7,710,122</td>
</tr>
<tr>
<td>Advances for construction</td>
<td>6,619</td>
<td>--</td>
<td>6,619</td>
</tr>
<tr>
<td>Loans payable, current portion</td>
<td>1,073,243</td>
<td>1,056,368</td>
<td>2,129,611</td>
</tr>
<tr>
<td><strong>Total Current Liabilities</strong></td>
<td>9,399,063</td>
<td>13,143,441</td>
<td>22,542,504</td>
</tr>
<tr>
<td><strong>Long-Term Liabilities</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Due to John Dempsey Hospital</td>
<td>9,035,784</td>
<td>--</td>
<td>9,035,784</td>
</tr>
<tr>
<td>Loans payable, net of current portion</td>
<td>14,254,438</td>
<td>151,640,204</td>
<td>165,894,642</td>
</tr>
<tr>
<td>Due to UConn Medical Group</td>
<td>4,061,366</td>
<td>--</td>
<td>4,061,366</td>
</tr>
<tr>
<td><strong>Total Long-Term Liabilities</strong></td>
<td>27,351,588</td>
<td>151,640,204</td>
<td>178,991,792</td>
</tr>
<tr>
<td><strong>Total Liabilities</strong></td>
<td>36,750,651</td>
<td>164,783,645</td>
<td>201,534,296</td>
</tr>
<tr>
<td><strong>Net Position</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net investment in capital assets</td>
<td>13,901,429</td>
<td>8,673,594</td>
<td>22,575,023</td>
</tr>
<tr>
<td>Unrestricted (Deficit)</td>
<td>(5,996,926)</td>
<td>(8,851,654)</td>
<td>(14,848,580)</td>
</tr>
<tr>
<td><strong>Total Net Position (Deficit)</strong></td>
<td>7,904,503</td>
<td>(178,060)</td>
<td>7,726,443</td>
</tr>
<tr>
<td><strong>Total Liabilities and Net Position</strong></td>
<td>$ 44,655,154</td>
<td>$ 164,605,585</td>
<td>$ 209,260,739</td>
</tr>
</tbody>
</table>

*See independent auditors’ report.*
UNIVERSITY OF CONNECTICUT HEALTH CENTER
FINANCE CORPORATION

SCHEDULE II – CONSOLIDATING STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION

FOR THE YEAR ENDED JUNE 30, 2014

<table>
<thead>
<tr>
<th>University of Connecticut Health Center</th>
<th>UCHCFC Munson Road Corp.</th>
<th>UCHCFC Circle Road Corp.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating Revenues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rental and other income</td>
<td>$3,340,230</td>
<td>$--</td>
<td>$--</td>
</tr>
<tr>
<td>Total Operating Revenues</td>
<td>$3,340,230</td>
<td>$--</td>
<td>$--</td>
</tr>
<tr>
<td>Operating Expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional services</td>
<td>$24,995</td>
<td>$--</td>
<td>$105</td>
</tr>
<tr>
<td>Interest expense</td>
<td>$1,006,708</td>
<td>$--</td>
<td>$--</td>
</tr>
<tr>
<td>Depreciation</td>
<td>$753,300</td>
<td>$--</td>
<td>$--</td>
</tr>
<tr>
<td>Other</td>
<td>$25,150</td>
<td>$--</td>
<td>$27,381</td>
</tr>
<tr>
<td>Total Operating Expenses</td>
<td>$1,810,153</td>
<td>$--</td>
<td>$27,486</td>
</tr>
<tr>
<td>Operating Income (Loss)</td>
<td>$1,530,077</td>
<td>$--</td>
<td>$(27,486)</td>
</tr>
<tr>
<td>Nonoperating (Expenses)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loan servicing fee</td>
<td>$(6,043)</td>
<td>$--</td>
<td>$--</td>
</tr>
<tr>
<td>Total Nonoperating (Expenses)</td>
<td>$(6,043)</td>
<td>$--</td>
<td>$--</td>
</tr>
<tr>
<td>Increase (Decrease) in Net Position</td>
<td>$1,524,034</td>
<td>$--</td>
<td>$(27,486)</td>
</tr>
<tr>
<td>Net Position (Deficit) - Beginning</td>
<td>$2,971,660</td>
<td>$3,408,809</td>
<td>$(150,574)</td>
</tr>
<tr>
<td>UCHCFC Munson Road Corp. Dissolution</td>
<td>$3,408,809</td>
<td>$(3,408,809)</td>
<td>$--</td>
</tr>
<tr>
<td>Net Position (Deficit) - End</td>
<td>$7,904,503</td>
<td>$--</td>
<td>$(178,060)</td>
</tr>
</tbody>
</table>

See independent auditors’ report.
Audit Timeline

McGladrey Team:

Larry Schaedel – Client Service Coordinator
Mark Bloom - Partner
Lisa Plack - Director
Chris Kotos – In-Charge
Dave Potak - Supervisor

Timeline:

December 1-5, 2014 – Planning at the University of Connecticut
December 2, 2013 – Working Group Meeting
February 28, 2015 – First cut-off for downloads for project expenses
March 6, 2015 – Deadline to send all downloads to McGladrey
March 11, 2015 – Selections to be made from all the downloads
March 23-April 3, 2015 – Fieldwork for the audit and agreed upon procedures
April 15, 2015 – Second cut-off for downloads for project expenses
April 17, 2015 – Draft of report to be sent to the Working Group
Week of April 20, 2015 – Meeting (conference call) to discuss the reports with Working Group
May 6, 2014 – Senior Management meeting for approval of the financial statements
May 7, 2014 – Meeting with the JACC for approval of the financial statements
Joint Audit & Compliance Committee

### 2015 JACC Meeting Dates

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Tuesday, February 10, 2015</td>
<td>10:00-12:00</td>
<td>Rome Commons Ballroom, Storrs</td>
</tr>
<tr>
<td>2. Thursday, May 7, 2015</td>
<td>10:00-12:00</td>
<td>Rome Commons Ballroom, Storrs</td>
</tr>
<tr>
<td>3. Thursday, September 17, 2015</td>
<td>10:00-12:00</td>
<td>Rome Commons Ballroom, Storrs</td>
</tr>
<tr>
<td>4. Tuesday, December 1, 2015</td>
<td>10:00-12:00</td>
<td>Rome Commons Ballroom, Storrs</td>
</tr>
</tbody>
</table>
TAB 7
OACE Welcomes Chief Audit & Compliance Officer

David Galloway has joined the University as the new Chief Audit and Compliance Officer following a national search. David comes to UConn from Brigham Young University in Utah, where he served as the Executive Director of Compliance and Audit for 14 years.

At BYU, David directed all compliance and internal audit services. His accomplishments include the reorganization of the internal audit department to provide additional focus on high-risk areas of the campus and to facilitate implementation of continuous improvement programs. He also recommended and implemented an overall compliance program for BYU.

Prior to his time at BYU, David was the Director of Internal Audit for a Florida-based Tech Data Corporation, a Fortune 500 company, and was also Director of Internal Audit for the Washington Public Power Supply System in Washington State.

David, a CPA, received his undergraduate degree from BYU and has his Masters in Accounting from Utah State University. He also spent three years as a commissioned officer in the U.S. Army. He is a Certified Compliance and Ethics Professional (CCEP), and a member of the Association of College and University Auditors, the American Institute of Certified Public Accountants, the Institute of Internal Auditors, and the Society for Corporate Compliance and Ethics.

Please join us in welcoming David to UConn. David may be reached by contacting OACE at 860-486-4526.

Policy Updates

The following are University-wide policies found at policy.uconn.edu:

- **The University of Connecticut Sustainable Design and Construction Policy**—This policy was approved by the Board of Trustees in 2007 and describes the minimum environmental performance requirements for any building construction or renovation project entering the predesign planning phase, whenever estimated project cost exceeds $5 million.

- **Security Camera Policy**—This is a new Policy that provides guidelines for the use of University owned/utilized security cameras in a way that enhances security while respecting privacy.

UConn
Office of Audit, Compliance & Ethics

9 Walter’s Avenue, Unit 5084
Storrs, Connecticut, 06269-5084
Telephone: (860) 486-4526
Facsimile: (860) 486-4527

Web: www.audit.uconn.edu
REPORTLINE
Phone: 1-888-685-2637
Web: https://uconncares.alertline.com/gcs/welcome
Did You Know?

- We feature a “Policy of the Week” in the Daily Digest?
- Previous editions of our quarterly newsletter may be found at [http://audit.uconn.edu/newsletter.html](http://audit.uconn.edu/newsletter.html)?
- The Joint Audit and Compliance Committee (JACC) Meeting Minutes are viewable [here](http://audit.uconn.edu/meeting-minutes.html)?

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**When Should the Necessary Expenses Form be Filled Out?**

Knowing when to fill out a necessary expenses form ([Form ETHN-E](http://ct.gov/ethics) found at ct.gov/ethics) can be confusing. The following example and below flow chart are meant to assist faculty and staff in determining when this form must be submitted to the Office of State Ethics. Remember, Necessary Expenses are considered “necessary travel expenses, lodging for the nights before, of and after the appearance, speech or event, meals and any related conference or seminar registration fees”.

**EXAMPLE:** You are asked to speak at a conference in your state capacity. The entity that has invited you has offered to reimburse you for your airfare, hotel and meals. Do you have to fill out a necessary expenses form?

**ANSWER:** Yes, you will need to fill out the form unless the sponsoring entity is a Federal or State Government that is covering or reimbursing the cost. If you are invited to speak outside of your state capacity, consult all outside employment and consulting policies and bargaining unit contracts (you will **not** need to fill out Form ETHN-E if you are not attending the conference in state capacity). Call OACE with questions.

---

**Flow Chart:**

- Are you going as a state employee? **YES**
  - Are you receiving $$ in excess of necessary expenses? **NO**
  - Are the Federal Government or a state government paying/reimbursing the necessary expenses? **YES**
    - Do NOT fill out the Form
  - **YES**
    - REMINDER!
      - You may not personally accept $$ in excess of your necessary expenses. (A donation may be made to the University)
  - **NO**
    - Is a third party reimbursing or paying for necessary expenses for the employee? **YES**
      - Is there overnight lodging or out-of-state travel? **YES**
        - Yes, Fill out the Form
      - **NO**
        - Is the University reimbursing or paying for necessary expenses? **YES**
          - Is the UConn Foundation reimbursing or paying for necessary expenses directly to the employee? **YES**
            - Yes, Fill out the Form
          - **NO**
            - Do NOT fill out the Form
      - **NO**
        - You do NOT need to fill out the Form, however you should consult all relevant outside employment policies and bargaining unit contract language.
- **NO**
  - Are you a faculty member or member of AAUP? **YES**
    - You do NOT need to fill out the Necessary Expenses Form, however you must follow the University’s Consulting Policy and fill out a Request to Consult Form if you receive $$ in excess of your necessary expenses.
  - **NO**
    - Is the UConn Foundation reimbursing or paying for necessary expenses directly to the employee? **YES**
      - Yes, Fill out the Form
    - **NO**
      - Do NOT fill out the Form
Mandatory Compliance and Privacy/Security education is underway! This year’s topics include required refreshers on the Code of Conduct and State Code of Ethics, prevention of fraud, waste and abuse, and the importance of protecting confidential information.

Education is our first line of defense to prevent negative publicity and costly compliance violations and, for that reason, remains a key part of the Compliance Program. The more knowledgeable faculty, staff, and administrators are regarding the complex laws and compliance issues facing academic health centers, the better equipped UConn Health is to ensure ongoing compliance.

To access the online courses go to: http://saba.uchc.edu and follow these steps:

- Log in using your UConn Health Domain login name and password.
- View “Current Enrollments” on the right side of the page for a listing of all assigned courses
- Click “Launch Now” to begin a course.
- Once you have completed a course click the “Home” tab to view additional course assignments.

Mandatory compliance education must be completed by January 15, 2015.
For training questions please contact Ginny Pack at 860-679-1280 or pack@uchc.edu or Melanie O’Connor at 860-679-4180 or moconnor@uchc.edu

For technical issues with Saba, please contact Chris Desjardins at 860-679-7577 or cdesjardins@uchc.edu or the UConn Health IT Helpdesk at 860-679-4400.

Compliance Expectations and Goals

Everything you need to know about what is expected of a UConn Health workforce member can be found in the Compliance Expectations and Goals policy. This policy covers the basics for personal conduct and communication and reinforces the standards set to provide high quality health care, research and education in a safe and respectful environment. Individual responsibility will assure institutional success.

Please take time to review the UConn Health policy on Compliance Expectations and Goals at this link, http://www.policies.uchc.edu/policies/policy_2003_35.pdf

Peg DeMeo, Associate Clinical Compliance Officer, x1226, Demeo@uchc.edu
Reporting Compliance Concerns

UConn Health strives to maintain the highest standards of ethical conduct, professionalism and quality in all activities. In order to fulfill this mission, reporting compliance concerns in the manner outlined in Policy #2003-33 Reporting Compliance Concerns [http://www.policies.uchc.edu/policies/policy_2003_33.pdf](http://www.policies.uchc.edu/policies/policy_2003_33.pdf) helps to achieve this goal, as well as ensure compliance with all laws, regulations, standards, policies and procedures.

Effective implementation of this policy requires that reports of compliance concerns include the chain of command within the operating structure of an employee’s department and the Compliance Office. Individuals who would like to remain completely anonymous, may call REPORTLINE at 1-888-685-2637, a confidential service operated by a private (non-UConn Health) company, which forwards information to the Compliance Office. We also recognize that everyone has the right to report concerns directly to the state or federal government. Using internal mechanisms however, provides UConn Health with the opportunity to address and correct non-compliant activities in a timely and efficient manner.

If you are aware of a compliance violation, you are obligated to report it. Participating in activities that you know are non-compliant or suspect may be non-compliant creates individual risk for you as well as risk to the institution. Reporting known or potential compliance violations to a supervisor without satisfactory resolution of the concern does not relieve you of personal responsibility, should you continue to participate in a potentially non-compliant practice. When you have a concern about any business practice, process or behavior that you believe may not be compliant with current laws, regulations, standards, policies and/or procedures, reporting the concern and obtaining clear directions for its correction is required.

Please direct any questions about this article to Iris Mauriello RN, CHC Compliance Integrity & Privacy Officer, x3501 mauriello@uchc.edu

Medicare (NGS) Audits on In-Patient Rhythm Electrocardiographic Recording (ECG)

National Government Services Medical Review Department has been conducting a prepayment review of cardiology providers billing of CPT code 93040, Rhythm ECG, 1-3 leads; interpretation and report only in the in-patient setting. The results of their review are as follows:

<table>
<thead>
<tr>
<th>Month</th>
<th>Services Billed</th>
<th>Services Reduced or Denied</th>
<th>Error %</th>
</tr>
</thead>
<tbody>
<tr>
<td>July, 2014</td>
<td>132</td>
<td>130</td>
<td>99.1%</td>
</tr>
<tr>
<td>August, 2014</td>
<td>1,112</td>
<td>1096</td>
<td>98.5%</td>
</tr>
<tr>
<td>September, 2014</td>
<td>994</td>
<td>986</td>
<td>99.3%</td>
</tr>
</tbody>
</table>

Errors were due to:
- Lack of required specific order for an ECG rhythm strip followed by a separate signed, written and retrievable report
- Lack of documentation summarizing the telemetry strip findings.

The CPT Manual states that to document Codes 93040-93042 the following are required:
- the text is triggered by an event,
- the rhythm strip is used to help diagnose the presence or absence of an arrhythmia, AND
- a report is generated. There must be a specific, signed, written and retrievable report.

It is not appropriate to use these codes for reviewing the telemetry monitor strips taken from a monitoring system. The need for an ECG or rhythm strip should be supported by documentation in the patient medical record.

For documentation questions or concerns, please contact Janice McDonnell, Compliance Specialist at X4093 or jmcdonnell@uchc.edu
SUMMARY

Following are excerpts from news articles having a risk management or compliance impact. The full article may be seen at the referenced source. Topics for this month include the following:

- NCAA/Athletics
- Health Care
- Campus Safety

NCAA/Athletics

NCAA Releases Handbook on Athletics’ Role in Campus Sexual Assault


A handbook released last Friday by the NCAA calls on member institutions to fully cooperate with sexual-assault investigations and to educate their athletes on methods of response and prevention, among other things. The 50-page handbook is meant to be an educational resource for colleges and does not include any punishments for noncompliance.

“The [NCAA’s] executive committee acknowledges that it is our members’ collective responsibility to maintain campuses as safe places to learn, live, work, and play,” the handbook states.

The book’s release comes weeks after the executive committee passed a resolution requiring colleges not to interfere with sexual-assault investigations involving athletes.

The results of a survey conducted by Sen. Claire McCaskill, a Missouri Democrat, showed that 22 percent of surveyed institutions let their athletic departments oversee sexual-assault cases involving athletes. The new handbook includes the executive committee’s resolution on that issue verbatim.

Health Care

CDC Issues Guidance for Colleges and Universities about Ebola Outbreaks


The Center for Disease Control (CDC) has issued guidance to colleges and universities on how to respond to the spread of Ebola in West Africa. The guidance includes suggested precautions with respect to (a) study abroad programs, research and other education-related travel to the region, and (b) individuals arriving on campus from the region or otherwise known to have been exposed to Ebola.

Recommendations on Education-Related Travel to Countries Where the Ebola Outbreaks are Occurring

The CDC has issued a Warning-Level 3 Travel Notice for Guinea, Liberia and Sierra Leone, and an Alert-Level 2 Travel Notice for Nigeria. The CDC recommends that all non-essential travel to Guinea, Liberia and Sierra Leone be avoided, and advises that education-related travel to these countries by students and/or faculty be postponed until further notice. The CDC has not yet advised against travel to Nigeria, but recommends that travelers to Nigeria use enhanced precautions to prevent the spread of the Ebola virus. In addition, the CDC cautions that if conditions worsen in Nigeria, it may additionally recommend against non-essential travel to Nigeria, and advises that institutions consider this possibility when deciding whether to proceed with education-related travel plans in Nigeria.

These recommendations extend to all travelers, even if travelers do not plan to be in contact with people infected with the virus. The CDC advises that there is currently no known risk of contracting Ebola in other countries in the West Africa region where Ebola cases have not been reported, but cautions that circumstances could change rapidly and advises institutions to continue to monitor the situation.

Recommendations with Respect to Students and Faculty Arriving to Campus from Countries where the Ebola Outbreaks are Occurring or Otherwise Known to Have Been Exposed to the Virus
The CDC is not recommending that institutions quarantine individuals based solely on travel history. Rather, the CDC recommends that institutions conduct a symptom and risk exposure screening for all individuals (including students and faculty) who have traveled to countries where the Ebola outbreak is occurring, or who have had contact with an infected person, within the last 21 days. In the event that symptom screening is positive or if a student or faculty member has had any high or low risk exposure, the institution is advised to notify state or local health authorities for instructions regarding medical monitoring, lab testing, and control measures such as patient quarantines or isolation.

If an individual displays no symptoms and presents no known exposure risk, institutions are advised to instruct the individual to self-monitor through temperature and symptom reporting until the end of the 21 day period, and to report immediately if symptoms appear.

Additional Guidance and Recommendations

The CDC’s advice includes additional information as to how Ebola is, and is not, transmitted, and guidance as to corresponding cautionary measures for persons on campus.

Campus Safety

Too Many Campus Alerts?


The pings arrive at all hours of the day. The latest email sounded off at 3:11 a.m. A text message trailed behind a minute later.

They cover thunderstorms, tests, and warnings that, on at least two occasions this summer, posed "no immediate health or safety threat."

But the emails and text alerts that the University of North Carolina at Chapel Hill’s department of public safety sends to Lindsey R. Faraone’s iPhone all have one thing in common.

They’re not read.

"It’s kind of how it is with these messages," Ms. Faraone says. "The idea behind them is that they’re for emergencies, but because a lot of the times it’s about ‘It could rain this afternoon or it might storm later,’ a lot of the time I just don’t care to read them."

Ms. Faraone’s annoyance with the university’s emergency-alert system is shared by many college students, who gripe about not only the subject of the texts and emails but also their frequency.

Campus officials and people who sell those systems know they have a problem. "You don’t want the whole car-alarm syndrome. When you hear a car alarm, you just walk on by because you hear them all day," says Ara Bagdasarian, chief executive officer of E2 Campus by Omnilert, an emergency-alert system used by about 850 colleges across the nation.

Scott G. Burnotes, director of emergency management at the University of Miami, says he can understand the students’ frustrations, but he’s quick to note the university’s larger concerns.

"We cannot just rely on one type of technology. We can’t just rely on text. There are technology failures," Mr. Burnotes says. "To get people to take action, individuals need to hear something from at least three different sources. That’s why we hit them with the text. That’s why we hit them with the call. That’s why we hit them with the email."

In 2013, according to Mr. Burnotes, the University of Miami sent 17 emergency messages to students. Seventeen hardly seems like a bothersome number. But each of those messages was sent three ways, by text, by email, and by phone call, adding up to 51 contacts.
‘In Their Best Interest’

The popularity of emergency-alert systems increased drastically after the 2007 shootings at Virginia Tech, which left 33 people dead, the nation’s deadliest single-gunman massacre on a college campus.

"Even though they’re getting flooded with these, it’s in their best interest to be made aware," says Brian Bittner, Pennsylvania State University's director of emergency management.

Diane Brown, public-information officer at the University of Michigan at Ann Arbor’s police department, shares Mr. Bittner’s sentiments. While she hasn’t heard of students’ being annoyed by the alerts, she says they are a necessary tool to keep students safe.

"We still need to be responsive to the majority of our community," Ms. Brown says. "And they would expect to be notified, and rightfully so."

But another national expert on emergency alerts shares Mr. Bagdasarian’s concern about their overuse.

"The danger is fatigue. It’s just making sure you find the right balance between keeping urgency and not crying wolf," says Scott W. McGrath, public-safety-solutions architect at Rave Mobile Safety. "But what are you going to do about that? We can’t stop sending alerts. It’s a tricky situation for the institution."

According to Rave’s website, more than 1,000 colleges, reaching about 40 percent of the nation’s college students, use Rave’s emergency-alert system.

‘A Preventable Problem’

One student suffering from that fatigue and "car-alarm syndrome" is Dina M. Marando, who graduated this past spring from the University of Miami's law school and is still on its emergency-alert system. She recognizes the university’s emergency-alert phone number as soon as it flashes across her screen. She never bothers to answer it.

"When I’d see the number call me, I’d let it go to voicemail," she says.

Once, within an hour this summer, the university sent Ms. Marando three text messages, fired off two emails, and called her twice.

"And that was after I graduated and studying for the bar!" she says.

Ms. Marando offers an antidote to the fatigue. "A text message is sufficient. You don’t need automated, incessant, annoying phone calls," she says. "Maybe the next day if they want to send an email explaining what happened; that’s fine. That would actually make you pay attention to it instead of being annoyed by it."

But for a major event like a tornado or an armed robbery near the campus, aside from sometimes being legally required under the Clery Act, aren’t the text messages and emails needed to keep students safe?

"A rule of thumb is to send a text if it’s a preventable problem," Mr. Bagdasarian says, citing an active shooter on the campus, a tornado warning or other severe weather, and a violent crime as examples of when a text is appropriate. "But we have too many communication channels nowadays," he adds. "If it’s not something that can make an impact now, use a channel that’s not as time-sensitive, including posting to a website or email."

Mr. Burnotes, who says the University of Miami police department has an "EZ button" to immediately send out alerts via text, phone call, and email simultaneously, sees it differently.

"It’s probably a little bit of annoyance for them, but if something turned into a bigger event, it would have saved people’s lives," he says. "And I’ll take a bit of the annoyances and then save people’s lives."

OSHA Issues Final Rule On Reporting Transparency

Federal Register – September 18, 2014

The most significant change represented in the final rule are requirements for reporting work-related fatality, injury, and illness information to OSHA. The current regulation requires employers to report work-related fatalities and inpatient hospitalizations of three or more employees within eight hours of the event. The final rule retains the
requirement for employers to report work-related fatalities to OSHA within eight hours of the event but amends the regulation to require employers to report all work-related in-patient hospitalizations, as well as amputations and losses of an eye, to OSHA within 24 hours of the event.

Under the final rule, events reported to OSHA will be maintained in a comprehensive database that the Agency, researchers, and the public can use to identify hazards related to reportable events and to identify industries and processes where these hazards are prevalent.

And…in case you missed the Ig Nobel Awards:

**PUBLIC HEALTH PRIZE [CZECH REPUBLIC, JAPAN, USA, INDIA]:** Jaroslav Flegr, Jan Havlíček and Jitka Hanušová-Lindova, and to David Hanauer, Naren Ramakrishnan, Lisa Seyfried, for investigating whether it is mentally hazardous for a human being to own a cat. (Turns out, it might be.)


REFERENCE: "Decreased level of psychobiological factor novelty seeking and lower intelligence in men latently infected with the protozoan parasite Toxoplasma gondii Dopamine, a missing link between schizophrenia and toxoplasmosis?" Jaroslav Flegr, Marek Preiss, Jiří Klose, Jan Havliček, Martina Vitáková, and Petr Kodym, Biological Psychology, vol. 63, 2003, pp. 253–268.


**BIOLOGY PRIZE [CZECH REPUBLIC, GERMANY, ZAMBIA]:** Vlastimil Hart, Petra Nováková, Erich Pascal Malkemper, Sabine Begall, Vladimír Hanzal, Miloš Ježek, Tomáš Kušta, Veronika Němcová, Jana Adámková, Kateřina Benediktová, Jaroslav Červený and Hynek Burda, for carefully documenting that when dogs defecate and urinate, they prefer to align their body axis with Earth's north-south geomagnetic field lines. (Mine seems to always point north, so…if I’m ever lost, I just have to wait for Magnus to do his thing!)


**WHO ATTENDED THE CEREMONY:** Vlastimil Hart, Petra Nováková, Pascal Malkemper, Sabine Begall, Veronika Němcová, Hynek Burda
SUMMARY

Following are excerpts from news articles having a risk management or compliance impact. The full article may be seen at the referenced source. Topics for this month include the following:

- Federal Contracts
- Copyright
- Accessibility
- Athletics/NCAA
- Title IX/VAWA
- Gainful Employment
- Health and Safety

Federal Contracts

New Employment rules for Federal Government Contractors

*Greenberg Trauric, LLP News and Events* – September 25, 2014

President Obama recently issued two Executive Orders requiring federal government contractors to adopt practices to ensure fair treatment of certain classes of workers. The first, titled the "Fair Pay and Safe Workplaces Executive Order," (the "FPSW Order") makes a contractor's compliance with certain federal and state labor laws a part of the procurement process. The second - and more controversial - Executive Order prohibits government contractors from discriminating against lesbian, gay, bisexual and transgender ("LGBT") employees in hiring decisions.

The stated goal of the FPSW Order is to increase government contractors' understanding and compliance with both federal and state labor laws designed to promote safe, healthy, fair and effective workplaces. To that end, it requires government contractors to disclose any violations of fourteen specific federal labor laws in the preceding three years, or their state-law equivalents, as part of its proposal for any contract that exceeds $500,000. Furthermore, contracting officers must take any violations of these laws into account in determining whether the contractor is a responsible source that has a satisfactory record of integrity and business ethics. The 14 laws subject to this executive order are:

- Fair Labor Standards Act
- Occupational Safety and Health Act of 1970
- Migrant and Seasonal Agricultural Worker Protection Act
- National Labor Relations Act
- Davis-Bacon Act
- The Service Contract Act
- Executive Order 11246 of September 24, 1965 (Equal Employment Opportunity)
- Rehabilitation Act of 1973
- Vietnam Era Veteran's Readjustment Assistance Act of 1974
- Family and Medical Leave Act
- Title VII of the Civil Rights Act of 1964
- Americans with Disabilities Act of 1990
- Age Discrimination in Employment Act of 1967
- Executive Order 13658 of February 12, 2014 (Establishing a Minimum Wage for Contractors)

Accessibility

For Bill on Disabled Access to Online Teaching Materials, the Devil’s in the Details

*The Chronicle of Higher Education* – September 30, 2014

As smart classrooms become the norm on more campuses and online courses proliferate, some observers worry that the digital revolution will leave students with disabilities behind. But a bill under consideration in the U.S. Congress, the *Technology, Equality, and Accessibility in College and Higher Education Act* (HR 3505), would deal with that
concern by creating accessibility guidelines for electronic materials used or assigned by college professors and administrators.

While the bill, known as the Teach Act, has bipartisan support in Congress, several higher-education organizations have raised concerns about what they consider the legislation’s broad language, inflexibility, and misplaced oversight. For example, the American Council on Education objects to the bill in part because it grants authority to create guidelines to the Architectural and Transportation Barriers Compliance Board, which the council says lacks higher-education expertise.

“This provision creates an impossible-to-meet standard for institutions and will result in a significant chilling effect in the usage of new technology,” wrote Molly Corbett Broad, ACE’s president, in a letter last month to Sen. Tom Harkin, an Iowa Democrat who is chairman of the education committee. The letter was sent on behalf of the council and 19 other higher-education groups. “Such a proposal, if implemented, will seriously impede the development and adoption of accessible materials, harming the very students it is intended to assist.”

The National Federation of the Blind and the Association of American Publishers are proponents of the measure, which would allow colleges to opt out of the guidelines if they already provide materials that serve students with disabilities “in an equally effective and equally integrated manner.”

“Every day, blind college students face frustration and despair in the pursuit of their education because of inaccessible technology,” Marc Maurer, president of the National Federation of the Blind, said in a written statement in February. “E-readers, web content, mobile applications, and learning management systems are integral to the 21st-century college experience, and students with disabilities are being needlessly left behind. … Schools and manufacturers must embrace readily available accessibility solutions so that all students can benefit from educational technology, and the guidelines established by the Teach Act will make it clear how manufacturers and institutions of higher education can best serve students with disabilities.”

In a letter published this month in The Chronicle, Terry W. Hartle, ACE’s senior vice president for government and public affairs, rejected the assertion that the Teach Act is the best way to protect students with disabilities.

“The bottom line is that the bill as written would damage the quality of learning for all students, and it would freeze the development and implementation of new learning technologies to benefit our students, including students with disabilities,” he wrote.

Officials at the associations declined requests for further comment.

“The legislation sets up a safe harbor for institutions of higher education and, at the same time, approaches the work of the manufacturers of materials with some amount of flexibility,” he said.

Federal guidelines would prove especially useful for helping disability-services offices justify their budget requests, Ms. Moreno predicted.

“Whenever we go up for budget reasons, we could say, ‘We need this, the federal guidelines say we should have this or something similar,’” she said. “It allows us to justify different acquisitions within the college.”

With midterm elections in November and the end of the current Congressional session around the corner, no action on the legislation seems imminent, Mr. Brooks said, but he is optimistic about the bill’s ultimate prospects, especially because it has 52 cosponsors, from both sides of the aisle. Mr. Brooks said Representative Petri’s office had met with the American Council on Education, and since the congressman is retiring, he will pass suggestions to whoever introduces the bill during the next Congress.

“The standards we’re trying to put in place are not impossible standards,” Mr. Brooks said. “We’re willing to work with the groups to make sure we come to a mutually beneficial outcome that would solve the problem.”
Title IX/VAWA

EEOC Revises Pregnancy Bias Rules After 30 Years
*Corporate Counsel* - July 17, 2014

It’s been 30 years, but the Equal Employment Opportunity Commission has finally updated its enforcement guidance on pregnancy discrimination and related issues, according to a recent release.

The guidance addresses issues such as circumstances when employers need to provide pregnant workers with lighter duties, discrimination based not only on pregnancy, but on a woman’s potential to become pregnant, and the requirement that parental leave be provided to both men and women on the same terms.

“Despite much progress, we continue to see a significant number of charges alleging pregnancy discrimination, and our investigations have revealed the persistence of overt pregnancy discrimination, as well as the emergency of more subtle discriminatory practices,” said EEOC Chairwoman Jacqueline Berrien in a statement. She says this guidance will help employers and workers alike comply with the Pregnancy Discrimination Act and Americans with Disabilities Act.

According to Jeff Nowak of Franczek Radelet, this new guidance is “groundbreaking” and will impact employers, especially with respect to providing reasonable accommodations to all pregnant employees, whether they’re defined as “disabled” under the ADA. Indeed, he says that some EEOC commissioners have even issued individual statements over the importance of it, while others have argued it’s premature as the U.S. Supreme Court is taking up many of the issues in a case next term. But until that happens, employers are advised to read it over, and quickly; we're including the full text.

**Regarding Students:**

Title IX of the Education Amendments of 1972 prohibits sex discrimination in education. Pregnancy is a condition contingent on sex, so any discrimination or exclusion based on pregnancy is prohibited under Title IX.

With some limited exceptions, Title IX applies to “any education program or activity receiving Federal financial assistance.” Because UConn receives federal funding for research as well as federal student financial aid, the university is required to comply with Title IX.

Generally, Title IX prohibits the exclusions of students from educational programs based on their “actual or potential parental, family, or marital status.” Pregnancy and related conditions must be treated in the same way as temporary disabilities. Any services (such as tutoring) and policies the institution has in relation to short-term disabilities must be administered in the same way for pregnant students.

For more information see [http://www2.ed.gov/about/offices/list/ocr/docs/pregnancy.pdf](http://www2.ed.gov/about/offices/list/ocr/docs/pregnancy.pdf).

Clery/VAWA Final Regulations Issued by ED
NACUA New Cases and Documents – October 14-17, 2014

Final regulations have been issued by the Department of Education to implement amendments made to the Clery Act by the Violence Against Women Reauthorization Act of 2013 (VAWA). The new regulations amend 34 C.F.R. § 668.46 to implement these statutory changes and incorporate provisions added to the Clery Act by the Higher Education Opportunity Act. The new regulations require institutions to:

1) Record incidents of stalking based on the location where either the perpetrator engaged in the stalking or the victim first became aware of the stalking;

2) Add gender identity and national origin as new categories of bias for a determination of a hate crime;

3) Describe each type of disciplinary proceeding used in cases of alleged sexual misconduct;

4) Provide the accuser and the accused the same opportunities to have an advisor of their choice present during the disciplinary proceeding; and

5) Include in their annual security report a statement of policy regarding their programs to prevent sexual misconduct and stalking, as well as the procedures that the institution will follow when such a crime is reported.
The Department of Education reminds institutions that while the final rule is not effective until July 1, 2015, "the VAWA statutory provisions are in effect now and institutions are expected to make a good faith effort to comply with those requirements."

Health and Safety

University Paid $4.5-Million in Legal Fees for Fatal Lab Fire at UCLA


The University of California paid nearly $4.5-million in legal fees to defend itself and a UCLA professor in the case of a 2008 lab fire that left one dead, the _Los Angeles Times_ reports. Records obtained by the _Times_ show that nearly five dozen lawyers and other staff members billed the university for upwards of 7,700 hours of work on the case.

On December 29, 2008, a chemical ignited and burned a 23-year-old research assistant, Sheharbano (Sheri) Sangji, who died 18 days later. The professor supervising the lab, Patrick G. Harran, was charged with four felony counts of willfully violating state health and safety standards. The university also faced charges but settled them with prosecutors two years ago. Mr. Harran settled his case earlier this year, agreeing to pay $10,000 and perform 800 hours of community service while admitting no wrongdoing.

“We defended ourselves and our faculty member as was our right and obligation, using funds in a systemwide self-insurance program,” the university said in a statement.

Update on Ebola for Colleges and Universities

_Higher Education Law Report, Bond Schoeneck & King_ – October 20, 2014

Given the ongoing concerns and availability of more guidance and information relating to Ebola, we are offering this update with our own recommendations to ensure that you have current information and consider the aspects of this health concern from the perspective of a college or university.

According to the CDC, a person infected with Ebola is not contagious until symptoms appear. Symptoms may appear anywhere from 2 to 21 days after exposure to Ebola but the average is 8 to 10 days. The signs and symptoms of Ebola typically include:

- Fever (greater than 38.6°C or 101.5°F)
- Severe headache
- Muscle pain
- Vomiting
- Diarrhea
- Stomach pain
- Unexplained bleeding or bruising

The CDC’s recommendations for student health centers in responding to potential Ebola exposure and managing individuals presenting with symptoms consistent with Ebola disease are the same as those for other US health care workers and settings.

As a planning step, colleges and universities should review and consider utilizing the American College Health Association Emergency Preparedness Planning Considerations for College Health Centers Regarding Ebola Virus Disease:

1. _Is your campus emergency response plan up to date so it can be activated if needed to respond to a case of Ebola on campus or in the local community?_ Is it coordinated with the local public health department on a community response to a case of Ebola?

2. _Does your campus have a communications plan and team in place to respond to the communications need if a case were to emerge on campus, in the community, or at another institution?_ Is the communications plan coordinated with the local community so that your campus would be informed if a case emerges in the community, allowing communication to students and parents?
3. If the public health department orders a quarantine for a high-risk exposure, does the campus have a location and plan to provide food and clothing to a quarantined person? Does the campus have a mechanism (qualified contractor) in place to dispose of waste?

4. Is the student health center screening all patients for travel in the past 21 days? Are there plans in place to quickly respond to an ill student with a travel history from an Ebola affected area? What about other emerging pathogens?

5. Is there a mechanism to identify and contact students, faculty, and staff who are returning to campus from an Ebola affected area and refer appropriately to the public health department for monitoring?

6. Who is responsible for monitoring individual and group institutional travelers? Is there a policy and/or mechanism in place to restrict travel based on the CDC travel warning?

In keeping with these recommended planning steps, institutions should consider the following actions:

- Ensure that student health center staff are aware of exposure risks, signs and symptoms of Ebola and are prepared to follow recommendations in the CDC Health Advisory: Guidelines for Evaluation of US Patients Suspected of Having Ebola Virus Disease.

- Consider providing information to the campus community with recommendations for people who have recently arrived from countries where Ebola outbreaks are occurring and provide specific Ebola education to all people who have recently arrived from countries where outbreaks are occurring in accordance with the screening procedures.

- Continue to monitor the countries of concern in terms of Ebola outbreak. Here are the current CDC travel notices related to Ebola even if travelers do not plan to be in contact with people infected with the virus:
  - **Warning** – Avoid nonessential travel: Ebola in Liberia, Guinea and Sierra Leone
  - **Alert** – Practice enhanced precautions: Ebola in Democratic Republic of the Congo
  - **Watch** – Practice usual precautions: Ebola in Nigeria

- Based on current travel notices consider making adjustments to programs for the current semester and upcoming spring semester which would involve travel by students and faculty to these regions.

- Identify students, faculty, and staff who have been in countries where Ebola outbreaks are occurring within the past 21 days and conduct a risk assessment with each identified person to determine his or her level of risk exposure (high- or low-risk exposures, or no known exposure). Consult the CDC’s algorithm for evaluation of a returned traveler:

The following steps are consistent with current CDC guidance:

- If the student, faculty, or staff member has had NO symptoms of Ebola for 21 days since leaving a West African country with Ebola outbreaks, they do NOT have Ebola. No further assessment is needed.

- If the student, faculty, or staff member has had a high or low-risk exposure, state or local public health authorities should be notified, and school officials should consult with public health authorities for guidance about how that person should be monitored. Anyone with a potential exposure should receive thorough education about immediately reporting symptoms and staying away from other people if symptoms develop.

- In the event that a student, faculty, or staff member who has had a high or low-risk exposure develops symptoms consistent with Ebola, the person should be medically evaluated while following recommended infection control precautions. Guidance is available in the CDC Ebola Virus Disease Information for Clinicians in U.S. Healthcare Settings. Public health authorities should be notified.

- If the student, faculty, or staff member displays no symptoms and presents no known exposure risk, institutions are advised to instruct the individual to self-monitor through temperature and symptom reporting until the end of the 21 day period, and to report immediately if symptoms appear.

*Note that the CDC is still not recommending that colleges and universities quarantine individuals based solely on travel history. The system presently relies on individuals, including college students, to self-monitor for the*
onset of symptoms and to take immediate steps to self-report. This raises the questions as to whether the self-monitoring/reporting system is reliable enough or whether other steps should be considered to protect the campus community. Reasonable minds may differ as to whether all return travelers are reliable enough to self-monitor without some other level of mandatory oversight. One option, for example, may be for the Campus Health Center to actively participate in the monitoring of individuals to ensure accurate assessments and timely reporting and action if the individual develops symptoms.

- In the event that a potential case is identified, isolate the individual pending diagnostic testing.
- Although not a full list of precautions, student health center clinicians should be sure to follow these steps when caring for someone who is sick or may be sick with Ebola:
  - Separate the sick individual in a private room with its own bathroom.
  - Use proper infection prevention and control measures; standard, contact, and droplet precautions are recommended if Ebola is suspected.
  - Wear the right personal protective equipment (PPE), including masks, gloves, gowns, facemask and eye protection, when entering the patient care area. Before leaving the patient area, carefully remove PPE and make sure not to contaminate skin and clothing. Dispose of PPE as biohazard waste.
  - After removing PPE, wash hands using soap and water (preferred) or an alcohol-based hand sanitizer containing at least 60% alcohol. Use soap and water when hands are visibly dirty.
  - Notify local or state health department immediately if Ebola is suspected. The health department can provide additional guidance regarding medical evaluation or testing, if indicated.

Follow protocols for cleaning and disinfecting reusable medical equipment and proper disposal of needles and other disposable equipment.

Copyright

Fair Use Case Sent Back to Lower Court


The U.S. Court of Appeals for the 11th Circuit issued its opinion Oct. 17 in *Cambridge University Press v. Patton*, the case challenging the use of various scholarly works in the Georgia State University library’s electronic reserves.

The case was on appeal from the U.S. District Court in Atlanta, where in May 2012, Judge Orinda Evans rejected 70 copyright infringement claims filed by Cambridge University Press, Oxford University Press and Sage Publications, finding that only five excerpts exceeded the court's analysis of statutory fair use factors. ACE and other higher education associations submitted an amicus brief to the appeals court supporting the district court’s ruling.

In a lengthy opinion, the court sent the case back to the district court to reconsider the application of fair use doctrine, which allows use of published material without the consent of the copyright owner on a limited basis following evaluation of four factors:

1. The purpose and character of the use (commercial vs. non-commercial).
2. The nature of the copyrighted work.
3. The amount and substantiality of the portion used in relation to the copyrighted work as a whole.
4. The effect of the use upon the potential market.

The appeals court largely affirmed the district court’s analysis for the first (purpose of the use) and fourth (market effect) fair use factors. The court found that the district court should have been more nuanced in its consideration of the second (nature of work used) and third (the amount used) factors.
In determining how all four factors should be weighed, the court pointed out that one may not simply count up the factors for each side and grant judgment based upon that simple mathematical formula. Each factor must be carefully weighed for each work and each use, holistically and on a case-by-case basis.

The next steps are up to the actual parties to the case and the district court. Colleges and universities are encouraged to review the opinion with their legal counsel and consider if the various pronouncements, which are binding in Georgia, Florida and Alabama, provide reasons to review or revise any policies or practices on campus.

**Athletics/NCAA**

**New Lawsuit Targets NCAA and Every Division I School**

*USA TODAY Sports - October 23, 2014*

The legal attacks on the NCAA and its limits on what athletes can receive while playing college sports have been spread across a much wider front with the filing of a lawsuit that names the NCAA and every Division I school as defendants.

The suit — filed this week in U.S. District Court in Indianapolis, where the NCAA is headquartered — alleges that the NCAA and the schools are violating the wage-and-hour provisions of the Fair Labor Standards Act (FLSA).

The allegations are framed by the schools' employment of students in work-study positions that pay hourly wages.

"Student athletes meet the criteria for recognition as temporary employees of NCAA Division I Member Schools under the FLSA as much as, if not more than, work study participants, and, thus, NCAA Division I Member Schools are required by law to pay student athletes at least the federal minimum-wage of $7.25 an hour," the complaint alleges.

The complaint says that students in work-study, part-time jobs perform non-academic functions for no academic credit, so they meet the criteria for recognition as temporary employees of the schools under the FLSA. As result, the schools "must, and do, pay them" at least the minimum wage, the complaint says.

"Student athletes engage in non-academic performance for no academic credit in athletic competition," the complaint alleges. "By comparison to student participants in work study part-time employment programs, student athletes perform longer, more rigorous hours … are subject to stricter, more exacting supervision by full-time staff … and confer many, if not more, tangible and intangible benefits on" Division I schools.

The complaint, citing Bureau of Labor Statistics data, adds that this situation "produces the following perverse result: work study participants who sell programs or usher at athletic events are paid, on average, $9.03 an hour, but student athletes whose performance creates such work study jobs in the athletic department are paid nothing."

The suit's named plaintiff is Samantha Sackos, a University of Houston women's soccer player from 2010-11 through 2013-14. It was filed by a Philadelphia-based attorney, Paul L. McDonald.

The suit says it is being brought on behalf of all NCAA Division athletes in men's and women's sports and seeks what it terms "unpaid wages" -- essentially back-pay for athletes beginning at least two years ago -- as well as an injunction against the NCAA and the schools.

The suit says that McDonald approached the NCAA about this matter prior to filing the lawsuit and "the NCAA asserted that NCAA regulated sports are extracurricular activities in the same manner as, 'dramatics, student publications, glee clubs, bands, choirs, debating teams, radio stations, intramural and interscholastic athletics ... conducted primarily for the benefit of the participants as part of educational opportunities' and, thus exempt from FLSA requirements."

The NCAA's chief legal officer Donald Remy, in a statement, said of the lawsuit: "We are currently evaluating the complaint, but disagree that student-athletes are participating in athletics as employees. Student-athletes have a passion for their sport and a commitment to their teammates that can't be equated to punching a time clock."
McDonald said in a statement the suit "does not require significant changes to attain wage equity for student athletes. During playing and practice seasons, colleges could fold student athletes into existing payroll systems for work study — even utilizing NCAA required recording of countable athletically-related activities as weekly time sheets."

McDonald said in his statement this case does not propose giving athletes regular employee status and collective-bargaining rights.

**Gainful Employment**

**Department of Education Releases Final Rules on Gainful Employment**

*Federal Register – October 31, 2014 & Community College Daily – October 30, 2014*

The Depart of Education issued final rules amending regulations on institutional eligibility under the Higher Education Act of 1965, as amended (HEA), and the Student Assistance General Provisions to establish measures for determining whether certain postsecondary educational programs prepare students for gainful employment in a recognized occupation, and the conditions under which these educational programs remain eligible under the Federal Student Aid programs authorized under title IV of the HEA (title IV, HEA programs).

These rules are effective July 1, 2015.

The final rules establish (1) an accountability framework for GE programs that defines what it means to prepare students for gainful employment in a recognized occupation by establishing measures by which the Department will evaluate whether a GE program remains eligible for title IV, HEA program funds, and (2) a transparency framework that will increase the quality and availability of information about the outcomes of students enrolled in GE programs.

To remain eligible for federal funding under Title IV, the rules require GE programs to meet a minimum standard for the debt-to-earnings ratio of graduates. Programs whose graduates have annual loan payments greater than 12 percent of total earnings and greater than 30 percent of discretionary earnings would fail the standard. Programs whose graduates have annual loan payments between 8 and 12 percent of total earnings, or between 20 and 30 percent of discretionary earnings, would fall into a warning “zone.”

Programs that fail in two of any three consecutive years or are in the zone for four consecutive years would lose eligible for Title IV funding.

According to the Education Department, the vast majority of institutions would pass the accountability metric, but about 1,400 institutions would not. The department estimates that about 840,000 students are enrolled in institutions that would not pass, and 99 percent of them are at for-profit institutions.

The rules require institutions to make public disclosures regarding the performance and outcomes of their GE programs, including information on costs, earnings and debt, and completion rates.

In one key change from the proposed regulations published in March, the program cohort default rate was eliminated as an accountability metric.
### The Office of Audit, Compliance Ethics  
**JACC Agenda Forecast**

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[i]: currently BKD
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