U.S. Department of the Interior
Office of Inspector General

Office of the Virgin Islands Inspector General
Government of the Virgin Islands

Administrative Functions, Roy Lester Schneider Regional Medical Center,

Government of the Virgin Islands

Report No. V-IN-VIS-0001-2007 **July 2008**

U.S. Department of the Interior
Office of Inspector General

Office of the Virgin Islands
Inspector General
Government of the Virgin Islands

July 28, 2008

The Honorable John P. de Jongh, Jr.
Governor of the Virgin Islands
No. 21 Kongens Gade
St. Thomas, VI 00802

Re: Final Audit Report *Administrative Functions, Roy Lester Schneider Regional Medical Center, Government of the Virgin Islands* (Report No. V-IN-VIS-0001-2007)

Dear Governor de Jongh:

In October 2007, the Offices of Inspectors General of the U.S. Department of the Interior (DOI) and of the Virgin Islands completed their joint audit of the Roy Lester Schneider Regional Medical Center (Medical Center). Unfortunately, we faced an alarming degree of secrecy and deliberate concealment of financial records that limited our ability to complete a comprehensive review of the Medical Center's administrative functions[1]. To get the information on which we base this report, we were forced to issue subpoenas. A court proceeding in the Superior Court of the Virgin Islands was ultimately required to enforce the subpoenas.

The secrecy concealed an alarming depth of mismanagement of Medical Center funds and a complete lack of oversight of these monies by the Center's District Governing Board, as well as a lack of Medical Center financial viability. We list below some of the more egregious examples, which resulted in several referrals to criminal investigators in our respective offices.

- Inappropriate retirement fund payments;
- Compensation overpayments to Medical Center executives;
- Abuse of credit card privileges;
- Inappropriate cost reimbursements to Medical Center executives; and
- Underreporting of executive compensation.

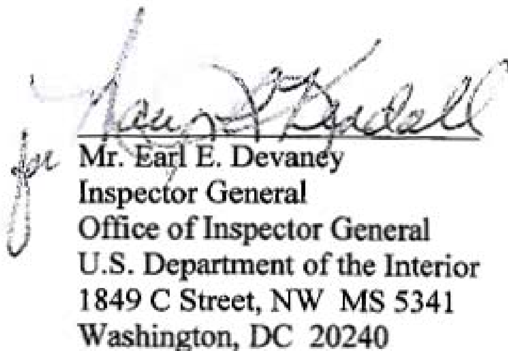
We provide six recommendations and believe their implementation is essential to continuing health care delivery, efficient use of funding, and restoration of public trust in

[1] See Appendix 1 *Audit Scope and Methodology* for additional information on audit work progression

this public institution. In addition, implementation of these recommendations should vastly improve the transparency of the Medical Center's operations and provide for a more informed allocation of government revenue. We are pleased that you agree with our recommendations, as stated in your July 10, 2008 response to our draft report (Appendix 2). We commend your decisive action to address the deficiencies in this report and your commitment to making significant improvements in the fiscal accountability of the Medical Center. Based on your response, we consider all of the recommendations resolved but not implemented (Appendix 3).

The legislation, as amended, creating the Office of Inspector General requires that we report to Congress semiannually on all audit reports issued, the monetary effect of audit findings, actions taken to implement our audit recommendations, and recommendations that have not been implemented. The monetary impact of the findings in this report is shown in Appendix 4.

Please provide a response to this report, by August 29, 2008, to both Inspectors General. The response should provide the information requested in Appendix 3. If you have any questions concerning this report, you may call Mr. Devaney at 202-208-5745 or Mr. van Beverhoudt at 340-774-6426.


Mr. Earl E. Devaney
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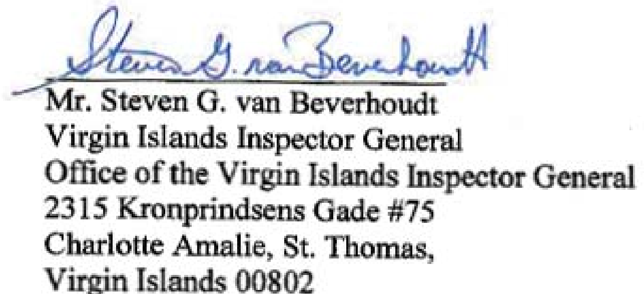
Mr. Steven G. van Beverhoudt
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Virgin Islands 00802

cc: Amos W. Carty, Chief Executive Officer, Roy Lester Schneider Regional Medical Center
Douglas W. Domenech, Acting Deputy Assistant Secretary for Insular Affairs

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INTRODUCTION

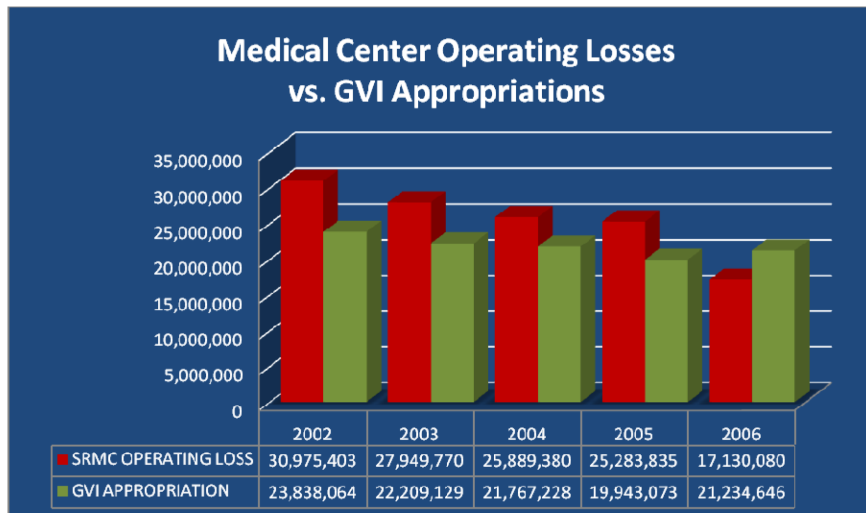
MEDICAL CENTER REGULATORY OVERVIEW AND FINANCIAL STANDING

In 1999, the Virgin Islands Government Hospitals and Health Facilities Corporation was created as a public entity of the Government of the Virgin Islands (GVI) to manage health care delivery in partnership with the GVI. The corporation is administered by a Board of Directors consisting of fifteen members representing St. Thomas, St. Croix, and St. John, Virgin Islands. The corporation delegates power to two district governing boards; one for the District of St. Thomas-St. John, and the other for the District of St. Croix.

The District Governing Board for St. Thomas-St. John (District Board) is comprised of eight community members who are appointed by the VI Governor and confirmed by the VI Legislature for 3-year terms. The District Board is responsible for overseeing the operations of the Roy Lester Schneider Hospital and the Charlotte Kimelman Cancer Institute on St. Thomas and the Myrah Keating Smith Community Health Center on St. John. These three institutions comprise the Schneider Regional Medical Center, a 169-bed, acute care facility accredited by the Joint Commission on Accreditation of Health Care Administration and Centers for Medicaid and Medicare.

The District Board delegates management operations to a Chief Executive Officer (CEO) and holds him accountable for the execution of hospital policy decisions. The CEO, the Chief Operating Officer/General Counsel (COO), and the Chief Financial Officer (CFO) are the key executives responsible for the day-to-day operation of the Medical Center.

The Medical Center exists as a public entity of the GVI to preclude the need for government funding through fiscal responsibility and efficient management. However, it has a long-standing financial deficit and reported annual operating losses, averaging $25.4 million annually during the period of fiscal year 2002 through 2006. In an attempt to fund the Medical Center's losses, the Virgin Islands Legislature appropriated an annual average of $21.8 million over the same period (see Figure 1). The $21.8 million represented 37 percent of the Medical Center's revenues before grant proceeds.



Data from VI Legislature's budget analysis based on information presented by the Medical Center for Fiscal Year 2007 budget hearings **Figure 1**

As a public entity of the GVI relying heavily on GVI funding, the Medical Center is required to present an annual detailed account of its revenue and expenditures to the Executive and Legislative branches, which use the information to make an informed decision on the level of funding to be provided.

Medical Center employee salaries are reported via Notices of Personnel Action (NOPA). A NOPA is the official GVI personnel document that confirms employment and includes the amount of salary to be paid and the position title.

RESULTS OF AUDIT

MEDICAL CENTER MANAGEMENT FOSTERED AN ENVIRONMENT OF FISCAL IRRESPONSIBILITY

A breakdown of key controls resulted in a flagrant disregard for accountability and transparency by the District Board and senior executives at the Medical Center, thereby exposing the Medical Center to fraud and mismanagement which resulted in a litany of abuses. The District Board, rather than fulfilling its public trust responsibilities, acquiesced and colluded with the Medical Center's senior executives both to divert Medical Center funds for personal gain and waste Medical Center funds, all the while fostering an environment of secrecy within an entity of the GVI. The District Board demonstrated fiscal irresponsibility in its continual neglect of the Medical Center's poor financial standing by awarding lucrative compensation packages to senior executives. The Medical Center's CFO exacerbated this irresponsibility by making excess payments to the CEO above employee contract amounts. The District Board then concealed the true amounts paid to these executives by reporting significantly understated amounts to the Executive and Legislative branches of the GVI, whose oversight and scrutiny of the funding needs of the Medical Center was based on faulty and misleading information. Senior executives further misused Medical Center official credit cards for personal gain and failed to exercise good judgment in approving credit card purchases and reimbursable expenses. They also allowed overpayments owed to patients and insurers and medical service overbillings to help fund these fiscally irresponsible practices. These conditions, taken in totality, were serious enough to warrant the initiation of a criminal investigation.

EXCESSIVE COMPENSATION PACKAGES

In light of the Medical Center's operating losses, the amounts paid as executive compensation, particularly to the CEO, were excessive and fiscally irresponsible. Between 2002 and 2007, the CEO was paid $3.8 million under three employment contracts laden with lucrative and questionable perquisites (perks). Of this amount, $1.3 million represented payments in excess of the amounts specified in the employment contracts. Overpayments were also made to the CFO and COO, who between 2005 and 2007, were compensated at least $456,100 above their reported salaries. The Medical Center's District Board then misrepresented the actual amount of compensation provided to their top executives by providing inaccurate and incomplete information to the Legislative and Executive branches of the GVI during the annual budgetary process and by omitting all compensation decisions from their board minutes.

►CEO Hired at Average Annual Compensation of $197,500

On April 17, 2002, the District Board awarded a 3-year contract for the services of the CEO for a total of $450,000 in salary payments ($150,000 per year). The contract also provided for at least an additional $142,400 in perks for items such as housing allowances and performance bonuses. The contract, which contained a 2-year renewal option, stated that the CEO was an exempt employee of the GVI employed by NOPA.

Although the contract's total compensation provided for $592,400, the CEO was only entitled to $557,100 based on the actual duration of the contract term. However, the CEO in fact received $648,700, an excess of $91,600, for extra housing allowance payments and educational expenses not covered by his contract.

►CEO's Compensation Package Balloons to $1.9 Million

More than a year before the expiration of the first contract, the District Board proposed evaluating the CEO's compensation package relative to a peer group consisting of other semi-autonomous GVI agencies. To conduct this evaluation the District Board hired Clark Consulting – Healthcare Group (Clark), which specializes in analyzing executives' compensation and benefits. Clark's evaluation was based on a peer group of health care organizations in the United States similar to the Medical Center in size and complexity.

Clark warned the District Board that it would be "problematic" to increase the CEO's salary because of the Medical Center's heavy reliance on GVI subsidies. Clark recommended a compensation package of $585,300 over a 2-year period, placing the CEO's salary in the 25th percentile of the national peer group. The District Board, however, ignored this recommendation and opted for a 2-year agreement, with a 1-year renewal, worth $1,886,900, which placed the CEO's salary in the 90th percentile of the national peer group.

The District Board's agreement included $530,000 in base salary payments ($265,000 per year) and $1,356,900 in lavish perks, including a Rabbi Trust allowance (a tax deferred compensation package), a signing bonus, a retention bonus, and travel for the CEO's spouse. (See Figure 2 for details.)

Under this employment agreement, the CEO was entitled to the full $1,886,900 only if the 1-year renewal option was exercised. The renewal option was not exercised; therefore, the CEO was only entitled to $1,661,900 under the terms of the contract. Instead, over this 2-year term the CEO actually received $2,068,300, an excess of $406,400.

►District Board Agrees to 1-Year CEO Agreement worth $1.3 Million

Rather than exercising the 1-year renewal option included in the second agreement, the District Board again contracted with Clark to review the CEO's employment compensation and benefit programs. Clark recommended that the Medical Center maintain their current pay structure under the 2005 contract, which was about $897,600, but warned that special cash compensation could adversely affect the Medical Center's finances and that the Medical Center may in the future face public criticism if called to defend the reasonableness of the CEO's total compensation. Instead of adhering to Clark's recommendation, the District Board decided to create an entirely new 1-year employment agreement for the CEO valued at $1,302,500 for 2007.

"SRMC is aware that any special cash compensation and benefit program provided to any employee of the hospital may draw attention . . . and could potentially adversely affect its finances and SRMC's reputation. . . . SRMC might face public censure, as well as the interest of the IRS in addressing the reasonableness of [the CEO's] total compensation package."

--Clark Consulting – Healthcare Group's appraisal of third CEO contract.

The District Board's 1-year agreement included a salary of $310,000 and $992,500 in perks, including yet another signing bonus, as illustrated below (Figure 2).

Employment Agreement Perks
May 2005 and May 2007

Description	2005 – 2007 Agreement	2007 Agreement
Signing Bonus	$66,200	$77,500
Cost of Living Adjustment	$26,500	$15,500
Performance Bonus*	$159,000	$93,000
Housing Allowance	$80,000	$40,000
Retention Bonus	$106,000	-
Education Allowance	$20,000	$10,000
Rabbi Trust Allowance	$771,200	$722,700
Vacation	$40,800	$23,800
Spousal Travel	$20,000	$10,000
Insurance	$67,200	-
Total Perks	$1,356,900	$992,500

*There was no documentation of performance reviews to support performance bonus payments.

Figure 2

The CEO voluntarily resigned in November 2007 before the completion of the agreement and was therefore only entitled to $302,900 under the terms of the agreement. Instead, the CEO was actually paid $1,076,100, an excess of $773,200.

►$1.5 Million in Questionable Rabbi Trust Payments

The Rabbi Trust perk contained in both the second and third employment agreements was particularly questionable. A Rabbi Trust is essentially an employer funded tax deferred compensation plan similar to a 401k plan for a company's top executives. The employer pays compensation to an independent third-party, such as a bank or trust company for the ultimate benefit of the top executive. In this case, however, the District Board failed to

establish the CEO's Rabbi Trust and instead authorized payments of $1,469,000 which was subsequently deposited directly into the CEO's personal accounts.

►CEO's Excess Compensation Totaled $1.3 Million Over 5-Year Period

Over the 5-year period of the three agreements the Medical Center's District Board approved payments of $2,521,900 in salary and perks. Instead, the CEO received $3,793,100 in payments as illustrated in Figure 3. These overpayments totaled $1,271,200.

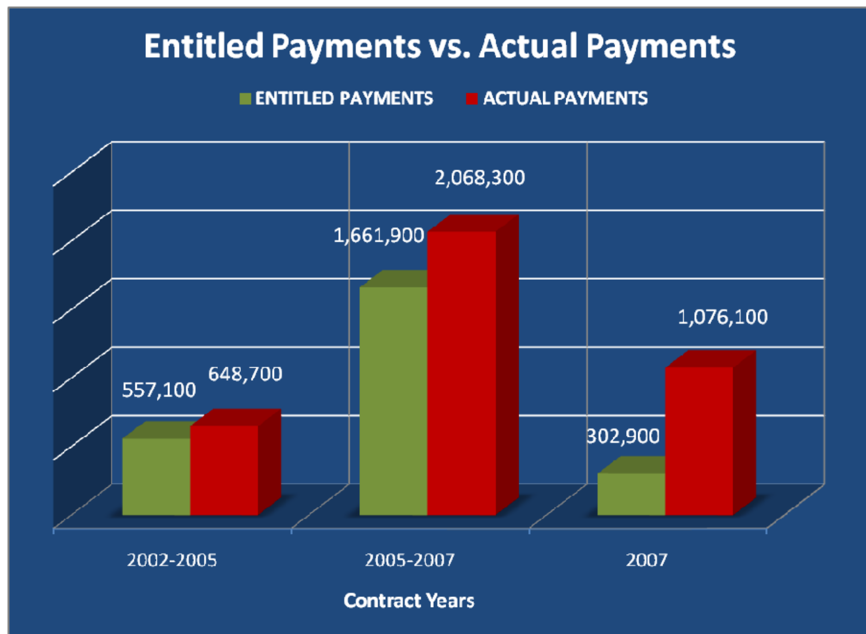


Figure 3

►Overpayments of at least $456,100 to CFO and COO

In August 2005, the District Board contracted with Clark to also perform an analysis of the total compensation and benefit programs for the Medical Center's COO and CFO. NOPAs for both executives stated that they were receiving annual salaries of $80,000. Based on information the Medical Center provided to Clark and 2005 tax form calculations provided to the Offices of Inspectors General, it was evident that both executives received payments in excess of the amount stated on their NOPAs. Between 2005 and 2007 the COO and the CFO received annual compensation of at least $166,000 and $146,000 respectively. These overpayments amounted to $456,100 over the period. Both executives also received the benefit of extra life insurance and long and short term disability insurance payments totaling $96,000 in 2006 and 2007 that were not available to other employees at the Medical Center.

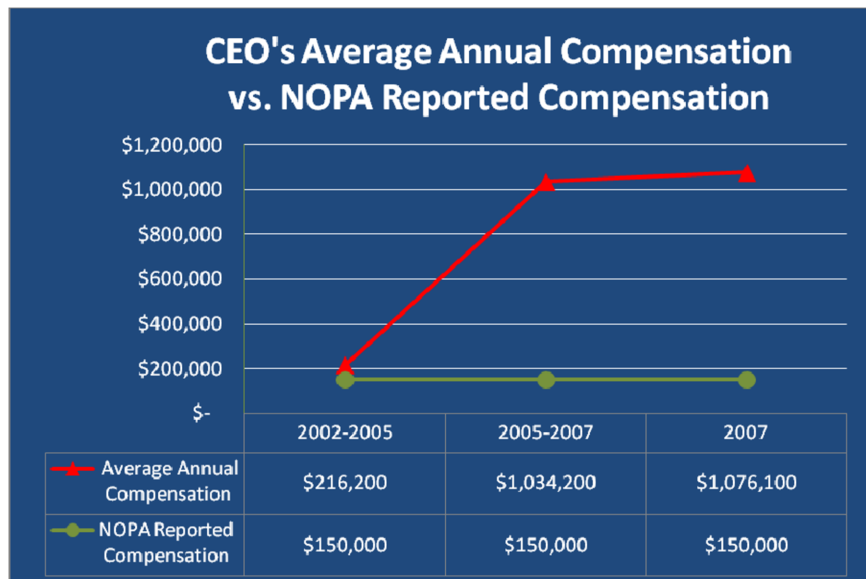
On several occasions we asked if employment agreements or contracts existed for the COO and CFO and requested copies of them if they did. Although it was clear that these two executives

were paid in excess of their NOPA amounts, the CFO stated that there were no such agreements.

►Actual Compensation to Medical Center Executives Hidden by District Board

The Legislative and Executive branches of the GVI were not made aware of the magnitude of the compensation packages paid to Medical Center executives. Instead, during Medical Center budget hearings, the District Board significantly misrepresented the actual amount of compensation provided to their top executives by providing inaccurate information to the Executive and Legislative branches, leading them to believe that Medical Center executives were paid only the salaries reported on their NOPAs.

For example, the District Board continued to represent that the CEO's annual salary was $150,000 as detailed in his original 2002 NOPA. By 2007, however, the CEO's actual compensation had mushroomed to a total annual salary of $1,076,100, including perks. See Figure 4.



	2002-2005	2005-2007	2007
Average Annual Compensation	$216,200	$1,034,200	$1,076,100
NOPA Reported Compensation	$150,000	$150,000	$150,000

Figure 4

The District Board further perpetrated the secrecy of the executive compensation plans by omitting from District Board minutes, their decision to award lucrative compensation packages and overpayments, and the effect of those payments on the Medical Center's limited financial resources.

►No Control Environment

This flagrant abuse occurred because of a lack of key controls over compensation and payroll processes. In the 6 months preceding the CEO's voluntary termination, the CFO electronically transferred $1,867,900 to the CEO's personal accounts, based on direct authorizations from the Chairperson of the District Board and the CEO. The CFO did not have a copy of any of the

employment agreements to determine whether payment amounts requested by the CEO were justified. Since the CFO was the only person making the electronic transfers, no one else had knowledge of the total compensation being paid out. For example, the CFO transferred $250,000 on May 21, 2007, $250,000 on May 24, 2007, and $466,456 on May 25, 2007, for a total of $966,456 over a 5-day period alone based on calculations provided by the CEO himself.

Had the District Board and Medical Center executives acted according to basic business management practices, there would have been transparent accountability of transactions by several other people in the processing of compensation payments. Instead the senior executives acted in a spirit of collusion and secrecy and evaded the segregation of duties inherent in normal transaction processing, which are designed to detect and prevent improper transactions.

ABUSIVE CREDIT CARD USAGE AND QUESTIONABLE REIMBURSEMENTS

Top level executives also ignored the Medical Center's weak financial position by their lack of oversight in determining the eligibility of amounts claimed prior to approving credit card purchases and reimbursable expenses. Four Medical Center executives were allowed to incur at least $317,200 in credit card charges that were unsupported, personal, or ineligible for payment by the Medical Center. In addition, at least $30,400 in reimbursements for expenses was paid that was ineligible or did not have proper supporting documentation.

►Unsupported and Personal Charges Represented 63% of Credit Card Charges

We audited all credit card charges of the four Medical Center executives from October 2004 to September 2006, totaling $500,200. Of those charges, $317,200 was unsupported by either receipts or an explanation of why the charges were incurred, yet they were approved for payment by either the CEO or CFO. As a result, there was little assurance that all of these charges were actually legitimate Medical Center business expenses.

The COO incurred $31,900 in personal and ineligible charges including airline tickets, airline upgrades, rental cars, meals, golf outings, and charges associated with his duties at the Virgin Islands Bar Association. Among the COO's personal charges was travel primarily on weekends that coincided with holidays such as Christmas, Thanksgiving, and Labor Day. For example:

- The COO incurred $1,100 in charges for travel from December 24, 2004, to December 26, 2004, Christmas weekend, to Orlando, Florida.

- The COO incurred $1,300 in charges for travel from September 2, 2005, to September 6, 2005, Labor Day weekend, to Ft. Lauderdale, Florida.

- The COO incurred $1,100 in charges for travel from December 23, 2005, to December 26, 2005, Christmas weekend, to Miami, Florida. Among those charges were tickets to the Metro Zoo.

►$30,400 Paid in Ineligible or Unsupported Reimbursements

We also audited $106,800 of reimbursements made to Medical Center executives over a 5-year period and found that $30,400 was paid for expenses that either were not substantiated by any supporting documents or were ineligible for reimbursement. For example:

- The CFO was reimbursed $18,900 for moving expenses although there was no written agreement in place authorizing those expenditures.

- The CFO was reimbursed $2,700 for charges relating to an educational seminar in March 2004 although the training occurred one month before he was hired.

UNPROCESSED REFUNDS AND OVERBILLING

In continuing with their fiscal irresponsibility, Medical Center officials failed to make a determination of the amount of refunds actually owed to patients and insurers, utilized refunds due to insurers, and did not maintain proper controls over the processing of refunds. In addition, Medical Center officials allowed patients and insurers to be overbilled for air ambulance services and allowed contractual discounts to be inappropriately applied.

►$8.8 Million in Refunds Potentially Owed and $948,100 Unpaid

Over the past five years, the Medical Center's accounting system reflected possible refunds due to patients and insurers that were either caused by an actual overpayment for services or by data entry errors. Rather than analyzing the amounts to determine how much were actually due to overpayments, Medical Center officials allowed these possible refunds to increase to $8.8 million. Medical Center officials acknowledged that it was likely that they may owe patients and insurers refunds for overpayments, but claimed they did not have the personnel necessary to conduct the analysis. Thus, the Medical Center's level of patient overpayments was allowed to grow because all payments received, including overpayments, were entered into their operating account as revenue and used to support the Medical Center's normal operating expenses.

Medical Center officials indicated that previously analyzed potential overpayments resulted in the Medical Center confirming that it owed $948,100 to private insurers. However, they were unable to reimburse any of these overpayments because of "cash flow problems." The Medical Center is in the process of making refunds of confirmed overpayments to patients.

►Refunds Subject to Fraud and Abuse

The Medical Center's poor internal control environment in the area of processing refunds for overpayments subjected those funds to fraud and abuse. Employees with access to the computerized accounting system could potentially issue themselves refunds because refund requests were not verified for proper authorization.

There was no restriction on the Cashier's Office from posting refund requests independent of management's approval because the Accounts Payable Division printed refund checks based solely on an electronic request from the Cashier's Office without obtaining a signed authorization for payment. Moreover, the Accounts Payable Division printed checks up to $25,000 in value using only the computer generated signature of the CEO, and then returned the checks to the Cashier's Office for mailing to the patient or insurer. As a result, there was no assurance that refunds were accurate or paid to appropriate persons.

In addition, the system was not set to restrict the posting of refund requests to only the Cashier's Office. We found that, as of August 2007, 108 accounting system users from various departments were allowed to post refund requests. After the discovery, a Medical Center official informed us that steps had been taken to limit access to only two cashiers.

►Insurance Companies Overbilled

The Medical Center utilized the services of independent air ambulance providers and then billed the patients or their insurers for the associated charges. Our review of 12 instances totaling $249,100, where the Medical Center billed insurers and patients for independent air ambulance services, revealed that the Medical Center had a pattern of overbilling for those services. In 10 of the 12 instances reviewed, the Medical Center overbilled by charging over $122,200 more than the actual invoice amounts submitted to the Medical Center by the independent ambulance suppliers. For example:

- An independent air ambulance supplier provided an invoice to the Medical Center totaling $23,900. Rather than billing Medicare and a secondary insurer based on the actual invoice, the Medical Center overbilled the insurers by nearly $40,000.

- An independent air ambulance supplier provided an invoice to the Medical Center totaling $16,500. Rather than billing the private insurer based on the actual invoice, the Medical Center overbilled the private insurer by approximately $10,000.

In determining why the pattern of overbilling was allowed to continue for independent air ambulance services, we were told by Medical Center employees that they were instructed to inflate claims by the Medical Center's Director of Patient Accounts and one of their consultants. The Director instead attributed the overbillings to the utilization of incorrect medical procedure codes by employees. She also stated that the employees did not possess adequate education to process claims for air ambulance charges.

►Contractual Discounts Unapplied

The Medical Center was contractually obligated to extend discounts to patients covered by two private insurers at rates of 10 to 28 percent of the overall bill. We reviewed 20 patient accounts and found 13 instances where contractual discounts were either not applied or were applied incorrectly. As a result, patients may have been billed for amounts greater than they should have owed. In some instances, the Medical Center's accounting system showed that patients owed for services when they may have been entitled to a refund. Other than by manually reviewing each account, Medical Center staff did not have any way of determining which accounts had not been appropriately discounted.

RECOMMENDATIONS

TO THE GOVERNOR OF THE VIRGIN ISLANDS

We recommend that the Governor of the Virgin Islands:

1. Take immediate action to evaluate the performance of individual board members and remove those members who have contributed to the current management and financial crisis by failing to live up to their fiduciary responsibilities.

2. Take immediate action to evaluate the performance of senior management and recommend disciplinary action for those members who contributed to the current management and financial crisis by failing to live up to their fiduciary responsibilities.

3. Establish an independent Audit Committee which reports directly to the Board and establish a requirement that instances of fraud must also be referred to appropriate law enforcement agencies.

4. Take immediate action to establish effective internal controls and appropriate control structures.

5. Take action to recover payments and credit card charges which were inappropriate or did not benefit the Medical Center.

6. Take actions to evaluate credit balances due patients and insurance providers and make refunds as appropriate.

GOVERNOR'S RESPONSE AND OFFICE OF INSPECTOR GENERAL (OIG) REPLY

In his July 10, 2008 response to our draft report (Appendix 2), the Governor of the Virgin Islands concurred with our recommendations. The Governor stated that the reported mismanagement and lack of transparency has exposed the Medical Center to a loss of public confidence and damaged the reputation of the Medical Center and its Governing Board. He also added that the many years of outstanding work by the Medical Center, its staff, management, and Board may have been irrevocably damaged by the awarding of questionable compensation packages which were not fully disclosed by either the Board or senior management, especially in light of the institution's well-known fiscal challenges.

In response to our recommendations, the Governor stated that based on our report and any other evidence which may arise, he

would either dissolve the St. Thomas-St. John District Board or replace, for cause, those Board members who have failed to live up to their fiduciary responsibility. The newly reconstituted District Board will evaluate the actions and performance of senior management to take an unbiased look at the findings of the audit, to address all deficiencies, lack of internal controls, and possible acts of fraud or other improper conduct. As part of his response, the Governor also provided information showing that the Medical Center had either initiated or was in the process of initiating plans of action to implement each recommendation.

We are encouraged by the Governor's concurrence with our recommendations and the decisive actions taken to address the deficiencies addressed in the report. We look forward to receiving continued confirmation of this ongoing work. Based on the Governor's response, we consider all six recommendations resolved but not implemented. The status of the audit recommendations is shown in Appendix 3.

Appendix 1 – Audit Scope and Methodology

OBJECTIVE AND SCOPE

This audit was conducted as a joint initiative by the Office of the Virgin Islands Inspector General and the Department of the Interior's Office of Inspector General. The objective of the audit was to determine whether the Medical Center carried out its administrative functions, including billing, collecting accounts receivable, contracting, and incurring costs in accordance with applicable laws and regulations. However, we were limited in our ability to complete a comprehensive review of the Medical Center's administrative function since critical records, such as contracts, board minutes, and transaction authorization forms were not made available to us during our review, and Medical Center executives were uncooperative to the point of concealing information from us. As a result, we were unable to evaluate the overall administrative function of the Medical Center and are instead reporting on those aspects for which we believe we have sufficient information upon which to report.

Throughout the course of the audit, we were faced with numerous challenges and obstacles resulting in delays in conducting our audit. The Medical Center's COO insisted that all requests for information be channeled through him and reviewed prior to auditors receiving them and that he be notified of persons being interviewed. As a result, the Office of the Virgin Islands Inspector General was forced to issue seven subpoenas for audit information directly to either the Chairperson of the District Board or to the Medical Center's top executives. For example, our request for copies of the CEO's employment agreements was made in April 2007. However, after several attempts, it wasn't until a subpoena was issued in July 2007 that the Chairperson of the District Board wrote that they would "reluctantly" produce copies of the CEO's agreements.

In November 2007, the Offices of Inspectors General were eventually forced to initiate court proceedings in the Superior Court of the Virgin Islands to obtain the information necessary to complete our audit.

We performed our audit work from December 2006 to October 2007. To accomplish our objective, we interviewed officials and reviewed financial reports and records pertaining to credit balances, refunds, cash collections, accounts receivable balances, discounts, contracts, gross receipt taxes, credit cards, and reimbursements. We also consulted with officials from the

Departments of Health and Human Services, Finance, Personnel, and Licensing and Consumer Affairs, and the Bureau of Internal Revenue, and Lieutenant Governor's Office.

Our audit was conducted in accordance with the *Government Auditing Standards*, issued by the Comptroller General of the United States. Accordingly, we included such tests of records and other auditing procedures we considered necessary under the circumstances. As part of the audit, we evaluated the internal controls related to the administration of Medical Center funds to the extent we considered necessary to accomplish the audit objective.

Our audit disclosed significant internal control deficiencies that brought into question the accuracy and totality of information received and reviewed at the Medical Center. We obtained information from the Medical Center that purported to be a complete showing of all information relative to contracts and bank accounts that we later found to be inaccurate and incomplete.

Internal control weaknesses identified as a result of our audit are discussed in the Results of Audit section of this report. The recommendations, if implemented, should improve the internal controls in these areas.

PRIOR AUDIT COVERAGE

Neither Office of Inspectors General has conducted any prior audits on the Medical Center within the past 10 years.

Appendix 2 – Governor of the Virgin Islands Response

THE UNITED STATES VIRGIN ISLANDS

OFFICE OF THE GOVERNOR
GOVERNMENT HOUSE
Charlotte Amalie, V.I. 00802
340-774-0001

July 10, 2008

Mr. Earl E. Devaney
Inspector General
Office of the Inspector General
U.S. Department of the Interior
1849 C. Street, NW MS5341
Washington, D.C. 20240

Mr. Steven van Beverhoudt
Virgin Islands Inspector General
Office of the Virgin Islands Inspector General
2315 Kronprindsens Gade #75
Charlotte Amalie
St. Thomas, VI 00802

RE: Response of the Government of the Virgin Islands to Draft Report
Administrative Functions, Roy Lester Schneider Regional Medical Center,
Government of the Virgin Islands
Assignment No. V-IN-VIS-0001-2007, June 2008

Dear Messrs. Devaney and van Beverhoudt:

First, let me express my appreciation to you and your staff for the Draft Audit Report: *Administrative Functions*; Roy Lester Schneider Regional Medical Center (SRMC), Government of the Virgin Islands (V-IN-VIS-0001-2007). Second, let me reiterate the pledge of cooperation that I have made to the Office of the Inspector General. Your office plays a vital role in fulfilling the requirement that our Government operate in an effective and efficient manner and maintain the transparency necessary for the Government to earn and retain the public trust.

From your report it appears there has been an abdication of fiduciary responsibility by the Governing Board and senior executives of the SRMC. The reported mismanagement and lack of transparency has resulted in allegations of potential fraud, exposed the SRMC to a loss of public confidence, and damaged the reputation of the SRMC and its Governing Board. The many years of outstanding work by the SRMC, its staff, management and Board may have been irrevocably damaged by the awarding of questionable compensation packages which were not fully disclosed by either the Board or senior management, especially in light of the institution's well-known fiscal challenges. These actions have only served to undermine the credibility of the SRMC. With this in mind, and considering any other evidence which may arise regarding this institution, I will either dissolve the St. Thomas-St. John District Board or replace, for cause, those Board members who have failed to live up to their fiduciary responsibility pursuant to your recommendation number one (1).

Under either scenario, the first order of business of the newly reconstituted District Board of Directors will be to evaluate the actions and performance of senior management, to take an unbiased look at the findings of this audit, and to establish and forward to me any additional corrective measures, beyond those already suggested by SRMC, to address all deficiencies, lack of internal controls, and possible acts of fraud or other improper conduct. Recommendations for disciplinary or legal actions will be acted upon forthwith by the Board and my Administration, and referred to the Attorney General for a full review of any possible collusion or other violations of Virgin Islands law, and for determination of what recovery of public funds may be available to us in response to your recommendation number two (2).

In anticipation of the release of this audit, the current District Governing Board has revised its "By-Laws, Rules and Regulations" effective April 11, 2008 to better focus the functions and effectiveness of its new Finance and Audit Committee. The reconstituted Board will further amend the By-Laws to permit the appointment of a financial expert to the Finance and Audit Committee in addition to maintaining membership by Board members who are independent and financially literate.

The SRMC concurs that it does not currently have a written policy requiring that incidences of fraud or potential fraud be reported to the appropriate enforcement agencies. A resolution to address this deficiency will be proposed to the Board at its next meeting on July 16, 2008, and the Chief Financial Officer (CFO) will be responsible for implementation of all actions taken in response to recommendation number three (3). I expect written confirmation of the passage of this resolution to be forwarded to me.

The SRMC concurs with findings regarding lack of sufficient credit card controls. Senior management employees have not been in compliance with the current credit card policy and the Board will amend the language to include the statement *"The deadline for the employee to reimburse SRMC for the unsupported expenses is the date of the employee's next pay check. If the employee does not reimburse SRMC then this event will be documented in the employee personnel file and the employee will be subject to further disciplinary action up to and including termination."* The Board will be expected to take action to enforce this policy with employees who are in violation. Any employee found in violation should also have his or her credit card privileges revoked. These revisions to the current policy will be effectuated at the next Board meeting. The CFO will be responsible for the implementation of this policy which will also be monitored closely by the Board, through the Finance and Audit Committee.

The SRMC also concurs with findings regarding reimbursable expense controls. Although it does have a Travel and Expense reimbursement policy in its Financial Approval Policy, the policy will be revised and amended to require 1) supporting documentation; 2) repayment by the next pay day if charges are not documented; 3) a statement that these expenses were for business only and does not include any personal expenses; 4) documentation in the personnel or other file of any employee or Board member who does not pay by the next pay day or end of the next pay period and 5) disciplinary action up to and including termination for any employee who does not pay. Any Board member in violation of these policies will be reported to the Chairman of the Board, who in turn will report these violations to the Governor.

Additionally, the SRMC concurs with the Draft Audit Report regarding refund controls. The current "Refund Policy" of SRMC does not meet the recommended reforms of the Inspectors General and will therefore be amended. The new language is embodied in the attached "Refund Authorization Policy." The person responsible for implementation of recommendation number four (4) is the CFO and implementation will be aggressively monitored by the Board.

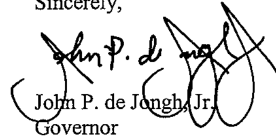
In response to recommendation number five (5), the Governing Board has assured me that, with the implementation of the new credit card policy, actions will be taken to ensure the recovery of any future payments and credit card charges that are personal, inappropriate or do not benefit the Medical Center, and that those who are found in violation of the new policy will be promptly disciplined. With respect to the allegations in this report, I will direct the Board, through its Finance and Audit Committee, to retain the services of an independent auditor to review and report on the appropriateness of the credit card expenditures cited. The auditor will forward the report to the Governing Board and the Governor by the end of the fiscal year.

In compliance with Recommendation number 6, the SRMC, with the implementation of its revised refund policy, will evaluate credit balances due to both patients and insurance providers and make refunds as appropriate on a timely basis. The SRMC will have the internal auditor review and report on the implementation of the revised policy on a quarterly basis to the Board. An external auditor will review and verify the internal auditor's report. The Board then will submit an annual report to the Governor. With respect to the matter of an apparent pattern of overbilling cited in this report, I have referred this matter to the Attorney General to determine whether there was any collusion or bad faith involved on the part of the SRMC staff and/or management.

A direct response, with supporting documents from SRMC, is enclosed for your review. Although the Board has taken the initiative to seek clarification and possible repayment of possible overpayment to the former CEO, I have referred this matter to the Attorney General to ensure that legal interpretation of various provisions of the Miller contracts is consistent and clear and to determine whether in fact there was any collusion or bad faith involved.

Should you have any further questions, do not hesitate to contact my office.

Sincerely,



John P. de Jongh, Jr.
Governor

pc: Mr. Amos W. Carty, Jr., President and CEO
Ms. June Adams, Chairperson, St. Thomas-St. John District Governing Board
Honorable Vincent F. Frazer, Attorney General

Appendix 3 – Status of Audit Recommendations

Finding/ Recommendation	Status	Action Required
1	Resolved, Not Implemented.	We look forward to receiving written results showing that the actions of the District Board have been reviewed and the results of the corrective actions taken.
2	Resolved, Not Implemented.	We look forward to receiving evidence of the new District Board's review of the actions and performance of senior management and the results of recommendations made by the Board.
3	Resolved, Not Implemented.	We look forward to receiving evidence of the written requirement that instances of fraud must be referred to the appropriated authorities.
4	Resolved, Not Implemented.	We look forward to receiving evidence of revisions made to the Travel and Reimbursement Policy. We also require written evidence showing that controls have been established to ensure that compensation payments are processed in accordance with Generally Accepted Accounting Principles.
5	Resolved, Not Implemented.	We look forward to receiving a copy of the new credit card policy and evidence that inappropriate payments and credit card charges were recovered.
6	Resolved, Not Implemented.	We look forward to receiving a copy of the internal auditor's first quarterly review and report on the implementation of the revised refund policy. Also provide a copy of the results of the review of possible refunds and ambulance service overbillings cited in the report.

Appendix 4 – Monetary Impact

FINDING AREA	WASTED FUNDS	QUESTIONED COSTS	OVERSTATED REVENUES
EXCESSIVE COMPENSATION PACKAGES			
Subtotal	$1,706,500	$3,292,300	
CREDIT CARDS AND REIMBURSEMENTS			
Subtotal		$347,600	
UNPROCESSED REFUNDS AND OVERBILLING			
Subtotal			$9,893,400
Totals	**$1,706,500**	**$3,639,900**	**$9,893,400**

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