VIRGINIA STATE UNIVERSITY

REPORT ON AUDIT

FOR THE YEAR ENDED

JUNE 30, 2020

Auditor of Public Accounts
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AUDIT SUMMARY

We have audited the basic financial statements of Virginia State University (University) as of and for the year ended June 30, 2020, and issued our report thereon, dated January 27, 2022. Our report, included in the University's Annual Report, is available at the Auditor of Public Accounts' website at www.apa.virginia.gov and at Virginia State's website at www.vsu.edu. Our audit found:

- the financial statements are presented fairly, in all material respects;
- internal control findings requiring management's attention; however, we do not consider them to be material weaknesses; and
- instances of noncompliance or other matters required to be reported under Government Auditing Standards.

The University has not taken adequate corrective action with respect to the findings included in the section entitled "Status of Prior Year Findings and Recommendations." The University has taken adequate corrective action with respect to audit findings reported in the prior year that are not repeated in this report.

Our audit also included testing over the major federal program of the Education Stabilization Fund for the Commonwealth's Single Audit as described in the U.S. Office of Management and Budget Compliance Supplement; and found no internal control findings requiring management's attention or instances of noncompliance in relation to this testing.

We did not perform audit work related to the prior audit finding entitled "Improve Reporting to National Student Loan Data System," because the University was in the process of implementing corrective action during our audit period. Despite the timing of the corrective action, we were required to complete certain procedures in this area for fiscal year 2021 to support our opinion on compliance over the Student Financial Assistance Cluster major federal program for the Commonwealth of Virginia's Single Audit. Additional information regarding the Commonwealth of Virginia's Student Financial Assistance Programs Cluster audit is available as part of a standalone Student Financial Assistance Programs Cluster report which was issued in February 2022.

–TABLE OF CONTENTS–

STATUS OF PRIOR YEAR FINDINGS AND RECOMMENDATIONS

Match Federal Grants with Qualifying State Expenses
Type: Internal Control and Compliance
Severity: Significant Deficiency
Repeat: Yes (first issued in fiscal year 2019)

In our 2019 audit, we reported that Virginia State University (University) and its Cooperative Extension and Agricultural Research Services (Cooperative Extension) undermatched two federal awards that support agricultural extension programs and agricultural research. This undermatching was primarily due to the University claiming unallowable expenses related to the Center for Agricultural Research Engagement and Outreach, facility maintenance, information technology (IT) services, utilities, and payroll expenses unrelated to extension or research activity. Although the University began addressing some of these areas in 2019, the University continued to claim unallowable expenses during fiscal year 2020 resulting in additional funds that the University needs to return to the National Institute of Food and Agriculture (NIFA).

Title 2 U.S. Code of Federal Regulations (CFR) § 200.306(b)(1) requires that all matching funds be verifiable from the University's records. The University and Cooperative Extension continued to claim unallowable expenses for matching during fiscal year 2020 because they did not have formal documented policies and procedures over monitoring, review, approval, or reporting of matching expenses. In addition, the expense review and approval process was inconsistent, and there was a lack of communication between the University and Cooperative Extension. By not having detailed policies and procedures, the University cannot ensure that the annual SF-425 financial reports are accurately and consistently prepared each year. In August 2021, the University approved a formalized policy for the review and expenditure of state matching funds.

As of June 30, 2020, the University reported a liability of $4,092,792, which represents the amount due to NIFA. Additionally, for fiscal year 2020, the University recorded an unearned revenue amount of $3,133,293, which represents 2019 and 2020 federal funds spent prior to June 30, 2020, with no matching expenses. Since the 2019 and 2020 federal periods did not close until September 30, 2020, and September 30, 2021, respectively, the University had an opportunity to record matching expenses in fiscal years 2021 and 2022.

Beginning with the 2015 award, Cooperative Extension began extending the range of transactions used to meet the matching requirement, while still staying within the period-of-performance. The University continued this practice through the 2019 award. Beginning with the 2020 award, the University, in collaboration with Cooperative Extension, created a plan to return to the process used prior to 2015. This revised process will result in all state matching expenses occurring within the first 12 months of the federal period of performance for fiscal year 2021 and subsequent fiscal years going forward. In 2021, the University began returning unmatched funds to NIFA. Between April and September 2021, the University returned $5,793,933 for the 2015 to 2019 awards.

The University and Cooperative Extension should continue to monitor matching expenses to ensure only allowable expenses are charged to the two federal land grants. If Cooperative Extension identifies unallowable expenses, it should investigate and correct the expenses prior to year-end reporting. Ongoing communication between the University and Cooperative Extension should facilitate the identification of potentially unallowable expenses and corrective measures. There should be reciprocal access, input and information exchanged between the University and Cooperative Extension to adequately track expenses and prepare accurate and timely reporting. Additionally, the University should continue to work with Cooperative Extension to develop detailed policies and procedures for the preparation, review, and submission of the annual SF-425 financial report, along with other required federal reports.

Improve Documentation of Emergency and Sole Source Procurements
Type: Internal Control
Severity: Significant Deficiency
Repeat: Yes (first issued in fiscal year 2017)
Prior Title: Improve Documentation of Sole Source Procurement

Procurement Services did not provide documentation to verify that emergency and sole source procurements were made in accordance with the Agency Procurement and Surplus Property Manual (Procurement Manual). During fiscal year 2020, Procurement Services procured two emergency contracts and 14 sole source contracts. We reviewed all 16 contracts and identified Procurement Services did not retain the following:

- signed written determination for one of two (50%) emergency procurements;
- documentation justifying vendor selection for one of two (50%) emergency procurements;
- evidence that noncompetitive negotiations occurred for seven of 14 (50%) sole source procurements;
- documentation, or insufficient documentation, of the determination of price reasonableness for two of 14 (14%) sole source contracts;
- documentation, or insufficient documentation, of why the product/service is the only item that meets the needs of the University for seven of 14 (50%) sole source contracts; and
- documentation of why the vendor is the only practicably available source for two of 14 (14%) sole source contracts.

Without retaining documentation, purchasing officers cannot provide evidence that emergency and sole source contracts were properly procured. Chapters 8 and 9 of the Procurement Manual outline all requirements for sole source and emergency procurements. According to Chapter 8, sole source documentation must include written explanations of why a product is the only product that meets a

need, why the vendor is the only practicable source to provide the product, an explanation of price reasonableness (defined in Section 4.10 of the Procurement Manual), and noncompetitive negotiations. While sole source procurements may be warranted, management should ensure that there is adequate research and analysis to ensure that the good or service required is practicably available from only one source. Chapter 9 states emergency procurements should include a written determination indicating the nature of the emergency and the reason for selection of the contractor.

While Procurement Services has implemented the use of checklists and other forms to help document procurement requirements, staff do not consistently utilize the checklist, nor are they including adequate detail and information to justify sole source and emergency procurements. Procurement Services should ensure that all emergency and sole source procurements occur according to Procurement Manual guidelines. Procurement staff should document all requirements of the Procurement Manual to properly support award decisions and retain the documentation in the contract files.

Improve Processes for Employment Eligibility
Type: Internal Control and Compliance
Severity: Significant Deficiency
Repeat: Yes (first issued in fiscal year 2018)

The University's Human Resources Department (Human Resources) has not completed Employment Eligibility Verification (I-9) forms timely, in accordance with guidance issued by the U.S. Citizenship and Immigration Services of the U.S. Department of Homeland Security. In December 2019, Human Resources implemented new policies to ensure staff completed I-9 forms in accordance with the U.S. Department of Homeland Security's guidelines; therefore, we reviewed employees hired on or after January 1, 2020. Our review of employment eligibility verification documentation found that Human Resources staff did not complete Section 2 of the I-9 form, nor did staff create a case in the E-Verify system within 3 days of the first day of employment for two of six employees (33%).

Failure to comply with the federal employment eligibility verification requirements could result in monetary fines. We recommend that Human Resources inform, and adequately train, staff on the U.S. Department of Homeland Security's guidelines. Furthermore, Human Resources should periodically review employment eligibility documentation to ensure that employees and staff complete and properly retain employment eligibility documentation.

Improve Retirement Benefits System Reconciliation Process
Type: Internal Control
Severity: Significant Deficiency
Repeat: Partial (first issued in fiscal year 2018)
Prior Title: Improve Processes over Payroll and Human Resources Reconciliations

Our prior audit included a review of the retirement benefits system reconciliation. As part of the retirement benefits system reconciliation process, Human Resources is not reconciling creditable compensation from the benefits system to the human resource system.

Our prior audit recommended that Human Resources implement policies to ensure compliance with the Commonwealth Accounting Policies and Procedures (CAPP) Manual Topic 50410. Creditable compensation reconciliations should be properly documented, completed, and all exceptions are clearly identified. As of October 2020, Human Resources has developed policies to complete reconciliations and the department has begun completing the required reconciliations. Human Resources should ensure that it documents its reconciliation policies and completes the reconciliations in accordance with those policies. We will review the implementation of management's corrective actions during our next audit.

Establish a Process for Periodically Reviewing Stagnant Grants and Contributions

Type: Internal Control
Severity: Significant Deficiency
Repeat: Yes (first issued in fiscal year 2018)

The University continues to have unused grants and contributions included in the unearned revenue balance in its financial statements. Grants or contributions that have not been used for extended periods of time comprise over $765,125 of the University's unearned revenue balance. We identified approximately 75 grants not used since 2017; however, the exact nature and circumstances for each grant remain unknown. A primary concern is whether the University is effectively deploying its resources. The likelihood of the University forgetting restricted grants and contributions are available for use and, therefore the funds going unused, increases with the passage of time. It is possible that, if made aware that a grant or contribution has not been used, the grantor or contributor of these funds may be willing to ease some or all the restrictions that were initially placed upon the grant or contribution.

The Grants and Contracts Office does not currently have a process in place to periodically review unused grants and contributions. The Grants and Contracts Manager position has experienced significant turnover in the last 3 years and the position is currently vacant. The University hired a consultant in 2021 to aid in clearing some of the stagnant grants and contributions. The University plans to complete the process by April 2022. We will review the implementation of management's corrective actions during our next audit.

INTERNAL CONTROL AND COMPLIANCE FINDINGS AND RECOMMENDATIONS

Improve Infrastructure Device Security
Type: Internal Control and Compliance
Severity: Significant Deficiency
Repeat: No

The University does not manage a critical infrastructure device that safeguards its secure internal network in accordance with University policy or the Commonwealth's Information Security Standard, SEC 501 (Security Standard).

We communicated five control weaknesses to management in a separate document marked Freedom of Information Act (FOIA) Exempt under § 2.2-3705.2 of the Code of Virginia, due to it containing descriptions of security mechanisms. The University's policy and the Security Standard require the documentation and implementation of certain controls that reduce unnecessary risk to the confidentiality, integrity, and availability of the University's information systems and data. A lack of resources, and the prioritization of other information technology (IT) operations, led to the weaknesses.

The University should develop a plan to implement the controls discussed in the communication marked FOIA Exempt in accordance with its policies and the Security Standard in a timely manner. Implementing corrective action will help to ensure the University secures its network to protect its systems and data.

Improve Change Control Management
Type: Internal Control and Compliance
Severity: Significant Deficiency
Repeat: No

The University does not record the required information in its change management system to track changes to devices and systems in its IT environment. All 22 of the change tickets sampled contained omissions or errors that do not comply with the University's IT change control policy. Additionally, the University's IT change control policy does not include any expectations of how the University should manage IT system or device pre-implementation testing.

The IT 6810 Change Control and Configuration Policy (Policy) states that the University needs to record certain information regarding changes to its IT environment in its change management system. This information includes, but is not limited to, implementation plans, approvals and sign offs, rollback plans or criteria, change priorities and schedules, and post-implementation lessons learned. Additionally, the supplemental guidance in the Commonwealth's Information Security Standard, SEC 501 (Security Standard), Section CM-3 (2), states that organizations should ensure that post-implementation testing does not interfere with information system operations.

By not consistently including all elements in its change documentation as required by Policy, the University cannot ensure that changes are performed according to expectations, and it introduces the

risk of the University implementing unapproved changes that may affect business process controls. Also, the omission of a policy that states the University's expectations for post-implementation testing may introduce unknown behavior into its IT environment.

Several factors contributed to the University not following or updating its policy. The rapid need to transition to remote work due to the COVID-19 pandemic impacted the Change Advisory Board's ability to maintain proper change control documentation. Additionally, the University experienced significant turnover in IT management personnel in the spring of 2020. And lastly, the University does not have an established process to perform periodic reviews of its change management documentation to ensure compliance with its Policy.

The University should perform periodic reviews of its change management documentation to ensure that all change requests contain the necessary information as required by its Policy. If the University determines that some changes do not warrant documentation of all attributes, the University should amend its policy to reflect the possibility of these deviations and provide the appropriate guidance to staff on how to determine required information. The University should also update its Policy to include IT system or device pre-implementation testing expectations.

Improve Access and Account Management Controls
Type: Internal Control and Compliance
Severity: Significant Deficiency
Repeat: No

University system owners are not consistently removing terminated employees' access to systems on the last day of work, nor are they removing access when an employee no longer needs the access for their job responsibilities. The IT Department and system owners should improve access and account management controls over all systems utilized by the University. Our audit identified the following:

- The University did not remove access to the Commonwealth's purchasing system on the employee's last day of employment for two employees. The University disabled access between seven and 23 days after the employees' termination dates.

- IT did not remove three employees from the University's active directory on their last day of employment. IT disabled access between two and 382 days after the employees' termination dates.

- The University did not remove access to the University's financial system on the employee's last day of employment for 11 employees. The University disabled access between five days and more than a year after the employees' termination dates.

- The University did not remove access to the University's housing system on the employee's last day of employment or when the employee no longer needed access for 11 employees.

The University disabled access between 231 days and four years after the date the employee no longer needed access.

The University's termination process includes completing a personnel clearance form which initiates access removal. In certain instances, the Technology Services employee signing the clearance form did not have access to disable a user's access and did not inform another responsible party of the need to remove access. In addition, in several instances proper notification to individuals responsible for removing access did not occur timely.

Despite any mitigating controls, such as automatic password expiration and removal of access in the University's active directory, system owners must remove access to all applications used by terminated employees, or employees who no longer need access. Part D of University Policy 6310, Logical Access Control and Account Management Policy, requires applications security administrators to disable user accounts for terminated or separated employees effective on the last day of work. The University developed this policy to be consistent with, and to comply with, the Security Standard, Section PS-4, Personnel Termination, which requires organizations to disable access within 24 hours of employee separation or termination. Untimely removal of user access increases the risk of unauthorized transactions and access that can compromise the integrity of the University's systems.

The University should require system administrators to disable user accounts according to the University's policy. System owners should remove access within 24 hours of when an employee terminates employment, or when the employee no longer needs access to the system. Information should be provided timely to those individuals responsible for making changes to system access.

Improve Internal Controls Surrounding Identification and Capitalization of Capital Assets
Type: Internal Control
Severity: Significant Deficiency
Repeat: No

The Fixed Asset Accountant did not capitalize twelve equipment assets, totaling approximately $896,000, the University acquired in fiscal years 2018 and 2019. Fixed asset staff and central receiving staff identified these assets during fiscal year 2020 and the Financial Reporting Department included these assets as additions to equipment, instead of recognizing a beginning balance adjustment.

The Commonwealth's Accounting Policies and Procedures Manual (CAPP Manual) Topic 30205, Asset Acquisition, requires the University to record all capitalizable assets in the Commonwealth's capital asset system as soon as possible after the University receives the equipment, and within the proper fiscal year. To accomplish this, the University's Fixed Asset Management Policy (Policy 5800) requires the Central Receiving Office to immediately notify the fixed asset staff of all new equipment received or new equipment delivered directly to a department. Upon notification from the Central Receiving Office or notification of direct receipt by a University department, the fixed asset staff then tags all capitalizable equipment purchased and received by the University.

Typically, assets are delivered to the Central Receiving Office. However, the assets in question were delivered to both the Central Receiving Office and to the respective department. Neither Central Receiving nor the responsible persons in the department communicated with the fixed asset staff to ensure that the staff properly tagged the asset and recorded the asset in the Commonwealth's capital asset system during the fiscal year acquired. The departments receiving equipment directly forgot to notify the fixed asset staff following receipt of the assets. The Central Receiving Office did not notify the fixed asset staff that the assets should be tagged and recorded in the Commonwealth's capital asset system due to not uncrating the assets in a timely manner.

The University included assets acquired during fiscal years 2018 and 2019 in fiscal year 2020 equipment additions instead of recognizing a beginning balance adjustment because Financial Reporting staff were unaware that the additions were not related to current year equipment purchases. Failure to capitalize these assets in the Commonwealth's capital asset system, in accordance with CAPP Manual policy, resulted in a $896,000 material overstatement of equipment additions in the capital asset footnote disclosure. Additionally, by failing to properly capitalize and track these assets, the University cannot ensure proper stewardship of these assets.

The University's fixed asset staff should ensure that the Central Receiving Office staff and departmental staff receiving assets understand the protocol for communicating the receipt of capital asset purchases to the fixed asset staff. Additionally, fixed asset staff and financial reporting staff should communicate to ensure the University appropriately discloses fixed asset activity in its financial statements.

Review and Document System and Organization Control Reports of Third-Party Service Providers
Type: Internal Control and Compliance
Severity: Significant Deficiency
Repeat: No

The University outsources certain business tasks and functions to service providers who transmit, process, or store sensitive data and assets. The University does not have a sufficient process or a formal policy for gaining assurance that third-party service providers have adequate controls related to financial processes and data security including, but not limited to, external investment activities. Specifically, the University is not obtaining assurance to confirm that the internal controls at one of its external investment managers are operating effectively, nor are they performing procedures to obtain assurance over financial information the investment manager provides.

The CAPP Manual Topic 10305 requires agencies to have adequate interaction with providers to appropriately understand the providers' internal control environment. Agencies must also maintain oversight over providers to gain assurance over outsourced operations. Additionally, the Commonwealth's Hosted Environment Information Security Standard, SEC 525 (Hosted Environment Security Standard), Section SA-9-COV 3.1, requires agencies to perform an annual audit of the environment or review the annual audit report of the environment conducted by an independent, third-party audit firm on an annual basis.

System and Organization Control Reports (SOC reports) provide an independent description and evaluation of a provider's internal controls. Without a formal process for obtaining, reviewing, and documenting SOC reports, the University cannot ensure that providers' controls are properly designed, implemented, and operating effectively. Although the University maintains a high degree of interaction with most of its providers, insufficient review of SOC reports increases the University's risk that it will not detect a weakness in a provider's environment, which could negatively impact the University. Furthermore, the University's interactions with the external investment manager do not extend to the adequacy or effectiveness of the external investment manager's internal controls, or the information provided for financial reporting.

Based on the testwork we performed, the University received ten separate SOC reports related to its various service providers; however, the University did not maintain documentation, other than e-mails, supporting review of seven of the SOC reports. Additionally, the University did not maintain documentation supporting that it identified and evaluated complimentary user controls detailed in the SOC reports. The University has not allocated proper resources to develop and implement policies and procedures to review, assess, and document the effectiveness of provider controls reported through SOC reports.

The University should develop and implement policies and procedures related to annual SOC report reviews. If the University identifies control deficiency in a SOC report, the University should determine if departments should implement additional controls to mitigate the risk until the provider corrects the deficiency. In addition, the University should ensure that SOC report reviews include the identification and evaluation of complimentary controls on an annual basis. The University should use SOC reports as a component of its oversight activities over its providers to confirm they comply with the requirements outlined in the CAPP Manual and the Hosted Environment Security Standard. Furthermore, the University should determine how to obtain assurance over the external investment manager's operations as well as the information included in the financial reports.

Properly Reconcile Student Account Collections

Type: Internal Control
Severity: Significant Deficiency
Repeat: No

The Bursar's Office and the Student Accounts Department (Student Accounts) are not properly reconciling student account collections. The Bursar's Office did not perform monthly reconciliations of student loan collections during fiscal year 2020. The University's Institutional and Perkins Loan Reconciliation Policy states that the Bursar's Office should reconcile collections from loan servicer reports to the accounting system monthly.

As a result of not performing reconciliations, the University incorrectly reported $271,080 in student loan receipts as a credit to accounts receivable, which also resulted in the University incorrectly presenting these funds in its financial statements. Furthermore, if the Bursar's Office does not perform reconciliations timely, the University cannot ensure that Student Accounts appropriately receives and records the collections of student loan funds appropriately in the accounting system.

Student Accounts could not reconcile $624,878 of tuition and fee revenue reported in the accounting system to supporting charges in the student system or other detailed support. Per University policy, Student Accounts must reconcile student accounts receivable transactions to finance accounts daily. During fiscal year 2020, Student Accounts did not perform daily reconciliations between the accounting system and the student system. As a result, Student Accounts did not identify and address variances between the two systems.

Turnover in the Bursar's Office and Student Accounts resulted in a lack of staff available to perform the reconciliations. The University should allocate additional staff resources to the Bursar's Office and Student Accounts to ensure the departments timely reconcile student collections.

Perform Purchase Card Administrator Responsibilities

Type: Internal Control
Severity: Significant Deficiency
Repeat: No

During fiscal year 2020, the Purchase Card Administrator did not monitor cardholder transactional data monthly to ensure compliance with University procurement policy, nor did they perform and document an annual analysis of cardholders' usage and limits. Additionally, we selected nine cardholders for review and requested the following information:

- supporting documentation for the removal of permanent and temporary industry restrictions;
- evidence that cardholders completed the applicable annual training; and
- evidence that cardholders' supervisors completed the required annual training.

The Purchase Card Administrator did not provide any of the above information for the nine cardholders selected for review. The Purchase Card Administrator was on extended leave for most of fiscal year 2020 and the back-up administrator, the Procurement Director, assumed the administrator's responsibilities during this time. Due to the Procurement Director's competing work priorities, many of the Purchase Card Administrator's responsibilities were not completed during fiscal year 2020.

The CAPP Manual Topic 20355 states the Procurement Director, or a designee, will act as the Purchase Card Administrator for each agency or institution. The CAPP Manual outlines several administrator responsibilities including, but not limited to, monitoring transactional data; performing and documenting an analysis of cardholder usage and limits; and removing industry restrictions as needed. Without proper completion of Program Administrator responsibilities, the University cannot effectively monitor cardholder compliance with purchase card requirements, which increases the risk of inappropriate purchases.

The University should designate a Purchase Card Administrator and backup administrator who can fulfill the Purchase Card Administrator responsibilities as outlined in the CAPP Manual. Management

should consider if the Office of Procurement Services requires additional staffing to monitor the purchase card program and fulfill the CAPP Manual requirements.

Improve Document Retention and Purchase Card Reconciliations
Type: Internal Control
Severity: Significant Deficiency
Repeat: No

Procurement Services did not provide all requested documentation and support for purchase card transactions. During our audit, we requested documentation and support related to purchase card transactions. Procurement Services did not provide supporting documentation for two of the 17 (13%) purchases selected for review; therefore, we were unable to determine whether these purchases were reasonable.

In addition, we selected nine cardholders to review the required monthly reconciliations, and we identified the following:

- Procurement Services did not provide the purchase card reconciliations for two of nine (22%) cardholders selected for review.

- For three of seven (43%) reconciliations tested, the cardholder did not date the reconciliation, and thus, we were unable to determine if the cardholder completed the reconciliation timely.

- For five of seven (71%) reconciliations tested, the cardholder's supervisor did not approve the reconciliation timely. The supervisor did not date two of the reconciliations, and the supervisor did not approve the other three until between one month and over a year after the due date.

- For one of seven (14%) reconciliations tested, the cardholder did not provide any receipts to support the purchases.

- Procurement Services revised the University's charge card policy in December 2019. The revised policy requires the cardholder to utilize the purchase card online platform. For all four of the reconciliations completed after the policy revision, Procurement Services did not provide evidence that the cardholder completed the reconciliation in the online platform.

CAPP Manual Topic 20355 requires cardholders to retain all documentation pertaining to charge card purchases including receipts and packing slips and reconcile the card statements to the purchasing log and supporting documentation to verify that the statements are accurate prior to receipt of the next monthly statement. Additionally, Procurement Services' purchase card policy requires the cardholder to complete the reconciliations utilizing the online platform.

By not maintaining proper documentation and support, Procurement Services is unable to ensure the effectiveness of internal controls, and the risk of unauthorized transactions increases. Additionally,

without proper supporting documentation, supervisors cannot verify charges to ensure proper usage and recording in the University's financial system. Untimely reconciliations and lack of supporting documentation are due to the lack of communication and enforcement of required processes. Procurement Services was unable to provide the documentation because the documentation did not exist, or the cardholder/supervisor did not properly maintain the documentation.

Procurement Services should ensure that all cardholders maintain adequate documentation for all transactions. The cardholders should complete monthly reconciliations and supervisors should review and approve reconciliations by the established deadlines. Cardholders should complete reconciliations utilizing the online platform as required by University policy.

Improve Internal Controls over Unauthorized Purchases and Adhere to Procurement Policy
Type: Internal Control
Severity: Significant Deficiency
Repeat: No

The University is not adequately preventing or resolving unauthorized purchases. The Office of Procurement Services identifies and tracks unauthorized purchases. During fiscal year 2020, the Procurement Services identified 23 unauthorized purchases totaling over $145,000. Our review of the unauthorized purchases and 34 additional vouchers processed during fiscal year 2020 identified the following:

- Procurement Services did not receive a written response for nine of 23 (39%) of unauthorized purchase letters.

- Procurement Services did not clearly document the recommended action to approve or not approve the unauthorized purchase on two of 23 (9%) unauthorized purchase letters.

- Procurement Services did not document the rationale for the recommended action to approve or not approve the unauthorized purchase on six of 23 (26%) unauthorized purchase letters.

- Procurement Services did not timely resolve 15 of 23 (65%) unauthorized purchases resulting in payments between four and 14 months after the date of the invoices.

- In addition to the 23 unauthorized purchases identified by Procurement Services, our random sample of 34 vouchers (24 of which required purchase orders) identified one (4.2%) purchase made without an approved purchase order.

- Our sample of 34 vouchers identified two (5.9%) purchases paid more than 100 days after the receipt of the invoice. The delay in payment for one of these vouchers was due to the purchase being made without a valid purchase order.

University Policy 5508, Procurement of Goods and Services, states that employees may not order goods or services without the appropriate authority, or without the issuance and approval of the proper documents or purchase order by Procurement Services. Additionally, the policy states that an employee who makes an unauthorized purchase may have their purchasing responsibilities suspended or revoked, may face additional administrative disciplinary action including termination of employment, and may be held personally liable for any charges incurred.

When purchases are made without the required authority or approval, it increases the risk that the purchase does not comply with the Virginia Public Procurement Act. Additionally, unauthorized purchases can lead to the University paying for goods or services that are not in the best interest of the University. Ultimately, for the 23 unauthorized purchases identified by Procurement Services in fiscal year 2020, the Vice President of Finance approved all for payment. The inconsistent enforcement of the University's procurement policy has led to the continued existence of unauthorized purchases. Additionally, the lack of enforcement has led to repeat occurrences of unauthorized purchases. For example, three employees were responsible for more than one unauthorized purchase each during fiscal year 2020.

The University should review the current procurement policy and determine if it adequately addresses unauthorized purchases. Additionally, the University should determine if the current internal controls are adequately designed to prevent and/or detect unauthorized purchases. Finally, the University should consistently enforce the procurement policy including appropriate disciplinary action for repeat offenders.

Improve Processes and Controls for Leave Activity
Type: Internal Control
Severity: Significant Deficiency
Repeat: No

Between October 2019 and December 2019, the University overpaid an employee more than $12,300 of wages and benefits because the Payroll Department was unaware that the employee had exhausted their leave balance and was on leave without pay. The Department of Accounts was able to void three pay checks for approximately $5,000. The amount the employee should repay to the University is unclear due to uncertainty of when the employee's leave without pay status began.

University policy requires employees to complete and submit a leave activity form to their supervisor for approval. Upon approval, the supervisor submits the leave form to the Human Resources Leave Coordinator for processing in the Commonwealth's payroll system. The employee was out of work on extended leave for approximately four months and had a pending disability claim. During this time, the employee did not submit leave activity forms and the employee's supervisor submitted forms to the Leave Coordinator late. Once the supervisor submitted the leave forms to the Leave Coordinator, the Leave Coordinator did not process the forms timely. In some cases, the supervisor did not approve leave forms until nearly two months after leave was taken and the Leave Coordinator processed leave over three months after leave was taken. These delays resulted in the lack of awareness regarding the employee's leave without pay status.

Human Resources indicated that leave may have been processed untimely because of the vacant Leave Coordinator position. The Leave Coordinator moved to another role in late 2018 and there was no designated Leave Coordinator until the University hired a new coordinator in September 2019. Additionally, Human Resources did not notify the Payroll Department that the employee was in leave without pay status until December 16, 2019, one month after the Leave Coordinator processed leave and identified that the employee was on leave without pay status. Human Resources did not notify the Payroll Department of the issue until after they had performed additional research to verify the employee's status. As a result, the Payroll Department continued to process the employee's payroll because it was unaware that the employee was in leave without pay status.

According to the employee handbook and the University's leave administration procedures, employees are responsible for managing their leave balances and submitting time off requests in a reasonable time frame, while managers are responsible and should be held accountable for ensuring that their employees' leave balances are monitored appropriately. In addition, per the procedures, leave should be processed in the Commonwealth's payroll system within the pay period leave has been taken. The employee handbook and leave administration procedures do not explicitly address the process for submitting leave forms if an employee is out on extended leave. If leave requests are not processed timely, and leave balances are not properly monitored, the risk that payroll may pay employees for time when they do not have sufficient leave balances increases.

The University should update procedures to address the process for submitting leave activity forms if an employee is on extended leave and is unable to submit leave activity forms. The University should require employees to submit leave activity forms timely. Finally, the University should ensure that supervisors approve leave activity forms timely, and the Leave Coordinator processes leave in the Commonwealth's payroll system timely.

Commonwealth of Virginia

Auditor of Public Accounts

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January 27, 2022

The Honorable Glenn Youngkin
Governor of Virginia

Joint Legislative Audit
and Review Commission

Board of Visitors
Virginia State University

INDEPENDENT AUDITOR'S REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in Government Auditing Standards, issued by the Comptroller General of the United States, the financial statements of the business-type activities and aggregate discretely presented component units of **Virginia State University** (University) as of and for the year ended June 30, 2020, and the related notes to the financial statements, which collectively comprise the University's basic financial statements and have issued our report thereon dated January 27, 2022. Our report includes a reference to other auditors. We did not consider internal controls over financial reporting or test compliance with certain provisions of laws, regulations, contracts, and grant agreements for the financial statements of the component units of the University, which were audited by other auditors in accordance with auditing standards generally accepted in the United States of America, but not in accordance with Government Auditing Standards.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered the University's internal control over financial reporting (internal control) as a basis for designing audit procedures that are 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 University's internal control. Accordingly, we do not express an opinion on the effectiveness of the University'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 a 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. A significant deficiency is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist that were not identified. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. We did identify certain deficiencies in internal control titled "Match Federal Grants with Qualifying State Expenses," "Improve Documentation of Emergency and Sole Source Procurements," "Improve Processes for Employment Eligibility," "Improve Retirement Benefits System Reconciliation Process," "Establish a Process for Periodically Reviewing Stagnant Grants and Contributions," "Improve Infrastructure Device Security," "Improve Change Control Management," "Improve Access and Account Management Controls," "Improve Internal Controls Surrounding Identification and Capitalization of Capital Assets," "Review and Document System and Organization Control Reports of Third-Party Service Providers," "Properly Reconcile Student Account Collections," "Perform Purchase Card Administrator Responsibilities," "Improve Document Retention and Purchase Card Reconciliations," "Improve Internal Controls over Unauthorized Purchases and Adhere to Procurement Policy," and "Improve Processes and Controls for Leave Activity," which are described in the sections titled "Status of Prior Year Findings and Recommendations" and "Internal Control and Compliance Findings and Recommendations," that we consider to be significant deficiencies.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the University's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the financial statements. However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion. The results of our tests disclosed instances of noncompliance or other matters that are required to be reported under Government Auditing Standards and which are described in the sections titled "Status of Prior Year Findings and Recommendations" and "Internal Control and Compliance Findings and Recommendations" in the findings and recommendations titled "Match Federal Grants with Qualifying State Expenses," "Improve Processes for Employment Eligibility," "Improve Infrastructure Device Security," "Improve Change Control Management," "Improve Access and Account Management Controls," and "Review and Document System and Organization Control Reports of Third-Party Service Providers."

The University's Response to Findings and Recommendations

We discussed this report with management at an exit conference held on January 28, 2022. The University's response to the findings identified in our audit is described in the accompanying section titled "University Response." The University's response was not subjected to the auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on it.

Status of Prior Findings and Recommendations

The University has not taken adequate corrective action with respect to the previously reported findings "Match Federal Grants with Qualifying State Expenses," "Improve Documentation of Emergency and Sole Source Procurements," "Improve Processes for Employment Eligibility," "Improve Retirement Benefits System Reconciliation Process," and "Establish a Process for Periodically Reviewing Stagnant Grants and Contributions." Accordingly, we included these findings in the section titled "Status of Prior Year Findings and Recommendations." The University has taken adequate corrective action with respect to audit findings reported in the prior year that are not repeated in this report.

We did not perform audit work related to the finding included in our report dated June 20, 2019, entitled "Improve Reporting to National Student Loan Data System" because the University did not implement corrective action during our audit period. We will follow up on this finding during the fiscal year 2021 audit. The University has taken adequate corrective action for the finding titled "Improve Reporting to the Common Origination and Disbursement System" from our report dated June 20, 2019.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with Government Auditing Standards in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Staci A. Henshaw
AUDITOR OF PUBLIC ACCOUNTS

JMR/vks

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Vice President for Administration
and Finance and CFO

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January 31, 2022

Staci Henshaw
The Auditor of Public Accounts
P.O. Box 1295
Richmond, VA 23218

Dear Ms. Henshaw:

Virginia State University has reviewed the Financial Internal Control and Compliance Findings and Recommendations provided by the Auditor of Public Accounts for the year ended June 30, 2020. The University acknowledges and is in agreement with the significant deficiencies noted in the report. Please be advised that the University has already initiated a corrective action plan and intends to address each of the findings and recommendations.

Sincerely,

Kevin Davenport
Senior Vice President for Finance and Administration

VIRGINIA STATE UNIVERSITY

As of June 30, 2020

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