

**Audit Committee Report
June 7, 2017**

*presented by
Richard Givens, Vice President*

SIGNIFICANT PROVISIONS OF COMPLIANCE CHARTER

Purpose and Mission

- Provides oversight and guidance to university-wide ethics and compliance activities;
- Promotes greater coordination of and consistency among individual University compliance programs;
- Support the University's mission and strategic plan by proactively partnering with faculty, staff and management to:
 - Ensure compliance risks are identified, prioritized and managed appropriately;
 - Establish a control environment, level of accountability, and ethical framework that promotes commitment;
 - Provide general compliance training;
 - Provide an avenue for anonymous reporting of potential non-compliance or unethical behavior;
 - Develop effective policies and procedures to promote compliance and ethical behavior.

SIGNIFICANT PROVISIONS OF COMPLIANCE CHARTER

Reporting Structure and Independence

The Chief Compliance & Ethics Officer reports administratively and functionally to the Vice President of Audit and Compliance.

Authority

- The Compliance & Ethics Office has the authority to review or investigate all areas of the university;
- Reviews and investigations shall not be restricted or limited by management, the president, or the Board of Trustees.

SIGNIFICANT PROVISIONS OF COMPLIANCE CHARTER

Organizational Oversight

The Board of Trustees will:

- Approve the charter of the Compliance & Ethics Office;
- Approve the annual Program Plan;
- Receive communications from the Chief Compliance and Ethics Officer on the compliance activity's performance;
- Make appropriate inquiries of management and the Chief Compliance and Ethics Officer to determine whether there is inappropriate scope or resource limitations; and
- Ensure the Compliance & Ethics Office has appropriate staff and resources in which to fulfill its duties and responsibilities.

SIGNIFICANT PROVISIONS OF COMPLIANCE CHARTER

Duties and Responsibilities

Projects and activities that fulfill the requirements for an effective compliance and ethics program as required by Chapter 8 of the Federal Sentencing Guidelines and Board of Governors Regulation 4.003. The specific duties and responsibilities of the office are defined.

Professional Standards

- The *Florida Code of Ethics*; the *Code of Professional Ethics for Compliance and Ethics Professionals*; and the *U.S. Federal Sentencing Guidelines'* criteria for an effective compliance program;
- Investigation activities will be governed by adherence to professional standards issued for the State University System.

DIRECT SUPPORT ORGANIZATION REPORTS

University Regulation Requirements for Certification, Budget and Audit Review, Section 11.001(5) provides that Direct-support organizations shall provide for an annual audit and management letter, as prescribed by applicable laws and rules, which shall be submitted to the President and to the Audit Committee of the Board for Board review and approval.

The audit reports and management letters for the year ended June 30, 2016 for the Foundation and Alumni Association were received. A summary of the audit reports are presented below:

Organization	Type of Opinion on financial Statements	Were deficiencies noted in internal control over financial reporting?	Were issues reported for compliance or other matters?	Were management letter comments reported?
Foundation	Unmodified	No	No	Yes (1)
Alumni Association	Unmodified	No	No	No
Rattler Boosters	Unmodified	No	No	Requested, but not provided (2)

(1) There were no management letter comments for the year ended June 30, 2016. Two management letter comments noted in the prior year had been corrected.

(2) A management letter was issued dated August 16, 2016 per audit report.

BACKGROUND

Quality Assurance Review for 2015-16

- Required by auditing standards for internal audit function;
- External review required every 3 years, with internal assessment every year;
- Performed by Kaye L. Kendrick, CIA, CPA, CGMA, CPM.

OBJECTIVES

The principal objectives of the quality assessment were:

- To assess the internal audit activity's conformance to The Institute of Internal Auditors' (IIA's) International Standards for the Professional Practice of Internal Auditing (Standards);
- To evaluate the internal audit activity's effectiveness in carrying out its mission (as set forth in its charter and expressed in the expectations of FAMU's management), and
- To identify opportunities to enhance management and work processes.

OPINION AS TO CONFORMANCE WITH THE STANDARDS

The internal audit activity generally conforms with the Standards and Code of Ethics. The IIA's Quality Assessment Manual suggests a scale of three (3) ratings,

- Generally Conforms means that an internal audit activity has a charter, policies, and processes that are judged to be in conformance with the Standards;
- Partially Conforms means deficiencies in practice are noted that are judged to deviate from the Standards, but these deficiencies did not preclude the internal audit activity from performing its responsibilities in an acceptable manner;
- Does Not Conform means deficiencies in practice are judged to be so significant as to seriously impair or preclude the internal audit activity from performing adequately in all or in significant areas of its responsibilities.

SCOPE AND METHODOLOGY

- Methodology included reviewing and gathering background information, conducting interviews during the onsite fieldwork, and reviewing policies and procedures, as well as other administrative and monitoring documents.
- The document review included the internal audit activity's risk assessment and audit planning processes, audit tools and methodologies, engagement and staff management processes. A representative sample of the internal audit activity's work papers and reports were also reviewed.

RECOMMENDATIONS AND OBSERVATIONS

The quality assessment team identified opportunities for further enhancement

PART I—RECOMMENDATION FOR CONSIDERATION BY FAMU MANAGEMENT

ENTERPRISE RISK MANAGEMENT

Many organizations have found value in implementing an enterprise-wide risk management (ERM) function to help them anticipate and mitigate obstacles to accomplishing their mission and goals.

Recommendation

Since the University is currently in the process of implementing a more robust compliance function, it may also be an opportune time to consider the compliance function needs within the context of an enterprise-wide risk management system.

CORRECTIVE ACTION PLAN

- The Board of Trustees (BOT) Audit Committee will continue consideration of establishing an ERM function to address how the University manages its risks.
- Until an ERM function is established by the University, the University's audit function will continue to perform an annual university-wide risk assessment that considers strategic, operational, compliance, and financial risks from a high-level overview. The results of the annual risk assessment is reported to the Audit Committee.
- The compliance function is being expanded to allow the University to have a more in-depth view of the compliance risks at the University;
- The Division of Audit and Compliance (DAC) will also consider developing departmental trainings on how management and staff can effectively identify and manage risks relevant to their department.

Implementation Date: December 2017

VALUE ADDED SERVICES

To continue to add value to the University, the following strategies should be considered:

- Keep the internal audit activity as the “second line of defense” in risk management and control in ensuring that University controls are in place achieve its goals and mission and ensuring compliance with policies and procedures;
- Ensure the prompt and effective resolution of findings by the DAC.

RECOMMENDATION

To better realize these goals, a strategic planning workshop should be considered, to include the University President and a Board Audit Committee Chair.

CORRECTIVE ACTION PLAN

- ▶ DAC will continue to function as a “second line of defense” by reviewing established internal controls and compliance activities at the University during audit, consulting, and investigative engagements and make recommendations on how the controls can be improved to more effectively and efficiently meet the intended purpose. The Division will collaborate with the newly established Strategic Planning Division regarding internal control monitoring activities. Additionally, the University’s compliance function, upon full implementation, will perform regular monitoring and reviews for adherence to compliance policies and procedures;
- ▶ Updates of the status of implementation of corrective actions will be provided to the Senior Leadership Team monthly. Additionally, we will develop a dashboard, in consultation for reporting to the audit committee. Periodic reports will be provided to the BOT Audit Committee, with an emphasis where corrective actions have not been effectively or timely implemented.

Implementation Date: September 2017 and ongoing

STAFF RECOGNITION AND SUPPORT

Additional recognition and staff support could help enhance the audit function.

Recommendation

Strategies such as a position specification career ladder and a recognition program for accomplishments of DAC staff should be explored.

Corrective Action Plan

We will consult with Human Resources (HR) to explore reclassification and establishment of positions to provide opportunities for advancement and recognition. Additionally, we will explore other options available for recognition of staff accomplishments with HR and senior management.

Implementations Date: December 2017

PART II—RECOMMENDATIONS FOR THE INTERNAL AUDIT ACTIVITY

USE OF TECHNOLOGY

The DAC has made efforts toward *use of more technology* and can now begin to pilot and implement them (e.g., data analytics, electronic work papers, shared files and storage).

Recommendation

Goals should be established for the pilot and implementation of more technology use.

Corrective Action Plan

- ▶ We have acquired software and received training for use in data analytics
- ▶ We are in the process of acquiring an automated work paper system.

Implementation Date: Ongoing

PART III - OBSERVATIONS OF BEST PRACTICES

PERFORMANCE REPORTING

A consistent performance reporting format should be developed that demonstrate value and resource needs, with key performance measures.

Corrective Action Plan

- ▶ We have identified our “key” performance measures as # hours/percent investigations, audits, advisory services, special projects, administrative time, training, and survey results;
- ▶ We will develop a consistent performance reporting format for communicating the results of these efficiency and effectiveness measurements;
- ▶ Our goal for the 2017-18 year is to increase direct time by 5% through reduced administrative time.

Implementation Date: September 2017

LINKING OF RISK ASSESSMENT WITH STRATEGIC PLAN

The risk assessment framework used by the DAC is a “best practice” model for a University, and the results it has yielded in project prioritization have been effective.

Recommendation

It may be possible to enhance this model even further by ensuring outcome clarity for each attribute and “*cross-walking*” to the *University strategic plan* to ensure clear understanding of the “bridging” between the documents and possibly identifying more desired risk categories that may be unique to FAMU.

Corrective Action Plan

We will formalize our process of linking risks identified during the risk assessment with the University’s strategic plan in order to cross-walk the audit topics in the work plan to the strategic plan of the University.

Implementation Date: June 2017

PART IV - OBSERVATIONS OF PROCESS IMPROVEMENT OPPORTUNITIES

PROJECT TIME MANAGEMENT SYSTEM

There are a variety of methods by which audit functions demonstrate their ability to effectively and efficiently manage their resources.

Recommendation

DAC should consider setting goals for implementing a project *time management system* and formal process for *documenting and maintaining its necessary work plan revisions*.

Corrective Action Plan

- *Resources have been provided to acquire an automated work paper system, to enable better tracking of hours expended on the various projects. We expect to acquire the system by June 30, 2017.*
 - *We will use this system to more closely monitor time charged to projects and correlate with the time budget for the project;*
 - *We will emphasize that the time budgets established for projects should be adhered to and any excess of more than 10% be justified;*
 - *Performing projects within budgeted times will also be an attribute in staff performance evaluations.*

Implementation Date: September 2017

STAFF DEVELOPMENT AND MANAGEMENT

The DAC has established a goal and strategy to *ensure efficiency* in its audit work, which will be monitored for desired audit duration times, and to overcome any risks and obstacles which may affect efficiency goals.

Recommendation

It is recommended the DAC consider additional strategies, if target goals are not being met.

Corrective Action Plan

In addition to monitoring of project time mentioned above, bi-weekly meetings will be held with project managers to more closely monitor project progress to ensure the project does not get delayed.

Implementation Date: March 2017

ONGOING RISK ASSESSMENT

The nature of the work in DAC results in the *risk assessment and work plan being a dynamic process.*

Recommendation

It could help the DAC better attain and communicate its value, to view these processes as “on-going”, incorporating risk and plan changes throughout the year.

Corrective Action Plan

We will evaluate the potential impact of new conditions that arise during the year, such as legislative changes and other factors that could change the University’s risks, and consider the impact on the work plan projects. Periodic discussions with the President, senior leadership team, and staff will assist in identifying and evaluating the impact of new conditions. The considerations will be documented in a risk assessment file. In addition, data mining will be explored as a means of identifying areas in which risks may be changing.

Implementation Date: March 2017

OPERATING MANUAL

The internal audit function is supported with an operational policy and procedure manual and Quality Assurance Improvement Program that helps ensure compliance with IIA Standards.

Recommendation

It is recommended the DAC establish a time certain goal to make its desired enhancements to its operational policy and procedure manual.

Corrective Action Plan

We will review the operational policy and procedures manual to update for procedural changes that have been implemented. Training on purpose, use, and documentation requirements of various tools incorporated in the policies and procedures manual will be provided to staff through periodic staff meetings and to project managers in meetings monitoring progress of projects.

Implementation Date: October 2017

RATTLER BOOSTERS AUDIT STATUS

- ▶ Ernst & Young was engaged in January 2017 to perform the audit;
- ▶ Status as of May 31;
 - A records request was made January 9, 2017 ;
 - To date, we have received bank statements for all accounts;
 - Current Booster management has promised cooperation to provide records;
 - At this point we do not know if records needed to perform the audit as originally defined can be provided;
- ▶ The Rattler Boosters did not have staff from November 2016 until May 2017;
- ▶ If records cannot be provided, Chair Reed will be notified.

Findings Follow-up - as of May 31, 2017

Finding Rating	Late	Revised	Open	Closed	Total
Red			7	2	9
Yellow	6		19	1	31
Green		5	9	1	10
Totals	6	5	35	4	50
Percentages	12%	10%	70%	8%	100%

Summary of Late Findings (continuation)

Finding Rating	Finding Description	Reason
1	The Booster organization was not in compliance with BOT Policy 2005.18	There has been almost no financial activity since October, 2016. The organization is in the process of re-organizing under new management.
2	Access to PeopleSoft AP & Purchasing roles were not timely removed or locked.	Staffing change at CIO & CISO level. A new target date for implementation has been established.
3	The University had not established security policies and procedures related to parts of the security program.	Staffing change at CIO & CISO level. A new target date for implementation has been established.
4	The University lacked a security awareness policy to ensure that all faculty, staff, students, and contractors were appropriately trained on pertinent security policies and their roles and responsibilities for ensuring data security.	Staffing change at CIO & CISO level. A new target date for implementation has been established.
5	Recreation center revenues are not reconciled with collections.	The procedures implemented did not correct the issue. Additional procedures to be implemented.
6	Transportation Services revenues are not reconciled with collections.	The procedures implemented did not correct the issue. Additional procedures to be implemented.

Risk Rating Definitions

The following risk rating definitions are used in assessing the relative risk of internal audit observations and do not represent an opinion on the adequacy or effectiveness of internal controls. Responsible management is responsible for assessing whether the controls the University has implemented are adequate to meet its operational, compliance and financial reporting objectives.

- **High:** Immediate management attention is required. This is a serious internal control or risk management issue that if not mitigated, may, with a high degree of certainty, lead to: 1) Substantial losses, possibly in conjunction with other weaknesses in the control framework or the organizational entity or process being audited; 2) Serious violation of university strategies, policies, or values; 3) Serious reputation damage, such as negative publicity in national or international media; and/or 4) Significant adverse regulatory impact, such as loss of accreditation or material fines.
- **Medium:** Timely management attention is warranted. This is an internal control or risk management issue that could lead to: 1) Financial losses (stipulate levels); 2) Loss of controls within the organizational entity or process being audited; 3) Reputation damage, such as negative publicity in local or regional media; and/or 4) Adverse regulatory impact, such as public sanctions or immaterial fines.
- **Low:** Routine management attention is warranted. This is an internal control or risk management issue, the solution to which may lead to improvement in the quality and/or efficiency of the organizational entity or process being audited. Risks are limited.



“At FAMU, Great Things Are Happening Every Day.”

established 1887