Office of Inspector General Services

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Pictured Left to Right: Madison Meehan, Nathalie Pierre, Heather Harrell, Jeffrey Caines, Sam McCall, Natalia Salnova, Pam Damitz, Janice Foley, Kitty Aggelis, Candace Tibbetts and Leah Gigi.
Message from the Chief Audit Officer (CAO)

This Annual Report of the Office of Inspector General Services (OIGS) summarizes audit and investigative efforts for fiscal year 2017-18. During the year, staff worked very diligently to issue audit, control and compliance, and investigation reports important to University operations.

We issued seventeen reports to include ten audit reports, six control and compliance reports, and one investigation report. Two of the ten audit reports were follow-up reports issued to show management’s level of implementation of recommendations made in previously issued audit reports. For 2017-18, 27 percent of previously identified issues had been fully implemented, corrective actions had been started for 59 percent of the issues, and action was pending for 14 percent of the issues. We also processed 39 investigative inquiries during the year of which 37 were closed and two were carried over to fiscal year 2018-19. By issuing reports that are fair and objective, by management taking ownership and responsibility for addressing areas for improvement, and by our Office following up to validate management actions taken, every effort is being made to demonstrate accountability.

Of significance, during the year we issued our fourth Performance Based Funding (PBF) Audit as required by the State University System Board of Governors (BOG). In doing so, President Thrasher, Board of Trustees (BOT) Chairman Burr, the BOT, and the BOG have independent assurance that data submitted to the BOG by Florida State University is valid and reliable.

Two significant events occurred this year that directly relate to the OIGS. First, in June 2018, the BOT approved a Charter for the Audit and Compliance Committee. The Charter was jointly drafted by the Chief Audit Officer (CAO) and the Chief Compliance and Ethics Officer (CCEO) for Committee review, changes as needed, and recommended BOT approval. Both the OIGS and the Office of Compliance and Ethics (OCE) report to this Committee. Second, the BOT, supported by an Audit and Compliance Committee recommendation, approved an updated Charter for the OIGS. That Charter was updated to recognize responsibilities previously assigned to the OIGS and now by BOG regulation assigned to the OCE. Standards for the Professional Practice of Internal Auditing recommend periodic review and updating of the internal audit charter and this latest review accomplishes that requirement. We are very pleased with the leadership and accountability efforts provided by Trustees Gonzalez, Alvarez, Henderson, Sembler, and Pierre. We look forward to continuing to work with them, seeking their guidance, and assisting in the accomplishment of Audit and Compliance Committee responsibilities.

In addition, in January 2018, we submitted our annual investigative report to the Commission on Florida Law Enforcement Accreditation (CFA) for continued accreditation. In June 2017, the Commission for Florida Law Enforcement Accreditation recognized the OIGS as an accredited investigative organization. Accreditation is received only after a rigorous review of investigative policies and procedures, investigative files, and investigation reports. As a result, the FSU OIGS is the first and so far the only state university to receive CFA recognition.

During the 2017-2018 year, we welcomed four new employees, Pam Damitz, Leah Gigi, Nathalie Pierre, and Candace Tibbetts. In
October of 2018, Sudeshna Aich will join the Office. With the addition of these employees, I believe the OIGS has the most talented and experienced staff that we have had since I have been CAO. We welcome these members to the Office and look forward to working with them as they grow, develop, and contribute to the University.

The goal of the OIGS is to be seen as essential to the successful operation of University programs, activities, and functions, and to provide a comprehensive program of internal auditing and investigations that add value and assist management in the accomplishment of organizational goals and objectives. We are mindful of the need to conduct independent, objective, and unbiased audits and investigations.

It is an honor to serve President Thrasher and the Board of Trustees and to work with faculty, and staff. I view the action of the BOT to establish a separate Audit and Compliance Committee in June 2017 as a significant step toward greater transparency and accountability of University operations. The Audit and Compliance Committee has addressed several important topics and has demonstrated their desire for the University to be seen as transparent and accountable.

The Office of Inspector General Services values the trust placed in us by the President and Board of Trustees and we will work toward meeting expectations in the 2018-19 fiscal year. The 2018-19 Annual Work Plan recommended by the President and formally approved by the Board of Trustees is shown at the end of this Annual Report.

Sam M. McCall, PhD, CPA, CGMA, CGFM, CIA, CGAP, CIG

Authority for the Office

The Florida State University President and Board of Trustees (BOT) initially approved a charter for the Office of Audit Services (OAS) in September 2003. Subsequently, in November 2012, the President approved changing the name of the OAS to the Office of Inspector General Services (OIGS).

Purpose, Mission, and Vision

Purpose

Internal auditing at Florida State University is an independent, objective assurance and consulting activity designed to add value and improve University operations. It helps the University accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes.

The Office also performs investigations of alleged fraud, waste, abuse or other allegations of wrongdoing, which could result in the loss or misuse of University resources. Such allegations may come to the attention of the Office during the audit process or through reporting by University faculty, staff, students, or the general public.
Mission

The OIGS’ mission is to provide an independent, objective, and comprehensive program of auditing and investigating University operations; to advance accountability through the provision of assurance and consulting services and investigations; and to actively work with University Boards and Committees, management, faculty, and staff in identifying risks, evaluating controls, and making recommendations that promote economical, efficient, effective, equitable, and ethical delivery of services.

The OIGS, headed by the Chief Audit Officer (CAO), provides a central point for coordinating and carrying out activities that promote accountability, integrity, and objectivity.

Vision

The Office of Inspector General Service’s vision is to be an exemplary professional audit and investigative organization that adds value, promotes accountability, fosters transparency and understanding, and is viewed by the University as essential to the proper functioning of University controls and operations.

Audits

Internal audits are conducted in conformance with The International Standards for the Professional Practice of Internal Auditing. The audits are carried out in accordance with an Annual Work Plan approved by the President and the Board of Trustees. The OIGS takes a facilitative approach to our audits by actively engaging with our University colleagues in developing action plans in response to audit observations.

The following audits on our Annual Work Plan were completed during 2017-18. Many of the resulting planned actions have either been implemented or significant progress on them has been made.

For a more thorough understanding of each audit, please contact the OIGS and request the full report.

The Legacy Fountain
The purpose of our audit was to determine whether the University has a comprehensive and cohesive administrative strategy to coordinate multiple departmental incident-related services to achieve an efficient and effective response to international incidents impacting its students, faculty, and/or staff.

Our primary five-audit objective were to determine whether University Management has:

- Established effective oversight structures, reporting lines, and appropriate authorities and responsibilities;
- Systematically identified the University-wide risks related to health, safety, and security of international travelers representing the University;
- Implemented controls to effectively manage identified risks (e.g., a University-wide written plan for health, safety, and security);
- Adequately communicated its expectations to all persons and entities involved in international activities; and
- Periodically re-evaluated and updated its approach for handling international incidents, as necessary.
The scope of our audit:

- Encompassed international activities for outbound students participating in University-approved programs abroad and employees (faculty and staff) traveling abroad on behalf of the University; and

- Consisted of examining records and processes related to FSU international activities abroad including, but not limited to, a review of all University planning documents and internal written policies and procedures for responding to international incidents concerning students and employees.

Overall, our audit determined the University has not established a comprehensive and cohesive administrative strategy to coordinate multiple departmental incident-related services to achieve an efficient and effective response to international incidents affecting its students, faculty, and/or staff. Our conclusions for each audit objective were as follows:

**University-Wide Organizational Structure and Oversight**

We determined that the administration of education abroad programs and activities at FSU does not have a single, functioning, overarching entity that is clearly responsible for international incident management University-wide. Management has not designed lines of reporting to enable effective and efficient execution of authorities and responsibilities, and flow of information through the University, to manage and respond to international incidents.

**University-Wide Risk Assessments for International Travel**

We determined that University management has not systematically identified University-wide risks related to the health, safety, and security of international travelers representing the University. The University has not performed, at the institutional level, formal risk assessments for its international activities abroad, as well as international travel of students, faculty, and/or staff.

**Control Activities for International Travel**

- **Written Policies and Procedures:**

  We determined that three of the six FSU written policies at the University level that are specifically tailored to international activities (those that are not University policies under the Vice President for Finance and Administration), are not official policies, in accordance with Florida State University Policy 2-1 Development and Approval of University Policies. Nevertheless, these unofficial policies are active and have been the primary University-level sources for guidance for international activities. Additionally, the six University policies, together with the one set of written procedures among them, do not achieve:

  - Referencing or showing broad application of the national standards (the Forum on Education Abroad and IES Abroad);

  - Offering a one-stop website where users can go to view all University policies and procedures, forms, and other related guidance (specific or general) that have implications for international activities across the University, including for international incidents; or
Articulating clear, sufficiently detailed, comprehensive, and cohesive expectations of programs and students to provide reasonable assurance of the safety and security of students participating in international experiences (and faculty and staff).

- **Training for Students, Faculty, and Staff Traveling Abroad:**

  We concluded that FSU’s written policies and procedures make minimal mention of required training for University units and education abroad offices organizing or promoting student travel abroad. Moreover, University-wide training requirements for students participating in international programs and faculty/staff independently traveling abroad in University-level policies and procedures are similarly insufficiently detailed, and we found no references in University-level written policies and procedures pertaining to training for faculty/staff independently traveling abroad for University purposes.

- **International Insurance for Students, Faculty, and Staff Traveling Abroad:**

  We determined that FSU does provide or offer international insurance for all outbound students participating in international experiences – either automatically through International Programs or CGE, where the international insurance coverage is provided as part of the program fee or, for those whom this is not the case, through the students obtaining coverage through the FSU health insurance plan or purchasing the University’s international health insurance plan (CISI for 2016). However, for faculty/staff, with the exception of Beyond Borders team leaders in CGE and International Programs faculty/staff, where program fees cover their insurance, the remaining faculty/staff traveling abroad for University purposes are not provided or offered such international insurance coverage.

**Information and Communication Related to International Incidents Response**

- **Information and Communication Not Related to Travel/Incident Tracking:**

  Respondent’s comments on University-level communication regarding written policies and procedures and communication of roles and responsibilities concerning international incidents pointed to the need for improvement in University-level communication in these areas – particularly as concerns entities with students and/or faculty/staff traveling abroad outside the two major entities of International Programs and CGE. Concerning entity-level communication, we asked questionnaire participants to describe how they communicate incident response roles and responsibilities and significant matters to employees, those charges with governance, and appropriate external parties. While responses from International Programs and CGE, as expected, indicated structured responses to this question, others referred to University guidelines/policy, which we determined to have several shortcomings, and still others expressed methods of communication that indicate impromptu, informal approaches. Some acknowledged the need to improvement in this area.

- **Travel Tracking and International Travel Registry:**

  We determined that contrary to national standards and the best practices of other universities, FSU does not currently require/have the means for centrally
registering and tracking University students, faculty, and staff. We asked our sample of University entities chosen whether their entities’ information and communication system support the identification, capture, and exchange of information in a form and time frame that enables the University to carry out its responsibilities in responding to international incidents. The average rating, on a scale from 0 to 100, given by the 23 respondents to this question was 61 percent – ranging from the lowest rating of 15 percent to the highest rating of 100 percent. The absence of a central registration for students, faculty and staff represents a missed internal control opportunity for the University to ensure at the point of registration that all of its students, faculty and staff traveling abroad have met pre-departure requirements (e.g., orientation, insurance, etc.).

The University does have two University policies it follows that have certain provisions for registering and tracking travel, at a decentralized level – the Florida State University Policy for International Experiences and the FSU Student Travel Policy – both of which are unofficial University policies, which require all FSU students traveling internationally on University-sponsored or affiliated international experiences, prior to beginning their international experiences, to be registered in either the International Programs database (through FSU International Programs) or the Student International Experience database/Global Pathways student database (through FSU’s Center for Global Engagement). These databases can serve to track the registered travelers.

Although this seems a reasonable arrangement to ensure that all University students traveling abroad have their travel registered and tracked (by these two major international activities entities within the same University), the International Programs and CGE databases are not designed to track the “real-time” locations of program participants.

Additionally, the two databases may be incomplete. This is especially true for CGE, as students pursuing academic credits abroad are likely known by International Programs. CGE manages SIEP Forms for all known students abroad in non-credit programs or activities – those under CGE and those initiated by individual University departments – and its purpose for doing so is to enter this information into its student database in order to have records of all FSU students traveling abroad in non-credit programs or activities. University departments may (and reportedly do) initiate non-credit international activities without going through the SIEP process, so that this international travel by students and the Program Coordinators or Faculty/Staff advisors is not known beyond perhaps their departments, and the students (and/or faculty/staff) are not entered into CGE’s database. Also, International Programs expressed a concern with for-credit interns going abroad without registering with International Programs before their departure, though they are required to do so.

Besides the risk of participants (students, and/or faculty/staff) in non-credit international activities outside CGE not being registered in CGE’s database, a second group of “at-risk” international travelers is faculty and staff who are not participants in International Programs and/or CGE international activities. These are faculty/staff in the large remainder of University departments. Travel Authorizations, if submitted to Travel
Services prior to the beginning of travel, may let the University know the travelers’ destinations, as well as certain other relevant information. However, OMNI Financials international travel information is likely incomplete, as it would not include travel not paid for through University accounts – e.g., by outside parties or travel where Travel Authorizations are entered post-trips, along with Expense Reports, which is not unusual. Recently, (February 15, 2017), we learned FSU plans to implement Concur Travel Management for its employees. Depending on how this new system is designed, it is our understanding the system could be used to register all faulty/staff travel, including international travel, regardless of funding source. Thus, the system could be used to track faculty/staff travel abroad and send notifications to international travelers, including regarding their safety. The system was scheduled to be implemented November 2017.

**International Incident Tracking Reporting:**

We determined that at the University level, there are no requirements for tracking and reporting international incidents, and this is not being done centrally. Also, currently there is no central monitoring of world events and notification of University travelers of potential threats to their health and safety.

Without central tracking of international incidents, the University’s ability to respond effectively to the needs of students, faculty and staff abroad in the event of emergencies, and to keep persons with the need to know timely informed, may be compromised. The absence of comprehensive centralized tracking of international incidents impedes the University’s ability to identify trends in order to inform future decision making and assist with advising, and to comply with federal and state reporting requirements, e.g., the Clery Act and Title IX.

**Monitoring Activities**

The University has conducted one recent (May 2014) separate periodic monitoring activity related to international incidents, and it has not followed up on the one recommendation related to international incidents (concerning the safety of outbound students) in that evaluation report. Further, there are no routine, ongoing monitoring activities related to international incidents at the University level. Additionally, monitoring of international incidents at the level of international activities is limited. At the level of University entities where international activities occur, based on responses to our detailed internal control questionnaire sent to a sample of entities, six of 23 respondents (26 percent) indicated they experienced international incidents in the past three years, and the same six respondents did so in the past five years. Thirteen out of 23 respondents (56.5 percent) indicated their entities’ management has not periodically re-evaluated and updated their approaches for handling international incidents. Of the 23 entities that responded, less than half (11 or 48 percent) expressed confidence that the University is prepared to effectively respond to international incidents, and the same number (and percentage) expressed confidence that their entities are prepared to effectively respond to international incidents.

We made seventeen recommendations to address the issues identified during our audit.

An action plan was developed by the University to address each of these identified issues/recommendations.
The primary objective of our audit was to evaluate the Florida Center for Advanced Aero-Propulsion’s (FCAAP) management and administration over its Polysonic Wind Tunnel Auxiliary. Our specific objectives were to:

- Evaluate the financial condition of the Auxiliary account; and
- Determine if the Auxiliary:
  - Is correctly classified and operates in accordance with its approved mission;
  - Assesses reasonable rates that are supported by adequate documentation; and
  - Operates in compliance with University policies and procedures and has established effective internal controls.

Our audit period was July 1, 2015 through June 30, 2017.

Our findings are as follows:

- The Auxiliary has operated at a deficit since its inception in Spring 2014, in part because Universities that self-identified as future collaborators and/or major users of the Polysonic Wind Tunnel in the National Science Foundation funding proposal, have not used the Wind Tunnel as was anticipated. In fiscal year 2016-17, Wind Tunnel administration entered into a commercial contract, bringing in additional revenues to apply toward expenses. Until there is additional research requiring Wind Tunnel usage, it is likely the Auxiliary will require financial subsidies and/or external commercial contracts to meet expenditures.

- The Wind Tunnel is correctly classified as a Sales and Services of Educational Activities auxiliary. However, in fiscal year 2016-17, the auxiliary entered into a commercial sales contract that, while providing needed income, does not accomplish the Auxiliary’s mission “to support instruction, research, and public services both within and outside the classroom, helping to demonstrate classroom or related educational techniques.” Such commercial contracts may be subject to Unrelated Business Income Tax (UBIT). In addition, this revenue-generating contract was not reviewed by the University General Counsel, University Controller and the Office of Business Services, as required by policy.

- Costs and usage assumptions used to develop recently proposed Wind Tunnel Auxiliary billing rates require revision.

- Auxiliary documents did not readily allow for a reconciliation between
usage and billings to determine whether all usage had been billed.

- While the Wind Tunnel Auxiliary conducted routine reconciliations of its departmental ledgers, timeliness and responsibility for completing and reviewing these reconciliations were not evidenced by preparer and reviewer signatures and dates. The Auxiliary also did not have reconciliation procedures as part of its written policies and procedures.

- There are significant opportunities for the Auxiliary to strengthen its controls over cash handling.

We had thirteen recommendations to address issues identified during the audit.

Management developed an action plan to address each of these recommendations.

Florida State University Police Department Administration of University Compliance with the Jeanne Clery Disclosure of Campus Security Policy and Campus Crime Statistics Act

The objective of our audit was to determine the effectiveness of the University’s efforts to comply with the Clery Act and to identify opportunities for improvement. Specifically, our objectives were to determine whether:

1) The University had properly identified all campuses required to publish an ASRFR consistent with Clery Act criteria;

2) The University has an adequate infrastructure to support compliance with the Clery Act;

3) The University has adequate policies to provide for emergency notification, response and recovery;

4) The crime and fire statistics in the University’s October 2015 and 2016 ASRFRs were correctly reported and supported by adequate documentation. Our review was updated to include any corrections made in the October 2017 report; and

5) The ASRFR contained the policy statements required by the Clery Act and was published by the October 1 deadline.

The scope of our audit included crime statistics in the 2015-16 and 2016-17 ASRFR, issued on September 29, 2015 and September 29, 2016, respectively. We updated our report to reflect reporting in the 2017-18 ASRFR, issued on September 28, 2017.

Our findings were as follows:

- The University published ASRFRs for the Tallahassee and Panama City, Florida campuses as required by the Clery Act. The University did not compile and published a stand-alone ASRFR for the Republic of Panama campus, which meet the criteria to be
considered a separate campus under the Clery Act.

- Clery Act compliance is a campus-wide responsibility. The FSUPD has met its responsibility, as a law enforcement agency, to comply with Clery Act requirement and has successfully compiled the annual ASRFR required under the Clery Act. The University does not have a policy that would establish management’s expectations for Clery Act compliance and should consider the policy proposed by FSUPD.

- In January 2015, an “Important Announcement” email was distributed to the Deans, Directors and Department Heads with the approval of the Vice President of Finance and Administration. This announcement requested that the names of individuals that meet the criteria to be considered a Campus Security Authority under the Clery Act be provided to the FSUPD. The FSUPD reported that several departments originally provided comprehensive lists of CSAs while other departments provided only the name of a representative or a less comprehensive list. The 2016 and 2017 annual requests for Clery crime reporting requested that new CSA’s be identified but the listings have not otherwise been updated. Formally identifying and maintaining a listing of CSA’s, or the positions with CSA responsibilities, would provide increased assurance that allegations of Clery Act crimes that are made outside of the FSUPD, are reported to the FSUPD for inclusion in the annual ASRFR data. In addition, this identification would allow training and guidance to be timely provided to individuals with Clery Act responsibilities.

- While the FSUPD provided access to Clery Act Training, the identities of individuals accessing the training is not tracked and 12 of 28 entities identified as having Clery Act responsibilities have not accessed training materials.

- Emergency notifications have been issued when significant emergencies and dangerous situations have been identified and confirmed, as required by the Clery Act.

- The FSUPD has developed criteria and policies for use of the ALERT Emergency Notification and Warning system. The system has also been tested as required by the Clery Act. While reviewing the notification elements of the University’s Comprehensive Emergency Management Plan (CEMP), we determined the CEMP could strengthen the plan by providing the additional detail necessary to guide emergency response and University operations before, during and after an emergency.

- The crime and fire statistics for calendar years 2014 and 2015 reported in the Tallahassee campus ASRFR were supported by adequate documentation. The FSUPD notified us that the 2015 ASRFR mistakenly reported 25 fires when there were 26. This is being corrected in the information provided for the USDOE Campus Safety and Security Survey and will be corrected in future ASRFRs. Unfounded allegations were reported as having been closed.
This was corrected in the 2017 ASRFR.

- The University should not combine Clery Act crime statistics for its separate campuses when reporting data to the USDOE for the Campus Safety and Security Survey.

- The University’s 2017 ASRFRs, which were issued for the main and Panama City, Florida campuses, met requirements for disclosing University policy statements, and included other required information that supports Clery Act compliance. The 2015, 2016 and 2017 ASRFRs were timely published prior to the October 1 deadline.

We had seven recommendations to address issues identified during the audit.

Management developed an action plan to address each of these recommendations.

**Office of the University Registrar Internal Controls over the Driver and Vehicle Information Database (DAVID)**

The purpose of this audit was to evaluate the management and administration of the Driver and Vehicle Information Database (DAVID) system by the Florida State University Office of the University Registrar (Registrar). The audit objectives were derived from the Department of Highway Safety and Motor Vehicles Memorandum of Understanding and the DAVID Audit Guide.

The objectives of our audit were to determine whether the information exchanged was safeguarded by the Registrar pursuant to the Memorandum of Understanding (MOU), Contract Number HSMV-0131-17, and whether internal controls over personal data have been evaluated and are adequate to protect the data from unauthorized access, distribution, use, modification, or disclosure.

Specifically, our objectives were to determine whether:

- Quarterly quality control reviews of authorized users and DAVID usage had been conducted by the Registrar and whether all users and usage were authorized;

- DAVID information was protected by physical and logical access controls; and

- Personnel acknowledged their understanding of the confidential nature of DAVID information and the criminal sanctions specified in state law for unauthorized use, and the acknowledgements were current.

Our review covered activity between November 2016 and October 2017.

Our findings were as follows:

- The MOU between the Registrar and DHSMV requires documented quarterly quality control reviews by the Registrar to ensure all DAVID users and DAVID usage are appropriately authorized. While the Registrar reports reviewing usage during the contract period, these reviews were not conducted.
consistent with DHSMV requirements and were not documented.

- Access to DAVID information is required to be updated immediately upon employee termination. Our review identified system access for an employee that remained active 24 days after the individual’s retirement date. The employee did not access the system after retirement.

- DAVID information is protected by adequate physical and logical access controls.

- DAVID users acknowledged their understanding of the confidential nature of DAVID information and the criminal sanctions specified in state law for unauthorized use of the data. Acknowledgements were current.

We had two recommendations to address issues identified during the audit.

Management developed an action plan to address these recommendations.

The overall purpose of the audit was to report on the controls and processes established by the University to ensure the completeness, accuracy, and timeliness of data submissions to the BOG that support the University’s PBF Metrics, and to provide an objective basis of support for the University’s President and Board of Trustees Chair to sign the representations included in the Performance-Based Funding – Data Integrity Certification, which was submitted to the University’s Board of Trustees and filed with the BOG by March 1, 2018. This audit included an evaluation of the key controls that support these processes, as well as testing of the actual data upon which the University’s PBF Metrics are based.

The Performance-Based Funding 2017 Metrics (along with their definitions), as of March 14, 2017, were published on the BOG website. Subsequently, at its November 9, 2017 meeting the BOG made a decision to immediately discontinue its BOG Choice Metric 9b - Number of Faculty Awards, which had been used by Florida State University (FSU) and the University of Florida. This change resulted in all SUS members now having the same BOG Choice Metric 9a - Percent of Bachelor’s Degrees without Excess Hours. The complete current listing of the 2017 PBF Metrics follows:

1) Percent of Bachelor's Graduates Enrolled or Employed ($25,000+) in the U.S. One Year after Graduation

2) Median Wages of Bachelor’s Graduates Employed Full-Time One Year after Graduation

3) Cost to the Student (Net Tuition and Fees per 120 Credit Hours)

4) Six-Year Graduation Rate for First-Time-in-College Students

Performance-Based Funding Metrics Data Integrity Certification Audit Fiscal Year 2017-18

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5) Academic Progress Rate (Second Year Retention Rate with Grade Point Average (GPA) Above 2.0)

6) Bachelor’s Degrees Awarded within Programs of Strategic Emphasis (including Science, Technology, Engineering, and Mathematics (STEM))

7) University Access Rate (Percent of Undergraduates with Pell Grants)

8) Graduate Degrees Awarded within Programs of Strategic Emphasis (including STEM)

9) Percent of Bachelor’s Degrees without Excess Hours (Board of Governors’ Choice Metric for all SUS universities)

10) National Rank Higher than Predicted by the Financial Resources Ranking, Based on U.S. News and World Report (FSU’s Board of Trustees’ Choice Metric)

This audit solely addressed the integrity of the University’s data submissions to the BOG that support the University’s Performance-Based Funding Metrics for the 2016-17 Annual Accountability Report. The BOG extracts data from the files provided it by the University and performs additional calculations to derive the final PBF Metrics data published by the BOG. The University is not involved in these extractions or additional calculations by the BOG.

Overall, we concluded that the University has adequate processes for collecting and reporting Performance-Based Funding (PBF) metrics data to the Board of Governors (BOG). In addition, we provided an objective basis of support for the University’s President and Board of Trustees Chair to sign the Performance-Based Funding – Data Integrity Certification, which the BOG requested to be filed with it by March 1, 2018.

Contract Between the University College of Medicine and Florida Psychological Associates

The objective of this audit was to provide the President and the Board of Trustees an independent assessment of the contract between the College of Medicine and Florida Psychological Associates. This audit included assessment of contract terms and conditions, program design and implementation, the linkage of program goals and objectives to measurable outputs and outcomes, and the basis for contract termination.

The scope of this audit included a review of information made available from early 2016 to July 2017.

Our detailed audit conclusions are as follows:

- The University did not request the appropriation. There were no instructions, legislative intent, or guidance provided other than spreadsheets that identified FPA as the mental health screening provider.
FPA provided to the COM the program description previously provided to the Senate and Office of the Governor. The program description did not clearly or adequately identify program outputs and outcomes.

FPA’s initial proposal estimated 12,500 screenings would be “administered” in Nassau, Clay and Duval public schools and in the judicial system in the 4th judicial circuit. That deliverable was subsequently changed to 7,100 “attempted screenings” and that is the number used in the contract. The COM staff emphasized to FPA the need to report the actual number of screenings administered and the number of referrals made for further mental health services.

In following due diligence, the COM was advised by Procurement Services that procurement of mental health services is exempt from competitive procurement processes. Also, the University Deputy General Counsel opined that no conflict of interest existed when the CEO (Chief Executive Officer) of FPA also owned an interest in the screening tool.

The adequacy of the contract itself:

- The COM appropriately requested assistance from entities within the University in drafting the contract to include legal, procurement, COM finance and accounting, and sponsored research.

- This was a fixed price contract in the amount of $800,000 and provided FPA (a for-profit corporation) predetermined monthly payments based on budgeted annual expenses. The contract did not require an accounting of payments made by the COM to actual expenses incurred by FPA nor a return of unspent funds. This fixed price contract had no demonstrated history of program costs or measurable deliverables thereby making accountability efforts more difficult.

- The contract was not clear on whether acceptable program performance (the deliverable) was based on “screenings attempted” or “screenings administered.”

- In April 2017, FPA’s attorney stated in a letter to the Speaker of the House of Representatives that the screening deliverable was the number of letters sent to parents requesting permission to administer screenings to their children (8,363 letters were sent to parents of school children in Nassau County only). Previously in January 2017, the FPA CEO stated in a letter to the Senate Education Appropriations Committee that the specific measure and data source for program output was the number of screeners administered. The CEO’s statement is contrary to the attorney’s assertion.

- We concluded that screenings measured by the number of letters sent to parents of schoolchildren requesting permission to screen their children as falling significantly short of earning amounts paid and the accomplishment of program intent.

- We concluded FPA’s pilot project proposal, much of which was incorporated into the contract by attachment, did not clearly describe the number and costs of screenings to be administered (program economy and efficiency) or how a determination would be made that
the screening tool had reliability and validity (program effectiveness).

- We also concluded that as a result of the above inadequate linkage existed between the program purpose and measurable outputs and outcomes.

- Neither FPA nor the COM anticipated the amount of time needed to obtain IRB approval to administer screenings to human subjects.

- The contract called for screenings in schools and the judicial system to begin in September 2016. FPA received IRB approval to administer screenings to schoolchildren on October 13, 2016. FPA began screenings in Nassau County in November 2016 but did not request screening approval from Clay or Duval County schools until March 2017 – some five months later.

- FPA should have been in contact with all three school systems at least in June 2016 when they initiated contact with the IRB so they could have started screenings as soon as IRB approval was received.

- IRB approval to conduct screening for the judicial system did not occur until April 2017. Judicial system approval was affected by reasons that can be attributed to both IRB (the responsible IRB member was absent for two IRB meetings) and FPA (responding to IRB request for additional information).

- The COM had a difficult contract to manage.

- FPA received an appropriation and had not previously demonstrated to the Legislature program support from all three school districts, parents of children in those school districts, or the judicial system in the judicial circuit.

- The contract was not clear on whether the output deliverable was screenings attempted or screenings administered. There was not clear linkage of program goals to desired and measurable outputs and outcomes.

- Time needed to obtain IRB approval to screen human subjects was not anticipated and screenings could not be performed until approval was received. By contract, school and judicial system screenings were scheduled to begin in September 2016. IRB approval to conduct screenings in schools was received October 13, 2016, and approval to conduct screenings in the judicial system was received in April 2017. No screenings had been administered in schools as of the end of October 2016.

- Even so, FPA had startup and ongoing monthly operating expenses and no screenings were administered in August, September or October. Notwithstanding, the COM made monthly payments to FPA – July through October 2016.

- From November 2016 to March 2017, it became clear that FPA had not and could not administer the number of screening deliverables called for in the contract. Even so, the COM paid monthly invoices through February 2017.
• Had the COM cancelled the contract in December 2016 or earlier, such cancellation could have been viewed as not giving FPA the opportunity to demonstrate performance subsequent to IRB approval to administer screenings in schools.

• Only 20, 3, and 80 screenings occurred in the months of November, December and January, respectively, and all of those screenings occurred in Nassau county public schools. The FPA February deliverables report showed that the 103 screenings that had occurred would increase to 7,100 by June 30, 2017, with 1,500 screenings to be conducted in each of the three public school systems for a total of 4,500 school system screenings. The remaining 2,600 screenings were to be administered in the three county judicial systems (Clay-1,350, Duval-2,600, and Nassau – 850 screenings). The FPA CEO January 2017 projection to the Senate Education Appropriations Committee that 7,100 screenings would be administered by June 30, 2017, was highly improbable.

• The COM was justified in ceasing to make payments to FPA as of March 2017.
  - Although referrals were made for participants needing further mental health service, FPA did not report the number of referrals in the monthly deliverables reports.
  - As of March 2017, 358 cumulative screenings had been performed whereas the contract called for 4,800 screenings by March 17, 2017. No screenings had been performed in Duval or Clay county schools and no screenings had been performed in the 4th judicial circuit. As of the end of March 2017, FPA had been paid $590,192 of the $800,000 contract.

• Subsequently, in April 2017, FPA provided financial information to the Speaker of the House of Representatives. Our review showed that of the $590,192 paid to FPA by the COM to March 2, 2017, FPA had incurred expenses attributable to the contract amounting to $420,699, or a difference of $169,493.

• Given the contract as written and implemented, the COM had no sound basis to request the return of unspent funds. Also, the costs to litigate the issue may not have been justified.

• In July 2017, the COM and FPA signed a consent agreement to officially and mutually terminate the contract.

• Also in July 2017, the COM returned $310,000 to the State of Florida representing $210,000 in contract funds not disbursed to FPA and $100,000 representing one-half of the administrative overhead amount originally allocated to FSU.

• The Legislature did not provide funding to the COM to continue the contract for the 2017-2018 fiscal year.

In view of the contract between the COM and FPA being terminated, this audit report did not contain an action plan for follow-up. Action plans are intended to allow management to take ownership of actions they intended to take in response to an audit with the intent of improved performance going forward.

The issues described in this report address program design and implementation. We do
not question the sincerity or desire of FPA to provide mental health screening and referral services. As a pilot project, much was learned should this or a similar organization request and receive funding to provide mental health screening and referral services in the future.

**Cybersecurity Training**

The objectives of our audit were to evaluate cybersecurity training by selected university units and to determine whether security training is being implemented by university units in accordance to Florida State University (FSU) policies and procedures Information Security Policy, 4-OP-H-05 and Safeguarding of Confidential and Personal Information, 4-OP-F-7.

Specifically, our objectives were to:

- Determine whether faculty and staff are receiving cybersecurity training;
- Determine who is responsible for the units data resources and ensuring that cybersecurity training occurs;
- Determine the types of cybersecurity training available to and received by faculty and staff;
- Determine if the cybersecurity training faculty and staff are receiving is adequate to safeguard protected and private information; and
- Determine how the Information Technology Services (ITS)/Information Security Privacy Office (ISPO), the University’s central information technology organization cybersecurity training practices align with recommended best practices and how they compare with practices of contacted agencies, organizations, and universities.

Our audit of cybersecurity training concluded that:

- University units are not ensuring that all faculty and staff receive cybersecurity training. Based on survey results, 97 of 165 (59%) responding employees stated that they had not received cybersecurity training.
- University units in general do not have procedures in place to record and track employee training. Only three of eleven units had procedures in place to record and track employee training.
- By policy, the Data Owner, being the dean, director, or department head is ultimately responsible for the unit’s data resources and ensuring that required training is provided and obtained.
- Representatives from seven of eleven units reported their awareness of cybersecurity training available at the University and that unit employees have access to and have received cybersecurity training on a variety of
topics and issues hosted by the unit or via ISPO on-site training of SANS videos.

- University units’ cybersecurity training practices in general are not adequate to ensure faculty and staff are trained to safeguard protected and private information. Only three of eleven units interviewed had formal cybersecurity training and only the Controller’s Office has demonstrated and implemented training practices outlined in the Unit Security and Privacy Training Plan.

- The University’s central information technology organization (ITS/ISPO) security practices generally align with and in some instances exceed those of contacted agencies, organizations, and universities.

We had seven recommendations to address issues identified during the audit.

Management developed an action plan to address each of these recommendations.

Follow-up

In conformance with the International Standards for the Professional Practice of Internal Auditing, the OIGS follows up on audit observations and other significant issues to determine if reported planned actions have been taken in response to our observations. Follow-up is performed every six months and all observations are followed up on until final resolution. During the 2017-2018 fiscal year, two follow-up reports were issued for the six-month periods ending June 30, 2017 and December 31, 2017. The follow-up report for the January 1, 2018 through June 30, 2018 was still in progress at the time of this report release.

Implementation of recommendations during this fiscal year was at 27 percent. The pie chart below show the percentage of recommendations for the six-month period ending December 31, 2017.

We had seven recommendations to address issues identified during the audit.

Management developed an action plan to address each of these recommendations.

Review of DSO Financial Statements

Each year, by Delegation of Authority from President Thrasher, the Chief Audit Officer (CAO) reviews audit reports issued by external auditors on Direct Support Organization (DSO) financial statements. A summary of the CAO’s review is prepared and distributed internally to the President and applicable staff and externally to the Board of Trustees, Board of Governors, and the Auditor General.

Overall, external audit reports for DSO’s resulted in unmodified audit opinions which means the issued financial statements were presented in accordance with general accepted accounting principles. Also, except for the Seminole Boosters, the external auditors noted no reportable issues relating to internal control.
For the Seminole Boosters, the external auditors identified one material weakness and one significant deficiency in internal control over financial reporting. The material weakness had three parts:

- an adjustment of $2.1 million was needed to address the investment in College Town;
- a $641,000 adjustment was needed to accounts receivable to adjust the balance of pledges receivables; and
- the auditors assisted the Boosters in drafting the financial statements.

The significant deficiency in internal control over financial reporting related to difficulties the auditors encountered in obtaining sufficient competent evidence. For all issues noted, management was responsive as to the proposed plan of corrective action.

In addition, the Boosters’ audited financial statements were issued February 16, 2018. By BOT Regulation 2.025, those audited financial statements should have been received by the University no later than October 31, 2017. To this issue of noncompliance, the Boosters provided assurance to the BOT Audit and Compliance Committee that the audit for the year ending June 30, 2018 would be timely issued and prior to October 31, 2018.

In Progress and Carry Forward

At fiscal year-end, we had audits in various stages of progress. Some of them were close to being finished, while others were in the early stages of the process.

Audits in progress at fiscal year-end were:

- Title IX Compliance;
- Chemical Inventories;
- Business Practices Enhancement Program (BPEP) – Ringling;
- Undergraduate Student Tuition and Fee Waivers;
- Center for Leadership and Social Change – Operational Audit including Cash Handling;
- College of Engineering.
The Office of the Inspector General Services (OIGS) maintains the EthicsPoint Hotline for employees and contractors to report suspected acts of fraud, waste, and abuse, including mismanagement or violations of laws, rules, or procedures by University employees or contractors.

Reports can be made anonymously.

Complaints/Investigations

The OIGS receives complaints and allegations reported directly from internal and external parties, and through the University’s EthicsPoint Hotline. The OIGS occasionally initiates an investigation based on concerns arising from routine audits and existing investigations. In addition, the OIGS provides investigative assistance to the FSU Police Department and other law enforcement entities, when requested. Upon receipt, each complaint or request is evaluated to determine what type of investigative action is needed. Complaints that do not fall within the jurisdiction of the OIGS are referred to the appropriate entity. During 2017-18, approximately 15 percent of our direct effort was invested in reviewing complaints and conducting investigations.

TYPES OF INVESTIGATIVE ACTIVITY

Standard Investigations (SI) are opened when complaints allege violations of laws, rules, or policies and procedures related to suspected acts of fraud waste and abuse. Substantiated allegations are referred to management for their consideration and further action. If potential criminal activity is identified, the allegations are immediately referred to law enforcement.

Preliminary Inquiries (PI) are opened when a complaint is received and additional information needs to be obtained to determine whether an investigation is warranted. Once the OIGS completes additional fact-finding, a determination is made whether to proceed with an investigation, close the complaint, or address the complaint without investigation.

Management Referrals (MR) are complaints received by the OIGS that are the responsibility of management and do not require investigation. Our office refers these complaints for review and action deemed appropriate. The OIGS closes the case if the management response appears to address the concerns satisfactorily. However, if the concerns, in our opinion, are not adequately addressed or if management identifies other issues, our office may initiate an investigation.

No Investigative Action (NI) is taken when complaints are not supported by facts, are not violations of law or policy, or have already been investigated or resolved. These complaints are closed on receipt.

Criminal Assistance Investigations (CI) are opened when the OIGS receives allegations of a criminal nature that are referred to the appropriate law enforcement agency. They also occur when our assistance is requested in an ongoing criminal investigation by law enforcement. In these cases, the law enforcement agency is the lead and the OIGS provides investigative assistance as requested.
TYPES OF INVESTIGATIVE WORK

PRODUCT

**Investigative Reports** communicate the results of an investigation into allegations determined to be significant to University operations and that reflect a violation of law or University policy. Investigations are conducted in accordance with the *Principles and Standards of Office of the Inspector General, Quality Standards for Inspections, Evaluation and Reviews*, commonly known as the *Green Book*, the *Standards for Complaint Handling and Investigations for the State University System of Florida*, and the *Commission for Florida Law Enforcement Accreditation Standards for Florida Inspectors General*. The Investigative Report will conclude as to whether allegations(s) made are determined to be substantiated, unsubstantiated, or unfounded.

**Controls and Compliance Reports** are used to report internal control and/or compliance weaknesses. These weaknesses are most often identified by staff during an investigative project but may be brought to the attention of the OIGS during an audit. Such limited scope services are not integral or directly related to an investigation and are not integral to the scope, objectives, or findings of a specific audit project. Such findings are provided to management for information, consideration, and corrective actions. In such instances, a full audit is not warranted and the limited scope of services provided is clearly identified.

INVESTIGATIVE ACTIVITY
For Fiscal Year 2017-18

![Sources of Investigative Projects](chart.png)

At the close of the prior fiscal year ended June 30, 2017, we had one (1) Whistle-blower Investigation (Standard Investigation), five (5) Preliminary Investigations, and one (1) Criminal Assistance investigation that remained open for a total of seven (7) cases continuing into the 2017-18 fiscal year.

Between July 1, 2017 and June 30, 2018, the OIGS opened 32 new cases, which included thirteen cases that were brought to us anonymously. Together with the seven cases carried over from the prior fiscal year, the OIGS managed 39 investigative cases during 2017-18.

The OIGS reviews and evaluates each complaint received to determine how it should be processed. During fiscal year 2017-18, of the complaints received: one (1) was immediately determined to require a standard investigation; four (4) complaints needed further information and a preliminary inquiry was conducted; fifteen (15) were referred to management for resolution, including cases to be managed by Title IX, Human Resources, and Ethics and Compliance; two (2) were referred to FSUPD; eight (8) complaints
were closed at intake because the allegations were not a violation of law or policy, were not sufficiently supported by fact, or were not within our jurisdiction; and two (2) complaints were closed and referred for audit review.

<table>
<thead>
<tr>
<th>NEW CASES OPENED 2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fraud/Theft</td>
</tr>
<tr>
<td>Misuse of University Resources</td>
</tr>
<tr>
<td>Misconduct</td>
</tr>
<tr>
<td>Lack of Compliance with Policy</td>
</tr>
<tr>
<td>Information</td>
</tr>
<tr>
<td>Academic</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
</tr>
</tbody>
</table>

The Chief Audit Officer’s responsibilities also include the analysis of all complaints to determine if the criteria is met for whistle-blower protection pursuant to Section 112.3189, Florida Statutes. The complainant must be a current or former employee, contractor or contractor employee, or applicant for University or contractor employment. During the fiscal year, six complainants were in this category. The OIGS determined that none of the complaints were found to qualify for investigation under the Whistle-Blower Act and the complainants were notified by letter.

Of the 39 active investigative projects during the year, 37 were closed in fiscal year 2017-18. Two cases were carried over into the 2018-19 fiscal year.

The OIGS was accredited as an Inspector General office by the Commission for Florida Law Enforcement Accreditation during the 2016-2017 fiscal year. The Commission requires annual reporting of information related to accreditation compliance by January 31 each year. The OIGS submitted our annual report to the Commission on January 18, 2018.
Results of a Significant Criminal Investigation

Investigation of the Center for Prevention and Early Intervention Policy (CPEIP)

In May 2017 (prior to the 2017-18 fiscal year), the OIGS initiated a Whistle-blower investigation to address allegations that CPEIP used federal grant monies to pay a $60,000 advance to a vendor for video production services, misrepresented the services were completed prior to the contract end date of June 30, 2016, and used a third party vendor to create transactions which allowed materials to be charged against federal grants at a price above cost.

The OIGS substantiated the advance payment allegation and determined the CPEIP paid $60,000 in advance to a vendor for video production services. The services were misrepresented by CPEIP to have been completed by June 30, 2016, when services continued into calendar year 2017. A CPEIP employee requested the vendor provide competing quotes and also misrepresented the video production services as being part of the final deliverable for a federal grant when the services were unrelated. The OIGS also identified two additional advance payments from the same federal grant to vendors who updated materials unrelated to the contract.

The OIGS substantiated the allegation related to third party transactions finding that the CPEIP used a third party vendor to create transactions which allowed materials to be charged against federal grants at a price above cost.

Subsequent to our investigation, the two CPEIP employees who were the subject of our investigation received written reprimands.

Doak Campbell Stadium

Direct Services

Each year, the OIGS conducts a risk assessment of University activities and services. The risk assessment process includes interviews with the University President, Vice Presidents, key administrators, and the Chairperson of the Audit and Compliance Committee of the Board of Trustees. Feedback received through these interviews contributes significantly to the successful development of our Annual Work Plan.

The Annual Work Plan contains a detailed schedule of projects planned for the year. Estimated hours are allocated to each project in an effort to optimize utilization of OIGS staff.

Our direct service level of effort for 2017-18 was 65 percent. During the year, we had 588 hours (9.4 percent of indirect time) relating to administrative leave, which was primarily due to University closures from Hurricane Irma and snow. In addition, 244 hours (4 percent of indirect time) relating to maintaining our investigation accreditation with the Commission for Florida Law Enforcement.

The three graphs that follow show the 2017-18 fiscal year level of effort, planned versus actual direct service effort for fiscal year 2017-18, and a nine-year trend of direct service effort for fiscal years 2009-10 through 2017-18.

1 Although the OIGS determined the expenditure was charged to a Medicaid federal grant, through the Agency for Healthcare Administration, the grant was a fixed-price contract and all deliverables were met before this expenditure was made. Programs are not to retain excess funds from fixed-price contracts. University Policy dictates how these funds are to be distributed.
Activity Charts

2017-18 LEVEL OF EFFORT

- Direct Time to Audits and Investigations: 65%
- CPE Training: 31%
- Investigation Accreditation: 1%
- Other Indirect Time (i.e., Office Administration, Holidays/Leave): 3%

HISTORY OF DIRECT EFFORT
2009-10 THROUGH 2017-18

- Audits
- Consulting Projects - Starting in 2013-14, hours were added to Audits
- General Investigations
Provision of Training to the University Community

The OIGS is keenly aware of the importance of training and its benefits to the University and to its employees’ professional development. As such, we are fully committed to this essential component of our services.

The OIGS provides training to the University’s employees, including those outside Tallahassee at the Ringling Museum of Art in Sarasota and our Panama City Campus, in the following areas:

- Ethics;
- Internal controls;
- Fraud awareness, prevention, and detection; and
- Other topics of interest to the requesting entity.

Additionally, the OIGS offers presentations to academic classes at the request of instructors. This fiscal year, the CAO was guest speaker for the FAMU Governmental Accounting Class. In addition, the CAO is consulting with the Student Government Association and College of Business students that are members of Beta Alpha Psi in a joint accounting and auditing project.

Professional Activities and Certifications

The OIGS is proud of the experience and professionalism of its staff. During 2017-18, we continued our commitment to external organizations that support higher education and internal auditing activities. OIGS staff members belong to a number of professional organizations including the following:

- American Institute of Certified Public Accountants;
- American Society of Public Administration;
- Association of Certified Fraud Examiners;
- Association of College and University Auditors;
- Association of Government Accountants;
- Association of Inspectors General;
- Florida Institute of Certified Public Accountants;
- Information Systems Audit and Control Association (ISACA);
• Institute for Internal Auditors; and
• Institute of Internal Controls.

Our staff is actively involved with several professional boards. These include the:

• Tallahassee Chapter of the Association of Government Accountants;
• Tallahassee Chapter of the Institute of Internal Auditors; and
• Tallahassee Chapter of ISACA.

**Certifications**

Our staff maintains various professional certifications demonstrating their continued commitment to the audit profession. Current certifications held by staff include:

• Certified Fraud Examiner;
• Certified Government Auditing Professional;
• Certified Government Financial Manager;
• Certified Internal Auditor;
• Certified Internal Controls Auditor;
• Certified Information Systems Auditor;
• Certified Inspector General;
• Certified Inspector General Auditor;
• Certified Inspector General Investigator;
• Certified Public Accountant;
• Chartered Global Management Accountant;
• Certification in Risk Management Assurance; and
• Sworn Law Enforcement Officer.

In addition to professional certifications, advanced degrees held by staff include:

• Doctor of Philosophy – Public Administration;
• Master of Accountancy;
• Master of Arts – Spanish;
• Master of Business Administration;
• Master in Public Administration;
• Master of Science – Instructional Systems; and
• Master of Social Work – Program Evaluation.
Post-Project Surveys

Upon completing our audits and major consulting engagements, the OIGS provides the individuals with whom we worked most closely on our projects the opportunity to evaluate our services through post-project surveys. These survey results provide the OIGS with valuable feedback and help us improve our operations.

Our University colleagues evaluate us on a scale from 1 to 5 (with 5 being the most favorable) in several categories, and provide an overall rating as to the value provided by the engagement. The compiled results of the surveys received for projects completed during 2017-18 appear in the following chart:

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>AVERAGE RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professionalism</td>
<td>4.54</td>
</tr>
<tr>
<td>Relations of Staff</td>
<td>4.29</td>
</tr>
<tr>
<td>Communications</td>
<td>4.42</td>
</tr>
<tr>
<td>Technical Knowledge</td>
<td>4.29</td>
</tr>
<tr>
<td>Helpfulness</td>
<td>4.17</td>
</tr>
<tr>
<td>Report was Unbiased</td>
<td>4.29</td>
</tr>
<tr>
<td>Report was Issued Timely</td>
<td>4.17</td>
</tr>
<tr>
<td>Clear and Accurate Report</td>
<td>4.29</td>
</tr>
<tr>
<td>Provided Value</td>
<td>4.29</td>
</tr>
<tr>
<td>Overall Average</td>
<td>4.31</td>
</tr>
</tbody>
</table>

We constructively assess feedback received and continually strive to improve services provided.

Upcoming Year

We look forward to working with our colleagues as we implement our 2018-19 Annual Work Plan, and to the many challenges the new fiscal year will likely bring.

The chart below reflects our expected allocation of personnel resources during 2018-19.
Allocation of Time for 2018-19

Annual Work Plan 2018-19

<table>
<thead>
<tr>
<th>Audit Projects Carried Forward from 2017-18 Work Plan</th>
<th>Hours</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2017-18 Audit Projects Carried Forward to Be Completed in 2018-19</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Title IX Compliance</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Chemical Inventories</td>
<td>315</td>
<td></td>
</tr>
<tr>
<td>Business Practices Enhancement Program (BPEP) – Ringling</td>
<td>298</td>
<td></td>
</tr>
<tr>
<td>Undergraduate Student Tuition and Fees Waivers</td>
<td>407</td>
<td></td>
</tr>
<tr>
<td>Center for Leadership and Social Change - Operational Audit including Cash Handling</td>
<td>758</td>
<td></td>
</tr>
<tr>
<td>College of Engineering</td>
<td>840</td>
<td></td>
</tr>
<tr>
<td><strong>Total Hours for Audit Projects Carried Forward from 2017-18 Work Plan</strong></td>
<td>2,718</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>New Audit Projects for 2018-19</th>
<th>Hours</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>State University System Performance-Based Funding (Mandatory)</td>
<td>902</td>
<td></td>
</tr>
<tr>
<td>Review of Major Construction Project Pay Application – Earth, Ocean, and Atmospheric Sciences (EOAS) Building</td>
<td>255</td>
<td></td>
</tr>
<tr>
<td>Graduate Assistant Tuition Waivers</td>
<td>867</td>
<td></td>
</tr>
</tbody>
</table>
Business Services – Contracts Management 1,080
Network Security – Device Configuration 925
Seminole Boosters – Financial Reporting and Collection of Booster Pledges 787
Internal Controls 820
Athletics 965
Republic of Panama Campus 330
University Disaster Recovery and Business Continuity Plan*2 435
Concur Travel System* 382
College of Medicine* 475
National High Magnetic Field Laboratory* 120
Direct Support Organizations (DSOs) External Audits – Financial Report Reviews (Required) 40
DSOs IRS Form 990 Reviews (Required) 20
Management of RSM Construction Consulting Project -- University Housing Replacement Phase II (Required) 50
Management of RSM Construction Consulting Project -- Doak Campbell Stadium Renovations (Required) 50
Fraud and Internal Controls Training to University Entities (Required) 40

Total Hours for New Audit Projects Begun in 2018-19 8,563

C. Follow-Up Projects for 2018-19

Follow-up activities for previously completed audits 495

Total Hours for Follow-Up Projects for 2018-19 495

D. Contingency for 2018-19

These hours are for new, unplanned projects given priority during the fiscal year.

Sponsored Research Services – Post Award and Sciquest/Jaggaer (FSU SpearMart) Electronic Procurement System are two audits having priority status to begin during fiscal year 2018-19, provided we have unforeseen available hours for them.

Total Hours for Contingency for 2018-19 0

E. Investigations for 2018-19

This includes ongoing and new investigations that may result from faculty and/or staff requests, Whistleblower complaints, and complaints received from the Ethics Point hotline.

Total hours for Investigations for 2018-19 2,025

Total Direct Service Hours for 2018-19 13,801

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2 We have planned that these four audit projects indicated by an asterisk (*) will be carried over with additional hours and completed in the next fiscal year, 2019-20.
<table>
<thead>
<tr>
<th>Audit Management and Administration for 2018-19</th>
<th>Hours</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit management and administration includes administrative meetings, continuing professional development, and approved employee leave and holidays. It also, for this fiscal year, includes maintenance of audit software and efforts towards continued accreditation in investigations.</td>
<td>6,459</td>
<td></td>
</tr>
<tr>
<td><strong>Total Audit Management and Administration</strong></td>
<td>6,459</td>
<td></td>
</tr>
<tr>
<td><strong>Total Hours for 2018-19</strong></td>
<td>20,260</td>
<td></td>
</tr>
</tbody>
</table>