



Audit & Compliance Committee

October 2026

October 8, 2026

Approximately 15 minutes following adjournment of Finance & Operations Committee

Campus View Room, McNamara Alumni Center

AUD - OCT 2026

1. 2026–27 Committee Work Plan

Docket Item Summary - 3

2026–27 Committee Work Plan - 5

2. Internal Audit Update

Docket Item Summary - 7

Internal Audit Update Report - 9

3. Information Items

Docket Item Summary - 20



BOARD OF REGENTS

DOCKET ITEM SUMMARY

Audit & Compliance

October 8, 2026

AGENDA ITEM: 2026–27 Committee Work Plan

☐

Review

☐

Review + Action

☐

Action

☒

Discussion

☐

This is a report required by Board policy.

PRESENTERS: Regent Kodi J. Verhalen
Quinn Gaalswyk, Chief Auditor

PURPOSE & KEY POINTS

The purpose of this item is to review and discuss the 2026–27 committee work plan.

BACKGROUND INFORMATION

Board of Regents Policy: *Board Operations and Agenda Guidelines* describes the role of the Audit & Compliance Committee as follows:

The Audit & Compliance Committee oversees the University's system of risk assessment and internal controls, audits, financial reporting practices, and the institutional compliance program. The committee is to assist the Board in discharging its oversight responsibilities related to the audit and compliance functions by:

- promoting the development of an effective, efficient, and continuously improving control environment, in concert with the administration, to achieve the institution's objectives through an appropriate system of risk assessment and internal control;
- overseeing the University's integrated framework of internal control, risk management practices, and institutional compliance program to ensure that the administration executes the provisions of Board of Regents Policy: *Internal Control*;
- serving as an informed voice on the Board by relaying the audit and compliance perspective when related issues are brought before the Board and its standing committees; and
- providing a direct channel of communication to the Board for the chief auditor and the appointed independent external auditor.

Consistent with Board of Regents Policy: *Reservation and Delegation of Authority* Article I, Section X, the Board reserves to itself authority to adopt policies regulating the audit function; approve selection of the appointed independent external auditor and the chief auditor; review audit plans; and evaluate the performance of the appointed independent external auditor and, jointly with the president, the performance of the internal audit function.

Specific duties of the Audit & Compliance Committee include the following:

- (a) Oversight of the Appointed Independent External Auditor. The appointed independent external auditor reports directly to the Board through the Audit & Compliance Committee. The committee shall recommend for Board approval the appointment, engagement, and related fees of the appointed independent external auditor to perform the annual financial statement and federal compliance audits. The committee shall approve in advance all audit and non-audit services provided by the appointed independent external auditor that may impair the appointed independent external auditor's independence regarding the University. Such impairment of independence is currently limited to prohibited non-audit services as defined in the United States General Accounting Office Government Auditing Standards. Engagements not requiring approval by the Board shall be reported to the Audit & Compliance Committee at the next scheduled meeting of the committee. The committee shall annually review and evaluate the appointed independent external auditor's performance, independence, and effectiveness of coordination with other assessment activities, including those performed by the Office of Internal Audit.
- (b) Oversight of the Internal Audit Function. The Audit & Compliance Committee shall recommend for Board approval changes to the Office of Internal Audit's charter and any material revisions to internal audit plans or budgets. In consultation with management and the chief auditor, the committee shall review the annual internal audit plan and the extent to which it addresses high risk areas.
- (c) Review of the Annual Financial Report. The Audit & Compliance Committee shall review, in advance of final issuance, the proposed formats and wordings of the annual financial report, including the management's discussion and analysis, financial statements, footnotes, statistics, and disclosures.
- (d) Review of Audit Results. The Audit & Compliance Committee shall review the internal and external audit results and discuss significant issues of internal control and compliance with the independent auditor, chief auditor, and management. The committee shall monitor management's progress in addressing audit recommendations.
- (e) Investigation of Reported Concerns Regarding Accounting or Auditing Matters. The Audit & Compliance Committee shall be apprised of investigations conducted under administrative policy.
- (f) Requests for Audits. The Audit & Compliance Committee is authorized to request supplemental reviews or other audit procedures by the chief auditor, the appointed independent external auditor, or other advisors.
- (g) Engagements of External Audit Firms Other Than the University's Appointed Independent External Auditor. Engagements with external audit firms other than the University's appointed independent external auditor shall be reported to the Audit & Compliance Committee at the next scheduled meeting of the committee.
- (h) This committee provides additional oversight of compliance initiatives and the enterprise risk management program, including risk identification, mitigation, and the institutional risk profile.

This committee also reviews:

- the annual report on institutional risk and financial reports;
- responses to questions regarding audit issues, reports on enterprise systems, administrative program reviews, investigations conducted under administrative policy, and other items relevant to the audit function;
- the annual institutional compliance report; and
- the institutional conflict of interest report.

**Audit & Compliance Committee
2026–27 Work Plan**

Date	Topics
2026	
October 8–9	• 2026–27 Committee Work Plan • Internal Audit Update This item provides an update on Internal Audit activities, results, and observations, including the status of outstanding audit recommendations. <i>Review of Annual Financial Statements</i> <i>The committee is required to review the annual financial statements prior to their finalization. The committee will be provided with the draft financial statements and provide any feedback they have to the chair.</i>
December 10–11	• External Auditor Report and 2026 Annual Financial Report The committee will receive and discuss the results of the FY 2026 external auditor report and other audit-like work from the University’s appointed independent external auditor. The item will also include the University’s 2026 Annual Financial Report. • Institutional Compliance and Conflict of Interest Reports The Chief Compliance Officer will present the annually required reports. • Resolution to Conduct Non-Public Meeting of the Audit & Compliance Committee to Discuss Data Management and Information Technology Security – Review/Action
2027	
February 11–12	• Review of External Audit Results and FY 2027 External Audit Plan The University’s appointed independent external auditor will discuss the results for the audit and audit-like services performed since July 2026 and will present the proposed plan for FY 2027 audit engagements including the financial statement audit and the uniform guidance federal compliance audit. • Update on the University’s Institutional Risk Profile The committee will review updates to the institutional risk profile and provide input on focus areas based on the current risk landscape and strategic priorities and goals of the University. • Internal Audit Update This item provides an update on Internal Audit activities, results, and observations, including the status of outstanding audit recommendations.
April 8–9	• University Compliance Landscape Analysis Recommendations Follow-Up The committee will receive an update on progress being made to implement the recommendations from the compliance landscape analysis conducted in October 2025 to strengthen the University’s compliance framework. • [Enterprise Risk Management Process Refresh] The committee will discuss the enterprise risk management (ERM) process and provide feedback on the current risk management approach, changes to ongoing risk assessments, and the reporting framework. • Information Items ○ Review of External Auditor Relationship and Services Provided

June 10–11	• Internal Audit Update This item provides an update on Internal Audit activities, results, and observations, including the status of outstanding audit recommendations. • Internal Audit Plan – Review/Action The committee will review and discuss the Internal Audit Plan for FY 2028. This item includes the annual review of the Office of Internal Audit Charter and the University of Minnesota Foundation Audit Plan. • Information Items ○ Annual Report on Institutional Risk and Financial Reports
------------	---



BOARD OF REGENTS DOCKET ITEM SUMMARY

Audit & Compliance

October 8, 2026

AGENDA ITEM: Internal Audit Update

☐

Review

☐

Review + Action

☐

Action

☒

Discussion

☒ *This is a report required by Board policy.*

PRESENTERS: Quinn Gaalswyk, Chief Auditor

PURPOSE & KEY POINTS

The purpose of this item is to update the committee on Internal Audit activities, results, and observations to help the committee fulfill its fiduciary responsibilities under the Board's reserved authority for oversight of the internal audit function.

- Since the last Internal Audit Update at the June 2026 meeting, 31 percent of outstanding high-risk report items (i.e., items with residual risk rated as "high") have been fully resolved. This aligns with historical performance and is a slight improvement over June's 30 percent rate. In addition, only 24 percent of outstanding items are past management's planned remediation dates, and 51 percent have been open for less than a year.
- All outstanding high-risk items were resolved for one audit.
- Five high-risk items across two audits have remained open for more than two years: the Bell Museum audit (1 item) and the HIPAA Governance and Oversight audit (4 items). Additional details regarding these items and the status of remediation are included in the docket.
- While remediation of high-risk items remains reasonable, continued oversight is necessary to manage the current volume of open items and maintain implementation progress.
- Five new audit reports were issued in the last four months, containing 23 recommendations associated with addressing risks rated as "high".
- Other summary information important to the committee for their oversight of the internal audit function is also included in the docket.

BACKGROUND INFORMATION

[An overview of the internal audit process was presented at the October 2025 committee meeting and can be viewed here.](#) It provides context about the Office of Internal Audit (OIA) and the internal audit process, including the scope of work, audit approach, development of the annual audit plan, and the Office of Internal Audit Charter.

The Internal Audit Update is prepared three times per year and is presented to the committee as required by Board of Regents Policy: *Board Operations and Agenda Guidelines*, Section IV, Subd. 6. Audit & Compliance Committee Charter.

Internal Audit Update

University of Minnesota Regents Audit and Compliance Committee
October 8, 2026

This report includes:

- Audit Observations/Information/Status of Critical Measures/Other Items
- Follow-Up on High Risk Audit Report Items
- Audit Activity Report
- Audit Reports Issued Since June 2026
- Management Remediation Plans that Involve PEAK

Details of any of the items in this report are available on request. Individual reports have been distributed to senior leadership for their respective units.

Audit Observations/Information

Status of Critical Measures

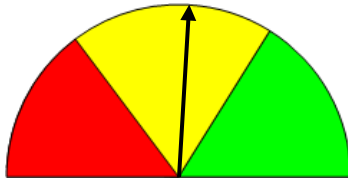
As part of our ongoing efforts to provide the Audit and Compliance Committee with critical information concisely, we have developed the following charts to present a quick overview of work performed by the Office of Internal Audit since our last Internal Audit Update.

The first chart, “Remediation of High Risk Audit Report Items,” provides our assessment of management’s overall progress on addressing high levels of risk identified in audit report issues and their associated recommendations. Readings in the yellow or red indicate remediation rates less than, or significantly less than, what is normally expected in four months. Lower overall remediation rates could be due to a number of factors (e.g., complexity of remediation, or a large number of items added from newly issued reports) and does not necessarily mean a lack of focus or effort by management. Detailed information on follow-up, both institution-wide and for each individual unit, is contained in the next section of this report.

The second chart, entitled “Progress on Audit Plan and Other Assurance Work” is our assessment of the amount of time we have been able to devote to planned audit work. This assessment includes our progress on completion of carryover audits from FY 2026, Tier 1 audits on the FY 2027 audit plan, and Tier 2 audits or their substitutes. Readings less than green could be influenced by a variety of factors (e.g., insufficient staff resources or increased time spent on non-scheduled audits or investigations).

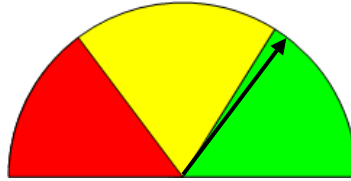
The final chart, “Time Spent on Non-Scheduled Audit Activities,” provides a status report on the amount of time consumed by investigative activities, special projects, follow-up on outstanding high risk items from audit reports, and other management requests. We estimate a budget for this type of work, and the chart will indicate whether we expect that budget to be sufficient. Continued readings in the yellow or red may result in seeking Audit and Compliance Committee and Board of Regents approval for modifying the Annual Audit Plan.

Remediation of High Risk Audit Report Items



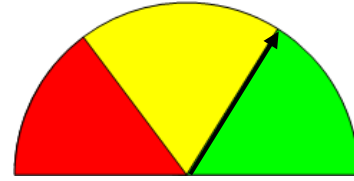
Remediation improved slightly but work is still needed. While most outstanding issues are on track within management's original target dates, continued oversight is necessary to prevent the open item volume from becoming a persistent trend.¹

Progress on Audit Plan & Other Assurance Work



Progress on audit plan and other assurance audit work is on the low side of expectations.²

Time Spent on Non-Scheduled Audit Activities



Time spent on investigations, special projects, follow-up, and management requests is in alignment with expectations.³

¹As detailed in the "Follow-Up on High Risk Audit Report Items," there was an overall implementation rate of 31%. This aligns with the three-year historical average. 51% of open items have been open for less than a year, and only 24% of all outstanding issues are past management's planned remediation date, matching the three-year low previously set in October 2025.

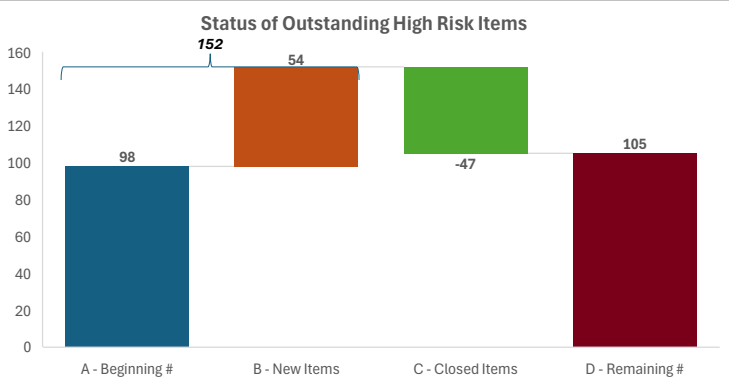
²Progress on the FY 2027 audit plan is on the low side of expectations due to staffing transitions, staff absences, investigations and special reviews, implementation of the department's new audit management software, and some carryforward audits taking longer than expected. See "Other Items" below.

³While overall time on these activities is within expectations, the quantity of investigations and special reviews have trended higher; requiring additional time and resources to review.

Other Items:

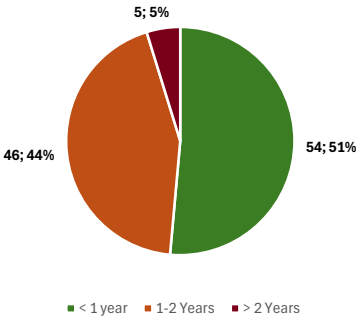
- Internal Audit Staffing Update – The Office of Internal Audit continues to manage department transitions and extended leaves. The department is operating with two vacancies; however, the department has successfully integrated three recent additions, an IT auditor and two staff financial auditors who joined earlier this spring and summer. Given existing structural deficits and potential budget reductions in FY 2028 and FY 2029, we will discuss with senior leadership and committee leadership before hiring these open positions. Additionally, the department continues to support eligible staff utilizing extended leave options under University policy and the Minnesota Paid Family and Medical Leave program. When fully staffed, the department consists of 16 auditors in addition to the chief auditor.

Follow-up on High Risk Audit Report Items

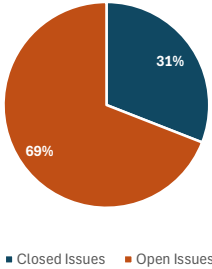


A - The number of items opened at the start of this follow-up period.
B - The number of new items issued since the prior follow-up period.
C - The number of items closed this follow-up period.
D - The number of items remaining open at the end of this follow-up period.

Non-Remediated High Risk Items - Duration Open



Current Period Follow-up: Total High Risk Item Remediation Rate



Status of High Risk Items Follow-up by Audit

tus of High Risk Items Follow-up by Audit						Items Partially Implemented		Items Not Implemented							
Audit Name	Audit Report Issue Date	Initial # of Items	Items Closed Previously	Items Open at the start of this Follow-up Cycle	Items Closed This Period	Not Past Target Date	Past Target Date	Not Past Target Date	Past Target Date	Items Remaining	% of All Items Complete	Time Since Report Issuance			
												6 Months	1 Year	18 Months	2 Years
Bell Museum FY23	04-2023	12	11	1			1			1	92%				
HIPAA Governance & Oversight FY24	07-2024	24	13	11	7		4			4	83%				
Neuroscience, Department of FY25	12-2024	11	4	7		7				7	36%				
Firewall Management FY25	01-2025	7	4	3	2	1				1	86%				
Pharmacy, College of FY25	01-2025	7	6	1			1			1	86%				
BioSafety Level 3 Labs FY25	05-2025	3	2	1			1			1	67%				
Data Management FY25	05-2025	11	1	10	2	1	1	6		8	27%				
Cloud Computing and Oversight FY25	05-2025	10	1	9	2	3	2	1	1	7	30%				
Minnesota Landscape Arboretum	06-2025	22	9	13	8	2	1	2		5	77%				
UMD International Programs and Services FY25	06-2025	3	1	2	1	1				1	67%				
Supplier Onboarding and Payments FY26	08-2025	6	1	5	1		4			4	33%				
Biostatistics and Health Data Science FY26	09-2025	16	5	11	1	3		7		10	38%				
University Threat Assessment FY26	09-2025	4	3	1		1				1	75%				
Psychology, Dept of FY26	11-2025	4		4	2	2				2	50%				
UMD RSOP FY26	11-2025	9	1	8	6	2				2	78%				
Mechanical Engineering, Dept of FY26	12-2025	7	3	4	2	2				2	71%				
Leave of Absence Process FY26	01-2026	2		2	2						100%				
U Services IT FY26	01-2026	7	2	5	1	4				4	43%				
University of Minnesota Police Department FY26	05-2026	17		17	4	5	1	5	2	13	24%				
Purchasing Services Travel & Expense FY26	06-2026	14		14		3	3	8		14	0%				
University of Minnesota Crookston FY26	06-2026	23		23	6	8	3	6		17	26%				
Note : First time follow-up for items in <i>bold/italics</i> .		219	67	152	47	45	22	35	3	105	52%				

Month / Year of Follow Up Report

	Oct 2026	Jun 2026	Feb 2026	Oct 2025	Jun 2025	Feb 2025	Oct 2024	Jun 2024	Feb 2024	Oct 2023	Previous 3 Yr. Average
Total Items	152	140	152	142	99	88	74	86	86	96	-
Items Remediated	47	42	43	22	31	24	28	29	32	36	-
Remediation Rate	31%	30%	28%	15%	31%	27%	38%	34%	37%	38%	31%
Open Items Past Due	24%	28%	30%	24%	34%	34%	61%	32%	57%	55%	39%

Current Status of Outstanding “High” Risk Report Items Over Two Years Old and Are Not Fully Implemented

Audit/Report Date	Status- Partially Implemented or Not Implemented	Responsible Administrator	Summary of the Issue/Risk Involved	Current Comments From Management
Bell Museum April 2023 # of Items: 1	Partially Implemented	Holly Menninger	Bell should implement a periodic valuation process of the art collection. Additionally, Bell management should work with the University's Office of Risk Management to ensure the valuations of Bell's collections submitted for insurance purposes are sufficient for reporting requirements and to mitigate the risk of loss.	As of August 2026, we are continuing to scope this project and are actively working to select an appraiser who has the appropriate skills for the project. We have a short list of three appraisers with whom we are discussing the project. We are also preparing the art collection space and our records, ensuring that all artworks are stored in their proper locations and developing a description of our main assets, as an aid to our conversations with appraisers. Finding a contractor with the right expertise for this project has proven more difficult than we thought, but we believe we are on track to select an appraiser in the next month. We will settle on a timeline for completion in accordance with the selected contractor's availability. In the meantime, the collection is safe in a locked space. We are not loaning works, and have nothing from the collection currently on view.
HIPAA Governance and Oversight July 2024 # of Items: 1	Partially Implemented	Codi Kraus	HIPCO should continue evaluation and implementation efforts of OCR's framework for meeting HIPAA standards compared to existing University requirements, as well as developing more robust University HIPAA policies and procedures.	The primary drivers to HIPCO's delays for recommendation 2a were: (1) Delayed central university policy review process: A review of the University's current policies and procedures relating to HIPAA has taken longer than anticipated. The changes to the University's overall PHI Policy as recommended in the audit findings were submitted in April/May of 2026 to the Health Sciences FCC and the Senate Research Committee. HIPCO was informed the policy changes would be reviewed by the policy committees in the early fall of 2026. Once those proposed changes are formally adopted, the OCR framework portion of this 2a finding is expected to be closed. (2) Delayed due to #1 and staffing issues: Updates to the HIPCO website need to be made regarding the updated policies (see #1 above). Some cosmetic and architectural changes have been made, but the final change of updating the Policies section, has been delayed due to a few HIPCO staffing issues including HIPCO director resignation and delayed new summer law clerk appointment. HIPCO's law clerk is drafting the new policies, and we anticipate that the HIPCO website will reflect those updates by the end of 2026.
HIPAA Governance and Oversight July 2024 # of Items: 2	Partially Implemented	Codi Kraus	The University should assess its current structure for HIPAA compliance, including re-evaluating reporting lines between HIPCO and the HIPAA Security Officer and determining whether HIPCO should remain housed in OACA given its institution-wide authority. Additionally, HIPCO should collaborate with OIC and/or OGC to define privacy oversight beyond HIPAA and health data management, ensuring duplicated efforts are minimized and privacy responsibilities are clear across the University community.	The primary drivers to HIPCO's delays for recommendations 4a & 4b were: (1) Pursuant to a plan to strengthen the University's compliance and privacy functions, HIPCO will be moved under the Office of Institutional Compliance and the supervision of the Chief Compliance Officer (CCO) and a Chief Privacy Officer (CPO). This move will strengthen coordination among privacy, data protection, and regulatory oversight activities. (2) The move of HIPCO will occur after the CCO and CPO positions are filled. As of September 18, finalists have been identified for the Chief Compliance Officer (CCO) position. The newly hired CCO will be responsible for conducting the search and hire of a Chief Privacy Officer.
HIPAA Governance and Oversight July 2024 # of Items: 1	Partially Implemented	Codi Kraus	HIPCO should develop a formal privacy assessment process that complies with University policy. The privacy assessment process should include the target number of assessments to complete in a given time period, notification of recommendations made, mitigation plans, and monitoring of implementation. In addition, HIPCO should document who is responsible for ensuring recommendations from privacy assessments are implemented (i.e., final authority or escalation process).	The primary drivers to HIPCO's delays for recommendation 13 were: (1) Development of a privacy assessment framework was completed. (2) Once HIPCO is moved under the supervision of a CPO, and the new structure and organization is settled, the General Privacy Compliance Officer anticipates that privacy assessments could be started shortly thereafter.
Total: 5				

Audit Activity Report

Assurance Activity

Scheduled Audits

Completed Audits Of:

- Medical School Duluth Campus
- Export Controls and the Fly America Act
- Clinical and Translational Science Institute - IT Processes
- Transition Review: Vice President of Clinical Affairs and Dean of the Medical School
- Transition Review: Executive Vice President for Finance and Operations

Began/Continued Audits Of:

- Clery Act Compliance
- College of Science & Engineering - IT
- Department of Anesthesiology
- Dining Services/Chartwells Contract
- Minnesota Supercomputing Institute
- Natural Resources Research Institute
- School of Nursing
- Senior Leaders and Board of Regent Expenses
- Twin Cities Admissions
- UMD College of Education and Human Service Professions
- University of Minnesota Extension
- Transition Review: School of Dentistry Dean
- Transition Review: College of Food, Agricultural and Natural Resource Sciences Dean

Other Audit Activity

Flash Reviews (formerly known as SNAP Reviews)

Flash reviews are highly focused reviews conducted on a single University process or activity. These reviews are designed to be completed quickly and often leverage data analytics to minimize unit disruptions. They are intended to provide prompt results to business process owners so that potential problems can be addressed prior to formal audit reviews.

No Flash reviews were completed during this reporting period.

Limited Transition Reviews

Limited transition reviews are narrowly scoped reviews of senior University leader transitions focused on financial or other arrangements implemented by the outgoing leader. This review is to aid in transparency for the new leader and to identify any areas which may warrant additional administration or audit attention. These reviews involve interviews with the former leader's core staff members and a limited review of financial and human resource records.

During this reporting period, we completed a Limited Transition Review for:

- Dean of the Graduate School

Gift Testing

Completed gift testing for the University of Minnesota Foundation according to the memorandum of understanding.

Investigation Activity

- Performed investigative work on nine issues in accordance with the University Policy on Reporting and Addressing Concerns of Misconduct.

Advisory Services

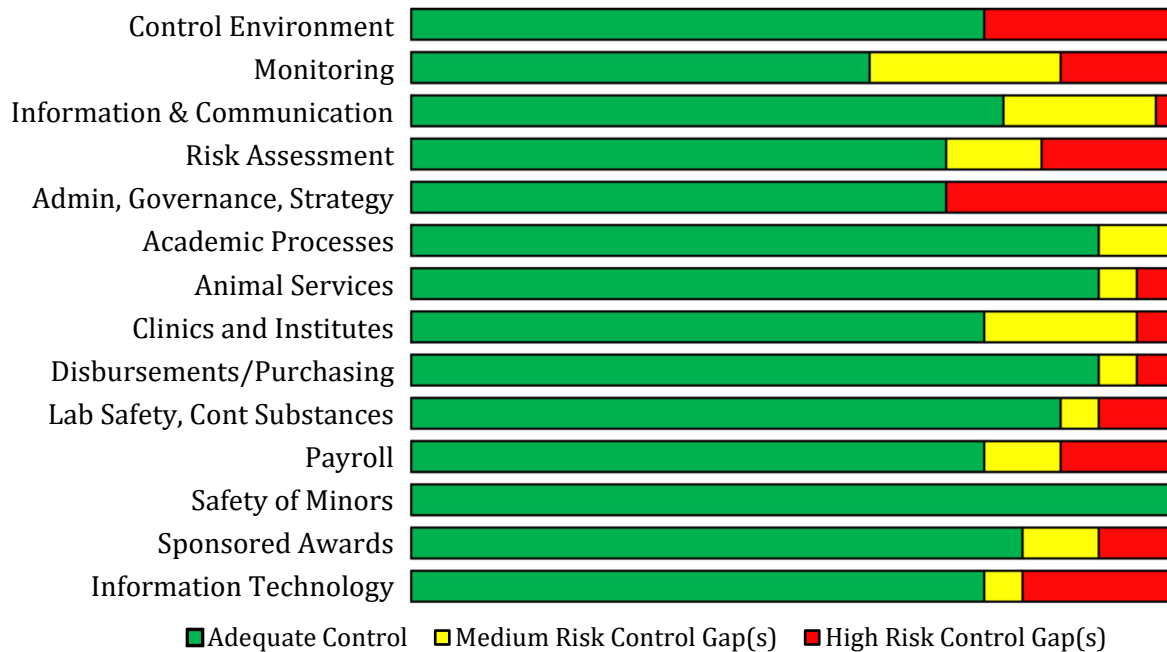
- Consulted with the Provost's Office regarding University policy related to financial aid and admissions decisions, and managing international activities.
- Provided technology advisory services in several areas including IT governance and oversight, Artificial Intelligence, data center controls, identity and access management, data management, vendor management, logging and monitoring, and information security and compliance.
- Participated in the following University committees:
 - Senior Leadership Team
 - Select President Cabinet Meeting Presentations
 - Policy Advisory Committee
 - University Consultative Team (UReport Reviewers)
 - Institutional Conflict Review Panel
 - Institutional Strategic Risk & Compliance Group
 - IT Leadership Committees
 - HRPP Advisory Committee
 - Research Integrity and Safety Collaborative
 - Diversity Community of Practice
 - Civil Service Senate
 - Support Unit Leaders Retreat
 - Chief Compliance Officer Search Committee

Other Activities

- Provided regular communications with the Office of the Legislative Auditor (OLA), to satisfy institutional and officer reporting requirements for the University to report allegations of misuse of public resources and/or disclosure or use of non-public data without authorization as specified in Minnesota Stat. sec. 3.971.
- Continued implementing improvements post the Quality Assessment Review (QAR) and update to the Institute of Internal Auditors (IIA) *Global Internal Audit Standards*. This included implementing the new audit management software and continued development of a departmental strategic plan.
- Implementation and configuration of the new audit management software is underway, with expectations that all future audit work will be migrated to the new tool starting January 2027. We expect to implement additional reporting and process improvements in the subsequent months and retirement of the former tool by September 2027.
- Participated in the following outside professional committees:
 - University of Minnesota Foundation Audit Committee
 - Association of College and University Auditors (ACUA) Committee on Athletics
 - National Consortium of Academic Body Donation Programs
 - Institute of Internal Auditors Quality Assurance Review of Ohio State University

Audit Reports Issued Since June 2026

Medical School Duluth Campus Control Chart



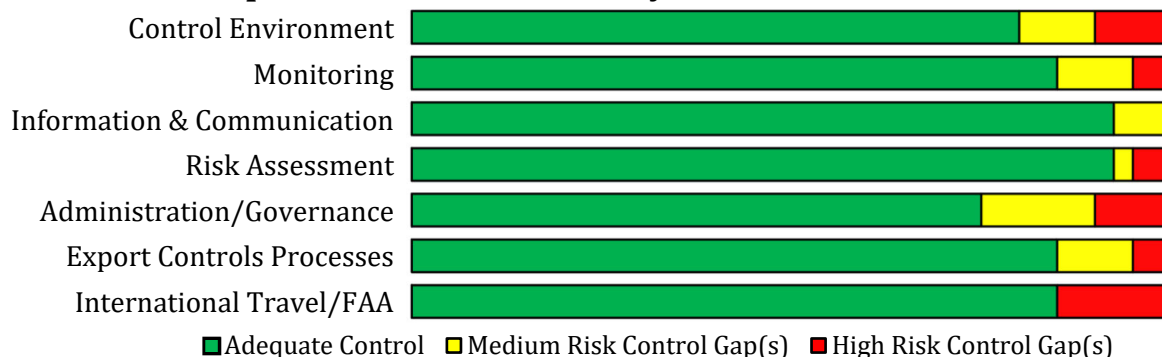
Report Number:	2623	Issue Date:	June 2026
# of High Recs:	12	Total # of Recs:	26
Overall Assessment:	Adequate	Adequacy of MAP:	Good

The Medical School Duluth Campus (DMED) is one of three campuses of the University of Minnesota Medical School (UMMS). Founded in 1972, its focus is on educating physicians dedicated to family medicine and serving the needs of rural Minnesota and Native American Communities. Fall 2025 saw the expansion of the Duluth campus from a two-year to a four-year program. DMED has approximately 35 faculty, 75 staff, and \$27 million in expenditures. It has 65 medical students per cohort, along with approximately 40 master's and non-degree seeking students. In addition to its core academic curriculum, the campus is involved with multiple specialized activities, including the Memory Keepers Medical Discovery Team, the Center of American Indian and Minority Health, the Hope Clinic, and the Whiteside Institute.

The Medical School Duluth Campus's governance, risk management, and system of internal controls address many of its major operational, financial, compliance, and information technology risks. Our survey of faculty and staff found the campus also has a generally positive work environment. However, there are opportunities to improve compliance with University policies and strengthen monitoring to ensure these processes operate effectively.

The audit identified a total of 12 issues and 26 recommendations, with 12 recommendations associated with addressing a "High" level of residual risk and 14 rated "Medium." The "High" risk items relate to: resolving issues with sponsored awards, ensuring payroll accuracy and timely I-9 and background checks, managing IT devices through central services, securing controlled substances, remediating lab safety inspection findings, and restricting physical access to sensitive areas. The "Medium" risk items relate to: effort certification, updating existing agreements with outside entities, scholarship administration, and ensuring compliance with University purchasing and travel requirements. Some of these risks likely stem from DMED working through a structural deficit, and oversight and administrative reporting challenges associated with navigating recent organizational and governance shifts.

Export Controls and the Fly America Act Control Chart



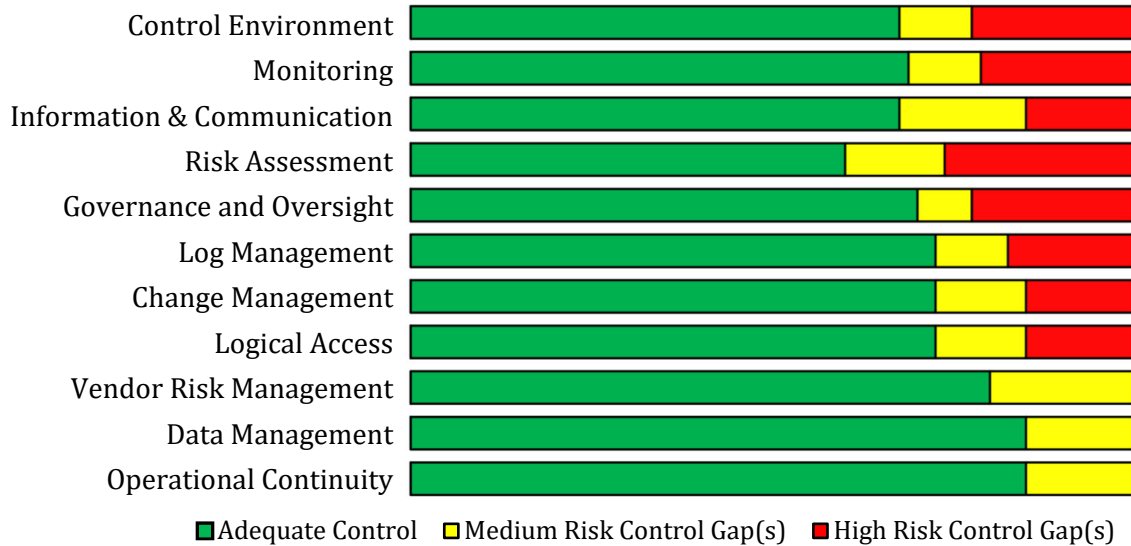
Report Number:	2701	Issue Date:	July 2026
# of High Recs:	3	Total # of Recs:	9
Overall Assessment:	Good	Adequacy of MAP:	Good

Export controls are federal regulations that restrict the physical and informational transfer of sensitive technologies, software, and information to foreign nationals or entities. These regulations are in place to protect national security and promote foreign policy objectives. The Fly America Act mandates the use of U.S. flag air carrier service, even if non-U.S. carriers offer cheaper options, except in certain situations. The University's Export Controls and Research Security (ECRS) is responsible for ensuring compliance with these requirements in research, international travel, purchasing, external sales, and outgoing material transfer agreements. Global Program and Strategy Alliance (GPSA) manages the University's International Travel Registry, which allows for University experts such as ECRS to provide specific international guidance including ensuring travelers to countries subject to trade sanctions do not violate federal law.

ECRS' governance, risk management, and system of internal controls successfully address most major operational and compliance risks. The ECRS team also continues to review, assess, and enhance processes and operations in response to changing federal requirements. Collaborating units report strong working relationship with ECRS, and that ECRS' expertise and knowledge are exemplary. While ECRS has established detailed procedures, there are opportunities to improve University policy associated with data management and enhance monitoring to ensure processes operate effectively.

The audit identified 4 issues and 9 recommendations, with 3 recommendations associated with addressing "High" levels of residual risk. These high-risk items relate to the need to: better implement and document data management and export control standards, establish appropriate monitoring processes to ensure compliance with international travel registration requirements, and review specific unreviewed transactions to determine compliance with the Fly America Act and sanctioned country travel rules. The "Medium" risk items relate to: gaps in resource materials, ECRS' reporting structure, visa review documentation and retention, and some foreign external sales contract handling and retention issues.

CTSI Information Technology Control Chart



Report Number:	2702	Issue Date:	September 2026
# of High Recs:	8	Total # of Recs:	17
Overall Assessment:	Needs Improvement	Adequacy of MAP:	See Below

The Clinical and Translational Science Institute (CTSI) operates under the Office of Academic Clinical Affairs and serves as a University-wide hub consolidating specialized data pipelines, technical services, and administrative oversight to accelerate laboratory discoveries into clinical treatments. Central to its mission is the handling of highly sensitive health and research data. CTSI maintains dedicated staff for advanced research and application development, driven primarily by its Clinical Trial Management Systems (CTMS) and Best Practices Integrated Informatics Core (BPIC) teams, and relies on the Office of Information Technology (OIT) and Health Sciences Technology (HST) for baseline infrastructure and operations.

CTSI's technology and research support staff provide valuable expertise as specialized application administrators, data analysts, and informatics consultants. Furthermore, the staff demonstrates a strong commitment to data integrity, regulatory compliance, and a secure operational framework that successfully drives research while prioritizing the protection of sensitive health data. However, significant residual risks remain in CTSI's technology environment given the high-level of inherent risk associated with their systems and the data they store. The most pressing is a lack of formalized governance with agreed upon responsibilities between CTSI IT units and outside technology groups for managing CTSI's and Masonic Cancer Center's (MCC) systems (whose IT support team was embedded into BPIC several years ago). This lack of shared understanding is reflected in CTSI-IT's management action plan where they disagree on the responsibility for addressing some issues.

The audit identified 8 issues and 17 recommendations, with 8 recommendations associated with addressing "High" levels of residual risk. In addition to improving IT governance, other high-risk items relate to the need to: develop a strategy to perform gap analyses; enhance logging and monitoring processes; minimize and monitor vendor access; establish technical segregation of duties for administrative changes; and develop comprehensive user administration. The "Medium" risk items relate to: Data Use Agreements (DUAs), vendor and change management, and Continuity of Operations (COOP). Management has provided an action plan to address these control gaps, and once clear support responsibilities are established as part of this remediation, the Office of Internal Audit will collaborate with CTSI, HST, and other partner groups to ensure the underlying risks are fully resolved.

Transition Review Reports Issued Since June 2026

Due to the targeted scope of these audits no overall assessments or control evaluation charts are provided.

Vice President of Clinical Affairs and Dean of the Medical School

Report Number:	2703	Issue Date:	September 2026
# of High Recs:	0	Total # of Recs:	0
Overall Assessment:	NA	Adequacy of MAP:	NA

The transition review of the Vice President of Clinical Affairs and Dean of the Medical School focused on operational and financial procedures from January 1, 2023, through February 28, 2026, to provide transparency and facilitate a smooth transition for incoming interim leadership. The audit results affirmed that the activities of the former Vice President and Dean were consistent with expected administrative practices. We identified only minor issues: one annual performance review was not completed, and official merit letters did not match actual merit increases for some direct reports. Medical School and Health Affairs leadership were informed of these documentation discrepancies and committed to addressing them.

Executive Vice President for Finance and Operations

Report Number:	2704	Issue Date:	September 2026
# of High Recs:	0	Total # of Recs:	0
Overall Assessment:	NA	Adequacy of MAP:	NA

The transition review of the Executive Vice President for Finance and Operations focused on operational and financial procedures from the first half of fiscal year 2026 and up to three years prior, to provide transparency and facilitate a smooth transition to the incoming interim leadership. The audit results affirmed that the activities of the former Executive Vice President were consistent with expected administrative practices. We identified some opportunities for minor administrative and documentation improvements. Executive Vice President for Finance and Operations staff were informed of these matters and committed to addressing them going forward.

Management Remediation Plans that Involve PEAK

The following table includes recommendations and risks identified in Internal Audit reports issued to date for which management stated would be resolved at least in part through the PEAK Initiative and these items' current status.

Audit	Report Date	Summary of the Issue	Management Response	Recommendation Rating	Status of Recommendation	PEAK Service Area	PEAK Phase (of unit)	Comments
Fiscal Year 2027								
In fiscal year 2027, to date there have been no recommendations and risks identified in Internal Audit reports for which management stated would be resolved at least in part through the PEAK Initiative.								
Fiscal Year 2026								
University of Minnesota Crookston	June 2026	University contract policies are not being consistently adhered to. A sample review identified gaps in contract management and purchasing compliance. Key exceptions included missing Office of the General Counsel (OGC) reviews, a lack of required University of Information Security (UIS) vendor risk assessments, instances of missing or unprovided contracts, and the use of incorrect agreement types.	The University of Minnesota Crookston (UMC) will develop a contract management process that includes a documented inventory of all contracts, proper reviews (OGC/UIS), signatures, and renewal dates. UMC will utilize FinOps for following proper PO process and required documentation for professional services. UMC will obtain a certificate of insurance for all chartered bus services being used, in accordance with University policy.	High	Not Implemented	Finance	Phase 1	Remediation efforts have not yet commenced; however, UMC anticipates completing all implementation activities by the planned October 2026 target date.
Fiscal Years 2022 - 2025								
All previously reported recommendations addressing "High" risk items from fiscal years 2022-2025 for which management initially stated would be resolved at least in part through the PEAK Initiative were followed up on and are now resolved.								



BOARD OF REGENTS DOCKET ITEM SUMMARY

Audit & Compliance

October 8, 2026

AGENDA ITEM: Information Items

☐

Review

☐

Review + Action

☐

Action

☒

Discussion

☒ *This is a report required by Board policy.*

PRESENTERS: Quinn Gaalswyk, Chief Auditor

PURPOSE & KEY POINTS

The purpose of this item is to report engagements with external audit firms other than the University's appointed independent external auditor, as required by Board policy.

Engagements of External Audit Firms Other Than the University's Appointed Independent External Auditor Requiring After-the-Fact Reporting

- KPMG LLP was engaged to perform a security risk assessment to determine compliance with HIPAA security requirements. This engagement did not present an independence issue regarding KPMG LLP. The fees for this engagement are estimated at \$398,929.

BACKGROUND INFORMATION

Engagements of external audit firms other than the University's appointed independent external auditor are reported at the next scheduled meeting of the committee as required by Board of Regents Policy: *Board Operations and Agenda Guidelines*, Section IV, Subd. 6(g).