LEGISLATIVE AUDIT COMMISSION

Review of
Department of Human Services
Two Years Ended June 30, 2017

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REVIEW: 4486
DEPARTMENT OF HUMAN SERVICES
TWO YEARS ENDED JUNE 30, 2017

FINDINGS/RECOMMENDATIONS - 42

IMPLEMENTED - 24
ACCEPTED AND PARTIALLY IMPLEMENTED - 18

REPEATED FINDINGS - 20
PRIOR RECOMMENDATIONS - 33

This review summarizes the reports on the Department of Human Services, which includes the facilities operated by the Department—six Developmental Centers, six Mental Health Centers, one combined Mental Health and Developmental Center, one Treatment and Detention Facility, and three Rehabilitation Services Facilities—for the two years ended June 30, 2017. The auditors performed a financial audit for FY16 and FY17 filed with the Legislative Audit Commission on February 16, 2017 and March 20, 2018, respectively, and a compliance examination for FY16-17, filed on June 14, 2018. The reports were performed in accordance with *Government Auditing Standards* and the Illinois State Auditing Act. The auditors stated that the financial statements were fairly presented. However, the accountants stated that because of the significance and pervasiveness of the findings described within the report, they expressed an adverse opinion on the Department's compliance.

The Illinois Department of Human Services was created in 1997 and consolidated the Departments of Alcoholism and Substance Abuse, Mental Health and Developmental Disabilities, and Rehabilitation Services, along with the client-centered services provided through the Departments of Children and Family Services, Healthcare and Family Services, and Public Health. Its mission is strengthening Illinois by building up lives and communities. The Department provides an array of comprehensive, coordinated services through programs for persons with developmental disabilities, mental illness, or substance abuse problems, employment, training, and independent living programs for persons with disabilities, and financial support, employment and training programs, community health and prevention programs, child care, and other family services for low-income families.

The Secretary of the Department during the audit period was Mr. James T. Dimas who served from May 2015 until March 2019 when Grace Hou was appointed Secretary. Ms. Hou served as Assistant Secretary at DHS from 2003 until 2012.

The number of employees by division at June 30 appears on the following page.

Division	FY17	FY16	FY15
Administrative & Program Support	762	766	787
Division of Alcohol & Substance Abuse	39	42	44
Division of Rehabilitative Services	1,541	1,505	1,513
Division of Developmental Disabilities	3,768	3,900	3,896
Division of Mental Health Services	2,510	2,575	2,545
Division of Family & Community Services	3,880	3,970	4,140
TOTAL	**12,500**	**12,758**	**12,925**

Service Efforts and Accomplishments

Appendix A provides a summary of the Department's service efforts and accomplishments for the years ended June 30, 2017 and 2016, in all major divisions: Addiction Treatment and Related Services; Developmental Disabilities; Family and Community Services; Home Services; Mental Health Services; and Vocational Rehabilitation.

Expenditures From Appropriations

During FY16 and FY17, the Department operated without enacted appropriations until PA99-0491, PA99-0524, and PA100-0021 were signed in law. During the budget impasse, the Circuit Court of St. Clair County ordered the Comptroller to draw and issue warrants for wages of State employees at their normal rates of pay. Various other courts ordered the Comptroller to make payments necessary to comply with consent decrees and to process payments to serve Medicaid patients. The Public Acts also authorized the Department to pay FY16 and FY17 with appropriations from either FY17 or FY18.

- DHS spent $210.1 million from FY17 appropriations to cover FY16 costs.
- DHS spent $9.4 million in FY18 appropriations to cover FY17 costs.
- DHS incurred $4.3 million in prompt payment interest in FY16 and $1 million in prompt payment interest in FY17.
- Ten vendors participated in the Vendor Support Initiative Program for 1,131 invoices totaling $1.6 million.

The Department's expenditure authority in FY17 was $6.97 billion compared to $6.39 billion in FY16. Total expenditures (including expenditures from non-appropriated funds) were $5.57 billion in FY17 compared to $5.21 billion in FY16, an increase of $361 million, or 6.9%. Appendix B presents a summary of appropriations and expenditures by fund for FY17 and FY16.

Appendix C presents a summary of expenditures by major object code for FY17-FY15. Expenditures were $6.1 billion in FY15 compared to $5.21 billion in FY16, and $5.57 billion in FY17. Expenditures for awards and grants were decreased from FY15 due to not paying any "awards and grants" that were not covered under court order such as Child and Adolescent MH Services, Grant to Autism Program, Addiction Treatment, and Sexual

Assault. Similarly contractual services and telecomm were reduced from FY15. Expenditures for Human Services was higher in FY17 compared to FY16 due to appropriations to DHS for deposit into the Commitment to Human Services Fund and other awards and grants. Lapse period expenditures for the Department were almost $525 million, or 9.6%, in FY17. The increase in expenditures was due to the availability of appropriations during the lapse period.

Appendix D presents a summary of expenditures by facility. Total facility expenditures were $521.6 million in FY17 compared to $488 million in FY16. The Department had an average total population of 3,606 residents/students at centers in FY17 compared to 3,748 in FY16. Cost of care ranged from a high of $416,889 per resident/student at Madden Mental Health Center to a low of $75,111 at the School for the Visually Impaired. The average number of employees at the facilities was 6,453 in FY17.

Cash Receipts

Appendix E provides a summary of the Department's cash receipts, which totaled $1.8 billion in FY17. Cash receipts decreased by $43.4 million, or about 2.3%, from FY16.

- An increase of $60 million in GRF was necessary to cover liability in the Child Care Program through TANF and a $16 million decrease in GRF was due to a reduction in food stamps.
- A decrease of $27 million in Employment and Training was due to declining liability in the Child Care Program.
- A decrease of $21 million in Early Intervention Services was due to transfer to GRF for cash management.
- A decrease of $42 million in Electronic Benefits Transfer is due to a caseload decrease in TANF because of the expanding economy.
- A decrease of $14 million in USDA Women, Infants & Children Fund was due to reduced use of WIC coupons.

Property and Equipment

Appendix F provides a summary of property and equipment for which the Department was accountable during FY17 and FY16. The value of the Department's property and equipment, which includes the facilities, was $760,219,230 at June 30, 2017. The decrease in property and equipment in FY17 was due to increased equipment transfers.

Accounts Receivable

Appendix G provides a summary of accounts receivable for FY17 and FY16. The Department's net accounts receivable totaled $382,552,000 as of June 30, 2017. About $141 million in receivables is due from the Federal Departments of Health and Human Services, Agriculture, Education, and the Social Security Administration. Other

receivables, net, included an increase of $189 million in amounts due from other State funds for FY17.

Accountants' Findings and Recommendations

Condensed below are the 42 findings and recommendations included in the audit reports. Twenty findings repeat from previous reports. The following recommendations are classified on the basis of updated information provided by Amy DeWeese, Chief Internal Auditor, Department of Human Services, in a memo received via email on March 26, 2019.

Accepted and Implemented

1. Increase the level and quality of supervisory review of year-end financial reporting including the following:

- **Determine through analytical procedures and inquiry whether there are any unrecorded expenditures/liabilities, including amounts billed to the Department by other State agencies.**
- **Complete a report checklist, such as the one available on the Government Finance Officers' Association (GFOA) website, to determine if all amounts and disclosures in the financial statements are complete and accurate. Also obtain documentation prepared by the 2 pension systems (SERS and TRS) for their members' employers, and compare amounts to the schedules prepared by the Illinois Office of the Comptroller.**
- **Reconcile the Department's accounting system (CARS) to the Illinois Office of the Comptroller's Statewide Accounting Management System (SAMS) each month in a timely manner. Beginning in FY2018, the SAMS manual requires that receipt reconciliations be final approved within 60 days after the end of the month.**
- **Support payments to DCFS with documentation that demonstrates the amount paid complies with the Illinois Public Aid Code.**
- **Instruct Management Information Services (MIS) division to activate the automated control in CARS which prevents an employee from preparing and approving the same journal entry.**
- **In order to improve the accuracy of amounts reported in the SCO 563 forms for cash basis expenditures by program, reconcile the amounts recorded in CARS to amounts reported by the Federal Financial Reporting division. (Repeated-2009)**

Finding: The Department of Human Services' (Department) year-end financial reporting in accordance with generally accepted accounting principles (GAAP) contained inaccurate information. The Department does not have a complete general ledger or adequate controls over the completeness and accuracy of monthly and year-end annual financial reporting which resulted in errors in the GAAP basis financial statements, GAAP

schedules prepared for the Illinois Office of the Comptroller, and additional supporting schedules and analysis.

The Department does not perform a sufficient supervisory review of all amounts recorded in its GAAP packages and financial statements. Auditors noted the following issues with the year-end financial reporting process:

- During testing of amounts owed to other State funds, auditors noted the Department did not record certain invoice/vouchers for Central Management Services (CMS) which amounted to approximately $54 million, or associated unapplied credits of approximately $33 million, which netted to a $21 million unrecorded liability in the General Fund.

- Certain Department facility employees participate in the Teachers Retirement System of Illinois (TRS), which is a multiple employer cost sharing plan with a special funding situation. GASB Statement No. 68 *Accounting and Financial Reporting for Pensions*, requires that the Department, as an employer, record its portion of the non-employer contributing entity (NECE) pension expense pertaining to Department employees in the government wide financial statements (as a revenue and an expense). This amount for the year ended June 30, 2017 was approximately $7.3 million and was not recorded.

- Monthly fund cash receipt reconciliations were not completed or reviewed in a timely manner and some reconciliations lacked documentation of final review.

- The Department makes a federal draw of $17.2 million every third month and remits it to the Department of Children and Family Services (DCFS), totaling $68.8 million for the year. The agreement, signed November 3, 2000, provided in support of these payments did not contain any information regarding the required amount of the payments under the agreement, or the frequency of the payments. Management of both agencies have agreed to this amount; however, they have not put it in writing. The Department was not able to provide an analysis or reconciliation to indicate the amount paid complied with language in the statute.

- The automated control within the Consolidated Accounting Reporting System (CARS) that restricts the same individual from initiating a journal entry and approving that same entry is not being used. CARS does have the ability to restrict approvals to only approved employees that did not initiate the entry. However, this security setting for processing journal entries has never been enacted.

- Amounts reported on the SCO 563 form for cash basis federal expenditures for Fund 0081 (CFDA 84.126 Rehabilitation Services - Vocational Rehabilitation Grants to States) were overstated by approximately $9.7 million. Additionally, the

Accepted and Implemented – continued

- related receivable, due from Federal Government, was overstated by $7.5 million on the form and in the financial statements.

Department management stated the financial reporting exceptions are due to the complexity of the Department's financial statements and compiling data from numerous disparate systems and sources.

Response: Accepted. The Department has procedures and completes checklists for the compilation and review of year-end financial reporting. The Department will thoroughly analyze and report all liabilities at year end for GAAP reporting. The Department will compare the schedules prepared by the Illinois Office of the Comptroller to the SERS and TRS financial statements for the departmental financial statements. In addition, the Department will work to ensure the receipt reconciliations are prepared and approved in a timely manner. The Department has drafted proposed revisions to the legislation regarding the amount of the TANF Block Grant to be drawn for the Department of Children and Family Services. The Department addressed and activated the CARS control for approval of journal vouchers on February 16, 2018. For the accurate reporting of SCO-563 forms, the Department will analyze and reconcile the amounts provided by the Federal Financial Reporting division and the program areas.

Updated Response: Implemented.

- The Bureau of General Accounting (BGA) has new procedures/contacts in place to identify and/or verify liabilities and note disclosures;

- Reconciliations are being completed within 60 days of month-end;

- The Department has activated the CARS control for approval of journal vouchers;

- DHS Office of Budget has drafted a proposed legislation revision for 305 ILCS 5/12-5. PA 100-0587 has been approved and provides language supporting transfers to DCFS. A statutory change was made by Public Act 098-0024 effective June 19, 2013. The change no longer requires the transfer;

- The Bureau of Federal Reporting and the Bureau of General Accounting (BGA) staff will reconcile expenditure patterns to accounts reported in CARS. BGA has made note of this recommendation and has implemented this into the GAAP procedures.

2. Work with DHFS to gain assurance that the data provided is complete and accurate. In addition, propose an interagency agreement with DHFS.

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Finding: The Department does not have an adequate understanding of the internal controls in place over all data recorded in its financial statements and the Department does not sufficiently review transactions initiated by other State agencies and recorded in the Department's financial statements.

During testing of the financial statements auditors noted the following:

- The Department could not provide documentation of its preparation or review of expenditure reconciliations for the Federal Medical Assistance Program (MAP) funds (Funds 0120, 0142, 0365, 0502, 0718) between amounts reported in the Department's Consolidated Accounting and Reporting System (CARS), and amounts reported in the Illinois Office of the Comptroller's Grant / Contract Analysis Forms (SCO 563) which support the receivable calculation for financial reporting. The amount per the SCO 563 Forms (totaling approximately $425 million) is a computed amount (a formula), which is the amount needed to achieve the reported receivable balance provided by the Department of Healthcare and Family Services (HFS), a separate State agency. The Department does not retain a reconciliation between amounts reported on the SCO 563 Form (claimable expenditures) and amounts recorded within CARS (all expenditures) for each fund. Additionally, there is no documentation maintained by the Department to support the calculation and methodology used by HFS in preparing the federal receivable amount.

- During testing of expenditures and liabilities payable from future year appropriations, auditors determined that the Department is not monitoring or reviewing the payments submitted by HFS, or the liabilities calculated by HFS on behalf of the Department. Although HFS is a separate State agency, certain activities and balances are recorded within the Department's financial statements. Currently, the Department receives summarized information from HFS and records the transactions into CARS and the GAAP packages without performing sufficient procedures to determine the accuracy of the information.

- The Community Developmental Disability Services Medicaid Trust Fund (Fund 142) is the designated recipient of federal funds received in accordance with the Mental Health and Developmental Disabilities Administrative Act (20 ILCS 1705/18.5). These eligible amounts were drawn from the federal government by HFS, received by HFS and deposited in the HFS General Fund; however, on the draft financial statements the amounts were reported in Department's Fund 142 as an asset "due from the federal government". The amount should have been reported as "due from other State agency funds". The misclassification of the receivable also resulted in a $42 million overstatement of deferred inflows of resources (unavailable revenue). These errors were corrected in the final financial statements.

Accepted and Implemented – continued

Department management stated that in order to meet the State Comptroller's due dates for GAAP reporting packages, DHS has to rely on information submitted by other agencies to the State Comptroller. DHS reviewed the other agencies' information for reasonableness, but did not review the information at a detailed level.

Response: Accepted. The Department will work with HFS to gain assurance that the data provided is complete and accurate. In addition, the Department will propose an interagency agreement with HFS.

Updated Response: Accepted and Partially Implemented.

- The Bureau of General Accounting (BGA)/DHS Office of Budget will contact the Department of Healthcare and Family Services (HFS) again regarding an interagency agreement for access to the HFS Enterprise Data Warehouse to obtain payment voucher detail;

- The Bureau of General Accounting (BGA) will determine a reconciliation process for Federal Medical Assistance Program expenditures reported in various funds for GAAP;

- The Division of Substance Abuse Prevention and Recovery (SUPR) will determine a reconciliation process to ensure billings entered into DARTs are processed through the HFS-MMIS system and vouchers are paid. Documentation to support vouchers paid with DHS appropriations will be available for auditor review. DHS is working with HFS to obtain access to their data warehouses;

- The Division of Developmental Disabilities (DDD) will determine a reconciliation process to ensure applicable billings entered into the HFS online billing system are processed through the HFS-MMIS system and vouchers paid. Documentation to support vouchers paid with DHS appropriations will be available for auditor review. DHS is working with HFS to obtain access to their data warehouses;

- The Division of Mental Health (DMH) will determine reconciliation process to ensure applicable billings entered in HFS online billing system are processed through the HFS MMIS system and vouchers paid. Documentation to support vouchers paid with DHS appropriations will be available for auditor review. DHS is working with HFS to obtain access to their data warehouses.

- The Bureau of General Accounting (BGA) will review accruals provided by HFS for reporting in DHS funds and monitor fund activity to ensure amounts are drawn in a timely manner. BGA has made note of this recommendation and will implement into the GAAP procedures.

  Expected Implementation Date: 07/30/19

3. Improve controls over the tracking, review, and assessment of SNAP overpayment referrals, so the Department can establish SNAP overpayment referrals within the timeframe established by the Code in order to comply with the Code and maximize State revenues.

Finding: The Department does not have sufficient controls over the tracking and processing of Supplemental Nutrition Assistance Program (SNAP) potential overpayments resulting in significant delays in processing overpayment referrals for the program.

SNAP overpayment referrals (claims) are first initiated and processed at the various Department field offices, with final assessments and the "debt" establishment occurring in the Department's central office Bureau of Collections (BOC). The Department has a significant time lag for processing these referrals, sometimes taking several years to fully establish the debt. The BOC does not have an inventory of initiated SNAP overpayment referrals while they reside at the various field offices.

FY	QTR	Period	No. of Claims Est Late	Total No. of Claims Est	% Claims Late	Range of Days Late
FY18	1	July - Sept 2017	429	7,098	6.04%	117 - 11,249
FY17	4	April - June 2017	452	5,405	8.36%	100 - 1,434
FY17	3	Jan - March 2017	891	9,455	9.42%	95 - 4,072
FY17	2	Oct - Dec 2016	435	7,066	6.16%	100 - 1,641
FY17	1	July - Sept 2016	337	5,625	5.99%	99 - 2,149

(Est = established)

Based on the Department's quality control error rate of 5.45% applied to FY2017 SNAP benefits paid, auditors estimate approximately $128 million in SNAP benefits were overpaid to SNAP recipients on or before June 30, 2017, for which the claim has not been established at year-end.

The 5 tested overpayments established in FY2017 were late by 95 to 178 days, and ranged in amount from $333 to $7,990. The Department was not able to provide the total dollar amount of all late claims.

Department management stated that the cause of the finding is due to insufficient resources in Family and Community Resource Centers to handle the establishment of overpayment claims on a timely basis.

Response: Although the Family and Community Resource Center (FCRC) staff is insufficient in order to handle the establishment of claims on a timely basis, it is expected that the full implementation of the Integrated Eligibility System (IES) will assist in providing a solution.

IES will improve the identification of overpayments in a timely manner. Although the Department is still working through a few design flaws in the system, IES will systematically identify overpayments based on the date of the change, date reported, and

Accepted and Implemented – continued

entry of the changed information while applying State Policy and Federal regulations. This system will eliminate the need for workers to identify overpayments as IES will determine if there is an overpayment automatically in the course of their daily responsibilities of maintaining case management.

Updated Response: Accepted and Partially Implemented.

- This Audit was focused on the Legacy year, so the implementation of IES has greatly improved the ability of the field to identify referrals for potential overpayments. There are over 100,000 referrals of potential overpayments that have been identified/created since IES went live. However, DHS found that approximately 70% of those referrals do not turn out to be overpayments;

- The defect tracking application, JIRA, is used by DHS and Deloitte for identifying and tracking defects, enhancements, issues and risks related to the IES. DHS identifies defects, enhancements, issues and risks and works with Deloitte to implement changes with DHS input and approval. DHS will continue to monitor the issues that are identified and tracked in JIRA which will allow the IES to systematically identify overpayments.

- DHS will continue to work towards completion of the Supplement Overpayment Project (SOP). We have completed design of the SOP, but are awaiting Initial Advanced Planning Document (IAPD) approval from USDA's Food and Nutrition Service to begin development on the solution. Once we have IAPD and Task Order approval, we can better estimate the timeline for completion.

  Expected Implementation Date: 12/30/19

4. Analyze all available collection data annually and adjust the methodology for calculating the allowance for doubtful accounts as necessary so balances are accurately reported in the financial statements. Include recoupment amounts in order to calculate an estimated collection percentage. Determine and use individual program allowance amounts to calculate the amount owed to the federal government. Review all calculations thoroughly by a knowledgeable supervisor. Limit amounts reported for unavailable revenue in governmental funds to the net receivable reduced by lapse period collections of those receivables.

Finding: The Department did not correctly use all information it had available in determining the allowance for doubtful accounts and calculated unavailable revenue incorrectly.

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During testing of the allowance for doubtful accounts for the DHS Recoveries Trust Fund (Fund 0921), auditors noted that the Department was not including "recoupment" amounts when calculating the collection percentage. Additionally, the Department's allowance analysis used an average of an average in determining the collection rate which was not weighted and thus not reflective of the true collection history.

Auditors performed an independent calculation of the collective allowance amount, as well as each individual program amount and concluded that the collective allowance recorded and used by the Department was within a reasonable range of the estimate. Auditors also performed an independent calculation of the estimated liability owed to the Federal government. The impact was an understatement of approximately $3.5 million. This amount was deemed immaterial and not recorded in the final financial statements.

The amount recorded each year in the DHS Recoveries Trust Fund as "deferred inflows of resources - unavailable revenue" reflects the net receivable, less collections on those receivables during the lapse period (July and August). The amount of unavailable revenue in the draft financial statements was further reduced by the liability to the federal government resulting in an understatement of unavailable revenue and an overstatement of revenue in the draft financial statements of approximately $92 million. This was corrected in the final financial statements.

Department management stated that the methodology was revised in FY14 pursuant to a potential audit finding. At the time, the Department was not utilizing all available collection data to calculate the collection percentage. The procedure was subsequently revised to include all available data. The Department currently analyzes all available collection data. Although the recoupment amounts were included on the reports utilized for the collection percentage calculation, the amounts were not included in the calculation.

Response: Accepted. Although the recoupment amounts were included on the reports utilized for the collection percentage calculation, the amounts were not included in the calculation. The recoupment amounts will be included in the calculation to determine the total collection percentage in future years. An MIS request to accommodate this change has been submitted. The Department feels this is the best method for calculating the collection percentage.

Updated Response: Implemented.

- The Bureau of Collections Staff worked with DoIT to revise the calculation of the allowance for doubtful accounts to include recoupment. The new calculation will be included with the new Fiscal Year 2019 calculations;

- The Bureau of General Accounting staff has revised the calculation of the unavailable revenue amount. The revised calculation was used by the Bureau of General Accounting staff for FY18 GAAP calculations.

Accepted and Implemented – continued

5. **Strengthen controls to confirm all external service providers are considered when compiling a population. Further, obtain or perform independent reviews of internal controls associated with external party service providers at least annually.**

   The independent reviews should include an assessment of the following five key system attributes, as applicable:

   - **Security - The system is protected against both physical and logical unauthorized access.**
   - **Availability - The system is available for operation and use as committed or agreed.**
   - **Processing integrity - System processing is complete, accurate, timely, and authorized.**
   - **Confidentiality - Information designated as confidential is protected as committed or agreed.**
   - **Privacy - Personal information is collected, used, retained, disclosed, and disposed of in conformity with Department requirements.**

   Perform a timely review of the reports, assess the effect of any noted deficiencies, and identify and implement any compensating controls. Document and maintain reviews and corrective actions taken by the service provider. In addition, perform an analysis to determine the need to obtain information as to the subservice organization's internal controls and perform reviews as needed.

Finding: The Department did not obtain or conduct independent internal control reviews over external service providers.

The Department could not provide a complete population of external service providers utilized during FY17. Due to these conditions, the auditors were unable to conclude the Department's population records were sufficiently precise and detailed under CPA Professional Standards.

The Department utilized significant external service providers:

- To provide the Department with services for the Illinois Link Program which distributes SNAP (Supplemental Nutrition Assistance Program) and TANF (Temporary Assistance for Needy Families) benefits.
- To provide banking and processing for payment of food benefits, including the review and reconciliation of Women, Infants and Children (WIC) and Farmer's Market and Senior Farmer's Market benefits.

During testing, auditors noted:

- The Department did not obtain System and Organization Control (SOC) reports or conduct independent internal control reviews of all the external service providers.

- Although the Department received a SOC report for the three external service providers listed above, the Department's review and analysis of the reports, if performed, had not been documented.

Department management stated that a documented review of the SOC-1 was not completed due to competing priorities in the current workflow.

Response: Accepted. The Department agrees that a more formal documentation of the SOC-1 review can be implemented. A review sheet has been identified to use to document the review and, if necessary, any corrective action plan measures that are needed. This form will be utilized for all SOC-1 reviews going forward.

Updated Response: Implemented.

WOMEN INFANT AND CHILDREN (WIC) PROGRAM:

- WIC has identified and developed a review sheet to be used for the documentation of the SOC 1 reporting.

ELECTRONIC BENEFIT TRANSFER (EBT):

- EBT has identified and developed a review sheet to be used for the documentation of the SOC 1 review and follow-up.

6. Perform reconciliations between CARS and the systems that are interfaced into CARS on a regular basis with documented supervisory review and approval of the reconciliation. (Repeated-2016)

Finding: The Department does not document the performance of any reconciliations between its Consolidated Accounting and Reporting System (CARS) and the systems that electronically interface into CARS.
Monthly reconciliations between CARS and the Statewide Accounting Management System (SAMS), the Illinois Office of the Comptroller's accounting system, are performed to ensure transactions recorded in CARS are transmitted to SAMS correctly. However, it is not evident that reconciliations between CARS and several interface systems are being performed on a regular basis.

Department management stated that during transition, a breakdown in communication occurred and these duties were not properly transferred to the appropriate staff. In some cases, reconciliations were not documented.

Response: Accepted. The Department will review the current reconciliation processes for major systems interfacing with CARS to ensure reconciliations are performed on a regular basis, with documented supervisory review and approval of the reconciliations.

Updated Response: Implemented.

Accepted and Implemented – continued

DHS-MIS/DDD-CRS RECONCILIATIONS

- The Community Reimbursements System (CRS) fiscal jobs run weekly each Thursday. The process identifies the bills that are to process and calculates the bill amounts. It then builds the following mobius reports: ECR31021-3 (CARS Interface Summary) and ECR31021-4 (Voucher Listing). These reports are pulled each week and a reconciliation between the two reports is performed.

CHILD CARE

- DHS designed an extract and matching process from CCMS and CARS, to design reports to show mismatched items and matched but unequal items, and to develop tests to perform production runs for previous months in the current fiscal year.

DHS-MIS/DRS-CPS RECONCILIATION

- Staff review transmission reports on a regular basis to confirm the transmission has no discrepancies. In addition, staff document reconciliations on a regular basis.

DHS-MIS/DDD-CPS RECONCILIATION

- The person conducting the reconciliation is required to complete a sign-off sheet and sign as the preparer. In addition, a supervisor signs-off as the reviewer.

7. Work with the Department of Healthcare and Family Services to implement controls to comply with the requirement that applications are reviewed and approved or denied within 45 days.

Finding: The Department of Human Services and the Department of Healthcare and Family Services (Departments) did not maintain adequate controls to ensure applications for human service programs were reviewed and approved or denied within the mandated 45-day timeframe.

The Departments' Integrated Eligibility System (IES) takes in applications from individuals in order to determine eligibility and subsequent payments for the State's human service programs.

As of June 30, 2017, the Departments had incurred a backlog of 74,649 applications that were more than 45 days old, with the oldest application dating back to November 19, 2014. As of January 12, 2018,

- The Departments had worked 1,714 applications, which resulted in payments totaling $209,894 for medical services that were incurred during FY17.
- The Departments had worked 676 applications, which resulted in payments totaling $47,568 for SNAP (Supplemental Nutrition Assistance Program) and

TANF (Temporary Assistance for Needy Families) services that were incurred during FY17.

Departments' management stated the delay in processing was due to increased numbers of applications from expanded Medicaid programs and open enrollment periods, delays in receiving some Federally Facilitated Marketplace applications (transfers from the Federal Marketplace), training of new caseworkers hired, and availability of caseworker staff to process applications due to training on the new IES processing system prior to Phase II implementation of IES.

Response: Accepted. The Departments continue to strive to be in compliance with its mandated application disposition timelines. There are several factors that lead to the current backlog. During the audit period, the Departments were planning for the implementation of a new processing system, for which substantial training was needed for all casework staff. As the implementation of the system stabilizes, and staff become more efficient in the processing of applications, it is expected that any backlog of applications will be reduced considerably.

Updated Response: Partially Implemented.

- DHS has worked with CMS on a new expedited hiring process and will be implementing and robust training of staff as needed to use the new system as efficiently as possible to work toward decreasing the backlog of applications. As staff gain familiarity with IES Phase II, we expect the backlog to decline.

- DHS is reviewing all statewide business processes in order to streamline outdated processes to increase efficiency through the rapid results team.

- HFS has initiated the temporary procurement of an outside contractor to assist the State with the processing of Medicaid long-term care applications, which is expected to have a very positive impact on the backlog of those applications.

Expected Implementation Date: 07/30/2020

8. Work with the Department of Healthcare and Family Services to establish the appropriate controls to monitor eligibility redeterminations, and assign the resources necessary so that redeterminations of eligibility are performed annually as required by the Code of Federal Regulations.

Finding: The Department of Human Services and the Department of Healthcare and Family Services (Departments) did not conduct redeterminations every 12 months as required for eligibility for Medicaid recipients.

In order to determine if redeterminations were performed timely, auditors tested all individuals who received a capitation payment on their behalf to a managed care

Accepted and Implemented – continued

organization during the audit period and reviewed their redetermination dates. The testing results indicated 8,187 individuals' eligibility redeterminations were not performed within the required 12-month period.

The Departments made payments on behalf of these individuals, totaling $71,300,077, for medical services during FY17.

Departments' management stated staff turnover and availability contributed to the delay in completing all of the redeterminations due each month.

Response: Accepted. The redetermination process will be enhanced with the implementation of the newly updated processing system in IES Phase II, which went live on October 24, 2017. In Phase II, both new applications and case maintenance are completed within one system. The IES Phase II system will assist in tracking and auto initiating renewal notices to eligible customers using a three step process. Beginning with cases due for renewal effective February 2018, anyone who is required to return their redetermination notice but does not respond will have their benefits automatically canceled by IES. Previously, these cancelations had to be completed manually by casework staff. Online and classroom training venues are available to all staff using the new system.

Updated Response: Partially Implemented.

Corrective Action Completed:

- The Department completed implementation of the Illinois Integrated Eligibility System (IES) Phase II, which provides enhancements to the redetermination process for many medical cases. This enhancement utilizes a 3-step process:

    1. Selection/Exclusion – The system selects cases eligible for the enhanced, more automated, redetermination process;

    2. Medical Redetermination Clearances – prior to the redetermination due date, the system automatically runs eligibility clearances for the selected cases;

    3. Processing the Redetermination – using the information gathered from the client and from the automated clearance runs, eligibility is determined.

    These capabilities are expected to increase the timeliness of eligibility re-determination completions.

- The Department is also exploring policy options that may expedite redeterminations:

- Task targeting is currently being performed by regions. The regions are targeting overtime to work on both initial SNAP applications and SNAP redeterminations. The offices which are struggling more are being assisted by offices in other regions, especially during overtime. We have begun to see the impact of the targeted work.

- The Department is promoting Manage My Case (MMC) accounts and has also created "handouts" for FCRCs to discuss and provide to clients. The benefits of MMC is also discussed at monthly provider/advocate conferences. In addition, the Department is working on I.D. Proofing to simplify the enrollment process.

- DHS has been researching other states regarding 36 month SNAP certification periods for elderly clients. This would decrease the monthly SNAP redeterminations and interviews required.

Expected Implementation Date: 7/30/2020

9. Work with the Department of Healthcare and Family Services to improve controls over caseworker involvement and system defects by refining supervisory oversight to confirm all applications are properly approved and caseworkers are properly obtaining and retaining documentation in IES to support eligibility. (Repeated-2015)

Finding: The Department of Human Services and the Department of Healthcare and Family Services (Departments) lacked adequate controls over the operation of the State of Illinois' Integrated Eligibility System (IES) to sufficiently prevent the inaccurate determination of eligibility.

The Departments have shared responsibility for various human service programs in the State. This includes the intake, processing, and approval of applications for benefits. The Departments have shared responsibility for internal control over manual and automated processes (such as IES) relating to eligibility for these programs.

The Departments implemented IES for the intake and processing of applications in order to determine eligibility for the State's human service programs. During FY17, the Departments processed:

Applications submitted via IES	677,753
Application approved via IES	496,154
Expenditures associated with applications approved via IES	$1,316,575,345

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Accepted and Implemented – continued

To ensure the accuracy of the Departments' determination, through IES, of eligibility for social service programs, auditors selected the non-financial criteria (citizenship, residency, social security information) for detailed testing. Testing noted 251 distinct applications which were approved even though the IES data indicated the eligibility criteria had not been met. Specifically, applications were approved:

- Without meeting immigration requirements,
- Without verification of citizenship,
- Without verification of residency, and/or
- Without valid Social Security Numbers (SSNs) or documentation of submitted application for SSNs.

As a result of the exceptions noted, the Departments incurred expenditures of $1,028,316 for individuals who may not have been eligible for benefits received.

In addition, auditors selected a statistical sample of 138 distinct applications to determine if they were properly approved based on all eligibility criteria (financial and non-financial). In order to determine if the applications were properly approved, auditors reviewed each distinct application in IES. Testing noted 28 of 138 applications did not contain necessary support.

The Department of Human Services incurred expenditures of $18,571 for these individuals who may not have been eligible for benefits received.

Response: Accepted. The errors noted in the testing of the 138 cases are attributed to casework error. The current transition the Departments were undertaking from one system to another comes with an unfamiliarity of processing procedures and nuances that are still being learned and perfected. During the audit period, casework staff had been required to spend substantial time participating in training of the new system. The transition from paper case records to electronic case records required a massive change in the gathering and maintaining of documentation. Although the new system does allow for proper maintenance of documentation in an electronic format, the conversion to the new process is still being refined. It is expected that as the transition to the new system stabilizes, casework errors will be reduced.

Updated Response: Partially Implemented

TO ADDRESS CASEWORKER ERRORS:
The Department is working to:

- Train staff to reduce caseworker error;
- Communicate the errors found in the audit testing to the field, so training can be targeted accordingly.

TO ADDRESS SYSTEM DEFECTS:
The Department is working to:

- Implement monthly batch job(s) to duplicate SQL queries and exclusions being used by the OAG during the audit to identify if any system defects exist;
- Ensure FCS and HFS review each month's results to identify anomalies or potential financial impacts that would warrant additional action(s);
- Recommend actions to Agency leadership based on each month's review.

Expected Implementation Date: 07/30/2020

10. Work with the Department of Healthcare and Family Services to implement controls over changes to IES. Specifically, develop change control policies, and procedures to control changes. The policies and procedures should include at a minimum:

- **Procedures to generate a complete list of program changes,**
- **Formal documentation authorizing the change by the Departments,**
- **Testing and documentation requirements,**
- **Formal documentation authorizing the change prior to being moved to the production environment.**

In addition, the Department should require that programmers' access be properly restricted and an adequate segregation of duties exists.

Finding: The Department of Human Services and the Department of Healthcare and Family Services (Departments) lacked controls over changes to the Integrated Eligibility System (IES).

In October 2013, the Departments contracted with a vendor for the development and maintenance of IES; however, the Departments were responsible for ensuring proper controls were in place. As noted in the past two audits, the Departments still had not developed policies and procedures to control changes over IES. As such, auditors were unable to determine if changes were properly controlled.

In addition, auditors requested documentation to demonstrate programmers' access was restricted; however, the Departments were unable to provide complete and accurate documentation. During discussions with the Departments, it was also noted vendor programmers had access to the production environment. In fact, a programmer had moved a change into the production environment that caused problems with the use and processing of IES data.

Departments' management stated that control policies and procedures for IES have not been fully documented due to competing IES priorities.

Updated Response: Partially Implemented.

- DHS continues to document the control policies and procedures for IES;

Accepted and Implemented – continued

- Through the Infrastructure Refresh Project, the Department will restrict programmer access and enforce segregation of duties.

Expected Implementation Date: 10/01/2020

11. Work with the Department of Healthcare and Family Services to implement suitable security controls over the computing environment supporting IES.

Finding: The Department of Human Services and the Department of Healthcare and Family Services (Departments) failed to implement adequate security controls over the computing environment supporting the Integrated Eligibility System (IES).

IES is utilized for the intake of applications and the determination of eligibility for the State's human service programs. During FY17, IES determined eligibility for 677,753 applications.

Auditors requested that the Departments provide the population of servers in which IES resides in order to determine the security over the servers. In response, the Department provided a listing of servers; however, during testing, auditors noted servers which were not included on the listing. Due to these conditions, auditors were unable to conclude the Department's population records were sufficiently precise and detailed.

Even given the population limitations noted above, auditors performed testing and noted:

- 209 of 346 servers were running operating systems that were no longer supported by the vendor.
- The IES Disaster Recovery Plan had not been updated to reflect the current environment.

In addition, the Departments' own internal review noted:

- Personal identifiable information (PII) and protected health information (PHI) is exposed in shared service areas.
- Lack of documentation or inaccurate documentation of users on infrastructure devices.
- Separation of duties not being exercised.
- Access privileges are not limited.
- Security functions assigned to personnel outside of security.
- Devices incorrectly configured and not working correctly.
- Server configuration setting maintained only by a vendor.
- Audit logs are not generated.
- Hardware/software contains out of date batches and fixes.
- Password reset questions are maintained in clear text.

Departments' management stated the IES Plan of Action and Milestones included all items identified during this audit. These items are in various stages of development and implementation; several of which require significant time and resources to resolve. The Departments determined that those items presenting the highest risk would be included with the Phase II Go-Live release in October 2017. The remaining items, moderate and low risk, were determined by the Departments as acceptable risks due to compensating or other implemented security controls. The remaining three high risk items are among those that require substantial code and infrastructure changes.

Response: Accepted. The security issues were previously identified by the Departments and a Plan of Action and Milestones were developed to track each issue, with the exception of two items which are tracked in the weekly infrastructure technical meeting. In addition, corrective action plans are in progress for each.

Updated Response: Partially Implemented

Corrective Action Completed:

- The Department has worked to ensure all hardware (servers/components) are included on the Hardware Inventory and maintained in a location accessible by the Department, IES Security and Technical leads;

- For Infrastructure User Access: Current POA&M:
    - All new users submit appropriate documentation for approval/access;

- For Separation of Duties, Least Privilege, Security Functions

    - The Department has worked to ensure there is adequate separation of duties and the Department ensures compliance with Least Privilege and Security Functions.

Corrective Action in Progress:

- Server End of Life (EOL): Extended Support Agreements and/or upgrade completed for EOL software (12 products);
    1. Two products with Extended Support Agreements;
    2. Nine products for which purchase requests were submitted to DoIT and are currently in DoIT procurement process;
    3. One product will not be needed once DB2 is upgraded by DoIT. Task Order has been submitted and planned implementation of DB2 is to be determined.

Accepted and Implemented – continued

- PII/PHI Exposure: Current POA&M
    1. Develop requirements of design: In progress
    2. Application has been updated with requirements, tested and moved to production.

- Incorrectly Configured Devices: Current POA&M
    1. Decommission 2nd LDAP used in IES during infrastructure maintenance transition to DoIT: In progress;
    2. Risk mitigated through use of other controls.

- Server Configuration: Current POA&M
    1. Resolved with infrastructure maintenance transition to DoIT: In progress.

- Audit Logs: Current POA&M
    1. Develop requirements of design: In process;
    2. Application updated with requirements, tested and moved to Production.

- Patches/Fixes: Tracked in weekly Tech meeting
    1. This is an ongoing process as new technology, threats and vulnerabilities are identified;
    2. Moderate to high likelihood of being exploited are prioritized and completed in a timely manner;
    3. Unlikely or unable to be exploited are prioritized as low and worked in relation to other system priorities that may be outside of security;

- Password reset and text: Current POA&M
    1. Remove password: Completed;
    2. Reset accessible only to limited system/security administrators: Completed;
    3. Encryption: Resolved with IES AD moved to DoIT AD structure and with infrastructure maintenance transition to DoIT: In progress.

- Change Management: Current POA&M
    1. State and contractor will work to analyze the impacts of adopting Department of Information Technology (DoIT) tools and processes;
    2. Incorporate DHS change management processes into the JIRA request/approval change.

    Expected Implementation Date: 10/01/2020

12. Work with the Department of Healthcare and Family Services to improve controls over caseworker involvement by refining supervisory oversight to confirm all applications are properly approved and caseworkers are properly

obtaining and retaining documentation in IES to support eligibility. In addition, the Departments should seek reimbursement for improper payments.

Finding: The Departments did not have adequate controls to ensure the social security information of applicants for human services programs was sufficiently supported.

As part of the testing of the Integrated Eligibility System (IES), auditors compared the applications approved utilizing IES to the Social Security Administration (SSA) Master Death Records. 164 approved applicants had applied for services after the date of death associated with the Social Security Number (SSN) the applicant had provided. In addition, 39 approved applicants had death dates associated with the SSN the applicants had provided that were prior to their birth dates within IES.

Auditors reviewed case information within IES for a sample of five cases, noting the case information documented the applicant's SSN as not being valid. However, it appeared each case had been overridden by the caseworker, thus allowing services. As a result, the Departments incurred expenditures of $983,656 for applicants that may not have been eligible for the benefits received.

The Departments' management stated the errors were the result of caseworker error.

Updated Response: Partially Implemented.

Corrective Action Plan Completed:

- The 203 cases (0.019%) identified as having a social security number in question were entered into the system manually and appear to have been entered incorrectly. These cases will be reviewed and corrected. DHS worked with the Social Security Administration Programs Control unit to address those that were not already corrected by the caseworker.

Corrective Action Plan in Progress:

- Discussions with Department Integrated Eligibility System (IES) designers will be held in order to determine if more stringent edits in the system are needed to eliminate the approval of cases with incorrect social security numbers. An IES Enhancement Request (ILIES 250102) was logged October 8, 2018. The enhancement will notify a case worker via a pop-up message that the worker is attempting to certify an individual for which the SSN has not been verified through clearances in order to help eliminate future SSN entry errors.

  Expected Implementation Date: 10/31/2019

Accepted and Implemented – continued

13. Direct management and staff to strengthen controls over records maintenance for each area in which a compliance requirement is present. To every extent possible, number population records sequentially.

Finding: The Department was unable to provide adequate records substantiating the completeness of populations for one or more laws, regulations, or other requirements selected for testing, as of the end of fieldwork. Due to these conditions, auditors concluded the Department's population records were not sufficiently precise and detailed according to the following:

- While testing compliance with awards and grants, auditors were unable to obtain adequate records substantiating a complete population of all state grants overseen by the Department.
- The Department could not provide a complete Mandate Listing governing its operations.
- While testing compliance with the Community-Integrated Living Arrangements (CILA) Licensure and Certification Act, auditors were unable to obtain an adequate listing to substantiate a complete population of Notices of Violation (NOV) for CILA community agencies.
- While testing compliance with various Mental Health and Developmental Disabilities Administrative Acts Ludeman Developmental Center was unable to substantiate the population of clients under its care, released from its care, or restrained during care.
- While testing compliance with the Mental Health and Developmental Disabilities Code, Alton Mental Health Center, Chester Mental Health Center, Choate Mental Health and Developmental Center, and Elgin Mental Health Center were unable to provide adequate records substantiating the population of individuals requesting information on residents' admissions.
- While testing compliance with the Mental Health and Developmental Disabilities Code, the Ludeman Developmental Center was unable to provide adequate records substantiating the population of all clients who were under the care of the facility during the examination period.

Upon testing, the auditors reported noncompliance for Finding 2017-014 for the CILA Act (210 ILCS 135/4); Finding 2017-018 for the Mental Health and Developmental Disabilities Administrative Act (20 ILCS 1705/7); Finding 2017-015 for the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-108(g) thru 5/2-108(h)); Finding 2017-017 for the Mental Health and Developmental Disabilities Code (405 ILCS 5/4-704), (405 ILCS 5/2-113(a) through (f)), and (405 ILCS 5/4-203).

Department management indicated that substantiating a complete population was difficult based on the nature of the populations.

Updated Response: Partially Implemented.

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Corrective Action Completed:

DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)

- Appropriate staff at Ludeman and Choate have been retrained on how to properly input information into the Clinical Inpatient System and how to print appropriate e-reports to be able to correctly provide the Center's populations.

- The Regional Management of State Operated Developmental Centers (SODC) Operations has conducted random checks of these Center's reports to monitor compliance.

DHS – BALC

- BALC has two employees who are responsible for reviewing the Survey Results Form (Notice of Violations – NOV) and entering data. The supervisors then conduct random samples to check for accuracy.

- The BALC database manager ensures the reports accurately reflect the entered information.

- An Administrative Assistant I was hired for BALC.

Corrective Action in Progress:

DHS – BUDGET

- The Department's Office of the Budget discussed with the external auditors on 3/21/2019 what information is needed on awards and grants to identify a complete population for the auditors. Office of the Budget is currently working on gathering the information for the upcoming compliance examination.

OFFICE OF LEGISLATION/DHS LEGAL

- The complete version of State of Illinois legislation is published by the Secretary of State and can be found at www.ilga.gov. DHS Legal can provide a list of most of the statutes related to DHS and Legislation keeps a list of new statute changes after each legislative session. DHS can provide the information that is complete to the best of our knowledge.

DHS – BALC

- BALC is in the process of updating the process and procedure manual to reflect the changes related to reviewing the Survey Results Form/Notice of Violation (NOV).

Accepted and Implemented – continued

DIVISION OF MENTAL HEALTH (DMH)

- Department could not provide populations and records requested while testing compliance with various Mental Health and Developmental Disabilities Administrative Acts:

    - DMH will develop and implement a Phone Inquiry Form for staff to compile all required information when an inquiry is made about a patient's presence at a mental health center (MHC);

    - DMH will develop and implement a Phone Inquiry Tracking spreadsheet to maintain an ongoing mechanism of tracking those who call to inquire about a patient's presence in a facility.

    Expected Implementation Date: 7/30/19

14. Comply with the law by completing and adopting rules related to the assignment and operations of monitors and receiverships for CILA arrangements as required by statute. In addition, improve internal controls over providing timely reviews of substantiated allegations. Lastly, adopt a reasonable date for providing information on the website for each agency regarding licensure and quality assurance survey results; licensure and contract status; and substantiated findings of abuse, egregious neglect, and exploitation, as specified in the applicable Act.

Finding: The Department failed to finalize and implement certain community integrated living arrangement (CILA) rules. Further, the Department failed to adequately monitor CILA providers during the examination period.

Failure to Finalize and Implement Rules

The Community-Integrated Living Arrangements Licensure and Certification Act (210 ILCS 135/9) states that by December 31, 2011, the Department shall adopt rules under the Illinois Administrative Procedure Act that govern the assignment and operations of monitors and receiverships for community-integrated living arrangements wherein the Department has identified systemic risks to individuals served. The rules are required to specify the criteria for determining the need for independent monitors and receivers, their conduct once established, and their reporting requirements to the Department. These monitors and receivers shall be independent entities appointed by the Department and not staff from State agencies.

During the examination period, auditors noted the Department had drafted but had not yet finalized and implemented rules related to the assignment and operations of monitors and receiverships for CILAs as required by the Act.

Department management stated the proposed, draft language for this rule amendment has been completed and reviewed by the DD Regulatory Advisory Board (Board); however, the proposed amendment is tied to other needed changes to the rule, which are still pending with the Board. Department management stated it is a statutory requirement (405 ILCS 80/11-1) that any Rule 115 revisions be reviewed and commented upon by this Board. According to the Department, the Board has not completed this due to competing priorities.

Failure to Follow-up on Substantiated Allegations and Publishing Testing Results on Website

The Community-Integrated Living Arrangements Licensure and Certification Act (210 ILCS 135/4 (g-5)) states as determined by the Department, a disproportionate number or percentage of licensure complaints; a disproportionate number or percentage of substantiated cases of abuse, neglect, or exploitation involving an agency; an apparent unnatural death of an individual served by an agency; any egregious or life-threatening abuse or neglect within an agency; or any other significant event as determined by the Department shall initiate a review of the agency's license by the Department, as well as a review of its service agreement for funding. The Department shall adopt rules to establish the process by which the determination to initiate a review shall be made and the timeframe to initiate a review upon the making of such determination.

For all three community agencies which had substantiated allegations in FY17, the Department could not provide supporting documentation that the community agencies had been subsequently reviewed by the Department, as of the testing date in December 2017.

In addition, the Community-Integrated Living Arrangements Licensure and Certification Act (210 ILCS 135/14) states that by July 1, 2012, the Department shall make available through its website information on each agency regarding licensure and quality assurance survey results; licensure and contract status; and substantiated findings of abuse, egregious neglect, and exploitation. The Department shall adopt rules regarding the posting of this information and shall inform individuals and guardians of its availability during the initial provider selection process.

During the examination period, it was noted the oversight activities conducted by the Department were not published as of the testing date in December 2017.

Department management indicated insufficient staff resources were the cause for the delays.

Updated Response: Implemented.

- The BALC database manager provides updated survey results quarterly to the Division of Developmental Disabilities personnel for posting on the DDD webpage. This practice began February 20, 2018 followed by an update on April 25, 2018.

Accepted and Implemented – continued

15. Establish comprehensive Department-wide policies, procedures, and internal controls over compliance with State mandates regarding the use of restraints that is applicable to all Facilities. These policies, procedures, and internal controls should include requirements for training personnel on compliance requirements and should outline management oversight over compliance requirements. (Repeated-2011)

Finding: The Department did not comply with statutory requirements regarding the use of restraints.

Auditors performed on-site testing regarding the use of restraints across all seven facilities sampling a total of 73 employees who administered restraints and 73 residents who were placed in restraints, which resulted in the following exceptions at five of the Department's facilities:

Alton Mental Health Center

- Two out of 9 employees tested did not receive the required annual training in the safe and humane application of the type of restraint used and type of restraint that was authorized by the facility. Training was completed 24 to 221 days after the date the restraints were applied.
- For 6 out of 9 (78%) residents placed in restraints, the facility Director or designee was not informed in writing of the use of the restraint within 24 hours by the person who ordered the restraint.

Chester Mental Health Center

- For 3 out of 10 residents placed in restraints, facility staff did not obtain prior written authorization by the facility Director prior to employing the use of restraints again within 48 hours after restraints were first used.

Elgin Mental Health Center

- For 9 out of 9 residents placed in restraints, it could not be determined if the person who applied the restraint was appropriately trained in the use of restraints.

- For 3 out of 9 residents placed in restraints, the facility Director or designee was not informed in writing of the use of the restraint within 24 hours by the person who ordered the restraint.

Ann M. Kiley Developmental Center

- For 2 out of 9 residents placed in restraints, the facility Director or designee was not informed in writing of the use of the restraint within 24 hours by the person who ordered the restraint.

Ludeman Developmental Center

- For 1 out of 9 residents placed in restraints, adequate documentation was not maintained for a restraint order**.**

- For 2 out of 9 residents placed in restraints, adequate documentation was not maintained for the type of restraint used.
- For 3 out of 9 residents placed in restraints, adequate documentation was not maintained that the facility Director or designee was informed in writing of the use of the restraint within 24 hours by the person who ordered the restraint.
- For 2 out of 9 residents placed in restraints, adequate documentation was not maintained regarding the necessity of the restraint.
- Three out of 9 employees tested did not receive the required annual training in the safe and humane application of the type of restraint used and type of restraint that was authorized by the facility.

The Mental Health and Developmental Disabilities Code (MH Code) (405 ILCS 5/2-108(a)) requires a written order of a physician, clinical psychologist, clinical social worker, clinical professional counselor, or registered nurse with supervisory responsibilities to employ the use of restraint. The MH Code requires the person who ordered the restraint to inform the facility Director or his designee in writing of the use of the restraint within 24 hours. The MH Code requires the facility Director to review all restraint orders daily and inquire into reasons for the orders for restraint by any person who routinely orders them. The MH Code states that restraints may be employed during all or part of one 24-hour period, the period commencing with the initial application of the restraint. However, once restraint has been employed during one 24-hour period, it shall not be used again on the same resident during the next 48 hours without the prior written authorization of the facility director. Finally, the MH Code mandates all employees authorized to employ restraints on patients receive training in the safe and humane application of restraints and is required to maintain records detailing which employees have been trained and are authorized to apply restraint, the date of the training, and the type of restraint that the employee was trained to use.

Department management indicated the situation was due to a combination of staff turnover and policies and procedures not being followed.

Updated Response: Implemented

- Policy TX.06.00.00.03, Use of Restraint and Seclusion, has been revised to reflect that the Administrator on Duty is the designee of the Hospital Administrator on Duty for notifications;

- Appropriate staff at the DD Centers have been retrained on Administrative Directive 02.02.06.030 for training staff and the statutory requirements regarding the use of restraints;

- The Division has developed and implemented Quality Assurance checks at the DD Centers to ensure statutory requirements regarding Facility Director/Designee notification and annual training requirements are adhered to.

Accepted and Implemented – continued

- The Regional Management of SODC Operations have developed a periodic Quality Assurance Report requiring all Centers to monitor/verify compliance in these areas.

16. Enforce adequate policies and procedures to ensure compliance with the MH Act regarding visitors to facilities. The policies and procedures should include training personnel on compliance requirements and implement management oversight over compliance requirements.

Finding: The Department did not comply with statutory requirements regarding the monitoring of facility visitors.

The Mental Health and Developmental Disabilities Administrative Act (MH Act) requires the facility's director to develop and implement written policies and procedures to insure that employees and visitors are properly identified at all times they are on the grounds of the facility.

During fieldwork, auditors performed on-site testing at seven of the Department's State-operated facilities regarding monitoring of facility visitors, sampling and testing 64 entry logs across the seven facilities. The testing of entry logs resulted in the following exceptions at two of the Department's facilities:

Ann M. Kiley Developmental Center

- For 6 out of 9 entry logs tested, switchboard sign-in sheets were not provided. In addition, 1 visitor signed in at the switchboard but did not sign in at the home of the individual being visited.

Ludeman Developmental Center

- Six out of 9 entry logs tested were incomplete. Dates, purpose of visit, time-in, or time-out information were missing on the entry logs.

Department management indicated the discrepancies noted were due to staff error and failure to update records.

Updated Response: Implemented

- DHS has developed and implemented Quality Assurance checks at the DD Centers to ensure monitoring and compliance of 20 ILCS 1705/47 and the Center's Visitor Policy;

- All staff at the DD Centers have been retrained on 20 ILCS 1705/47 & the Center's Visitor Policy;

- The Regional Management of SODC Operations has developed a periodic Quality Assurance Report requiring all Centers to monitor and verify compliance in this area.

17. Review systems of internal control over compliance to ensure:

- **The Department's policies and procedures at each facility are up-to-date with current law and communicated to all staff;**
- **Facility-level and Department-wide training on the Department's policies and procedures for areas with recurrent noncompliance or complexity are performed; and,**
- **A monitoring process is functioning to timely identify areas of noncompliance with State laws and Department policies at the facilities and implement corrective action.**

Finding: The Department did not comply with statutory requirements regarding residents' admissions and discharges.

Noncompliance with Resident Admission Rules and Regulations

The Mental Health and Developmental Disabilities Code (MH Code) (405 ILCS 5/2-113(a)) requires that upon admission, the facility inquire of the resident if a spouse, family member, friend, or an agency is to be notified of their admission. Good internal control requires employees to complete an admission form and maintain a copy of the admission form in the resident's file. The form should be signed by the employee making the inquiry of the resident.

Additionally, the MH Code states, "Any person may request information from a developmental disability or mental health facility relating to whether an adult recipient or minor recipient has been admitted to the facility. Any parties requesting information must submit proof of identification and list their name, address, phone number, relationship to the recipient, and reason for the request. The facility shall respond to the inquirer within 2 working days. If the recipient is located at the facility, the facility director shall inform the recipient of the request and shall advise the recipient that disclosure of his presence at the facility will not obligate the recipient to have contact with the inquirer. No information shall be disclosed unless the recipient consents in writing to the disclosure."

Auditors performed on-site testing at seven of the Department's State-operated facilities regarding resident admissions. Auditors sampled and tested 65 residents across the seven facilities, and found many exceptions to the resident admission rules and regulations at the Alton, Chester, Choate, and Elgin Centers.

The MH Code states, "A person with an intellectual disability shall not reside in a Department mental health facility unless the person is evaluated and is determined to be a person with mental illness and the facility director determines that appropriate treatment and habilitation are available and will be provided to such person in the unit. In all such cases the Department mental health facility director shall certify in writing within 30 days of the completion of the evaluation and every 30 days thereafter…."

Accepted and Implemented – continued

Additionally, the MH Code requires any person admitted to a Department mental health facility to be evaluated within a reasonable period of time, but in no case should that period exceed 14 days after admission….

The MH Code requires every developmental disabilities facility to maintain adequate records which should include information regarding the section of the MH Code under which the resident was admitted, any subsequent change in the resident's status, and requisite documentation for such admission and status….

During fieldwork, auditors performed on-site testing at five of the Department's State-operated facilities regarding residents with intellectual disabilities and mental illness. Auditors sampled and tested 60 residents across four facilities, which resulted in the exceptions at five of the Department's facilities: Alton, Chester, Choate, Elgin, and Ludeman. Some of the exceptions were as follows:

Alton Mental Health Center

- For 3 out of 15 (20%) residents tested, the residents were ruled out from having a mild or moderate intellectual disability during the period but were not removed from the facility's listing.
- For 11 out of 15 (73%) recipients tested, the recipients had habilitation plans that did not contain information on the role of the family/guardian in the implementation of the plan.

Chester Mental Health Center

- Facility staff did not adequately complete all monthly reports for dually diagnosed persons.

Clyde L. Choate Mental Health and Developmental Center

- For 1 out of 15 (7%) residents tested, facility staff did not timely complete the evaluation of patients reasonably suspected of being mildly or moderately intellectually disabled and also have a mental illness. The evaluation was completed 1 day late.

Elgin Mental Health Center

- For 5 out of 15 (33%) residents tested, the facility Director did not certify in writing within 30 days of the completion of the evaluation the recipient had been appropriately evaluated. The Director's certifications were completed between 2 and 34 days late.
- For 2 out of 15 (13%) residents tested, the resident's treatment plans did not have a timestamp or date of when the plan was made.
- For 5 out of 15 (33%) residents tested, the resident's treatment plan was not reviewed and updated every 30 days.

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Ludeman Developmental Center

- For 1 out of 9 (11%) residents tested, adequate documentation was not maintained for the section of the MH Code under which the resident was admitted.

Noncompliance with Resident Discharge Rules and Regulations

The Mental Health and Developmental Disabilities Code (MH Code) (405 ILCS 5/4-704(a)) requires the facility Director to give written notice of the discharge to the resident, if he or she is 12 years of age or older, to the attorney and guardian, if any, to the person who executed the application for admission, and to the resident's school district when appropriate, at least 14 days prior to the discharge of a resident from a Department developmental disabilities facility under Section 4-701 or 4-702 of the MH Code. The notice, except that to the school district, should include the reason for the discharge and a statement of the right to object.

Additionally, the MH Code requires the facility Director to give written notice of discharge from a Department mental health facility to the recipient, his attorney, and guardian, if any, or in the case of a minor, to his attorney, to the parent, guardian, or person in loco parentis who executed the application for admission, to the resident school district when appropriate, and to the minor if he is l2 years of age or older. The notice, except that to the school district, should include the reason for discharge and a statement of the right to object. Whenever possible, the notice should be given at least 7 days prior to the date of intended discharge.

During fieldwork, auditors performed on-site testing at four of the Department's State-operated facilities regarding discharge rules and regulations and found exceptions at Ludeman Developmental Center.

Department management indicated the discrepancies noted were due to staff error, the use of paper records, and failure to update records.

Updated Response: Partially Implemented.

Corrective Action Completed:

DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)

- Appropriate staff at the DD Centers have been retrained on the statutory requirements (405 ILCS 5/2-113 & 405 ILCS 5/3-903) regarding Residents' Admissions and Discharges;

- The Division has developed and implemented Quality Assurance checks at the DD Centers to ensure compliance with statutory requirements;

- The Regional Management of SODC Operations has developed a periodic Quality Assurance Report requiring all Centers to monitor/verify compliance in these areas.

REVIEW: 4486

Accepted and Implemented – continued

DIVISION OF MENTAL HEALTH (DMH)

- Regarding record keeping issues with Dually Diagnosed population, the Department of Mental Health's Office Associate was retrained regarding the process;

- Elgin made changes including training and certifying additional staff, moving the responsibility for tracking compliance to the Director of Clinical Services, and developing improved treatment and habilitation formats for staff use. Compliance has been 100% timely certification for one month as reported to the Quality Council;

- As of October 17, 2017, the Alton Mental Health Center (MHC) has begun scanning all clinical documentation to protect against potential loss and ease of access;

- Nursing staff were trained on completion of the Nursing Intake Note, which includes the notification of patient admission;

- Social work staff complete the Mental Illness and Intellectual Disability Redetermination form on all patients diagnosed as intellectually disabled. Alton MHC identified that while patients were being assessed by Psychology staff, Psychiatric staff were assigning a provisional diagnosis, but discussions were not occurring to eliminate the diagnosis of those that were ruled out through testing. Alton MHC fostered collaboration and communication and updated the policy.

DIVISION OF MENTAL HEALTH (DMH)

- Policy RI 03.05.03.02, Request for Patient Information, has been revised to address the finding. Chester Mental Health Center implemented the policy on 5/24/2018.
- The Chester Mental Health Center implemented use of the IL Application of Voluntary Admission form on 11/21/2017.

Corrective Action in Progress:

Elgin Mental Health Center

- The center will implement the Application of Voluntary Admission form for voluntary admissions following training on its use. Use will be audited for 3 months to ensure compliance.

Expected Implementation Date: 6/1/2019

18. Obtain and retain a record of all residents' medical care. Further, establish comprehensive Department-wide internal controls over compliance with the MH Act regrading dental, mental, or physical examinations, which should include training personnel on compliance requirements and outline management oversight over compliance requirements.

Finding: The Department did not comply with statutory requirements regarding residents' dental, mental, and physical examinations at Elgin Mental Health Center.

During fieldwork, auditors performed on-site testing at seven of the Department's State-operated facilities regarding resident dental, mental, and physical examinations. Auditors sampled and tested 66 residents across the seven facilities, which resulted in the following exceptions at one of the Department's facilities:

Elgin Mental Health Center

- For 4 out of 9 (44%) residents tested, facility staff did not maintain adequate documentation to determine if dental examinations were completed every 18 months. For one of these residents, no dental treatment records were located in the resident's chart. For three of these residents, dental treatment records were located in the resident's charts, but the forms were blank.
- For 5 out of 9 (56%) residents tested, the residents did not have a dental examination performed at least once every 18 months.
- For 1 out of 9 (11%) residents tested, facility staff did not maintain adequate documentation to determine if a comprehensive psychiatric evaluation was completed on an annual basis during the examination period.
- For 1 out of 9 (11%) residents tested, facility staff did not maintain adequate documentation to determine if a physical examination was completed on an annual basis during the examination period.

Department management indicated the discrepancies noted were due to staff turnover and staff error.

Response: Accepted. The Center did not have a dentist for part of the period in question and contractual dental services were not adequate to meet requirements. The Center has hired a dentist who has been able to address backed-logged cases. In addition, the Department will implement a process to obtain and retain a record of all residents' medical care. The Department will also establish comprehensive Department-wide internal controls over compliance with the MH Act regarding dental, mental, or physical examinations, which will include training personnel on compliance requirements and ensuring management oversight over compliance requirements. In addition, the Department notes that the Office of the Auditor Generals Audit Guide Exhibit 24-B incorporates AICPA Statement on Standards for Attestation Engagements Section 205.A18 (Standard) issued in April 2016 which provides qualitative and quantitative factors in assessing materiality.

Updated Response: Implemented.

Accepted and Implemented – continued

- The Center has hired a Dentist that started full-time employment at Elgin Mental Health Center (EMHC) and who has been able to address backed-logged cases.

- The dentist is now completing dental examinations of all patients who were in the hospital for 12 months (Statute requires completion within 18 months', but management determined this is impractical to track), as well as all whose previous dental examinations were approximately (but not more than) 12 months previously. This was completed by September 30, 2018;

- The MHC developed a process and trained staff to maintain adequate documentation to determine if a physical examination was completed on an annual basis. Policy 1520 was revised to require transferred patients to be treated as admissions;

- The MHC developed a process and trained staff to maintain adequate documentation to determine if a comprehensive psychiatric evaluation was completed on an annual basis. Policy 1520 was revised to require transferred patients to be treated as admissions.

19. Obtain and retain approval documentation for providing medical care to a resident prior to conducting the care. Retain a record of all residents' medical care provided. Further, establish comprehensive Department-wide internal controls over compliance with the MH Act regarding pregnancy testing and residents' menstrual cycles, which should include training personnel on compliance requirements and outline management oversight over compliance requirements.

Finding: The Department did not comply with statutory requirements regarding administering pregnancy tests and recording resident's menstrual cycles.

During fieldwork, auditors performed on-site testing at six of the Department's State-operated facilities. They sampled and tested 60 residents across the six facilities, which resulted in the following exceptions regarding resident records at Alton, Elgin, Kiley, and Ludeman Centers.

Department management indicated the discrepancies noted were due to staff error, staff turnover, and failure to update records.

Updated Response: Implemented.

DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)

- Appropriate staff at the DD Centers have been retrained on the statutory requirements (20 ILCS 1705/10.1) regarding consent for pregnancy testing and proper filing of such documentation as well as the requirements for maintaining menstruation records.

DIVISION OF MENTAL HEALTH (DMH)

- Department of Nursing (DON) has provided retraining to all Registered Nurses (RN's);
- Menstrual Record has been added to the audit sheet to ensure compliance.

20. Allocate sufficient resources to improve compliance with the Code and the CRP Manual for monitoring provider agencies who were Division of Rehabilitation Services (DRS) grant recipients. Also, submit the Independent Living Council State Plan annually. Lastly, formal processes and procedures regarding timely communication of deficiencies identified from the internal paper review. (Repeated-2013)

Finding: The Department did not adequately monitor Independent Living Program provider agencies which were Division of Rehabilitation Services (DRS) grant recipients. Further, the Department did not comply with the Rehabilitation of Persons with Disabilities Act regarding the annual Independent Living Council State Plan.

Inadequate Monitoring of Provider Agencies

During 2017, the Independent Living Unit within the DRS implemented an internal paper review process, where information was received from all its 22 provider agencies and combined for Federal Reporting purposes. However, the Department had not developed formal processes and procedures to allow the Independent Living Unit to report any deficiencies to the 22 provider agencies in a timely and systematic manner.

Department management indicated they did not develop formal processes and procedures due to competing priorities.

Furthermore, testing of the Department's monitoring of the Independent Living Program provider agencies revealed the following:

- Timely on-site compliance reviews were not conducted for 12 out of 22 providers (55%) in the Independent Living Program within the last three years. Reviews were last conducted for the 12 providers between 2006 and 2011.

  Department management indicated staffing vacancies led to instances where on-site reviews were not completed timely.

  The Department performed nine on-site reviews at provider agencies during FY16 and FY17. One written report of the review was sent to the provider 39 days late. Department management indicated staffing vacancies led to instances where reports were not completed timely.

Accepted and Implemented – continued

Inadequacy in Filing the Annual State Plan

During the examination period, the Department submitted an Independent Living Council State Plan that covered a three-year period. The Independent Living Council State Plan should be submitted to the Commissioner of the Rehabilitation Services Administration in the United States Department of Education on an annual basis.

Department management indicated a three-year plan was developed because of competing priorities.

Updated Response: Implemented.

- A Project Officer and Program Manager have been hired to help manage the workload and are working in their respective roles regarding monitoring the Centers for Independent Living (CILs).

21. Execute all interagency agreements as required by law. In addition, all parties to the IGAs should sign the agreement prior to the effective date. Further, enter into interagency agreements with HFS, other State agencies, and the sheriffs' offices of every Illinois County which do not have signed agreements. (Repeated-2015)

Finding: The Department failed to adequately execute interagency agreements.

Auditors noted the following:

- The Department did not have an interagency agreement with the Department of Healthcare and Family Services (HFS) to govern the administration of the Home Services Medicaid Trust Fund (Fund 0120). Total revenues and expenditures for Fund 0120 for the year ended June 30, 2017 were $246,868,000 and $234,727,000, respectively.

  Department management stated it has an interagency agreement with HFS; however, it is out-of-date and not comprehensive.

- During testing of interagency agreements between the Department and multiple other State agencies, 6 out of 33 interagency agreements sampled were not signed before the effective date. These agreements were signed between 2 and 235 days after the effective date.

  Department management stated they believe the Department cannot control the internal processes by which other governmental agencies decide when and if to sign interagency agreements.

- The Department did not enter into intergovernmental agreements (IGAs) with all sheriff offices, in order to collect incarceration data to determine if those individuals

were still eligible for benefits administered by the Department.

Department management stated they believe the Department cannot control the internal processes by which other governmental agencies decide when and if to sign IGAs. Also, the exception (pertaining to IGAs with all sheriff offices) exists due to the non-cooperation or unwillingness of county sheriff's departments in agreeing to share data with the Department.

- The Department did not enter into an interagency with the Department of Children and Family Services (DCFS), HFS, the State Board of Education (ISBE), the Department of Juvenile Justice (DJJ), and the Department of Public Health (DPH) as of June 30, 2015, as required. The Department ultimately entered into the interagency agreement on April 19, 2016, 294 days late.

  Department management indicated the delay was due to the involvement of multiple agencies.

Response: Accepted. DHS is working with DoIT to create an internal/external tracking system to ensure that all deadlines are met in regards to intergovernmental agreements.

DHS will work to renew IGAs with the Department of Healthcare and Family Services (HFS) to govern the administration of the Home Services Medicaid Trust Fund (Fund 0120).

Although the Department has not been successful in entering into IGAs with all Illinois Sheriffs, we have performed the following in order to improve our success rate. In December, 2017, the Department's Bureau of Performance Management sent letters to each Illinois Sheriff, requesting their cooperation in identifying ineligible, incarcerated SNAP recipients by reviewing and signing an IGA. In addition, Department staff initiated and held a meeting with the Executive Director of the Illinois Sheriff's Association (ISA) in an effort to improve communication, clarify our goal in entering into the IGAs and obtain their support to assist in cooperation of the sheriffs. Also, the Department relies upon the county sheriffs to agree to cooperate however, the law does not require cooperation from the county sheriffs. The Department has requested a change to the state statute language from "…shall enter into IGAs with all Sheriffs", to "…..may enter into IGAs with all Sheriffs." The proposed change did not progress through the 99th General Assembly. The Department will request a similar change of the 100th General Assembly later in 2018. The Department has also begun some discussion with DHS-Legal, in order to find ways that make the Intergovernmental Agreement process less formal and more accommodating, in an attempt to generate more participation and cooperation with county sheriffs.

Updated Response: Partially Implemented.

Corrective Action Completed:

Accepted and Implemented – continued

FAMILY AND COMMUNITY SERVICES (FCS)

- The Division of Family and Community Services (FCS) sent request letters to all Illinois Sheriffs, requesting cooperation with the required IGA;

- FCS met with the Illinois Sheriff's Association to obtain support of our efforts to enter IGAs with Illinois Sheriffs.

Corrective Action in Progress:

FAMILY AND COMMUNITY SERVICES (FCS)

- Work with IDHS Legislation to modify the statute to require the Illinois Sheriffs to cooperate with IGA requests. HB2941 represents our proposed change, and on March 6, 2019, passed out of the House Human Services Committee and is currently in the queue for 3rd reading in the House.

DIVISION OF REHABILITATION SERVICES (DRS)

- DHS will work to renew Interagency Agreements with HFS.

DHS-GENERAL COUNSEL

- DHS is working with DoIT to create an internal/external tracking system to ensure that all deadlines are met regarding IGAs. Due to a major workflow re-design, the deadlines have been adjusted. The current plan is to test the system by 5/1/19 and roll it out on 6/5/19.

  Expected Implementation Date: 06/30/2019

22. Strengthen internal controls and compliance over the Home Services Program as follows:

- **Increase monitoring by assigning additional staff resources or by enacting alternative means for monitoring program activities.**
- **Perform customer redeterminations in accordance with the Department's Administrative Rules governing the Home Services Program. (Repeated-2005)**

Finding: Internal control weaknesses were identified in the Department's Home Services Program managed by the Department's Division of Rehabilitation Services. These weaknesses were first noted in a review of the Home Services Program that Department management had performed in FY2005.

The Home Services Program allows individuals with disabilities (customers) who are at risk of placement in a nursing home to remain in their homes. According to the

Department, this is accomplished through the use of a variety of services, the most prevalent of which is the use of individual caregivers known as Personal Assistants. During FY17 and FY16, the Home Services Program maintained 45 field offices and, over the course of FY17 and FY16, on behalf of the customers, paid 39,713 Personal Assistants $449,367,292 and 39,025 Personal Assistants $439,983,207, respectively. Personal Assistants are hired, supervised, and fired by the customer. Therefore, the Home Services Program relies on the customer under an "honor system" to guard against abuse and to ensure compliance. The customer is responsible for approving and signing their Personal Assistant's timesheets.

Through testing and discussions with Home Services Program personnel, auditors noted the following:

- There was insufficient monitoring of case files to ensure program objectives were being met. There was an average of 37 supervisors at 45 field offices to monitor Home Services Program activities. On average, each supervisor was responsible for approximately 792 case files during FY17 and FY16. There was an average of 135 counselors during FY17. There was an average of 217 case files per counselor during FY17.
- The customer receiving services is to be visited by the Case Counselor once annually and the counselor is to perform a redetermination of need. In circumstances of a traumatic brain injury, the customer is to be visited twice annually. Five out of 20 personal assistant payments tested, totaling $4,809, were without a redetermined service plan. The services performed ranged from 64 to 754 days after the required redetermination period, as indicated on the customer service plan.

Department management indicated that staffing levels and the overall scale of the program contributed to the issues identified.

Updated Response: Partially Implemented.

Corrective Action Completed:

- Administrative code changes related to Home Services Program compliance, and Specifically the TBI waiver were adopted 1/24/2019;
- The Home Services Program (HSP) has revised internal quality tools to monitor and automate, where possible, policy compliance methods and to ensure all service settings are inclusive rather than institutional;
- The Home Services Program deployed 9 regionally based Rehabilitation Service Advisors throughout the State to monitor and assist with programmatic issues at a regional and local office level; this is an increase of 4 new positions.
- DRS continues to monitor caseloads and staffing and continually reviews the needs for staff in each office to most appropriately serve their customer base.

Accepted and Implemented – continued

- DRS continually works to fill office supervisor positions as they become open, as well as create a series of supervisor support roles to provide coverage and assistance during a prolonged vacancy.

Corrective Action in Progress:

- Beginning November 14, 2016 overtime was authorized for counselors to assess additional redeterminations. From November 2016 to current we have reduced the number of overdue redeterminations from 12,339 to 3,071. We will continue to work to reduce the number of overdue redeterminations;

- The finding cites there was an average of 37 supervisors at 45 offices and each supervisor is responsible for an average of 792 casefiles in FY16/17 and 797 during FY14/15. Also, during FY17 there was an average of 135 counselors (average of 217 case files per counselor) and during FY16 an average of 120 counselors (average of 244 case files per counselor). As of March 2019 there are 130 Caseworkers with a total of 29,506 total caseloads for an average of 227 cases per counselor. The Division is actively seeking to fill vacancies.

  Expected Implementation Date: 07/30/2019

23. Comply with the written policies and procedures setting forth the circumstances under which a facility or agency response to an OIG investigative report is required and policies for documenting the dates investigative reports are provided to facility or agency personnel. Also, direct facility or agency management to improve internal controls over providing timely written responses to OIG investigative reports. Finally, add the required identifiers to its database to capture information on dependents of military service members who are absent from the State due to the member's military service. (Repeated-2015)

Finding: The Department did not have adequate internal controls to comply with certain provisions of the Department of Human Services Act.

State law requires that the Department compile and maintain a cross-disability database of Illinois residents with a disability who are potentially in need of disability services funded by the Department. During testing, auditors noted the following noncompliance:

Approval of written responses

Statute requires that within 30 days from receipt of an OIG substantiated investigative report, the facility or agency must file a written response. The response includes the implementation and completion dates of the actions. If the written response is not filed within the allotted 30 calendar day period, the Secretary of the Department shall

determine the appropriate corrective action to be taken. The Secretary of the Department is required by the Act to accept or reject the facility's or agency's written response.

- For 3 out of 25 (12%) investigative reports tested that required a written response from the facility, the written responses were not received within the required 30 days.
- For 3 out of 25 (12%) investigative reports tested that required a written response from facility, documentation of the date the OIG report was received by the facility as not maintained.

Department management stated that during the impasse, the Department did not have U.S. Postal Service (USPS) funds to send out substantiated case reports via USPS certified mail. The Department either sent the substantiated cases out via email, hand delivered (facility) or fax (agency) and some of the dates received were not tracked appropriately.

Dependents of Military Service Members

The Act (20 ILCS 1305/10-26(d)) states, "The Department shall allow legal residents who are dependents of a military service member and who are absent from the State due to the member's military service to be added to the cross-disability database to indicate the need for services upon return to the State."

- Auditors noted the Department did not track military related identifier(s) in its cross-disability database and, therefore, could not identify dependents of military service members within its cross-disability database in order to determine needs for services upon return to the State. Department management indicated the deficiency noted above was due to employee oversight.

Response: Accepted. The Division of Developmental Disabilities will request DoIT to make necessary changes to the Prioritization of Urgency of Need for Services (PUNS) database to capture information on dependents of military service. In addition, the Division of Mental Health concurs that it should improve internal controls over the OIG investigative reports and ensure that the necessary responses are prepared and filed in a timely manner. Specifically, the Director's office will establish a log of OIG investigative reports received, indicating the date received and whether a response is due and to which facility. The Director's office will also continue to monitor the responders to ensure responses are returned in a timely fashion and if not, the rationale for the delay. Finally, the Director's office will work with the OIG to ensure compliance with the policies and procedures. In addition, the Department notes that the Office of the Auditor Generals Audit Guide Exhibit 24-B incorporates AICPA Statement on Standards for Attestation Engagements Section 205.A18 (Standard) issued in April 2016 which provides qualitative and quantitative factors in assessing materiality. This new Standard had an impact in the repeat audit finding type being modified from a significant deficiency and noncompliance last year to a material weakness and material noncompliance this year.

Updated Response: Partially Implemented.

REVIEW: 4486

Accepted and Implemented – continued

Corrective Action Completed:

DIVISION OF MENTAL HEALTH (DMH)

- The Division of Mental Health improved internal controls over the process related to OIG investigative reports to ensure that the necessary responses are prepared and filed in a timely manner;

- The Director's Office established a log of OIG investigative reports received, indicating the date received and whether a response is due and to which facility. The Director's Office monitors the responders to ensure responses are returned in a timely fashion and if not, the rationale for the delay;

- The Director's office works with the OIG to ensure compliance with the policies and procedures developed by the OIG for investigative reports.

- DMH utilizes an OIG spreadsheet containing Agency Name, New Intake number, Date Received, Date of Incident, Allegation, DMH Region, Date Sent to Region, Due Date, Date Written Response returned/and sent to OIG and Comments;

- OIG sends a monthly report of Mental Health agency cases requiring written responses on the first of every month.

Corrective Action in Progress:

DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)

- The Division of Developmental Disabilities will request DoIT to make the necessary changes to the PUNS database to capture information on dependents of military service.

BUREAU OF QUALITY MANAGEMENT (BQM)

- Upon receipt of OIG case reports indicating a case requires a written response, DDD's Bureau of Quality Management will contact the provider agency to confirm receipt of the case report, the due date and the submission process for the written response;

- DDD-BQM will track receipt of written responses and contact the provider agency approximately 5 working days prior to the due date for written responses that are not yet received;

- DDD-BQM will initiate a monthly report and provide the report to the Division Director noting agencies with one or more past due written responses. The report

will include efforts made to date to secure the written response and a recommendation for any administrative action needed;

- The DDD Director will review the need for administrative action with the DHS Secretary and notify DDD-BQM of action to be taken;

- DDD-BQM will advise the OIG and BALC of administrative action taken related to past due written responses.

Expected Implementation Date: 07/30/2019

24. Comply with current policies and procedures regarding locally held funds and petty cash, and follow the control system in place. (Repeated-2009)

Finding: The Department inadequately administered locally held funds (bank accounts) during the examination period. Exceptions were noted regarding the administration, accounting, reconciliation, reporting, receipt and disbursement of these funds.

During fieldwork, auditors performed on-site testing of the Department's petty cash funds and quarterly reporting of receipts and disbursements of locally held funds at four of the Department's State-operated facilities, sampling and testing a total of 110 Resident Trust Fund transactions and 120 petty cash transactions across the four facilities. Some of the 19 exceptions are noted below:

Elgin Mental Health Center

- The facility did not maintain adequate supporting documentation for receipts and disbursements. For 3 out of 30 (10%) Resident's Trust Fund transactions tested, totaling $1,427, the amount per the receipts/disbursements journal did not agree to the supporting documentation provided by the facility.

Ann M. Kiley Developmental Center

- The facility paid sales tax when purchasing items which were in accordance with the mission of the Department. Specifically, in the Rehabilitation Fund (Fund 1144), sales tax totaling $12 was paid on 9 of 20 (45%) disbursements tested.
- The facility does not reconcile its locally held funds' bank statements to the corresponding funds' General Ledger to ensure accurate reporting of locally held funds. Instead, the facility reconciles the bank statements to the check register but not the General Ledger.

Elisabeth Ludeman Developmental Center

- For 1 out of 30 Resident's Trust Fund transactions tested, totaling $2,679, the disbursement did not trace to the supporting documentation or the bank statement. This resulted in a $1,042 overstatement of disbursements.

Accepted and Implemented – continued

- For 8 out of 30 (27%) Other Special Trust Fund disbursements tested, totaling $2,914, the disbursements were not recorded in the General Ledger timely. The amounts were recorded from 1 month to 10 months after the month of the check date.
- Cash as reported in the facility's June 30, 2017 General Ledger did not reconcile to the June 30, 2017 bank reconciliation. For the Resident's Trust Fund, an overstatement in the General Ledger compared to the bank reconciliation of $5,833. For the Other Special Trust Fund, an overstatement in the General Ledger compared to the bank reconciliation of $1,781.

Shapiro Developmental Center

- For 3 out of 30 (10%) Other Special Trust Fund receipts tested, totaling $14,304, amounts were not deposited timely. The deposits ranged from 8 to 19 business days late.
- The facility's Other Special Trust Fund does not have sufficient segregation of duties. The custodian of the imprest fund is responsible for entering transactions into the system, depositing receipts, and performing the reconciliations for the fund.

Department management indicated that the cause of this finding was staff error.

Updated Response: Implemented.

DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)

- Appropriate staff at the DD Centers will be retrained on Administrative Directives 02.08.01.010 and 01.09.01.020 as well as the Public Funds Deposit Act (30 ILCS 225/1) to ensure compliance with these areas;

- The Division will work to develop and implement Quality Assurance checks for bank statements reconciling with the General Ledger as well as quarterly C-17 reports at the DD Centers to ensure compliance;

- The Regional Management of SODC Operations will require these checks to be reported to SODC Operations-Fiscal for oversight and monitoring.

DIVISION OF MENTAL HEALTH (DMH)

- The Division will work to increase supervision of work related to Locally Held Funds and Petty Cash. Elgin Mental Health Center hired an Account Clerk in December 2018 to provide further accountability and consistency for all locally held funds and to ensure proper checks and balances are in place to ensure accuracy.

- DMH provided additional training for staff who handle Locally Held Funds and Petty Cash. Training of staff was completed in March 2019.

25. Implement a policy on charging residents for services and a corresponding rate structure to comply with statute. Also, take steps to determine whether any costs of services that were provided during the examination period can be recouped.

Finding: The Department did not comply with statutory requirements regarding charging residents for services at the Rushville Treatment and Detention Facility (Facility).

Under the Sexually Violent Persons Commitment Act (Act) (725 ILCS 207/90), each person committed or detained under the Act who receives services provided directly or funded by the Department and the estate of the person is liable for the payment of sums representing charges for services to the person at a rate to be determined by the Department.

The Department has not implemented a policy and a corresponding rate structure for charging residents for services. Under the existing conditions, a resident may have access to assets to pay for services the facility provides, but the resident would not be required to pay without a documented policy in place.

As of June 30, 2017, the Facility had 566 residents. The facility's expenditures for FY17 were approximately $30,865,100.

Department management stated upon reviewing Title 59 Part 299, it was determined that the Rules required significant revision beyond that initially anticipated to implement the Act. Facility Administration, along with the Department's Division of Mental Health, and the Office of General Counsel, convened to re-write the entirety of Part 299 to reflect the current state of the Facility and the evolution of its operating policies along with changes in the legal environment. The re-write of Part 299 is currently in process.

Updated Response: Partially Implemented.

Corrective Action in Progress:

- The Treatment and Detention Facility (TDF) has developed a Rate Structure and a Reimbursement Rule Draft in accordance with 725 ILCS 207/90 SVP Act in FY2015;
- Title 59 ILAC Part 299 has been re-written (revision as of December 2018);
- The Department will seek reimbursement after the ruling has been adopted by the JCAR process. This involves a multi-step process that includes additional input of residents and adapting a TDF form to capture payment. Title 59 ILAC Part 299 is scheduled to be out of review from DHS Legal by 3/29/2019. We anticipate corrective action to be completed by 12/31/2019.

Expected Implementation Date: 12/31/2019

Accepted and Implemented – continued

26. Establish a system to electronically share information regarding a registered, qualifying patient's identification card information and certification that the individual is permitted to engage in the medical use of cannabis in accordance with the Compassionate Use of Medical Cannabis Pilot Program Act.

Finding: The Department failed to establish a system to electronically share information regarding a registered, qualifying patient's identification card information, and certification that the individual is permitted to engage in the medical use of cannabis in accordance with the Compassionate Use of Medical Cannabis Pilot Program Act.

Department management stated a required system to electronically share information regarding the Compassionate Use of Medical Cannabis Pilot Program Act has not yet been established due to understaffing.

Updated Response: Implemented.

OFFICE OF CLINICAL, ADMINISTRATIVE AND PROGRAM SUPPORT (OCAPS)

- The PMP staff members have designed and built the web pages to display the medical marijuana data on the PMP website. PMP has received the medical marijuana data and is currently displaying the data on the PMP website. The project is complete.

27. Establish procedures to timely submit required reports to the Governor or General Assembly and to ensure meeting minutes are maintained to document the Task Force has convened quarterly as required by the MH Act.

Finding: The Department did not comply with statutory requirements related to required actions and administrative support services of the Mental Health Services Strategic Planning Task Force in accordance with the Mental Health and Developmental Disabilities Administrative Act.

Auditors noted the Department could not provide documentation to support the Mental Health Services Strategic Planning Task Force's 5-year comprehensive strategic plan was submitted to the Governor or General Assembly, as required by the MH Act. Further, the Department could not provide documentation, such as minutes or recordings, to support Task Force meetings had taken place during FY16 and FY17.

Department management indicated the final report was finished on February 19, 2013. When the report was submitted, the correspondences from filing with the appropriate parties were either not saved or not returned to the Office of Legislation.

Response: Accepted. The Department prepared the final report on February 19, 2013. The Division concurs that there should be a better system to document that the reports

were sent to the required parties. The Division will work with the Office of the Legislative Liaison to document compliance better.

The Department stated that pursuant to statute, the Task Force was required to continue meeting quarterly once the final report was approved and authorized. The General Assembly did not approve the report or authorize continued meetings and there was no appropriation for continued meetings or to implement the strategic plan. The quarterly meetings of the Task Force were subject to appropriation [20 ILCS 1705/18.6(g)].

The Division of Mental Health has instituted a protocol of placing information that is subject to the Open Meetings Act on its internet site by listing the meeting by date, the agenda, the approved minutes and other documentation submitted.

Updated Response: Implemented.

DIVISION OF MENTAL HEALTH (DMH)

- In accordance with Executive Order 2019-01, DHS prepared a listing of mandated reports as well as an internal log to track each report, the report due date, who completed the report and who the report must be submitted to. DHS will maintain this log and documentation of submission of required reports.

28. Work with the HFS to deposit amounts under the MH Act directly into Fund 0142 throughout a given Fiscal Year, or work to obtain legislative relief from this requirement.

Finding: The Department did not comply with statutory requirements relating to the depositing of federal funds in accordance with the Mental Health and Developmental Disabilities Administrative Act (MH Act). Specifically, the Department did not directly deposit certain federal funds into the Community Developmental Disability Services Medicaid Trust Fund (Fund 0142) throughout the applicable fiscal year.

During the examination period, it was the practice of DHS to have the Department of Healthcare and Family Services (HFS), as the federally designated Medicaid State agency, draw these amounts from the federal government throughout the fiscal year and deposit them into the General Fund. After fiscal year-end, HFS would calculate the Fiscal year's qualifying services amount; and then on a future federal draw, deposit that amount directly into Fund 0142.

After the FY17 year end, the amounts calculated by HFS pertaining to FY17's qualifying services were determined to be approximately $42 million. Department officials stated the $42 million deposit into Fund 0142 was made on April 4, 2018. After the FY16 year end, the amounts calculated by HFS pertaining to FY16's qualifying services were determined to be approximately $49 million which were deposited into Fund 0142 on August 15, 2016.

Accepted and Implemented – continued

Department management indicated that funds were not directly deposited into Fund 0142 because the amount pertaining to Fund 0142 cannot be measured until the end of the fiscal year.

Updated Response: Implemented.

- DHS, in collaboration with the Department of Healthcare and Family Services, has provided the Governor's Office of Management and Budget (GOMB) with language to amend the statute governing the 0142 fund regarding deposits. GOMB will include the language in the Budget Implementation Bill for fiscal year 2019.

    - Page 315 of Illinois Public Act 100-0587 amended the statute governing the 0142 fund deposits.

29. Comply with the law by serving as the lead agency or seek legislative remedy. (Repeated-2015)

Finding: The Department did not comply with a law requiring it to serve as the lead agency to establish a cross-agency prequalification process or master service agreement for contracting with human service providers.

Auditors noted the Department in its role as "lead agency" did not work with each State human services agency to establish joint rules for the pre-qualification process for contracting with human service providers and did not establish cross-agency master service agreements of standard terms and conditions for contracting with human service providers.

Department management indicated it believes the responsibility of the initiative to establish joint rules for the pre-qualification process and cross-agency master service contracts with human service providers was transferred to the Governor's Office of Management and Budget (GOMB) under the Grant Accountability and Transparency Act.

Updated Response: Implemented.

The Department contends that the need for joint rules as required by this statute are no longer necessary in light of the Grant Accountability and Transparency Act, 30 ILCS 708 (effective 7/16/14). Therefore, the Department has sought a legislative remedy. This remedy is a request to repeal the provision concerning cross-agency master service agreements between State agencies and human service providers (repeal of 20 ILCS 1305/1-37a). Both Senate Bill 2902 and House Bill 5031 were filed on February 14, 2018.

Public Act 100-0955 repealing Section 1-37a was effective as of 8/19/18.

30. Develop a methodology to calculate prompt payment interest that results from late medical payments to vendors processed through MMIS. The methodology

should include the creation of an interagency agreement with HFS to obtain the necessary detailed documentation to allow the Department to determine that prompt payment interest is calculated and paid accurately as outlined in the Act and the SAMS Manual. Also, estimate a liability for such contingency when preparing financial statements. (Repeated-2013)

Finding: The Department failed to ensure prompt payment interest that resulted from late medical assistance payments to vendors were accurately calculated and paid.

During testing, auditors determined the Department does not have a methodology to calculate prompt payment interest that results from late medical payments to vendors processed through MMIS; therefore, it cannot determine if it accurately paid all such amounts going back to the year ended June 30, 2010.

The Department provided support for the payment of $222,298 for MMIS Prompt Payment Interest during FY17 and FY16. Auditors were unable to determine the entire population of MMIS Prompt Pay Interest owed to vendors in order to determine if all amounts were paid.

Department management stated the Department only receives summary transactions data for entry into its Consolidated Accounting and Reporting System (CARS).

No liability is recorded for unpaid claims in the Department's financial statements because any demanded amounts paid after the lapse period would be paid outside of the Department, from the Court of Claims.

Department management indicated a verbal agreement to pay and process MMIS interest payments was initiated back in FY10 between the Department and HFS. However, no written interagency agreement has ever been in place to handle processing MMIS payments or paying interest. The Department also noted that because its access to MMIS data is limited, it felt it was impossible to calculate the full amount of eligible prompt payment interest.

Updated Response: Partially Implemented

Corrective Action in Progress:

- DHS has an existing primary IGA with HFS regarding MMIS. In addition, HFS has provided DHS staff with Electronic Data Warehouse information regarding DHS MMIS payments, including interest payments. DHS Fiscal staff will discuss this with the auditors during the upcoming compliance examination to determine if this is sufficient and whether an IGA is no longer necessary. The Department will also estimate a liability for this contingency when preparing its financial statements.

Expected Implementation Date: 07/30/19

Accepted and Implemented – continued

31. Submit all reports on or before the due date as specified in the applicable State Law. (Repeated-2013)

Finding: The Department did not submit required reports to the Governor, the General Assembly, and other officials in a timely manner as required by State Law.

During the examination period, the Department was required to submit various reports to the Governor, the General Assembly, and other officials. The topics of these reports include the Community Developmental Disability Services Medicaid Trust Fund (Trust Fund) – Fund 0142, the Williams v. Quinn consent decree, and the Code of Criminal Procedure of 1963. None of these reports were filed in a timely manner.

Department management indicated employee error contributed to the deficiencies identified above.

Response: Accepted. The Division of Mental Health (DMH) will work with the Office of Legislation for a better system of collecting documentation when items are received. DMH will also create a tracking system maintained by our Legislative Liaison to ensure future compliance is met. The Division of Developmental Disabilities (DDD) has developed a process to submit all reports on or before the due date as specified in the applicable State Law.

Updated Response: Implemented.

- In accordance with Executive Order 2019-01, DHS prepared a listing of mandated reports as well as an internal log to track each report, the report due date, who completed the report and who the report must be submitted to. DHS will maintain this log and documentation of submission of required reports.

32. Appoint the appropriate personnel to the commission and task forces and evaluate processes to make statutorily required appointments to ensure they are made in a timely manner.

Finding: The Department did not make appointments to State commissions, councils, and task forces as required.

During the examination period, auditors noted the Department lacked the following representation on commissions, councils, and task forces:

- Department division representatives for the Employment and Economic Opportunity for Persons with Disabilities Task Force. Department management stated it is still working on making appointments due to changes in personnel.

- A Department housing office representative for the Commission on Environmental Justice. Department management stated it was unaware of the vacancy, and was unable to acquire an appropriate appointee for the Commission.

- A Department representative for the Comprehensive Community-Based Youth Services (CCBYS) Program on the Mental Health Opportunities for Youth Diversion Task Force.

  Department management stated they believed the person who served on the Task Force as the Department's Mental Health and Juvenile Just Program representative represented both Department representatives required by the Mental Health Opportunities for Youth Diversion Task Force Act; however, the Department could not provide supporting documentation that the person was appointed by the Secretary of Human Services for both positions.

Updated Response: Implemented.

DHS - LEGISLATION

- The DHS-Office of Legislation maintains a master document of all appointments the Department is expected to make and has developed a plan to ensure the appointments are made timely.

33. Continually review and update the contingency plan to reflect the current operating environment and ensure all facilities have an adequately developed contingency plan; annually participate in disaster recovery exercises and strive to recover critical systems within the 24-hour timeframe; and ensure facilities perform and document tests of their recovery capabilities at least once a year. (Repeated-2005)

Finding: The Department's Disaster Recovery Plan (Plan) did not reflect its current operational environment, and had not assured adequate recovery planning and testing had been performed at its facilities.

Although the Department's Plan was last updated in August 2015, auditors reviewed the Plan and noted the Plan was outdated regarding the off-site storage location, back-up storage, and recovery or business continuity information.

The Department participated in the annual comprehensive Disaster Recovery exercise on September 19 and 20, 2016. The Department considered the test to be successful; however, critical systems were recovered in approximately 31 hours rather than within the required 24-hour timeframe as specified within the Department's Disaster Recovery Plan. Additionally, not all of the Department's facilities performed adequate recovery planning and testing during the review period.

Department management indicated they believed the above items were current processes. Department management believed necessary facilities had established Disaster Recovery Plans (DRP) and were testing annually.

Accepted and Implemented – continued

Response: Accepted. The Illinois Department of Human Services (DHS) Bureau of Information Security (BIS) will clarify with the Department of Innovation and Technology, Security and Compliance regarding information included in their Disaster Recovery. BIS will also update the DHS Disaster Recovery Plan (DRP) to include information regarding facilities need for DRP and testing.

Updated Response: Implemented.

- The DHS-Bureau of Information Security (BIS) has clarified with the Department of Innovation and Technology, Security and Compliance regarding information included in their Disaster Recovery.

- The DHS-Bureau of Information Security (BIS) has updated the Illinois Department of Human Services (IDHS) Disaster Recovery Plan (DRP) to include information regarding facilities need for DRP and testing.

- DoIT DHS approved the IDHS Disaster Recovery Plan (DRP) on October 3, 2018

34. Comply with DHS' Administrative Directive and ensure confidential information is adequately protected; review existing policies regarding the security and control of confidential information, and assure Department-wide procedures exist for ensuring confidential and personal information is adequately secured in both electronic and hardcopy format; secure confidential and personal information in hardcopy format at all times prior to shredding; in addition, effectively communicate and enforce procedures for safeguarding, retention, and subsequent disposal of all confidential information to all Department personnel, including facilities. (Repeated-2005)

Finding: The Department had not ensured compliance with procedures for disposal of documents containing confidential information.

During walkthroughs of various Department facilities, auditors found the following:

- Illinois School for the Visually Impaired – auditors found 39 instances of confidential information in a recycling bin located in the personnel office waiting area.
- Ludeman Developmental Center - auditors found documents containing protected health information (PHI) in three wastebaskets tested.
- Elgin Mental Health Center - auditors found a document containing PHI in a recycling bin.
- Central Office – Division of Rehab Services - auditors found an instance of a document with a patient's SSN in a wastebasket.

REVIEW: 4486

Department management indicated that although staff were trained in regard to the secure disposal of confidential documents, the staff members did not comply with the established procedures.

Response: Accepted. The Department will re-enforce its procedures for safeguarding, retention, and subsequent disposal of all confidential information.

Updated Response: Implemented.

DIVISION OF MENTAL HEALTH (DMH)

- DMH sent a reminder to all staff on July 1, 2017;
- On-going HIPAA audits have been completed with any findings resulting in immediate retraining.

DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)

- All staff at the DD Centers have been retrained on the procedures for disposal of confidential information;
- All Local Privacy Officers have been retrained on standard checks and reporting responsibilities;
- SODC Operations will ensure that Local Privacy Officers complete standard checks for improper disposal of Protected Health Information (PHI) and Personally Identifiable Information (PII) at the Centers and transmit the findings to the General Counsel Privacy Officer.

ILLINOIS SCHOOL FOR THE VISUALLY IMPAIRED (ISVI)

- All employees completed the DHS required HIPPA online training between 08/15/2018 – 09/14/2018;
- All supervisors were reminded of the importance of HIPPA and PIPA regulations at the Advisory Council Meeting;
- The Superintendent hosts a “Welcome Back” meeting for the staff on an annual basis prior to the school year starting. Staff members are reminded of the HIPPA guidelines and the trainings they will have to complete throughout the year – the annual DHS online training as well as Public School Works annual training;
- Three large locked shred bins were purchased for ISVI. The bins have been placed in controlled, secured areas to hold confidential information until proper disposal is made;
- Three shredders were purchased with two placed in the dorms and one in the dorm supervisor area;
- All active staff members must complete HIPAA training on an annual basis on the Public School WORKS site;
- Staff have been reminded again of the importance of protection of confidential information and locking confidential bins have been acquired for all field offices.

Accepted and Implemented – continued

DIVISION OF REHABILITATION SERVICES (DRS)

- Staff will be reminded of the importance of proper disposal of all confidential information;
- Locked confidential recycling bins are being purchased for field offices.

35. Comply with the statutes and ensure confidential information is adequately protected; effectively communicate and enforce procedures for safeguarding, retaining, and communicating confidential information to all Department personnel, including facilities; provide staff with training and information on available encryption resources such as those available from the Department of Innovation & Technology. (Repeated-2013)

Finding: The Department regularly collects and maintains various types of documents, including confidential and personally identifiable information, necessary for fulfilling its mission.

In addition to administrative directives regarding the maintenance and safeguarding of confidential information, the Department was also required to comply with Acts that required the protection of personal information, including:

- Personal Information Protection Act (815 ILCS 530)
- Identity Protection Act (5 ILCS 179)
- Health Insurance Portability and Accountability Act (45 CFR § 164) and its implementing rules

Although required to protect personal and confidential information, the Department put such information at the risk of disclosure during the examination. Department staff sent multiple unprotected emails to the audit staff during fieldwork that contained confidential, sensitive, or personally identifiable information.

Department management indicated that although staff were trained in regards to encryption policy and procedures, the staff member did not comply with established procedures.

Updated Response: Implemented.

DIVISION OF MENTAL HEALTH (DMH)

- The Business Administrator was retrained on the need to use ENTRUST for any emails sent out of DHS;
- The Business Administrator resigned from the position on April 23, 2018. The Hospital Administrator is aware and will ensure the successor is aware of the

requirement ensuring protected information sent in email is encrypted for HIPAA Security. The newly hired Business Administrator obtained HIPAA Training;

GENERAL COUNSEL

- DHS-Legal has advised on how the issue can be mitigated, but ultimately the Center will have to make the corrective actions necessary to ensure compliance;
- Elgin Local Privacy Officers are monitoring emails sent externally to ensure protected health information (PHI) is not being sent via electronic mail without proper encryption. This will be completed on a monthly basis.

DoIT

- The Department of Innovation and Technology (DoIT) DHS ensures Security and Privacy Awareness training includes information regarding secure transmission of protected information.

36. Comply with current processes and procedures regarding providing additional training to supervisors pertaining to its Administrative Directive and the Act and hold staff accountable for maintaining appropriate time records.

Finding: The Department did not maintain all necessary and required supporting documentation in employee payroll and personnel files. Also, the Department failed to timely administer employee performance evaluations and inaccurately calculated fringe benefits of employees. Finally, the Department did not maintain time records in compliance with the State Officials and Employees Ethics Act.

Department management indicated supervisors did not complete the evaluations timely due to competing priorities and the fringe benefit calculations and time record errors were due to staff error.

Response: Accepted. The Department of Human Services (DHS) will implement a process to ensure management and staff comply with the current processes and procedures regarding employee evaluations. DHS will continue to provide additional training to supervisors pertaining to its Administrative Directives (AD) and the Act, and hold staff accountable for maintaining appropriate time records.

Updated Response: Implemented.

HUMAN RESOURCES (HR)

- Working to develop and establish an in-house database to keep track of evaluation due dates;
- Schedule and provide periodic training to supervisors pertaining to its administrative directives and the act and hold staff accountable for maintaining appropriate time records.

Accepted and Implemented – continued

PAYROLL

- An email was sent to staff on May 4, 2018 that included the Quick Reference Guide (QRG) on Vehicle Usage for reference;
- Speak with staff regarding the errors noted and make sure they understand the process to ensure future compliance.

37. Comply with current policies and procedures regarding property and equipment, and follow the control system in place. Additionally, adequately maintain buildings and facilities to prevent further deterioration. (Repeated-2005)

Finding: The Department did not have adequate control over State property inventories and recordkeeping.

As of June 30, 2017, the Department valued its State property at $195.9 million. During testing of property and equipment at the Central Office and Department State-operated facilities, some of the discrepancies noted by the auditors were as follows:

Central Office and Central Office Site Locations:

- For 10 out of 33 obsolete equipment items sighted at the Decatur location, the Department had not prepared the disposal paperwork to remove the item from its inventory listing.
- For 2 out of 40 additions tested at the Central Office, totaling $4,144, supporting documentation, such as an invoice, was not provided.
- While testing lease and installment purchase agreements, auditors noted the Department did not provide complete information within the Accounting for Leases.

Elgin Mental Health Center

- For 1 out of 15 equipment disposals tested, the item did not trace to appropriate documentation.
- The “1 South” Building appears to be used as storage for unused equipment. Thirty equipment items (15 items with Department property tags and 15 items with Federal property tags) were tested from this building. All 30 (100%) equipment items appeared to be unused. Additionally, 8 of these equipment items did not trace to the inventory listing. Three of the Federal tagged equipment items traced to a listing maintained by the Department’s Central Office; however, were marked on the records as deleted.
- Elgin had an agreement with the Department of Corrections (DOC) for use of the facility’s Goldman building. This agreement was only a verbal agreement and was not a written agreement. Additionally, DOC made improvements to the Goldman

building; however, the improvements were not reported on Elgin's Real Property Listing.

Ann M. Kiley Developmental Center

- During the examination period, the facility was using seven homes for storage/warehouse purposes. During a tour of these homes, the homes appeared to have water damage and deterioration issues with the floors and ceilings. The homes contained several items that were in oversupply or appeared to be obsolete.
- During a walkthrough of the facility, donated items at the facility were not tagged and were not recorded in the inventory listing at their fair market value (or acquisition value) at the time of the donation.

Ludeman Developmental Center

- For 5 out of 30 equipment items tested from the inventory listings, totaling $1,000, the item could not be located at the facility.

Shapiro Developmental Center

- For 1 out of 15 (7%) equipment transactions tested, totaling $30,430, the item did not trace to appropriate documentation. The transaction was a transfer within the agency.
- For 6 building improvements noted on the Property Utilization Report, totaling $244,822, the improvements were not listed on the Real Property Listing. The building improvements included window and roof replacements with $118,302 and $126,520 incurred in FY2016 and FY2017, respectively.

Department management indicated that insufficient headcount and an outdated and insufficient inventory system contributed to the discrepancies noted.

Response: Accepted. The Department does agree that all staff must comply with the policies and procedures regarding property/inventory control. The Office of Business Services (OBS) will work with DHS Divisions to ensure compliance in the field through improved communication and timely submission of the required paperwork. OBS staff is working diligently to ensure the proposed ERP/SAP solution has the functionality necessary to correct the shortcomings of the current legacy inventory systems.

In addition, the Office of Business Services priority is to maintain buildings occupied with the residents and patients we serve. Buildings which are not occupied by individuals are maintained to in an effort to keep them water tight. As funding is made available, roofs are repaired that need replaced or the contents of the building are moved to another vacant building that does not have a current roof leak. The Department anticipates funding for some repair and maintenance work and roof repairs and replacements will be available in fiscal year 2019.

Updated Response: Partially Implemented.

Accepted and Implemented – continued

Corrective Action Completed:

DIVISION OF DEVELOPMENTAL DISABIITIES (DDD)

- DD Centers corrected the issues noted in this audit;
- The Regional Management of SODC Operations ensured all Center Property Control Coordinators received the Property Control training.

DIVISION OF MENTAL HEALTH (DMH)

- Excess inventory items are being offered Statewide on an ongoing basis for redistribution.

OFFICE OF BUSINESS SERVICES (OBS)

- OBS coordinates annually with the Capital Development Board to identify repair and maintenance needs and prioritize according to impact and available funding;
- Emergency requests are done as needed and expedited to provide timely corrective action.

Corrective Action in Progress:

OFFICE OF BUSINESS SERVICES

- Office of Business Services (OBS) is currently in the process of reassigning some headcount specifically for property/inventory control purposes;

DIVISION OF MENTAL HEALTH (DMH)

- Facility will add storage areas to the CDB list to improve and maintain the buildings to prevent further deterioration. The Business Administrator met with the plant engineer on 3/21/2019 to discuss prioritization of projects;
- Facility will comply with the control procedures and policies by properly accounting for all State property, maintaining an accurate current inventory and properly disposing of unusable, damaged or missing items;
- Real Property recording of IDOC upgrades will be obtained from IDOC or the building contractor for proper documentation;
- A candidate for property control was interviewed on 3/19/2019 and an offer has been made;
- The facility is currently reviewing the inventory list, developing an inventory plan and identifying items that should be disposed.

Expected Implementation Date: 12/31/2019

38. Comply with current policies and procedures regarding accounts receivable and follow internal control systems put in place at the facilities. Additionally, maintain detailed records of all billings and the corresponding collections to facilitate proper reporting of accounts receivable activity. Consider writing off delinquent or uncollectible accounts to reflect only realizable amounts. Finally, allocate sufficient staff so that job duties are performed as required and accounts receivable transactions are processed and accounts are properly maintained. (Repeated-2007)

Finding: The Department is in violation of its own policies and procedures as well as statutory requirements regarding the administration of accounts receivable.

During fieldwork, auditors performed on-site testing of accounts receivable at four of the Department's State-operated facilities. They sampled and tested 60 residents (with receivables) across the four facilities. Some of their exceptions they noted are as follows regarding accounts receivable at two of the Department's facilities:

Elgin Mental Health Center

- For 5 out of 15 resident files tested with receivables, totaling $1,014,542, the receivables went unpaid for over 180 days and were not submitted to the Department's Central Office Bureau of Collections (BOC) for collection.
- For 2 out of 15 resident files tested with receivables, totaling $193,844, the residents were sent a Notice of Determination between 9 and 27 days after the recommended 60-day period.
- For 1 out of 15 resident files tested with receivables, totaling $52,665, the receivable balance was not accurate. The resident filed for bankruptcy, but the charges existing up until the bankruptcy filing were not removed from the account balance as required.
- A majority of the accounts receivable (80%), totaling $8,411,419, have been uncollected in excess of one year. The facility and the Department's Central Office did not appear to analyze the related financial history of these accounts receivable in order to determine the appropriateness of a potential write-off.
- The accounts receivable listing had two line items titled "Settlements," totaling ($2,082,774). These negative amounts understate the total receivable. The facility was unable to provide support for these amounts.

Ludeman Developmental Center

- While testing accounts receivable at the facility, auditors noted the facility is not re-determining the cost of care for patients whose income levels (i.e. benefits amounts) change while under the care of the facility. During testing, 14 out of 15 of the residents tested gave the facility permission to receive their benefits; thus, making the facility the payee. When the facility is the payee, the facility receives the resident's benefits directly. Of those benefits received directly, $30 is applied to the patient's trust fund and the remainder is applied to the patient's account for

Accepted and Implemented – continued

cost of care. When benefits decrease, the amount applied to the cost of care is reduced. The amount owed will only be paid back if the benefits increase.

- For 10 out of 15 resident files tested with receivables, totaling $7,893, the receivables went unpaid for over 180 days and were not submitted to the Department's Central Office Bureau of Collections (BOC) for collection.

Department management indicated that the cause of this finding was staff error.

Response: Accepted. Due to lack of uniform procedures, antiquated systems, and staff turnover; State Operated Hospital's (SOH) were unable to track and follow up on each individual account receivable. SOH's will continue to work with the DHS Central Office to alleviate errors in the RE2 system that are associated with this finding and ultimately establish uniform controls over SOH's Accounts Receivables.

Updated Response: Partially Implemented.

Corrective Action Completed:

DIVISION OF DEVELOPMENTAL DISABIITIES (DDD)

- Appropriate staff at the DD Centers were retrained on the timely entry of rate changes and the monitoring of aged accounts receivables;
- The Regional Management of SODC Operations are continuing to monitor compliance of aged accounts receivables monthly via the Business Office Compliance Tool

Corrective Action in Progress:

DIVISION OF MENTAL HEALTH (DMH)

- DMH will train Reimbursement Officers to properly bill the Recipient Reimbursement System (RE2). The prior employee has retired and a new staff was hired on 3/1/2019. Training will be provided within 90 days.

Expected Implementation Date: 07/30/19

39. Increase the level of supervisory review of the voucher process. Allocate adequate resources to the area and direct staff to follow established policies so that invoice vouchers are reviewed and approved in a timely manner. Further, file emergency purchase affidavits timely. (Repeated-2011)

Finding: The Department did not perform an adequate level of supervisory review over the processing, approval, and payment of vouchers as required by the Illinois

Administrative Code and Department policy. Further, the Department did not maintain adequate internal controls over filing emergency purchase affidavits.

Voucher Processing and Payment Testing

For 100 of 660 vouchers tested, auditors noted the Department did not review each vendor's invoice and either deny the bill in whole or in part, ask for more information necessary to review the bill, or approve the voucher in whole or in part, within 30 days after the receipt of the bill. Voucher testing also noted lack of obligating or supporting documentation and items charged to an incorrect detail object code.

Emergency purchases

During testing of emergency purchases, 17 out of 22 (77%) emergency purchases tested, totaling approximately $4.2 million, the Department filed affidavits between 1 to 538 days late with the Procurement Policy Board and the Auditor General.
Department management indicated that untimely approval of vendor invoices, lack of maintaining the supporting documentation, and untimely filings pertaining to emergency purchases is attributable to staff oversight and/or competing priorities.

Updated Response: Implemented.

DHS-OFFICE OF PROCUREMENT

- The Procurement Office will review the list of emergencies monthly and set reminders on Outlook in order to request the actual cost amounts of the emergencies when the emergency ends.

DHS-OFFICE OF FISCAL SERVICES

- A reminder has been sent to staff to follow the procedure of processing vouchers in a timely manner;
- A reminder will be sent to ensure staff file emergency purchases affidavits timely;

DHS-OFFICE OF PROCUREMENT

- The Office of Procurement made available the small business purchase training on DHS OneNet on 3/26/2019.

40. Comply with current policies and procedures regarding commodities and follow the control system in place. (Repeated-2013)

REVIEW: 4486

Accepted and Implemented – continued

Finding: The Department does not maintain adequate oversight over commodities, resulting in inadequate controls. Inventory control includes responsibilities at the Department's State-operated facilities, multiple Central Office warehouses, and other Central Office locations.
The Department incurred commodities expenditures of $36.563 million and $25.642 million during FY17 and FY16, respectively. In addition, the Department recorded ending commodities inventories of $7.526 million and $7.044 million for those fiscal years.

During testing of inventory at the Central Office and the Elgin, Kiley, Ludeman, and Shapiro Centers, some of the discrepancies included:

- Physical counts did not agree with test counts.
- Annual inventory physical counts did not agree with test counts.
- Items were noted to have differences between the facility's count sheet, facility's final count sheet, and the Monthly Commodity Status Report.
- Facility personnel could not provide explanations for variances of 20% or greater noted in the general and mechanical inventory year-end balances.
- Facility did not physically count 100% of its inventory items.
-
- Emergency supplies and food that are kept off the inventory listing which resulted in an unknown understatement of the overall inventory valuation.

Department management indicated that insufficient headcount, human error with miscounts, and an outdated and insufficient inventory system contributed to the discrepancies noted.

Response: Accepted. The Department concurs that the potential for human error must be mitigated to the highest degree possible. The agency will work to ensure new staff are properly trained and that there is sufficient oversight to ensure consistent compliance with policies and procedures. The Department agrees that legacy systems may contribute to some of the discrepancies noted. Facility and Business Services staff are working diligently to ensure the proposed ERP/SAP solution has the functionality necessary to correct the shortcomings of the current legacy inventory systems.

State Operated Hospital's (SOH) staff will receive retraining in recording the various types of general stores packages containing different counts of items. In addition, all appropriate staff in the Developmental Disabilities (DD) Centers will be retrained on Administrative Directive 01.05.07.010 Annual Inventory Procedures and proper storage guidelines.

Updated Response: Partially Implemented.

Corrective Action Completed:

OFFICE OF CLINICAL, ADMINISTRATIVE AND PROGRAM SUPPORT (OCAPS)

- OCAPS reminded the Kiley Pharmacy Manager that circle labels need to be used to track inventoried items;
- Kiley Pharmacy Manager used labels during FY2018 annual inventory completed June 28, 2018;
- OCAPS instructed the Kiley Pharmacy Manager to not post quantities to shelves or use any other method to provide quantities to counter/recorder teams;

DIVISION OF DEVELOPMENTAL DISABIITIES (DDD)

- All appropriate staff were retrained on Administrative Directive 01.05.07.010, Annual Inventory Procedures, and proper storage guidelines.
- The Kiley Pharmacy Manager indicated he did not have any notes with pre-counts posted to shelves while conducting FY2018 annual inventory.

DHS-OFFICE OF BUSINESS SERVICES (OBS)

- All commodities are accounted for using a two-person verification system. One employee will either receive or pull the commodity and a second employee will do the follow-up and verify the amount received;

DIVISION OF MENTAL HEALTH (DMH)

- Training to properly handle the various types of general store packages was provided on 3/1/2019.

Corrective Action in Progress:

DHS-OFFICE OF BUSINESS SERVICES (OBS)

- Continue to pursue adding additional headcount within OBS specifically to increase compliance within agency facilities, and schools.

Expected Implementation Date: 12/31/2019

41. Enhance processes and controls so that accidents are reported within the DCMS required time frame and vehicles are properly maintained in compliance with DCMS policies. Further, assess whether underutilized vehicles are needed and either transfer unnecessary vehicles in accordance with DCMS policies or work with DCMS to obtain an exception provision to DCMS policy.

Accepted and Implemented – concluded

Finding: The Department did not comply with reporting requirements pertaining to vehicle accidents and did not comply with Department of Central Management Services (DCMS) policies and procedures to ensure State vehicles were properly maintained and utilized.

During testing, auditors noted 5 out of 21 (24%) instances of accidents involving State owned vehicles used by Department employees that were not reported to DCMS within 7 calendar days as required. The reporting ranged from 1 to 7 days late. Additionally, the Department did not comply with DCMS policies and procedures to ensure state vehicles are properly maintained and utilized. For example:

- For 31 out of 60 (52%) vehicles tested, oil changes were not done within maximum mileage and/or time requirements.
- For 28 out of 60 (47%) vehicles tested, the vehicle was under-utilized. Usage for these passenger vehicles ranged from 382 to 13,586 miles over the 2-year period.

Department management indicated the travelers did not comply with the reporting procedures for accidents and maintenance due to error. For the under-utilized vehicles, management indicated certain vehicles are utilized by facilities and often do not leave facility grounds. Therefore, the vehicles will never surpass the miles, but still serve a valuable purpose at the facilities.

Updated Response: Implemented.

DHS-OFFICE OF BUSINESS SERVICES (OBS)

- Provide employees clear and concise information with respect to accident reporting procedures and related enforcement.
- Continue to track the performance and reporting of maintenance on agency assigned vehicles.
- Quarterly reminders regarding accident and reporting procedures and enforcements are sent quarterly to the coordinators responsible for beginning the accident reporting process.
- Quarterly reviews are conducted for Individually Assigned Vehicles (IAV) usage. This allows the agency to forecast total usage each year and to spotlight potential reassignment for vehicles that are underutilized.

42. Strengthen controls over the processing of refund receipts including the timely deposit of refunds. (Repeated-2015)

Finding: The Department lacked controls over the Department's refund process and did not deposit the refund receipts timely.

In 10 out of 60 refund receipts tested, totaling $306,881, the refund receipts were not deposited timely ranging between 4 to 235 days late.

Department management indicated the exceptions were due to staffing vacancies and the lack of an integrated accounting system.

Response: Accepted. The Department will implement controls to ensure the timely processing of and deposit of refunds.

Updated Response: Implemented.

DHS-OFFICE OF BUSINESS SERVICES (OBS)

- Provide employees clear and concise information with respect to accident reporting procedures and related enforcement;
- Continue to track the performance and reporting of maintenance on agency assigned vehicles.
- Quarterly reminders regarding accident and reporting procedures and enforcements are sent quarterly to the coordinators responsible for beginning the accident reporting process.
- Quarterly reviews are conducted for Individually Assigned Vehicles (IAV) usage. This allows the agency to forecast total usage each year and to spotlight potential reassignment for vehicles that are underutilized.

Emergency Purchases

The Illinois Procurement Code (30 ILCS 500/) states, "It is declared to be the policy of the State that the principles of competitive bidding and economical procurement practices shall be applicable to all purchases and contracts...." The law also recognizes that there will be emergency situations when it will be impossible to conduct bidding. It provides a general exemption when there exists a threat to public health or public safety, or when immediate expenditure is necessary for repairs to State property in order to protect against further loss of or damage to State Property, to prevent or minimize serious disruption in critical State services that affect health, safety, or collection of substantial State revenues, or to ensure the integrity of State records; provided, however that the term of the emergency purchase shall not exceed 90 days. A contract may be extended beyond 90 days if the chief procurement officer determines additional time is necessary and that the contract scope and duration are limited to the emergency. Prior to the execution of the extension, the chief procurement officer must hold a public hearing and provide written justification for all emergency contracts. Members of the public may present testimony.

Notice of all emergency procurement shall be provided to the Procurement Policy Board and published in the online electronic Bulletin no later than three business days after the contract is awarded. Notice of intent to extend an emergency contract shall be provided to the Procurement Policy Board and published in the online electronic Bulletin at least 14 days before the public hearing.

A chief procurement officer making such emergency purchases is required to file an affidavit with the Procurement Policy Board and the Auditor General. The affidavit is to set forth the circumstance requiring the emergency purchase. The Legislative Audit Commission receives quarterly reports of all emergency purchases from the Office of the Auditor General. The Legislative Audit Commission is directed to review the purchases and to comment on abuses of the exemption.

The Department filed 13 affidavits for emergency purchases in FY16 totaling $3,918,489.69 as follows:

- $2,766,231.18 for repairs and equipment at the various Centers;
- 818,195.00 for development of instruction in policies for Case Management programs;
- $116,285.50 for GAAP assistance services;
- $88,093.68 to continue onsite food services at Treatment and Detention Facility;
- $74,750.00 for Federally required compliance monitoring of Federal monies; and
- $54,934.33 for laundry services.

During FY17 the Department filed seven affidavits for emergency purchases totaling $2,400,505.16 as follows:

- $2,290,505.16 for repairs or equipment replacement at the various centers; and
- $110,000.00 to purchase licenses for software to maintain digital historical records.

Headquarters Designations

The State Finance Act requires all State agencies to make semiannual headquarters reports to the Legislative Audit Commission. Each State Agency is required to file reports of all its officers and employees for whom official headquarters have been designated at any location other than that at which official duties require them to spend the largest part of their working time. The Department filed a headquarters report in July 2017 indicating 439 employees were assigned to locations other than official headquarters.

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DEPARTMENT OF HUMAN SERVICES
TWO YEARS ENDED JUNE 30, 2017

APPENDIX A

Service Efforts and Annual Cost Statistics

	FY17	FY16
Addiction Treatment and Related Services		
Total expenditures - all sources	$ 155,153,500	109,942,100
Number of clients discharged from alcohol and other drug treament	51,198	58,610
Percentage of clients discharged who successfully completed services	57.5%	56.5%
Developmental Disabilities - Community & Facility Services		
Total Expenditures - all sources	$ 1,561,807,500	$ 1,562,682,900
Number of Individuals served in waiver settings	23,387	22,920
Number of individuals served in private Intermediate Care Facilities and Mental Retardation facilities (ICF/MR), including Skilled Nursing Facility/Pediatrics	4,682	4,904
Number of individuals served in SODC's (State Operated Developmental Centers)	1,660	1,653
Persons receiving developmental disability services as a percent of the estimated number of persons with a diagnosis of a developmental disability	14%	14%
Staff to resident ratio	2.4	2.2
Family and Community Services - Basic Family Supports		
Total expenditures - all sources	$ 1,148,579,100	$ 1,445,872,800
Total Number of Medical Assistance No Grant (Mang) Aid to the Aged, Blind and Disabled (AABD) applications approved	85,599	87,723
Average number of TANF families engaged each month (Fed. Participation Rate)	2,945	4,203
Number of children served through the Child Care program - avg. month	131,310	127,708
Total number of refugees and immigrants receiving citizenship assistance	6,374	N/A
Total number of children served through the Crisis Nursery program	962	917
Total number of seniors accessing services through the Donated Funds Initiative program	10,252	10,144
Percent of TANF clients working and/or engaged in the required number of average countable activities per week	69.1%	69.4%
Family and Community Services - Family Wellness & Early Intervention		
Total expenditures - all sources	$ 593,871,200	$ 574,426,300
Number of pregnant women and infants enrolled in Family Case Management (FCM)	140,952	172,885
Number of 0-2 year olds immunized	299,421	302,154
Number of WIC participant births	46,485	51,229
Number of children who have Early Intervention - Individualized Family Service Plan	21,206	20,689
Family and Community Services - Community & Positive Youth Development		
Total expenditures - all sources	$ 78,811,000	$ 27,144,900
Number of Teen REACH participants (a)	7,288	N/A
Number of CCBYS recipients	4,660	5,713
Numberof Re-Deploy IL Youth recipients (b,c)	332	607
Number of CYEP recipients (d)	2,487	N/A
Proportion of 10th grade children reporting use of marijuana in the past month	N/A	14.0%
Proportion of 10th grade children reporting use of alcohol in the past month	N/A	25.0%
Proportion of CCBYS recipients that are referred by law enforcement organizations	45.6%	47.6%
Birth rate per 1,000 females ages 15-17	9.8%	10.4%
Percent of live births to 15-17 year olds as a percent of births to women of all ages	1.6%	1.7%

Appendix A - continued	FY17	FY16
Home Services		
Total expenditures - all sources	$ 608,275,000	$ 602,434,200
Persons with disabilities receiving in-home services to prevent institutionalization	29,379	29,325
Persons moved out of nursing homes	54	125
Average monthly cost of in-home services per client	$ 1,573	$ 1,538
Mental Health - Community & Facility Services		
Total Expenditures - all sources	$ 558,154,100	$ 363,753,400
Number of Individuals served in DHS/DMH Assertive Community Treatment Program	776	1,201
Number of juveniles found eligible for mental health juvenile justice services	214	338
Percent of re-admissions to state hospitals within 30 days of discharge	9.1%	7.4%
Staff to patient ratio in state hospitals	1.9	1.9
Mental Health - Sexually Violent Persons Program		
Total expenditures - all sources	$ 39,312,100	$ 17,005,100
Number of detainees/sexually violent persons in the Treatment/Detention Facility	603	593
Annual cost per detainee/sexually violent person in the TDF (in dollars)	$ 65,194	$ 28,926
Vocational Rehabilitation		
Total expenditures - all sources	$ 118,231,100	$ 110,731,100
Persons in supported employment	1,260	1,211
Persons competitively employed	4,990	5,538
Rehabilitation rate (success rate)	51.6%	50.1%
Average hourly wage earned by Vocational Rehabilitation customers	$ 11.01	$ 10.42
Average lifetime cost per rehabilitation (in dollars)	$ 5,202	$ 5,001

(a) The Teen REACH program was eliminated in fiscal year 2016 and 2017; therefore, there is no data to report for those two years. It was reinstated in mid fiscal year 2017. Performance data reflects 6 months of programming rather than 9 months.

(b) Data reflects lack of payment in fiscal year 2017 and fiscal year 2016.

(c) Re-Deploy commitment reduction data lags by approximately one year.

(d) The CYEP program did not exist in mid FY17. CYEP data for FY17 reflects partial year implementaiton and is self-reported.

APPENDIX B

Summary of Appropriations and Expenditures

	FY17	FY16
TOTAL EXPENDITURE AUTHORITY	**$ 6,976,339,000**	**$ 6,394,585,000**
EXPENDITURES, BY FUND		
General Revenue Fund	$ 3,283,074,000	$ 3,153,086,000
Prevention and Treatment of Alcohol and Substance Abuse Block Grant Fund	70,079,000	72,066,000
Group Home Loan Revolving Fund	30,000	-
Illinois Veterans' Rehabilitation Fund	3,491,000	2,422,000
Mental Health Fund	18,503,000	16,985,000
Group Special Olympics Fund	1,000,000	700,000
Vocational Rehabilitation Fund	110,447,000	123,472,000
Home Services Medicaid Trust Fund	234,787,000	234,381,000
Youth Alcoholism and Substance Abuse Prevention Fund	504,000	475,000
State Gaming Fund	646,000	497,000
Community DD Services Medicaid Trust Fund	49,975,000	49,506,000
Mental Health Reporting Fund	87,000	163,000
Sexual Assault Services & Prevention Fund	600,000	600,000
DHS Technology Initiative Fund	6,114,000	4,380,000
Drunk and Drugged Driving Prevention Fund	1,547,000	1,618,000
Illinois Affordable Housing Trust Fund	13,748,000	11,898,000
Care Provider for Persons with Developmental Disabilities Fund	33,045,000	32,820,000
Employment and Training Fund	389,381,000	412,859,000
Health and Human Services Medicaid Trust Fund	21,211,000	31,459,000
Drug Treatment Fund	2,902,000	3,948,000
Gaining Early Awareness and Readiness for Undergraduate Programs Fund	398,000	1,210,000
Sexual Assault Services Fund	100,000	100,000
DHS Special Purposes Trust Fund	258,389,000	261,573,000
Autism Awareness Fund	81,000	-
Old Age Survivors Insurance Fund	77,520,000	79,081,000
Early Intervention Services Revolving Fund	160,551,000	160,783,000
DHS Community Services Fund	29,733,000	8,033,000
Juvenile Accountability Incentive Block Grant Fund	191,000	1,039,000
DHS Federal Projects Fund	13,385,000	11,918,000
Special Olympics Illinois Fund	13,000	59,000
Commitment to Human Services Fund	279,845,000	-
Alcoholism and Substance Abuse Fund	7,002,000	8,398,000
Budget Stabilization Fund	24,787,000	-
U.S.D.A Women, Infants and Children Fund	253,653,000	262,093,000
Community Mental Health Medicaid Trust Fund	54,504,000	57,294,000
Local Initiative Fund	18,088,000	18,953,000
Rehabilitation Services Elementary and Secondary Education Act Fund	700,000	837,000
Farmer's Market Technology Improvement Fund	4,000	-
Domestic Violence Shelter and Service Fund	539,000	543,000
Maternal and Child Health Services Block Grant Fund	3,050,000	3,271,000
Community Mental Health Services Block Grant Fund	18,798,000	20,634,000
Youth Drug Abuse Prevention Fund	530,000	250,000
Juvenile Justice Trust Fund	1,691,000	1,590,000
DHS Recoveries Trust Fund	10,863,000	11,778,000
Total Expenditures, Appropriated Funds	**$ 5,455,586,000**	**$ 5,062,772,000**

Appendix B - continued

EXPENDITURES, NON-APPROPRIATED FUNDS

	FY17	FY16
Vocational Rehabilitation Fund	869,000	-
Hansen-Therkelsen Memorial Fund	4,000	-
DHS Special Purposes Fund	-	97,000
Electronic Benefits Transfer Fund	117,034,000	149,592,000
DHS Federal Projects Fund	486,000	833,000
DHS State Projects Fund	231,000	73,000
DHS Private Resources Fund	156,000	2,000
DHS Recoveries Trust Fund	3,403,000	3,205,000
Total Expenditures, Non-Appropriated Funds	**$ 122,183,000**	**$ 153,802,000**
TOTAL EXPENDITURES, ALL FUNDS	**$ 5,577,769,000**	**$ 5,216,574,000**

APPENDIX C

Expenditures By Major Object Code

Expenditures	FY17	FY16	FY15
Awards and Grants	$ 612,655,000	$ 597,295,000	$ 870,737,000
Awards and Grants to Students	4,000	-	4,000
Awards and Grants, Lump Sums & Other Purposes	3,579,191,000	3,348,918,000	3,804,605,000
Commodities	7,555,000	5,831,000	5,918,000
Contractual Services	65,824,000	64,490,000	136,470,000
Group Insurance	18,404,000	19,238,000	18,291,000
Equipment	278,000	80,000	938,000
Funeral and Burial Expenses, Payments to Vendors	2,121,000	-	6,372,000
Interfund Cash Transfers	51,000,000	1,175,000	1,175,000
Lump Sum and Other Purposes	496,560,000	474,869,000	508,714,000
Lump Sum Operations	73,085,000	24,726,000	31,142,000
Medical Preparation & Food Supplies for Free Distribution	201,294,000	208,021,000	222,049,000
Operation of Automotive Equipment	10,000	12,000	487,000
Other Refunds	534,000	272,000	701,000
Permanent Improvements, Lump Sums & Other Purposes	4,629,000	-	1,293,000
Personal Services	398,981,000	407,023,000	421,291,000
Printing	1,298,000	1,047,000	1,562,000
Refunds of Federal and Other Grants	2,543,000	1,962,000	3,275,000
Retirement	27,107,000	30,006,000	29,938,000
Social Security	29,392,000	29,836,000	30,829,000
Student, Member or Inmate Compensation	-	-	22,000
Telecommunications	4,492,000	1,402,000	10,041,000
Tort, Settlements and Similar Payments	-	-	608,000
Travel	812,000	371,000	1,400,000
TOTAL	**$ 5,577,769,000**	**$ 5,216,574,000**	**$ 6,107,862,000**

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APPENDIX D

Expenditures By Facility

Expenditures	FY17	FY16	FY15
Alton Mental Health Center	$ 24,590,968	$ 19,976,448	$ 23,510,588
IL Center for Rehabilitation Education, Roosevelt & Wood	5,010,433	3,856,900	4,768,200
Illinois School for the Visually Impaired	8,938,194	7,341,149	8,309,301
Illinois School for the Deaf	16,882,663	14,147,759	17,239,632
McFarland Mental Health Center	25,181,438	19,856,638	23,354,250
Chester Mental Health Center	43,148,670	35,218,504	39,297,087
Shapiro Developmental Center	73,522,782	75,018,244	77,172,494
Elgin Mental Health Center	67,602,398	59,834,475	67,412,719
Madden Mental Health Center	31,243,107	28,216,004	31,969,821
ChicagoRead Mental Health Center	28,621,600	24,083,670	27,859,851
Ludeman Developmental Center	56,152,778	55,292,838	59,320,936
Fox Developmental Center	17,374,236	18,373,761	18,482,958
Murray Developmental Center	34,574,898	35,944,150	27,924,610
Kiley Developmental Center	33,017,844	33,712,610	33,765,632
Choate Mental Health and Developmental Center	41,229,477	43,438,153	42,461,941
Mabley Developmental Center	14,591,230	13,692,853	14,341,779
TOTAL	**$ 521,682,716**	**$ 488,004,156**	**$ 517,191,799**

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APPENDIX E

Summary of Cash Receipts -- By Fund

	FY17	FY16
General Revenue Fund	$ 158,646,000	$ 111,577,000
Prevention & Treatment of Alcoholism & Substance Abuse Block Grant Fund	67,837,000	72,556,000
Group Home Loan Revolving Fund	14,000	20,000
Mental Health Fund	28,349,000	27,494,000
Vocational Rehabilitation Fund	122,574,000	115,054,000
Hansen-Therkelsen Memorial Deaf Student College Fund	5,000	20,000
Specialized Services for Survivors of Human Trafficking Fund	1,000	-
DHS Technology Initiative Fund	2,616,000	1,994,000
DCFS Children's Services Fund	68,800,000	68,800,000
Income Tax Refund Fund	46,034,000	51,292,000
Employment & Training Fund	397,510,000	424,602,000
DHS Special Purposes Trust Fund	238,701,000	225,729,000
Old Age Survivors Insurance Fund	77,584,000	79,224,000
Early Intervention Services Revolving Fund	82,886,000	103,215,000
DHS Community Services Fund	3,000,000	6,000,000
Electronic Benefits Transfer Fund	117,034,000	159,026,000
DHS Federal Projects Fund	13,231,000	14,086,000
DHS State Projects Fund	10,000,000	3,000
Commitment to Human Services Fund	11,000,000	-
Alcoholism & Substance Abuse Fund	7,386,000	8,176,000
Private Resources Fund	121,000	175,000
USDA Women, Infants & Children Fund	253,459,000	267,249,000
Rehabilitation Services Elementary & Secondary Education Act Fund	700,000	813,000
Maternal & Child Health Services Block Grant Fund	2,640,000	3,902,000
Community Mental Health Services Block Grant Fund	18,825,000	20,388,000
Youth Drug Abuse Prevention Fund	312,000	334,000
Juvenile Justice Trust Fund	1,488,000	1,958,000
DHS Recoveries Trust Fund	18,533,000	17,504,000
Social Services Block Grant Fund	53,338,000	64,899,000
TOTAL CASH RECEIPTS	**$ 1,802,624,000**	**$ 1,846,090,000**

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APPENDIX F

Property and Equipment

	FY17		FY16	
Balance, July 1	**$ 761,185,020**		**$ 757,416,605**	
Additions	5,431,402		5,336,658	
Deductions	(5,897,047)		(2,754,486)	
Net Transfers	(500,145)		1,186,243	
Ending Balance June 30	**$ 760,219,230**	*	**$ 761,185,020**	*
* Represented by:				
Equipment	93,577,664		96,227,061	
Land & land improvements	3,415,140		3,415,140	
Building & building improvements	580,303,386		578,400,723	
Site Improvements	82,217,198		82,217,198	
Capital lease equipment	705,842		924,898	
TOTAL	**$ 760,219,230**		**$ 761,185,020**	

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APPENDIX G

Accounts Receivable

	FY17	FY16
Taxes receivable, net	$ 160,000	$ 205,000
Due from other governments - federal	141,096,000	223,867,000
Due from other governments - local	223,000	328,000
Other receivables, net	189,698,000	161,136,000
Due from other State funds	50,881,000	8,255,000
Due from component units	-	5,000
Loans and notes receivable	494,000	445,000
Total Receivables	**$ 382,552,000**	**$ 394,241,000**