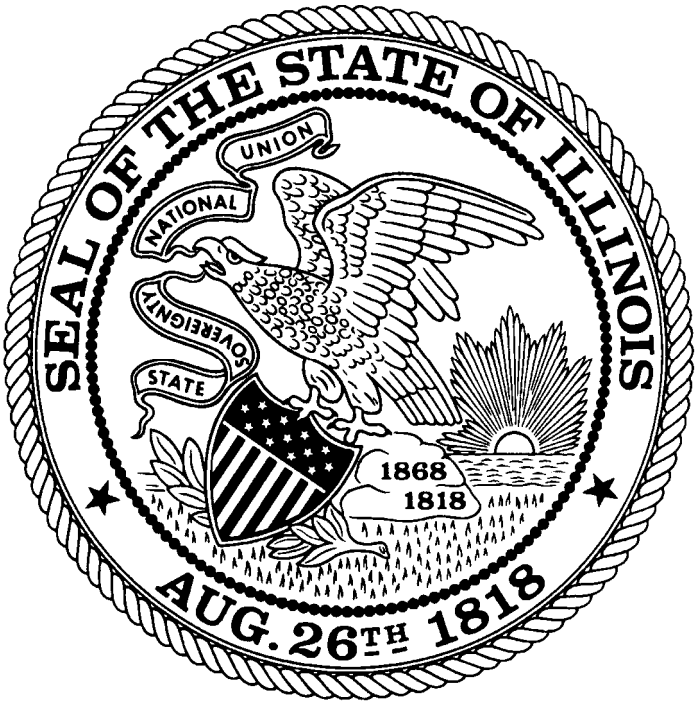
LEGISLATIVE AUDIT COMMISSION



Review of
Statewide Single Audit
Year Ended June 30, 2010

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Springfield, Illinois 62706
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REVIEW: 4356
STATEWIDE SINGLE AUDIT
YEAR ENDED JUNE 30, 2010

TOTAL FINDINGS/RECOMMENDATIONS - 103

TOTAL REPEATED RECOMMENDATIONS - 64

TOTAL PRIOR AUDIT FINDINGS/RECOMMENDATIONS - 93

Beginning with FY2000, the Office of the Auditor General converted to a Statewide Single Audit approach to audit federal grant programs. In prior years, audits of federal grant programs were conducted on a department by department basis. This review summarizes the FY10 Statewide Single Audit of federal funds. The compliance audit testing performed in this audit was conducted in accordance with *Government Auditing Standards,* the federal Single Audit Act*,* and Office of Management and Budget (OMB) Circular A-133. The auditors stated that the financial statements were fairly presented.

The Statewide Single Audit includes all State agencies that are a part of the primary government and expend federal awards. In total, 44 State agencies expended federal financial assistance in FY10. The Statewide Single Audit does not include those agencies that are defined as component units such as the State universities and finance authorities.

The Schedule of Expenditures of Federal Awards (SEFA) reflected total expenditures of $29.3 billion for the year ended June 30, 2010. This represents a $5.6 billion increase over FY09, or about 23.6%. Overall, the State participated in 402 different federal programs; however, 11 of these programs or program clusters accounted for approximately 87.3% ($25.6 billion) of the total federal award expenditures as exhibited in the following table.

Federal Program Award	Total Expenditure	% of Total
Medicaid	$ 8,612,800,000	29.4%
Unemployment Insurance	8,555,000,000	29.2%
Supplemental Nutrition	2,814,100,000	9.6%
Highway Planning, Construction	1,609,600,000	5.5%
State Fiscal Stabilization	1,015,200,000	3.5%
Special Education	742,800,000	2.5%
Title 1 Education Grants	696,300,000	2.4%
TANF	573,100,000	2.0%
Child Nutrition	495,300,000	1.7%
Children's Insurance Program	274,300,000	0.9%
Fed. Family Education Loans	238,000,000	0.8%
All Others	3,716,800,000	12.5%
Total Federal Awards	$ 29,343,300,000	

The funding for the 402 programs was provided by 23 different federal agencies. The table below shows the five federal agencies that provided Illinois with the vast majority of federal funding in FY10.

Federal Funding Agency	Total Grant	% of Total
Health & Human Services	$11,052,600,000	37.7%
Labor	8,851,600,000	30.1%
Agriculture	3,712,300,000	12.6%
Education	3,182,400,000	10.9%
Transportation	1,766,100,000	6.0%
All Others	788,300,000	2.7%

A total of 33 federal programs were identified as major programs in FY10. The 33 major programs had combined expenditures of $28.2 billion, and 369 non-major programs had combined expenditures of $1.1 billion. Eleven State agencies accounted for approximately 98.5% of all federal dollars spent in FY10 as depicted in the table below.

State Agency	Federal Expenditures	% of Total
DHFS	$ 8,800,400,000	30.0%
Employment Security	8,597,100,000	29.3%
Human Services	4,505,600,000	15.3%
Board of Education	3,288,600,000	11.2%
Transportation	1,764,600,000	6.0%
DCEO	687,700,000	2.3%
DCFS	403,000,000	1.4%
Public Health	277,000,000	1.0%
Student Assistance	246,000,000	0.8%
EPA	206,700,000	0.7%
IEMA	135,300,000	0.5%
All Others	431,300,000	1.5%

The table below summarizes the number of report findings by State agency and identifies the number of repeat findings.

State Agency	Number of Findings	Repeat Findings
State Comptroller/Office of the Governor	1	1
Human Services	10	7
Revenue	1	1
Healthcare and Family Services	24	14
DCFS	6	4

State Agency	Number of Findings	Repeat Findings
Aging	5	3
Public Health	5	4
State Board of Education	6	4
Community College Board	1	1
Board of Higher Ed	1	0
ISAC	7	3
Employment Security	9	9
Commerce & Economic Opportunity	4	1
Transportation	9	6
Emergency Management Agency	6	4
State Police	1	1
EPA	4	0
GOMB	2	0
Central Management Services	1	1
TOTAL	103	64

RECOMMENDATION 1
Office of the Governor
Office of the Comptroller

10-01. The auditors recommend the Office of the Governor and the IOC work together with the State agencies to establish a corrective action plan to address the quality and timeliness of accounting information provided to and maintained by the IOC as it relates to year end preparation of the CAFR and the SEFA. (Repeated-2002)

Findings: The State of Illinois' current financial reporting process does not allow the State to prepare a complete and accurate Comprehensive Annual Financial Report (CAFR) or the Schedule of Expenditures of Federal Awards (SEFA) in a timely manner.

In discussing these conditions with the Office of the Governor, they stated that the weakness is due to (1) lack of a statewide accounting and grants management system and (2) lack of personnel adequately trained in governmental accounting and federal grants management. The lack of a statewide accounting system is due to the State's current inability to obtain the capital funding required to acquire and implement such a system. Without adequate financial and grants management systems, agency staff are required to perform highly manual calculations of balance sheet and SEFA amounts in a short time frame which results in increased errors. The lack of adequate financial and grants management personnel is due to a failure to update the qualifications in the respective job titles to ensure that applicants have the minimum required education and skill sets to be properly trained.

In discussing these conditions with IOC personnel, they stated delays were caused, in part, by inaccurate data being submitted by some agencies. GAAP packages with inaccurate data cause delays in the audit process which in turn causes delays in releasing the final reports.

Governor's Response: The Governor's Office agrees with the finding. The State has been working with the Senate Committee on Governmental and Veteran Affairs to solve some of these problems. The Governor's Office, Governor's Office of Management and Budget (GOMB) and the Office of the Comptroller have developed a timeline for short term, mid-term, and long range plans. In the short term, GOMB is taking steps to assure that the agencies under the Governor provide timely financial information to the Comptroller. In addition, job descriptions are being developed by Central Management Services to allow agencies to hire employees skilled in financial statement preparation, and legislation has been proposed that will make changes in the personal policy that facilitate hiring such qualified individuals. The next phase of this process is to develop a business plan to present to the legislature. GOMB and the Governor's Office will be primarily responsible for developing such a plan, with input from a steering committee. Ideally, the business plan will be submitted to the Senate Committee on Governmental and Veterans Affairs for review during the 2011 fall legislative session. Based on the business plan, the legislature will need to provide capital funding for a new financial accounting system. Once funding is secured, an RFP will be used seeking proposals for software that meet the State's requirements. One of the requirements of the implementation process is expected to take several years. We expect this finding to continue until the implementation process is complete. Until that time we will continue working with the agencies to provide as complete information possible given the State's current capacities.

Comptroller's Response: The Office of the Comptroller will assist the Governor's Office in their efforts to increase the quality of the GAAP packages by providing training and technical assistance to State agencies.

RECOMMENDATIONS 2-11
Department of Human Services

10-02. The auditors recommend DHS review its current process for identifying and reporting interagency expenditures and implement monitoring procedures to ensure that federal and State expenditures expended by other State agencies meet the applicable program regulations and are not claimed or used to meet matching or maintenance of effort requirements under more than one federal program. (Repeated-2003)

Findings: IDHS does not have an adequate process for monitoring expenditures claimed under TANF and Child Care programs operated by various State agencies.

As the State agency responsible for administering these programs, IDHS has executed interagency agreements with each of the State agencies expending federal and/or State program funds. The interagency agreements require periodic reporting of a summary of the agency's "allowable" expenditures to IDHS for preparation of the financial reports required for each program.

During the year ended June 30, 2010, IDHS used expenditures from other agencies to claim reimbursement for or satisfy maintenance of effort (MOE) requirements for the TANF and Child Care programs as follows:

Program	Expending State Agency	Expenditures Claimed	Total Expenditures
Federal TANF	Department of Children and Family Services (DCFS)	$234,674,103	$573,086,000
Federal TANF	Illinois Student Assistance Commission (ISAC)	$56,564,211	$573,086,000
Federal TANF	Illinois Department of Revenue (IDOR)	$16,818,345	$573,086,000
Federal TANF	Department of Healthcare and Family Services (DHFS)	$1,421,390	$573,086,000
Program	**Expending State Agency**	**Expenditures Claimed**	**Total Expenditures**
TANF MOE	Department of Healthcare and Family Services (DHFS)	$20,020,324	$445,580,000
TANF MOE	Illinois State Board of Education (ISBE)	$56,443,793	$445,580,000
TANF MOE	Illinois Community College Board (ICCB)	$3,171,987	$445,580,000
Child Care MOE	Department of Children and Family Services (DCFS)	$6,303,430	$128,802,000

However, during testwork over the documentation of the monitoring procedures, auditors noted the following deficiencies:

- IDHS is not performing a detailed review of any costs claimed from expenditures reported by other State agencies.
- The interagency agreements with DHFS and DCFS are vague in nature and simply require the State agency to follow the applicable rules, regulations, and policies of the applicable federal program and provide all data, documents, reports, and information necessary for IDHS to manage the applicable federal programs. However, the specific federal regulations and requirements of the State Plan are not identified in the agreements.
- The questionnaires provided to IDHS by each of the State agencies did not include documentation of all areas applicable to the expenditures reported.

During FY10, auditors identified the following instances of non-compliance in testing of interagency expenditures which are reported as separate findings in this report for each of the respective agencies:

- Federal TANF expenditures provided by IDOR included amounts that did not qualify as allowable expenditures under the TANF regulations (see finding 10-12);
- Expenditures provided by DCFS under all programs identified above included expenditures to subrecipients for which DCFS has not established adequate monitoring procedures (see finding 10-37).

In discussing these conditions with IDHS officials, they stated this is due to lack of adequate staff with necessary skill set for monitoring interagency program expenditures.

Response: The Department agrees with the recommendation. We have enhanced our controls to ensure that federal and state expenditures expended by other state agencies meet the applicable program regulations and are not claimed or used to meet matching or maintenance of

effort requirements under more than one Federal program. The Office of Contract Administration has scheduled and started conducting onsite reviews of program policy and procedures at each of the six affected agencies to be completed by June 30, 2011.

Updated Response: Corrective action implemented:

- The Office of Contract Administration (OCA) has conducted onsite reviews of program policy and procedures at each of the six affected agencies.

- The Office of Contract Administration (OCA) reviewed a sample of expenditures as they conducted their on-site review.

In the future, the Office of Fiscal Services, Bureau of Federal Reporting will conduct the reviews of expenditures.

- The interagency agreements have been reviewed by Legal. The Office of Fiscal Services, Bureau of Federal Reporting has been advised to obtain from the various other agencies the procedures they use and attach to the agreement.

Corrective Action to be completed:

- The Office of Fiscal Services, Bureau of Federal Reporting is currently in the process of obtaining from the various other agencies the procedures they use and attach to the agreement.

10-03. The auditors recommend DHS review its current process for performing eligibility redeterminations and consider changes necessary to ensure all redeterminations are performed within the timeframes prescribed within the State Plans for each affected program. (Repeated-2003)

Findings: IDHS is not performing "eligibility redeterminations" for individuals receiving benefits under TANF, Children's Health Insurance Program (CHIP), and Medicaid programs in accordance with timeframes required by the respective State Plans.

During testwork over eligibility, auditors noted the State was delinquent (overdue) in performing the eligibility redeterminations for individuals receiving benefits under the TANF, CHIP, and Medicaid Cluster programs. In evaluating the eligibility redetermination delinquency statistics, auditors noted the statistics for the CHIP and Medicaid Cluster programs do not appear to have improved as a result of implementing an inadequate passive redetermination process as reported in finding 10-13. The delinquency statistics by program for June of FY10 are as follows:

Program	Average Number of Overdue Redeterminations	Total Number of Cases	Percentage of Overdue Cases
TANF	1,501	33,029	4.54%
CHIP	30,636	746,276	4.11%
Medicaid Cluster	47,729	455,965	10.47%

Payments made on behalf of beneficiaries of the TANF, CHIP, and Medicaid Cluster programs totaled $33 million, $242 million, and $8 billion, respectively, during FY10.

In discussing these conditions with IDHS officials, they stated this finding has repeated due to the TANF, CHIP, and Medicaid caseload increase from 1,213,653 to 1,270,933. This represents an increase of 57,280 cases. During FY10, casework staff decreased from 2,142 to 2,086. Given the significant increase in caseload, and the decrease in casework staff, and the speculation that casework staff will continue to decrease due to current fiscal constraints, improvements to redetermination currency will continue to be a challenge.

Updated Response: Accepted. Corrective Action to be Implemented:

- The Department of Human Services (DHS) is currently working with the Department of Health Care and Family Services (HFS) on implementing an online redetermination system. This will enable the department perform renewals more quickly and efficiently.

- Rollout is expected in December 2011.

10-04. The auditors recommend DHS review its current process for maintaining and controlling beneficiary case records and consider the changes necessary to ensure case file documentation is maintained in accordance with federal regulations and the State Plans for each affected program. (Repeated-2007)

Findings: IDHS does not have appropriate controls over case file records maintained at its local offices for beneficiaries of the SNAP Cluster, TANF, Children's Health Insurance Program (CHIP), and Medicaid programs.

During testwork, auditors noted the procedures in place to maintain and control beneficiary case file records do not provide adequate safeguards against the potential for the loss of such records. Specifically, the areas in which case files are maintained were generally disorganized and case files were stacked on or around file cabinets. Also, case files were generally available to all DHS personnel and that formal procedures have not been developed for checking case files in and out of the file rooms or for tracking their locations.

Additionally, during testwork over 240 case files selected relative to the TANF, CHIP, and Medicaid programs, auditors noted several delays in receiving case files due to the fact that case files had been transferred between local offices as the result of clients moving between service areas. One CHIP case record (out of 50 tested) could not be located for testing. Payments made on the behalf of beneficiaries of all these programs exceed $11.2 billion.

In discussing these conditions with IDHS officials, they stated this is due to the lack of staff and file cabinets and/or file cabinet space in which to properly store case records.

Updated Response: Corrective action to be completed:

Long Term:

- The DHS, Division of Human Capital Development (HCD) is implementing a document management system that will capture much of the information that is currently printed and placed in a paper file, and route it to an electronic file. This will reduce the overwhelming size and amount of files in the offices, and better track the location of case files.

- A Fall 2011 rollout of the document management system is anticipated.

10-05. The auditors recommend DHS review its current process for performing eligibility determinations and consider changes necessary to ensure procedures to verify whether beneficiaries have been convicted of a Class 1 or Class X felony are implemented. (Repeated-2006)

Findings: IDHS does not have adequate procedures in place to ensure individuals convicted of Class 1 or Class X drug felonies, probation and parole violators, and fugitive felons do not receive benefits under the TANF program.

During testwork, auditors noted IDHS' process for determining whether TANF applicants have been convicted of a Class 1 or Class X felony consists of applicants answering questions on the standard application which require a yes or no response. IDHS does not have procedures in place to corroborate the applicant's statements through cross matches with the Illinois Department of Corrections, Illinois State Police, or other mechanisms.

In discussing these conditions with IDHS officials, they stated this is due to the lack of cross match with other State agencies in order to better identify convicted drug felons.

Updated Response: Corrective action to be implemented:

Long Term:

- The Department is currently discussing the possibility of implementing a cross match with the Illinois State Police in order to better identify convicted Class 1 or X drug felons.

- On June 3, 2011, the Division of Human Capital Development (HCD) staff discussed the possible match with the State Police.

- As predicted, the cost would be high, and the accuracy of the match would be questionable. Discussions will continue with the State Police.

- The cost of the match would be prohibitive: During July, August, and September 2011, there was an average of 7,820 TANF applications submitted statewide. At $10 per inquiry, this would amount to a $78,200 monthly cost. Additionally, for cases that have a positive match, there would be a 30 – 45 day wait for the Illinois State Police (ISP) conviction details.

10-06. The auditors recommend IDHS review its current process for maintaining documentation supporting eligibility determinations and consider changes necessary to ensure all eligibility determination documentation is properly maintained. (Repeated-2001)

Findings: IDHS could not locate case file documentation supporting eligibility determinations for beneficiaries of the Children's Health Insurance Program (CHIP) and the Medicaid programs.

During testwork of 65 CHIP and 125 Medicaid beneficiary payments, auditors selected eligibility files to review for compliance with eligibility requirements and for the allowability of the related benefits provided and noted the following exceptions:

- In 24 CHIP case files and seven Medicaid case files, IDHS could not locate the supporting documentation of the redetermination completed and signed by the beneficiary in the case file.
- In two CHIP case files, IDHS could not locate adequate documentation supporting that the required State Online Query (SOLQ) and Division of Child Support Enforcement (DCSE) cross match procedures were performed.
- In five CHIP case files, IDHS could not locate adequate documentation supporting income verification procedures were performed. In lieu of collecting copies of pay stubs to verify income, the caseworkers verbally confirmed income information, relied on client handwritten notes, or used income verified on previous applications.

In each of the case files missing documentation, each of the eligibility criteria was verified through additional supporting documentation in the client's paper and electronic case files. Therefore all information necessary to establish and support the client's eligibility for the period was available; however, the respective application and/or source documentation related to the redetermination/income verification procedures performed including evidence of case worker review and approval could not be located.

In discussing these conditions with IDHS officials, they stated the finding is due to lack of adequate staffing and proper filing storage devices.

Response: The Department agrees with the recommendation. We will continue to ensure that staff understands the importance of proper and accurate filing processes. A rapidly growing caseload coupled with the inability to hire additional staff to handle the caseload presents the potential for paper filing errors and backlog. In the fall of 2011, the Department is planning to pilot a document management system that will capture much of the information that is currently printed and placed in a paper file, and route it to an electronic file. This will reduce the overwhelming size and amount of files in the offices, and better track the location of case files and their contents.

Updated Response: Corrective Action to be Implemented:

- The DHS, Division of Human Capital Development (HCD) is implementing a document management system that will capture much of the information that is currently printed and placed in a paper file, and route it to an electronic file. This will reduce the overwhelming size and amount of files in the offices, and better track the location of case files.

- A Fall 2011 rollout of the document management system is anticipated.

10-07. The auditors recommend DHS notify all subrecipients in writing of the specific federal program name, award number, CFDA number, and amount of non-cash assistance on a quarterly basis. Auditors also recommend IDHS implement procedures to ensure ARRA information and requirements are properly communicated to its subrecipients. (Repeated-2009)

Findings: IDHS does not have adequate procedures to communicate non-cash expenditures to its subrecipients.

During testwork over the award notification process for subrecipients of the WIC, TANF, Child Care, and Title XX programs, auditors noted IDHS only reports the non-cash assistance attributable to each subrecipient on an annual basis. Because IDHS does not identify the specific federal program name, award number, catalog of federal domestic assistance (CFDA) number, or amount of non-cash assistance until several months after the end of the State's fiscal year, subrecipients cannot prepare their SEFAs or have OMB Circular A-133 audits performed until the information is received from IDHS.

In addition, IDHS expended ARRA funding for certain beneficiary payments made under the Child Care program which were not separately identified as ARRA funded in the non-cash assistance notifications sent to Child Care subrecipients. Further, IDHS' grant agreements for the Child Care program did not identify the requirement for subrecipients to separately report ARRA funded non-cash program expenditures on their schedule of expenditures federal awards (SEFA) and data collection form.

In discussing these conditions with IDHS officials, they stated procedures for reporting non-cash assistance to providers were still being established and implemented during fiscal year 2010.

Updated Response: Corrective Action Implemented:

- We have implemented procedures to ensure ARRA information and requirements are properly communicated to its subrecipients on quarterly basis.

WIC non-cash

- The Office of Contract Administration in conjunction with WIC program staff have prepared and mailed the four consecutive quarterly reports for FY11 (11/17/10, 2/9/11, 5/16/11, and 9/16/11).

Child Care non-cash

- The Office of Contract Administration in conjunction with Child Care program staff and Fiscal services staff have prepared and mailed four consecutive quarterly reports for FY11 (5/3/11 – reported two quarters, 5/20/11 and 9/16/11).

10-08. The auditors recommend DHS revise the expenditure report and related instructions provided to its subrecipients to ensure an appropriate level of information is obtained by IDHS to monitor the expenditures and matching requirements of the SNAP Cluster and to properly determine amounts to be reimbursed to the subrecipients. (Repeated-2009)

Findings: IDHS does not have adequate procedures in place to ensure expenditures submitted by its subrecipients are allowable under program regulations for the SNAP Cluster.

During testwork, auditors noted the expenditure report used by the subrecipient of the SNAP Cluster is highly summarized and does not provide sufficient information for IDHS to properly monitor the subrecipient's expenditures and matching contributions or compute the amount to be reimbursed. Specifically, the report does not separately identify in-kind contributions from other expenditures used to meet the matching requirement. As a result, the amount reimbursed by IDHS includes in-kind contributions from local governments which are not allowed to be reimbursed from

federal sources. In-kind contributions included in the expenditure reports submitted for quarters ending on or during the year ended June 30, 2010 approximated $2.4 million.

In discussing these conditions with IDHS officials, they stated this is due to subrecipient expenditures and matching requirements not being properly monitored.

Response: The Department agrees with the recommendation. Beginning Oct. 1, 2010 the SNAP-Ed program changed significantly. The program was revised by USDA to become a 100% reimbursement program. States will no longer be required to document any matching costs. As a result, the program does not need to pursue additional documentation of match. Documentation from USDA outlining the changes to the program was provided to the auditors during the exit conference.

Updated Response: Corrective Action Implemented:

- The Department has established procedures to review SNAP-Ed expenditures requirements.
- Beginning October 1, 2010 the SNAP-Ed program changed significantly.
- The program was revised by USDA to become a 100% reimbursement program. States will no longer be required to document any matching costs.
- As a result, the program does not need to pursue additional documentation of match.
- Documentation from USDA outlining the changes to the program was provided to the auditors during the exit conference.

10-09. The auditors recommend DHS review its current process for sanctioning beneficiaries and consider changes necessary to ensure sanctions are only applied when appropriate.

Findings: IDHS does not have adequate procedures to ensure that TANF Sanction Procedures are properly followed for individuals receiving benefits under the program who were the adult custodial parent of a child under six when child care was not available.

During testwork over 40 cases of single custodial parents caring for a child who is under six years of age whose benefits were reduced or terminated, auditors noted one case in which a client was sanctioned prior to failing to comply with program requirements. Upon further investigation of this case, the individual ultimately failed to attend a required appointment subsequent to the sanction being applied to her case. The case record did not include and IDHS could not provide an explanation for the discrepancy in the timing of these sanctions.

In discussing these conditions with IDHS officials, they stated the finding is due to caseworker error.

Updated Response: Corrective Action Implemented:

- Sanction policy and procedure are set forth in a clear, concise manner in the Cash, Medical and Food Stamp manual and staff has been reminded of the policy requirements to ensure sanctions are only applied when appropriate.
- Family and Community Resource Center (FCRC) management has reviewed sanction policy in a staff meeting.
- The Division of Human Capital Development (HCD) Central Office staff have discussed the finding with the Local Office Administrators (LOAs) in Regional meetings.
- Underpayments that resulted from the premature sanction have been calculated and issued.

10-10. The auditors recommend DHS implement procedures to ensure all financial reports are submitted within the established deadlines. The auditors also recommend IDHS implement standardized procedures to monitor reporting requirements and submissions.

Findings: IDHS does not have a process in place to ensure financial reports are prepared and submitted within required timeframes for the Vocational Rehabilitation program.

During testwork over financial reports required to be submitted during FY10 for the Vocational Rehabilitation program, auditors selected two quarterly financial status (SF-269 and SF-425) reports for all open Vocational Rehabilitation Grants and the annual RSA-2 report submitted during the year ended June 30, 2010 to review for compliance with reporting requirements and noted several of the reports tested were not submitted within the required timeframes.

In discussing these conditions with IDHS officials, they stated delays in submission of the federal reports were due to inadequate staffing and changes in the data elements required to be reported. The conversion of federal financial status reports from SF-269 forms to SF-425 forms, which required changes in data collection for particular elements, resulted in data elements from not being available in time to meet the required timeframes.

Updated Response: Corrective Action Implemented:

- The Division of Rehabilitation Services staff has implemented a process for more comprehensive review of data used in the completion of the Rehabilitation Services Administration (RSA-2) report prior to submission.
- Staff position has also been created to complete federal reports for the Division of Rehabilitation Services.

10-11. The auditors recommend DHS review the process and procedures in place to prepare the annual program cost report and implement procedures necessary to ensure this report is accurate.

Findings: IDHS did not accurately report expenditures in the RSA-2 Program Cost Report (RSA-2) for the Vocational Rehabilitation program. During testwork over the RSA-2 report for the federal fiscal year ended September 30, 2009, auditors noted IDHS improperly reported small business enterprises expenditures.

In discussing these conditions with IDHS officials, they stated this occurred due to a typographical error in entry into one of the worksheets used to produce the Rehabilitation Services Administration report.

Updated Response: Corrective Action Implemented:

- The Division of Rehabilitation Services staff has implemented process for a more comprehensive review of data used in the completion of the Rehabilitation Services Administration (RSA-2) report prior to submission.

- Staff position has also been created to complete federal reports for the Division of Rehabilitation Services.

RECOMMENDATION 12
Department of Revenue

10-12. The auditors recommend the Department of Revenue review the process and procedures in place to identify earned income tax credit expenditures claimed under the TANF program and implement changes necessary to ensure only amounts eligible for claiming are reported to IDHS. (Repeated-2005)

Findings: IDOR has not established adequate procedures to determine whether earned income tax credits claimed under the TANF meet the federal allowability criteria.

During testwork, auditors noted IDOR's procedures for verifying the validity of taxpayer's earned income tax credit claims with federal tax returns are not completed prior to paying refunds to taxpayers or preparing the earned income tax credit claiming report for IDHS. Without this information, IDOR relies solely on limited data edits designed to verify the mathematical accuracy of the return and to identify individuals who may not meet the earned income tax credit criteria. The data verification procedures are not performed until the middle of the following year and have historically resulted in adjustments to amounts previously claimed.

Further, auditors noted that IDOR's limited data edits to identify individuals who may not meet the earned income tax credit criteria do not consider all information available to IDOR when they process the taxpayer's return and pay a refund. During testwork of earned income tax credits claimed under the TANF program, auditors identified:

- The population of earned income tax credits claimed under the TANF program during FY10 included 391 transactions (totaling $31,139) that had been flagged by IDOR for having a W-2 form on file that was considered questionable and required further taxpayer correspondence or investigation to support the taxpayer's return. In discussing this issue with IDOR officials, they stated that IDOR only considers the validity of a taxpayer's W-2 in determining whether to claim State withholding credits, but not to determine whether the taxpayer had earned income during the tax year.

- The population of earned income tax credits claimed under the TANF program during the year ended June 30, 2010 included 3,591 transactions (totaling $354,775) refunded to a taxpayer with an address outside of the State of Illinois who was not serving in the military. IDOR's practice is to process returns showing out-of-State addresses as Illinois residents,

unless the filer checks a box indicating that they are a part-year resident or non-resident. As a result, IDOR had not determined whether or not the earned income tax credits for these taxpayers were allowable under the TANF program. In discussing this issue with IDOR officials, they stated that IDOR does not use the taxpayer's address or compare to other State databases to determine that a TANF claim was a resident of the State.

In discussing these conditions with IDOR officials, they stated they disagree with the finding and believe their process is adequate.

Response: The Department of Revenue disagrees with the finding. The underlying issue is twofold:

(1) The Department pays the refundable earned income credit before it is possible to verify that the federal Earned Income Credit (EIC) has been paid by the IRS.

(2) The Department requests the draw-down of TANF match for the refundable portion of the tax refund before it is possible to verify that the federal Earned Income Credit has been paid.

Federal Health and Human Services (HHS) policy administrators in Washington D.C. validated the Department's process in 2006. The communication, which was approved by the Director of State TANF Policy, states: "The State has a reasonable verification process in place. Tax claims are checked against tax returns. Then reconciliation/validation of the tax claim occurs subsequent to actual payment of the refundable portion of the credit – the usual and customary method of reconciliation of tax issues."

The Department pays the Illinois EIC based on the information reported on the taxpayer's Illinois 1040 filing (as required by Illinois Statute, the Illinois EIC is 5% of the federal EIC), before the IRS has shared the federal EIC information, and works with the Illinois Department of Human Services to periodically draw-down federal funds to replenish the Refund fund. The Department does not receive the IRS report on federal EICs paid to Illinois taxpayers until October or November. Based on this report, when the IRS has made changes to what the taxpayer originally claimed, the Department bills the taxpayer and adjusts the draw-down accordingly. As a result, at the conclusion of the process, no TANF funds were utilized for ineligible EIC payments.

In addition, it should be noted that the two bullet points referenced by the auditor only identified "population of transactions" and the auditor did not perform procedures to verify if these transactions were invalid TANF EIC payments.

The Department does not believe it is reasonable to require taxpayers to wait for federal data to be available in order to receive the TANF portion of their refund; the Department believes that splitting a tax refund into two payments would be inefficient use of State resources and confusing to the taxpayer.

Auditors' Comment: *As stated in the finding above, the verification procedures are not performed by IDOR until several months after IDHS has claimed the tax credits reported by IDOR. The State's current procedures allow unallowable costs to be claimed to the TANF program. Our finding and recommendation pertain solely to the timing of the claiming of TANF expenditures, not how IDOR chooses to process refunds or operate the Illinois Earned Income Tax Credit program.*

Additionally, the populations of transactions identified in the finding are transactions which may not be eligible for claiming and should be evaluated by IDOR prior to claiming under the TANF Cluster.

RECOMMENDATIONS 13-36
Department of Healthcare and Family Services

10-13. The auditors recommend DHFS review its current process for performing eligibility redeterminations and consider changes necessary to ensure redeterminations are performed in accordance with federal regulations and the State Plans for each affected program. (Repeated-2007)

Findings: Eligibility redetermination procedures implemented by DHFS for the Children's Health Insurance Program (CHIP) and Medicaid are not adequate.

Effective in February 2006, DHFS revised its procedures for performing eligibility redeterminations for children *receiving* services under the CHIP and Medicaid programs, The passive redetermination procedures require recipients to review the renewal form and report any changes to eligibility information; *however,* in the event there are no changes to the information and there are only children on the case, a response is not required.

Upon further *review* of the passive redetermination process, auditors noted neither DHFS, nor the Illinois Department of Human Services (IDHS) which performs most eligibility determinations for these programs, maintains a formal record of the cases subject to passive redetermination procedures, As a result, auditors were unable to quantify the number of cases subject to the passive redetermination policy.

Payments made on the behalf of beneficiaries of the CHIP and Medicaid programs were $242,508,000 and $8,254,467,000 during FY10.

In discussing these conditions with DHFS officials, they stated the inadequate procedures identified during the audit are the Department's passive redetermination procedures, As to quantifying the number of cases subject to the passive redetermination policy, DHFS stated they are working with DHS to obtain a listing of the cases subject to the passive redetermination procedures.

Updated Response: Partially Implemented. The Department submitted a request to Federal CMS asking that all family health plans require an active renewal annually, Federal CMS has informed Department that eliminating passive renewal would be inconsistent with MOE requirements, Policy changes that would make the renewal process more restrictive and burdensome and thereby have the effect of restricting eligibility would constitute a violation of the MOE provision of the ACA. They asked the State to develop a plan for incorporating the use of electronic data matching into the annual renewal process and submit it to federal CMS for their approval. The Department is in the process of developing that plan. Once approved, an implementation timeline will be established.

The Department has completed a report to quantify passive redeterminations, which has been run and verified to ensure the data is accurate.

10-14. The auditors recommend DHFS review its current process for maintaining documentation supporting eligibility determinations and consider changes necessary to ensure all eligibility determination documentation is properly maintained. (Repeated-2009)

Findings: DHFS could not locate case file documentation supporting eligibility determinations for beneficiaries of the Children's Health Insurance Program (CHIP) and the Medicaid programs.

During testwork of 65 CHIP and 125 Medicaid beneficiary payments totaling $168,841 and $200,011, respectively, auditors noted the following exceptions:

- In one CHIP case file (with medical payments sampled of $80), DHFS could not locate adequate documentation supporting income verification procedures were performed. In lieu of collecting copies of pay stubs to verify income, the caseworkers verbally confirmed income information, relied on client handwritten notes, or used income verified on previous applications. Medical payments made were $2,864.

- In ten CHIP case files (with medical payments sampled of $3,297), DHFS could not locate the supporting documentation of the redetermination completed and signed by the beneficiary in the case file. Medical payments made were $62,389 during FY10.

In discussing these conditions with DHFS officials, they stated the cases identified as exceptions were subject to the Department's passive redetermination process.

Updated Response: Under Study. The Department submitted a letter to Federal CMS to request that all family health plans require an annual verification of income. Federal CMS informed the Department that requiring income verification at renewal would be inconsistent with MOE requirements. Policy changes that would make the renewal process more restrictive and burdensome and thereby have the effect of restricting eligibility would constitute a violation of the MOE provision of the ACA. They asked the State to develop a plan for incorporating the use of electronic data matching into the annual renewal process and submit it to federal CMS for their approval. The Department is in the process of developing that plan, Once approved, an implementation timeline will be established.

10-15. The auditors recommend DHFS review its current process for processing and paying medical payments and consider changes necessary to ensure medical payments are made within the timeframes prescribed within the federal regulations. (Repeated-2008)

Findings: DHFS is not paying practitioner medical claims for individuals receiving benefits under the Children's Health Insurance Program (CHIP) and Medicaid programs within timeframes required by federal regulations.

Federal regulations require the medical providers to submit all medical claims within twelve months of the date of service and require the State to pay 90% of all clean claims within 30 days of the date of receipt and 99% of all clean claims within 90 days of the date of receipt. Further, under the American Reinvestment and Recovery Act (ARRA), states must comply with these claims processing requirements or lose their eligibility for the increased federal medical assistance percentage (FMAP) for certain expenditures. Subsequent to February 17, 2009, any practitioner claim received on a day in which the State was not in compliance with the claims processing requirements is ineligible to receive the increased FMAP rate.

During a review of the analysis covering practitioner medical payments during FY10, auditors noted medical payments were not made within the payment timeframes required. Management's daily analysis of claims processed after the enactment of ARRA identified 24 days in which the State was not in compliance with the claims processing requirements, The State received claims totaling $353,022,405 on those days, resulting in $41,048,595 of lost federal reimbursement.

In addition, during the review of a USDHHS audit and procedures performed, auditors noted the following:

- The agency improperly calculated the prompt payment compliance based on 31 day and 91 day thresholds instead of the required 30 day and 90 day thresholds, and consequently, incorrectly determined some days were eligible for the increased FMAP rate.
- The agency incorrectly excluded categories of claims from its initial prompt payment calculations including zero paid claims with no warrants, denied clean claims, and dental claims previously excluded.
- The agency improperly included certain non-matchable claims in its initial prompt payment calculations.
- The agency did not adjust the financial expenditure report for the quarter ending June 30, 2009 for expenditures not eligible for the increased FMAP rate that were previously claimed on the March 31, 2009 financial expenditure report, and consequently, the agency inappropriately received increased FMAP related to the ineligible expenditures.

As a result of the deficiencies noted above, DHFS was not eligible for $2,586,522 of increased FMAP previously received on $22,262,056 of claims received on days when it did not comply with the prompt payment requirements.

Response: The Department accepts the finding. During the ARRA period, DHFS prioritized Medicaid claims to assure compliance with the regulations to the degree that cash allowed. In the scope of the entire Medical assistance budget, the number of instances where timely payment did not occur was not considered significant. The errors identified in the USDHHS audit had already been corrected by the Department on the Quarter Ending December 2009 CMS 64 quarterly report. The Department will continue to process medical claims within the timeframe required under federal regulations, although they may be held for payment until cash is available.

Updated Response: Implemented. The Department continues to pull practitioner bills well in advance of 30 days (approximately 10 days) and communicates priorities to the Comptroller's cash management staff. As stated in the response, appropriations (funding) and cash availability are the keys to being able to actually pay the bills within the prescribed timeframes.

10-16. The auditors recommend DHFS implement procedures to ensure all hospital assessment payments are disbursed within the required timeframes.

Findings: DHFS did not disburse monthly hospital assessment payments within the required timeframes. The Hospital Assessment Program was approved by the Federal Centers for Medicare and Medicaid Services (CMS) to provide approximately $900 million a year in new federal funding to strengthen Illinois' health care system over five years.

During testwork over monthly hospital assessment payments, auditors noted payments made in July 2009 totaling $77,352,213 that were not paid by the seventh business day of the month. Delays ranged from 18 to 39 days after the required timeframe.

In discussing these conditions with DHFS officials, they stated this was a one-time error that occurred as part of an electronic file submission that resulted in a rejected file. As soon as the rejection was acknowledged, a corrected file was submitted resulting in the late payment. All subsequent months were processed in a timely manner, resulting in no financial impact to either DHFS or the providers.

Updated Response: Implemented. The Department has assigned additional personnel to review the file to assure that the annual changeover of fiscal year notes reflect the change in year.

10-17. The auditors recommend DHFS implement procedures to ensure provider audits are performed and completed in a timely manner. (Repeated-2008)

Findings: DHFS did not initiate and complete audits of providers of the Children's Health Insurance Program (CHIP) and Medicaid programs in a timely manner.

During testwork over 50 providers recommended by the OIG for audit, auditors noted there were significant time delays between the date DHFS determined a provider audit should be performed and the start date of the audit. Specifically, nine of the 50 provider audits tested had not been started as of the date of testwork. The number of days that had elapsed ranged from 191 to 798 days. For the 41 provider audits completed, the number of days that had elapsed between the dates the provider was recommended for audit and the audit start date ranged from six to 1,121 days. In addition, provider audits were not completed in a timely manner.

In discussing these conditions with DHFS officials, they stated that one audit was not completed timely due to staff turnover. The second audit was not completed timely because a customized audit protocol was utilized, which required significant manual data entry to determine discrepancies. The last audit noted as untimely was delayed due to availability of information to be audited.

Response: The Department accepts the finding. It should be noted that there is no federally prescribed timeframe for completion of provider audits; however, the OIG strives to complete all audits in a timely manner. As with the nature of the audit profession, situations occur that may extend the time necessary to complete the audit such as the type and volume of documentation to be audited (hospital records vs. individual practitioner records) the type of audit (i.e. pharmacy script audit vs. pharmacy inventory audit) or the availability of the information to be audited. There are also delays due to external entities such as the Federal Bureau of Investigation or Illinois State Police performing investigations on the same auditee. As agreed to in the exit interview with KPMG, these types of extenuating circumstances must be and will be considered during the assessment of an audit being completed timely.

The timeframes listed above are indicative of OIG's efforts to reduce the length of time to complete any audit. The OIG will further enhance the controls in place to improve the process for completing audits within 180 days. The OIG will also ensure adequate documentation is maintained to support any extenuating circumstances that cause audits to surpass the 180 day timeframe.

Updated Response: Accepted. The Bureau Chief, Assistant Bureau Chief and Audit Manager for the OIG Bureau of Medicaid Integrity meet on a monthly basis to review all open audit cases. In addition, the OIG has completed the assessment of the workflow and have determined the necessary changes to maintain efficient and expeditious throughput for audit tasks. The OIG

Bureau of Information Technology is currently working on the system changes need to implement the new workflow.

10-18. The auditors recommend DHFS review its current process for performing Medicaid Eligibility Quality Control (MEQC) reviews and consider changes necessary to ensure reviews are completed in a timely manner and summary reports are submitted within the timeframes required by CMS. (Repeated-2008)

Findings: DHFS did not complete Medicaid Eligibility Quality Control (MEQC) reviews in a timely manner.

The DHFS Office of the Inspector General (OIG) is responsible for performing and reporting the results of quality control reviews of beneficiary eligibility determinations performed by the State for the Medicaid and CHIP programs. In place of the traditional MEQC program, the OIG participates in various MEQC pilot programs which target specific eligibility risk areas. These reviews are designed to assist the State in monitoring the accuracy of eligibility determinations and the appropriateness of medical payments made on the behalf of beneficiaries. The results of these reviews are required to be reported to the Center for Medicare and Medicaid Services (CMS) within ten months of the end of the applicable fiscal year.

During the *review* of the 1,177 pilot program reviews completed in FY10, auditors noted reviews were not completed within a reasonable timeframe as follows:

Timeframe	Number of Reviews
0-60 days	490
61-120 davs	512
121-180 days	155
181-240 days	17
240 + days	3

In discussing these conditions with DHFS officials, they stated the reviews were not completed timely due to staff turnovers and delayed receipt of information from 3rd party resources.

Response: The Department accepts the finding. It should be noted that the only federally prescribed timeframe for completing MEQC reviews is the submission of the summary of findings by August 1 for the previous year's review; *however,* the OIG strives to complete MEQC reviews in a timely manner. There are circumstances, such as the delay in receiving information back from a critical 3rd party resource, that may extend the time to complete a *review.*

The OIG is implementing controls to improve the process for ensuring the MEQC reviews are completed within 180 days. These controls include improving monitoring reports and higher level management approvals for exceptions to completion target dates.

Updated Response: Implemented. OIG management is using an Aging Report to monitor the timeliness of the reviews. Specifically, the Aging Report is reviewed by the supervisory and managerial staff and then discussed with the Bureau Chief and Assistant Bureau Chief in monthly conferences.

10-19. The auditors recommend DHFS review its current process for monitoring and reporting overpayments and implement any changes necessary to ensure such overpayments are reported on the quarterly financial expenditure reports and returned to the federal government.

Findings: DHFS does not have an adequate process to monitor and report overpayments identified with providers of the Home and Community Based Services Waiver programs administered by the Illinois Department of Human Services (IDHS).

Specifically, DHFS did not report Medicaid overpayments identified by the Fraud Unit for services provided from December 1, 1999 through December 31, 2008 on quarterly financial expenditure reports in accordance with federal requirements. 75 overpayments (totaling $26,383) out of 100 overpayments tested (totaling $134,449) were not reported on quarterly financial expenditure reports and, consequently, were not returned to the federal government. Overpayments identified by the Fraud Unit from December 1, 1999 through June 30,2009 totaled $3,874,265.

Auditors noted DHFS has not modified its process for reporting these overpayments since receiving the federal audit report. Overpayments identified by the federal audit were $940,704 for the year ended June 30, 2010.

In discussing these conditions with DHFS officials, they stated that they did not report the overpayments as they had not developed and implemented internal controls to ensure overpayments identified by the Fraud Unit were reported on the CMS-64.

Response: The Department accepts the finding. The Department has refunded the amount identified. The Department will work with DHS to assure that it is aware of the requirement to inform us when Medicaid overpayments are identified. Furthermore, the Department will perform routine follow up to verify that DHS complies with this requirement.

Updated Response: Accepted. The Department has scheduled meetings with DHS/DRS to discuss progress on developing and implementing necessary system changes. Upon completion the department will perform routine follow up to verify that DHS complies with this requirement.

10-20. The auditors recommend DHFS implement procedures to verify with recipients whether services billed by providers were received.

Findings: DHFS does not have adequate procedures in place to verify with beneficiaries of the Medicaid Cluster program whether services billed by providers were actually received.

During testwork, auditors noted DHFS procedures for verifying with beneficiaries whether services billed by providers were actually received by Medicaid Beneficiaries consisted of 7 special projects performed by the DHFS Office of Inspector General and Bureau of Comprehensive Health Services. However, the current projects only cover procedures billed by non-emergency transportation providers, optometric providers, and dental providers which only account for 2% of total provider reimbursements. Further, DHFS does not perform any verification procedures for services billed by the following provider types:

- Hospitals
- Mental Health Facilities
- Nursing Facilities
- Intermediate Care Facilities

- Physicians
- Other Practitioners
- Managed Care Organizations
- Home and Community-Based Service Providers
- Physical Therapy Providers
- Occupational Therapy Providers

In discussing these conditions with DHFS officials, they stated that processes utilized by DHFS, IDHS and IDPH appeared to meet the federal requirement, which was supported by no exceptions noted during the recently completed federal Program Integrity audit.

Response: The Department accepts the finding. There are various recipient verification processes employed by DHFS, in conjunction with DHS and IDPH. DHFS also incorporated the requirement for the Medicaid Managed Care Organizations (MCOs) to perform recipient verification in the current MCO contracts and the MCOs began conducting these verifications during FY10. The Department will develop a risk-based methodology to perform recipient verification for the remaining high risk provider types that are not covered by other processes.

Updated Response: Accepted. The design phase for the development of a risk-based methodology to perform recipient verifications is scheduled to begin January 1, 2012. The scheduled implementation date is March 1, 2012.

10-21. The auditors recommend DHFS review its current process for calculating provider reimbursements and consider the changes necessary to ensure provider payments are properly calculated and paid. (Repeated-2009)

Findings: DHFS did not properly reimburse a provider of the Medicaid program in accordance with its established reimbursement methodology.

During testwork of Medicaid Cluster program beneficiary payments, auditors selected a sample of 125 beneficiary payments (totaling $200,011) to review for compliance with eligibility requirements and for the allowability of the related benefits. For one provider reimbursement, auditors noted that DHFS erroneously calculated a reimbursement using a provider rate of $1,151 for a claim where actual charges totaled $957. Upon review of all charges included in the retroactive rate adjustment calculation, DHFS identified the provider received overpayments of $20,021 relative to 33 claims in which actual charges were less than the negotiated rate.

In discussing these conditions with DHFS officials, they stated claims were adjusted due to being incorrectly priced as Per Diem, instead of DRG.

Response: The Department accepts the finding. The 33 claims, including this particular claim, were determined as affected, and have been correctly adjusted. Repricing logic will include an additional step to ensure future adjustments do not exceed the provider's billed charges.

Updated Response: Implemented. The DRG exclusion code error was a data entry error, however, an additional step has been added to the repricing logic limiting payment to the lesser of computed payment or covered charges.

10-22. The auditors recommend DHFS review its current process identifying and recouping ineligible reimbursements and consider any changes necessary to ensure provider recoupments are identified and made in a timely manner.

Findings: DHFS did not identify and recoup an ineligible reimbursement for a beneficiary of the Medicaid Managed Care program.

In the review of a Managed Care provider reimbursement for one Medicaid beneficiary for $1,780 selected for testwork, auditors noted a recipient continued to receive benefits under the Managed Care program despite moving to an address outside the service area of the specific health plan participating in the Managed Care program. Despite notifying the Illinois Department of Human Service (IDHS) of the move on December 2, 2009, eligibility for the health plan for the recipient was not terminated until the physical case file was transferred to the IDHS local office responsible for maintaining the case file under the new service area on January 31, 2010. Ineligible Managed Care program reimbursements for this beneficiary that occurred from December 2, 2009 through January 31, 2010 totaled $3,910.

In discussing these conditions with DHFS officials, they stated that when the enrollee moved out of the Managed Care Organization (MCO) contracting area, DHS did not take action to transfer the case in a timely manner, thereby not closing out the MCO. The MCO continued to receive the capitation payment until DHS took action to update the case to show the client had moved. At that point, DHFS completed a disenrollment form and initiated recoupment of the capitation payment back to the beginning of the month the client moved out of the contracting area.

Response: The Department accepts the finding. The Department will notify DHS that action to transfer cases needs to be completed in a timely manner. The Department will continue to ensure provider recoupments are processed as required.

Updated Response: Implemented. The Department retroactively disenrolled the client from the MCO and voided the capitation payment to the MCO in February, 2011. The Department of Human Services (DHS) developed a new procedure and policies allowing the HFS hotline to update client addresses in the DHS and HFS eligibility systems.

10-23. The auditors recommend DHFS implement procedures to ensure all disproportionate share hospital payments are updated and made in a timely manner to government owned hospitals.

Findings: DHFS did not update and make disproportionate share hospital payments in a timely manner to government owned hospitals participating in the Medicaid Cluster. On December 4, 2008, the Department received approval from the Centers for Medicare and Medicaid Services (CMS) for an amendment to the Medicaid State Plan, which changed the methodology for reimbursing two government owned hospitals participating in Medicaid and was retro-active as of July 1, 2008. Each hospital was to receive an annual disproportionate share hospital award which is required to be paid out in twelve equal monthly installments throughout the year.

During testwork of 65 CHIP and 125 Medicaid beneficiary payments, auditors reviewed provider reimbursements for accuracy and the allowability of the related benefits provided. During those procedures, the following exceptions related the provider reimbursements and disproportionate share hospital payments:

- For one of the government owned hospitals, an updated interagency agreement reflecting the changes made by the Medicaid State Plan amendment to the methodology for calculating reimbursement rates was not executed until March 9, 2010, 460 days after the State Plan was amended and 616 days after the methodology was implemented. The methodology used to reimburse the hospital was not updated to agree with the changes made by the Medicaid State Plan amendment until July 7, 2009, 217 days after the State Plan was amended.
- The agency did not set the per diem rates for the two providers until September 20, 2010 and June 29,2010, respectively.
- Because the agency did not set the provider per diem rates for 2009 until July 7, 2009 and May 20, 2009, these hospitals' previous reimbursements were subsequently adjusted by $31,602,000 and $10,359,157, respectively, during the year ended June 30, 2010.
- For one provider, the disproportionate share hospital payments of $123,006,230 for the period October 2007 through September 2008 were not made until November 9, 2009.
- For the second provider, the disproportionate share hospital payments of $29,187,500 for the period July 2008 through July 2009 were not made until September 11, 2009.

Total medical reimbursements and disproportionate share hospital payments made to these two providers of the Medicaid Cluster and CHIP program totaled $847,519,000 and $479,711,000, respectively, during FY10. Payments made on behalf of beneficiaries of the CHIP and Medicaid Cluster programs totaled $242,508,000, and $8,254,467,000, respectively.
In discussing these conditions with DHFS officials, they stated this was an isolated incident that occurred as a result of transitioning the rate methodology for two government providers.

Response: The Department accepts the finding. The Department has streamlined the process which was agreed to between the Department and the providers, resulting in a timelier implementation of rates. A limited amount of lag is expected to be an option, as the initial rates are considered interim until final data is received, reviewed and agreed to between the State and the Local Government providers.

Updated Response: Accepted. The Department is finalizing new procedures manual, outlining annual rate determination schedule and step, including rate calculation redundancy protocols. The Department will publish rate sheets to providers as soon as provider supplied cost report information is deemed finalized. The Department will also begin the process to finalize the requisite cost report information used in the rate determination earlier each calendar year. These items are expected to be completed effective January 1, 2012.

10-24. The auditors recommend DHFS update the provider agreements for the 734 providers enrolled between June 2007 and December 2009 and obtain the required information about ownership and control, business transactions, and criminal convictions. (Repeated-2009)

Findings: During testwork of the CHIP and Medicaid programs, auditors noted the DHFS standard provider applications and agreements used from June 2007 through December 2009 (during which 734 new providers were enrolled) did not address all elements of the required disclosures about ownership and control, business transactions, and criminal convictions. Further, no procedures have been performed to obtain the missing information from these 734 providers as of the date of this report.

In discussing these conditions with DHFS officials, they stated that there has always been a requirement on the Provider Enrollment Application that providers comply with federal regulations. The Department used the federal disclosure statement (CMS-1513) to gather the required ownership disclosure until discontinuance of the form in June of 2003. In June 2006, CMS redesigned the CMS-1513, which the Department instituted in June of 2009 for all newly enrolled providers.

Updated Response: Accepted. The Department reviewed and noted that there were only 653 active providers of the 734 providers identified in the finding, of which 248 already had 1513's in their file. The Department sent letters to the remaining 405 providers to obtain the required statement. The Department has obtained the requisite 1513 for 324 providers from the remaining providers. The Department will follow up with phone calls to the remaining 81 providers in November and December to obtain the required statement. The Department is requiring disclosure statement on all new providers.

10-25. The auditors recommend DHFS review its on-site monitoring procedures for subrecipients of its Child Support program and implement changes necessary to ensure procedures performed adequately address all compliance requirements that are direct and material to subrecipients. (Repeated-2008)

Findings: DHFS did not perform adequate on-site monitoring procedures for subrecipients of the Child Support Enforcement program.

DHFS passes through Child Support program funding to various local governments within the State to administer particular aspects of operating the program, including locating absent parents, assisting in establishing paternity, obtaining child support obligations, and enforcing support obligations owed by non-custodial parents.

During the review of the on-site monitoring procedures performed by DHFS for a sample of 16 subrecipients, auditors noted DHFS has not developed adequate procedures to monitor all relevant fiscal and administrative processes and controls of its subrecipients.

Specifically, on-site monitoring procedures are not performed to determine whether subrecipients are documenting administrative expenditures in accordance with the applicable cost principles or whether subrecipients are following appropriate procurement procedures.

Updated Response: Implemented. The Department has completed a draft Monitoring Procedures and Review Tool. The draft is being circulated among the Department's Senior Staff for review and comment. Completion of the first review is estimated to be done by December 1, 2011.

10-26. The auditors recommend DHFS establish procedures to ensure management decisions are issued for all findings affecting its federal programs in accordance with OMS Circular A-133. (Repeated-2008)

Findings: DHFS did not issue management decisions on OMS Circular A-133 findings for subrecipients of its Child Support Enforcement program and Medicaid program.

During testwork over OMS Circular A-133 audit reports for sixteen subrecipients of the Child Support program, auditors noted the following:

- The audit report for one subrecipient reported three separate instances of noncompliance. DHFS did not issue a management decision relative to these findings or follow up on the conditions identified in the findings. Amounts passed through to this subrecipient were $55,459.
- The audit report for one subrecipient reported three separate instances of noncompliance. Although DHFS performed procedures to follow up on this finding with the subrecipient, DHFS did not issue a management decision relative to these findings. Amounts passed through to this subrecipient were $24,416.
- The audit report for one subrecipient reported the subrecipient did not have a general ledger system that specifically identified individual federal receipts and disbursements for each federal program. Although DHFS performed procedures to follow up on this finding with the sub recipient, DHFS did not issue a management decision relative to this finding. Amounts passed through to this subrecipient were $211,619.
- The audit report for one subrecipient reported two separate instances of noncompliance. Although DHFS performed procedures to follow up on this finding with the subrecipient, DHFS did not issue a management decision relative to these findings. Amounts passed through to this subrecipient were $682,660. Auditors also noted that this subrecipient received Medicaid funding of $1,200,005.
- The audit reports of two subrecipients were not reviewed within the required six months after receiving the reports. Delays in completing the desk reviews were 175 and 212 days after the required timeframe.

In discussing these conditions with DHFS officials, they believed adequate procedures were performed when conducting the reviews. The A-133 checklist was utilized as a guide during the review of the findings affecting federal programs related to DHFS, and discussions were held with the applicable program areas regarding the findings prior to issuing a management decision letter to the subrecipient.

Updated Response: Implemented. The Department has updated the procedural manual, including adding management letter examples, to ensure follow up is performed on the conditions identified in the findings; ensure findings affecting HFS programs are clearly referenced in the management decision letter; and clearly referencing the outcome of the entity's corrective action in the management decision letter.

10-27. The auditors recommend DHFS review its procedures for ensuring the need to have an audit in accordance with OMB Circular A·133 and consider any changes necessary to ensure this requirement is properly included in grant agreements for Subrecipients of the Child Support program.

Findings: DHFS did not communicate the requirement to *have* an audit in accordance with MS Circular A-133 in grant agreements for subrecipients of the Child Support Enforcement Program. During the *review* of subrecipient award notifications for a sample of 16 subrecipients, auditors noted DHFS did not communicate to two subrecipients the need for an audit in accordance with OMS Circular A-133.

In discussing these conditions with DHFS officials, they stated the grant award documents should *have* included the OMS Circular A-133 language.

Updated Response: Implemented. The Department added the language referencing the A-133 audit requirement to all Subrecipient agreements/contracts.

10-28. The auditors recommend DHFS develop comprehensive written procedures for determining which subrecipients should be selected for on-site reviews. (Repeated-2008)

Findings: DHFS is not adequately performing on-site monitoring for subrecipients of the Medicaid program.

DHFS passed through approximately $11,889,778 in Medicaid funding to the County Health Departments (CHDs) during FY10 to assist DHFS in identifying students whose families may need Medicaid assistance and to monitor the coordination of the student's medical care.

During the review of the monitoring procedures performed by DHFS, auditors noted DHFS has not established measurable selection criteria for determining which subrecipients will be subject to on-site monitoring procedures on an annual basis. Although DHFS has established a risk based approach to selecting subrecipients for desk reviews of administrative claims, DHFS was unable to adequately demonstrate the correlation between subrecipients identified as high risk for desk reviews and those selected for onsite reviews.

In discussing these conditions with DHFS officials, they stated that budget constraints required the Department to limit on-site reviews to larger subrecipient groups, such as local Education Agencies.

Updated Response: Accepted. The Department has corresponded with Department of Human Services in regard to exchanging documentation of their on-site review. DHS will compile and provide the on-site review documentation to HFS for additional *review.*

10-29. The auditors recommend DHFS implement procedures to ensure quarterly expenditure reconciliations are performed and completed in a timely manner and adjustments identified in the reconciliation process are made in a timely manner. Repeated-2009)

Findings: DHFS did not complete quarterly cash management reconciliations of cash draws to actual expenditures for assistance payments made under the Medicaid, CHIP, and Child Support Enforcement (CSE) programs or make adjustments identified as a result of these reconciliations in a timely manner (quarterly). Auditors noted the following differences in the review of the quarterly reconciliations of the CSE, CHIP, and Medicaid Cluster programs:

	Medicaid		CHIP		CSE
Quarter	Over/(Under) Drawn Position	Date Reconciliation Completed	Over/(Under) Drawn Position	Date Reconciliation Completed	Date Reconciliation Completed
09/30/09	($133,118,764)	06/14/10	($32,908,425)	01/29/10	03/25/10
12/31/09	($ 62,109,109)	06/16/10	($15,528,339)	04/29/10	06/24/10
03/31/10	($118,704,577)	06/16/10	($ 2,535,098)	06/18/10	11/29/10
06/30/10	($133,118,764)	08/30/10	($22,518,322)	08/27/10	11/29/10

In discussing these conditions with DHFS officials, they stated that the quarterly reconciliations were not completed as timely as usual due to on-going discussions with federal CMS central office staff regarding the proper handling (claiming, offsets, negative grant awards and reconciliation) of Medicare A and B premiums. This required research by the Department and on-going discussions with federal CMS central office staff. Due to concerns regarding the appropriate handling of these transactions, the reconciliations and adjustments were not completed as timely as usual.

Response: The Department accepts the finding. A full-time staff person has been assigned to complete the reconciliations each quarter. The Department will also utilize additional staff in the preparation and review of the quarterly reconciliations to increase timeliness as needed.

Updated Response: Implemented. The Department completed all quarterly cash reconciliations through QE *3/31/2011* by May 31, 2011. The Department will complete adjustments to future cash draws required pursuant to the reconciliations.

10-30. The auditors recommend DHFS implement procedures to ensure cash draws are performed in accordance with the Treasury-State Agreement. (Repeated-2008)

Findings: DHFS does not have adequate procedures in place to ensure Medicaid program cash draws are performed in accordance with the Treasury-State Agreement (TSA).

Annually, the State of Illinois negotiates the Treasury-State Agreement with the US Department of the Treasury which details the funding techniques to be used for the drawdown of federal funds. DHFS is required to request funds based on actual cash outlays for direct administrative costs during the month. Because the funding technique is on a reimbursement basis, it is interest neutral.

During follow-up on prior year findings relating to subrecipients of the Medicaid program, auditors noted the State's cash draws for payments to Local Education Agencies (LEAs) were performed on an advance basis (prior to paying the LEAs). Upon review of all cash draws for payments to LEAs during FY10, the number of days cash was drawn in advance of actual cash outlays ranged from one to 14 days.

In discussing these conditions with DHFS officials, they stated they believed that the funding technique included in the TSA for payments to LEAs was appropriately being utilized.

Updated Response: Partially Implemented. The amendment to the Treasury State Agreement was submitted to GOMB on 10/21/2011. Interest calculation on LEA pass through draws will be performed in December 2011, as part of the CMIA Annual Report for State Fiscal Year 2011.

10-31. The auditors recommend DHFS develop procedures to ensure indirect costs are coded to the correct cost centers and claimed at the proper reimbursement rate. (Repeated-2008)

Findings: DHFS did not accurately allocate costs to its federal programs in accordance with the Public Assistance Cost Allocation Plan (PACAP).

During the review of costs allocated to federal programs during the quarter ended December 31, 2009, auditors noted DHFS allocated overhead costs to the "Special Assistance for Health Insurance Portability and Accountability and Computers Security Programs" cost center rather than

directly charging these costs to the Medicaid Infrastructure Grant in accordance with PACAP. As a result, DHFS under reported Medicaid claimable expenditures for indirect costs by $904.

In discussing these conditions with DHFS officials, they stated that the condition occurred as the result of a data entry error.

Updated Response: Implemented. The Department entered a prior period adjustment on the CMS 64 and CMS 21 for QE 9/30/10 to correct the overage to Medicaid indirect costs on 10/29/10. The Department will continue supervisory review of claim work papers.

10-32. The auditors recommend DHFS establish procedures to ensure that vendors contracting with DHFS are not suspended or debarred or otherwise excluded from participation in federal assistance programs. (Repeated-2009)

Findings: DHFS did not obtain required certifications that vendors were not suspended or debarred from participation in federal assistance programs for the Child Support Enforcement, Children's Health Insurance Program, and Medicaid Programs.

During a review of twenty vendors of the Child Support Enforcement program and 20 vendors allocated to all federal programs, auditors noted DHFS did not include a suspension and debarment certification in 16 of its vendor agreements. Additionally, DHFS did not perform a verification check with the "Excluded Parties List System" (EPLS) maintained by the General Services Administration for vendors.

In discussing these conditions with DHFS officials, they stated 15 of the 16 contracts identified are master contracts entered into between the vendor and the Illinois Department of Central Management Services (CMS). The remaining contract was executed prior to the CMS boilerplate being updated by CMS to include the required disclosures and certifications for suspension and debarment.

Updated Response: Accepted. The Department is in the process of researching, developing and issuing updated procurement policy to require staff to secure the required disclosures for all contracts. After completion of this process, the Department will train staff on the updated procurement policy.

10-33. The auditors recommend DHFS implement procedures to ensure that all procurements are performed in accordance with the applicable rules and regulations.

Findings: DHFS did not competitively bid a professional service contract for $31,200 purchased for the administration of the Child Support program.

In discussing these conditions with DHFS officials, they stated that the procurement did not qualify as a Professional & Artistic contract per DHFS Office of General Counsel (OGC) and the Office of State Procurement Officer (OS PO) and, therefore, was not bid out.

Updated Response: Implemented. The Department will continue to review all contracts to ensure they are bid out when required, however, they consider this an isolated incident.

10-34. The auditors recommend DHFS follow procedures established to ensure support orders are established within the required timeframes and ensure failed attempts to establish support orders are adequately documented.

Findings: During testwork of 40 child support cases, in one case DHFS did not make timely attempts to enforce and obtain medical insurance of the absent parent. Auditors noted that attempts were made to serve the court order in October 2006 with no subsequent attempts made to add the insurance. The insurance was subsequently added in November 2010 after testwork.

In discussing these conditions with DHFS officials, they stated they believe that the case has documented Medical Support Obligation. As the KIDS system did not have an updated address for Aetna at the time of receiving notification of insurance, the worker was unable to enter the data, Therefore, the worker entered the data on the Notes screen to show compliance. According to Department records, the insurance was placed and enforced on the system, and verified with Aetna.

Response: Accepted. The Department considers this a one time incident, however,they will continue to obtain and enforce medical insurance of the absent parent as required.

10-35. The auditors recommend DHFS implement procedures to ensure that approved cost allocations included in the Public Assistance Cost Allocation Plan (PACAP) are followed.

Findings: DHFS did not follow the approved allocation methodology in the Public Assistance Cost Allocation Plan (PACAP) to allocate certain cost centers to the Children's Health Insurance Program (CHIP) and Medicaid Cluster programs.

DHFS administers federal and State programs to provide healthcare coverage for Illinois adults and children. In administering these programs, DHFS incurs significant expenditures, which are directly and indirectly attributable to the administration of its programs.

During the review of costs allocated to federal programs during the quarter ended December 31, 2009, auditors noted the PACAP prescribed that expenditures from a specific cost center be allocated to the "Bureau of All Kids". However, based on payroll records and time certifications, expenditures totaling $146,490 from the cost center were allocated using the "Supportive Medical" allocation methodology. As a result, costs of $146,490 were allocated to Medicaid instead of CHIP and State funded programs.

In discussing these conditions with DHFS officials, the Department agreed that the costs were not being allocated to the cost pool indicated on the December 2009 PACAP. This is due to the fact that the PACAP did not accurately reflect the correct cost pool for these costs. Based upon the duties being performed, the costs were being allocated to the correct cost pool. The US DHHS Department Appeals Board rulings have stated that costs must be allocated consistent with actual duties performed regardless of the 'methodologies in the PACAP. The expenditures were allocated appropriately.

Updated Response: Implemented. The Department submitted the PACAP amendment with an effective date of January 1, 2011 clarifying the language seeking a revision to the designated cost pool. The amendment was approved by the U.S. DHHS Division of Cost Allocation on 6/21/2011.

10-36. The auditors recommend DHFS implement procedures to ensure a" financial reports are submitted within the established deadlines.

Findings: DHFS does not have a process in place to ensure financial reports are prepared and submitted within required timeframes. DHFS is required to prepare various quarterly financial reports relative to awards under the Child Support Enforcement, CHIP, and Medicaid programs. During testwork over the financial reports required to be submitted during FY 10, auditors noted the following:

- Six quarterly reports (out of eight tested) for the Child Support Enforcement program were not submitted by the reporting deadline. Delays ranged from three to 24 days.
- One quarterly report (out of four tested) for the CHIP program was not submitted by the reporting deadline. The delay was 31 days.
- One quarterly report (out of four tested) for the Medicaid Cluster was not submitted by the reporting deadline. The delay was 31 days.

In discussing these conditions with DHFS officials, they stated that there were several reasons for the lateness of the reports, including: an error that occurred during programming changes; needing additional time to accurately prepare and certify the claims; requests received from federal staff to make an adjustment to costs claimed; time required to research and calculate the appropriate adjustment amount; receipt of federal guidance regarding the proper reporting of estimated administrative expenditures; and time required to determine the effect of the guidance on the budget estimate.

Updated Response: Implemented. The Department will continue to file claims according to the due dates outlined in bureau reference manual/procedures. All claims and reports for SFY11 were filed timely.

RECOMMENDATIONS 37-42
Department of Children and Family Services

10-37. The auditors recommend DCFS properly report federal awards passed through to subrecipients and implement on-site monitoring procedures to review compliance requirements administered by subrecipients of its federal programs. (Repeated-1999)

Findings: DCFS did not perform fiscal and administrative on-site monitoring procedures for subrecipients who receive awards under TANF, Foster Care, and Adoption Assistance programs.

During testwork over the subrecipient monitoring compliance requirement for these programs, DCFS determined that organizations previously considered subrecipients should be considered vendors because the initial eligibility determinations for children served under these programs are performed by the State. As a result, DCFS ceased all subrecipient monitoring activities and reported the amounts passed through to these organizations as contractual service expenditures. However, the nature of the services provided by these organizations goes beyond those provided in a vendor relationship. These organizations assist the State in complying with program requirements relative to the allowability of costs and the continuing eligibility of program beneficiaries. Amounts passed through to subrecipients exceeded $224 million.

Auditors' Comment: *As discussed in the finding above, DCFS determined amounts previously reported as subrecipient expenditures were vendor payments. As a result, DCFS did not identify the amounts passed through to these entities as subrecipient expenditures on the State's schedule*

of federal awards or in award communications. DCFS notes in their response that they will continue to perform a review of OMB Circular A-133 reports and perform programmatic procedures; however, since these organizations are not considered subrecipients they are not required to have audits performed in accordance with OMB Circular A-133. Finally, consistent with the prior year, DCFS did not perform fiscal monitoring procedures.

Updated Response: Disagree. The Department has not ceased all subrecipient monitoring as stated in the finding. The Department requires audit reports be submitted by all purchase of care providers receiving $150,000 or more during a fiscal year and all reports are desk reviewed. Additional reports are to be submitted by those providers who receive $500,000 or more in federal funds. The majority of reports received do not contain major issues. Additionally, on-site reviews are made for selected providers. The Department's policy is that on-site fiscal and administrative reviews should include procedures that consider all compliance requirements direct and material to the programs funded by the Department and to ensure compliance with contract program plan requirements established for the services approved and being obtained for children. On-site reviews are also used when the assessment of risk so indicates the necessity, and staff resources are available.

The Department has developed and implemented procedures to address A-133 Findings noted in the sub recipients' OMB Circular A-133 reports and to address findings and management letter comments noted in purchase of care vendor audit reports. Additional follow up is conducted for each financial finding, programmatic findings are referred to the appropriate division for follow up, and a Decision Memo is issued.

DCFS private agency case management providers do not make client or service eligibility determinations for those individuals eligible for foster care or adoption assistance which if they did would be the primary cause for ineligible services. Private agencies assist in recruiting foster parents including assisting foster parents to get licensed, however only DCFS licenses foster homes; DCFS provides training to foster parents. Private agencies assist foster parents who wish to adopt but DCFS is responsible for managing and approving adoptions. The private agency case worker has involvement with the foster home once the adoption is finalized. Further, the DCFS foster care and adoption programs are state programs, some of which may qualify for federal reimbursement. DCFS foster care and adoption providers serve all clients referred by DCFS without regard or knowledge of federal program eligibility. Programmatic monitors and licensing representatives are in regular contact with foster care, substitute care providers, many on a monthly basis. Those providers selected for field visits for fiscal review are generated from the desk reviews completed in the prior year that have notable negative issues. Auditors contact the Department's programmatic monitors and the licensing representatives to discuss and share any potential problems at providers to aid in the scheduling of on-site visits, and prioritize on-site audit activities.

Future schedules for on-site fiscal reviews will prioritize visits to agencies not previously visited, or visited years ago. The ability of DCFS to conduct more on-site visits each year is dependent upon the Department's ability to hire additional staff, and implement improvements in efficiency. Staff size is dependent on the State's financial position. Proposals to improvements in efficiency must be developed and evaluated in the field and this process is continuing. Additionally, following receiving information from the Department's OIG and the Governor's Office of Executive Inspector General regarding a former Director and one of the former providers contracted by DCFS, the Department is currently assessing issues identified and plans to recommend additional steps to improve its fiscal monitoring of providers.

10-38. The auditors recommend DCFS review its procedures for retaining and documenting how beneficiaries have met eligibility requirements and implement changes necessary to ensure adequate judicial determinations and background checks of prospective adoptive parents exist for all children for whom adoption subsidy payments and nonrecurring expenditures are claimed. (Repeated-2005)

Findings: DCFS could not locate case file documentation supporting eligibility determinations for beneficiaries of the Adoption Assistance program.

During testwork of 65 Adoption Assistance beneficiary payments (totaling $47,463), auditors reviewed case files for compliance with eligibility requirements and for the allowability of related benefits paid and noted documentation could not be located to support certain eligibility criteria. Specifically, the case file for one beneficiary (with a sampled assistance payment of $445) did not contain documentation supporting a criminal background check and child abuse and neglect registry check were performed on the prospective adoptive parents evidencing the placement would be in the best interest of the child. Additionally, the temporary custody order for this case did not contain the probable cause finding for removing the child from the home and did not give guardianship of the child to DCFS.

DCFS claimed reimbursement for adoption assistance beneficiary payments totaling $91,351,317 during the year ended June 30, 2010.

In discussing these conditions with DCFS officials, they stated this child came into care via a guardianship order dated July 12, 1993. The court order did not have the required findings and DCFS was unable to obtain a transcript for the hearing.

Updated Response: Implemented. The Department made a claiming adjustment of $3,017 for actual beneficiary payment amount claimed during the fiscal year and questioned by the auditor. Additionally, an internal review process was implemented to review all case documentation prior to the finalization of an adoption. A review of the background check results is a part of this process. Periodic reviews are performed on cases which opened prior to the review process was initiated to ensure that the proper documentation is included in the case files.

10-39. The auditors recommend DCFS implement procedures to ensure recertification forms are received in accordance with the State's established process and maintained in the eligibility files for children receiving recurring adoption assistance benefits. (Repeated-2006)

Findings: DCFS did not ensure that adoption assistance recertifications were performed on a timely basis for children receiving recurring adoption assistance benefits.

During testwork of 65 recurring subsidy payments (totaling $47,463) made under the Adoption Assistance program, DCFS could not locate a recertification form submitted by the adoptive parent within the most recent two year period for two case files (with sampled payments of $890). DCFS claimed reimbursement for adoption assistance benefits made on behalf of these children totaling $10,680 during the year ended June 30, 2010.

DCFS claimed reimbursement for adoption assistance beneficiary payments totaling $91,351,317 during the year ended June 30, 2010.

In discussing these conditions with DCFS officials, they stated recertification letters are sent out via an automated process. If the first letter is not returned, a second letter is automatically mailed 60 days later. When the second letter was not returned, notification of these cases was not received in the Post-Adoption Unit for further follow up due to an oversight. A follow-up letter was sent on December 14, 2010 for one case where a recertification was not on file and this letter was returned indicating that the adoptive parent still has legal responsibility for this child and wishes the subsidy to continue.

Updated Response: Accepted and partially implemented. The Department agreed and conducted further review of the recertification process and implemented additional procedures to ensure reporting to the Post-Adoption Unit and the reporting of follow-up is completed. Additional tasks are in process to assess the changes made to procedures.

10-40. The auditors recommend DCFS review its procedures for retaining and documenting how beneficiaries have met eligibility requirements and implement changes necessary to ensure documentation supporting eligibility criteria exists for all children for whom foster care benefits are claimed.

Findings: DCFS could not locate case file documentation supporting eligibility determinations for beneficiaries of the Foster Care program.

During testwork of 65 Foster Care beneficiary payments (totaling $77,982), auditors reviewed case files for compliance with eligibility requirements and allowability of related benefits and noted the following exceptions:

- The case file for one beneficiary (with a sampled maintenance payment of $422) did not include adequate documentation supporting the initial removal of the child from the home was in the best interest of the child. Specifically, the temporary custody order for this case did not contain the probable cause finding for removing the child from the home and did not document whether reasonable efforts were made to prevent the removal of the child from the home by DCFS. DCFS claimed reimbursement for foster care benefits made on behalf of this child totaling $5,064 during the year ended June 30, 2010.
- The case file for one beneficiary (with a sampled maintenance payment of $410) did not include evidence supporting the annual guardianship recertification was performed. Specifically, the annual recertification form required to be signed and returned by the guardian was not on file for the period under audit. DCFS claimed reimbursement for foster care benefits made on behalf of this child totaling $4,920 during the year ended June 30, 2010.

DCFS claimed reimbursement for foster care beneficiary payments totaling $87,598,418 during the year ended June 30, 2010.

In discussing these conditions with DCFS officials, they stated the child in the case identified with missing documentation came into care via a temporary custody order dated June 14, 2006. The court order did not have the required findings and auditors were unable to obtain a transcript for this hearing.

Updated Response: Implemented. The Department agreed and procedures were reviewed and revised so that the initial order is reviewed during the Administrative Case Review process. In addition, the Department requested a revision to the CYCIS legal screen to more clearly capture

the information regarding the findings needed in a court order. Procedure now requires that if there is a question regarding the initial court order, the case is to be forwarded to the Federal Financial Participation (FFP) Unit for further review. The Department made a claiming adjustment for actual amount claimed, $2,883 during the fiscal year, for the beneficiary payment questioned by the auditor.

10-41. The auditors recommend DCFS implement procedures to ensure all financial reports are submitted within the established deadlines.

Findings: DCFS does not have a process in place to ensure financial reports are prepared and submitted within required timeframes.

DCFS is required to prepare the *Foster Care and Adoption Assistance Financial Report* (ACF-IV-E report) on a quarterly basis. During testwork over the two quarters ended December 31, 2009 and March 31, 2010, the reports were submitted 44 and 61 days after their required due dates, respectively.

In discussing these conditions with DCFS officials, they stated they believed the extension request submitted to USDHHS was granted and extended the reporting deadline.

Response: The Department concurs that there is a 30 days filing requirement. However it has been a long standing practice of DHHS-ACF to grant filing extensions if the request is received timely from the State Title IV-E agency. DCFS consulted with our regional DHHS-ACF Fiscal staff and they are in agreement with our practice. While DCFS intends to continue to make efforts to improve the time required to prepare claims, DCFS still anticipates claim preparation to take longer than 30 days and to continue filing timely extension with DHHS-ACF.

Auditors' Comment: *DCFS could not provide documentation supporting an extension of the reporting deadline had been approved by USDHHS.*

10-42. The auditors recommend DCFS stress the importance of preparing and completing the initial service plans timely to all caseworkers to comply with federal requirements. (Repeated-1999)

Findings: DCFS did not prepare initial case plans in a timely manner for Child Welfare Services beneficiaries.

During a review of 40 case files selected for testwork, auditors noted nineteen of the initial case plans were completed within a range of two to 71 days over the 60-day federal requirement.

In discussing these conditions with DCFS officials, they stated timely preparation of case plans is always a concern. Unfortunately, due to staff changes and reductions, placement changes, and coordination with other procedures and agencies including law enforcement, there are times when case plans are not prepared within the established timeframes.

Response: The Department agrees and continues to stress the importance of adequate and timely documentation for child case files through training and communications to all case staff. Based on the fundamentals of good social work practice, requirements of the Council of Accreditation, and Federal Review Outcomes, Illinois has implemented an Integrated Assessment

program that includes preparation of a comprehensive service plan where one cannot be completed without the other. Additionally, a workgroup has established a plan to implement changes to procedures in order to prepare timely service plans and resolve the matters that cause delays as well as provide an on-going monitoring of timeliness. That implementation project is continuing. Through trainings, we continue to stress the importance of adequate and timely case planning as a key component of providing quality service to children.

Recommendations 43-47
DEPARTMENT ON AGING

10-43. The auditors recommend the Department on Aging perform periodic on-site reviews of all subrecipients which include reviewing financial and programmatic records, observation of operations and/or processes to ensure their subrecipients are administering the federal program in accordance with the applicable laws, regulations, and the annual area plan. (Repeated-2003)

Findings: IDOA is not adequately monitoring subrecipients receiving federal awards for the Aging Cluster.

During testwork over four subrecipients of the Aging Cluster with expenditures of approximately $21,949,000 during the year ended June 30, 2010, on-site monitoring procedures had not been performed since 1998 for any of the subrecipients selected. Also, fiscal on-site monitoring procedures were not performed for any subrecipients during the year ended June 30, 2010. However on-site reviews were performed over internal controls related to the operation of the program at each area agency on aging. The reviews were only over internal controls in place and there were no reviews over financial or programmatic records to ensure the federal awards were used for authorized purposes.

In discussing these conditions with IDOA officials, they stated on-site programmatic monitoring is performed at all subrecipient locations annually and the fiscal monitoring tool has been updated and reviewed as outlined in OMB Circular A-133 for use in fiscal year 2011.

Updated Response: Accepted. The Division of Fiscal Administration (DFA) initiated a fiscal on-site monitoring program in June, 2011, that is being conducted by DFA staff, in addition to the programmatic on-site monitoring program conducted by the Division of Home and Community Services (DHCS). These monitoring programs cover the compliance requirements enumerated in the OMB Circular A-133 Compliance Supplement and should be sufficient to ensure that subrecipients are administering federal programs in accordance with applicable laws, regulations, and the annual area plan. Additionally, the Internal Audit Unit is conducting compliance examinations of subrecipient activities. These compliance examinations have been scheduled so that each subrecipient will receive at least one formal financial and administrative compliance examination during a three year period.

10-44. The auditors recommend the Department on Aging establish procedures to ensure that: (1) desk reviews are performed on a timely basis for all subrecipients, (2) expenditures reported by the subrecipients are reconciled to the schedule of expenditures of federal awards submitted in the OMB Circular A-133 audit reports, and (3) supervisory reviews are documented to evidence their completion. (Repeated-2006)

Findings: IDOA is not adequately monitoring the OMB Circular A-133 reports submitted by its subrecipients receiving federal awards for the Aging Cluster.

During testwork of four subrecipients of the Aging Cluster (with total expenditures of approximately $21,949,000), the A-133 desk review checklist was not completed in a timely manner and a management decision was not issued for findings reported in the audit report reviewed for one subrecipient tested (with expenditures of $7,753,000). Additionally, the expenditures in the schedule of expenditure of federal awards for this subrecipient were not reconciled to IDOA's financial records.

Response: The Department has filled the position responsible for performing A-133 desk reviews, which will ensure that all A-133 desk reviews are completed timely and in accordance with the requirements of OMB Circular A-133.

Updated Response: Implemented. The Division of Fiscal Administration (DFA) has written policies and procedures to ensure that (1) desk reviews are performed timely for all subrecipients; and (2) expenditures reported by the subrecipients are reconciled to the schedule of expenditures of federal awards submitted in the audit reports; and (3) supervisory review be documented to evidence completion of the review.

10-45. The auditors recommend the Department on Aging implement procedures to ensure the maintenance of effort requirement is met.

Findings: IDOA does not have an adequate process to ensure the Aging Cluster maintenance of effort (MOE) requirement has been met.

During testwork over the Aging Cluster MOE requirement for federal fiscal year 2009 (reported in fiscal year 2010), auditors noted IDOA had not prepared or submitted the annual MOE certification as of February 15, 2011. Accordingly, IDOA had not determined whether State funded expenditures for aging services were sufficient to meet the MOE requirement. In May 2011, IDOA certified MOE expenditures of $5,323,630 for federal fiscal year 2009.

In discussing these conditions with IDOA officials, they stated maintenance of effort is monitored on a continuous basis during the life of the grant to ensure the MOE requirements are met. USDHHS sends an email reminder to agency staff responsible for preparing the MOE. This staff position was vacant when the email reminder was sent, contributing to this oversight.

Response: We agree that the MOE for federal fiscal year 2009 was not filed in a timely manner. Upon identification of the oversight, the Department immediately prepared and submitted the report to AoA. Additionally, the Department has completed MOE for federal fiscal year 2010 and submitted the report to AoA in a timely manner.

10-46. The auditors recommend the Department on Aging review its advance funding policies and techniques for subrecipients and implement a monitoring process to ensure subrecipients receive no more than 30 days of funding on an advance basis and that the subrecipient interest certified and remitted appears reasonable. (Repeated-2006)

Findings: IDOA does not have adequate procedures to monitor the cash needs of subrecipients and to determine whether subrecipients are minimizing the time elapsing between the receipt and disbursement of funding for the Aging Cluster program.

During testwork, auditors noted that IDOA requires its subrecipients to prepare a quarterly reconciliation of their net cash position; however, IDOA does not reduce a subrecipient's cash advance if the reconciliation identifies the subrecipient has excess cash on hand. As a result, subrecipients remitted approximately $17,103 in interest earned on excess federal funds to IDOA. Additionally, IDOA does not have a process in place to determine if the interest remitted is reasonable.

In discussing these conditions with IDOA officials, they stated subrecipients are not required to provide monthly expenditure reports; therefore, the actual expenditures are reconciled on a quarterly basis.

Updated Response: Accepted. The Division of Fiscal Administration (DFA) and the Division of Home and Community Services (DHCS) are in the process of revising advance funding policies and techniques for subrecipients to ensure subrecipients do not receive more than 30 days of funding on an advance basis. The revised funding policies and forms are anticipated to be rolled out to the subrecipients by January 1, 2012. The changes in funding technique are expected to result in a considerable decrease in the amount of interest earned on federal funds. The amount of interest certified and remitted by the subrecipients will be reviewed to ensure that the amount appears reasonable. Additionally, the on-site fiscal monitoring program, implemented in June, 2011, includes procedures for testing subrecipient compliance with advance funding requirements.

10-47. The auditors recommend the Department on Aging implement procedures to ensure the financial status reports submitted for its federal awards are complete and accurate.

Findings: The IDOA did not accurately report indirect costs in its annual financial status reports (SF-269 reports).

IDOA is required to submit semi-annual SF-269 reports for the Aging Cluster program. These reports are intended to identify the direct federal expenditures, as well as the indirect cost base, the applicable indirect cost rate, and amount of indirect costs attributable to the award. During testwork over the SF-269 report for the semi-annual period ending March 31, 2010, auditors noted the IDOA did not report the indirect cost base, indirect cost rate, or indirect costs attributable to the award.

In discussing these conditions with IDOA officials, they stated the Department was under the impression that indirect costs did not have to be reported on the SF-269 based upon discussion with USDHHS personnel.

Response: Accepted. The Department will continue to work with AoA to further clarify the reporting requirements related to indirect costs.

RECOMMENDATIONS 48-52
Department of Public Health

10-48. The auditors recommend IDPH revise the on-site monitoring procedures to include procedures to review each applicable compliance requirement and the fiscal and administrative controls of its subrecipients. IDPH should also evaluate the current staffing of its monitoring department to ensure resources are adequate to complete reviews within prescribed timeframes.

Findings: IDPH does not sufficiently perform on-site reviews of subrecipients receiving federal awards under the Public Health Emergency Preparedness (PHEP) program.

During testwork of 25 subrecipients of the PHEP program, auditors noted IDPH does not perform on-site monitoring procedures to review the fiscal and administrative capabilities and internal controls of any of its PHEP subrecipients. IDPH also has not established procedures to monitor the matching amounts reported by subrecipients to ensure the expenditures reported by the subrecipients meet general allowable cost requirements or PHEP program specific requirements.

In discussing these conditions with IDPH officials, they stated that staffing shortages have contributed to the conditions cited.

Response: The Department concurs in the finding and recommendation. The Department will revise the on-site monitoring procedures to include procedures to review applicable compliance requirements, including the fiscal and administrative controls of subrecipients. This will be accomplished by revising the job description of a current fiscal staff member to include on-site fiscal reviews, which should facilitate completion of on-sites reviews in a more timely manner.

10-49. The auditors recommend IDPH establish procedures to ensure all subrecipients receiving federal funds have audits performed in accordance with OMB Circular A-133. Additionally, desk reviews of A-133 audit reports should be formally documented using the A-133 desk review checklist, which includes procedures to determine whether the audit reports meet the requirements of OMB Circular A-133, federal funds reported in the schedule of expenditures of federal awards reconcile to IDPH records, and Type A programs are audited at least once every three years. (Repeated-2005)

Findings: IDPH does not have an adequate process for ensuring subrecipients of the Public Health Emergency Preparedness (CDC Investigations and Technical Assistance), and HIV Care Formula Grants programs have complied with OMB Circular A-133 audit requirements.

During testwork of over 50 subrecipients (25 for each program), there were seven subrecipients of the Public Health Emergency Preparedness program (with expenditures totaling $6,578,190 during the fiscal year) and seven subrecipients of the CDC Investigations and Technical Assistance program (with expenditures totaling $1,007,379 during the fiscal year) whose A-133 reports were not obtained within the required nine months after the subrecipients' year-end, and there was no evidence of follow up procedures performed by IDPH. Specifically, these reports were received between 35 and 218 days after the nine month requirement.

Additionally, a standard checklist was not used to document the review of subrecipient A-133 reports received from subrecipients of the Public Health Emergency Preparedness, CDC Investigations and Technical Assistance, and the HIV Care Formula Grants programs.

In discussing these conditions with IDPH officials, they stated that staffing shortages have limited their ability to meet these requirements.

Response: The Department concurs in the finding and recommendation. The Department will monitor compliance more closely, working with staff when specific program findings are identified. The Department will continue to monitor receipt of audit reports from its subrecipients and be more diligent in its follow up to obtain any missing reports. The Department supports efforts to consolidate the A-133 audit function across State agencies as recommended by HB5124 which is now P.A. 96-1141.

10-50. The auditors recommend IDPH revise the on-site monitoring procedures to include procedures to review the subrecipients' fiscal and administrative capabilities. IDPH should also evaluate the current staffing of its monitoring department to ensure resources are adequate to complete reviews within prescribed timeframes. (Repeated-2004)

Findings: IDPH is not adequately performing on-site monitoring of subrecipients receiving federal awards under the CDC Investigations and Technical Assistance and the HIV Formula Care Grants programs.

During testwork of 25 subrecipients of the CDC Investigations and Technical Assistance program and eight subrecipients of the HIV Formula Care Grants program, auditors noted the following:

- On-site programmatic reviews were not performed for one subrecipient of the CDC Investigations and Technical Assistance program (with expenditures of $244,024 during the fiscal year) and two subrecipients of the HIV Formula Grants program (with expenditures of $291,072 during the fiscal year).
- The standard monitoring tool was not used to document the on-site programmatic review for one subrecipient of the CDC Investigations and Technical Assistance program (with expenditures of $141,438).

In discussing these conditions with IDPH officials, they stated that throughout the programs audited, staffing shortages have hampered meeting on-site monitoring requirements.

Response: The Department concurs in the finding and recommendation. A new internal control review questionnaire is being prepared with the expert assistance of the agency's internal audit staff and will be used by specific program staff who performs on-site program reviews. For the HIV Formula Grants program, programmatic and fiscal site visits are conducted annually in all eight Care Connect offices. The Direct Services Unit in our HIV Section is planning to hire an additional fiscal monitoring staff person to help ensure a more complete audit of each lead agency. The HRSA Ryan White program uses specific monitoring tools for on-site visits which utilizes a scoring system that yields a percent compliance for various categories. Strengthening the fiscal component by hiring an additional staff person would further improve that process.

10-51. The auditors recommend IDPH implement procedures to (1) verify income and insurance information with third party sources (i.e., employers, third party insurers,

etc.) and other State agencies and (2) perform recertifications of eligibility every six months. (Repeated-2004)

Findings: IDPH does not have an adequate process for performing client eligibility determinations for its HIV Care Formula Grant (HIV) program.

During testwork of benefits provided to HIV beneficiaries, auditors noted that in six cases, the beneficiary's application indicated the beneficiary had no income. Although the individual's income level was below 500% of the poverty level and IDPH confirmed the individual was not receiving benefits under Medicaid, a determination of Medicaid eligibility had not been performed. As a result, no income verification procedures were performed to determine whether the income reported (or lack thereof) was accurate.

Additionally, IDPH only recertifies (redetermines) eligibility of beneficiaries on an annual basis, instead of every six months as required by program requirements.

In discussing these conditions with IDPH officials, they stated that staffing issues impacted timely recertifications and that sound public health policy dictates presumptive eligibility for ADAP.

Response: The Department concurs in the finding and recommendation. ADAP does utilize the following forms of documentation when verifying income; two recent pay stubs, current tax return for self-employed individuals; IDES letter of unemployment reward; Social Security award letters (SSDI and/or SSI). In the instances that a client reports income less than $500 per month or zero income, then a letter of support is required by ADAP. The auditor also noted during the site visit that ADAP needed to print off the Medicaid screen when verifying Medicaid standing and place a hard copy of the screen print in the client's file. This procedure was implemented on June 1, 2010.

Regarding the six month recertification requirement from the Health Resources and Services Administration (HRSA), ADAP implemented the 6 month recertification requirement on April 1, 2010, which is ongoing at this time.

Updated Response: Implemented.

10-52. The auditors recommend IDPH review its current process for investigating complaints received against Medicaid providers and consider changes necessary to ensure all complaints are investigated within the timeframes required by State law. (Repeated-2007)

Findings: IDPH did not investigate complaints received relative to providers of the Medicaid Cluster within required timeframes.

During testwork of 40 complaints filed against Medicaid providers during the year ended June 30, 2010, there were eleven complaints that were not investigated within the timeframes required by the State's law. The delays in investigating these complaints ranged from eight to 70 days in excess of required timeframes.

In discussing these conditions with IDPH officials, they stated that the cause of the problem was significant staffing shortages due to the inability to fill surveyor vacancies.

Response: The Department concurs in the finding and recommendation. The current process for complaint intake and investigation is adequate. The root cause of failing to meet all investigation timeframes was reduced staffing levels. Due to State budget constraints in the years preceding the audit time period, many field surveyor vacancies were left unfilled.

PA 96-1372 (SB326) significantly revised the Illinois Nursing Home Care Act, as well as several related State statutes. Among the revisions to State law was a mandate that the Department increase nursing home surveyor staffing levels and these staffing increases are underway. Presently, 45 additional nurse positions have been hired. With increased survey staff, the Department will be able to initiate the investigation of complaints within the mandated timeframes.

RECOMMENDATIONS 53-58
Illinois State Board of Education

10-53. The auditors recommend ISBE implement procedures to appropriately monitor and sanction LEAs not meeting the comparability of services requirement. (Repeated-2006)

Findings: ISBE does not take adequate measures to sanction a LEA that did not meet the comparability of services requirement under the Title I.

LEAs must provide educational services for schools receiving Title I funds that are comparable (equal) to those that are not receiving Title I funds within the same school district ("comparability of services"). Based on information provided from a USDE audit and procedures performed during the audit, ISBE did not sanction one LEA which did not properly calculate comparability ratios or determine the amount of federal funds that should have been returned as a result of the LEA not meeting the comparability requirement. Specifically, ISBE did not sanction the LEA for continuously having non-comparable schools or for including improper salary information in the calculations. During the initial comparability calculation, the LEA had 21 non-comparable schools. To make the schools comparable, the LEA allocated just enough funds (totaling $1.6 million) to each of the non-comparable schools to make them comparable. However, the LEA only expended $955,000 of that amount and 20 of the 21 schools remained non-comparable. Further, this LEA continues to improperly include longevity salary information in the calculation.

In discussing these conditions with ISBE officials, they stated the non-comparability issue was first raised in the U.S. Department of Education (ED) Office of the Inspector General Report on Comparability issued June 7, 2007. This report states that; "Determinations of corrective action to be taken, including the recovery of funds, will be made by the appropriate Department of Education officials, in accordance with the General Education Provisions Act." ISBE must wait to receive the ED determination of corrective action before the Agency can sanction the LEA.

Updated Response: Implemented. ISBE has received guidance from the U.S. Department of Education (USDE) regarding corrective action and has recovered funds from the LEA. Also, according to the Settlement Agreement between ISBE and USDE, ISBE has subsequently repaid $1.2 million to the USDE.

10-54. The auditors recommend ISBE evaluate the current staffing of the External Assurance Department to ensure resources are allocated to perform this function. The auditors also recommend ISBE review its risk assessment criteria and establish

measurable selection criteria for selecting individual school sites for on-site reviews. Finally, ISBE should review and update its monitoring instruments to ensure they include procedures for all direct and material compliance requirements. (Repeated-2007)

Findings: ISBE is not adequately performing on-site fiscal monitoring reviews of subrecipients of the Title I, Special Education, Career and Technical Education, Twenty-First Century Community Learning Centers, Reading First State Grants, and Improving Teacher Quality State Grants programs (collectively referred to as the Education programs).

ISBE selects subrecipients of the Education programs to perform on-site fiscal and administrative monitoring procedures using a risk based approach. Specifically, ISBE places each subrecipient receiving funding into a risk level (low, medium, and high) category that dictates the frequency (annual, every 2 years, and every 3 years) of on-site fiscal and administrative monitoring procedures. The risk assessments consider the following factors: the funding level received by the entity, the entity's financial status, the entity's improvement status, any past audit findings, and the type of entity.

In reviewing the subrecipient risk assessment procedures performed by ISBE, auditors noted the risk criteria were evaluated on an entity-wide basis for each subrecipient; however, several subrecipients selected for on-site reviews were comprised of numerous individual school sites of which only a portion were subject to on-site fiscal and administrative review procedures. Upon further investigation, auditors noted ISBE has not developed measurable selection criteria for determining which individual school sites will be subject to on-site monitoring procedures for each subrecipient selected for review.

Further, during testwork over a sample of 40 subrecipients from each of the Education major programs, auditors noted a number of subrecipients were selected for on-site fiscal and administrative reviews but an actual review was not performed.

In discussing these conditions with ISBE officials, they stated the level of External Assurance staffing continues to impact the ability of the division to meet scheduled monitoring visits. The External Assurance division has been reorganized. Management is in the process of posting vacancies and hiring additional staff throughout the state.

Updated Response: Partially Implemented. The Division of External Assurance (EA) is currently under new management. They have developed a new risk assessment tool for FY12, performed the risk assessment for FY12, and have implemented a new FY12 subrecipient monitoring plan for ISBE. The new monitoring plan is a multi-year plan; therefore, it will take several years for the finding to not repeat. EA has also hired 3 additional staff for monitoring.

10-55. The auditors recommend ISBE evaluate the current staffing of the External Assurance department to ensure resources are allocated to perform this function. The auditors also recommend ISBE review its risk assessment criteria and establish measurable selection criteria for selecting individual school sites for on-site reviews. Finally, the auditors recommend ISBE update its monitoring instruments (programs) to ensure that the subrecipients' compliance with certain program requirements is properly monitored and documented. (Repeated-2007)

Findings: ISBE is not adequately performing on-site programmatic monitoring reviews of subrecipients of the Title I and Improving Teacher Quality State Grants programs.

Specifically, ISBE places each subrecipient receiving funding into a risk level (low, medium, and high) category that dictates the frequency (annual, every 2 year, and every 3 year) of on-site monitoring procedures.

In reviewing the subrecipient risk assessment procedures performed by ISBE, auditors noted the risk criteria were evaluated on an entity-wide basis for each subrecipient; however, several subrecipients selected for on-site reviews were comprised of numerous individual school sites of which only a portion were subject to on-site fiscal and administrative review procedures. Upon further investigation, ISBE had not developed measurable selection criteria for determining which individual school sites will be subject to on-site monitoring procedures for each subrecipient.

Further, auditors selected a sample of 40 subrecipients for both Title I and Improving Teacher Quality State Grants and noted a number of subrecipients were selected for an on-site programmatic review but an actual review was not performed:

Additionally, the USDE performed a review of ISBE's administration of the Title I and Improving Teacher Quality State Grants programs. During this review, USDE identified several instances of noncompliance with program regulations at the subrecipient level, which have been attributed to deficiencies in ISBE's monitoring procedures for subrecipients of these programs.

In discussing these conditions with ISBE officials, they stated the level of External Assurance staffing continues to impact the ability of the division to meet scheduled monitoring visits. The External Assurance division has been reorganized. Management is in the process of posting vacancies and hiring additional staff throughout the State.

Updated Response: Partially Implemented. The Division of External Assurance (EA) is currently under new management. They have developed a new risk assessment tool for FY12, performed the risk assessment for FY12, and have implemented a new FY12 subrecipient monitoring plan for ISBE. The new monitoring plan is a multi-year plan; therefore, it will take several years for the finding to not repeat. EA has also hired 3 additional staff for monitoring.

10-56. The auditors recommend ISBE review its on-site monitoring procedures for subrecipients of the State Fiscal Stabilization Fund Cluster and implement changes necessary to ensure procedures performed adequately address all compliance requirements that are direct and material to subrecipients.

Findings: ISBE did not perform on-site monitoring procedures for subrecipients receiving federal awards under the State Fiscal Stabilization Fund Cluster.

During a review of the on-site monitoring procedures performed by ISBE for a sample of 40 subrecipients, auditors noted ISBE has not developed adequate procedures to monitor all relevant fiscal and administrative processes and controls of its subrecipients.

In discussing these conditions with ISBE officials, they stated the delay in developing and implementing on-site monitoring procedures for subrecipients of the State Fiscal Stabilization Fund Cluster was due to timing and limited resources.

Updated Response: Implemented. ISBE has contracted with 3 accounting firms to perform on-site monitoring for subrecipients receiving federal awards under the State Fiscal Stabilization Fund (SFSF) Cluster. The Division of External Assurance has also performed a mandatory training session along with a demonstration of the audit process.

10-57. The auditors recommend ISBE review its current process for calculating MOE expenditures incurred by its subrecipients to ensure all expenditure categories are properly included in the MOE calculation.

Findings: ISBE does not have adequate procedures in place to ensure the maintenance of effort (MOE) requirement for subrecipients of the Title I and Improving Teacher Quality State Grants (Title II) programs is accurately calculated.

During testwork over the MOE calculations for 40 subrecipients of the Title I and Title II programs, the calculations for 20 subrecipients did not include all MOE expenditures.

In discussing these issues with ISBE officials, they stated that the calculation errors occurred due to a misunderstanding related to designing the formula to extrapolate expenditure data used in the MOE calculations.

Updated Response: Implemented. The Division of External Assurance (EA) has reviewed the process for calculating MOE expenditures incurred by subrecipients to ensure all expenditure categories are properly included in the MOE calculation. It was determined that the automated process was not including all necessary expenditure categories. In addition, EA selected a sample of districts and performed manual calculations to ensure that the automated calculations were accurate. Testing results found the manual calculations to be consistent with the automated MOE reports. This finding is not expected to repeat for FY11.

10-58. The auditors recommend ISBE establish procedures to monitor the cash position of subrecipients. These procedures should be designed to ensure subrecipients receive no more than 30 days of funding on an advance basis. (Repeated-2009)

Findings: ISBE does not have adequate procedures to monitor the cash needs of subrecipients and to determine whether subrecipients are minimizing the time elapsing between the receipt and disbursement of funding for Title I, Special Education Cluster, and the State Fiscal Stabilization Fund (SFSF) Cluster programs.

During testwork, auditors noted ISBE is not monitoring the cash position of the subrecipients throughout the year to ensure that the subrecipients do not have excess federal cash on-hand at the time of each payment.

In discussing these conditions with ISBE officials, they stated that due to a similar finding identified by the Federal Office of Inspector General in a February 2010 audit of ISBE's internal controls regarding federal stimulus funds, the agency has made a significant policy change in how federal funds will be distributed to local education agencies beginning in fiscal year 2012.

Updated Response: Partially Implemented. ISBE announced a major policy change beginning in FY12. Monthly payment schedules will be eliminated from paper and electronic Federal grant applications. Payments will be made on a reimbursement basis as LEAs submit

expenditure reports through the Electronic Expenditure Reporting System in IWAS. This finding will not be cleared until FY12.

RECOMMENDATION 59
Illinois Community College Board

10-59. The auditors recommend ICCB:

- **Update its checklist to include additional criteria to ensure that a sufficient review is performed over the reports,**
- **Establish a process for updating the subrecipient files with the results of the findings follow-up review, and**
- **Require its subrecipients to certify that less than $500,000 was expended in total federal awards if an OMB A-133 audit report is not submitted. (Repeated-2006)**

Findings: ICCB is not adequately reviewing OMB Circular A-133 audit reports that are required to be received from subrecipients of the Career and Technical Education (post-secondary education) program.

In discussing these conditions with ICCB officials, they stated the A-133 desk review checklist and subrecipient certification procedures were not updated until fiscal year 2011.

Updated Response: Implemented.

RECOMMENDATION 60
Illinois Board of Higher Education

10-60. The auditors recommend IBHE establish procedures to ensure subrecipients are not suspended or debarred or otherwise excluded from participation in Federal assistance programs and that all required information is properly communicated to its subrecipients.

Findings: IBHE did not obtain required certifications that subrecipients were not suspended or debarred from participation in federal assistance programs and did not communicate program requirements to subrecipients of the State Fiscal Stabilization Fund Cluster program.

Additionally, IBHE's grant agreements did not identify the specific program name, CFDA number and federal award number under which federal funding had been provided during the year ended June 30, 2010 or the requirement to have an audit performed in accordance with OMB Circular A-133.

In discussing these conditions with IBHE officials, they stated the unusual nature of this grant and evolving federal guidance during the grant period contributed to the noncompliance identified.

Updated Response: Implemented.

RECOMMENDATIONS 61-67
Illinois Student Assistance Commission

10-61. The auditors recommend ISAC establish procedures to ensure borrower payments from outside collection attorneys are received on a timely basis. (Repeated-2005)

Findings: ISAC does not deposit the federal share of borrower payments into the Federal Fund within the required 48 hours. During testwork over 40 borrower payments, auditors noted three instances where borrower payments were not deposited into the Federal Fund within the required 48 hours. The delays were approximately five to eight days. ISAC is aware of the delay, and, as a result, calculates interest on funds remitted outside of the 48-hour requirement. During the year ended June 30, 2010, ISAC transferred approximately $2,450 from the operating fund to the Federal Fund as interest payments on untimely remittances.

In discussing these conditions with ISAC officials, they stated that delays in receipt of borrower payments from certain outside legal collection agencies were the reason for non-compliance with the 48-hour rule.

Response: Implemented. Payments received untimely from certain outside collection attorneys are 1% of total borrower payments. Ninety-nine percent of borrower payments are deposited on a timely basis. ISAC has thoroughly evaluated its deposit process and is working with the outside legal collection agencies to reduce processing time for remitting collections into the Federal Fund. In addition, ISAC continues to transfer interest on a monthly basis for those deposits that fall outside the 48-hour deposit period into the Federal Fund.

10-62. The auditors recommend ISAC review its process to ensure that loan information is properly verified and reported to the NSLDS. (Repeated-2008)

Findings: ISAC does not have an adequate process to verify unreported loans.

ISAC maintains loan level information in its guaranty loan subsidiary ledger (guaranty system) for all loans guaranteed by ISAC through the Federal Family Education Loans program. This information is reported to the National Student Loan Data System (NSLDS). The information in the guaranty system is updated by lenders primarily through an electronic lender manifest (update file) submitted to ISAC on a quarterly basis.

In addition to lender manifests, ISAC has additional processes in place to identify and adjust the guaranty system records for loans with no activity reported from lenders. The first process is the "presumed paid" process. ISAC runs a semi-annual report that identifies loans in the guaranty system that have been in repayment status for twelve years, and that have not been updated through any lender reporting in the past four years. The status of these loans is then changed from repayment to paid in full, and reported as such to the NSLDS.

The second process is called the "unreported loans" process. Through this process, ISAC runs a semi-annual report that identifies loans in the guaranty system that have not been updated through the lender manifest reporting process during the previous 180 days. Any loans included on this listing are sent to the lenders with instructions to review the loan information and update as appropriate in the next lender manifest. However, ISAC has limited means to follow-up with the lenders to verify that the lenders have made the appropriate changes. The primary mechanism

available to ISAC is the bi-annual compliance reviews of the lenders performed by ISAC personnel, in which the status of the unreported loans list is noted.

During testwork over the accuracy of the loan information included in the guaranty system, auditors selected a sample of 100 student loans to confirm the accuracy of the loan information with the lender. For one loan in the sample, the guaranty system had an outstanding loan balance of $75 as of March 31, 2010, while the lender reported an outstanding loan balance of $13.50 as of March 31, 2010. For one loan in the sample, the lender was unable to locate the loan in their records. The outstanding loan balance in the guaranty system was $2,625 as of March 31, 2010. For one loan in the sample, auditors were unable to obtain a response from the lender.

Response: Implemented. ISAC recognizes the importance of obtaining accurate and timely data from its lenders. As there is not a federal requirement for lenders to respond to the unreported loans report, ISAC relies on standard business processes with the approval of the U.S. Department of Education (ED) to verify unreported loans.

The following business processes will continue to be in place to accept changes and updates to loan records:

- ISAC will continue to process monthly lender manifest submissions.
- ISAC will continue its "presumed paid" process which is a method to change the loan status to presumed paid for loans that have been in repayment status for twelve years and that have not been updated through any lender reporting in the past four years. ISAC will continue to create the semi-annual unreported loans report as the means for lenders to report changes and updates to loan records.
- ISAC will continue to initiate an unreported loans follow up process with e-message reminders to lenders/servicers to make the necessary corrections and report loans on their Lender Manifest submission. The reminders will be sent at 60 day intervals to remind lenders/servicers to make the necessary corrections and report loans on their Lender Manifest submission.

ISAC will continue to participate in the Common Review Initiative (CRI) to conduct the compliance audits of participating lenders. The CRI review process includes a verification and determination that the lender/servicer is diligently working unreported loan reports to reduce overall unreported loan rates.

10-63. The auditors recommend ISAC review its process to ensure that lender agreements are executed fully and the lender agreements specify the loan programs for which the agreement is being executed. Further, ISAC should have a process in place to periodically review lender agreements in order to ensure they are complete and enforceable. (Repeated-2009)

Findings: ISAC does not have a process to ensure lender agreements are complete and enforceable.

ISAC works directly with eligible lenders to provide individuals subsidized and unsubsidized Federal Stafford loans and Federal PLUS loans. During an internal review of twenty lender agreements, ISAC identified three lender agreements that did not specify the loan programs ISAC authorized and guaranteed. In addition, ISAC noted one lender agreement wherein the lender's authorization signature was not dated on the lender agreement. However, no follow-up was

performed by ISAC to review the remaining population of lender agreements to ensure they were complete and enforceable. In addition, during the review of 25 lender agreements, auditors identified four lender agreements that did not specify the loan programs ISAC authorized and guaranteed.

Response: Implemented. The following business processes are in place with ISAC and the U.S. Department of Education (ED) to ensure that lender agreements are complete, enforceable and reviewed periodically:

- A process has been in place to ensure lender agreements are complete at the time of initial execution since the ISAC Compliance department became responsible for this activity in 2003. An Agreement Check List has been used to ensure that all agreements are properly executed. To our knowledge, this process was not reviewed during field work testing. Although ISAC provided a listing of Lender Agreements executed within the audit period, FY10, the sample of agreements chosen by the auditors did not include any of these agreements in order to test the current process. All Lender Agreements found to be incomplete were executed prior to 2003. (It also is important to clarify that the Lender Agreements found in the auditor's review that do not have check marks next to the loan programs are those identified by ISAC and are not additional.)
- The U.S. Department of Education determines whether a lender is eligible to participate in the FFEL programs, not ISAC. - "In accordance with 34 CFR Section 682.503(a)(1), to participate in the Federal Guaranteed Student Loan Programs, a lender must have a guarantee agreement with the Secretary." The Secretary is the U.S. Department of Education (ED) and a lender is determined eligible to participate in the FFEL programs by ED. Before making FFELP loans to borrowers, lenders must enter into agreements with guarantors and receive U.S. Department of Education approval to participate. The lender is not eligible to begin making FFELP loans until a complete Lender Participation Questionnaire is approved by ED.
- ISAC has a supplemental process in place to gather information about loan programs - As part of the lender participation process, ISAC has had a procedure in place since the 1980's that gathered loan program data in order for the guaranty operations to correctly identify and guarantee the loan types in which the lender wanted to participate. The procedure calls for a lender data sheet to supplement the Lender Agreement. The lender data sheet contains specific contact information along with a notation of the programs for which the lender is/was to participate. It was from this form that the loan programs were entered into the guaranty system.
- The U.S. Department of Education already has a process in place that requires lenders to submit a newly signed Organization Participation Agreement (OPA) every two years. This process makes a periodic review of lender agreements by ISAC redundant and unnecessary since lender participation is determined by ED.
- ISAC has a procedure in place that requires lenders to submit new agreements when program changes impact the terms and conditions as stated in the Lender Agreement.

Final note: ISAC will not be executing any new lender participation agreements due to the elimination of the Federal Family Education Loan Program (FFELP) effective July 1, 2010.

Auditors' Comment: *As discussed above, seven out of 45 lender agreements tested did not specify the loan programs ISAC authorized or guaranteed and one out of 45 did not include the date of the lender's signature. After identification of this issue of incomplete lender agreements,*

ISAC failed to follow up on the remaining population of lender agreements to ensure they were complete and enforceable.

10-64. The auditors recommend ISAC assign all defaulted loans to the USDE that meet the criteria contained in federal regulations or obtain a written waiver which specifies the number and criteria for assignment of loans to the USDE.

Findings: ISAC does not have an adequate process to ensure all defaulted loans that meet the requirements specified in federal regulations (34 CFR 682.409) are assigned to the USDE.

In June 2009, USDE lifted a moratorium on the assignment of defaulted loans that was enacted in FY08. As a result, ISAC is required to assign all defaulted loans that meet certain criteria by April 15th of each year to the USDE. Auditors noted 7,021 defaulted loans should have been assigned to the USDE but were not as of August 4, 2010. Management indicated it was their practice to only assign approximately 10,000 loans per year.

Updated Response: Accepted. ISAC will make every attempt to assign all eligible loans in a timely manner. It should be noted that the Department of Education (ED) put a hold on assignment of files beginning April 22, 2011. Another email was received from ED on April 27, 2011 which changed the hold date to May 6, 2011. Per another email from ED, the hold date was changed to August 1, 2011. During these change dates, ISAC did send assignment files, attempting to keep up with the changes. The hold was lifted on October 8, 2011 and we began to assign loans once again. On December 23, 2011, ED again placed a hold on assigning loans and the hold remains in effect as of today (January 11, 2012).

10-65. The auditors recommend ISAC review its current process for performing post claim reviews and consider any changes necessary to ensure reviews are completed within the required timeframes.

Findings: ISAC did not review post claim data within the required timeframes.

On a quarterly basis, ISAC performs a post claim review over a sample of claims of defaulted loans purchased from lenders to verify data provided by lenders on claim filing forms matches the actual collection and repayment history of the loan. If any errors are observed during the post claim review of the claims, ISAC expands the sample of claims from the specific lender whose account contained the error.

Auditors noted the post claim reviews for the quarters ended March 31, 2010 and June 30, 2010 were not performed within the required timeframes. Specifically, the post claim reviews for these quarters were not completed until November 4, 2011.

In discussing these conditions with ISAC officials, they stated that the reviews were late due to a change in staffing.

Response: Implemented. ISAC post claim sampling reviews are currently submitted within the required timeframes.

10-66. The auditors recommend ISAC review its current process for remitting payment receipts on defaulted loans and consider any changes necessary to ensure such payment receipts are remitted in a timely manner.

Findings: ISAC did not ensure payments on defaulted loans were remitted to U.S. Department of Education (USDE) within the required timeframes.

ISAC receives payments on defaulted loans directly from borrowers and indirectly through outside collection agencies. When a borrower makes payments on a loan after the guarantee agency has paid a claim on that loan, the guarantee agency must pay the USDE an equitable share of those payments within 45 days. ISAC remits the USDE share of those payments by netting the payment against future claims and reports the payments on the monthly claiming reports. During testwork over 40 payment receipts (totaling $49,265) on defaulted loans, auditors noted one payment for $508 that was not remitted to the USDE within 45 days of the payment because it was improperly excluded from the subsequent month's claiming report. The delay in remitting this payment receipt was five days after the required federal timeframe.

In discussing these conditions with ISAC officials, they stated this was a one time issue due to human error.

Response: Implemented. ISAC has reviewed its current process for remitting payment receipts. Amounts posted are reconciled to amounts deposited daily. Any discrepancies are immediately investigated and resolved.

10-67. The auditors recommend ISAC implement procedures to perform formal reviews of user access rights on a periodic basis to ensure that the access rights granted to each user are appropriate based on their job responsibilities and that the planned level of segregation of duties is achieved on a continuing basis. Additionally, the auditors recommend ISAC review its current process for performing system change validation procedures and consider any changes necessary to ensure such procedures are formally documented. Lastly, the auditors recommend ISAC review the password complexity and account lockout settings for the system network and implement any changes necessary to ensure those setting are properly configured in accordance with the internal password policy.

Findings: ISAC does not have adequate documentation of access and program development controls over the information systems that support the Federal Family Education Loans (FFEL) program.

During testwork over the access, program change and development, and computer operations controls of the two systems, auditors noted the following:

- There are no formal procedures to periodically review user access for each user of the Loan Guarantee System.
- There is no formal documentation maintained to support the periodic review of user access for each user of the Odyssey Accounting System.
- There were two program and application changes in our sample of 5 system changes for which no formal documentation was maintained to support the testing and validation

procedures performed before the system changes were implemented and placed into production.

- The password complexity and account lockout settings for the system network are not properly configured in accordance with the internal password policy.

In discussing these conditions with ISAC officials, they stated the reviews of system access for personnel transferring within the Agency were not documented.

Updated Response: Implemented. ISAC acknowledges the benefit of performing formal reviews of user access rights on a periodic basis. IT staff initiated a formal, comprehensive review of all user access privileges in fall 2010, and completed the review prior to June 30, 2011. The process is intended to be performed annually for all staff. The procedure will be formalized in our agency security policy, which was updated by management 7/25/2011, and reviewed and signed by all staff by August 31, 2011.

Regarding system change validation, production migration procedures were enhanced this year to specifically check for evidence of User Acceptance Test signoff. With this enhancement, production migration staff will not promote a change request from the application maintenance and development teams without first seeing evidence of UAT signoff. In conjunction with this procedural enhancement, ISAC implemented a robust project/change request system this year. JIRA is a collaborative, transparent request management software tool employed by both IT and business unit staff. Issues are 'opened' by staff from business units and 'closed' by them as well. The significance of this aspect of JIRA is that not only do we now capture all activities relating to a request in a single, centralized repository, we also including such things as UAT sign-off and final production implementation user-verification (via the 'close' action) by business users as well. In addition, project-related documents are attached to JIRA requests, so that artifacts like requirements and scope documents, project plans, test plans, test results documents are now all a part of the permanent work request record, saved in a centralized, transparent repository.

While we agree that a disparity existed between our published password policy and the actual settings in our network, we do not view this as a substantive risk. In November 2010, ISAC increased the password complexity required for access to both our network and mainframe. Our users were informed of the new password complexity requirements via all-staff email, and all staff are scheduled to review and sign ISAC's updated security policy in August 31, 2011.

RECOMMENDATIONS 68-76
Department of Employment Security

10-68. The auditors recommend IDES implement procedures to ensure adequate eligibility certifications are obtained from all claimants on a continuing basis throughout the period for which benefits are paid. (Repeated-2008)

Findings: IDES does not obtain continuing certifications that claimants have not refused suitable work offers throughout the eligibility period prior to the payment of benefits under the Unemployment Insurance (UI) Program.

In discussing these conditions with IDES officials, they stated claimants were previously required to certify that they had not refused suitable work through Teleserve for each week of benefits they certified to; however, the refusal to work question was removed from the script over thirteen years ago due to a perceived confusion from claimants in answering the question.

Response: Implemented. The refusal of work question was added to the Teleserve Interactive Voice Response (IVR) System and the Internet Claims Bi-weekly Certification page when Release 4 of IBIS was implemented in August 2010. The system records the claimant's response to the question and where appropriate, the certification will be suspended if the claimant indicates he/she refused an offer to work.

10-69. The auditors recommend IDES implement procedures to ensure all eligibility determinations are made within the prescribed timeframes. (Repeated-2008)

Findings: IDES is not issuing eligibility determinations for individuals applying for Unemployment Insurance benefits in accordance with timeframes required by the State Plan.

During testwork auditors conducted unannounced site visits to three local offices and requested the most recent pending adjudication report as of the date of the visit. Auditors noted a significant backlog in the resolution status of claims in the adjudication process. Specifically, a total of 691 out of 1,775 claims at the three local offices were outstanding for time periods ranging from 22 to 247 days as of the date of the visits.

Additionally, during the review of the FY11 State Quality Service Plan (Plan) submitted by IDES to the USDOL, IDES did not meet the acceptable level of performance for issuing eligibility determinations on certain disqualifying issues as defined by the USDOL (non-monetary issues) for the federal fiscal year 2010, resolving only 62.3% of these determinations within 21 days of the detection date. The standard is 80%.

In discussing these conditions with IDES officials, they stated the significant increase in the volume of claims and the under-funding of the UI program in recent years have worsened the situation.

Response: We agree.

10-70. The auditors recommend IDES implement additional procedures to ensure the automated stop is generated for all invalid social security numbers to prevent payment of benefit to ineligible claimants and to ensure all requests are returned from the SSA. (Repeated-2009)

Findings: IDES does not have adequate procedures to follow up on invalid social security numbers for claimants of the Unemployment Insurance program.

During testwork over the eligibility of UI benefit payments, auditors selected a sample of 50 claimants from a listing of invalid social security numbers and noted two did not have the automatic stop applied and as such, were not properly investigated by IDES. Total benefits paid to these two claimants were $9,767 during the year ended June 30, 2010. During the year ended June 30, 2010, a total of 2,006 out of 833,274 social security numbers were reported as potentially invalid by the Social Security Administration for which benefits paid to 238 claimants were approximately $1,680,000.

In discussing these conditions with IDES officials, they stated the two numbers were submitted to the Social Security Administration but were not returned on the file and as such had not been uploaded to BIS. When the annual rematch was done for the auditors, these numbers were on the return file from SSA.

Response: We agree. IDES intends to have an online verification process with the Social Security Administration in place as part of the implementation of IBIS. This should ensure responses are received for each new claim filed. This should be in place by June 30, 2011.

10-71. The auditors recommend IDES reinforce procedures to ensure all eligibility determination documentation is complete and properly maintained. (Repeated-2006)

Findings: IDES did not maintain complete documentation supporting client eligibility determinations made for the Unemployment Insurance program.
During testwork of the UI program, auditors selected 60 beneficiary payments to review for compliance with eligibility requirements and for the allowability of the related benefits, and noted the following exceptions:

- In one case, the UI application could not be located. Auditors verified each of the eligibility criteria through information in the electronic files.
- In one case, the claimant's application contained insufficient documentation to determine if the claimant had dependents and provided over half the support, however the benefit payment included a dependent allowance. Total dependent benefits paid to this individual was $3,871.
- In fifteen cases, the claimant was not registered on the Illinois Skills Match system. In each of these cases, auditors were able to determine the individuals were actively seeking employment through the weekly certifications made to IDES.

In discussing these conditions with IDES, they stated the application that was not located may have been misfiled or mislabeled when microfilmed. Regarding the dependent allowance, the IDES representative failed to document clarification of the claimant's responses to the applicable questions. Claimants are advised to register in the Skills Match system, but do not always do so.

Response: We agree. Since the implementation of IBIS on 8/30/10, all claimants that require registration with Illinois Skills Match are automatically partially registered at the time of claim filing.

10-72. The auditors recommend IDES review its procedures for monitoring its third party servicers and implement any changes necessary to ensure significant internal controls at the service organizations are operating effectively. (Repeated-2009)

Findings: IDES does not adequately monitor a service organization of the Unemployment Insurance program. In September 2008, IDES began utilizing debit cards to pay UI benefits. IDES has contracted with a third party service provider (financial institution) to administer the debit card processing of UI benefits.

Auditors noted IDES does not require its service provider to obtain an independent examination of the operating effectiveness of internal controls during the year (commonly referred to as a Type II SAS 70 report). As a result, IDES is not able to adequately monitor its third party service provider to determine whether internal controls that are essential to compliance with federal requirements of the UI program are operating effectively.

In discussing these conditions with IDES officials, they stated that in their opinion it was sufficient to have received a Type I SAS 70 report from this bank, which provided a description of the internal controls and reasonable assurance that the controls were properly designed, as well as a Type II SAS 70 from the debit card provider, who subcontracts with the bank.

Response: IDES accepts this finding. We have implemented a procedure to formalize our review of third party service provider controls and have included a Type II SAS 70 review as a requirement in the new bank contract.

10-73. The auditors recommend IDES complete and document the resolution of each claim in a timely manner on the exception and monitoring report (including supervisory review), and retain the reports as considered necessary to facilitate completion of the audit. IDES should also automate the claim exception and monitoring edit reports into the Benefits Information System in future years to facilitate a more efficient and effective process for claims exception resolution documentation. (Repeated-2005)

Findings: The IDES local offices did not clearly document the resolution of the issues identified on the claim exception and monitoring reports, and the reports did not always indicate that a supervisory review had been performed.

The IDES Central Office generates several system (exception and monitoring) reports to facilitate proper benefit payment that are utilized at the local office level and monitored by local office and/or regional office management. These reports include the following:

- SSN Verification From SSA
- Sensitive Changes Report
- Immigration Record Check For Unemployment
- Combined Application Error Report.
- File Maintenance Error Report and Rejected Transaction Report
- Media Transfer Report
- Daily Rejected Report
- All Transactions Report
- Claims Application Error Report
- Internet Claims Deletion Report
- First Certification Report
- Certification Summary Report
- Pending Adjudication Report

Auditors conducted unannounced site visits to three local offices and requested the above claim exception and monitoring reports for the most recent date that had been reviewed by the local office staff. Auditors reviewed a total of 39 reports and noted that resolution of exceptions and supervisory review was not consistently documented.

In discussing these conditions with IDES officials, they stated that not all reports and/or items on reports require resolution and supervisory review.

Response: We accept the finding and have automated the reports. Most of the errors that occurred in BIS have been eliminated with the new benefit system (IBIS) or become workflow items that are automatically tracked in the system for follow up.

10-74. The auditors recommend IDES implement procedures to ensure the information technology systems are properly configured to offset overpayments in accordance with the federal regulations. (Repeated-2009)

Findings: IDES has not configured its information technology systems to properly offset overpayments related to the Federal Additional Compensation (FAC) and the Emergency Unemployment Compensation (EUC08) programs, which were established by the American Recovery and Reinvestment Act and administered as a part of the Unemployment Insurance Program.

Based on a review performed by the U.S. Department of Labor, auditors noted the following:

- IDES had not properly configured its information technology system to offset the FAC overpayments with FAC benefits. IDES' information technology system was configured to offset the FAC overpayments against the EUC08 benefit payments and other federally funded benefits, which resulted in slower collections of FAC overpayments. Total FAC payments made during the fiscal year ended June 30, 2010 were $600,564,325, of which $11,858,375, or 2.0%, consisted of overpayments.

- IDES had not properly configured its information technology system to offset EUC08 fraud overpayments to a maximum of 50% against the weekly benefit amount. The system is currently programmed to offset EUC08 fraud overpayments with 100% of the EUC08 weekly benefit amount. Total EUC08 benefits paid during the fiscal year ended June 30, 2010 were $2,688,389,967, of which $10,466,937, or 0.4%, consisted of overpayments related to fraud.

In discussing these conditions with IDES officials, they stated they were following past practices of previous federal extension programs by following State law which provides for a higher recoupment for fraudulent overpayments than does federal law. Concerning the failure to offset a FAC overpayment with a FAC payment, it was assigned a low priority compared to other requirements of the American Recovery and Reinvestment Act that significantly expanded the Unemployment Insurance Program. In addition, resources to perform the necessary programming tasks had been diverted to performing implementation and conversion tasks related to the implementation of the new benefit information system (IBIS).

Response: Implemented. Changes to ensure that fraudulent EUC overpayments are only recouped at 50% instead of 100% were implemented as well as the ability to offset a FAC overpayment with a FAC payment.

10-75. The auditors recommend IDES establish procedures to perform out-of-state wage verifications at the beginning of the initial EUC08 and extended benefit periods, and at the end of each quarter to determine if UI eligibility could be established in another state. (Repeated-2009)

Findings: IDES did not perform all required out-of-state wages verification procedures for Emergency Unemployment Compensation (EUC08) beneficiaries.

Based on a review performed by the U.S. Department of Labor and discussion with management, auditors noted IDES does not examine out-of-state wages at the beginning of the initial EUC08 and initial extended benefit claim or at the end of each quarter to determine if UI eligibility could be established in another state. IDES procedures for verifying whether a claimant has exhausted all rights to regular benefits only include examining out-of-state wages each time a claimant establishes a new benefit year.

In discussing these conditions with IDES officials, they stated they had explored different solutions as a result of the finding last year that were not viable and only recently learned of another option.

Response: We agree. USDOL has recently provided an option and we are exploring it.

10-76. The auditors recommend IDES implement procedures to ensure the ATAA benefit payments are properly calculated and paid on at least a monthly basis. (Repeated-2008)

Findings: IDES did not accurately calculate benefit payments for the Alternative Trade Adjustment Assistance (ATAA) grant administered under the Unemployment Insurance Program.

The ATAA grant is available to a subset of beneficiaries who were eligible for benefits under the Trade Readjustment Assistance (TRA) grant. The objective of the TRA grant is to provide benefit payments to assist individuals who become unemployed or underemployed as a result of increased imports or a shift of production to Mexico or Canada to return to suitable employment. The objective of the ATAA grant is to provide workers 50 years of age or older with the option of receiving a temporary wage subsidy upon prompt reemployment at lower pay than their previous adversely affected employment as an alternative to other TRA benefits. The ATAA wage subsidy must be evaluated on a monthly basis to determine whether the subsidy should be adjusted to accommodate pay changes resulting from changes in employment or shift differentials.

During testwork of the ATAA program, IDES disclosed an internal review of beneficiary payments for the quarter ended September 30, 2009 which identified several instances of non-compliance consistent with the prior year's audit results. Specifically, auditors noted the following exceptions were identified in IDES' review:

- In ten cases (with sampled weekly payments of $4,482), the ATAA weekly benefit amount was not accurate due to changes in hours not reflected in the benefit calculation. As a result, eight beneficiaries were underpaid by $1,019 and two beneficiaries were overpaid by $115.
- In five cases (with sampled weekly payments of $2,235), benefits paid were calculated using a monthly rate instead of a weekly rate which resulted in overpayments of $102.
- In one case (with sampled weekly payments of $528), benefits paid were calculated using a monthly rate instead of a semi-monthly rate which resulted in an underpayment of $42.
- In one case (with sampled weekly payments of $244), benefits paid were calculated using a weekly rate instead of a bi-weekly rate which resulted in an overpayment of $2.

In discussing these conditions with IDES officials, they stated that staff calculating benefit payments were still in training and there was no monitoring process in place.

Response: We agree. Draft procedures have been modified to include payment accuracy verification by staff who do not process payments prior to payment file creation in ACCESS and

upload to IBIS. Quarterly reviews of 60 A/RTAA payments per quarter will continue to be conducted to ensure accuracy of payments.

RECOMMENDATIONS 77-80
Department of Commerce and Economic Opportunity

10-77. The auditors recommend DCEO establish procedures to follow up on on-site monitoring findings to verify corrective actions have been implemented by subrecipients prior to reimbursing program expenditures. The auditors also recommend DCEO implement procedures to perform and document supervisory reviews of on-site monitoring files.

Findings: DCEO did not have an adequate process in place for following up on monitoring findings for subrecipients of the Weatherization Program and did not document supervisory reviews of on-site monitoring files for subrecipients of the Weatherization and Low Income Home Energy Assistance Program (LIHEAP) programs.

During a review of monitoring reports and checklists prepared for on-site reviews conducted for 15 Weatherization subrecipients, auditors noted DCEO identified and reported several instances of non-compliance with program requirements to its subrecipients. However auditors noted DCEO had not performed procedures to ensure timely corrective action was taken by subrecipients prior to reimbursing program expenditures and, as a result, unallowable costs may have been paid to subrecipients during the year ended June 30, 2010.

In addition, auditors noted the on-site monitoring review files tested for the 15 Weatherization subrecipients identified above and for 15 LIHEAP subrecipients did not have adequately documented supervisory reviews to ensure the review checklist procedures were properly completed.

In discussing these conditions with DCEO officials, they stated an Excel spreadsheet was being used to track Weatherization monitoring visits and findings prior to the implementation of a SharePoint tracking system in September 2010. Supervisors were reviewing the monitoring finding letters and files but were not documenting their reviews for both the LIHEAP and Weatherization programs.

Response: The Department agrees with the finding and implemented a SharePoint monitoring and finding tracking system in September 2010 for the Weatherization program. The SharePoint system also documents the supervisory reviews for the Weatherization program. The Department plans on developing a SharePoint monitoring and finding tracking system for LIHEAP which will also document supervisory reviews.

Updated Response: Implemented.

10-78. The auditors recommend DCEO properly communicates ARRA information and requirements to its subrecipients. (Repeated-2009)

Findings: DCEO did not communicate American Recovery and Reinvestment Act (ARRA) information and requirements to subrecipients of the Workforce Investment Act Cluster (WIA Cluster), Weatherization, and Community Services Block Grant programs.

During testwork over disbursements to subrecipients of the WIA Cluster, Weatherization, and CSBG Cluster programs, auditors noted DCEO did not identify the federal award number, catalog of federal domestic assistance (CFDA) number, or the amount attributable to ARRA at the time of each disbursement for the period from July 1, 2009 to May 9, 2010. Additionally, DCEO's grant agreements did not identify the requirement for subrecipients to separately report ARRA program expenditures on their schedule of expenditures federal awards (SEFA) and data collection form.

In discussing these conditions with DCEO officials, they stated they became aware of this issue in May 2010 when it was identified as a finding for the previous audit period (State fiscal year 2009). As a result of the timing of the previous audit, these conditions were still present for the current audit period even though DCEO completed corrective action in June 2010.

Response: The Department agrees with the recommendation and completed corrective action in June 2010. The Department revised the audit provisions in the grant agreement to include the specific requirement for subrecipients to separately report ARRA expenditures on their SEFA and data collection forms. The Department also modified its voucher submissions to include the required ARRA information on disbursements to the subrecipients.

Updated Response: The Department cannot comply since the period of availability has expired and all agreements have been terminated.

10-79. The auditors recommend DCEO review the process and procedures in place to prepare and submit ARRA 1512 reports to ensure expenditures reported are accurate and reconcile to DCEO's financial records.

Findings: DCEO did not accurately report expenditures in the quarterly ARRA 1512 report for the Weatherization Program. During a review of one of the four quarterly reports submitted during the fiscal year ended June 30, 2010, the total federal amount of ARRA expenditures reported did not agree to DCEO's financial records or to the program expenditures reported on the SF-425 Federal Financial Report filed for the respective quarter.

In discussing these conditions with DCEO officials, they stated the Department did not provide updated reporting information for allocated costs that are collected from another State agency after the initial 10 day deadline. The Department did not believe that the amount of the additional allocated costs met the intended requirement of the OMB guidance for "continuous correction" reporting provision relating to "significant reporting errors, material omissions and administrative/technical problems." The Department also assumed that using a cumulative basis to report the costs in the subsequent quarter was adequate and in compliance with the OMB guidance.

Response: The Department agrees with the recommendation and will modify its monthly closing and reconciliation procedures to eliminate differences in expenditures due to timing issues.

10-80. The auditors recommend DCEO establish procedures to identify reporting requirements and to ensure all required reports are prepared and submitted in accordance with program requirements.

Findings: DCEO failed to prepare and submit separate financial status reports required for the LIHEAP Leveraging Incentive program award.

DCEO is required to submit an annual financial status report for each open LIHEAP award. During testwork, auditors noted DCEO did not prepare or submit financial status reports for the LIHEAP Reach Program and the LIHEAP Leveraging Incentive Program during the fiscal year ended June 30, 2010.

In discussing these conditions with DCEO officials, they stated the failure was directly attributable to information exchanged during the transfer of the LIHEAP program to DCEO from the Department of Health and Family Services (DHFS). DCEO understood from DHFS that all reporting for both the LIHEAP Reach and the LIHEAP Leveraging Incentive programs should be included in the reporting for the regular LIHEAP award. DCEO reported all the financial transactions for these programs in the regular LIHEAP award annual report for the fiscal year ended June 30, 2010.

Response: The Department agrees with the finding and continues to maintain procedures that help to identify all program reporting requirements. In this instance, DCEO immediately filed the required reports when the auditors identified the reporting exception during the course of this audit. DCEO also contacted DHFS to ensure there were no other awards or reporting requirements involved in the transfer that were not clearly identified during the initial transfer of the program.

RECOMMENDATIONS 81-89
Department of Transportation

10-81. The auditors recommend IDOT establish formal criteria for determining which subrecipients will be subject to periodic on-site reviews on an annual basis. (Repeated-2005)

Findings: IDOT is not adequately performing on-site monitoring procedures for subrecipients receiving federal awards under the Airport Improvement Program.

IDOT passed through approximately $25,358,000 to 39 subrecipients of the Airport Improvement Program during the fiscal year ended June 30, 2010. The majority of the subrecipient grants pertain to construction projects for airport improvement or noise abatement projects. Effective in FY10, IDOT developed standardized checklists for conducting on-site reviews of its subrecipients receiving federal awards under the Airport Improvement Program. The auditors noted IDOT has not established criteria for determining which subrecipients will be subject to on-site monitoring procedures on an annual basis. Only one subrecipient was subject to an on-site review during the fiscal year ended June 30, 2010.

In discussing these conditions, IDOT officials stated they monitored subrecipients by reviewing grant applications, receiving periodic expenditure reports, reviewing invoices for noise abatement projects, and reviewing OMB Circular A-133 audit reports.

Response: The Department agrees with the finding. Although the Department believes that they have documented reasonable assurance of federal AIP grant compliance for local let projects in accordance with OMB Circular A-133, the Department will expand its on-site monitoring efforts to include auditing 20% of the projects that are let locally each year. As such, the 'Administrative Bulletin 2010-01' will be revised to establish formal criteria for determining which subrecipients will be audited.

10-82. The auditors recommend IDOT review its current record retention policies and procedures and implement the changes necessary to ensure documentation is retained in accordance with federal regulations.

Findings: Contractors must receive advance approval from IDOT to bid on construction projects. As a condition of obtaining IDOT's advance approval, contractors are required to submit an affidavit of availability, which identifies the total value of work previously awarded but not yet complete by the contractor, the contractor's commitment of equipment and personnel on payroll for the planned project, any proposed work on which the contractor is the low bidder which has not yet been awarded, all subcontractors used by the contractor on its projects, and the value of work sublet by the contractor. This affidavit is used by IDOT to determine whether the contractor has available capacity to complete the project.

During testwork over 40 contractor payments (totaling $74,578,444), auditors noted the affidavit of availability for eight contractors (with sampled payments of $11,085,747) could not be located. These projects were originally bid prior to FY05 and the affidavits of availability were purged in accordance with IDOT's record retention policy which only requires documentation of this nature to be retained for a five year period. Accordingly, IDOT has purged the affidavits of availability for all projects which were bid prior to July 1, 2004. Federal regulations require records to be retained for a period of three years after final payments and all other pending matters are closed.

In each of the procurement files missing the affidavit of availability, each of the advance approval criteria was verified through additional supporting documentation in IDOT's electronic records.

Response: The Department agrees with the finding. The Department will review the current record retention policy and revise as necessary.

10-83. The auditors recommend IDOT establish procedures to ensure the provisions requiring the contractors and subcontractors to comply with the Davis-Bacon Act and Department of Labor Regulations are included in all executed contracts. (Repeated-2009)

Findings: IDOT did not include provisions in the construction contracts requiring the contractors and subcontractors to comply with the Davis-Bacon Act and Department of Labor Regulations for the Highway Planning and Construction Cluster Program.

The regulations require, in part, that all laborers and mechanics employed by contractors or subcontractors who work on construction contracts in excess of $2,000 financed by federal assistance funds must be paid prevailing wage rates established for the locality of the project. IDOT's process to comply with these requirements includes informing their contractors of the applicability of these requirements through communications in the bid documents and obtaining weekly certified payroll reports from contractors. However, IDOT did not include in all of their contracts a requirement that the contractor or subcontractor comply with the requirements of the Davis-Bacon Act and related DOL regulations.

Response: Implemented. The Contracts Office of the Bureau of Design and Environment has been including the required provisions for the Davis-Bacon Act and U.S. Department of Labor regulations in the proposals/contracts subject to those requirements since the November 6, 2009 letting.

10-84. The auditors recommend IDOT implement procedures to ensure amounts reported by subrecipients in the schedule of expenditures of federal awards are reconciled to departmental records. (Repeated-2002)

Findings: During testwork, auditors noted the checklist used by IDOT to perform A-133 desk reviews does not include procedures to reconcile federal funds spent by IDOT to the schedule of expenditures of federal awards reported by the subrecipient. As a result, IDOT is not able to determine whether federal awards passed through to subrecipients have been properly included in the subrecipients' OMB Circular A-133 audits.

In discussing these conditions with IDOT officials, they stated reconciliation procedures were being developed.

Response: Implemented. During fiscal year 2011, a process of reconciling the amount of federal awards passed through IDOT and reported by subrecipients in the schedule of federal awards has been implemented. The new protocol has been adopted and included as part of the subrecipient monitoring programs.

10-85. The auditors recommend IDOT implement procedures to ensure ARRA information and requirements are properly communicated to subrecipients.

Findings: IDOT did not communicate American Recovery and Reinvestment Act (ARRA) information and requirements to subrecipients of the Airport Improvement Program and the Highway Planning and Construction Cluster Program.

During testwork over five ARRA disbursements totaling approximately $1,732,000 to three subrecipients of the Airport Improvement Program and four ARRA disbursements totaling approximately $4,834,000 to two subrecipients of the Highway Planning and Construction Cluster Program, auditors noted IDOT did not identify the federal award number, catalog of federal domestic assistance (CFDA) title and number, or the amount of the award attributable to the ARRA at the time of each disbursement. Additionally, IDOT's grant agreements did not identify the requirement for their subrecipients to separately report the ARRA program expenditures on the schedule of expenditures federal awards (SEFA) and the data collection form.

In discussing these conditions with IDOT officials, they stated the Department implemented a web application by which subrecipients could retrieve the Federal Award number, CFDA title number and the amount of the award attributable to the ARRA. However, the use of this application was not required in order to receive payment.

Updated Response: Implemented. The Department has notified all staff of the requirement to provide subrecipients with ARRA information in accordance with 2 CFR 176.210 (c) and (d).

10-86. The auditors recommend IDOT review its current process for preparing subrecipient funding notifications to ensure all required information is properly communicated to its subrecipients. (Repeated-2004)

Findings: IDOT did not provide required program information relative to federal funds passed through to the subrecipients of the Airport Improvement Program and Highway Planning and Construction Cluster Program for the year ended June 30, 2010.

During testwork of 25 grant awards to 17 subrecipients who received approximately $23,502,000 in Highway Planning and Construction Cluster Program funds and 25 grant awards to 19 subrecipients who received approximately $8,956,000 of the Airport Improvement Program funds, auditors noted the following:

- Twelve grant award notices for the Highway Planning and Construction Cluster Program and eighteen grant award notices for the Airport Improvement Program did not communicate the need for an audit in accordance with OMB Circular A-133.
- Thirteen grant award notices for the Highway Planning and Construction Cluster Program and seven grant award notices for the Airport Improvement Program included incorrect information regarding the need for an audit in accordance with OMB Circular A-133.
- Six grant award notices for the Airport Improvement Program did not communicate the specific program or CFDA number and title under which federal funding had been provided.
- Twenty-five grant award notices for the Highway Planning and Construction Cluster Program did not communicate the specific program or CFDA number and title under which federal funding had been provided.

In discussing these conditions with IDOT officials, they stated that the projects identified were initiated before the prior year corrective action that revised the agreements had been fully implemented.

Response: The Department agrees with the finding. As of the previous audit finding, the Department has modified the agreements to include notification of the CFDA number and federal funding program for the grant award notices. The Department will revise the current award notices to reflect the correct OMB Circular A-133 language.

10-87. The auditors recommend IDOT implement procedures to ensure all materials are tested in accordance with the sampling and testing program approved by the FHWA. (Repeated-2009)

Findings: IDOT did not test materials used for construction activities under the Highway Planning and Construction Cluster Program in accordance with their approved sampling and testing program.

IDOT utilizes the Materials Integrated System for Test Information and Communication (MISTIC) system to track which materials require testing and the method of testing to be used. This system is integrated with IDOT's construction billing system in which resident engineers enter quantities used during construction to generate payments to the contractors. If quantities entered do not have a test number which conforms to the type of testing required by the Guide assigned in MISTIC, it is the resident engineer's responsibility to ensure the proper test is completed before payment is made.

During testwork, auditors selected 115 materials from ongoing (open) construction projects and advanced construction projects and noted the following exceptions:

- In five instances, materials were accepted using a method of acceptance that was not in accordance with the Manual.
- In two instances, documentation could not be located to support the testing completed over the materials sampled.

In discussing these conditions with IDOT officials, they stated that the 2009 Manual had been just recently published when two to three of the exceptions happened. The methods of acceptance for the materials involved were changed in the 2009 Manual. This may have lead to some confusion for the IDOT field staff. Another exception occurred in 2005, well before the 2009 Manual was published, and the material involved was seldom used and is no longer specified or used by IDOT. Only one to two items were true exceptions to a long-standing method of acceptance and these items were the same material selected twice from the same contract. The separately denoted items that involved not being able to find the source documents on microfilm are considered non-issues by IDOT since the correct method of acceptance information was retrieved from IDOT's official database, MISTIC.

Response: The Department agrees with the finding. The Bureau of Materials and Physical Research (BMPR) will notify the districts of these audit findings and encourage improvement in the materials areas involved in the identified exceptions. At this time, BMPR believes that continued use of the updated Manual and Project Procedures Guide will reduce the exceptions in the future.

Updated Response: Accepted. The Manual for Materials Inspection was updated as of 03/25/11. The Project Program Guide is scheduled to be updated prior to the FY12 construction season.

10-88. The auditors recommend IDOT implement procedures to ensure cash draws are performed in accordance with U.S. Treasury Regulations.

Findings: IDOT does not have procedures to ensure cash draws are performed in accordance with the Treasury-State Agreement. During review of 50 expenditures totaling approximately $16,252,500, auditors noted warrants were not issued for two expenditure vouchers totaling approximately $406,000 within three business days of receiving the federal funds intended to finance these expenditures. The number of days between the receipt of federal funds and the issuance of warrants for these two expenditures was four and five business days.

In discussing this condition with Department officials, they stated this was the result of an oversight.

Response: Implemented. The Department has implemented procedures to ensure cash draws are performed in accordance with current U.S. Treasury Regulations by not drawing down federal funds until such time as the State's financial systems indicate the payment has been vouchered. This finding results in a 97.5% success on the expenditures and 96% success on the number of expenditures.

10-89. The auditors recommend IDOT account for and remit interest earned on the Homeland Security Cluster Program funds to the U.S. Treasury. (Repeated-2006)

Findings: IDOT did not account for and remit interest earned on advance funding received under the Homeland Security Cluster Program.

During the year ended June 30, 2010, IDOT received approximately $797,300 in advance funding under the Homeland Security Cluster Program. Auditors noted IDOT deposited the advance funding into an interest-bearing account with the State Treasurer which is commingled with other

funds. However, IDOT did not account for and remit interest earned on the Homeland Security Cluster Program funds to the U.S. Treasury.

In discussing these conditions with IDOT personnel, they stated the corrective action for this repeat finding had not been fully implemented in 2010.

Response: The Department agrees with the finding. A separate appropriation was created in 2009 to reimburse Homeland Security expenditures to vendors prior to drawing down any federal funds. This corrective action had unfortunately not been fully implemented during the audit period. We believe that the new appropriation and protocols will alleviate the concern noted in the finding.

RECOMMENDATIONS 90-95
Emergency Management Agency

10-90. The auditors recommend IEMA sufficiently perform on-site reviews to ensure subrecipients are administering the federal program in accordance with the applicable laws and regulations. (Repeated-2008)

Findings: IEMA is not sufficiently performing on-site reviews of subrecipients receiving federal awards under the Homeland Security program.

Auditors selected fifteen subrecipients who received site visits and noted the following:

- The certification form was not completed for site visits conducted at two subrecipients.
- The certification form for eight subrecipients identified deficiencies which were not resolved. Specifically, the certification forms for these site reviews indicated 42 of the 89 equipment items selected for observation were not located and ITTF did not perform follow-up procedures or issue a report to communicate the deficiencies.
- Evidence of a supervisory review of the certification form was not documented.

In discussing these conditions with IEMA personnel, they stated appropriate ITTF policies and procedures had been established and followed during the audit period. However, adequate sampling selection methodologies need to be better defined and documented.

Response: IEMA accepts this recommendation.

During the audit period, IEMA complied and followed the established policies for on-site monitoring. The auditors' testing identified 42 of the 89 equipment items were not located. However, according to the policy, the 42 items were not selected as part of the sample for testing and therefore would not have been reviewed. The 42 items were also certified as part of the inventory listing by the sub-recipient (per the policy).

Per the policy, a sample is to be selected prior to the on-site visit. IEMA's documentation did not adequately clarify the sample prior to the on-site review.

IEMA will select the sample prior to the visit and ensure the certification documentation is clearer in regards to which items selected were the sample versus the universe of equipment items.

10-91. The auditors recommend IEMA establish procedures to ensure desk reviews are performed on a timely basis for all subrecipients, and management decisions are issued for all findings affecting its federal programs in accordance with OMB Circular A-133.

Findings: IEMA is not adequately performing the reviews of OMB Circular A-133 reports which are required to be received from subrecipients of the Homeland Security Cluster.

During testwork of 24 subrecipients of the Homeland Security, auditors noted the following regarding the desk review process:

- Desk reviews were not performed for two subrecipients. Amounts passed through to each subrecipient were $11,248,484 and $7,388 during the year ended June 30, 2010.
- IEMA did not obtain documentation from one subrecipient certifying that an OMB Circular A-133 audit was not required. Amounts passed through to this subrecipient were $11,000 during the year ended June 30, 2010.
- Two subrecipient OMB Circular A-133 reports were received late, and IEMA did not retain documentation of its attempts to collect the reports and to follow-up with the subrecipients. Specifically, these reports were received between 231 and 290 days after the nine-month submission requirement. Total amounts passed through to each subrecipient were $2,734,102 and $2,364 during the year ended June 30, 2010.
- Although IEMA indicated meetings were held to discuss remediation plans for one subrecipient for which findings were reported in the OMB Circular A-133 report, IEMA did not issue a management decision relative to the findings. Amounts passed through to this subrecipient were $13,640,884 during the year ended June 30, 2010.

In discussing these conditions with IEMA officials, they stated procedures had been established to ensure compliance with OMB Circular A-133.

Response: IEMA accepts the recommendation.

IEMA does have established procedures in place. IEMA management will continue to work with staff to ensure compliance with established procedures.

In addition, IEMA will be implementing a tracking system to ensure all deadlines are met. This will include tracking any follow up to findings required by OMB Circular A-133 and ensuring receipt of the required documentation of the subrecipients.

10-92. The auditors recommend IEMA review its advance funding policies and techniques for subrecipients and implement policies, techniques and a monitoring process to ensure subrecipients receive no more than 30 days of funding on an advance basis.

Findings: IEMA provided funds to a subrecipient of the Homeland Security Program in excess of its immediate cash needs during the year ended June 30, 2010.

During a review of the subrecipient's invoices on January 28, 2010, IEMA determined a duplicate payment was made for invoices submitted by the subrecipient totaling $22,347 on July 11, 2008. IEMA received a refund from this subrecipient on March 2, 2010, approximately 565 days after the duplicate payment was made.

In discussing these conditions with IEMA personnel, they stated agency staff identified the duplicate payment made to the subrecipient via IEMA's policies and procedures and obtained the refund from the subrecipient.

Response: IEMA accepts this recommendation.

It should be noted that IEMA does conduct a final review of all payments made to a grantee out of each grant or interagency agreement as part of a comprehensive post-grant internal reconciliation. Before this audit, IEMA staff had already identified this error through this internal review and implemented procedures to resolve the problem. This step verifies the accuracy of documentation submitted by the grantee and Single Audit submissions. In September 2009, IEMA established policy statement for grantee compliance for the management of the overpayment of funds. In January 2010, IEMA completed the business plan for the development of a comprehensive grants management system which should go online in July 2011 to consolidate all internal financial data systems used to support the federal preparedness funds awarded by the ITTF. This system will provide another level of payment tracking and reconciliation to decrease the possibility of future duplicate and over payments whereby tracking all payments to a sub-recipient between federal preparedness grants and federal fiscal years.

Updated Response: Implemented.

10-93. The auditors recommend IEMA implement procedures to ensure cash drawn in advance is disbursed in accordance with program regulations. (Repeated-2009)

Findings: IEMA did not minimize the time elapsing between the drawdown of federal funds from the U.S. Treasury and their disbursement for program purposes.

During our review of 25 expenditures related to the Disaster Grants Public Assistance (Presidentially Declared Disasters) program, warrants were not issued for 19 expenditure vouchers within three business days of receiving federal funds intended to finance these expenditures. The number of days between the receipt of federal funds and the issuance of warrants ranged from four to 22 business days.

In discussing these conditions with IEMA personnel, they stated the payment vouchers and federal fund draws have historically been processed simultaneously; however, processing a voucher and creating a warrant has taken more than three business days during fiscal year 2010. This process was a shared responsibility between the Public Safety Shared Services Center and IEMA (as required by Executive Order 6 (2006) and the established Interagency Agreement).

Response: IEMA accepts this recommendation.

Public Safety Shared Services Center (SS) accepts this recommendation.

The Agency and SS currently works to minimize the time between draws and payment. The current process is to submit vouchers to SS where they are entered for payment into AIS. Once the vouchers are entered, grant fiscal staff submit a request for federal funds online. It then requires at most two days for the Treasurer to receive the funds and for the Comptroller to post to their appropriate fund. An additional two days are required for assembling schedules at SS and delivering that information to the Comptroller.

Both the Agency and Shared Services will review our processes to identify opportunities for improvement. However, the Agency nor SS has control over the length of time vouchers spend at the Office of the Comptroller. We will reach out to their office to determine if the timeframe can be shortened.

Updated Response: Implemented.

10-94. The auditors recommend IEMA deposit all federal funds received in an interest-bearing account and calculate and remit interest owed to the U.S. Treasury. (Repeated-2008)

Findings: IEMA did not deposit Homeland Security Cluster program funds received in advance of issuing warrants into an interest-bearing account.

During the year ended June 30, 2010, IEMA received $93,489,318 in draws under the Homeland Security Cluster program that were not deposited into an interest-bearing account. Additionally, IEMA did not calculate or remit any potential interest owed to the U.S. Treasury on funds received in advance of disbursement.

In discussing these conditions with IEMA personnel, they stated federal funds are currently not being deposited into an interest-bearing account. IEMA understands that federal funds drawn for non-immediate spending should be placed in an interest-bearing account for up to 120 days, as long as all interest proceeds are returned to the federal government. IEMA has pursued legislation to create an interest-bearing account – House Bill 1316.

Response: IEMA accepts this recommendation.

This finding is repeated from the previous year's audit. In the agency's previous response, we stated we would pursue legislation needed to create interest-bearing accounts. We have done so with House Bill 1316.

However, monitoring over 30 grant accounts on a daily basis in order to track the amount of interest owed may require an additional full time headcount. This employee would track all federally drawn funds from each program account, track the number of days from receipt to expenditure and complete payment forms for voucher processing at the Public Safety Shared Services Center for the accumulation of interest payment back to the Federal Government. We estimate the cost to hire an individual to be more than five times the amount of interest that would be returned to the federal government.

10-95. The auditors recommend IEMA follow their established internal control procedures to reconcile equipment expenditures to additions recorded in the property records. (Repeated-2009)

Findings: IEMA did not follow their established internal control procedures to reconcile equipment expenditures to additions recorded in the property (equipment) records.

Auditors noted IEMA did not complete any of the monthly reconciliations during the year ended June 30, 2010.

In discussing these conditions with IEMA personnel, they stated the reconciliations were not completed by the Public Safety Shared Services Center (as required by Executive Order 6 (2006) and the established Interagency Agreement).

Response: IEMA cannot accept or reject this recommendation.

Public Safety Shared Services Center accepts this recommendation.

Per Executive Order (6) 2006, the fixed assets administrative functions were transferred to the Public Safety Shared Services Center (SS) at the Department of Corrections.

Per the Interagency Agreement dated September 25, 2008 between IEMA and SS, SS is responsible for performing the inventory reconciliations. The Agreement states, "*In the event either the Auditor General or the Office of Internal Audits makes recommendations or audit findings with respect to any of the administrative functions performed by Shared Services under this Agreement, it shall be the responsibility of Shared Services to ensure corrective action and to account to the affected agency or agencies with respect to such action.*"

The Public Safety Shared Services Center will perform the reconciliation of fixed assets (property) to expenditures on AIS on a monthly basis. The reconciliations will be completed for fiscal year 2011 (brought current) and then continue.

RECOMMENDATION 96
Illinois State Police

10-96. The auditors recommend State Police deposit all federal funds received in an interest-bearing account and calculate and remit interest owed to the U.S. Treasury. (Repeated-2008)

Findings: State Police did not deposit Homeland Security program funds received in advance of issuing warrants into an interest-bearing account.

During the year ended June 30, 2010, State Police received approximately $1,868,000 in draws under the Homeland Security Cluster program that were not deposited into an interest-bearing account. Additionally, State Police did not calculate or remit any potential interest owed to the U.S. Treasury on funds received in advance of disbursement.

In discussing these conditions with State Police personnel, they stated the Department has been working on legislation to amend the ISP Federal Projects Fund to be an interest-bearing account.

Response: Concur. House Bill 1316 will make the ISP Federal Projects Fund an interest-bearing account. Once this is accomplished, the State Treasurer will deposit all interest into this fund and then it will be remitted to the U.S. Treasury for all federal funds received.

RECOMMENDATIONS 97-100
Environmental Protection Agency

10-97. The auditors recommend IEPA establish procedures to ensure: (1) subrecipient A-133 audit reports are obtained in a reasonable timeframe and (2) management decisions are issued for all findings affecting its federal programs in accordance with OMB Circular A-133.

Findings: IEPA does not have an adequate process in place for obtaining and issuing management decisions on subrecipient A-133 audit reports for subrecipients of the Clean Water State Revolving Fund (CWSRF) and Drinking Water State Revolving Fund (DWSRF) program.

During testwork over nine subrecipients of the CWSRF program and nine subrecipients of the DWSRF program who were required to submit OMB Circular A-133 reports:

- There were three subrecipients of the CWSRF program and two subrecipients of DWSRF program for which no OMB Circular A-133 audit reports were received. .

- There was one subrecipient of the CWSRF program whose OMB Circular A-133 report identified material weaknesses and questioned costs for the CWSRF program for which IEPA did not issue a management decision.

In discussing these conditions with IEPA officials, they stated that the existing procedures were previously considered to have been adequate, but IEPA agrees to modify the current procedures based on the response listed below.

Response: Accepted. The Illinois EPA has procedures established for monitoring subrecipients. However, the Agency agrees to modify those procedures to target weaknesses identified in this audit.

Specifically, the Illinois EPA agrees to strengthen the follow-up procedure in those instances when multiple requests fail to produce audit reports as required under the Single Audit Act. The Illinois EPA will modify the notice letters to specifically reference the potential consequences of noncompliance, including the commencement of legal action. The notice letters will further state that noncompliance will be in violation of the loan agreement and that the Illinois EPA may seek all remedies as set forth in the loan rules (35 IL. Admin. Code 365.310, 35 IL. Adm. Code 662.310) and refer the matter to the Federal Clearinghouse for further action as prescribed by Circular A-133.

The Illinois EPA also agrees to modify its Single Audit review procedures to objectively address the issuance of management decisions for all material findings contained in recipient audit reports. The Agency notes that all material findings are currently reviewed under our A-133 procedures; however management decision letters have not always been issued. This modification will mandate a management decision letter to document this review for all material findings.

Updated Response: Implemented.

10-98. The auditors recommend IEPA implement procedures to ensure ARRA information is properly communicated to its subrecipients at the time of each disbursement.

Findings: IEPA did not communicate American Recovery and Reinvestment Act (ARRA) information and requirements to subrecipients of the Clean Water State Revolving Fund (CWSRF) and Drinking Water State Revolving Fund (DWSRF) programs at the time of each disbursement.

During testwork over 80 disbursements (40 for each program), auditors noted IEPA did not identify the federal award number and catalog of federal domestic assistance (CFDA) number at the time of each disbursement.

In discussing these conditions with IEPA officials, they stated that existing procedures were adequate to track, monitor and report expenditures of the program. Although the subaward communicated the necessary information, the disbursement remittance had not included the federal award number or catalog of federal domestic assistance number due to oversight.

Response: Accepted. Future ARRA disbursements will include the federal award number or catalog of federal domestic assistance number.

10-99. The auditors recommend IEPA review the process and procedures in place to prepare and submit ARRA 1512 reports to ensure expenditures reported are accurate and reconcile to IEPA's financial records.

Findings: IEPA did not accurately report expenditures in the quarterly ARRA 1512 report for the Clean Water State Revolving Fund (CWSRF) and Drinking Water State Revolving Fund (DWSRF) programs.

In discussing these conditions with IEPA officials, they stated that they believed current procedures were adequate to properly report expenditures and receipts on the ARRA 1512 reports.

Response: Accepted. The Illinois EPA utilized expenditures as reported by the Office of the Comptroller as this system was identified by the State as the public accounting system of record. Utilizing this system provided for reconciling differences for payments in transit when compared to expenditures as reported from the common accounting system used by State agencies. The Illinois EPA's internal control processes correctly identify the specific reconciling items. The Illinois EPA will investigate the feasibility and impacts of delaying payments at the end of the reporting cycle in order to have no reconcilable differences between the expenditures reported by the Office of the Comptroller and the accounting system used by agencies.

10-100. The auditors recommend IEPA review the process and procedures in place to prepare and submit federal financial reports to ensure expenditures are accurately reported and supported.

Findings: IEPA does not have adequate procedures in place to ensure expenditures reported on quarterly financial reports of the Clean Water State Revolving Fund (CWSRF) and Drinking Water State Revolving Fund (DWSRF) programs are accurate.

Upon further investigation, auditors noted IEPA recorded adjustments to its financial records for the DWSRF program which affected the December 31, 2009 reporting period; however, the SF-425 was not amended to reflect the adjustments made. As such, the reports submitted were incorrect and did not agree to IEPA's financial records for the period tested.

In discussing these conditions with IEPA officials, they stated all financial records were updated, however due to oversight the SF-425 was not initially revised. It has, however, been revised subsequently and submitted to USEPA.

Response: Accepted. A procedure will be put in place that will require review of reports and work paper documentation by the Manager of the Finance Section before reports are submitted. In addition, the checklist that the Finance Section uses to monitor report due dates will be revised to provide for a check-off for revisions to accounting data/ any revised report submissions and date.

Updated Response: Implemented.

RECOMMENDATIONS 101-102
Governor's Office of Management and Budget

10-101. The auditors recommend the State establish procedures to ensure the TSA is amended for any necessary changes in accordance with federal regulations.

Findings: The State does not have adequate procedures in place to ensure the Treasury State Agreement (TSA) is amended in accordance with federal regulations.

Auditors noted the Weatherization Fiscal Stabilization Fund programs were expected to exceed the $60,000,000 program expenditure threshold in fiscal year 2010 based on amounts awarded; however, the TSA was not amended to include these programs during fiscal year 2010. In addition, the State did not include an amendment to update the methodology used to calculate interest for LIHEAP when the program transferred between State agencies. As a result, an unapproved interest rate calculation was used to calculate interest for the LIHEAP program.

In discussing these conditions with GOMB personnel, they stated the noncompliance occurred due to a misunderstanding of the federal requirements.

Response: The Governor's Office of Management and Budget agrees with this finding. Amendments to the Treasury State Agreement (TSA) were not timely filed by GOMB for the Weatherization Assistance for Low Income Persons and the Low Income Home Energy Assistance Program as required by 31 C.F.R. Part 205. To remedy this failure, senior staff at GOMB will ensure that the appropriate staff personnel is properly trained to assure understanding and full compliance with the Department of Treasury, 31 C.F.R Part 205 – Rules for Efficient Federal-State Fund Transfers.

10-102. The auditors recommend the State implement procedures to ensure required ARRA information is properly communicated to its subrecipients.

Findings: The State did not communicate American Recovery and Reinvestment Act (ARRA) information and program requirements to subrecipients of the State Fiscal Stabilization Fund program.

During testwork over disbursements to four subrecipients of the State Fiscal Stabilization Fund program, the State did not identify the federal award number, catalog of federal domestic assistance (CFDA) number, or the amount attributable to ARRA at the time of each disbursement

for any of the disbursements sampled. Upon further review, the State did not communicate the required ARRA information for any disbursements to public institutions of higher education.

In discussing these conditions with GOMB officials, they stated the noncompliance is a result of a misunderstanding of communication responsibilities by the IBHE.

Response: The Governor's Office of Management and Budget agrees with the finding that the State Board of Higher Education did not properly notify subrecipients of the requirements contained in the American Recovery and Reinvestment Act (ARRA) related to providing necessary funding information described above. With the implementation of ARRA, the Governor's Office set up procedures for agencies to follow with respect to ARRA guidelines. Every agency had at least one representative who participated in monthly meetings. Included in the instructions was a list of what must be included in the agreements between the agencies and their subrecipients. These instructions included identifying to each subrecipient the required information of the Federal Award number, CFDA number, and the amount of ARRA funds. The Office of Accountability worked with the Office of Internal Audit to set up internal controls assuring compliance with ARRA regulations.

The State Board of Higher Education and the State Board of Education shared responsibilities for the Administration of the State Fiscal Stabilization Fund Cluster. Unfortunately, despite internal controls, it appears the State Board of Higher Education did not provide proper information to its subrecipients. The efforts of internal control were concentrated on ISBE, the fiscal agent for the grants. The Governor's Office will review its procedures for the administration of special federal grants to assure that all agencies provided funding are included in the review to assure compliance.

Updated Response: Implemented.

RECOMMENDATION 103
Department of Central Management Services

10-103. The auditors recommend DCMS establish a process for evaluating internal service fund balances and implement the necessary procedures to ensure these fund balances do not exceed the 60 day threshold allowed under OMB Circular A-87. DCMS should also implement procedures to ensure only expenditures meeting allowable cost criteria are used in establishing rates for expenditures charged to federal programs. (Repeated-2006)

Findings: DCMS did not establish adequate procedures to identify fund balances in excess of maximum amounts allowed under OMB Circular A-87.

Additionally, auditors noted DCMS is not properly reconciling federal internal service fund reports to its GAAP based financial statements.

In discussing these conditions with DCMS officials, they stated that they believe their practices are in compliance with A-87 requirements. Timing differences do exist between the audited GAAP basis financial statements and federal reporting as a result of the required completion timeframes and as a result of past practices and related acceptance by the federal Department of Health and Human Services.

Response: Excess Balances: The Department has long employed an ongoing process to evaluate and address allowable balances for its internal service funds. Our annual SWCAP Section II submission is the culmination of a continuous annual process involving rate development, revenue and expense projections, capturing and matching of costs and revenues and truing up revenues and expenses.

The existence of excess balances is not in itself a violation of A-87. The federal requirement is that excess balances be remedied. The Department asserts that its adjustment methods, Per A-87 Attachment C, G.4., which include negotiated settlements, are appropriate and allowable.

The Department does agree that adjustments should be made as timely as possible, but there is no clear definition of timeliness in A-87. The Department does not simply wait for federal negotiations on excess balances to be completed. We proactively adjust rates annually to reduce exposure to excess balances. However, these adjustments cannot guarantee that all prior excess balances will be entirely eliminated for all services in any given year, since rates, usage and costs are projections. Therefore, direct negotiated paybacks have always been, and will likely continue to be, a part of the federally provided and federally sanctioned remedy for excess balances.

The timeliness of direct paybacks is dependent on the federal review cycle. The paybacks are negotiated during the federal review of the annual SWCAP. The federal review cycle is not completed annually, and in some cases stretches out several years. The refunds, which are negotiated, are formally set through the federal letter of determination at the end of the review process.

We also refer to the ASMB C-10 reference to making adjustments in the "next open fiscal period." At the time our SWCAP Section II filing is completed, we are typically in the late third or early fourth quarter of the new FY. The State's interpretation of the "next open fiscal period" is the next full fiscal year in which the State has the ability to adjust agency budgets to handle rate changes due to over/under billings.

Currently there are no carry-forward excess balances from prior fiscal years. The State has settled with DHHS for fiscal year 2009.

Reconciling Items:

The finding states that the Department is "*not properly reconciling federal internal service fund reports to its GAAP based financial statements as evidenced by the following unidentified reconciling items"*. In fact, the reconciliations are performed and accepted by DHHS, and the items are both identified and explained. In addition:

- Inmate Commissions have no federal impact. These are revenues generated from inmate usage of payphones at State correctional facilities. There is no Section I or II service provided by CMS. There is no service billed to any state or federal entity. There is no cost or claimable expense.
- Other Reconciling Items: Internal financial statements are reconciled to GAAP and the federal cost recovery data is reconciled to internal financial statements. This reconciliation process is completed in accordance with requirements outlined by the cognizant federal agency responsible for review of the SWCAP. The timing differences result in reconciling items in a single year and are always caught up within the next reporting period, which is the timeframe the State is allowed to correct excess balance situations.

The Department does agree that fewer reconciling items would be preferable, and will continue ongoing efforts to minimize the type and number of reconciling items in future fiscal years.

***Auditors' Comment*:** *DCMS has acknowledged the existence of excess fund balances, but believes that it is not a violation of federal regulations. Specifically, they state that negotiated settlements are appropriate and allowable. However, we believe federal regulations require DCMS to adjust rates or remit excess fund balances back to the applicable federal programs on a timely basis. DCMS' past practice of protracted negotiations and waiting for its cognizant agency to "agree to a settlement" is inconsistent with federal regulations.*

Updated Response: Implemented.