LEGISLATIVE AUDIT COMMISSION

Review of
Statewide Single Audit
Year Ended June 30, 2012

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REVIEW: 4406
STATEWIDE SINGLE AUDIT
YEAR ENDED JUNE 30, 2012

TOTAL FINDINGS/RECOMMENDATIONS - 91

TOTAL REPEATED RECOMMENDATIONS - 63

TOTAL PRIOR AUDIT FINDINGS/RECOMMENDATIONS - 101

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 FY12 Statewide Single Audit of federal funds. The Office of the Auditor General conducted a Statewide Single Audit of the FY12 federal grant programs in accordance with 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 FY12. 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 $22.9 billion for the year ended June 30, 2012. This represents a $5.2 billion decrease from FY11, or about 18.5%. Overall, the State participated in 412 different federal programs; however, 11 of these programs or program clusters accounted for approximately 85.1% ($19.5 billion) for the total federal award expenditures as exhibited in the following table.

Federal Program Award	Total Expenditure	% of Total
Medicaid	$ 6,729,100,000	29.3%
Unemployment Insurance	5,074,300,000	22.1%
Supplemental Nutrition	3,191,800,000	14.0%
Highway Planning, Construction	1,497,000,000	6.5%
Special Education	641,800,000	2.8%
Title 1	604,700,000	2.6%
TANF	581,900,000	2.5%
Child Nutrition	562,800,000	2.5%
Children's Insurance Program	220,200,000	1.0%
Spec. Supplemental for WIC	217,900,000	1.0%
Fed. Family Edu Loan Program	217,300,000	0.9%

All Others	3,394,100,000	14.8%
Total Federal Awards	$ 22,932,900,000	

The funding for the 412 programs was provided by 22 different federal agencies. The table below shows the five federal agencies that provided Illinois with the vast majority of federal funding in FY12.

Federal Funding Agency	Total Grant	% of Total
Health & Human Services	$8,931,600,000	38.9%
Labor	5,302,300,000	23.1%
Agriculture	4,154,800,000	18.1%
Education	1,971,500,000	8.7%
Transportation	1,816,700,000	7.9%
All Others	756,000,000	3.3%

A total of 34 federal programs were identified as major programs in FY12. The 34 major programs had combined expenditures of $21.1 billion, and 378 non-major programs had combined expenditures of $1.7 billion. Eleven State agencies accounted for approximately 98.4% of all federal dollars spent in FY12 as depicted in the table below.

State Agency	Federal Expenditures	% of Total
DHFS	$ 6,876,600,000	30.0%
Employment Security	5,123,100,000	22.3%
Human Services	4,766,100,000	20.8%
Board of Education	2,276,800,000	9.9%
Transportation	1,813,900,000	7.9%
DCEO	578,900,000	2.5%
DCFS	410,800,000	1.8%
Public Health	246,300,000	1.1%
Student Assistance	223,200,000	1.0%
IEMA	130,400,000	0.6%
EPA	112,500,000	0.5%
All Others	374,300,000	1.6%

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	11	7
Healthcare and Family Services	19	14
State Agency	**Number of Findings**	**Repeat Findings**
DCFS	9	6
Aging	3	2
Public Health	5	5
State Board of Education	4	0
ISAC	4	3
Employment Security	5	4
Commerce & Economic Opportunity	2	1
Transportation	19	14
Emergency Management Agency	4	3
State Police	2	1
EPA	1	1
GOMB	1	1
Criminal Justice Information Authority	1	0
TOTAL	91	63

RECOMMENDATION 1
Office of the Governor
Office of the Comptroller

12-01. 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.

The Office of the Comptroller has made significant changes to the system used to compile financial information and agencies have submitted GAAP packages in a timelier manner; however, the State has still not solved all the problems to effectively remediate these financial reporting weaknesses. The process is overly dependent on the post-audit program.

The State of Illinois has a highly decentralized financial reporting process. The system requires State agencies to prepare a series of complicated financial reporting forms (SCO forms) designed by the IOC to prepare the CAFR. Agency personnel may lack the qualifications, time, support, and training necessary to timely and accurately report year end accounting information to assist the Comptroller

in preparation of statewide financial statements in accordance with generally accepted accounting principles (GAAP). Although these SCO forms are subject to review by the IOC's financial reporting staff during the CAFR preparation process, the current process lacks sufficient internal controls at State agencies which has resulted in restatements relative to the financial statement reporting over the past several years.

Errors and delays identified in the SEFA reporting process over the past ten years have included the following:

- ARRA expenditures were reported based on cash receipts versus expenditures for the Child Support Enforcement, CHIP, and Medicaid Cluster programs by the Illinois Department of Healthcare and Family Services in 2012.
- Expenditures were reported based on cash receipts versus expenditures for the Airport Improvement Program, Highway Planning and Construction Cluster, and High Speed Rail programs by the Illinois Department of Transportation in 2012.
- Expenditures of approximately $3,294,000 were erroneously reported for federal awards which are not subject to OMB Circular A-133 audit requirements by the Illinois Department of Commerce and Economic Opportunity. As a result, the Type A threshold was reduced by approximately $5,000 and an additional major program was identified nearly eight months after the State's fiscal year end.
- Other correcting entries were required in order to accurately state the financial information provided by various State agencies.
- Preparation of the SEFA has not been completed by the State prior to March 15th in the past ten years.

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 in part 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 in part 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 management, they stated errors and delays at the departmental level were caused by a lack of sufficient internal control processes in State agencies for the accumulation and reporting of financial information used to prepare the financial statements. The IOC has the statutory authority to develop and prescribe accounting policies for the State but does not have the statutory authority to monitor adherence to these policies as performed by State agencies.

Governor's Response: The Governor's Office agrees with this finding. The Governor's Office, the Governor's Office of Management and Budget (GOMB) and the Office of the Comptroller are addressing these challenges and have been working to solve some of these problems.

The Governor's Office will continue working with the agencies to improve the State's performance both in the short term and the long term.

Comptroller's Response: The Office accepts the recommendation. The IOC will continue to work with the Governor's Office in their efforts to increase the quality of departmental financial information. The IOC will continue to provide training and technical assistance to State agencies and make improvements to the financial reporting system and procedures.

RECOMMENDATIONS 2-12
Department of Human Services

12-02. The auditors recommend IDHS 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: The Department of Human Services (IDHS) is not performing "eligibility redeterminations" for individuals receiving benefits under the Temporary Assistance for Needy Families (TANF), Children's Health Insurance Program (CHIP), and Medicaid Cluster 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 for the three programs during June 2012 as follows:

TANF	4,839 of 50,260 cases	9.63%
CHIP	52,686 of 781,853 cases	6.74%
Medicaid	92,059 of 468,695 cases	19.64%

In addition, during testwork of 50 TANF Cluster, 65 CHIP, and 125 Medicaid Cluster eligibility files selected for testwork, auditors noted redeterminations were not completed within required time frames for two TANF Cluster, four CHIP and nine Medicaid Cluster cases. Delays in performing redeterminations ranged from three to 67 months after the required timeframe.

Payments made on behalf for beneficiaries of the TANF Cluster, CHIP and Medicaid Cluster programs totaled $91,985,000, $208,669,000 and $6,275,740,000, respectively, during the year ended June 30, 2012.

In discussing these conditions with IDHS officials, they stated that the Department has absorbed a steady increase in caseload and a decrease in staff.

Failure to properly perform eligibility redetermination procedures in accordance with the State Plans may result in federal funds being awarded to ineligible beneficiaries, which are unallowable costs.

Updated Response: Accepted and partially implemented, to be completed by 4/30/2014.

Corrective Action completed:

- The Department of Health Care and Family Services (HFS) and the Department of Human Services (DHS) worked to contract with an outside vendor (Maximus) to perform electronic eligibility redeterminations.

- Maximus is performing eligibility factor verifications for earned income, unearned income, child support receipt, and Illinois residence.

- In order to assist in the goal that medical redeterminations become current, beginning in February 2013, Maximus began sending recommendations to HFS and DHS as to the continuation, cancelation, or modification of medical cases that had been overdue for redetermination.

- DHS and HFS caseworkers reviewed the information and material gathered by Maximus to make the recommendation, and followed-up with the appropriate action to continue, cancel, or modify the medical assistance. Supporting documentation is limited at this point, as the reports that monitor the progress are still being built.

- A modified Illinois Medicaid Redetermination Project began 2/1/14. Based on electronic datamatching, the new MAX-IL system will make automated recommendations regarding on-going eligibility. Max-IL will review sources that report deaths, out of state residence and income to make a recommendation about the case. State casework staff remain responsible for making the eligibility decision on each case.

Corrective Action to be completed:

- Beginning March, 2014, Central Redetermination Units began receiving and acting upon automated eligibility recommendations from the Max-IL system.

12-03. The auditors recommend IDHS 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, Temporary Assistance for Needy Families (TANF), Children's Health Insurance Program (CHIP), and Medicaid Cluster 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, in a review of case files at five separate local offices, auditors noted the areas in which case files are maintained were generally disorganized and case files were stacked on or around file cabinets. Auditors also noted 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. Auditors selected 10 TANF eligibility case records from each of the five separate local offices (50 total) and noted eight case records could not be located for testing.

Auditors noted several delays in receiving case files due to the fact that case files had been transferred between local offices as a result of beneficiaries moving between service areas.

Payments made on the behalf of beneficiaries of the SNAP Cluster, TANF Cluster, CHIP, and Medicaid Cluster programs were approximately $3,081,441,000, $91,985,000, $208,669,000 and $6,275,740,000 respectively, during FY12.

In discussing these conditions with IDHS officials, they stated that the finding was caused by inadequate staffing numbers and insufficient room for proper filing and storage.

Response: The Department agrees with the recommendation. Given our current fiscal, staffing, and space constraints, the Department continues to place a high priority on proper case file maintenance. The Department is now utilizing a document management system that is capturing a portion of the information that was previously printed and stored in the paper case file, and now stored electronically. This is assisting in the reduction of the overwhelming size and amount of paper files in the offices.

Updated Response: Accepted and partially implemented, to be completed by 12/31/2015.

Corrective Action to be completed:

- As part of the phase 2 implementation of the new Integrated Eligibility System scheduled for Summer 2015, all electronic documents produced will be done so in electronic format, significantly reducing the need for paper-based files stored at the local offices.

- As part of the new Illinois Medicaid Redetermination Project, copies of all redetermination forms mailed to the customer, returned redetermination forms, electronic data matching results, request for missing information, and verifications provided by the client will be stored in content manager, reducing the need for error prone paper case filing.

- The new Integrated Eligibility System enhances the paperless case file concept. The caseworker will have the ability to upload client documents and associate with the application on which they are working. Staff will be able to view these documents in IES.

12-04. 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 TANF, CHIP and the Medicaid programs.

During testwork of 50 TANF Cluster, 65 CHIP, and 125 Medicaid Cluster beneficiary payments, auditors noted the following exceptions:

- In two TANF Cluster eligibility case files, IDHS could not locate the redetermination application completed and signed by the beneficiary.
- In two TANF Cluster eligibility case files, IDHS could not locate the required Responsibility Service Plan completed and signed by the beneficiary.
- In 21 CHIP and 19 Medicaid case files, IDHS could not locate the redetermination application completed and signed by the beneficiary.
- In 12 CHIP and seven Medicaid case files, IDHS could not locate adequate documentation evidencing income and asset verification performed. Caseworkers verbally confirmed income information, relied on clients handwritten notes, or used income verified on previous applications.
- In two CHIP case files, DHS could not locate adequate documentation of the social security number of the beneficiary being verified.
- In two CHIP and two Medicaid case files, IDHS could not locate adequate documentation of citizenship or residence verification of the beneficiary.

- In one CHIP and one Medicaid case file, IDHS could not provide adequate documentation that cross match verifications had been performed with regard to the beneficiary's personal information. Medical payments made on behalf of this beneficiary exceeded $295,000.
    - For one Medicaid case, the State improperly made medical assistance payments on behalf of a beneficiary that was granted temporary medical benefits. However, after the beneficiary was determined ineligible, IDHS did not terminate the recipient's medical benefits for four months because system limitations would not allow immediate termination of benefits.
    - For one CHIP case, IDHS improperly excluded an individual family member's weekly earnings of $750 in completing the eligibility determination completed for a family.

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 addition, 40 TANF cases were tested for compliance with the penalty for refusal to work case files special test and IDHS could not locate the Responsibility and Services Plan (RSP) completed and signed for one TANF beneficiary.
Payments made on behalf of all beneficiaries of the TANF Cluster, CHIP and Medicaid Cluster programs totaled $91,985,000, $208,669,000 and $6,275,740,000, respectively, during the year ended June 30, 2012.

In discussing these conditions with IDHS officials, they stated that lack of adequate staff to properly file documentation contributed to the deficiencies noted.

Response: The Department partially agrees with the recommendation. We will continue to ensure staff understands the importance of proper and accurate filing processes. A growing caseload coupled with the inability to hire additional staff presents the potential for paper filing errors and backlog. The Department is currently utilizing a document management system that captures a portion of the information that is currently printed and placed in a paper file.

Specifically, the eighth dot point refers to a case in which the State improperly made medical assistance payments. The medical payments made by the Illinois Department of Healthcare and Family Services on behalf of the client on the case in question were appropriate and allowable. The IDHS Client Assessment Unit (CAU) issued a decision on September 14, 2011 which necessitated the denial of the case, which was appropriately receiving temporary medical benefits at the time. On September 19, 2011, IDHS denied the case based on the CAU decision. The DHS processing schedules dictate the effective date of an action, based on the date the action is taken. On September 19, 2011, an action taken on the case in question would have an effective month of November 2011. DHS policy, in WAG 17-03-03 states, "……the last date of temporary medical benefits is the last day of the month before the current processing month." Therefore, the last date of temporary medical benefits for the case in question – October 31, 2011 - was correct, and no improper payment was made.

Auditors' Comment: *We understand the limitations of the systems used by IDHS in its eligibility processes and that certain policies have been established to accommodate those system limitations; however, since the beneficiary was determined to be ineligible for medical benefits in September 2011, benefit payments claimed for federal reimbursement after the determination was made are not allowable costs.*

Updated Response: Accepted and partially implemented, estimated complete by 12/31/2015.

Corrective Action to be completed:

- As part of the phase 2 implementation of the new Integrated Eligibility System scheduled for Summer 2015, all electronic documents produced will be done so in electronic format, significantly reducing the need for paper-based files stored at the local offices.

- As part of the new Illinois Medicaid Redetermination Project, copies of all redetermination forms mailed to the customer, returned redetermination forms, electronic data matching results, request for missing information, and verifications provided by the client will be stored in content manager, reducing the need for error prone paper case filing.

- The new Integrated Eligibility System (IES) enhances the paperless case file concept. The caseworker will have the ability to upload client documents and associate with the application on which they are working. Staff will be able to view these documents in IES.

12-05. The auditors recommend IDHS review its current process for maintaining documentation supporting eligibility determinations and consider changes necessary to ensure all eligibility determinations and payments are properly made.

Findings: IDHS made an improper payment to a beneficiary of the TANF program.

During testwork of TANF program beneficiary payments, auditors selected 50 eligibility files to review for compliance with eligibility requirements and to determine that the appropriate benefits were paid. One payment ($113) made to a beneficiary was improperly calculated as the result of a child being incorrectly included in the family when determining the benefit amount. Upon further review, the benefit amount was subsequently corrected by IDHS on a prospective basis; however, the overpayment identified in the sample had not been calculated, recouped, or returned to the USDHHS as of the date of testing (October 2012).

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

Response: The Department agrees with the recommendation. The overpayment was established as a receivable on 7/30/2012 for the claim period of 7/11 thru 7/11 in the amount of $113. The overpayment occurred because the caseworker incorrectly added another child to the TANF case. There is no SNAP overpayment.

Although the client continues to receive SNAP and medical, she has not received TANF since August 2012. The current balance of the claim remains $113. Because the client no longer receives TANF, recoupment of the TANF overpayment cannot be executed at this time. Should the client begin receiving TANF, recoupment of the overpayment will begin. According to the DHS Bureau of Collections, the billing process has begun, and eventually the overpayment will be referred to the Office of the Comptroller for the offsetting of State warrants as well as to a private collection agency. TANF overpayments are not eligible for federal offset.

Updated Response: Implemented.

- The Division of Family and Community Services has removed the child from incorrect case, and added to the correct case.

- The Department has established overpayment for $113 in order to recoup the erroneous TANF payment made to the incorrect case.

- The DHS-Bureau of Collection has referred the case for Comptroller Offset and completed a Private Collector Referral.

12-06. The auditors recommend IDHS establish procedures to ensure: (1) subrecipient A-133 audit reports are obtained and properly reviewed in a reasonable timeframe, (2) management decisions are issued for all findings affecting its federal programs in accordance with OMB Circular A-133, and (3) follow up procedures are performed to ensure subrecipients have taken timely and appropriate corrective action. (Repeated-2011)

Findings: IDHS did not adequately review OMB Circular A-133 audit reports received from its subrecipients for WIC, Vocational Rehabilitation (VR) Cluster, TANF, Child Care, Social Services Block Grant (Title XX), and Block Grants for Prevention and Treatment of Substance Abuse (SAPT) programs on a timely basis.

Subrecipients who receive more than $500,000 in federal awards are required to submit an OMB Circular A-133 audit report to IDHS. The Office of Contract Administration is responsible for reviewing these reports and working with program personnel to issue management decisions on any findings applicable to IDHS programs. A desk review checklist is used to document the review of the OMB Circular A-133 audit reports.

Auditors selected a total sample of 200 subrecipients (40 from each program) to review and noted IDHS did not notify two subrecipients of the results of A-133 audit desk reviews or issue management decisions on reported findings within six months of receiving the audit reports. Total subrecipient expenditures for all five programs exceeded $667 million.

In discussing the desk review process with IDHS officials, they stated that lack of adequate systems and staff to perform adequate review of OMB Circular A-133 audit reports contributed to the discrepancy noted.

Response: The Department agrees with the recommendation. The Department has contracted the review of the audit reports to ensure timely and thorough review of the A-133 Single Audit Reports.

The Office of Contract Administration is enhancing its review process for A-133 reports to ensure subrecipient A-133 audit reports are obtained and properly reviewed in a reasonable timeframe, management decisions are issued for all findings affecting its federal programs in accordance with OMB Circular A-133, and follow-up procedures are performed to ensure subrecipients have taken timely and appropriate corrective action.

Updated Response: Accepted and partially implemented, estimated complete by 9/30/2014.
Corrective Action to be completed:

- The Office of Contract Administration (OCA) is issuing a "tentative listing of A-133 required reporters for the current fiscal year" – based upon either current agreement amounts or historical spending patterns at the onset of the current fiscal year. The provider will know they are anticipated to be an A-133 required reporter and what those requirements will be.

- OCA is revising the OCA Procedure Manual and review template for A-133 desk reviews.

- In addition, training will be provided to staff and providers on required federal reporting.

- OCA is restructuring the Audit Review Section and scheduling to outsource services to ensure a more timely and thorough review of the A-133 Single Audit Reports.

- OCA will update and maintain the database for more efficient tracking of OMB Circular A-133 audit reports received from its subrecipients.

12-07. The auditors recommend IDHS ensure programmatic on-site reviews are performed and documented for subrecipients in accordance with established policies and procedures. In addition, auditors recommend IDHS review its process for reporting and following up on findings relative to subrecipient on-site reviews to ensure timely corrective action is taken. (Repeated-2011)

Findings: IDHS did not follow its established policies and procedures for monitoring subrecipients of WIC, Vocational Rehabilitation (VR), TANF, Child Care, Social Services Block Grant (Title XX), and Block Grants for Prevention and Treatment of Substance Abuse (SAPT) programs.

IDHS has implemented procedures whereby program staff perform periodic on-site and desk reviews of IDHS subrecipient compliance with regulations applicable to the federal programs. Generally, these reviews are formally documented and include the issuance of a report of the review results to the subrecipient summarizing the procedures performed, results of the procedures, and any findings or observations for improvement noted. IDHS' policies require the subrecipient to respond to each finding by providing a written corrective action plan. Additionally, IDHS performs reviews of expenditure reports submitted by subrecipients. IDHS subrecipient monitoring procedures are subject to the review and approval of a supervisor.

During testwork over on-site review procedures performed for 200 subrecipients (40 for each program), auditors noted IDHS did not follow its established on-site monitoring procedures as follows:

- One subrecipient of the SAPT program did not submit additional corrective action information requested by IDHS in a timely manner. The requested information was submitted 196 days after its due date and IDHS could not provide evidence that follow up procedures had been performed to obtain the information from this subrecipient.
- Three subrecipients of the VR Cluster program did not submit corrective action plans for fiscal or programmatic on-site reviews performed. IDHS could not provide evidence that follow up procedures had been performed to obtain corrective action plans from these subrecipients.
- Three subrecipients of the VR Cluster did not receive timely notification (within 60 days) of the results of programmatic on-site reviews. Delays in reporting review findings to these subrecipients ranged from 73 to 120 days after the onsite review procedures were conducted.

- Seven subrecipients of the VR Cluster program did not receive timely communication from IDHS of the results of their on-site programmatic monitoring reviews. IDHS could not provide evidence that review findings were ever communicated to these subrecipients.
- One subrecipient of the VR Cluster program and one subrecipient of the Title XX program were required to have on-site monitoring reviews performed in FY12; however, reviews were not performed for these subrecipients.
- Two programmatic monitoring review files for subrecipients of the VR Cluster program did not contain evidence that a supervisory review had been performed.

Additionally, expenditure reports selected for testing do not appear to have been reviewed by IDHS personnel within 60 days for three subrecipients of the VR Cluster program. Delays in reviewing and approving the expenditure forms ranged from 64 days to 141 days.

In discussing these conditions with IDHS officials, they stated that lack of staff and changes in the staff responsible for monitoring these contracts resulted in on-site reviews not being completed and various supporting elements (cover letters, and follow-up related to corrective action plans) not being accessible.

Updated Response: Accepted and partially implemented, estimated complete by 6/30/2014.

Corrective Action Implemented:

DIVISION OF REHABILITATION SERVICES

- The Division of Rehabilitation Services (DRS) is now maintaining a schedule of reviews to ensure all on-sites are completed in a timely fashion.

- The Division of Rehabilitation Services (DRS) has established a centralized electronic unit folder so that copies of documents can be saved in a location independent of the staff who completed the review.

OFFICE OF CONTRACT ADMINISTRATION

- The need for administrative resources was identified in FY13. Funding was secured; the job was posted and filled.

Corrective Action to be Implemented:

DIVISION OF REHABILITATION SERVICES

- DRS will work to fill vacancies left by staff leaving the positions.

OFFICE OF CONTRACT ADMINISTRATION

- The need for additional technical resources was identified in FY13. OCA will update and maintain the database for more efficient tracking of OMB Circular A-133 audit reports received from its subrecipients.

- Job descriptions for an on-site review supervisor and an additional on-site reviewer were updated during this time period. However, the agency was not able to secure funding in FY13 for these positions. It is anticipated that we will be able to hire the additional resources during FY14.

12-08. The auditors recommend IDHS review its process for performing eligibility determinations and consider changes necessary to ensure eligibility determinations are made and documented in accordance with program regulations. (Repeated-2011)

Findings: IDHS did not determine the eligibility of beneficiaries under the Vocational Rehabilitation program in accordance with federal regulations.

During testwork of Vocational Rehabilitation program beneficiary payments, auditors noted the following exceptions in testwork of 50 files to review for compliance with eligibility requirements and allowability of benefits:

- For one case, IDHS could not provide the customer financial analysis form signed by the case worker and beneficiary; however, unsigned electronic forms were provided from the case management system.

- For two cases, IDHS did not complete the Individualized Plan for Employment (IPE) within 90 days after eligibility was determined. Additionally, for one of the cases, IDHS did not perform a timely redetermination of eligibility.

- For one case, IDHS could not provide the original certification of eligibility signed by the case worker and beneficiary; however, an unsigned electronic certification of eligibility was provided from the case management system.

In discussing these conditions with IDHS officials, they stated that field staff responsible for determining eligibility failed to obtain extensions of the eligibility determination that would require more than 60 days, or failed to print copies of documents completed in the web-based case management system and obtain the proper signatures as required.

Response: The Department agrees with the recommendation. The Department will review its process for performing eligibility determinations and consider changes necessary to ensure eligibility determinations are made and documented in accordance with program regulations.

Updated Response: Accepted and partially implemented, expected completion by 6/30/2014.

Corrective Action Implemented:

- The Division of Rehabilitation Services (DRS) has issued a reminder on OneNet regarding the audit findings typically seen regarding case work.

- The Division of Rehabilitation Services (DRS) Quality Assurance, as part of its case review process, is reviewing cases in light of meeting all eligibility requirements, and includes its findings in the report to office supervisors.

Corrective Action to be Implemented:

- The Division of Rehabilitation Services (DRS) will continue to stress the importance of following eligibility determination requirements as part of the New Employee Orientation.

- The discrepancies identified by the auditors will be communicated by DRS Executive Management to the direct Supervisors and Field staffs responsible for the findings and ensure that additional training is provided and documented.

12-09. The auditors recommend IDHS review the process and procedures in place to prepare financial reports required for the Vocational Rehabilitation Cluster and implement procedures necessary to ensure the reports are accurate. (Repeated-2010)

Findings: IDHS did not prepare accurate periodic financial reports for the Vocational Rehabilitation program. During testwork over two quarterly financial status reports for each open grant award and the annual cost report, auditors noted errors.

In discussing these conditions with IDHS officials, they stated that changes to the work documents used to assemble the reports contained unidentified formula errors that inaccurately presented the total values.

Updated Response: Implemented.

- The Division of Rehabilitation Services has revised the work-papers to ensure all formulas are accurate.

- The Division of Rehabilitation Services has implemented an in-house secondary review of all numbers used in the reports and the formulas to eliminate errors.

- The Division of Rehabilitation Services has implemented a process to have a third staff review the entry of the data into the website prior to final

12-10. The auditors recommend IDHS review the process and procedures in place to prepare financial and performance reports required for the TANF Cluster and implement procedures necessary to ensure the reports are accurate.

Findings: IDHS did not prepare accurate periodic financial and performance reports for the TANF Cluster program.

IDHS is required to report the federal maintenance of effort (MOE) expenditures for the TANF Cluster in financial status (ACF-196) reports each quarter. Additionally, IDHS is required to prepare a performance (ACF-204) report identifying all State funded and MOE expenditures for the TANF Cluster on an annual basis. During testwork, auditors noted several instances in which the actual MOE expenditures exceeded reported expenditures for the federal fiscal year ended September 30, 2011.

In discussing these conditions with IDHS officials, they stated that a formula error in the Excel spreadsheet contributed to the discrepancies noted.

Updated Response: Implemented.

- Procedures have been implemented to ensure a more thorough review of the ACF-196 report and the ACF-204 report.

- A formula error in the Excel spreadsheet has been corrected.

- We have additional staff person reviewing the report on quarterly basis.

12-11. The auditors recommend IDHS establish procedures to: (1) identify all subawards subject to the Federal Funding Accountability and Transparency Act (FFATA) reporting requirements and (2) report required subaward information in accordance with FFATA.

Findings: IDHS has not developed procedures to report information required by the Federal Funding Accountability and Transparency Act (FFATA) for awards granted to subrecipients of WIC, TANF, Child Care, Social Services Block Grant (Title XX), and Block Grants for Prevention and Treatment of Substance Abuse (SAPT) programs.

FFATA requires the State to report certain identifying information related to awards made to subrecipients in amounts greater than or equal to $25,000 under federal grants awarded on or after October 1, 2010. Specifically, auditors noted one SAPT contract, two TANF contracts, and one Title XX contract were not reported during FY12. Additionally, IDHS has not established procedures to report information required by FFATA for subawards made to subrecipients of the WIC program.

In discussing these conditions with IDHS officials, they stated that lack of staff and inadequate systems contributed to the discrepancies noted.

Response: The Department agrees with the recommendation. The Department is requesting additional resources and will modify existing systems to provide the required information to report Subaward Information to FFATA.

Updated Response: Accepted and partially implemented, to be completed by 6/30/14.

Corrective Action Implemented:

- The Department has selected Program Division staff to be the responsible party for uploading their grant awards.

Corrective Action to be Implemented:

- The Department will modify the Consolidated Accounting and Reporting System (CARS) and the Community Service Agreement (CSA) tracking system to include all fields required to report.

- The Department will enhance the accounting lines in the Consolidated Accounting and Reporting System (CARS) to show which year and award the money was obligated.

- The Department will provide training to staff on the system enhancements.

12-12. The auditors recommend IDHS implement policies and procedures to ensure access to its information systems is adequately secured and to generate a list of program changes from its information systems and applications.

Findings: IDHS does not have adequate program access and change management controls over information systems used to document and determine beneficiary eligibility and record program expenditures.

The information technology applications that support the IDHS major programs include the following:

- *Concurrent* – serves as the eligibility system for SNAP, TANF Cluster, CHIP, and Medicaid Cluster programs. The system is used by IDHS to store participant information, perform eligibility determinations for participants, and initiate and document the completion of a variety of required crossmatches for its federal programs.
- *Child Care Tracking System* – serves as the main database for the State's child care activities which is funded by the Child Care Cluster and TANF Cluster programs. The system is used by IDHS and its subrecipients to store participant information, perform eligibility determinations for participants, and track the issuance and redemption of child care vouchers.
- *Consolidated Accounting Record System (CARS)* – serves as the financial accounting database for all of IDHS' federal programs and State funded programs. This system is used by IDHS to track cash receipts and disbursements on an individual award basis. Information reported in this system is used to prepare financial reports.

During testwork over changes made to IDHS' information systems, auditors noted IDHS was not able to generate a list of changes made to its information systems from each respective information system or application identified above. In addition, during testwork over user access review procedures performed for the CARS financial reporting system, a signed access review form could not be located for one of the 15 user groups tested.

In discussing these conditions with IDHS officials, they stated IDHS was unaware of the audit requirement. Some supervisors did not return CARS access checklists or returned them very late to the Bureau of CARS System Administration.

Updated Response: Implemented.

BUREAU OF SYSTEM SUPPORT

- The Bureau of System Support has implemented a procedure that allows the Consolidated Accounting Reporting System (CARS), System Support to remove CARS access of staff if the supervisor does not return the checklist verifying access.

MANAGEMENT INFORMATION SERVICES (MIS)

- The Division of Management Information Services determined that the capability to produce a system generated report for these legacy mainframe systems does not exist through third party marketplace.
- These were developed 15 to 30 years ago when such technology did not exist.
- To develop a custom application create such system generated reports would be prohibitively expensive.
- The current change management process, Cost and Assignment Tracking System (CATS), has been utilized in both Concurrent and Child Care Tracking System (CCTS) and was deemed as an adequate control with low risk.

- CCTS is being replaced with Child Care Management System (CCMS) which utilizes Clearcase, which produces a system generated change management report due to the advanced technology used in its development. The CARs system utilizes PANVALET.
- Both CATS and PANVALET change management processes involve programmers submitting their changes to CMS who then move the changes to production.
- DHS staff cannot move programs into production. DHS considers this separation of duties a compensating internal control to our change management process.
- Due to the age and complexity of the Concurrent and CARS systems, DHS eventually plans on replacing the systems with newer technologies however, at this time it is not economically feasible.
- DHS management accepts the low risk associated with our change management process due to the compensating controls and procedures mentioned.

RECOMMENDATIONS 13-31
Department of Healthcare and Family Services

112-13. 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 Cluster (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. As part of the passive redetermination procedures, a renewal form which contains key eligibility criteria is sent through the mail to the beneficiary. The beneficiary (or the beneficiary's guardian) is required 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.

According to DHFS and DHS records, the following number of cases and related beneficiary payments were subject to the passive redetermination policy during the fiscal year ended June 30, 2012:

	Number of Redeterminations	Beneficiary Payments
Medicaid	209,066	$408,986,471
CHIP	70,305	$118,778,323
Total	279,371	$527,764,794

Payments made on the behalf of beneficiaries of the CHIP and Medicaid programs were $208,669,000 and $6,275,740,000, respectively, during FY12.

In discussing these conditions with DHFS officials, they stated that they do not believe the passive redetermination process failed to comply with federal regulations or the State Medicaid Plan.

Response: The Department accepts the recommendation. Although DHFS does not agree that its previous process failed to comply with federal regulations and the State Medicaid Plan, the

Department has implemented an entirely new redetermination process in compliance with the SMART Act.

Auditors' Comment: *As stated above, the current State Plans require redeterminations of eligibility for all recipients on an annual basis and 42 CFR 435.916(b) requires the State to have procedures designed to ensure that recipients make timely and accurate reports of any change in circumstances that may affect their eligibility. During our audit, we noted that the passive redetermination process is not used for expenditures under the "All Kids" program, a State funded health insurance program similar to Medicaid and CHIP, due to concerns that beneficiaries may not report changes in key eligibility factors in a timely manner. We believe those same concerns would be applicable to the federally funded programs. As a result, we do not believe the passive redetermination process meets the eligibility redetermination requirements of the Medicaid and CHIP programs.*

Updated Response: Implemented. This finding was not repeated in the FY13 Single audit.

12-14. 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 CHIP and Medicaid.

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

- In seven CHIP case files, DHFS did not have supporting documentation of the redetermination completed and signed by the beneficiary since these were administratively renewed.

- In one CHIP case file, DHFS could not locate adequate documentation evidencing income verification procedures were performed. Caseworkers verbally confirmed income information, relied on clients handwritten notes, or used income verified on previous applications.

Payments made on the behalf of beneficiaries of the CHIP and Medicaid programs were $208,669,000 and $6,275,740,000, respectively, during the year ended June 30, 2012.

In discussing these conditions with DHFS officials, they stated that the administrative renewal process does not require a hard copy document to be placed in the file.

Response: The Department accepts the recommendation. DHFS is working with DHS to establish electronic data matches for various factors of eligibility and are moving toward electronic case records.

Updated Response: Implemented. This finding was not repeated in the FY13 Single audit.

12-15. The auditors recommend the State review its current process for paying medical payments and consider changes necessary to ensure medical payments are made within the timeframes prescribed within the federal regulations. (Repeated-2008)

Findings: The State is not paying practitioner medical claims for individuals receiving benefits under the CHIP and Medicaid programs within the 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. Once a medical payment has been approved for payment, it is adjudicated, vouchered and submitted to the Office of the Comptroller for payment.

During a review of the analysis covering practitioner medical payments during FY12, auditors noted medical payments were not made within the 30-day payment timeframes required by federal regulations. Management's analysis identified that of the 40,150,513 claims for $5,400,967,941 paid in FY12, only 73.8% (29,623,747 claims for $1,477,676,233) were paid within 30 days of receipt, and 90.7% (36,397,416 claims for $3,071,790,831) were paid within 90 days of receipt. Management analysis also identified that of the 3,541,182 CHIP claims for $242,376,929 paid in FY12, only 77.7% (2,750,427 claims for $120,939,083) were paid within 30 days of receipt and only 92.8% (3,286,801 claims for $161,210,975) were paid within 90 days of receipt.

In discussing these conditions with DHFS officials, they stated State cash-flow limitations were the essential reason why some medical payments may not have been made within the federally prescribed timeframes.

Response: The Department accepts the recommendation. DHFS has established internal medical payment pull parameters to allow for payment within the prescribed federal timeframes. FY12 medical claims were adjudicated by the Department in a timely manner and staff engage in routine discussions with the Illinois Office of the Comptroller regarding medical payments. The Department will continue to process medical claims within the timeframes required under federal regulations; however, claims may be held for payment by the Comptroller until cash is available.

Updated Response: Implemented. This finding was not repeated in the FY13 Single audit.

12-16. The auditors recommend DHFS implement procedures to ensure all hospital assessment payments are disbursed in accordance with the Medicaid State Plan. (Repeated-2010)

Findings: DHFS did not disburse monthly hospital assessment payments within the required timeframes for the Medicaid Cluster.

During testwork over hospital assessment payments, auditors noted disbursements were not made in equal monthly installments during FY12. Specifically, DHFS made these payments in six equal and accelerated installments in July, August, September, October, November, and December 2011. Total payments made to providers for the hospital assessment program of the Medicaid Cluster totaled $1,483,036,000 during FY12.

In discussing these conditions with DHFS officials, they stated that enhanced federal matching percentages made it advantageous for the Department to disburse assessment funds on an

accelerated schedule. This schedule allowed DHFS to increase funds provided by the federal government.

Response: The Department accepts the recommendation. The Department is currently working with the federal Center for Medicare and Medicaid Services to amend the State Plan to allow accelerated assessment payments.

Updated Response: Implemented. This finding was not repeated in the FY13 Single audit.

12-17. The auditors recommend DHFS evaluate their procedures to ensure provider audits are performed and completed in a timely manner. Auditors also recommend DHFS implement procedures to report overpayments on its quarterly reports and remit the federal share of overpayments in accordance with federal regulations. (Repeated-2008)

Findings: DHFS did not initiate, complete, or report overpayments identified in audits of providers of CHIP and Medicaid programs in a timely manner.

The DHFS Office of Inspector General (OIG) conducts several types of audits and reviews of healthcare providers to monitor the integrity of payments made to providers of the CHIP and Medicaid Cluster programs. Specifically, the OIG performed post-payment compliance audits to identify improper payments and quality of care reviews to assess whether healthcare providers are giving proper care and services to CHIP and Medicaid beneficiaries. These audits may lead to sanctions against providers, recoveries of overpayments from providers, and/or criminal prosecution of providers. The OIG reports the results of these audits, as well as its other activities, to the Center for Medicare and Medicaid Services on an annual basis.

During testwork over 50 providers recommended by the OIG for audit, auditors noted there were significant time delays from 29 to 785 days between the date DHFS determined a provider audit should be performed and the start date of the audit. Specifically, 8 of the 50 provider audits tested had not been completed as of the date of testwork.

For the 42 provider audits completed, 12 provider audits were not completed in a timely manner. Specifically, for these 12 provider audits, the length of time to perform the audits ranged from 186 to 555 days.

In addition, based on information provided by a USDHHS audit and procedures performed during the audit, there were $324,100 of overpayments sampled from the period August 1, 2007 to July 31, 2009 that were not completely reported in accordance with federal requirements. In addition, for 116 of 137 overpayments sampled, DHFS did not report the overpayment in a timely manner which could have resulted in an increased interest expense to the federal government of $560,835. Further, auditors noted an overpayment in the appeals process that was identified June 8, 2007 and not reported on quarterly financial reports totaling $14,800,000.

In discussing these conditions with DHFS officials, they stated that efforts to timely complete provider audits have been hampered in part by insufficient resources, including reduced numbers of staff. DHFS has an informal policy of reporting overpayments not involving fraud or abuse at the conclusion of the provider appeals process, not within 365 days of discovery.

Updated Response: Accepted. The finding regarding overpayments was not repeated in the FY13 Single audit. However, the Department received a recommendation to initiate and complete

provider audits in a timely manner. 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. The OIG established the Executive Audit Compliance Committee to improve and streamline procedures, developed audit methodologies and processes for internal and external audits and continues to provide audit training.

12-18. 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. (Repeated-2010)

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

Auditors noted DHFS did not report overpayments identified by the Fraud Unit from FY09, FY10 and FY11 on its quarterly financial expenditure reports or return these amounts to the federal government until September 30, 2012. Overpayments identified by the Fraud Unit reported on September 30, 2012 financial report totaled $240,805. Overpayments for FY12 have not been reported as of the date of testwork on December 13, 2012.

In discussing these conditions with DHFS officials, they stated that their priority was to implement a system for DRS to process current overpayments through MMIS.

Response: The Department accepts the recommendation. A manual adjustment was made for FY09, FY10 and FY11. Current overpayments are now being identified by DRS and provided to DHFS in a timely manner. DHFS and DRS will continue to work together to monitor the process for submitting the overpayments as required. DHFS has implemented controls to monitor whether DRS is reporting overpayments to the Department on a quarterly basis.

Updated Response: Implemented. However, this finding repeated in FY13 due to the timing of the corrective action implementation.

12-19. The auditors recommend DHFS implement procedures to verify with recipients whether services billed by providers were received. (Repeated-2010)

Findings: DHFS does not have adequate procedures in place to verify with beneficiaries of the Medicaid 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 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 instead of hospitals and physicians.

Payments made to non-emergency transportation providers, optometric providers, and dental providers totaled $363,420,000 during FY12 while payments to providers on behalf of all beneficiaries of the Medicaid Cluster totaled $6,275,740,000.

In discussing these conditions with DHFS officials, they stated that the Department does not have the staff or resources to implement an expanded recipient verification process at this time.

Response: The Department accepts the recommendation, but does not have the staff or resources to implement a recipient verification process at this time. The tasks required to appropriately implement such a process are highly complex and burdensome. This process will be implemented as part of the new MMIS through various requirements that include:

- validation of Explanation of Benefits (EOB) online through the recipient portal;
- dynamic system functionality that support EOB sample selection;
- ability to include laymen's description of procedure and diagnosis codes on EOBs; and
- functionality that support linguistically and culturally appropriate EOBs.

12-20. 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. (Repeated-2010)

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 government owned hospitals participating in the Medicaid Cluster and was retro-active as of July 1, 2008.

During testwork of 65 CHIP and 125 Medicaid beneficiary payments, auditors noted DHFS has not developed a set of policies and procedures for developing rates used to calculate the inpatient, outpatient, and disproportionate share rates for government owned hospitals.

Further, DHFS did not finalize the 2012 per diem rates for two providers until September 2012. Because DHFS did not set the provider per diem rates for 2012 until September 2012 these hospitals' reimbursements for FY12 were subsequently adjusted by $10,180,107 and $1,818,891 in September 2012. FY13 rates were not finalized for these two providers until November 19, 2012.

In discussing these conditions with DHFS officials, they stated that recent changes in reimbursement rate methodology for large government-owned hospitals have necessitated rate recalculations and adjustments. This occurred due to approval of a Medicaid State Plan amendment that modified the inpatient cost inflator used to calculate rates.

Updated Response: Implemented. The Department is working more closely with the government owned providers to ensure there is a negotiated agreement of rates between the two parties, prior to issuing a finalized rate letter. Prior approval of the per diem rates between the Department and the hospitals will aid in calculating rates timely and prevent retroactive adjustments.

12-21. The auditors recommend DHFS obtain the required information about ownership and control, business transactions, and criminal convictions for all CHIP and Medicaid Cluster providers. (Repeated-2009)

Findings: DHFS did not obtain required disclosures from providers about ownership and control, business transactions, and criminal convictions. During testwork of CHIP and Medicaid programs,

auditors noted that DHFS utilizes a standard provider application and agreement which requires disclosure of the following information:

- each subcontractor in which the provider has an ownership interest of five percent or more;
- the address of each person with an ownership or controlling interest;
- business or familial relationships among the owners and subcontractors disclosed;
- past criminal convictions related to Medicare, Medicaid, or Title XX programs;
- ownership of any subcontractor with whom the provider had business transactions totaling more than $25,000 during the previous 12-month period if requested by DHFS; and
- significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the previous 5-year period if requested by DHFS.

During testwork on 44 providers, auditors noted a complete agreement was not on file for two of the providers tested; therefore, required disclosures were not obtained for these providers relating to the address of each person with an ownership or controlling interest, business or familial relationships among the owners and subcontractors disclosed, and past criminal convictions related to Medicare, Medicaid, or Title XX programs.

Additionally, based on information provided by a Center for Medicare and Medicaid Services (CMS) audit and procedures performed during the audit, DHFS does not have an adequate process to capture required ownership, control, and relationship information from Fee for Service providers, Home and Community Based providers, Dental Program Administrators, and Managed Care Organizations.

In discussing these conditions with DHFS officials, they stated that elements required to be disclosed by providers has changed several times since this finding was first reported which has delayed the implementation of planned corrective actions.

Response: The Department accepts the recommendation. DHFS modified the enrollment application and agreements to capture the newly required information as outlined in the Affordable Care Act. Prior to the new forms being distributed, the SMART Act was passed and required further review of the enrollment process to ensure compliance with laws and regulations. In January 2013, an administrative decision was made to not distribute the finalized paper application and associated forms and agreements to re-enroll over 200,000 providers via a manual process. Instead, DHFS decided to work to implement the provider enrollment piece of the new MMIS which will comply with all requirements. The projected implementation date for the new provider enrollment system is February 2014. DHFS will obtain the required disclosures from the two providers identified in this audit.

Updated Response: Implemented. This finding was not repeated in the FY13 Single audit.

12-22. 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 a 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. DHFS selects subrecipients to perform on-site fiscal and administrative monitoring procedures using a risk based approach. These risk assessments are based on the funding level received by the entity.

However, in reviewing the subrecipient risk assessment and on-site monitoring procedures performed by DHFS, auditors noted the following:

- the monitoring tools used by DHFS for on-site fiscal and administrative reviews of subrecipients did not include procedures designed to ensure costs meet the allowable costs criteria in OMB Circular A-87 or whether procurements were performed in accordance with the Illinois Procurement Code.
- the criteria for selecting subrecipients for on-site monitoring reviews appears to be solely weighted on the amount of funding expended by the subrecipient. Although DHFS indicated other criteria are considered in developing its monitoring approach, these other criteria were not documented.
- the on-site monitoring procedures for one subrecipient with a high risk score were not complete as of the date of testing (December 19, 2012).

In discussing these conditions with DHFS officials, they stated that some of the monitoring tools did not include enough detail to document the monitoring of whether costs were allowable. Additionally, the monitoring for one subrecipient was not completed on schedule due to the Department waiting for a response regarding a legal opinion that was being sought.

Response: The Department accepts the recommendation. DHFS will provide additional detail to better document the risk assessment and monitoring procedures already being performed.

Updated Response: Implemented. This finding was not repeated in the FY13 Single audit.

12-23. 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. Auditors also recommend DHFS work with agencies contracting with vendors on the behalf of DHFS to ensure the suspension and debarment certifications are included and the EPLS is checked. (Repeated-2009)

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

During a review of twenty vendors of the Child Support Enforcement program and twenty vendors allocated to all federal programs, auditors noted certifications were not obtained from two vendors to indicate whether or not these vendors were suspended or debarred from participation in Federal assistance programs. Additionally, DHFS did not perform a verification check with the "Excluded Parties List System" (EPLS) maintained by the General Services Administration for vendors. Auditors also noted DHFS has not developed procedures to perform verification checks of medical providers with EPLS as required by federal regulations.

In discussing these conditions with DHFS officials, they stated that the two vendors identified as exceptions were procured by the Illinois Department of Central Management Services (DCMS) under master contracts and the Department relied on procedures performed by DCMS. In addition, the Department stated that they believed procedures in place to check providers against the Illinois sanction database were adequate to meet this requirement.

Updated Response: Implemented. The Department has worked with the CPOs office to ensure the proper language is included in master contracts procured by DCMS. CPO Notice 2012.07 was issued on February 10, 2014, which provides language to be included in solicitations and contracts that may be paid for with federal funds. The CPO Notice states the certification language must be included in all statewide master contracts.

12-24. The auditors recommend DHFS implement procedures to verify psychiatric hospitals have been surveyed for compliance with the Medicare Conditions of Participation specific to this provider type. (Repeated-2011)

Findings: DHFS did not verify Medicaid eligibility for psychiatric hospitals participating in the Medicaid Cluster program as required by federal regulations.

Based on information provided by a USDHHS audit and procedures performed during the audit, DHFS has not established or performed procedures to verify facilities have demonstrated compliance with the Medicare Conditions of Participation specific to psychiatric hospitals. DHFS stopped reimbursing non-certified psychiatric hospitals for inpatient claims effective January 1, 2012. Total inpatient psychiatric services payments made to psychiatric hospitals for the period from July 2, 2011 to December 31, 2011 under the Medicaid Cluster program totaled $8,509,760.

In discussing these conditions with DHFS officials, they stated that they were in compliance with the approved State Plan which required accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Response: The Department accepts the recommendation. Since March 1, 1995, the approved Illinois State Plan has defined the qualifications of a DSH eligible hospital to include a state owned facility with JCAHO accreditation. The State Plan never required Medicare certification nor has federal CMS ever provided Illinois any guidance to indicate that our approved requirements did not meet federal regulations. CMS reviewed the State Plan language again in 1998 and the methodology for Institutions for Mental Disease DSH payments in 2000 and no concerns were raised. In response to the federal audit, the Department submitted a State Plan amendment to remove the language refereeing JCAHO accreditation and replace it with language referencing eligibility pursuant to federal regulations. The Department is currently verifying Medicaid eligibility of psychiatric facilities and is not processing payments for those facilities failing to meet this requirement.

Updated Response: Implemented. This finding was not repeated in the FY13 Single audit.

12-25. The auditors recommend DHFS review its current process for monitoring agencies operating Home and Community Based waivers to ensure monitoring is in accordance with the federal regulations.

Findings: DHFS does not have an adequate process to monitor agencies operating the Home and Community Based Services Waiver programs.

The Illinois Medicaid program, as administered by DHFS, currently has nine federally approved home and community based waiver programs. Eight of the nine waivers are operated by other state agencies. As the single state Medicaid agency, DHFS is responsible for oversight and monitoring of the other state agencies to ensure compliance with federal waiver assurances. DHFS contracts with a service provider to perform the medical claim record reviews and on-site reviews over an annual sample of 500 medical claim records and 28 providers.

During a review of monitoring procedures performed by DHFS and its service provider, auditors noted DHFS does not have a formalized process to follow up on deficiencies identified during on-site reviews for the Developmentally Disabled, Brain Injury, HIV and AIDS, and Persons with Disabilities waiver programs.

In discussing these conditions with DHFS officials, they stated that they believed the formal communications combined with quarterly meetings to discuss progress were adequate procedures.

Response: The Department accepts the recommendation. When the DHFS monitoring process was developed, DHFS expected a timely response from the operating agencies; therefore, the Department did not build in formal follow up procedures. For routine findings that do not impact health, safety or welfare, DHFS requires a response within 60 days from the date of the DHFS notification of findings. DHFS specifically requests that the operating agencies submit a plan of correction, including both individual and systemic remediation. Although a formal response is not received, DHFS and the operating agencies discuss the findings and remediation during quarterly meetings. For non-routine issues that may impact health, safety or welfare of wavier participants, DHFS notifies the operating agency immediately and issues are addressed by the operating agency as quickly as possible. DHFS follows up to closure to ensure the health, safety and welfare of wavier participants. The Department will review its current process and implement formal procedures to monitor follow-up responses from the operating agencies to ensure corrective action is taken.

Updated Response: Implemented. However, this finding repeated in FY13 due to the timing of the corrective action implementation.

12-26. The auditors recommend the Department's OIG review its current process for performing investigations and making fraud referrals to the State Police Medicaid Fraud Control Unit (MFCU) and consider any changes necessary to ensure cases of suspected provider fraud are properly referred.

Findings: DHFS did not adequately investigate and refer suspected instances of Medicaid provider fraud to the Illinois State Police Medicaid Fraud Control Unit (MFCU).

Within the Department of Healthcare and Family Services, the component dedicated to fraud and abuse detection is the DHFS Office of the Inspector General (OIG). Suspected criminal cases of fraud, waste, abuse, misconduct and mismanagement in programs are referred by the OIG to the MFCU within the Illinois State Police (ISP).

During a review of the OIG process for referring cases of fraud to MFCU, auditors noted the OIG made no referrals to MFCU during FY12. While the OIG received 137 fraud referrals from both internal and external sources in FY12, no cases were completely investigated or referred to MFCU during the year.

In discussing these conditions with DHFS officials, they stated that DHFS maintains adequate procedures to refer fraud to the Illinois State Police Medicaid Fraud Control Unit. The change made

to the federal rules on March 25, 2011 created problems for Program Integrity Units across the nation. This process was further diminished by process changes within related agencies. Administrative changes within the OIG (mid-fiscal year 2012) initiated the review and realignment of resources toward the current procedures in place.

Response: The Department accepts the recommendation. On March 23, 2012 Federal CMS provided final rules related to the changes made by the Affordable Care Act, modifying the referral standard and required imposition of payment suspensions from a "credible evidence" standard to a "credible allegation" standard. OIG has revised its processes for referring matters to the Illinois State Police Medicaid Fraud Control Unit. During FY12, the OIG reinitiated the Narrative Review Process which had previously been halted in 2009. Throughout the remainder of FY12, OIG provided 18 referrals to the Illinois State Police. OIG and the Department of Human Services (DHS) have also modified the DHS internal incident reporting system into a direct referral system to OIG, resulting in numerous referrals to MFCU. Processes continue to be analyzed, modified and implemented to increase the number and quality of referrals to law enforcement.

Auditors' Comment: *We respectfully disagree with the Department's response. Populations provided to us for testing during our audit identified 137 fraud referrals were received by the OIG and no cases were completely investigated or referred to the MFCU during the year ended June 30, 2012. Evidence could not be provided to support the 18 referrals made through the Narrative Review Committee.*

Updated Response: Implemented. This finding was not repeated in the FY13 Single audit.

12-27. The auditors recommend DHFS establish procedures to: (1) identify awards subject to Federal Funding Accountability and Transparency Act (FFATA) reporting requirements, (2) obtain subrecipient DUNS numbers, and (3) report required subaward information in accordance with the FFATA. (Repeated-2011)

Findings: DHFS did not report information required by the Federal Funding Accountability and Transparency Act (FFATA) for awards granted to subrecipients of the Child Support Enforcement and Medicaid programs.

During testwork, auditors noted DHFS did not report information required by FFATA for subawards made to subrecipients of the Child Support and Medicaid Cluster programs during FY12.

In discussing these conditions with DHFS officials, they stated that the Department was aware that the federal reporting system was not fully operational and did not assign a high priority to this project.

Response: The Department accepts the recommendation. After the end of the audit period, but prior to the auditor's testing, the Department identified the subawards subject to FFATA reporting. Several attempts to upload the information to the fsrs.gov reporting website were made. DHFS will continue our efforts to upload the subaward information to fsrs.gov for both fiscal year 2012 and fiscal year 2013.

Updated Response: Accepted. We believe the technical issues with reporting have been resolved. The Department will report past and future sub-awards in a timely manner.

12-28. The auditors recommend DHFS review its current process for completing annual Disproportionate Share Hospitals (DSH) audits and consider changes necessary to ensure such audits are completed within the required timeframes.

Findings: DHFS did not complete required audits of annual Disproportionate Share Hospitals (DSH) allotments and payments to hospitals within the required timeframes.

DHFS calculates each hospital's annual DSH allotment by estimating their costs to provide uncompensated care by using each hospital's most recent annual medical cost report and adjusting the uncompensated care costs in that report by inflation. Beginning in FY11, federal regulations require that annual DSH allotments to qualifying hospitals receive an audit after the fact to ensure such payments were in compliance with the hospital-specific eligible uncompensated care cost limit regulations.

During a review of the DSH audits completed by DHFS, auditors noted the annual audits performed by the Department were not completed and submitted to USDHHS within the required timeframes, ranging from 82 to 344 days late for FY05-FY08.

The federal statutes allow a transition period such that any overpayments identified in the results of the DSH audits for State Plan years 2005 to 2010 will not be given weight or required to be returned. However, since these audits were not completed until September 9, 2011, DHFS was not able to incorporate the $1.1 billion in overpayments related to Medicaid inpatient and outpatient reimbursements identified into the uncompensated cost of care estimates for the 2011 or 2012 DSH payments.

In discussing these conditions with DHFS officials, they stated that the Department was unable to initiate a contract with the audit firm hired to conduct the DSH audits until December 1, 2010, due to delays in the procurement process.

Response: The Department accepts the recommendation. DHFS met the deadline imposed by federal CMS for 2009.

Updated Response: Implemented. This finding was not repeated in the FY13 Single audit.

12-29. The auditors recommend DHFS implement procedures to ensure cost allocation methodologies prescribed in the Public Assistance Cost Allocation Plan (PACAP) are updated for change in job requirements.

Findings: DHFS did not amend the allocation methodology defined in the Public Assistance Cost Allocation Plan (PACAP) for the Child Support Enforcement program.

During a review of costs allocated to federal programs during the quarter ended December 31, 2011, auditors noted the position Special Assistant for Child Support was not allocated to the Child Support Enforcement program in accordance with the approved PACAP. Upon further review, the current job requirements of the position do not pertain to the Child Support program and are not consistent with the duties included in the approved PACAP cost allocation plan. Accordingly, DHFS did not claim these costs under the Child Support Enforcement program; however, the PACAP has not been amended to reflect these changes.

In discussing these conditions with DHFS officials, they stated that DHFS did not consider the temporary re-assignment of the employee noted in the finding as an organizational change requiring a plan amendment.

Response: The Department accepts the recommendation. DHFS submitted a cost plan amendment to the U.S. Department of Health and Human Services Division of Cost Allocation on March 1, 2013.

Updated Response: Implemented. This finding was not repeated in the FY13 Single audit.

12-30. The auditors recommend DHFS implement procedures to ensure cash draws are performed in accordance with the TSA approved funding technique and clearance pattern.

Findings: DHFS did not perform its cash draws in accordance with the funding techniques prescribed by the Treasury-State Agreement (TSA).

During testwork on 27 cash draws (totaling $957,386,468) for medical payments under Medicaid, auditors noted DHFS requested cash based on a two-day clearance pattern instead of the five-day clearance pattern prescribed in the approved TSA.

In discussing these conditions with DHFS officials, they stated that the Department had interpreted the clearance pattern days as a function of the State interest liability calculation and not as a specified day to draw funds.

Response: The Department accepts the recommendation. DHFS will submit amendatory language to the U.S. Treasury to clarify our actual process with regard to the funding technique and interest calculation methodology for the specific portion of CFDA 93.778 program costs in the Treasury State Agreement.

Updated Response: Implemented. This finding was not repeated in the FY13 Single audit.

12-31. The auditors recommend DHFS establish procedures to accurately report federal expenditures used to prepare the SEFA to the Illinois Office of the Comptroller. (Repeated-2011)

Findings: DHFS did not accurately report Federal expenditures under Medicaid, CHIP, and Child Support Enforcement (CSE) programs.

DHFS inaccurately reported federal expenditures which were used to prepare the schedule of expenditures of federal awards (SEFA) to the Illinois Office of the Comptroller (IOC) using a combination of actual expenditures claimed during the fiscal year and an estimate based on revenues and receipts. Specifically, auditors noted three differences for DHFS' major programs totaling about $105 million for FY12.

Additionally, DHFS could not reconcile expenditures reported on the quarterly claim reports for the Medicaid Cluster and CHIP program to expenditures reported on the SEFA.

In discussing these conditions with DHFS officials, they stated that that the breakout of ARRA expenditures occurred as a result of a misunderstanding of how ARRA receipts in 2012 affected the SEFA. The $33.5 million was caused by human error when the Department reported expenditures

relative to the ARRA receipts. The $21 million reported by IDHS was a change that was made after the DHFS reports had already been submitted.

Response: The Department accepts the recommendation and agrees that procedures to accurately report federal expenditures should be developed. At this time, DHFS does not have control over other agencies reporting to the Illinois Office of the Comptroller. If DHFS is to be responsible for the total Medicaid Cluster reporting, then any changes made to other agency's financial reports must be reported to DHFS.

Auditors' Comment: *As the State Medicaid Agency, DHFS is responsible for overseeing the Medicaid program. We believe such oversight includes ensuring information reported on the SEFA for the Medicaid Cluster is in accordance with the requirements of OMB Circular A-133 and reconciles to financial reports submitted for the Medicaid program.*

Updated Response: Implemented. This finding was not repeated in the FY13 Single audit.

RECOMMENDATIONS 32-40
Department of Children and Family Services

12-32. 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 make required communications or perform fiscal and administrative on-site monitoring procedures for subrecipients who receive awards under the TANF, Foster Care, and Adoption Assistance programs.

DCFS passes through federal funding under the Foster Care and Adoption Assistance programs to not-for-profit organizations which assist the State in carrying out the State's responsibilities under these programs. The services provided by these organizations assist the State in determining the continuing allowability of maintenance and subsidy payments made to foster and adoptive families on the behalf of eligible children. Certain of these costs which are not claimed under or used as match for the Foster Care and Adoption Assistance programs are claimed for reimbursement under the TANF program.

During testwork over the subrecipient monitoring compliance requirement for these programs, auditors noted DCFS determined that organizations previously identified as subrecipients should be considered vendors because the initial eligibility determinations for children served under these programs are performed by the State. However, the nature of the services provided by these organizations goes beyond those provided in a vendor relationship.

As a result of this determination, 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 to these organizations. DCFS also did not perform fiscal and administrative on-site monitoring procedures over the programs operated by these organizations.

Amounts passed through to subrecipients of the TANF, Foster Care, and Adoption Assistance programs which were improperly reported as contractual services during the year ended June 30, 2012 were $42,846,000, $56,568,000 and $4,778,000, respectively.

In discussing these conditions with DCFS officials, they stated that they disagree with the finding in light of the finding resolution letter received on April 5, 2013 from the Administration of Children and Family Services (ACF). DCFS is in the process of evaluating the letter with the auditors and ACF.

Response: The Department agrees that federal awards should be properly reported and monitored. While the Department disagreed with the finding in FY11 and the draft FY12 finding, it is currently reviewing the response received from the federal agency and discussing the intention and conditions contained in the letter regarding the classification as vendors and assurances requested. The response received permits the Department to classify its providers as vendors and requests the Department to continue its current practices to monitor provider performance.

The Department continues to send notices to all providers considered to be program sub-recipients (the only subrecipients the Department had contracts with in State FY12 were Family Preservation Service; Extended Family Service; and Adoption Preservation Service; none currently in Foster Care or Adoption programs) and notices are sent to all providers (including Foster Care and Adoption programs) for which an audit report is required (providers/agencies that receive over $150,000 during the State's fiscal year).

The Department's policy is that on-site fiscal and administrative reviews should and do 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.

The Department continues to conduct on-site monitoring of the substitute care providers who receive payments under the Foster Care, Adoption Assistance, and TANF programs and has never discontinued monitoring. Additionally, following receipt of 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 conducted an audit of one specific provider. That audit identified issues that were the basis for changes to monitoring procedures and regular provider reporting practices. The Department has further assessed the issues identified and instituted additional steps to improve its fiscal monitoring of providers. Corrective action has been taken to close all gaps in internal control that allowed this instance of fraud to incur including:

- Implementation of Grant Recoveries Act requirements;
- Quarterly monitoring of program expenditures compared to budget;
- Quarterly monitoring of program metrics;
- Quarterly monitoring of Provider key financial indicators; and
- Continuous monitoring of Program monitors site visits.

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 have continued 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 and we were unable to obtain a population of

expenditures for testwork. Finally, consistent with the prior year, DCFS did not perform fiscal monitoring procedures.

As noted in DCFS' response, a federal resolution letter was received on April 5, 2013 which stated that the entities in question are considered subrecipients. The resolution letter also included guidance to DCFS which appears to conflict with subrecipient monitoring requirements includes in OMB Circular A-133 and the OMB Circular A-133 Compliance Supplement. Accordingly, all parties are in the process of seeking clarification. As of the date of our report, clarification has not been obtained.

Updated Response: Not Accepted. The Department disagreed that it did not make required communications or perform fiscal and administrative on-site monitoring procedures for subrecipients who receive awards as stated in the finding. The Department has not ceased monitoring its providers as stated in past years for this on-going, repeat finding.

The Department has received a letter response regarding this on-going finding from the federal agency funding its major programs. The federal agency agreed that the Department conducts sufficient monitoring of providers. However, the Department is currently reviewing the response and discussing the intention and conditions contained in the letter regarding the classification as vendors and assurances requested. The response received permits the Department to classify its providers as vendors, requests the Department to continue its current practices to monitor provider performance and to schedule the auditor to include certain tasks within its audit work. Discussions with the Office of the Auditor General, the audit firm contracted to conduct the audit work, and the federal agency are continuing. And, for FY13 the Department is working with the audit firm on completing certain of its tasks to audit DCFS's monitoring of and reporting by Purchase of Service providers.

As a part of finding resolution, the Department has provided ACF with a letter providing assurances that the Department's programmatic and financial monitoring programs will continue. We stated that we will work with KPMG to include in the audit for 2013, reviews and tests of the annual rate setting determinations and the year end settlement process, our performance and the financial monitoring process, and allocations of costs to federal programs including use of random moment samples and costs charged through the PCAP.

12-33. The auditors recommend DCFS review its procedures for retaining current adoption subsidy agreements and implement changes necessary to ensure such agreements are maintained as required by program regulations. (Repeated-2005)

Findings: DCFS could not locate case file documentation supporting the amount of the current subsidy payments for beneficiaries of the Adoption Assistance program.

During testwork of 50 Adoption Assistance beneficiary payments (totaling $27,910), 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 the current amount of subsidy payments for three beneficiaries. DCFS claimed reimbursement for adoption assistance benefits made on behalf of the children totaling $18,554 during the year ended June 30, 2012.

DCFS claimed reimbursement for adoption assistance beneficiary payments totaling $74,259,026 during the year ended June 30, 2012.

In discussing these conditions with DCFS officials, they stated that adoption agreements for the three children support beneficiary payments totaling $32,296 for the year. Documentation supporting the increases in rates over the adoption agreements was inadvertently misplaced.

Updated Response: Implemented. The Department reviewed its procedures for retention of subsidy agreements, procedures followed where payment rates are entered in the system on newly opened subsidy cases, processes where historical rate information is retained or missing, access rights over the ability to enter and make rate changes in systems, and added an additional layer of over site on amendments. Procedures were tightened over retention and payment and an adjustment was made to a claim where the subsidy payment exceeded the amount authorized in the agreement.

12-34. 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 50 recurring subsidy payments (totaling $27,910) made under the Adoption Assistance program, auditors noted four case files (with sampled payments of $1,813) in which DCFS could not locate a recertification form submitted by the adoptive parent(s) within the most recent period. DCFS claimed reimbursement for adoption assistance benefits made on behalf of these children totaling $21,989 during the year ended June 30, 2012.

In discussing these conditions with DCFS officials, they stated that while there is no federal statute or provision requiring annual renewals, recertifications or eligibility re-determinations for title IV-E adoption assistance, they believe it is a good business practice.

Auditors' Comment: We respectfully disagree with DCFS' response. The procedures relative to the recertification forms are included in the State Plan for the Adoption Assistance program and federal regulations require the State to follow the provisions of its State Plan.

Updated Response: Implemented. The Department conducts annual recertifications as a good business practice, to confirm eligibility for a Medicaid card and that the children are still in continued care, and as a part of carrying out management and administrative internal control responsibilities stated in its State Plan. But, it should be noted that there is no Federal statute or provision requiring annual renewals, recertifications or eligibility re-determinations for title IV-E adoption assistance and, that the federal agency administering title IV-E did not sustain the finding when it was included in a previous audit (finding 10-39). DCFS suggests this finding and future findings like it be either removed or at a minimum not classified as "Material Non-Compliance" findings.

12-35. The auditors recommend DCFS establish procedures to ensure that providers and vendors receiving federal funds from DCFS are not suspended or debarred or otherwise excluded from participation in Federal assistance programs. (Repeated-2011)

Findings: DCFS did not obtain required certifications that providers and vendors were not suspended or debarred from participation in Federal assistance programs for the Foster Care and Adoption Assistance Programs.

During a review of 25 providers and 25 vendors of the Foster Care and Adoption Assistance programs, auditors noted DCFS did not include a suspension and debarment certification in any of the agreements of its provider or vendor agreements. Additionally, DCFS did not perform a verification check with the "Excluded Parties List System" (EPLS) maintained by the General Services Administration for any of these organizations.

In discussing these conditions with DCFS officials, they stated that in 2012 and previous years, the Department used the Central Contractor Registration Screen (CCR) instead of the Excluded Party List System and relied on the provider's debarment certification which was included as a part of the provider's contract.

Updated Response: Implemented. Beginning with the FY13 contract cycle, the Department's process was changed to verify with the new federal SAM system (System for Award Management) for both the CCR information (former CCR system) and the Excluded Party Listing information (former EPLS system). The Department also established a procedure to verify before awarding the contract to a perspective vendor and before a major modification is awarded to retain SAM screens as evidence (proper audit trail) of those checks within the contract files.

For FY2014, DCFS changed the Contract boilerplate for providers based on federal requirements that exclude the time limitations contained in the IL Procurement Code.

12-36. The auditors recommend DCFS implement procedures to ensure cash draws are performed in accordance with the TSA or amend the TSA to reflect cash draw request practices. (Repeated-2011)

Findings: DCFS did not perform its cash draws in accordance with the funding technique prescribed by the Treasury-State Agreement (TSA).

On an annual basis, the State of Illinois negotiates the TSA with the U.S. Department of the Treasury (the Treasury) which details, among other things, the funding techniques to be used for requesting federal funds. The TSA requires DCFS to draw funds in monthly installments (on the median day of the month) equal to 1/3rd of the quarterly grant awards for the Foster Care and Adoption Assistance programs. During testwork over cash draws performed for the Foster Care and Adoption Assistance programs, auditors noted DCFS drew funds four times during the year for each program on dates other than the median day of the month. These draws were in varying amounts which is not consistent with the requirements of the TSA.

In discussing these conditions with DCFS officials, they stated that the agency is doing everything necessary to minimize interest liability to the federal government and making draws in compliance with the CMIA criteria specified in the grant award.

Updated Response: Implemented. The Department, working with GOMB, modified the language of the State's TSA to make the TSA more consistent with the Department's procedures. The new TSA was approved by the federal government and the new draw procedures began in July 2013. We have modified procedures and are making draws to be consistent with the revised TSA.

12-37. The auditors recommend DCFS implement procedures to ensure subawards are accurately reported within timeframes required by the Federal Funding Accountability and Transparency Act (FFATA).

Findings: DCFS did not report information required by the Federal Funding Accountability and Transparency Act (FFATA) for awards granted to subrecipients of the Foster Care and Adoption Assistance programs within required timeframes.

During testwork, auditors noted DCFS awards contracts to providers (subrecipients) of the Foster Care and Adoption Assistance programs on an annual basis. The amounts to be paid under each federal and state program covered by these contracts are estimated based upon the provider's expected caseload, historical performance, and other factors. During testwork over contracts subject to FFATA reporting requirements, auditors noted DCFS did not report any of the contracts within required timeframes. Specifically, there were ten subawards required to be reported under FFATA in FY12 which were executed in late June 2010 and were not reported until October 2011 (when final contract amounts were known).

In addition, for the five contracts identified above, the amount of the subaward originally reported ($20,380,323) did not agree to the amounts actually passed through ($12,379,410) to the sampled subrecipients.

In discussing these conditions with DCFS officials, they stated that guidance on the reporting requirements relative to the Foster Care and Adoption Assistance programs has not been clear. Because these awards are posted quarterly versus annually on the reporting system by USDHHS and amounts to be claimed for reimbursement are only known after the completion of the respective quarter, DCFS reports each quarter after the claim has been determined. DCFS stated they are unable to report contract obligations made for the entire year at the start of each fiscal year since they are based on state funded appropriations not federal awards of which only a portion may be federally reimbursed after the service has been provided, paid for, and federally claimed. DCFS believes it would be inaccurate to label state obligations prior to service delivery, payment and claim determination as obligations on the FFATA reporting system.

Response: The Department agrees that information required by the Federal Funding Accountability and Transparency Act should be reported and will continue to seek direction from the federal government of how best to meet their expectations. The Department will continue discussions with the auditor as more information on reporting requirements is available to arrive at a consistent reporting criteria. While we are reporting actual expenditures after filing a claim which is our best estimate of the quarterly obligations, we will continue to seek a method whereby we would be able to report obligations within the time limits required by FFATA.

The federal agency posts DCFS foster care and adoption assistance awards quarterly (after the awards are made) and we can only report for the subawards after the federal awards are posted on the reporting system (the data in the FFATA system is pre-populated only when the federal agency posts the awards). According to the FSRS Awardee Guide, "In order for you to file a FFATA subaward report against your grant (or contract), your Federal grant making official must report your prime grant award information through their FAADS . . . the FAADS submission is the authoritative source for the basis grant award information used to pre-populate many of the prime award details in your FFATA report."

If we are to report the Department's obligation to providers for each contract at the beginning of our fiscal year, the federal agency will need to post the awards on the website for us at the start of the

fiscal year. Additionally, the Federal Funding Accountability and Transparency Act only requires the reporting of obligations; it does not require reporting of expenditures. The federal awards we receive each quarter are the reimbursements for foster care and adoption assistance program expenditures.

Updated Response: Partially Accepted. The Department agreed that information required by the Federal Funding Accountability and Transparency Act should be reported. The Department continues to seek direction from the federal government of how best to meet their expectations. And, while we are reporting actual claimed expenditures quarterly after filing a claim, we will continue to seek a method whereby we would be able to report obligations within the time limits required by FFATA. It should be noted that contract amounts (obligations) with providers are not the basis for claiming. Rather, DCFS spends State dollars on its programs and only seeks reimbursement from the federal agency for amounts attributable to children who meet federal eligibility requirements and then only a portion of the expenditure is reimbursable.

The Department will also continue discussions with the auditor as more information on reporting requirements are available to arrive at a consistent reporting criteria.

12-38. 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-1995)

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 seventeen of the initial case plans were completed from one to 126 days over the 60-day federal requirement.

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

Updated Response: Implemented. The Department implemented a modification to its case management systems in April 2013 that "decoupled" the service plan from completion of the integrated assessment which requires more time to complete. The change is expected to improve timing of completion of the initial case plan. Additionally, the Department continues to stress the importance of adequate and timely documentation for child case files through training and communications to all case staff. Trainings are used to remind case staff of the importance and need for timely completion of the initial case service plan. Through regular and reinforcement trainings, DCFS stresses the importance of adequate and timely case planning as a key component of providing quality service to children.

12-39. The auditors recommend DCFS review its procedures over monthly cash reconciliations and implement the procedures necessary to ensure reconciliations are complete, accurate, and adequately reviewed.

Findings: DCFS does not have adequate procedures in place to ensure monthly cash reconciliations are properly completed.

During testwork of two monthly reconciliations between the records of DCFS and the IOC, auditors noted the cash balances identified on the December 2011 reconciliation did not appear to agree or

reconcile. Upon further review, the difference between these amounts were the results of a mathematical error on the reconciliation.

In discussing these conditions with DCFS officials, they stated that this was a one-time error that had not previously occurred. The report generated from the data base containing the data from which the detail was pulled failed to list all detail yet the total was correct. Since that time, the error has not re-occurred.

Updated Response: Implemented. The Department agreed with the recommendation and has reviewed and implemented procedures to make sure the monthly reconciliations are complete, accurate and reviewed; and, the reviewer was retrained on the duties and responsibilities for the task.

12-40. The auditors recommend DCFS implement policies and procedures to: (1) ensure access to its information systems are adequately secured, (2) address processes relative to users employed by an organization outside of the State, and (3) to generate a list of program changes from its information systems and applications.

Findings: DCFS does not have adequate program access and change management controls over systems used to document beneficiary eligibility determinations or to record program expenditures.

During testwork over changes made to DCFS' claiming system and related general ledger and eligibility databases, DCFS was not able to generate a list of changes made to these information systems. DCFS' current change management procedures include tracking changes made to its information systems in a database; however, the information input into the database is based on manual change request forms. Accordingly, auditors were unable to determine whether the list of changes provided by DCFS from the database during the audit was complete.

In addition, DCFS does not have procedures in place to review access rights for users at subrecipient organizations who have been contracted to assist DCFS in performing and documenting case work. DCFS' IT policies do not currently address users with organizations outside of DCFS.

In discussing these conditions with DCFS officials, they stated that DCFS has the ability to generate, upon request, a list of all programs that were changed and any selected detail requested. Additionally, the Department contractually requires all organizations contracted with DCFS to follow their policies and procedures. DCFS procedures dictate that they be notified within 24 hours that an individual has left an agency.

Updated Response: Implemented. The Department accepted the recommendation and committed to generating the time and date stamp list on the libraries that can be used to produce a list of programs changed during a selected audit period and created a process to automatically produce an employee access listing monthly to be sent to contractual supervisors requesting that they initiate any required access changes. The procedure was formalized into our security policies.

RECOMMENDATIONS 41-43
Department on Aging

12-41. The auditors recommend IDOA implement procedures to ensure on-site reviews of Aging Cluster subrecipients are adequately documented.

Findings: IDOA is not adequately performing and documenting on-site monitoring procedures for subrecipients receiving federal awards for the Aging Cluster. Total awards passed through to subrecipients of the Aging Cluster were approximately $37,996,000 during the year ended June 30, 2012.

In FY12, IDOA implemented procedures for conducting on-site monitoring reviews and performed reviews for five subrecipients. IDOA has developed a standard checklist which is required to be completed for each monitoring visit. During testwork of on-site reviews performed in FY12 for four subrecipients (with expenditures of approximately $5,892,000), the auditors noted the following:

- The on-site monitoring checklist and supporting workpapers were not available for one subrecipient review tested.
- The on-site monitoring checklists prepared for three of the reviews tested were incomplete. Additionally, workpapers were not prepared or contained limited information for several areas reviewed.

In discussing these conditions with IDOA officials, they stated that the staff participating in the on-site reviews were not familiar with the process and were not aware of the requirement to complete the review tools in their entirety.

Updated Response: Implemented.

12-42. The auditors recommend IDOA establish procedures to ensure that management decisions are issued in accordance with OMB Circular A-133. (Repeated-2006)

Findings: IDOA did not issue management decisions on OMB Circular A-133 findings for subrecipients of the Aging Cluster.

During testwork over OMB Circular A-133 audit reports for four subrecipients of the Aging Cluster (with total expenditures of approximately $23,567,000), auditors noted the A-133 audit report for one subrecipient reported instances of noncompliance and control deficiencies for which IDOA did not issue a management decision.

In discussing these conditions with IDOA officials, they stated that staff were not aware of the requirement to issue management decision letters for findings that were not specific to Area on Aging programs.

Updated Response: Implemented.

12-43. The auditors recommend IDOA 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 required its subrecipients to prepare a quarterly reconciliation of their net cash position for the first three quarters of State FY12; however, IDOA did

not reduce a subrecipient's cash advance if the reconciliation identified the subrecipient has excess cash on hand. As a result, subrecipients remitted approximately $3,321 in interest earned on excess federal funds to IDOA. Additionally, IDOA did not have a process in place to determine if the interest remitted is reasonable.

In discussing these conditions with IDOA officials, they stated that a new cash draw process was implemented in February 2012 that will ensure that cash on hand is limited to the subrecipient's immediate cash needs.

Updated Response: Implemented.

RECOMMENDATIONS 44-48
DEPARTMENT OF PUBLIC HEALTH

12-44. The auditors recommend IDPH review its monitoring procedures for providers of Immunization Cluster program and implement changes necessary to ensure corrective action plans are obtained and evaluated for all deficiencies identified in provider reviews. (Repeated-2011)

Findings: IDPH is not adequately monitoring providers under the Immunization Cluster program. During testwork over 65 providers (receiving vaccines valued at $5,202,896 during the year ended June 30, 2012) of the Immunization program, auditors noted the following:

- Monitoring reviews performed for five providers (receiving vaccines valued at $51,541 during the year ended June 30, 2012) did not include procedures to review medical records evidencing that vaccine recipients met program eligibility requirements.
- Corrective action plans were not obtained for two providers (receiving vaccines valued at $43,427) who had findings identified in on-site monitoring reviews performed by IDPH.
- Corrective action plans were not evaluated or acknowledged as acceptable for one provider (receiving vaccines valued at $32,106) who had findings identified in an on-site monitoring review performed by IDPH.

IDPH passed through vaccines valued at $104,108,835 during the year ended June 30, 2012 to providers of the Immunization Cluster program.

In discussing these conditions with IDPH officials, they stated that IDPH is not adequately monitoring providers under the Immunization Cluster program.

Response: The Department concurs with the finding and recommendation. New procedures have been put into place and the Illinois Vaccines For Children (VFC) program providers have been notified of newly revised guidance from CDC on documenting patient eligibility. An audit and review of patient records to establish VFC eligibility is now required with all VFC compliance visits.

12-45. 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 (PHEP), Centers for Disease Control and Prevention – Investigations and Technical Assistance (CDC Investigations and Technical Assistance), and HIV Care Formula Grants programs have complied with OMB Circular A-133 audit requirements.

During testwork over 45 subrecipients of the PHEP, CDC Investigations and Technical Assistance, and HIV Care Formula Grants program with expenditures totaling $7,214,264, $2,064,403 and $4,961,017, respectively, during the year ended June 30, 2012, auditors noted the following:

- For one subrecipient of the PHEP program (with expenditures totaling $65,516 during the fiscal year), and one subrecipient of the HIV Care Formula Grants program (with expenditures totaling $42,484 during the fiscal year), A-133 audit reports were not obtained within nine months. Auditors noted that there was no evidence IDPH performed procedures to obtain the delinquent reports and the reports had not been obtained as of the date of testing (August 1, 2012).
- For one subrecipient of the PHEP program (with expenditures totaling $74,824 during the fiscal year), a desk review had not been performed over the single audit report as of the date of testing (August 1, 2012).
- For one subrecipient of CDC Investigations and Technical Assistance program (with expenditures totaling $679,228 during the fiscal year) and two subrecipients of the HIV Care Formula Grants program (with expenditures totaling $700,469 during the fiscal year), the A-133 reports were received between 11 and 97 days after the nine month deadline. Auditors also noted there was no evidence IDPH performed follow up procedures to obtain the delinquent reports.

Additionally, auditors noted that a standard desk review checklist was not used to document the review of subrecipient A-133 reports received from subrecipients.

In discussing these conditions with IDPH officials, they stated that IDPH does not have an adequate process for ensuring subrecipients of PHEP, CDC Investigations and Technical Assistance, and HIV Care Formula Grants programs have complied with OMB Circular A-133 audit requirements.

Response: The Department concurs with the finding and recommendation. The Department will continue to review audit reports for compliance and monitor receipt of audit reports from its subrecipients. The Department has become more diligent in its follow up as evidenced by the significant lessening of any missing or late audit reports. The Department continues to support efforts to consolidate the A-133 audit review function across human services State agencies as recommended in Public Act 96-1141. This consolidation would provide adequate resources and consistency across impacted State agencies in the review and documentation of A-133 audits.

12-46. 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. The auditors also recommend IDPH evaluate the current staffing of its monitoring department to ensure resources are adequate to complete reviews within prescribed timeframes. (Repeated-2010)

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 nine subrecipients of the PHEP program, auditors noted IDPH monitors subrecipients of the PHEP program by: (1) reviewing periodic expenditure reports, (2) examining single audit reports and findings, (3) performing on-site reviews of compliance with programmatic requirements on a periodic basis, and (4) periodic communication of program requirements. However, 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.

Total federal awards passed through to subrecipients of the PHEP program were approximately $13,679,000.

In discussing these conditions with IDPH officials, they stated that IDPH does not sufficiently perform on-site reviews of subrecipients receiving federal awards under the PHEP program.

Response: The Department concurs with the finding and recommendation. The Department has developed on-site monitoring procedures to review each applicable compliance requirement and the fiscal and administrative controls of subrecipients. Procedures have also been established to monitor the matching amounts reported by subrecipients to ensure the expenditures reported by the subrecipients meet general allowable costs requirements. A fiscal staff member allocates a portion of their time to perform on-site fiscal reviews. The on-site fiscal compliance monitoring program was implemented January 1, 2012.

12-47. 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 over 40 complaints filed against Medicaid providers during the year ended June 30, 2012, auditors identified nine complaints that were not investigated within the timeframes required by the State's law. The delays in investigating these complaints ranged from 8 to 75 days in excess of required timeframes. Additionally, auditors identified two complaints that had not been investigated as of the date of testwork. As of the date of testwork, the timeframes for investigation into these complaints were 91 and 120 days in excess of required timeframes.

In discussing these conditions with IDPH officials they stated that IDPH did not investigate complaints received relative to providers of the Medicaid Cluster within required timeframes.

Response: The Department concurs with the finding and recommendation. The Department has hired over 60 new nurse positions and is in the process of hiring additional survey staff for the investigation of complaints of abuse and neglect to meet the required federal timeframes. Until all new staff have been hired and trained, existing staff have been assigned to reduce the backlog of complaints and the Department has implemented a complaint team to focus on complaints only.

12-48. The auditors recommend IDPH implement policies and procedures to verify providers have met the State licensing requirements directly with licensing agencies upon enrollment and on a periodic basis. (Repeated-2011)

Findings: IDPH does not have adequate procedures to verify medical providers are properly licensed in accordance with applicable State laws.

During testwork over the licensing of 44 providers of the Medicaid Cluster program for the year ended June 30, 2012, auditors noted a license was not on file for seven providers sampled. Upon further review with IDPH personnel, auditors noted these providers were end stage renal disease facilities and IDPH stated this provider type was not required to be licensed. The CMS State Operations Manual for End Stage Renal Disease Facilities section 405.2135 requires these facilities to be licensed if State law provides for the licensure of such facilities. The Illinois End Stage Renal Disease Facility Act (210 ILCS 62/10) states that no person shall open, manage, conduct, offer, maintain, or advertise an end stage renal disease facility without a valid license issued by the State.

Payments to these providers under the Medicaid Cluster totaled $42,645,250, during the year ended June 30, 2012. Payments to end stage renal disease facilities under the Medicaid Cluster totaled $2,138,402, during the year ended June 30, 2012.

In discussing these conditions with IDPH officials, they stated that IDPH does not have adequate procedures to verify medical providers are properly licensed in accordance with applicable State laws.

Response: The Department concurs with the finding and recommendation. The Office of Health Care Regulation has been working with the End Stage Renal Disease (ESRD) Advisory Board Work Group to develop a draft set of regulations to implement the ESRD Licensing Act. The ESRD Advisory Board was to vote on the draft in December 2012, but a recent change by federal CMS regarding off-site dialysis required the Work Group to review further and make several changes. It is anticipated that the revisions will be completed and approved by the full Board meeting in May or early June 2013.

RECOMMENDATIONS 49-52
Illinois State Board of Education

12-49. The auditors recommend the State Board of Education (ISBE) revise its risk assessment criteria to incorporate other risk factors and reconsider the weighting assigned to each criterion to ensure the aggregate amount of funding is not the sole criteria driving the selection. The auditors also recommend ISBE establish measurable selection criteria for selecting individual school sites for on-site reviews, and update its monitoring instruments to ensure they include procedures for all direct and material compliance requirements.

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

During a review of the subrecipients selected for on-site reviews during FY12, auditors noted the criteria used by ISBE is limited and is heavily weighted on the aggregate amount of funding received by the subrecipient. As a result, there will be a small number of subrecipients designated as high risk and they will primarily consist of those subrecipients who receive the most funding from ISBE.

In addition to selecting those subrecipients with the highest risk scores, ISBE also selected a sample of subrecipients primarily based on their proximity to available ISBE monitoring resources.

ISBE has not demonstrated that the number of subrecipients and related amount of subrecipient expenditures reviewed for each individual Education program provides adequate coverage for each program under this approach.

Further, there are no measurable selection criteria for determining which individual school sites will be subject to on-site monitoring procedures for each subrecipient selected for review.

Finally, the monitoring tools used by ISBE for on-site reviews did not include procedures designed to ensure compliance with providing access to federal funding for new or significantly expanded charter schools.

In discussing these conditions with ISBE officials, they stated that this was an oversight during the development of new monitoring procedures in fiscal year 2012.

Updated Response: Implemented. The Agency considers this finding resolved for fiscal year 2014. ISBE evaluated and amended the risk assessment process related to risk factors used and the weighting assigned to each criterion when developing the FY14 monitoring plan. The Agency has implemented measureable selection criterion for selecting specific school sites and has updated the FY14 monitoring instrument to include procedures designed to ensure compliance related to new or significantly expanded charter schools.

12-50. The auditors recommend ISBE review its current process for calculating subawards under the Title II program and consider changes necessary to ensure all subawards are properly calculated based on correct low income and enrollment data.

Findings: ISBE did not properly allocate and award federal funds under the Improving Teacher Quality State Grants (Title II) program to Local Education Agencies (LEAs or subrecipients).

During testwork over the allocation of Title II funds, which totaled more than $93 million, auditors noted the allocation calculation prepared by ISBE for the low income allocation included erroneous data for foster care children served by the LEAs. As a result, 136 LEAs received Title II awards in excess of the amount for which they were eligible which totaled $36,716. Additionally, 732 LEAs received awards in amounts less than the amount for which they were eligible with 725 being affected by less than $250.

In discussing these conditions with ISBE officials, they stated that the error was due to oversight in using an incorrect poverty value provided by the U.S. Department of Education's Small Area Income and Poverty Estimates (SAIPE) count for income year 2009.

Updated Response: Implemented. The Agency considers this finding resolved for fiscal year 2014. The Division of Funding and Disbursement Services will calculate the NCLB Title II local education agency awards beginning with FY 2014. Staff will reconcile and conduct a peer review of student eligibility and enrollment updates provided by the Department of Education prior to the final

allocation of awards to LEAs. The Agency also developed a corrective action plan related to the questioned cost, which was discussed with the U.S. Department of Education. ISBE will be adjusting the allocations during the 2014 grant year to resolve the questioned costs identified during the audit.

12-51. 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.

Findings: ISBE did not monitor the cash needs of subrecipients of the School Improvement Grants Cluster to determine whether the time elapsing between the receipt and disbursement of funding was minimized.

ISBE passes through federal funding to Local Education Agencies (subrecipients) throughout the State to support education programs. During testwork, auditors noted ISBE provided advance funding (totaling $2,918,747) to two subrecipients of the School Improvement Grants Cluster. However, the advances were not fully expended by the subrecipients within 30 days of receipt.

In discussing these conditions with ISBE officials, they stated that the error identified in the testwork was a program year 2011 grant for the City of Chicago District 299 and Peoria District 150. These grants were issued in May 2011, prior to implementing the new cash management procedures on July 1, 2011.

Updated Response: Implemented. The Agency considers this finding resolved for fiscal year 2014. ISBE implemented a new cash management system on July 1, 2011 for all grants issued on or after this date. The new system resulted from a major policy decision that comprehensively changed the methodology for distributing Federal grant funds to local education agencies (LEAs) beginning in fiscal year 2012. LEAs no longer receive advance payments based on a pre-approved payment schedule but rather receive payments through a modified reimbursement method. LEAs are reimbursed as cumulative cash basis expenditures are reported. The "modified" option allows LEAs the ability to request a one month advance along with their cumulative cash basis expenditures. However, LEAs that exercise the one month advance are required to submit a cumulative monthly expenditure report that demonstrates the advance was expended before any further funds are requested.

12-52. The auditors recommend ISBE review its current process for reporting subaward information required by the Federal Funding Accountability and Transparency Act (FFATA) and consider any changes necessary to ensure all required subawards are properly submitted.

Findings: ISBE does not have an adequate process to ensure all subaward information is properly reported as required the Federal Funding Accountability and Transparency Act (FFATA).

During a review of ISBE's procedures to report subaward information required by FFATA, ISBE did not report 14 subawards made to subrecipients for Special Education Room and Board awards selected in testwork. Upon further review, ISBE did not report any of the Special Education Room and Board subawards made during FY12.

In discussing these conditions with ISBE officials, they stated that ISBE has met the reporting requirements for formula/entitlement programs; however, the Agency was unaware these requirements applied to Special Education Room and Board because it is a claim-based program.

Updated Response: Implemented. The Agency considers this finding resolved for fiscal year 2014. Room and Board awards are being reported to the Federal Funding Accountability and Transparency website as required.

RECOMMENDATIONS 53-56
Illinois Student Assistance Commission

12-53. The auditors recommend ISAC review its process to ensure that loan information is properly verified and reported to the National Student Loan Data System. (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.

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, noting four confirmations were returned "incorrect", three were returned to sender and one was not completed. For three loans of the four "incorrect" confirmations, the loans had been paid in full/consolidated; however, they were not updated within the guaranty system. For one of the loans of the four "incorrect" confirmations, the loan was canceled subsequent to fiscal year end, but before the confirmation request was sent, and the lender was unable to access the loan information.

In discussing these conditions with ISAC officials, they stated that 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 to verify unreported loans.

Response: Accepted. The following business processes will remain 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 regular 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 verification and

determination that the lender/servicer is diligently working unreported loan reports to reduce overall unreported loan rates.

12-54. The auditors recommend ISAC assign all defaulted loans to the U.S. Department of Education (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. (Repeated-2010)

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

ISAC is required to assign all defaulted loans that meet certain criteria as of April 15th of each year to the USDE. During the audit of the Federal Family Education Loan Program, auditors noted there were approximately 5,820 defaulted loans that meet these criteria as of July 17, 2012 that should have been assigned to the USDE but were not. Management indicated the Department of Education has put a moratorium on the subrogation of loans starting in December 2011. As such, ISAC has not subrogated any loans since December.

Response: ISAC believes that if the moratorium on assignment of loans to the U.S. Department of Education had not been in place, all eligible loans could have been assigned. During the period of the moratorium, ISAC revised its procedures to help ensure that more loans would pass USDE's assignment edits. Therefore, ISAC should be able to fulfill the number of loans due to be assigned to USDE for the coming fiscal year, assuming the U.S. Department of Education does not put a new moratorium in place.

It should be noted that the number of loans that are eligible to be assigned to USDE changes daily as loans reach the criteria for assignment eligibility. Therefore, there will always be loans that are waiting to be assigned.

Updated Response: Implemented.

12-55. The auditors recommend ISAC review its process of monitoring the investing activities of funds transferred in the Federal Fund to ensure such funds are invested in approved securities or securities that comply with program regulations. (Repeated-2011)

Findings: ISAC invests funds held in the Federal Fund in an investment pool which contains securities that do not comply with regulations for the Federal Family Education Loans program.

During testwork, auditors noted that funds are invested in securities that are not guaranteed by the United States, not guaranteed by a State, nor approved by the USDE as required by the federal regulations. Further, ISAC does not monitor the investing activities of the investment pool to ensure funds are invested in approved securities or obtain the appropriate approval for such investments.

For the year ended June 30, 2012, the investment pool's $5,822,884,000 portfolio of investments contained $3,150,026,000 of bank repurchase agreements, and $1,759,786,000 of corporate commercial paper investments that did not comply with program regulations.

In discussing these conditions with ISAC officials, they stated that as a state agency, ISAC is required to invest its funds with the State Treasurer's Office and therefore, does not have an ability to select or monitor the investments in the pool.

Response: Accepted. ISAC requested a waiver from the U.S. Department of Education on June 28, 2012, to allow for investment in the State of Illinois pooled investments maintained by the Illinois State Treasurer. We followed up with them on April 23, 2013 and are waiting for their response.

12-56. The auditors recommend ISAC review its procedures and implement any necessary changes to ensure loan records are accurately updated in accordance with program requirements.

Findings: ISAC did not accurately update borrower records within required timeframes which is within ten business days of receipt.

During testwork over a sample of 40 payments applied to borrower accounts, the auditors noted one payment sampled was posted to the wrong borrower's account. In addition, during testwork over 40 borrower repayment status changes, loan records for one borrower were not updated within 10 days of receipt. Specifically, the borrower's records were updated 28 days after ISAC was notified of the change.

In discussing these conditions with ISAC officials, they stated that these issues on these two accounts were due to human error.

Response: ISAC follows regulations to ensure that bankruptcy proof of claim information is entered timely upon receipt of documentation. Staff has been thoroughly trained and the process is closely monitored by management.

Regarding the item manually posted to the wrong account, processes have been put in place to ensure all manual postings are reviewed the day after posting, and if any errors are detected they are corrected immediately. It should be noted that the vast majority (over 96%) of payment postings are automated and are not subject to a manual process.

Updated Response: Implemented.

RECOMMENDATIONS 57-61
Illinois Department of Employment Security

12-57. The auditors recommend IDES implement procedures to ensure documentation to support key line items can be provided from the DART system for the ETA 9002D and the VETS 200C performance reports.

Findings: Sufficient documentation was not available to support information reported in the ETA 9002D and the VETS 200C performance reports.

Auditors are required by the OMB Circular A-133 compliance supplement to test key line items in these reports; however, complete information supporting the accumulation of average earnings data in these key line items (line 13 of the ETA 9002D report and line 26 of the VETS 200C report) by the DART reporting system was not available for testing.

In discussing this with IDES personnel, they stated the missing data was from the WRIS database which is managed by the federal government and they do not have any control over the availability of the data.

Response: Accepted. As the WRIS database from which these reports are partially compiled is managed by the federal government, IDES has no control over the information retained in this system. The information the auditors requested dated back to the 3rd quarter of 2010. This data had already been purged from the WRIS database. However, in the future, IDES will save the data request file to keep a snapshot of the WRIS data at the time it is requested so it will be available for the auditors if the actual source data from the WRIS database is no longer available.

12-58. The auditors recommend IDES follow established procedures to ensure the automated stop is generated for all invalid social security numbers to prevent payment of benefits to ineligible claimants. (Repeated-2009)

Findings: IDES does not have adequate procedures to follow up on invalid social security numbers for claimants of the Unemployment Insurance (UI) 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 six did not have a hold flag placed on the account and do not appear to have been investigated by IDES. Total benefits paid to these six claimants were $22,192 during the year ended June 30, 2012.

In discussing these conditions with IDES officials, they stated that on one or more occasions, the invalid social security number report may not have been properly generated, picked up from the print room, disseminated to the Service Delivery staff, and/or these issues may not have been entered into the IBIS system.

Response: Accepted. IDES went live with real-time social security number validation via the Social Security Administration in December 2012. As part of this process, when a claimant's social security number does not match their name, an issue is posted in IBIS, which stops any payments from being established for a new UI claimant.

12-59. The auditors recommend IDES implement procedures to ensure policies and procedures are adequately documented and followed. In addition, segregate the duties for developing and migrating program changes and perform user access reviews for IBIS and the data center. (Repeated-2011)

Findings: IDES does not have adequate documentation of the performance of access, program change, and computer operation controls over the information systems that support the Unemployment Insurance (UI) Program.

The IBIS is the centrally maintained information system designed to perform and document claimant eligibility determinations, to process claims for unemployment insurance benefits, and to assist IDES in complying with the requirements of the UI Act rules, policies, and procedures applicable to the UI benefits.

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

- Certain individuals have the ability to modify production code and data, as well as, the ability to migrate changes into production. As a result, these individuals may introduce unintentional changes into production that may not be detected.
- Of 25 new users selected for testwork, the UserID request form for one user was not signed by the employee. This user's signature evidences the user's understanding of and agreement to follow IDES' policies relative to computer data, resource usage, passwords, and confidentiality.
- Of 9 employees granted physical access to information system equipment (total population), IDES could not locate the request form for one user. Further, the request forms were not properly completed for two employees.
- Of 107 sampled users with access to the mainframe system, one user had inappropriate access rights based on his job description and two terminated employees still had active accounts. Additionally, there were eight generic user accounts not specifically assigned to an employee.
- Of the 30 system backup files created by IDES during the year and selected for testwork, one backup file could not be located.
- Formal policies and procedures related to identifying, reporting, and resolving system security breaches and related incidences have not been developed.
- Formal policies and procedures related to change management have not been developed for IBIS.
- Data recovery testing was not performed during the year ended June 30, 2012.

In discussing these conditions with IDES officials, they stated that the unsigned form was an oversight. IDES does not have control over the CCF facility, change management procedures have been developed, but have not been formalized, and the CMS alternate data center was not equipped to conduct a full disaster recovery test.

Response: Bullet 1: We disagree with this finding. IDES developers currently do not have access to modify production code and data, nor the ability to migrate these changes into production. Based on the documentation provided by auditors, they identified our two Library Version Control unit staff as the individuals who have the ability to modify production code and data and migrate these changes into production. These individuals are not developers and without access to the group datasets, they would not be able to promote various components to production, nor would they be able to create new development environments which the developers use to segregate their concurrent changes.

Bullet 2: We accept this finding. IDES policy dictates that in order to receive RACF access needed for testwork, a RACF UserID request form (TSS-100) must be completed, signed by the user, and reviewed by their cost center manager before our Technical Support and Security staff will grant the user access. In this instance, however, it does appear RACF access was granted despite the fact that the user's signature was missing from the RACF UserID request. IDES will update our policy to clarify that unsigned RACF UserID requests will not be processed but instead returned to the cost center manager.

Bullet 3: Based on the data provided by the auditors, this finding relates to access to the CCF facility in Springfield, IL that is managed by the Department of Central Management Services. IDES has no control or management oversight over this facility or physical access to this facility. IDES will, however, work with CMS to try and address this issue.

Bullet 4: Based on the data provided by the auditors, this finding relates to RACF access for Department of Central Management Services BCCS staff located in Springfield, IL. IDES has no

control or management oversight over the BCCS staff or their RACF access rights. IDES will, however, work with CMS to try and address this issue.

Bullet 5: Based on the data provided by the auditors, this finding relates to backups conducted at the CCF facility in Springfield, IL that is managed by the Department of Central Management Services. IDES has no control or management oversight over this facility or the system backup files managed by the CMS BCCS staff. IDES will, however, work with CMS to try and address this issue.

Bullet 6: Based on the data provided by the auditors, this finding relates to security breach procedures for the Department of Central Management Services BCCS staff. IDES has no control or management oversight over the BCCS staff or their policy and procedures for identifying, reporting and resolving system security breaches. IDES will, however, work with CMS to try and address this issue.

Bullet 7: We accept this finding. Over the past year IDES' new Quality Assurance (QA) unit in ISD hired a Quality Assurance Supervisor and additional Benefits Business Analyst. Additionally, this team hired four Subject Matter Experts who are specifically tasked with meeting with the business end users to create Scope of Work documentation, assist with Business Analysts with the creation of Functional Business Requirements and participate with the Quality Assurance unit in User Acceptance Testing. Now that we have been using this change management process for several months and several projects across business areas, IDES will officially formalize our IT change management procedures and properly update the IDES Policy and Procedures to reflect these new requirements.

Bullet 8: IDES is currently working with the Department of Central Management Services to build out a warm alternate disaster recovery site at the State's alternate data center.

Auditors' Comment: The results of our testing identified the exceptions noted above existed during the period from July 1, 2011 through June 30, 2012. We are not required to and have not performed procedures to determine if conditions identified in this finding have been corrected subsequent to June 30, 2012.

12-60. 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. (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.

During testwork auditors noted policies and procedures had not been established relative to the review process and retention time period for the reports identified.

Auditors conducted unannounced site visits to five 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 30 reports and noted that resolution of exceptions and supervisory review was not consistently documented.

Additionally, during on-site reviews, auditors noted IDES only retains claim exception and monitoring reports for a period of three months after the end of a quarter. As such, auditors were unable to determine whether claim exception and monitoring reports had been worked within three business days or subject to supervisory review prior to April 1, 2012.

In discussing these conditions with IDES officials, they stated that the procedures require the reports be reviewed and in some cases were not being properly documented due to lack of understanding of the procedure.

Response: Some reports no longer require manual review with the enhancements made with the launch of the IBIS system and those procedures will be revised or automated.

IDES has amended the procedures for the *Certification Batch Reconciliation Report* to append the report to each day's paper certifications and file them. The TRA *modified WBA/DC Report* has been centralized to ensure compliance and ease of tracing. The *Post Office Box Comments Report* procedure has been deleted as the utility for verifying the Post Office Box has diminished since all payments are made electronically.

The *Appeals Requiring Local Action Report* and the *Determination End Date Report* have been determined to become automated IBIS tasks that can be tracked systematically and the procedure will then be eliminated to require review of the paper report. In the interim, IDES will reinforce the current procedures for these reports and ensure that they are reviewed, signed, and kept in the local office.

12-61. The auditors recommend IDES continue working with USDOL 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 – Employment and Training Administration 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. Prior to April 23, 2012, 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 new benefit year. Effective April 23, 2012, IDES implemented procedures to access the State Identification Subsystem (SID) to verify out-of-state wages beginning with the quarter ended June 30, 2012.

In discussing these conditions with IDES officials, they stated that they were exploring a viable option but it continued to remain elusive.

Updated Response: Implemented.

RECOMMENDATIONS 62-63
Department of Commerce and Economic Opportunity

12-62. The auditors recommend DCEO establish procedures to follow up on on-site monitoring findings to verify corrective actions are being implemented by subrecipients prior to reimbursing program expenditures and monitoring reports are accurately prepared in a timely manner. Also, implement procedures to ensure supervisory reviews of fiscal on-site monitoring reviews are adequately documented. (Repeated-2011)

Findings: DCEO did not have an adequate process in place for communicating and following up on monitoring findings for subrecipients of the Workforce Investment Act Cluster (WIA Cluster), Weatherization Assistance for Low Income Persons (Weatherization), and Low-Income Home Energy Assistance Program (LIHEAP) programs.

During review of monitoring reports and checklists prepared for on-site reviews conducted for 16 Weatherization subrecipients (with expenditures of $32,962,430), 16 LIHEAP subrecipients (with expenditures of $90,410,763), and 12 WIA Cluster subrecipients (with expenditures of $44,788,749) during the respective grant periods, auditors noted DCEO identified and reported several instances of non-compliance with program requirements to its subrecipients. Findings identified in monitoring reports included items such as: (1) failing to refund amounts received in excess of program expenditures, (2) failing to ensure contractor costs were reasonable, and (3) failure to provide required analyses. Upon further review of the monitoring files, auditors noted the following:

- DCEO had not performed procedures to ensure timely corrective action was taken by thirteen subrecipients of the LIHEAP programs prior to reimbursing program expenditures and, as a result, unallowable costs may have been paid to subrecipients during the year ended June 30, 2012. Amounts passed through to these subrecipients under the LIHEAP program was $84,002,563.
- DCEO did not issue a monitoring report on on-site reviews of nine subrecipients of the WIA Cluster program and seven subrecipients of the LIHEAP program in a timely manner. The monitoring reports for these subrecipients were issued between 49 days and 267 days after the completion of the on-site reviews. Amounts passed through to these subrecipients were $31,613,429 and $18,440,379 under the WIA Cluster and LIHEAP programs, respectively.
- DCEO referenced inaccurate grant numbers in monitoring reports for five subrecipients of the Weatherization program and eight subrecipients of the LIHEAP program. Specifically, auditors noted that on-site monitoring reports for these subrecipients referenced grant award numbers from which the subrecipients did not receive or expend funding in the period covered by the review. Amounts passed through to these subrecipients were $9,400,771 and $19,741,320 and for the Weatherization and LIHEAP programs, respectively.
- DCEO did not document supervisory reviews performed for any of the twelve fiscal on-site monitoring reviews tested for subrecipients of the WIA Cluster program.

DCEO passed through approximately $140,952,000, $56,432,000, and $195,316,000 of federal funding to subrecipients of the WIA Cluster, Weatherization, and LIHEAP programs, respectively, during the year ended June 30, 2012.

In discussing these conditions with DCEO personnel, they stated that conditions identified in the finding were the result of limited staffing, human error, and unique situations that required extended time for completion of monitoring procedures.

Updated Response: Implemented.

12-63. The auditors recommend DCEO review its current procedures for monitoring SEP subrecipients to ensure monitoring tools adequately document the compliance requirements and fiscal/administrative controls being reviewed. Additionally, implement procedures to formally communicate the results of monitoring reviews in writing.

Findings: DCEO did not adequately document on-site monitoring procedures performed for subrecipients of the State Energy (SEP) program.

DCEO does not adequately document its performance of on-site monitoring procedures to review subrecipient compliance with programmatic requirements or the fiscal and administrative capabilities of any of its State Energy Program subrecipients. Specifically, auditors noted the checklist used for this program is highly summarized and does not adequately document the compliance requirements being reviewed of the procedures being performed. Auditors also noted the results of the review procedures are not formally communicated to subrecipients.

In discussing these conditions with DCEO personnel, they stated that on-site monitoring procedures for this program require two site visits, an initial visit and a final site visit, as grants are primarily for purchase and installation of equipment. Monitoring procedures include taking photographs of installed and operational equipment and reviewing records for equipment purchases and inventory as this verified the majority of grant activities. Program staff assumed the monitoring procedures were sufficient as the U.S. Department of Energy did monitor the program and found the program's monitoring procedures to be adequate.

Response: The Department accepts the recommendation and will review and modify on-site monitoring procedures and instruments for this program to adequately review and document compliance requirements for subrecipients. The Department will also implement procedures for this program to communicate the results of monitoring reviews in writing to subrecipients and implement follow-up procedures to ensure findings are properly tracked and adequately addressed by subrecipients.

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12-64. The auditors recommend IDOT develop formal policies and procedures to perform periodic on-site reviews and adequately document such reviews to ensure subrecipients are administering the federal program in accordance with the applicable laws and regulations. (Repeated-2005)

Findings: IDOT is not adequately performing and documenting on-site monitoring procedures for subrecipients receiving federal awards under the Airport Improvement Program. IDOT passed through approximately $36,808,000 to 36 subrecipients of the Airport Improvement program during the FY12 (non-ARRA funding).

During a review of four subrecipients who received approximately $2,359,000 and received an on-site review, auditors noted the standardized checklists were not utilized for two of the reviews conducted. Amounts passed through to these two subrecipients totaled approximately $1,983,000. Additionally, IDOT has not established criteria for determining which subrecipients will be subject to on-site monitoring procedures on an annual basis.

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 recommendation. IDOT, Division of Aeronautics (Division) has worked with the Office of Internal Audits to develop an acceptable procedure and checklist.

The Division has revised Design Section PPM 10.1 (4/24/2013) Local-let Construction Monitoring and Documentation to include audit determination provisions for monitoring/audit review of projects less than $500,000 in value. Projects in excess of $500,000 have mandatory requirement.

The Division has revised AER-50 (4/24/2013) Local Let Project Tracking Worksheet and Documentation to include Audit Determination Checklist, to be filed with each project, which assesses risk and explains the rationale for audit determinations.

Updated Response: Implemented. Finding cleared for FY13.

12-65. 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. (Repeated-2010)

Findings: IDOT did not retain documentation for construction projects in the Highway Planning and Construction Cluster (Highway Planning) program in accordance with federal regulations.

During testwork of 65 contractor payments (totaling approximately $45,514,000) and the related procurement files and other source documentation, auditors noted the following exceptions:

- The affidavit of availability could not be located for eight contractors (with sampled payments of $975,008).
- The summary of project costs approved by the chief accountant could not be located for three contractors (with sampled payments of $328,063).
- The approved invoice could not be located for one contractor payment totaling $405,000.
- The warrant and voucher could not be located for three contractors (with sampled payments of $328,063).

Auditors noted these projects were originally bid prior to FY06 and the information was purged in accordance with IDOT's record retention policy. However, federal regulations required records to be retained for three years after final payments and all other matters are closed.

In discussing these conditions with IDOT officials, they stated that the Department followed the approved retention requirements for the time period in which these contracts were processed.

Response: The Department agrees with the recommendation. It is IDOT's policy to prepare all construction projects according to federal regulations even if the contract will not be paid with federal funds. Occasionally, IDOT is allowed to convert non-federally funded contracts and reclaim federal funds for a portion of the work. At the time the contract work was performed, these contracts did not have federal funds. Last fiscal year, the Department was able to convert this group of contracts from state funded to federally funded and seek reimbursement from FHWA for the allowable costs. The Department is in the process of reviewing the current procedures to ensure all required documents are being properly retained.

Updated Response: Implemented. Finding cleared for FY13. The Department implemented a process where districts provide a list of projects to Project Control prior to destroying the records. Project Control verifies when/if the project has been final billed with FHWA and responds accordingly.

12-66. The auditors recommend IDOT establish procedures to ensure weekly payroll certifications are received prior to making payments to the contractors. (Repeated-2011)

Findings: IDOT did not obtain certified payrolls prior to making payments to contractors for the Highway Planning and Construction Cluster (Highway Planning) program.

During testwork of 56 contractor payments for regular construction projects (totaling approximately $45,514,000) and 9 contractor payments for advanced construction projects (totaling approximately $878,000), auditors noted the following:

- The certified payrolls for 7 contractor payments on regular construction projects (totaling approximately $7,892,000) were not received prior to payment, ranging from 5 to 19 days late.
- The certified payrolls for 30 contractor payments on regular construction projects (totaling approximately $20,439,000) were not date stamped, so auditors were unable to determine whether they were received prior to making payments to the contractors.
- The certified payrolls and statements of compliance for 5 contractor payments on advanced construction projects (totaling approximately $769,000) could not be located for testwork.
- The certified payrolls for 15 contractor payments on regular construction projects (totaling approximately $9,662,000) were not signed by either the Resident Engineer, documentation staff, or EEO personnel, so auditors were unable to determine whether the certified payroll was approved prior to making payments to the contractor.

Updated Response: Partially implemented. The Department discussed the issue at the Annual Construction/Materials meeting as planned. FHWA is currently conducting a process review to look at the Department's implementation of the prevailing wage laws (Federal and State law), which will include a review of the submission of certified payrolls. The process review is scheduled to conclude in December 2014.

12-67. The auditors recommend IDOT establish procedures to ensure that: (1) expenditures passed through to subrecipients per IDOT's records are reconciled to the schedule of expenditures of federal awards submitted in the subrecipients' OMB Circular A-133 audit reports, (2) follow up procedures are performed for all delinquent OMB Circular A-133 reports, (3) desk reviews are performed on a timely basis, and (4) management decisions are issued within six months after receipt of the subrecipients' OMB Circular A-133 audit reports. (Repeated-2002)

Findings: IDOT does not have an adequate process to review subrecipient OMB Circular A-133 reports.

During testwork of eleven subrecipients of the Airport Improvement Program with total expenditures of approximately $24,762,000, and 43 subrecipients of the Highway Planning program with total expenditures of approximately $118,231,000, auditors noted the following regarding the desk review process:

- The OMB Circular A-133 audit reports for three subrecipients of the Highway Planning program were not received and IDOT did not perform follow-up procedures to obtain the reports.
- The OMB Circular A-133 reports for two subrecipients of the Airport Improvement Program and four subrecipients of the Highway Planning program were received but had not been reviewed by IDOT as of January 23, 2013, the date of testwork. The days elapsed between the dates these reports were received and the date of testwork ranged from 220 to 502.
- IDOT did not issue a management decision related to findings reported by three subrecipients of the Highway Planning program and one subrecipient of the Airport Improvement Program.

In discussing these conditions with IDOT officials, they stated that the review and revision of current processes had begun, however completion and implementation was not possible until fiscal year 2013.

Updated Response: Implemented. The Department finalized and implemented the OMB A-133 Single Audit Review process manual in April 2013. All FY13 reviews were reviewed using revised procedures.

12-68. 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 the Highway Planning and Construction Cluster (Highway Planning) programs for the year ended June 30, 2012.

During testwork of 40 grant awards to 33 subrecipients who received approximately $27,487,000 of Airport Improvement Program funds and 40 grant awards to 31 subrecipients who received approximately $9,592,000 of Highway Planning funds, auditors noted the following:

- Eight grant award notices for the Airport Improvement Program and five grant award notices for the Highway Planning program did not communicate the need for an audit in accordance with OMB Circular A-133.
- Subrecipient expenditures under the federal programs for the year ended June 30, 2012 were as follows:
- Thirty-one grant award notices for the Airport Improvement Program and 33 grant award notices for the Highway Planning program included incorrect information regarding the need for an audit in accordance with OMB Circular A-133.
- One grant award notice for the Airport Improvement Program and five grant award notices for the Highway Planning 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, for the Highway Planning and Construction Program, all the local agency transactions listed had expenditures in FY12 but the original funding agreements were executed prior to the correction of the standard agreement forms. For the Airport Improvement Program, the Division of Aeronautics was not aware that the official document communicating the requirements to the subrecipients (i.e. Agency Agreement) still did not include the required language and the agreement was in need of updating.

Response: The Department agrees with the recommendation. For the Highway Planning and Construction Program, the Department implemented a revised version of the standard agreement in fiscal year 2010. All current standard agreement forms correctly notify the local agencies of the

Single Audit requirement and the CFDA number. The projects identified in this finding were initiated prior to full implementation of the revised agreement.

For the Airport Improvement Program, the Division of Aeronautics (Division) has worked with the Office of Internal Audits to develop an acceptable procedure to ensure all required information is properly communicated to its subrecipients and amended Agency Agreement language accordingly.

The Division has revised Aviation Systems and Programs Section PPM 7.1 Agency Agreement to add provisions for the development and utilization of the standardized Agency Agreement template.

Updated Response: Recommendation Partially Implemented. The Department is exploring a way to efficiently and effectively provide notice of the proper OMB A-133 Single Audit requirements to all open projects. In addition, we will notify all program areas of the proper forms and templates to be used in all new agreements.

12-69. The auditors recommend IDOT implement procedures to ensure all materials are tested in accordance with the sampling and testing program approved by the FHWA and retain documentation in accordance with federal regulations. (Repeated-2009)

Findings: IDOT did not test materials used for construction activities under the Highway Planning and Construction Cluster (Highway Planning) program in accordance with their approved sampling and testing program.
IDOT has developed a comprehensive sampling and testing program as documented in the Project Procedures Guide for Sampling Frequencies for Materials Testing and Inspection (the Guide) and the Manual for Materials Inspection (the Manual) that meets these requirements.

During testwork, auditors selected 65 materials from ongoing (open) construction projects and advanced construction projects and noted three instances where materials were accepted using a method of acceptance that was not in accordance with the Manual.

Additionally, one instance for material used on an advance construction project where the source documents for the material sampling could not be located and accordingly, auditors were unable to determine whether the proper method of testing was performed. This project was originally bid prior to fiscal year 2006 and the source documentation for materials sampling had been purged in accordance with IDOT's records retention policy.

In discussing these conditions with IDOT officials, they stated that the three occurrences of accepting materials using the wrong method of acceptance appear to be due to a lack of knowledge and/or an oversight. The instance that involves an irretrievable source document appears to be the case of a misplaced or lost document rather than a records retention issue. Other records from the same materials source for the same time period have been retained according to the current retention policy and are still available for review.

Updated Response: Implemented. In the Spring 2013 during each district's annual Project Implementation meeting, the Engineer of Materials & Physical Research encouraged construction and materials staff to obtain the proper Evidence of Inspection for all materials used in IDOT projects. In additions, in Fall 2012, Spring 2013 and Summer 2013, the Manual for Materials Inspection was updated and republished to keep it up-to-date with current specifications and testing and documentation policies.

12-70. The auditors recommend IDOT implement procedures to ensure ARRA information and requirements are properly communicated to its subrecipients. (Repeated-2010)

Findings: IDOT did not communicate American Recovery and Reinvestment Act (ARRA) information and requirements to subrecipients of the Highway Planning and Construction Cluster (Highway Planning), the High Speed Rail Corridors and Intercity Passenger Rail Service – Capital Assistance Grants (High Speed Rail) program, and the Surface Transportation Discretionary Grants for Capital Investment (TIGER) program.

During testwork over five ARRA disbursements totaling approximately $1,489,000 to five subrecipients of the Highway Planning program, twelve ARRA disbursements totaling approximately $107,647,000 to one subrecipient of the High Speed Rail program, and fifteen ARRA disbursements totaling approximately $13,745,000 to two subrecipients of the TIGER 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 ARRA at the time of each disbursement. Additionally, IDOT's grant agreements for the Airport Improvement and the Highway Planning programs did not identify the requirement for their subrecipients to separately report ARRA program expenditures on the schedule of expenditures of federal awards (SEFA) and the data collection form.

In discussing these conditions with IDOT officials, they stated that appropriate staff has been made aware of the requirements and the information is now being provided. Corrective action was implemented in December 2011. As for the Surface Transportation Discretionary Grants for Capital Investment program subrecipients were not identified as such, therefore notifications were not properly communicated.

Response: The Department agrees with the recommendation. In December 2011, the Department implemented corrective action required to properly communicate ARRA information to subrecipients. For the Highway Planning and Construction Program, all instances of non-compliance were prior to this implementation date. For the High Speed Rail program, the Department will properly notify all subrecipients as required if the program has subrecipients in the future. For the Surface Transportation Discretionary Grants for Capital Investment, the corrective action implemented in December 2011 will correct the deficiencies for this program now that the subrecipients have been properly identified.

Updated Response: Implemented.

12-71. The auditors recommend IDOT implement procedures to ensure cash draws are performed in accordance with U.S. Treasury Regulations. (Repeated-2010)

Findings: IDOT does not have procedures to ensure cash draws are performed in accordance with the Treasury-State Agreement.

Annually, the State of Illinois negotiates the Treasury-State Agreement (TSA) with the U.S. Department of the Treasury (the Treasury) which details the funding techniques to be used for the draw down of federal funds. During a review of eighty (80) expenditures totaling approximately $36,648,000, auditors noted a warrant was issued for one expenditure voucher totaling approximately $10,227,856 in 22 days instead of three business days of receiving the federal funds intended to finance these expenditures as required.

In discussing this condition with Department officials, they stated that it was unclear why there was a significant delay between the time the payment was vouchered and the time it was warranted. The

Division of Aeronautics monitors when expenditures are vouchered in the FOA system to ensure the warrant is issued within the three business days of receiving the federal funds.

Response: The Department agrees with the recommendation. The Department worked with the Comptroller's Office to implement a "Cash Management Hold" process on August 9, 2012. This process releases the warrants upon receipt of the federal funds to ensure that when federal funds are deposited in a State account they are not held more than three days prior to the day the State makes a disbursement.

Updated Response: Implemented.

12-72. The auditors recommend IDOT review the process and procedures in place to prepare and submit ARRA 1512 reports to ensure amounts reported are accurate and reconcile to IDOT's financial records. (Repeated-2011)

Findings: IDOT did not accurately report expenditures in the quarterly ARRA 1512 report for the Highway Planning and Construction Cluster (Highway Planning) program.

During a review of 40 quarterly reports submitted during FY12, auditors noted one quarterly ARRA 1512 report erroneously reported expenditure amounts. Additionally, differences between the ARRA 1512 reports and IDOT's financial records were not investigated and resolved before the reports were submitted.

In discussing these conditions with IDOT officials, they stated that expenditures were being reconciled monthly and at project close-out. The discrepancy which was noted for the quarter ended December 31, 2011, was actually reconciled the following quarter, ended March 31, 2012. This was when the final reconciled report for this project was submitted, in accordance with this process.

Response: The Department agrees with the recommendation. The Department strives to ensure accuracy in its quarterly reporting by conducting a "Phase A" review and a "Phase B" review. The "Phase A" review verifies the accuracy of information being entered into the system on new projects. The "Phase B" review is a random sampling of all existing projects to verify job creation numbers and expenditure amounts.

In addition, all projects receive a final reconciliation at close out. Expenditure amounts, award amounts, and subaward amounts are verified at this time. If any discrepancies are found, adjustments are made before the final report is submitted.

The above process is the most efficient and effective utilization of State and project resources. It also ensures that all information is accurate before the project is finalized.

Updated Response: Implemented. Finding cleared for FY13.

12-73. The auditors recommend IDOT establish procedures to follow up on on-site monitoring findings to verify corrective actions have been implemented by subrecipients prior to reimbursing program expenditures. (Repeated-2011)

Findings: IDOT is not adequately performing and documenting on-site monitoring procedures for subrecipients receiving federal awards under the Highway Planning Construction Cluster (Highway Planning) program.

During a review of monitoring reports and checklists prepared for on-site programmatic reviews conducted for eight Highway Planning subrecipients (with expenditures of $7,956,210) during FY12, auditors noted IDOT identified and reported several instances of subrecipient non-compliance with program requirements, including specific IDOT construction policies and procedures. However, IDOT had not performed procedures to ensure subrecipients had taken timely corrective action on monitoring findings prior to reimbursing program expenditures. IDOT's current practice is to follow up on monitoring findings during its final on-site review at the conclusion of the construction project which may occur several months or years later.

In discussing these conditions with IDOT officials, they stated that corrective action of the prior year finding was not completed during FY12.

Response: The Department agrees with the recommendation. Upon being notified of this finding in the fiscal year 2011 Single Audit, the Joint Construction Progress Review Audit Finding Follow-Up Protocol [corrective action plan] was issued (July 1, 2012) and made effective for the coming fiscal year 2013 construction season.

Updated Response: Implemented. Finding cleared for FY13.

12-74. The auditors recommend IDOT implement procedures to monitor each compliance requirement administered by its for-profit subrecipient of the High Speed Rail Program. (Repeated-2011)

Findings: IDOT did not monitor all applicable compliance requirements for a subrecipient receiving funding under the High Speed Rail program.

IDOT received a grant for approximately $1.1 billion to construct and install the infrastructure necessary to operate high speed passenger rail service between Illinois and Missouri. The agreement between USDOT and IDOT specified a for-profit organization would assist IDOT in completing the construction and installation of the high speed rails. Although IDOT did not consider this entity a subrecipient, the organization is responsible for carrying out significant compliance requirements that normally would be carried out by the State relative to this program. Specifically, the for-profit organization (for-profit subrecipient) is responsible for: (1) designing and engineering the rails, (2) purchasing any materials required to construct and install the rails, (3) selecting and contracting with vendors to assist in constructing and installing the rails, and (4) purchasing real estate along the project route and paying relocation assistance, as necessary.

During testwork, auditors noted IDOT has implemented certain procedures to monitor its for-profit subrecipient, which include: reviewing supporting documentation relative to time and material charges incurred by the for-profit subrecipient and its subcontractors, inspecting materials used in the construction of the rails, and performing site visits to monitor the progress of on-going construction and installation activities. However, IDOT has not established procedures to monitor whether the for-profit subrecipient and its subcontractors have complied with the Davis-Bacon Act prevailing wage rate requirements or procured services relative to this project in accordance with the Illinois Procurement Code.

Amounts passed through under the High Speed Rail program to IDOT's for-profit subrecipient during the year ended June 30, 2012 totaled $113,687,000.

In discussing these conditions with IDOT officials, they stated that the for-profit entity referenced was properly classified as a vendor, not a subrecipient. The Federal Rail Administration provided guidance during the initial phases of the program and supports this determination.

Response: The Department partially agrees with the finding. The Department is committed to monitoring the vendors for the High Speed Rail Program. We are coordinating our efforts with our Federal funding agency for the project, the Federal Railroad Administration (FRA), to ensure we are meeting their expectations and requirements for the program. The FRA considers the for-profit railroad in question to be a vendor and not a subrecipient. The High Speed Rail Program currently has no subrecipients but we are working on developing subrecipient monitoring protocols in the event of funds being passed through to any typical local agencies who could meet the definition of a subrecipient for this project. We have participated in teleconferences with the FRA and the auditors whereby FRA leadership explained in great detail their determination that they consider the railroad in question to be a vendor and not a subrecipient. The FRA Office of Chief Counsel will be providing a letter to us for the auditors' use, again stating their position that the railroad in question is a vendor and not a subrecipient.

As noted, the Department is committed to properly monitoring the for-profit vendor; however, the auditors are applying criteria applicable to the monitoring of subrecipients as provided in the Compliance Supplement to OMB Circular A-133 and as noted, we and the FRA have concluded that the for-profit railroad is not a subrecipient and subrecipient monitoring is not applicable. This is what precipitates our partial agreement with the finding, and not unwillingness to properly monitor our vendors.

The FRA has graciously worked with us and state they will provide for the auditors a formal letter memorializing the FRA's determination that the railroad in question is considered a vendor and not a subrecipient.

Auditors' Comment: As stated in the finding above, in our judgment, the for-profit entity receiving the High Speed Rail program funding is a subrecipient of IDOT because it is responsible for making programmatic decisions on IDOT's behalf and carrying out significant compliance requirements that normally would have been performed by IDOT. While we agree that the Federal Railroad Admnistration has stated that the for-profit entity referenced in this finding is a vendor, the formal finding resolution letter has not been issued and other documentation provided by IDOT from the Single Audit Coordinator appears to sustain the prior year finding.

Updated Response: Accepted. Finding cleared for FY13.

12-75. The auditors recommend IDOT review the process and procedures in place to prepare financial reports required for the High Speed Rail Program and implement the additional procedures necessary to ensure the reports are complete and accurate. (Repeated-2011)

Findings: IDOT did not prepare accurate financial reports for the High Speed Rail program.

During testwork over two financial status (SF-425) reports and two ARRA 1512 reports, auditors noted IDOT improperly reported required financial information as follows:

Report	Period Ending	Report Line Item	Amount Reported	Actual Amount	Difference

SF-425	9/30/11	10(a) Cash Receipts	$96,153,384	$85,563,489	$10,589,895
SF-425	3/31/12	10(a) Cash Receipts	$192,254,367	$194,860,030	($2,605,663)
ARRA 1512	9/30/11	Funds Invoiced/Received	$96,153,384	$85,563,489	$10,589,895

Although IDOT indicated federal expenditures on the SF-425 and ARRA 1512 reports were reported using the accrual basis of accounting, the expenditure amounts reflected the best available data at the time the report was prepared, and did not include estimates through the end of the reporting period. Additionally, IDOT did not have a process in place to review the submitted reports and determine if there are any material differences that would require the report to be corrected. IDOT was unable to quantify the amounts that should have been reported on the accrual basis of accounting.

In discussing these conditions with IDOT officials, they stated the issue noted was the result of human error.

Response: The Department agrees with the recommendation. This issue was discovered by the FRA and relayed to the Department's Project Management (PMC) reporting team November 1, 2012. The discovery was a result of two (2) new electronic reporting systems now being utilized by FRA. The FRA indicated that correction should take place from the discovery point forward and past reports were not to be corrected. The Department's PMC provided the correspondences with the FRA which indicated their notification. The corrective action was taken prior to the audit.

Updated Response: Implemented.

12-76. 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, 2012, IDOT received approximately $723,000 in advance funding under the Homeland Security Cluster program. 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 corrective action was implemented in March 2012.

Response: The Department agrees with the recommendation. The prior year corrective action of implementing a new procedure when requesting reimbursement funds has been developed to coincide with the drawdown of Federal funds for this appropriation. This approach will ensure the processing of Homeland Security invoices are paid to the vendor, and reimbursement deposited thereafter. This procedure was implemented March 1, 2012.

Updated Response: Implemented. Finding cleared for FY13.

12-77. The auditors recommend IDOT implement procedures to monitor each compliance requirement administered by its for-profit subrecipients of the TIGER program.

Findings: IDOT did not monitor all applicable compliance requirements for subrecipients receiving funding under the Surface Transportation Discretionary Grants for Capital Investment (TIGER) program.

IDOT received a grant for approximately $100 million to install new traffic control systems, construct a new rail bridge, and make other significant improvements to signals, switches, roadways, sidewalks and other components which will provide substantial congestion relief and safety benefits for the passenger rail and highway systems in Illinois. The agreement between USDOT and IDOT specified that two for-profit first-tier subgrantees or subrecipients would assist IDOT in completing the grant activities. Although IDOT did not consider these entities to be subrecipients, these for-profit organizations are responsible for carrying out significant compliance requirements that normally would be carried out by the State relative to this program. Specifically, the for-profit organizations (for-profit subrecipients) are responsible for: (1) completing the installation or construction activities as defined in each project agreement, (2) purchasing any materials required to complete the projects and complying with the Buy American provisions, (3) selecting and contracting with subcontractors to assist in the construction activities, (4) collecting the required certified payrolls in accordance with the Davis-Bacon Act, and (5) providing quarterly reporting as required by the grant agreement.

During testwork, auditors noted IDOT has implemented certain procedures to monitor its for-profit subrecipients, which include reviewing supporting documentation relative to time and material charges incurred by the for-profit subrecipients and its subcontractors and performing site visits to monitor the progress of on-going construction and installation activities. However, IDOT has not established procedures to monitor whether the for-profit subrecipients and their subcontractors have: (1) complied with the Buy American provisions when purchasing materials, (2) procured services relative to the projects in accordance with the Illinois Procurement Code, and (3) complied with Davis-Bacon Act prevailing wage rate requirements. Additionally, IDOT has not established procedures to monitor the accuracy of the financial and other data reported by these organizations which is used by IDOT to prepare reports filed with USDOT.

Amounts passed through under the TIGER program to IDOT's for-profit subrecipients during the year ended June 30, 2012 approximated $32,330,000.

In discussing these conditions with IDOT officials, they stated that due to staff turnover, compliance requirements were not fully implemented as required.

Response: The Department agrees with the recommendation. Procedures to better monitor the federal compliance requirements applicable to its subrecipients will be implemented. The Department will first review the procedures in place for federal grant compliance for TIGER I projects and work with the appropriate railroad CREATE partners to ensure there is a mutual understanding of those federal compliance requirements and any other regulations or stipulations as stated in the TIGER I grant agreement. The Department then will implement new procedures to monitor Sub-recipients more closely to ensure both The Department and its Sub-recipients are fully compliant with the TIGER I agreement and OMB Circular A-133.

Updated Response: Partially implemented. A formal documentation procedure is being developed for implementation for current and future TIGER projects.

12-78. The auditors recommend IDOT review the process and procedures in place to prepare financial reports required for the TIGER program and implement the

additional procedures necessary to ensure the reports agree or reconcile to its financial records.

Findings: IDOT did not prepare accurate financial reports for the Surface Transportation Discretionary Grants for Capital Investment (TIGER) program.

During testwork of two SF-425 reports and fourteen ARRA 1512 reports, auditors noted IDOT did not prepare the reports based upon its financial records. Additionally, IDOT could not demonstrate how the information reported agreed or reconciled to its financial records.
In discussing these conditions with IDOT officials, they stated that due to staff turnover, reporting requirements were not fully communicated in order to accurately complete the necessary forms.

Response: The Department agrees with the recommendation. Since multiple sources of reporting information are used for the three federal quarterly reports required for TIGER projects, the Department agrees to review the process and procedures in place to prepare the financial reports, and develop and implement additional quality assurance/quality control measures within that process to ensure consistently accurate financial and project information is being reported quarterly to the federal government.

Updated Response: Implemented.

12-79. The auditors recommend IDOT establish procedures to ensure required weekly payroll certifications are received and reviewed prior to making payments to the contractors.

Findings: IDOT does not have adequate procedures to document required certified payrolls are obtained prior to making payments to contractors for the Surface Transportation Discretionary Grants for Capital Investment (TIGER) program.

During testwork of three contractor payments (totaling approximately $3,040,000) for regular construction projects, auditors noted IDOT initially indicated certified payrolls were not collected and were not available for any TIGER contractor payments. Several months after testwork was performed, IDOT located the certified payrolls for the three contractor payments; however, IDOT did not document the date the certifications were received, so auditors were unable to determine if the certifications were received and reviewed by IDOT personnel prior to making payments to the contractors.

Payments made for construction contracts under the TIGER program were approximately $5,083,000 during the year ended June 30, 2012.

In discussing these conditions with IDOT personnel, they stated that due to staff turnover, new staff was unfamiliar with processes in place for gathering certified payrolls thereby creating confusion as to whether the payrolls had been collected.

Updated Response: Partially Implemented. The Department has implemented procedures in place to require contractors to submit certified payroll documentations on a weekly basis to IDOT EEO Contract Compliance Officer for review prior to issuance of payments. In addition, the construction manager has project managers/inspectors performing regular site-visits, coordinates with the on-site resident engineer and confirms which contractors are currently performing services at the construction site to ensure payrolls are appropriate to the services performed. A formal review

process is currently being developed to better document the certified payroll process with IDOT EEO for TIGER grant projects.

12-80. The auditors recommend IDOT establish procedures to ensure grantees receiving individual awards for $25,000 or more certify that their organization is not suspended or debarred or otherwise excluded from participation in Federal assistance program.

Findings: IDOT did not obtain required certifications that subrecipients were not suspended or debarred from participation in federal assistance programs for the Surface Transportation Discretionary Grants for Capital Investment (TIGER) program.

During a review of five grant agreement notifications to two subrecipients of the TIGER program (with expenditures totaling approximately $32,330,000), auditors noted IDOT did not include a suspension and debarment certification in four of the grant agreements with expenditures totaling approximately $22,060,000.

In discussing these conditions with IDOT officials, they stated that it was confirmed that procedures are in place to ensure that subrecipients are not suspended or debarred, however the process was not being documented.

Response: The Department agrees with the recommendation. The Department confirmed that procedures were being followed to ensure that subrecipients are not suspended or debarred. References to and documentation of these procedures will be included in the State Rail Agreements and/or the Phase III document as well as specifications for the railroads to check for suspended and debarred subrecipients.

Updated Response: Implemented.

12-81. The auditors recommend IDOT establish procedures to accurately report federal expenditures used to prepare the Schedule of Expenditures of Federal Awards (SEFA) to the Illinois Office of the Comptroller. (Repeated-2011)

Findings: IDOT did not accurately report Federal expenditures under the Airport Improvement Program, the Highway Planning and Construction Cluster (Highway Planning) program, and the High Speed Rail program.

IDOT inaccurately reported federal expenditures which were used to prepare the schedule of expenditures of federal awards (SEFA) to the Illinois Office of the Comptroller (IOC). Adjustments were subsequently made after these differences were identified during the audit to accurately report federal expenditures in the SEFA.

	Federal Expenditures Reported on the SEFA	Federal Expenditures Reported on the Expenditure Pattern	Difference
Airport Improvement Program	$ 77,830,000	$ 76,808,000	$ 1,022,000
Airport Improvement Program - ARRA	(263,000)	434,000	(697,000)
Highway Planning Program	1,449,598,000	1,421,003,000	28,595,000
Highway Planning Program - ARRA	75,337,000	75,607,000	(270,000)
High-Speed Rail - ARRA	125,635,000	143,301,000	(17,666,000)

In discussing this with IDOT officials, they stated the discrepancies are due to audit adjustments made in the Department financial records but not in the GAAP packages reported to the IOC.

Response: The Department agrees with the recommendation. The Department has added additional staff to the business unit responsible for the financial reporting. This will allow for the implementation of quality control procedures along with the review and revision of current financial reporting procedures.

Updated Response: Implemented.

12-82. The auditors recommend IDOT implement procedures to ensure all information systems are adequately secured and to generate a list of program changes from the information systems and applications.

Findings: IDOT does not have adequate program change management controls over the IDOT Integrated Transportation Project Management system.

During testwork over changes made to IDOT's information systems, auditors noted IDOT was not able to generate a list of changes made to its information systems from each respective information system or application. IDOT's current procedures include tracking changes made to its information systems in a database; however, the information input into the database is based on manual change request forms, so auditors were unable to determine whether the list of changes provided by IDOT from the database was complete.

In discussing these conditions with IDOT officials, they stated once IDOT submits an Action Request (AR) to the Illinois Department of Central Management Services (DCMS) there was not a process in place to tie the IDOT AR number to the DCMS change number.

Response: The Department agrees with the recommendation. The Department has been in communication with DCMS regarding the ability to track the IDOT AR number to the DCMS change ticket number. The Department and DCMS have developed the following corrective action to remediate this finding. BIP will include the AR number when submitting the production change request to DCMS Library Support. Upon the move to production, DCMS will include the job name and number on the communication to IDOT upon the successful move of the change to production. IDOT will store this number in the Action Request form. This change in procedure will link the IDOT AR number and the DCMS change number. This change is targeted for implementation by May 16, 2013.

Updated Response: Implemented.

RECOMMENDATIONS 83-86
Illinois Emergency Management Agency

12-83. The auditors recommend IEMA establish procedures to ensure that: (1) follow up procedures are performed for all delinquent OMB Circular A-133 reports; (2) expenditures reported in Subrecipient A-133 audit reports are reconciled to IEMA's records; (3) desk reviews are performed on a timely basis for all subrecipients; and (4) management decisions are issued within required timeframes. Also, review A-133 Audit Desk Review checklist and make the changes necessary to ensure all review requirements are included. (Repeated-2010)

Findings: IEMA does not have an adequate process to review subrecipient OMB Circular A-133 reports.

During testwork of 40 subrecipients of the Disaster Grants – Public Assistance (Presidentially Declared Disasters) (Public Assistance) program and 40 subrecipients of the Homeland Security Grant program with total expenditures of $37,405,640 and $9,727,986, respectively, auditors noted the following:

- IEMA did not obtain the OMB Circular A-133 audit reports for 21 subrecipients of the Public Assistance program, and did not perform follow up procedures to obtain the reports. Amounts passed through to these subrecipients totaled $3,076,639 during the year ended June 30, 2012.
- IEMA did not complete a desk review checklist for one subrecipient of the Homeland Security Grant Program. Amounts passed through to this subrecipient totaled $8,538,686 during the year ended June 30, 2012.
- IEMA did not reconcile the federal expenditures reported in the schedule of expenditures of federal awards included in subrecipient A-133 audit reports to IEMA's records for any subrecipients of the Public Assistance program selected for testwork or for one subrecipient of the Homeland Security Grant program selected for testwork. Amounts passed through to the subrecipient of the Homeland Security Grant program totaled $7,437,042 during the year ended June 30, 2012.
- IEMA did not issue management decisions related to findings reported by one subrecipient of the Public Assistance program and two subrecipients of the Homeland Security Grant program. Amounts passed through to these subrecipients under the Public Assistance and Homeland Security Grant programs during the year ended June 30, 2012 totaled $77,003 and $15,975,728, respectively.

Additionally, the standard checklist used by IEMA to document the review of the A-133 reports did not contain sufficient documentation to determine whether the audit reports met all audit requirements of OMB Circular A-133 and whether Type A programs were audited every three years.

In discussing these conditions with IEMA officials, they stated the error is partially attributed to the continued vacancy of the agency's Compliance Officer during the state fiscal year. The position is responsible for management of sub-recipient monitoring activities, including A-133 reviews. Additionally, IEMA has been in the process of revising the internal protocol for the oversight of A-133 submissions, resulting in missed reviews.

Response: IEMA accepts the finding and is continuing to work on improving the process by creating a standard procedure and checklist for use for all grant programs. We are also attempting to identify funding and staffing that can focus on performing these functions.

12-84. 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, 2012, IEMA received $44,594,000 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 Agency personnel, they stated legislation was required in order to deposit funds in an interest bearing account. That legislation was introduced in the Spring Session of 2012 and the Governor signed into law in July 2012.

Updated Response: Implemented.

12-85. 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 review of 40 expenditures (totaling $2,607,795) funded under the advanced basis related to the Disaster Grants – Public Assistance (Presidentially Declared Disasters) program, auditors noted warrants were not issued for 30 expenditure vouchers, totaling $2,161,053 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 28 business days. Total expenditures for the Disaster Grants – Public Assistance (Presidentially Declared Disasters) program administered by IEMA were $57,987,000 during the year ended June 30, 2012.

In discussing these conditions with IEMA personnel, they stated IEMA continuously strives to minimize the number of days between draws and payment.

Response: IEMA accepts this finding. During this period, IEMA's accounts payable function was still housed at the Public Safety Shared Services Center. This results in another entity to try to coordinate timing with and could sometimes cause additional delays. This function has now been returned to the agency.

However, in the best case scenario, it is almost impossible to complete the process so that the time elapsed between the drawdown of funds and issuance of a warrant is 3 days or less. IEMA will continue to review our process for further efficiencies, however.

12-86. IEMA establish procedures to report required subaward information in accordance with FFATA.

Findings: IEMA does not have an adequate process to ensure all subaward information is properly reported as required by the Federal Funding Accountability and Transparency Act (FFATA) for awards granted to subrecipients of the Homeland Security Grant program.

During testwork, auditors noted IEMA did not report required FFATA information for five Homeland Security Program subawards which totaled $22,093,000 during the year ended June 30, 2012. Subawards made under the Homeland Security Grant programs subject to FFATA reporting requirements totaled approximately $73,359,000 for the year ended June 30, 2012.

In discussing these conditions with IEMA personnel, they stated IEMA proactively developed an internal system for collection of FFATA information for sub-grantees impacted by the federal reporting requirement. Because of the infancy of the federal reporting program, some subaward information was inadvertently omitted from the report.

Response: IEMA accepts the finding, however, we believe we have continually made a good faith effort to report all required data. We have developed procedures that ensure that future FFATA information reported is complete and accurate.

RECOMMENDATIONS 87-88
Illinois State Police

12-87. 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 Cluster program funds received in advance of issuing warrants into an interest-bearing account.

During the year ended June 30, 2012, State Police received $3,530,000 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 Agency personnel, they stated legislation was pursued to make the Federal Projects Fund an interest bearing account. This was passed and enacted in FY13.

Updated Response: Implemented.

12-88. The auditors recommend the State Police implement procedures to ensure its property records are accurate.

Findings: State Police did not consistently maintain accurate inventory records of equipment purchased with Homeland Security Cluster program funding.

During physical observation of 65 pieces of equipment (totaling $914,472) purchased with Homeland Security Grant Funds, auditors noted one item selected from the equipment inventory listing (with a cost value of $6,079) had been destroyed in a prior year, but had not been removed from the equipment inventory list. As of June 30, 2012, the cumulative cost value of equipment purchased by the State Police with Homeland Security Cluster program funding was $3,046,000.

In discussing these conditions with State Police personnel, they stated that the mobile data computer was destroyed in a vehicular crash. It was inadvertently omitted from the deletion sheet for the equipment involved.

Response: Agree. We have procedures for property management. Human oversight was the cause of one item not being deleted from inventory.

RECOMMENDATION 89
Environmental Protection Agency

12-89. The auditors recommend the IEPA establish procedures to ensure: (1) subrecipient A-133 audit reports are obtained and properly reviewed in a reasonable timeframe and (2) management decisions are issued for all findings affecting its federal programs in accordance with OMB Circular A-133. (Repeated-2010)

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

During testwork over OMB Circular A-133 desk review procedures performed for 17 subrecipients of the CWSRF program and 17 subrecipients of the DWSRF program who were required to submit OMB Circular A-133 audit reports during the year end June 30, 2012, auditors noted the following exceptions:

- The OMB Circular A-133 audit reports for one CWSRF subrecipient and one DWSRF subrecipient contained findings for which the IEPA did not issue management decisions.
- The OMB Circular A-133 audit report for one DWSRF subrecipient appears to have improperly excluded the DWSRF program from the list of major programs in the schedule of findings and questioned costs. Auditors noted no follow up procedures were performed by IEPA to determine if the major program determination was properly performed.
- The OMB Circular A-133 audit report for one CWSRF subrecipient appears to have reported an inaccurate CFDA number for CWSRF funding passed through from the IEPA. Auditors noted no follow up procedures were performed by IEPA relative to this discrepancy.
- The A-133 desk review checklists for two CWSRF subrecipients were not properly completed by the IEPA.

In addition, auditors noted an A-133 audit report was not obtained for one of the 17 DWSRF subrecipients selected for testwork. Upon further review of all 78 subrecipients required to submit A-133 audits to IEPA during the year ended June 30, 2012, auditors noted the following:

- A-133 audit report desk reviews were not performed for seven subrecipients of the DWSRF program and seven subrecipients of the CWSRF program.
- A-133 audit reports were not obtained for one subrecipient of the DWSRF program as of the date of testwork. There was no evidence that additional follow-up procedures were performed by IEPA to obtain the missing report.

In discussing these conditions with IEPA officials, they stated these conditions were due to oversight and differing interpretations as to when a management letter was necessary.

Updated Response: Implemented.

RECOMMENDATION 90
Governor's Office of Management and Budget

12-90. The auditors recommend the State establish procedures to ensure the TSA is amended for any necessary changes in accordance with federal regulations. (Repeated-2010)

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

During the audit, auditors noted the High Speed Rail Corridors and Intercity Passenger Rail Service – Capital Assistance Grants, Title I Grants to Local Educational Agencies, Recovery Act, Special Education Grants to States, Recovery Act, and Education Jobs Fund programs were expected to exceed the $85,262,000 program expenditure threshold in FY12 based on amounts awarded; however, the TSA was not amended to include these programs during FY12.

In discussing these conditions with GOMB personnel, they stated that they continue to work as part of the task force designing and/or obtaining and implementing a statewide financial reporting system that will address both this and many other issues raised by the State's Single Audit.

Response: GOMB agrees with the auditor's recommendation. We have updated the procedures previously adopted to increase communications with agencies concerning the importance of timely amending the TSA. A copy of those procedures is available upon request. Additionally, we have sought more training on proper CMIA compliance for the staff responsible for this process.

RECOMMENDATION 91
Illinois Criminal Justice Information Authority

12-91. The auditors recommend ICJIA establish procedures to ensure all subrecipients receiving federal funds have audits performed in accordance with OMB Circular A-133 and management decisions are issued where required.

Findings: ICJIA did not obtain or review all OMB Circular A-133 audit reports for subrecipients of the Justice Assistance Grant (JAG) Cluster program.

During review of 25 subrecipient monitoring files for the JAG Cluster program, auditors noted ICJIA had not obtained OMB Circular A-133 audit reports for 11 of the subrecipients selected for testwork. Auditors also noted ICJIA did not perform procedures to follow up with subrecipients that had not submitted audit reports. Upon further review of the audit reports obtained by ICJIA, auditors noted ICJIA did not perform a review of the A-133 reports for any of its subrecipients during FY12. ICJIA passed through approximately $12,068,000 to subrecipients of the JAG Cluster program during the year ended June 30, 2012.

In discussing these conditions with ICJIA officials, they stated that the conditions identified in the finding were the result of a lack of staffing.

Response: The A-133 audit reviews had previously been conducted by ICJIA's Internal Auditor. However, that position has been vacant since the previous incumbent retired at the end of 2011. The Chief Financial Officer left ICJIA in March of 2012. Due to budget constraints and hiring delays, there are currently three vacancies out of ten positions in ICJIA's Office of Fiscal Management. These vacancies have adversely impacted ICJIA's OFM ability to review A-133 audits.

During State FY12 ICJIA's practice was not to require that grantees submit the A-133 audit reports until the close of the grant period. We recognize now that was not in strict compliance with the A-133 Circular and its Supplements and will take corrective action. However, ICJIA did engage in oversight procedures that mitigated the deficiency. ICJIA did require grantees subject to A-133 audits to submit the financial statements prepared by the grantee's auditors during the course of the A-133 on a yearly basis. Those statements would have alerted ICJIA if the auditors found a deficiency in internal controls by the grantee. The financial statements were reviewed by ICJIA's Acting Chief Fiscal Officer either at the time of receipt or within the week in which they were received.

While some of the A-133 audits received during State FY12 were reviewed by ICJIA within State FY12, some were not reviewed until after the close of the State fiscal year. In accord with the recommendation, ICJIA will take immediate steps to make its procedures with regard to sub-recipient A-133 audits more stringent.