LEGISLATIVE AUDIT COMMISSION

Review of
Statewide Single Audit
Year Ended June 30, 2013

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REVIEW: 4424
STATEWIDE SINGLE AUDIT
YEAR ENDED JUNE 30, 2013

TOTAL FINDINGS/RECOMMENDATIONS - 74

TOTAL REPEATED RECOMMENDATIONS - 59

TOTAL PRIOR AUDIT FINDINGS/RECOMMENDATIONS - 91

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 FY13 Statewide Single Audit of federal funds. The Office of the Auditor General conducted a Statewide Single Audit of the FY13 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, 45 State agencies expended federal financial assistance in FY13. 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 $23.5 billion for the year ended June 30, 2013. This represents a $0.6 billion increase from FY12, or about 2.6%. Overall, the State participated in 420 different federal programs; however, 10 of these programs or program clusters accounted for approximately 83.1% ($19.5 billion) of the total federal award expenditures as exhibited in the following table.

Federal Program Award	Total Expenditure	% of Total
Medicaid	$ 8,262,000,000	35.1%
Unemployment Insurance	3,894,300,000	16.6%
Supplemental Nutrition	3,444,100,000	14.6%
Highway Planning, Construction	1,429,800,000	6.1%
Title 1	614,400,000	2.6%
TANF	613,800,000	2.6%
Special Education	513,100,000	2.2%
Children's Insurance Program	348,900,000	1.5%
WIC Special Supplemental	222,900,000	0.9%
Child Care Dev. Funds	212,200,000	0.9%
All Others	3,975,800,000	16.9%
Total Federal Awards	$ 23,531,300,000	

The funding for the 420 programs was provided by 23 different federal agencies. The table below shows the five federal agencies that provided Illinois with the vast majority of federal funding in FY13.

Federal Funding Agency	Total Grant	% of Total
Health & Human Services	$ 10,645,500,000	45.2%
Agriculture	4,421,900,000	18.8%
Labor	4,086,300,000	17.0%
Education	1,814,300,000	7.8%
Transportation	1,742,700,000	7.4%
All Others	820,600,000	3.4%

A total of 33 federal programs were identified as major programs in FY13. The 33 major programs had combined expenditures of $21.7 billion, and 387 non-major programs had combined expenditures of $1.7 billion. Eleven State agencies accounted for approximately 98.5% of all federal dollars spent in FY13 as depicted in the table below.

State Agency	Federal Expenditures	% of Total
DHFS	$ 8,423,500,000	35.8%
Human Services	5,204,000,000	22.1%
Employment Security	3,942,000,000	16.8%
Board of Education	2,132,800,000	9.1%
Transportation	1,737,000,000	7.4%
DCEO	513,900,000	2.2%
DCFS	396,200,000	1.7%
Public Health	237,900,000	1.0%
Student Assistance	213,400,000	0.9%
IEMA	178,900,000	0.8%
EPA	176,300,000	0.7%
All Others	375,400,000	1.5%

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

State Agency	Number of Findings	Repeat Findings
State Comptroller/Office of the Governor	1	1
Human Services	13	9
Healthcare and Family Services	8	7
DCFS	7	7

State Agency	Number of Findings	Repeat Findings
Aging	1	1
Public Health	6	5
State Board of Education	3	3
ISAC	4	3
Employment Security	6	4
Commerce & Economic Opportunity	3	1
Transportation	15	12
Emergency Management Agency	3	3
State Police	1	1
Criminal Justice Information Authority	1	1
GOMB	1	1
Central Management Services	1	0
TOTAL	74	59

RECOMMENDATION 1
Office of the Governor
Office of the Comptroller

13-01. 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 of accounting information provided to and maintained by the IOC as it relates to year end preparation of the SEFA. (Repeated-2002)

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. Reporting issues at various individual agencies caused delays in finalizing the Statewide Financial Statements and SEFA.

The IOC has made significant changes to the system used to compile financial information, however, the State has not solved all the problems to effectively remediate these financial reporting weaknesses. The process is overly dependent on the post-audit program being a part of the internal control over financial reporting even though the Illinois Office of the Auditor General has repeatedly informed State agency officials that the post-audit function is not and should not be an internal control mechanism for any operational activity related to financial reporting.

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 involved with this process are not under the organizational control or jurisdiction of the IOC. Further, these 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 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.

Certain SCO forms are used by the IOC to collect financial information utilized in the SEFA compilation and reporting process. Internal control deficiencies have been identified and reported relative to the SEFA financial reporting process in each of the past eleven years as a result of errors identified during the external audits performed on State agencies. These problems significantly impact the preparation and completion of the SEFA and the identification of major programs.

Errors identified in the SEFA reporting process in the current year include corrections and unreconciled amounts identified in agency level findings for the Illinois Department of Human Services, the Illinois Department of Employment Security, the Illinois Department of Commerce and Economic Opportunity, and the Illinois Department of Transportation. Additionally, other correcting entries were required in order to accurately state the financial information provided by various other State agencies.

Major programs at the Illinois Department on Aging, Illinois State Board of Education, and Illinois Department of Commerce and Economic Opportunity were not identified until several months after year end.

Although the deficiencies relative to the CAFR and SEFA financial reporting processes have been reported by the auditors for a number of years, problems continue with the State's ability to provide accurate and timely external financial reporting. Corrective action necessary to remediate these deficiencies continues to be problematic.

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. Although a disciplined statewide project to implement a new system is underway, until project completion, 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. Although the State has enacted legislation that exempts certain positions whose functions relate to accounting and financial reporting connected with the CAFR process, and although agencies are beginning to make use of this legislative provision, the needs for trained skilled staff remain.

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 accurate accumulation and reporting of financial information. 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.

Office of the Governor's Response:

The Governor's Office agrees with this recommendation. The Governor's Office and the Governor's Office of Management and Budget (GOMB) are and will continue to work cooperatively with the Office of the Comptroller to address these challenges with effective solutions.

Governor Quinn signed into law SB 3794 (now codified as Public Act #97-1055), an initiative of the Governor's Office, in order to create a statutory framework to begin to address the basic issues with the State's financial reporting capabilities. The legislation has several components. First it creates a Financial Reporting Standards Board ("Board") composed of appointees of the Governor and the Comptroller. The Board first convened in September of 2013 and has met roughly monthly since then. The Board will provide leadership and a forum for project management and collaboration going forward. Additionally, the bill modified the State's personnel code to allow accelerated and targeted hiring of highly skilled employees to perform financial reporting, accounting, and project management activities for the annual financial reporting cycle. These include personnel to help improve the speed of the current process as well as other professionals who will help to design and implement an overhaul of the technology and establish a unified statewide system.

The Governor's Office has notified agencies of this new provision and encouraged its responsible utilization. In addition, the Governor's Office and GOMB continue to work with agencies to hire employees skilled in financial statement and single audit preparation for positions that remain subject to the Personnel Code.

GOMB and the Governor's Office have been primarily responsible for developing a plan for a statewide financial accounting system. This statewide financial accounting system would also include a grants management module. The State Chief Information Officer, a team of Governor's Office and GOMB representatives has reviewed the information available from work by prior consultants. A Request for Proposals (RFP) for an enterprise resources planning (ERP) project management office (PMO) consultant was issued in October, 2013; a contract award pursuant to this solicitation was made and a notice of award published in 2014. This consultant will develop the necessary statewide accounting requirements and develop an RFP for software and implementation services to address the state's need. In addition, due to a September 2012 debt issuance of 10-year notes aimed at technology modernization, the State has allotted some capital money for this project. These resources will be a significant help in getting the project underway. With an ERP system in place, the State will be able to complete in a timely and accurate way the Schedule of Expenditure of Federal Awards (SEFA).

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.

IOC's Response:

The Office accepts the recommendation. The audit of the 2013 SEFA was completed approximately two months earlier than the audit of the 2012 SEFA. We will continue to assist the Governor's Office in their efforts to increase the quality of departmental financial reporting by providing technical assistance to State agencies and by working with them to develop a statewide financial accounting system.

RECOMMENDATIONS 2-14
Department of Human Services

13-02. 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: IDHS did not perform "eligibility redeterminations" for individuals receiving benefits under the Temporary Assistance for Needy Families (TANF) Cluster, Children's Health Insurance Program (CHIP), and Medicaid Cluster programs in accordance with timeframes required by the respective State Plans.

During testwork of required eligibility criteria, auditors noted the State was delinquent (overdue) in performing the eligibility redeterminations of individuals for the three programs as follows:

Program	Overdue cases/Total cases	% delinquent
TANF	5,017 of 49,603	10.11%
CHIP	62.210 of 755,727	8.23%
Medicaid	138,047 of 506,292	27.27%

Delays in performing redeterminations ranged from two to five months after the required timeframe.

In discussing these conditions with IDHS officials, they stated that the cause of the finding was an increasing number of overdue redeterminations due to the absorption of cases that would have previously been eligible for administrative renewal; start up issues and time spent on process development with Maximus; and the amount of time spent on staff development for new hires.

Updated Response: Implemented. A modified Illinois Medicaid Redetermination Project began 2/1/14. As of April, 2014, the central redetermination units began receiving and acting upon automated eligibility recommendations from the MAX-IL system. The finding is considered resolved.

13-03. 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 Supplemental Nutrition Assistance Program (SNAP) Cluster, Temporary Assistance for Needy Families (TANF) Cluster, Children's Health Insurance Program (CHIP), and the 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 IDHS 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 thirteen case records could not be located for testing.

In addition, during testwork over case files selected for the TANF Cluster, CHIP, and Medicaid Cluster programs, auditors noted a number of case files were provided several weeks past the original request date due to the fact that case files had been transferred between local offices and were not easily located by IDHS. Auditors also noted several missing eligibility case files.

Finally, IDHS could also not locate five TANF Cluster case files selected for testwork with respect to the child support noncooperation, adult custodial parent of child under six when child care not available, and penalty for refusal to work special tests and provisions.

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.

Updated Response: Accepted. As part of the phase 2 implementation of the new Integrated Eligibility System (IES) 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 local offices. IES enhances the paperless case file concept. The caseworker will have the ability to upload client documents and associate them with the application on which they are working. Staff will be able to view these documents in IES.

The new Illinois Medicaid Redetermination Project (IMRP) allows copies of all redetermination forms mailed to the customer, retuned redetermination forms, electronic data matching results, requests for missing information, and verifications provided by the client to be stored in Content Manager, reducing the need for error prone paper case filing. Maximus, as part of the IMRP process, has begun to send backlogged case information to Content Manager. Eventually, when the backlog is worked, redetermination information, including copies of all redetermination forms mailed to the customer, returned redetermination forms, electronic data matching results, requests for missing information, and verifications provided by the client will be sent to Content Manager on a daily basis.

This finding will repeat until all backlogs in the redetermination process are cleared and records are uploaded into Content Manager on a daily basis. Estimated Date of Resolution is 12/31/2015.

13-04. 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 Temporary Assistance for Needy Families (TANF) Cluster, Children's Health Insurance Program (CHIP) and the Medicaid Cluster programs.

During test work, auditors selected eligibility files to review for compliance with eligibility requirements and for the allowability of the related benefits provided. Auditors noted the following exceptions during testwork:

- In 16 TANF cases, IDHS could not locate the redetermination application completed and signed by the beneficiary.
- In eight TANF cases, IDHS could not locate the Responsibility Service Plan completed and signed by the beneficiary.
- In three TANF cases, IDHS could not provide evidence of eligibility, asset or income verification, identity, or assignment of rights to the State.
- In four TANF Penalty for Refusal to Work special test cases, IDHS could not provide evidence that IDHS verified the beneficiary's participation in program work activities.
- In one TANF Penalty for Refusal to Work special test case, IDHS could not provide evidence that IDHS notified the beneficiary of sanctions prior to reduction of payments.

- In six TANF Adult Custodial Parent of Child under Six When Child Care Not Available special test cases, IDHS could not provide evidence that IDHS notified the beneficiary of reconciliation appointment notices before payment sanctions were levied.
- In four CHIP and 14 Medicaid case files, IDHS could not locate the redetermination application completed and signed by the beneficiary.
- In 14 CHIP and three Medicaid case files, IDHS could not locate adequate documentation evidencing income and asset verification performed.
- In one CHIP and two Medicaid case files, IDHS could not locate adequate documentation of residence verification of the beneficiary.
- In three Medicaid case files, IDHS could not provide adequate documentation that the beneficiary assigned their right to collect medical benefit payments to the State of Illinois.
- In 10 Medicaid case files, IDHS could not provide adequate documentation for asset verification to determine whether the beneficiary was eligible for program benefits.

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

In discussing these conditions with IDHS officials, they stated the cause of the finding was due to misplaced documents.

Response: The Department agrees with the recommendation. We will continue to ensure staff understands the importance of proper and accurate filing processes. The Department is increasing the use of electronic document management systems that capture some of the information that has been traditionally printed and maintained in paper case files.

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

Corrective action to date has been insufficient to resolve this finding, which is expected to repeat in FY2014.

13-05. 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. (Repeated-2012)

Findings: IDHS made an improper payment to a beneficiary of the Temporary Assistance for Needy Families (TANF) Cluster program.

During testwork of 50 TANF Cluster program beneficiary payments, auditors noted one beneficiary payment (in the amount of $603) was improperly calculated as the result of improperly excluding the beneficiary's disability income.

In discussing these conditions with IDHS officials, they stated that the finding was due to staff inadvertently misapplying a TANF budgeting procedure.

Updated Response: Implemented. The case was submitted to the Bureau of Collections and an overpayment has been established. This appears to be an isolated incident where a caseworker misapplied policy. A policy clarification has been discussed and distributed to the Family and Community Resource Centers (FCRC). This finding is resolved.

13-06. The auditors recommend IDHS establish procedures to accurately report federal expenditures (including subrecipient expenditures) used to prepare the SEFA to the IOC.

Findings: IDHS did not accurately report federal expenditures under SNAP, WIC, Emergency Food Assistance Cluster, ARRA – WIC Grants to States, Vocational Rehabilitation (VR), TANF, Child Care, Social Services Block Grant (Title XX), and Medicaid programs.

IDHS inaccurately reported federal expenditures which were used to prepare the schedule of expenditures of federal awards (SEFA) to the Illinois Office of the Comptroller. Specifically, auditors noted the following unreconciled differences for IDHS' major programs for the year ended June 30, 2013:

Program	Expenditures Reported on IDHS' Expenditure Pattern	Expenditures Reported on the Initial SEFA	Difference
Vocational Rehabilitation	$107,444,000	$105,712,000	$1,732,000
Child Care Cluster	212,167,000	204,047,000	8,120,000
Title XX	66,560,000	65,313,000	1,246,000

Auditors also noted corrections of $69 million, $133 million, and $137 million were necessary to accurately report IDHS' federal expenditures under the TANF, Child Care, and Medicaid programs, respectively. Further corrections were required to properly identify ARRA and non-ARRA funded expenditures reported under the SNAP Cluster, Emergency Food Assistance Program, and ARRA-WIC Grants to States programs.

Additionally, the following differences were identified relative to amounts passed through to subrecipients for the following major programs:

Program	Expenditures Reported on IDHS' Expenditure Pattern	Expenditures Reported on the Initial SEFA	Difference
SNAP Cluster	$875,000	$10,339,000	($9,464,000)
WIC	214,683,000	165,690,000	48,993,000
Vocational Rehabilitation	20,819,000	—	(20,819,000)
TANF	150,892,000	142,210,000	8,682,000
Child Care Cluster	203,074,000	200,447,000	2,627,000
Title XX	31,842,000	27,135,000	4,707,000

In discussing these conditions with IDHS officials, they stated the finding was caused by lack of a complete general ledger and grants management system as well as lack of a sufficient number of staff and corresponding positions to hire staff with adequate qualifications, education, and experience to prepare GAAP packages and financial statements in accordance with GAAP.

Updated Response: Accepted. DHS contracted with a GAAP vendor to prepare the financial statements and SEFA. Planning meeting was held before GAAP started, progress meetings were held weekly to monitor the GAAP preparation process and an exit meeting was held to evaluate the process and identify problems and weaknesses encountered during the GAAP preparation process. Plans to explore options of earlier spending cut-offs to assist us with having more complete information for GAAP preparation. DHS completely revised the process for the GAAP grant reporting and the SEFA in FY14.

13-07. The auditors recommend IDHS ensure award information communicated to subrecipients is reviewed for completeness and accuracy.

Findings: IDHS did not properly communicate required federal information to subrecipients at the time of award for WIC, Vocational Rehabilitation, TANF, Child Care, Social Services Block Grant (Title XX), and Block Grants for Prevention and Treatment of Substance Abuse (SAPT) programs.

Auditors selected a total sample of 240 subrecipients to review from the above programs. During testwork of the award communications for the sample of subrecipients, auditors selected the FY13 awarded contracts to each subrecipient to review for compliance with federal award communication requirements. During the review of the award communication files for the sample of awards, auditors noted seven instances wherein federal information to subrecipients was not properly communicated.

IDHS' subrecipient expenditures under the federal programs for the year ended June 30, 2013 were as follows:

Program	Total Fiscal Year 2013 Subrecipient Expenditures	Total Fiscal Year 2013 Program Expenditures	%
WIC	$214,683,000	$222,911,000	96.3%
Vocational Rehabilitation	20,819,000	107,444,000	19.4%
TANF Cluster	150,892,000	613,848,000	24.6%
Child Care Cluster	203,074,000	212,167,000	95.7%
Title XX	31,842,000	66,560,000	47.8%
SAPT	63,903,000	67,838,000	94.2%

In discussing these conditions with IDHS officials, they stated that the finding was caused by an incorrect contract template, coding general revenue fund (GRF) with CFDA of grant, and no CFDA on renewal of prior contract year.

Updated Response: Implemented – Re-evaluating. All grant agreements are now processed through the Community Service Agreement (CSA) system which details the CFDA number(s) for all establishments and modifications. The recording of the CFDA information is entered into the CSA system by the respective program divisions. This allows the ability to review information by personnel who are familiar with the various awards. Program Divisions were given training prior to the FY2014 reporting period.

This action was insufficient to resolve this finding, which is expected to repeat in FY2014.

13-08. 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, TANF Cluster, Child Care, Social Services Block Grant (Title XX), and Block Grants for Prevention and Treatment of Substance Abuse (SAPT) programs on a timely basis.

During a review of a sample of 240 subrecipient OMB Circular A-133 audit desk review files, auditors noted IDHS did not notify 79 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. These reviews were completed as follows:

Desk Review Period	Number of Subrecipients
180-210 days after receipt	24
210-240 days after receipt	18
240 - 270 days after receipt	13
270+ days after receipt	24

In addition, for one subrecipient, IDHS did not properly address and follow-up on their submitted corrective action plan.

In discussing these conditions with IDHS officials, they stated the finding was caused by a lack of adequate systems and staff to perform adequate review of OMB Circular A-133 audit reports.

Updated Response: Accepted. The Office of Contract Administration (OCA) has issued 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. A three year "look back" approach is used to see if providers have historically had to submit a Single Audit.

The OCA has revised the OCA Procedure Manual and review template for A-133 desk reviews and training has been provided to staff and providers on required federal reporting.

Follow up procedures have been written with the participation of fiscal program staff to ensure sub-recipients have taken timely and appropriate corrective action. The OCA has worked with the MIS department to allow a third party vendor to access the provider financial statements from the CRV in an effort to accelerate the review process. Electronic Receiving Log has been developed, tested and implemented.

OCA Database Administrator completed creating a tracking report for audit reports overdue and 15 days since the last action took place relative to the desk reviews of audited financial systems. The two new tracking reports for desk reviews will be deployed in January, 2015 by updating user interface.

Corrective action to date has been insufficient to resolve this finding, which is expected to repeat in FY2014.

13-09. The auditors recommend IDHS ensure programmatic on-site reviews are performed and documented for subrecipients in accordance with established policies and procedures. In addition, the 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 the WIC, Vocational Rehabilitation, TANF Cluster, Child Care, Social Services Block Grant (Title XX), and Block Grants for Prevention and Treatment of Substance Abuse (SAPT) programs.

During testwork over on-site review procedures performed for 246 subrecipients of the WIC, VR Cluster, TANF Cluster, Child Care Cluster, Title XX, and SAPT programs, auditors noted IDHS did not follow its established on-site monitoring procedures as follows:

- IDHS did not provide timely notification (within 60 days) of the results of the programmatic on-site reviews.

- IDHS did not receive corrective action plans (CAPs) on a timely basis (within 60 days) after communicating programmatic review findings.

- During testwork, auditors noted that IDHS did not perform on-site monitoring reviews of subrecipients in FY13 in accordance with IDHS' planned monitoring schedule. Specifically, auditors noted the following exceptions:

Federal Program	Number of Reviews Not Performed	Number of Subrecipients Tested
VR	5	40
Child Care	1	42
Title XX	1	41

In discussing these conditions with IDHS officials, they stated the finding was the result of insufficient staffing levels in order to execute 100% of the monitoring visits timely.

Updated Response: Accepted. The Division of Rehabilitation Services (DRS) has continue maintaining its schedule of on-site reviews to enable tracking by Project Officers regarding when the next on-site must be completed. Tracking of scheduled on-sites continues to be tracked by staff in the community resources unit. DRS has continued to utilize its centralized file location, ensuring that Project Officers have access and are filing documents appropriately. The centralized unit data drive has been established and is being utilized. Two additional staff have been hired as project officers to assist with the backlog and to effect a smoother transition between project officers.

The Division of Alcohol and Substance Abuse (DASA) began conducting monthly reviews of the DFI site visit tracking report which will indicate: Vendor, staff assigned for the review, scheduled review date, actual/completed review date, site visit review letter to provider date, and ending review date.

13-10. 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 Cluster program in accordance with federal regulations.

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

- For seven cases, IDHS did not perform a timely eligibility determination. The time between the application date and eligibility determination date exceeded the required 60-day timeframe.

- For one case, IDHS did not complete the Individualized Plan for Employment (IPE) within 90 days after eligibility was determined.

- 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 human error and larger than desired caseloads led to the Division of Rehabilitation Services (DRS) failing to meet all eligibility determination guidelines.

Updated Response: Accepted. Fiscal Quality Assurance (QA) Unit is reviewing completed documentation of plans as part of their case review process. QA continues to review completed documentation as part of their reviews. DRS has enhanced its process, DRS staff associated with the particular case has been notified of the audit finding issues the auditors identified. With the SFY 2013 audit, DRS passed along the details of the case findings to the counselors associated with the findings.

DRS continues to issue periodic reminders via the OneNet system to staff regarding audit issues. As part of the New Employee Orientation, staff is trained on the documentation requirements for a VR case.

Corrective action to date has been insufficient to resolve this finding, which is expected to repeat in FY2014.

13-11. The auditors recommend IDHS review its process for monitoring child care provider compliance with State health and safety requirements and implement the changes necessary to ensure required monitoring is performed.

Findings: IDHS did not perform monitoring reviews of health and safety requirements for providers of the Child Care program.

During the auditors' review of 25 providers who received child care funding, they noted a health and safety monitoring review was not performed for one provider during the year ended June 30, 2013.

In discussing these conditions with IDHS officials, they stated the cause of this finding was due to the Illinois Department of Children and Family Services (DCFS) failing to execute an annual health and safety monitoring visit for a licensed child care facility.

Response: The Department agrees with the recommendation. Administrative Code, Title 89, Chapter III, Subchapter D, Part 383, states that monitoring visits for child care institutions shall be conducted annually by a DCFS licensing representative. Although IDHS, as the Child Care lead agency, is not responsible for executing monitoring visits to licensed child care centers, the Department does assume responsibility for ensuring child care providers are monitored for compliance with health and safety requirements. The auditors tested IDHS for the proper health and safety monitoring of 25 child care facilities. Five of the tested facilities were license exempt facilities, for which IDHS is responsible for obtaining the self-certification form from the provider, which covers the health and safety issue. IDHS was able to obtain all five self-certification forms. The remaining 20 selections were state licensed providers, for which DCFS is responsible for the health and safety monitoring. We obtained the proper health and safety monitoring documents from DCFS for 19 of the 20 selections. According to DCFS, the required health and safety review was not performed for one of the selections. Prior to the conclusion of the audit, DCFS was able to perform the monitoring visit.

Updated Response: Implemented – re-evaluating. A sample of 25 providers was drawn in order to test the proper and timely monitoring performed by the Department of Children and Family Services (DCFS). The sample included 17 non-licensed child care providers and 8 licensed provides. DHS and DCFS staff concluded, based on their joint review, that 100% of the selected sample had timely health and safety monitoring performed.
The corrective action taken was not sufficient to resolve the finding, which is expected to repeat in FY2014.

13-12. The auditors recommend IDHS establish procedures to identify awards subject to Federal Funding Accountability and Transparency Act (FFATA) reporting requirements and report required subaward information in accordance with the FFATA. (Repeated-2012)

Findings: IDHS failed to report information required by the Federal Funding Accountability and Transparency Act (FFATA) for awards granted to subrecipients of WIC, TANF, Child Care Development Fund (Child Care) Cluster, Social Services Block Grant (Title XX), and Block Grants for Prevention and Treatment of Substance Abuse (SAPT) programs.

During testwork of 200 subawards (40 for each program), auditors noted the following exceptions:

- The subaward amounts reported to the federal government do not agree with the subaward documents for two WIC, one Child Care, and eleven SAPT subawards.
- The subaward dates and amounts reported to the federal government do not agree with the subaward documents for 17 SAPT subawards.
- Subaward information was not reported at all for four Child Care and three SAPT subawards as of the date of testing (November 15, 2013).

- Subaward information was not reported at all for any awards under FAIN numbers under the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Temporary Assistance for Needy Families (TANF) Cluster, and Social Services Block Grant (Title XX) programs as of the date of testing (November 15, 2013).

In discussing these conditions with IDHS officials, they stated that the award, CFDA, DUNS, and correct zip code were not available for all grants.

Updated Response: Accepted. The Department has modified the Consolidated Accounting and Reporting System (CARS) and the Community Service Agreement (CSA) tracking system to include all fields required to be reported under FFATA. The FEIN is being recorded in CARS on the Agency Grant Table. A new field was created and is populated by the Federal Reporting staff. The Department has identified Program Division staff to be the responsible party for uploading their grant awards into SAMS.gov.
Corrective action taken was insufficient to resolve the audit finding prior to the start of FY2014. Therefore, this finding is expected to be repeated in the FY 2014 Statewide Single Audit.

13-13. The auditors recommend IDHS review the process and procedures in place to prepare special reports required for the SNAP Cluster and implement procedures necessary to ensure the reports are accurate.

Findings: IDHS did not prepare an accurate special report for the SNAP Cluster.

IDHS is required to create and maintain a system of records for monitoring claims against households that receive more SNAP benefits than they are entitled to receive. During testwork, auditors noted errors in the FNS-209 report for the quarter ended September 30, 2012.

In discussing these conditions with IDHS officials, they stated that the cause of the finding was due to an inaccurate system-generated report.

Updated Response: Implemented. The Department has submitted a Management Information System Request (MISR #54195) on January 31, 2014 in order to correct the problem with report #16600205, Balance Summary of Claim Type. The MISR has been worked, and the report has been corrected.
This finding is expected to be repeated in the FY 2014 Statewide Single Audit due to a bad cell reference.

13-14. 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. (Repeated-2012)

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.

During testwork of IDHS' controls over user access to IDHS applications, auditors noted the following:

- One terminated employee (out of 25 tested) retained user access after their termination date for the Concurrent, Child Care Tracking System, and Consolidated Accounting Record System applications.

- Policies and procedures are not in place to review access rights for users at subrecipient organizations who have been contracted to assist IDHS in carrying out compliance requirements for the WIC, Child Care, and TANF.

Additionally, 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 discussing these conditions with IDHS officials, they stated that DHS internal controls are in accordance with federal National Institute of Standards and Technology (NIST) 800-53 standards.

Response: Disagree. One terminated employee ID was overlooked by a LAN Coordinator for deletion; internal RACF controls revoked ID after 60 days which resulted in minimal risk to unauthorized access to information system.

The policies and procedures to review access rights for Subrecipient organization are the same RACF policies and procedures currently in place for internal users. This includes a 3-year rotational review period approved by IDHS internal auditors.

Cornerstone and Case Control Management System (CCMS) utilizes Clearance which produces a system generated change management report due to the advanced technology used in its development. CARS, Concurrent, and CCTS are legacy mainframe systems that were developed 15 to 30 years ago. The capability to produce a system generated report for these mainframe systems does not exist through third party marketplace. To develop a custom application to create such system generated reports would be prohibitively expensive. The current change management process, CAT tracking system, has been utilized in both Concurrent and CCTS and was deemed as an adequate control with low risk. 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. IDHS staff cannot move programs into production. IDHS 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, IDHS eventually plans on replacing the systems with newer technologies however, at this time it is not economically feasible. IDHS management accepts the low risk associated with our change management process due to the compensating controls and procedures mentioned.

The internal controls utilized by the four systems provide adequate change management that meets federal National Institute of Standards and Technology (NIST) standards and therefore IDHS disagrees with this finding.

Auditors' Comment: As noted in the finding above, we noted exceptions relative to access and change management control procedures implemented by IDHS. Although we agree that certain compensating controls are in place, we are required to design our audit to obtain a low-level of control risk. We have evaluated the exceptions discussed above and have determined the exceptions rise to the level of a material weakness based on the criteria in OMB Circular A-133.

Updated Response: Not Accepted. This finding was not accepted by the Department. Therefore, no corrective action plan was put in place. This finding is expected to be repeated in the FY2014 Statewide Single Audit.

RECOMMENDATIONS 15-22

Department of Healthcare and Family Services

13-15. The auditors recommend DHFS evaluate their procedures to ensure provider audits are performed and completed in a timely manner. (Repeated-2008)

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

During testwork over 50 providers (40 completed audits and 10 pending audits) recommended by the OIG for audit, auditors noted there were significant time delays between the date DHFS determined a provider audit should be performed and the start date of the audit as follows:

- Ten of the 40 OIG provider audits completed as of June 30, 2013 were not started in a timely manner. The number of days that had elapsed between the dates the provider was recommended for audit and the audit start date ranged from 189 to 541 days.
- Five of the 40 OIG provider audits completed as of June 30, 2013 were not completed in a timely manner. The length of time to perform these audits ranged from 189 to 289 days.

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.

Response: The Department accepts the recommendation. 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. Factors that may extend the time necessary to complete an audit include the type and volume of documentation to be audited and the availability of information to be audited. The Department continues to review its procedures and implement changes to ensure that provider audits are performed and completed in a timely manner.

Updated Response: Implemented.

13-16. The auditors recommend DHFS review its current process for monitoring and reporting overpayments and implement any changes necessary to ensure such overpayments are reported as adjustments 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.

Auditors noted DHFS did not report adjustments for certain overpayments identified by the Fraud Unit in State FY12 on its quarterly financial expenditure reports or return these amounts to the federal government within the one year of identification as required. Overpayments identified in State FY12 by the Fraud Unit but not adjusted within one year totaled $32,840.

In discussing these conditions with DHFS officials, they stated that the overpayments identified in this audit occurred prior to the Department implementing a system for DRS to process current overpayments through the Medicaid Management Information System (MMIS).

Response: The Department accepts the recommendation. The Department has implemented procedures to monitor whether DRS is reporting overpayments and making the required

adjustments. The Department and DRS will continue to work together to monitor the process for submitting the overpayments and adjusting them in a timely manner as required.

Updated Response: Implemented May 2013.

13-17. 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 Cluster program whether services billed by providers were actually received.

During testwork, auditors noted DHFS procedures for verifying with beneficiaries whether services billed by providers were actually received by Medicaid Cluster 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 2.44% of total provider reimbursements. Further, DHFS does not perform any verification procedures for services billed by the following provider types:

- Hospitals
- Mental Health Facilities
- Nursing Facilities
- Intermediate Care Facilities
- Physicians
- Other Practitioners
- Managed Care Organizations
- Home and Community-Based Service Providers
- Physical Therapy Providers
- Occupational Therapy Providers

In discussing these conditions with DHFS officials, they stated that 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 Medicaid Management Information System (MMIS) through various requirements that include:

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

Updated Response: Accepted. Expected implementation 2017.

13-18. The auditors recommend DHFS implement procedures to ensure all per diem rates are updated and adjustments are made in a timely manner for government-owned hospitals. (Repeated-2010)

Findings: DHFS did not update per diem rates and make related adjustments in a timely manner for government-owned hospitals participating in the Medicaid Cluster.

During testwork of 65 CHIP and 125 Medicaid beneficiary payments, auditors reviewed provider reimbursements for accuracy and the allowability of the related benefits provided. During those procedures, DHFS did not finalize the 2013 per diem rates for two providers until November 2012. Because DHFS did not set the provider per diem rates for 2013 until November 2012 these hospitals' reimbursements for State fiscal year 2013 were subsequently adjusted by $9,328,957 for inpatient rates and $2,652 for outpatient rates in January 2013.

In discussing these conditions with DHFS officials, they stated that negotiations with the providers caused unforeseen delays in rate implementation.

Updated Response: Implemented April 2014. The Department experienced a delay related to the Fiscal Year 2014 rates due to negotiations between the Department and U of I which eventually resulted in a rate methodology agreement requiring an amendment to the State Plan effective March 1, 2014. The Department and U of I agreed on utilizing the prior set rates during the period of negotiations. At the time of the approval, the Department sent out the rate letters and made payments retroactively based on the change.

13-19. 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. (Repeated-2012)

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. Approximately 40,000 home and community-based waiver providers are eligible to participate in the waiver programs. Monitoring procedures primarily consist of medical record reviews, reviews of annual audited financial statements, and comprehensive on-site reviews developed in accordance with the State Plan. DHFS contracts with a service provider to perform the medical claim record reviews and on-site reviews over an annual sample of 600 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. Following each on-site review, DHFS sends the other State agencies a letter notifying them of the deficiencies identified, with a request to respond within 60 days with plans for individual and systemic correction. However, no formal follow up procedures are performed to ensure the corrective action plans were implemented or whether the deficiencies may still exist.

In discussing these conditions with DHFS officials, they stated that 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.

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 has implemented formal procedures to monitor follow-up responses from the operating agencies to ensure corrective action is taken.

Updated Response: Implemented January 2014.

13-20. 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. The 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 seven 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 System for Award Management (SAM) maintained by the U.S. Government. Auditors noted DHFS has not developed procedures to perform verification checks of medical providers with SAM as required by federal regulations.

In discussing these conditions with DHFS officials, they stated that the seven 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.

Response: The Department accepts the recommendation. The Department has worked with the Chief Procurement Office (CPO) 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.

Updated Response: Accepted. HFS vendor contracts include the required suspension and debarment language. CPO Notice 2012.07 was issued requiring certification language to be included in all Statewide master Contracts. HFS will develop a mechanism to capture complete information on all providers and applicable persons on a monthly basis once access to such a searchable database is federally granted and/or with the implementation of the new/updated MMIS. Full Implementation expected 2017.

13-21. The auditors recommend DHFS implement procedures to ensure cost allocation percentages are accurately calculated to ensure costs are properly allocated to its federal programs.

Findings: DHFS did not properly allocate costs to the Child Support Enforcement (Child Support), Children's Health Insurance Program (CHIP), and Medicaid Cluster programs.

During a review of costs allocated to Child Support, CHIP, and Medicaid Cluster programs during the quarter ended March 31, 2013, auditors noted a mathematical error in the computation of the percentage of assistance cases investigated related to DHFS and the Illinois Department of Human Services (IDHS). Specifically, the percentage of cases investigated used in the cost allocation plan workpapers were 98.9% and 1.1% for DHFS and IDHS, respectively; however, the actual percentage of cases investigated for each agency were 97.1% and 2.9% for DHFS and IDHS, respectively. As a result, programs administered by DHFS were allocated $6,865 (federally funded participation of $4,339) more than they should have been for the quarter ended March 31, 2013.

In discussing these conditions with DHFS officials, they stated that this finding was caused by a clerical error.

Response: The Department accepts the recommendation. A prior period adjustment will be made to correct the error.

Updated Response: Implemented.

13-22. The auditors recommend DHFS establish procedures to: (1) identify awards subject to Federal Funding Accountability and Transparency Act (FFATA) reporting requirements, (2) obtain subrecipient Data Universal Numbering System (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 for awards granted to subrecipients of the Child Support Enforcement (Child Support) and Medicaid Cluster 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 the year ended June 30, 2013.

In discussing these conditions with DHFS officials, they stated that technical issues with the federal website prevented them from reporting all subawards.

Updated Response: Accepted. The Department was able to report all Fiscal Year 2013 sub-awards, however, experienced difficulty reporting the local education agencies in Fiscal Year 2014 due to challenges related to DUNS number.

RECOMMENDATIONS 23-29
Department of Children and Family Services

13-23. 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 Temporary Assistance for Needy Families (TANF), Foster Care and Adoption Assistance programs.

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. These organizations assist the State in complying with program requirements relative to the allowability of costs and continuing eligibility of program beneficiaries.

As a result of this determination, DCFS did not identify the amounts passed through to these entities as subrecipient expenditures on the State's schedules 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, 2013 were $28,874,000, $38,946,000, and $4,126,000, 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).

Updated Response: Implemented.

13-24. 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 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 Adoption Assistance beneficiary payments (totaling $23,359), auditors noted one case file (with a sampled assistance payment of $409) in which DCFS could not locate a recertification form submitted by the adoptive parents within the most recent period. DCFS claimed reimbursement for adoption assistance benefits made on behalf of this child totaling $4,908 during the year ended June 30, 2013.

DCFS claimed reimbursement for adoption assistance beneficiary payments totaling $69,395,041 during the year ended June 30, 2013.

In discussing these conditions with DCFS officials, they stated that the Department conducts annual recertifications to confirm eligibility for a Medicaid card and that the children are still in continued care but notes 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 did not sustain the finding when it was included in a previous audit.

Response: The Department disagreed with the finding as the federal agency did not agree with and sustain the finding when it appeared in a previous audit report and that the federal agency has no recourse for any exception to the finding. However, the Department plans to continue its procedure to conduct recertification for Title IV-E adoption assistance cases as a part of a process to confirm their eligibility for a Medicaid card.

The Department agrees that annual recertification is a good business practice and is implementing additional procedures to ensure reporting to the Post-Adoption Unit and the reporting of follow-up is completed. Recertification letters are sent out via an automated process. If the first letter is not returned, a second letter is automatically mailed 30 days later. If the second letter was not returned, notification of these cases is sent to the Post-Adoption Unit for further follow up. Although the Department has greatly improved compliance in this area, there remains the obligation to continue monitoring of the process that has been successfully developed. Additionally we will re-look at our procedures and work with the Office of Information Technology Services (OITS) to review the logic related to generation of recertification notices for older subsidy recipients. Additionally, the Department notes that the number of missing recertifications has diminished (down to one for the 2013 audit) as the new procedures were implemented and refined.

Auditors' Comment: We respectfully disagree with DCFS' response. The procedures relative to the recertification forms are part of the Department's controls relative to verifying families continue to be eligible for Adoption subsidies. Additionally, these procedures are stated in the Title IV-E State Plan and federal regulations require the State to follow the provisions of its State Plan.

13-25. The auditors recommend DCFS establish procedures to ensure that providers and vendors contracting with 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 review of 25 providers and 25 vendors of the Foster Care and Adoption Assistance program, auditors noted DCFS did not include a suspension and debarment certification in any of its provider or vendor contracts.

Payments to providers allocated to the Foster Care and Adoption Assistance Programs totaled $50,046,000 and $5,976,000, respectively, during the year ended June 30, 2013. Payments to vendors allocated to the Foster Care and Adoption Assistance programs totaled $5,431,000 and $839,000, respectively, during the year ended June 30, 2013.

In discussing these conditions with DCFS officials, they stated that the Department changed the debarment certification in provider contracts but, due to lead times necessary in the contracting process, the provider's debarment certification was not included in the contracts until the FY14 contract cycle.

Updated Response: Implemented.

13-26. 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).

During testwork over cash draws performed for Foster Care and Adoption Assistance, auditors noted DCFS drew funds seven 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 Department was 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.

13-27. The auditors recommend DCFS implement procedures to ensure subawards are accurately reported within timeframes required by FFATA. (Repeated-2012)

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, auditors noted there were ten subawards required to be reported under FFATA in FY13 which were executed in late June 2011 and were not reported until October 2012 (when final contract amounts were known).

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.

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. Additionally, the Department will inform the auditor as more information on reporting requirements becomes available to arrive at consistent reporting criteria and continue discussions each year. While the Department is 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.

13-28. The auditors recommend DCFS stress the importance of preparing and completing the initial service plans timely to all caseworkers to comply with Federal requirements. (Repeated-1999)

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

During a review of 40 case files selected for testwork, auditors noted twelve of the initial case plans were completed within a range of one to 102 days over the 60 day federal requirement.

In discussing these conditions with DCFS officials, they stated 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 completed within the established timeframes, however, service delivery is not delayed just because a service plan hasn't been formally written. Services are put in place regardless of whether there is a written service plan; a plan is finalized/completed only when all input is made to the document.

Response: The Department agrees with the recommendation and continues to stress the importance of adequate and timely documentation for child case files through training and communications to all case staff. Since the exceptions are almost all Purchase of Service (POS) cases or involve case transfers, the Department will reach out to all case work staff to provide additional direction. 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, the Department stresses the importance of adequate and timely case planning as a key component of providing quality service to children.

A change in the automated case file system was implemented on Saturday, April 27, 2013, which is near the end of FY13, the year included in this audit. The Statewide Automated Child Welfare Information System (SACWIS) will now allow a service plan to be prepared and completed without an IA which should help improve the issue of delayed plans in fiscal year 2014. SACWIS 5.0 notes and trainings include instructions for case staff on the timely completion of service plans.

13-29. The auditors recommend DCFS implement policies and procedures to ensure access to its information systems is adequately secured and address processes relative to users employed by provider organizations. (Repeated-2012)

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

During testwork over access controls to DCFS' claiming system and related general ledger and eligibility databases, auditors noted system access changes made for 13 of 25 user accounts during the year ended June 30, 2013 did not have evidence of approval for the additional access privileges granted to these users by DCFS.

In addition, auditors noted DCFS does not have procedures in place to review access rights for users at provider 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 while they have procedures in place to control access covering all transactions, including access to confidential and critical transactions, the sample pulled contained modifications to access roles that included the removal of access or addition of inquiry access to non-restricted information. The security administrator mistakenly believed that the requested changes did not require approval at the individual account level due to the fact that approval would have been automatic based on what was being requested.

Response: The DCFS Security Administrator has been informed that there should be no exceptions made to the written procedure. A monthly audit report will be developed to identify any access request that does not have an associated account level request.

DCFS will create a process to automatically produce an "employee access listing" monthly to be sent to contractual supervisors requesting that they initiate any required access changes.

RECOMMENDATION 30
Department on Aging

13-30. 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 seven subrecipients of the Aging Cluster, auditors noted the A-133 audit report for one subrecipient reported a finding for which IDOA did not issue a management decision. Amounts passed through to this subrecipient under the Aging Cluster approximated $5,256,000 during the year ended June 30, 2013.

Total awards passed through to subrecipients of the Aging Cluster were approximately $41,992,000 during the year ended June 30, 2013.

In discussing these conditions with IDOA officials, they stated the finding reported in the audit report was noted, however was determined immaterial since the amount in question was $853.

Updated Response: Implemented.

RECOMMENDATIONS 31-36
DEPARTMENT OF PUBLIC HEALTH

13-31. The auditors recommend IDPH review its monitoring procedures for providers of Immunization Grants 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 Grants program. DPH receives the majority of its federal immunization Grants program funding in the form of vaccines which are distributed to medical providers throughout the State.

During testwork of 65 providers, auditors noted corrective action plans were not obtained for six providers who had findings identified in on-site monitoring reviews performed by IDPH. Additionally, no follow up procedures were performed to obtain the missing corrective action plans.

IDPH passed through vaccines valued at $95,723,597 during the year ended June 30, 2013 to providers of the Immunization Grants program.

In discussing these conditions with IDPH officials, they stated staff shortages in regional offices caused delays in following up on corrective action plans.

Response: The Department concurs with the finding and recommendation. The Immunization Section has taken steps in meeting the Centers for Disease Control (CDC) requirement concerning site visits to Vaccines for Children (VFC) providers in Illinois. A formal 2-day training of all compliance staff, including contractual, on the new procedures and follow-up including corrective actions was conducted in January 2014. A new tool has been developed to complete during site visits as well as a formal follow-up plan document. The VFC program will not ship any vaccine to a provider that is not in compliance of the program's rules.

Updated Response: Implemented. The Illinois Vaccines for Children (VFC) program now requires newly enrolled providers to receive a site visit from VFC compliance staff to ensure that the provider practice and staff were adequately prepared to comply with VFC program requirements to manage VFC vaccine. This provided the program with an opportunity to review all VFC requirements and provide appropriate tools to fully document compliance.

The VFC program also implemented annual training for state and local health department grantee staff performing VFC compliance visits. These provided content and guidance on addressing provider and practice-based deficiencies identified during compliance visits. A series of training programs for VFC compliance staff further oriented compliance staff on measures to identify and address provider deficiencies related to vaccine management and administration.

13-32. 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), CDC Investigations and Technical Assistance, and HIV Care Formula Grants programs have complied with OMB Circular A-133 audit requirements.

During testwork of 44 subrecipients, auditors noted the following:

- For one subrecipient of CDC Investigations and Technical Assistance, A-133 audit reports were not obtained within nine months and there was no evidence IDPH performed procedures to obtain the delinquent reports.
- For one subrecipient of the PHEP program and one subrecipient of the HIV Care Formula Grants program, the A-133 reports were received 115 and 16 days after the nine-month deadline, respectively. There was no evidence IDPH performed follow up procedures to obtain the delinquent reports.
- For one subrecipient of the HIV Care Formula Grants program, the A-133 audit report contained findings that pertained to IDPH. There was no evidence IDPH performed follow up procedures regarding the IDPH specific findings or issued required management decisions.

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

In discussing these conditions with IDPH officials, they stated due to shortage of qualified audit staff, the Department is limited in its ability to fully meet these requirements.

Updated Response: Accepted. The department has improved its receipt of required reports during the specified timeframes and continues to send follow up letters for any missing reports. The audits are reviewed for compliance and any IDPH program related findings are referred to the respective program office for follow-up and corrective action plans. Although one of the objectives of PA 96-1141 (streamlining legislation within human services agencies) was to consolidate the A-133 audit review function to eliminate duplication and additional workload for health care providers, that effort has slowed somewhat with the recent passage of the Grant Accountability and Transparency Act. The specific audit requirements contained in that legislation and the guidance that will be received by GOMB towards implementation of that Act may necessitate changes in the A-133 audit review function and we await that guidance.

13-33. The auditors recommend IDPH revise the on-site monitoring procedures to include procedures to review each applicable compliance requirement and the fiscal and administrative controls of its subrecipients. IDPH should also evaluate the current staffing of its monitoring department to ensure resources are adequate to complete reviews within prescribed timeframes. (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 did not perform on-site monitoring procedures of six subrecipients. IDPH also has not established procedures to monitor the matching amounts reported by subrecipients to ensure the expenditures reported by the subrecipients meet general allowable cost requirements or PHEP program specific requirements.

In discussing these conditions with IDPH officials, they stated current staff is not sufficient to perform annual on-site reviews of fiscal and administrative controls of all subrecipients.

Updated Response: Accepted. On-site fiscal monitoring procedures previously implemented will be reviewed to ensure compliance with all applicable requirements. Current staffing of the monitoring unit is not adequate to perform on-site fiscal compliance reviews annually for each sub recipient, however, the results of the on-site fiscal compliance monitoring performed have found that sub recipients are using the PHEP awards for authorized purposes in compliance with laws, regulations and provisions of the grant agreements. In addition to site visits, monitoring activities performed throughout the year include reviewing financial and performance reports submitted by sub recipients, and regular contact with sub recipients, including appropriate inquiries concerning program activities.

13-34. The auditors recommend IDPH review its current application approval process to consider changes necessary to ensure all required documents are obtained prior to approving an applicant as eligible to receive benefits.

Findings: IDPH did not obtain the required documentation supporting eligibility determinations performed for the HIV Care Formula Grants program.

During testwork of benefits provided to HIV program beneficiaries, auditors selected 65 eligibility files to review for compliance with eligibility requirements and for the allowability of the related benefits. In one file tested, the application submitted by the beneficiary disclosed that he/she previously declined the group health insurance provided by his/her employer. Accordingly, this individual was required to submit documentation from his/her employer detailing the dates of the next open enrollment period prior to receiving benefits.

In discussing this policy with IDPH officials they stated that the condition noted in this one particular case file was caused due to staff oversight.

Updated Response: Implemented. AIDS Drug Assistance Program (ADAP) and Continuation of Health Insurance Coverage (CHIC) Program staff received training on January 15, 2014 on the policy of securing Human Resource documentation of next open enrollment when a client declines employer based insurance. Staff will receive refresher training on the importance of the notes features of Provide Enterprise to chronicle correspondence with clients on HR documentation.

13-35. 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 30 days of receipt as required. Complaints alleging abuse or neglect are required to be investigated within seven days.

During testwork of 40 complaints filed against Medicaid providers during FY13, twenty-one complaints were not investigated within the timeframes required by the State's law. The delays in investigating these complaints ranged from 12 to 227 days.

In discussing these conditions with IDPH officials they stated due to lack of staff and the training of new staff the Office of Healthcare Regulation was unable to complete all complaints within the necessary timeframes.

Updated Response: Accepted. The Office of Health Care Regulation continues to actively hire surveyors to more closely meet required federal timeframes. As of October 1, 2014, 112 additional surveyors have been hired. With these additional hires, the department has reduced the backlog of complaints and has made significant progress in reducing the number of complaints that fall outside of the federal timeframes.

13-36. 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 FY13, a license was not on file for eight 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. However, the Illinois End Stage Renal Disease Facility Act 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.

In discussing these conditions with IDPH officials, they stated the implementation of licensure rules and regulations were delayed as the result of federal changes to Dialysis Conditions of Participation in Long Term Care (LTC) facilities.

Response: The Department concurs with the finding and recommendation. When the Illinois End Stage Renal Disease Facility Act (210 ILCS 62/10) passed, the Department created the End Stage Renal Disease Advisory Committee. The Advisory Committee met several times and established a workgroup to assist the Department in drafting the implementing regulations. After the federal changes to Dialysis Conditions of Participation in Long Term Care (LTC) facilities, the workgroup redrafted the regulations to be in compliance with federal guidelines. The ESRD workgroup finalized the proposed regulations January 2014. The Department will be scheduling a meeting with the full ESRD advisory committee in the spring of 2014 to approve and move forward with the rules to the Illinois Register.

Updated Response: Accepted. The ESRD advisory board met on August 26, 2014 and determined a few more revisions to the rules were required before submission to the State Board of Health. The next ESRD Advisory Board meeting is scheduled November 18, 2014 to finalize the regulations for submission to the State Board of Health and then the 1st public comment period will commence.

RECOMMENDATIONS 37-39
Illinois State Board of Education

13-37. 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. (Repeated-2012)

Findings: ISBE is not adequately performing on-site monitoring reviews of subrecipients of the Title I, Special Education Cluster, Twenty-First Century Community Learning Centers (21st Century), Improving Teacher Quality State Grants (Title II), School Improvement Grants Cluster (SIG), and Education Jobs Fund (ED Jobs) programs (collectively referred to as the Education programs).

During review of the subrecipients selected for on-site reviews during FY13, 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. While the level of funding is an important criterion, auditors believe there are other criteria that should be considered.

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

Auditors noted the approach described above resulted in the following distribution of reviews relative to the population of subrecipients of ISBE's Education programs:

Category	Number of subrecipients	Percentage of total subrecipients
High-risk subrecipients based upon risk score	62	6%
Subrecipients selected for onsite reviews based upon their proximity to monitoring resources	162	15%
Subrecipients not subject to onsite reviews	839	79%
Total subrecipients	1,063	100%

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.

Auditors further noted that the risk criteria were evaluated on an entity-wide basis for each subrecipient; however, several subrecipients selected for on-site reviews were comprised of numerous individual school sites of which only a portion were subject to on-site review procedures. 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.

Additionally, auditors noted the standard monitoring tool used by ISBE was not completed for programmatic on-site reviews performed for nine subrecipients of the School Improvements Grants program. Additionally, formal monitoring reports were not prepared and corrective action plans were not obtained in connection with these on-site reviews.

ISBE's subrecipient expenditures under the federal programs for the year ended June 30, 2013 were as follows:

Program	Total Fiscal Year 2013 Subrecipient Expenditures	Total Fiscal Year 2013 Program Expenditures	%
Title I, Part A Cluster	$607,017,000	$614,380,000	98.8%
Special Education Cluster	497,552,000	513,098,000	97.0%
21st Century Community Learning Centers	46,755,000	48,533,000	96.3%
Improving Teacher Quality State Grants	85,553,000	88,432,000	96.7%
School Improvement Grants Cluster	43,548,000	49,471,000	88.0%
Education Jobs Fund, Recovery Act	21,607,000	21,607,000	100.0%

In discussing these conditions with ISBE officials, they stated that this was an oversight during the development of new monitoring procedures in FY12, which due to timing carried over to the FY13 risk assessment.

Response: Partially implemented. ISBE has revised its risk assessment criteria for FY14 to include additional risk factors and has adjusted the weighting assigned to each criterion. ISBE has also implemented measurable selection criteria for the selection of specific school sites.

13-38. 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. (Repeated-2012)

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, 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, eight LEAs received Title II awards in excess of the amount for which they were eligible which totaled $1,120. Additionally, 70 LEAs received awards in amounts less than the amount for which they were eligible.

Subawards made under this program were $85,553,000 for the year ended June 30, 2013, of which $11,567,023 related to awards that were subject to allocation based on low income and enrollment data.

In discussing these conditions with ISBE officials, they stated the error was due to oversight in using inaccurate foster care data when performing the Title II calculation.

Updated Response: Implemented.

13-39. The auditors recommend ISBE review its process for reporting subaward information required by FFATA and consider any changes necessary to ensure all required subawards are properly reported. (Repeated-2012)

Findings: ISBE 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).

During review of ISBE's procedures to report subaward information required by FFATA, auditors noted that ISBE did not report all required information for subawards for the Education Program. Specifically, auditors noted the report generated by ISBE for the Title I, Special Education Cluster, and Title II programs did not include subawards made on the last day of each month throughout the year. In addition, ISBE did not report any of the subawards made in October 2012 for the 21st Century Learning program. As of the date of testwork (January 27, 2014), ISBE had not identified how many subawards were not reported as a result of these errors.

In discussing thes conditions with ISBE officials, they acknowledged that a report in the Financial Reimbursement Information System (FRIS), the electronic system from which FFATA data is extracted, was not capturing all of the data for reporting into the Federal Funding Accountability and Transparency Act Subward Reporting System (FSRS). The FRIS report in question was coded in error and did not capture the last calendar day of the month when a user entered a transaction range. Consequently, if a FFATA eligible grant was loaded in FRIS on the last calendar day of the month, it was not reflected in the report. The 21st Century Learning grants not reported in October 2012 was due to an oversight.

Response: The Agency agrees with this finding. The FRIS report used to extract the FFATA grant data has been modificed to account for the last calendar day of the month. Additionally, internal controls have been established to verify the monthly submissions of FFATA data from FRIS into the FSRS system. A new peer verification process has been implemented ensuring that all FFATA

eligible grants extracted from FRIS are transmitted to FSRS site each month. Once the FFATA data is uploaded, another staff member will go into the FSRS site and verify that all the valid projects have been submitted and accepted to the federal web site.

RECOMMENDATIONS 40-43
Illinois Student Assistance Commission

13-40. The auditors recommend ISAC review its process to ensure that loan information is properly verified and reported to the NSLDS. (Repeated-2008)

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

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 two confirmations that were returned "incorrect".

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 (ED) to verify unreported loans.

Response: 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.

13-41. The auditors recommend ISAC assign all defaulted loans to the USDE that meet the criteria contained in federal regulations or obtain a written waiver which specifies the number and criteria for assignment of loans to the USDE. (Repeated-2010)

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

During audit of the Federal Family Education Loan Program, auditors noted there were approximately 4,480 defaulted loans that meet these criteria as of July 17, 2013 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 which was subsequently lifted in November 2012. ISAC began subrogating loans again at this time.

In discussing these conditions with ISAC officials, they stated the moratorium combined with edit limitations in the ED system did not allow all the accounts to be placed in the noted time frame.

Updated Response: Implemented.

13-42. The auditors recommend ISAC review its procedures and implement any necessary changes to ensure loan records are accurately updated in accordance with program requirements. (Repeated-2012)

Findings: ISAC did not accurately update borrower records in accordance with required timeframes.

During testwork over a sample of 40 borrower status changes tested, auditors noted one record was updated 12 days after ISAC was notified of the status change.

In discussing these conditions with ISAC officials, they stated that the employee assigned to this function had been on a medical leave and this account status update was therefore two days late.

Updated Response: Implemented.

13-43. The auditors recommend ISAC implement the procedures necessary to ensure required on-site program reviews are performed in accordance with program regulations.

Findings: ISAC did not perform on-site program reviews of participating schools as required by program regulations.

During testwork of the enforcement action special test and provision, auditors noted ISAC had not performed any reviews for participating schools meeting the review criteria during the year ended June 30, 2013. As of the date of testing (January 10, 2014), ISAC has still not scheduled or completed any of the required on-site program reviews.

In discussing these conditions with ISAC officials, they stated because new loan originations and guarantees in the FFEL program ceased effective July 1, 2010, ISAC has not been the principal guaranty agency for participating schools since that date and participating schools have not been issuing new FFEL loans.

Response: ISAC is responsible for the oversight and administration of the ISAC-administered gift assistance programs (State Illinois - funded programs), and the FFEL program guarantee portfolio.

As a result, a single Program Review Schedule is developed each fiscal year to systematically plan for reviews for both the State of Illinois funded programs and FFEL schools with ISAC as the principal guaranty agency. The schedule is implemented based on available staff resources and a risk assessment methodology.

RECOMMENDATIONS 44-49
Illinois Department of Employment Security

13-44. The auditors recommend IDES establish procedures to accurately report federal expenditures used to prepare the SEFA to the IOC.

Findings: IDES did not accurately report Federal expenditures under the Employment Services Cluster and the Unemployment Insurance programs.

IDES 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). Specifically, auditors noted the following adjustments were made to SEFA expenditures reported for the year ended June 30, 2013:

Program	Expenditures Reported on the Initial SEFA	Expenditures Reported on the Final SEFA	Difference
Employment Services Cluster	$39,558,000	$43,783,000	($4,225,000)
Unemployment Insurance	2,852,624,000	3,894,269,000	(1,041,645,000)
Unemployment Insurance – ARRA	1,016,419,000	—	1,016,419,000

In discussing this with IDES officials, they stated, due in large part to federal funding reductions, IDES staff dropped by a third in the past two years. As a result, over a hundred employees moved to new positions via the bargaining unit contract's layoff provisions. As a result, the preparation of the SEFA was done by inexperienced staff that followed the previous year's reporting methodology.

Response: We agree that internal controls should include procedures to ensure federal expenditures are properly titled on the SEFA. The ARRA funding at question is the Emergency Unemployment Compensation (EUC08) program. The program provided additional weeks of unemployment insurance to qualified candidates once they exhausted the non-federally funded state Regular Unemployment Insurance program. In 2009, when Congress approved and the President signed legislation authorizing ARRA, federal directions included that EUC08 payments be included when tabulating ARRA payments. In the following four years, Congress passed, and the President signed, nearly a dozen pieces of legislation that re-authorized EUC08. IDES did not shift its reporting to reflect that EUC08 payments should no longer be considered ARRA related. That said, the US Department of Labor (US DOL) did not provide guidance alerting IDES that this funding was no longer considered ARRA related. IDES inquired with US DOL on how this funding should be classified. IDES changed it on our reporting and notified the auditors which is what led to this finding.

13-45. The auditors recommend IDES establish policies and procedures ensure documentation to support key line items can be provided from the DART system for the ETA 9002D and the VETS 200C performance reports. (Repeated-2012)

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 15 of the ETA 9002D report and line 28 of the VETS 200C report) by the DART reporting system was not available for testing.

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

Updated Response: Implemented.

13-46. The auditors recommend IDES follow established procedures to ensure the automated stop is generated for all invalid social security numbers to prevent payment of benefit 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 one claimant did not have a hold flag placed on their account and this instance does not appear to have been investigated by IDES. Total benefits paid to this claimant were $4,670 during the year ended June 30, 2013.

In discussing these conditions with IDES officials, they stated that on this one occasion, 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.

Updated Response: Implemented.

13-47. 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 these reports.

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 25 reports and noted that resolution of exceptions and supervisory review was not consistently documented. Specifically, auditors noted three claim exception and monitoring reports did not contain evidence of being worked by the local office staff within three days or evidence of a supervisory review.

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, 2013.

In discussing these conditions with IDES officials, they stated that under previous business practices this was identified as an issue. In response, the agency has transitioned to automated reporting and task management tracking.

Response: IDES accepts this finding. With the implementation of our new benefits system in August of 2010, most of the tasks from these monitoring reports were automated. IDES will update its procedures to reflect these changes in our business process.

13-48. The auditors recommend IDES implement procedures to ensure all eligibility determinations are made within the prescribed timeframes.

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

During testwork auditors conducted unannounced site visits to five local offices and requested the most recent pending issues detail report as of the date of the visit. Auditors noted a significant backlog in the resolution status of claims in the adjudication process. Specifically, auditors noted a total of 825 out of 4,144 claims at the five local offices that were outstanding for greater than 21 days of the detection date.

Additionally, during review of the FY14 State Quality Service Plan (Plan) submitted by IDES to the USDOL, auditors noted IDES did not meet the acceptable level of performance for issuing eligibility determinations on certain disqualifying issues as defined by the USDOL (non-monetary issues) for the federal FY13, resolving only 72.8% of these determinations within 21 days of the detection date.

In discussing these conditions with IDES officials, they stated that the majority of timeliness issues are attributable to significant reductions in staff as a result in reduced federal funding. Leading up to April, 2013, prior to the layoff, the agency was on track to significantly improve timeliness in a number of different areas.

Response: IDES agrees with this finding. Over the last few fiscal years, IDES federal funding for unemployment insurance has dropped by roughly 25%. At the same time the costs for pensions and health care have increased significantly. Because of these two factors IDES was compelled to reduce its staff by nearly 1/3. This was done through laying-off nearly 200 staff, non-scheduling nearly 200 intermittent employees and not backfilling positions. As a result of the layoff, over a hundred employees moved to new positions via the bargaining unit contract's layoff provisions. Those employees needed to be trained on their new positions. The progress IDES had been making in our timeliness measures suffered as a result.

13-49. 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.

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 15 new users selected for testwork, a signed UserID request form could not be provided by IDES for one user. 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.
- Controls over verifying the identity of an individual prior to resetting their password and the granting, modifying, or revoking of physical access badges has not been effectively implemented.
- Formal policies and procedures related to change management have not been developed for IBIS.

In addition, because the IBIS system cannot produce a system generated list of all program changes processed within the system, IDES cannot adequately monitor program changes.

In discussing these conditions with IDES officials, they stated that the unsigned form was an oversight, and change management procedures have been developed.

Response: Bullet 1: IDES policy dictates that forms must be completed by IDES developers and signed off on by senior management for any modifications to be made to the production code. These forms are then submitted to IDES staff who specifically oversees our Library Version Control (LVC) unit. This documentation is filed in our document library for tracking and auditing purposes. Once LVC staff members receive the appropriate paperwork and sign-offs, they migrate changes to our production environment. To ensure we properly monitor code migrated to production, on a monthly basis IDES will produce a system generated list of changes to review to ensure only approved code was promoted.

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. These forms are filed in our document library. For RACF UserID requests, files are organized in alphabetical order by the user's last name. 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 remind staff of our policy 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 RACF access for Department of Central Management Services Bureau of Communication and Computer Services (BCCS) staff located in Springfield, Illinois, as well as access to the Central Computer Facility (CCF) in Springfield, IL that is managed by the Department of Central Management Services. IDES has no control or management oversight over the BCCS staff, their RACF access rights or management of the CCF or physical access to this facility. IDES will, however, work with DCMS to try and address this issue. IDES has sought clarification from the auditor as to whether this is an issue with IDES' computer room or the DCMS controlled BCCS computer facility.

Bullet 4: We accept this finding. The Department follows a change management methodology to ensure that new development, maintenance programming tasks and emergency changes are authorized and effectively developed and implemented. IDES has not updated its Policy and Procedures to reflect this change management process. We will do so.

RECOMMENDATIONS 50-52
Department of Commerce and Economic Opportunity

13-50. The auditors recommend DCEO establish procedures to accurately report federal expenditures used to prepare the SEFA to the IOC and implement procedures to monitor revolving loan funds operated by subrecipients of the CDBG Cluster program.

Findings: DCEO did not accurately report Federal expenditures under the CDBG – State-Administered Small Cities Program (CDBG) Cluster, the Workforce Investment Act (WIA) Cluster, and the Low-Income Home Energy Assistance Program (LIHEAP) programs.

DCEO 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). Specifically, auditors noted the following unreconciled differences for the year ended June 30, 2013:

Program	Federal Expenditures Reported in DCEO's Records	Federal Expenditures Reported on the Final SEFA	Difference
CDBG Cluster	$ 97,190,000	$ 96,861,000	$ 329,000
WIA Cluster	124,505,000	121,632,000	2,873,000
LIHEAP	205,115,000	205,085,000	30,000

Auditors also noted a correction of $23 million was necessary to eliminate expenditures reported by DCEO that are not subject to A-133.

Additionally, DCEO provided local municipalities (subrecipients) funding to operate revolving loan funds under the CDBG Cluster in the 1980's which were not initially reported on the SEFA or in the related footnotes. During audit procedures, DCEO personnel identified loan balances of $59,843,000 were outstanding according to subrecipient records; however, DCEO was unable to determine the amounts originally provided to subrecipients. Accordingly, auditors were unable to verify if the loan balances ultimately reported in the footnotes to the SEFA were complete and accurate as of June 30, 2013. Auditors also noted DCEO had not implemented procedures to monitor the CDBG revolving loan fund balances as of June 30, 2013.

In discussing this with DCEO officials, they stated that they used a cash basis methodology adjusted for in-transits to prepare financial reports (SCO-563 forms) for the IOC and these amounts needed to be reconciled with cash basis only amounts provided to the auditors. They also indicated it was an error to include the amounts for the WIA Dislocated Workers program in the WIA Cluster. As there were no CDBG revolving loan fund expenditures by DCEO during the audit period, DCEO officials were unaware of the applicability of the A-133 requirement to include a footnote to the SEFA for the loan funds previously passed through to subrecipients.

Response: DCEO accepts the recommendation and will implement reporting procedures to ensure the IOC has the necessary information to include a footnote to the SEFA to identify the loan balances for the CDBG revolving loan funds held by subrecipients. DCEO completed corrective action for monitoring CDBG revolving loan funds and this was acknowledged by USHUD in a letter sent to DCEO on February 20, 2014. DCEO will review its procedures to ensure it provides the amounts from the SCO-563 forms filed with the IOC and any reconciling adjustments for in-transits to the auditor.

13-51. The auditors recommend DCEO implement procedures to monitor the consultant responsible for administering the CDBG disaster recovery grants.

Findings: DCEO did not adequately monitor the consultant responsible for the administration of the Community Development Block Grant (CDBG) disaster recovery grants.

During testwork, auditors noted the USHUD Office of Community Planning and Development had previously conducted (August 2012) a monitoring review of the CDBG disaster recovery grants at DCEO which indicated that DCEO had no policies or procedures in place to monitor consultants responsible for administering the CDBG disaster recovery grants. DCEO submitted a corrective action plan to USHUD in December 2012 describing the monitoring plan DCEO planned to implement; however, auditors noted DCEO had not yet performed any on-site monitoring of the consultant as of June 30, 2013.

In discussing these conditions with DCEO personnel, they stated that a lack of resources in the Office of Community Development contributed to the lack of an on-site review of the CDBG disaster recovery program consultant during the audit period.

Updated Response: Implemented.

13-52. The auditors recommend DCEO review its current procedures for monitoring SEP and Weatherization subrecipients to ensure monitoring tools adequately document the compliance requirements and fiscal/administrative controls being reviewed. Additionally, the auditors recommend DCEO implement procedures to formally communicate the results of monitoring reviews in writing. (Repeated-2012)

Findings: DCEO did not adequately document on-site monitoring procedures performed for subrecipients of the State Energy and the Weatherization Assistance for Low Income Persons (Weatherization) programs.

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 the subrecipients of the State Energy and Weatherization programs. Specifically, auditors noted the checklists used for these programs are highly summarized and do not adequately document the compliance requirements being reviewed or the procedures being performed. Auditors also noted the results of the review procedures are not formally communicated to subrecipients.

DCEO passed through approximately $1,366,000 and $20,006,000 of federal funding to subrecipients of the State Energy and Weatherization programs, respectively, during the year ended June 30, 2013.

In discussing these conditions with DCEO personnel, they stated that corrective action to improve the State Energy Program's (SEP) monitoring procedures and checklists began soon after becoming aware of the monitoring inadequacies from the prior audit but the current year audit period had already ended. For the Weatherization Assistance Program (WAP), Office of Energy Assistance (OEA) staff had assumed existing monitoring procedures were adequate.

Response: DCEO accepts the recommendation and has reviewed and modified monitoring procedures and documents for the SEP program to adequately review and document compliance requirements for subrecipients. Specifically, SEP staff has revised or implemented the following:

enhanced monitoring procedures, checklists and forms; a spreadsheet for SEP staff to track and follow-up on monitoring activities to ensure subrecipients are adequately addressing and resolving findings; and letters which communicate, in writing, the results of monitoring reviews to the subrecipients. SEP's corrective action will continue by implementing and training staff on these new procedures and monitoring tools.

The OEA staff will review current monitoring procedures and tools for programmatic monitoring of the WAP. The OEA staff will design and implement new procedures and monitoring checklists and/or enhance existing ones to ensure monitoring staff routinely and uniformly document compliance requirements and monitoring activities. The OEA staff will ensure adequate compliance monitoring is conducted on the subrecipient as well as individual weatherization projects funded through the subrecipient.

RECOMMENDATIONS 53-67
Department of Transportation

13-53. The auditors recommend IDOT establish procedures to accurately report federal expenditures used to prepare the SEFA to the IOC. (Repeated-2011)

Findings: IDOT did not accurately report Federal expenditures under the Highway Planning and Construction (Highway Planning) Cluster and the Surface Transportation Discretionary Grants for Capital Investment (TIGER) programs which were used to prepare the schedule of expenditures of federal awards (SEFA) to the Illinois Office of the Comptroller. Specifically, auditors noted the following unreconciled differences for IDOT's major programs for the year ended June 30, 2013:

Program	Expenditures Reported on IDOT's Expenditure Pattern	Expenditures Reported on the Final SEFA	Difference
Highway Planning Cluster	$1,443,775,000	$1,429,781,000	$13,994,000
Surface Transportation (TIGER) Program	34,177,000	28,657,000	5,520,000

Auditors also noted a correction of $689,000 was necessary to eliminate expenditures reported by IDOT that are not subject to A-133. Further corrections were required to properly identify ARRA and non-ARRA funded expenditures reported under the Highway Planning and Construction Cluster, High Speed Rail, Formula Grants for Rural Areas, and TIGER programs.

In discussing this with IDOT officials, they stated that adjustments necessary for the GAAP packages were flowed through to the SEFA.

Updated Response: Implemented. The initial corrective action was to seek out guidance/training for SEFA preparation, however we discovered this virtually does not exist. In order to address the finding, we have implemented additional reviews throughout the financial reporting process to ensure accuracy and written procedures were developed for the financial reporting process.

13-54. 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 TIGER programs. Regulations require, in part, that all laborers and mechanics employed by contractors or subcontractors who work on construction contracts in excess of $2,000 financed by Federal assistance funds must be paid prevailing wage rates established for the locality of the project.

During testwork of 48 Highway Planning contractor payments for regular construction projects, 17 Highway Planning contractor payments for advanced construction projects (totaling approximately $6,412,000), and three TIGER contractor payments for regular construction projects (totaling approximately $2,424,000), auditors noted the following:

- The certified payrolls for two Highway Planning contractor payments on advanced construction projects (totaling approximately $315,100) were received 2 to 235 days after payments were made to the contractors.
- The certified payrolls for 28 Highway Planning contractor payments on regular construction projects (totaling approximately $17,693,000) and 3 TIGER contractor payments on regular construction projects (totaling approximately $2,424,000) were not date stamped. As a result, auditors were unable to determine whether they were received prior to making payments to the contractors.
- The certified payrolls for 23 Highway Planning contractor payments on regular construction projects (totaling approximately $14,601,000) were not signed by either the Resident Engineer, documentation staff, or EEO personnel. As a result, auditors were unable to determine whether the certified payroll was approved prior to making payments to the contractor.

In discussing these conditions with IDOT personnel, they stated that with the reduced staffing coupled with the departure or retirement of experienced staff, specific training has not been adequately provided for the procedure of submission and review of certified payrolls.

Updated Response: Accepted and partially implemented. Direction was provided at the Annual Winter Project Implementation meeting held in January 2014 and will be addressed again at the 2015 Annual Project Implementation meeting as well as the annual spring meetings in each district. The Department's written procedures will be thoroughly reviewed and revised to provide better direction to meet federal and state laws as well as FHWA and state policy requirements.

13-55. 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 27 subrecipients of the Airport Improvement Program, 42 subrecipients of the Highway Planning program, and one subrecipient of the TIGER program, auditors noted the following regarding the desk review process:

- The OMB Circular A-133 audit report for one subrecipient of the Airport Improvement program and one subrecipient of the Highway Planning program were not received timely and IDOT did not perform follow up procedures to obtain the reports.
- The OMB Circular A-133 report for one subrecipient of the Highway Planning program was received on April 11, 2013 but had not been reviewed by IDOT as of November 20, 2013.
- IDOT did not issue a management decision related to findings reported within 6 months after receipt of the audit report for three subrecipients of the Airport Improvement Program, three subrecipients of the Highway Planning program, and one subrecipient of the TIGER program.
- IDOT did not reconcile the SEFA reported by the subrecipient to the amounts passed through per IDOT's records for seven subrecipients of the Airport Improvement program.

In discussing these conditions with IDOT officials, they stated that the majority of the issues noted were due to complex subrecipient audits that required additional processing. These processes were not completely defined until the revised procedure manual was implemented in April 2013.

Response: The Department agrees with the finding. The Department has developed a procedures manual for monitoring subrecipient's OMB Circular A-133 reports. The procedures include the use of an updated checklist that addresses reconciliation of expenditures, follow-up requirements for corrective action plans and established a timeline and workflow processes to ensure timely follow-up and completion of the desk review process. Implementation was in April 2013.

Updated Response: Implemented.

13-56. 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 federal program information to its subrecipients of the Airport Improvement Program, the Highway Planning program, and the TIGER program for the year ended June 30, 2013.

During testwork of awards to subrecipients of Airport Improvement Program funds, Highway Planning funds, and TIGER funds, auditors noted the following:

- Six 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.
- Eighteen grant award notices for the Airport Improvement Program, twenty-nine grant award notices for the Highway Planning program, and one grant award notice for the TIGER program included incorrect information regarding the need for an audit in accordance with OMB Circular A-133.
- Eleven grant award notices for the Highway Planning program or the TIGER program did not communicate the specific program or CFDA number and title under which federal financial assistance had been provided.
- One grant award notice for the TIGER program did not communicate (1) the requirement to register with the Central Contractor Registration, and (2) the SEFA and SF-SAC presentation requirements for ARRA-funded awards.

In discussing these conditions with IDOT officials, they stated that corrective action had been implemented in a previous fiscal year, however due the length of time an agreement is active, the

majority of the issues noted were with agreements executed prior to implementation of the corrective action. Due to the number of open agreements and staffing levels, it has not been feasible to amend all open agreements to include the proper language.

Updated Response: Partially Implemented. The Department will provide written notice to all subrecipients with active agreements to notify them of the correct federal program information as required by OMB Circular A-133. This has been completed for the Airport Improvement Program and will be completed for the Highway Planning and Construction Program by June 30, 2015. In addition, a memo will be sent to all business areas processing subrecipient agreements to instruction them to use the revised template when processing all future agreements.

13-57. 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.

During a review of eighty (80) expenditures totaling approximately $25,675,000 auditors noted a warrant was issued for three expenditure vouchers totaling approximately $8,814,000 within five business days of receiving the federal funds intended to finance these expenditures instead of three business days as required.
In discussing this condition with Department officials, they stated that the Cash Managed Hold procedures had been implemented; however this was the first draw after implementation so the Department's processing of vouchers may not have been timely.

Response: The Department agrees with the recommendation. The Department will coordinate with the Comptroller's Office to review the Cash Managed Hold Program to ensure the Department's vouchering process maximizes the benefit of this program to ensure compliance with the U.S. Treasury Regulations.

Updated Response: Implemented.

13-58. The auditors recommend IDOT review the process and procedures in place to prepare financial status reports required for the Airport Improvement program and implement the additional procedures necessary to ensure the reports are complete, accurate, and agree or reconcile to its financial records.

Findings: IDOT did not prepare accurate financial status reports for the Airport Improvement program.

During testwork of the SF-425 annual financial status reports submitted, auditors noted IDOT has not completed all information required to be reported on the SF-425 report. Specifically, lines 10(d) through 10(o) did not contain information on federal expenditures, obligations, recipient share of program expenditures, and program income were not completed. Additionally, auditors noted the following errors in completed lines on the SF-425 report for the federal fiscal year ended September 30, 2012:

Report Line Items	Reported Amount	Actual Amount	Difference
Line 10a – cash receipts	$708,185,581	$236,192,469	$471,993,112

Line 10b – cash disbursements	$708,185,581	$236,192,469	$471,993,112

In discussing these conditions with IDOT officials, they stated that this was the first time the Department had been required to provide the SF-425 and the instructions were unclear causing the amounts reported to be inaccurate.

Response: The Department agrees with the recommendation. The Department has communicated with the Federal Aviation Administration to obtain accurate instructions for completing their SF-425 annual reporting form. The reporting process will be reviewed and the accurate instructions will be implemented to ensure complete and accurate reporting of the financial status reports.

Updated Response: Implemented.

13-59. 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 program in accordance with their approved sampling and testing program.

During testwork, auditors selected 65 materials from ongoing (open) construction projects and advanced construction projects and noted the following:

- In one instance, the material was accepted using a method of acceptance that was not in accordance with the Manual.
- In one instance, the testing method of the material was not in accordance with the Manual.
- In one instance, 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.

In discussing these conditions with IDOT officials, they stated that the items identified were due to error, oversight and computer system limitations.

Response: The Department agrees with the recommendation. The Department will review its aggregate inspection data input practices and notify/remind the districts to correctly document/input aggregate inspection in MISTIC. Also, the Department will re-emphasize to the districts the importance of always using the current Manual for Materials Inspection to determine the method of acceptance for all construction materials.

Updated Response: Implemented. No change.

13-60. The auditors recommend IDOT implement procedures to ensure a value engineering analysis is performed for all applicable construction projects in accordance with its approved value engineering (VE) program.

Findings: IDOT did not perform a value engineering (VE) analysis for construction projects under the Highway Planning program in accordance with the approved VE program.

According to IDOT's approved VE program, IDOT is required to perform an analysis during the planning and development stages for applicable projects that utilize federal highway funding to determine whether: (1) the project provides the needed functions, considering community and environmental commitments, safety, reliability, efficiency, and overall life-cycle cost; (2) improvements can be made for the value and quality of the project; and (3) improvements can be made to reduce the time to develop and deliver the project. During testwork, auditors selected 30 applicable construction projects and noted one instance where a VE analysis was required, but was not performed.

In discussing these conditions with IDOT officials, they stated that there were several years between approval of the project for development of contract plans and the actual time plan production commenced for the occurrence in question.

Response: The Department agrees with the recommendation. The Department will first review the existing procedures in place to ensure VE studies are conducted on required projects. If deficiencies in those procedures are identified, the procedures will be revised in order to more effectively assure compliance with 23 CFR 627. Review and any revisions of the Department's VE procedures will be coordinated with the FHWA pursuant to the Stewardship/Oversight Agreement between the Department and FHWA.

Updated Response: Accepted and partially implemented.

13-61. The auditors recommend IDOT implement procedures to ensure ARRA information and requirements are properly communicated to subrecipients and obtain required Buy American certifications. (Repeated-2010)

Findings: IDOT did not communicate American Recovery and Reinvestment Act (ARRA) information and requirements to subrecipients of the TIGER program.

During testwork of fifteen ARRA disbursements to three subrecipients of the TIGER program, auditors noted one subrecipient agreement did not communicate the requirement to separately report ARRA program expenditures on the schedule of expenditures of federal awards (SEFA) and the data collection form. Additionally, this agreement did not include Buy American Act certifications required for ARRA awards.

In discussing these conditions with IDOT officials, they stated that the business area responsible for processing these agreements was not aware of these requirements prior to the FY12 audit.

Response: The Department agrees with the recommendation. The Department revised the subrecipient agreements to properly communicate the required ARRA information and obtain Buy American certifications for all new subrecipients. In addition, the Department will provide notification to current subrecipients of the required ARRA information.

Updated Response: Implemented.

13-62. The auditors recommend IDOT follow its established procedures to ensure grantees receiving individual awards for $25,000 or more certify that their organization and its principals are not suspended or debarred or otherwise excluded from participation in federal assistance programs. (Repeated-2012)

Findings: IDOT did not obtain required certifications that subrecipients and their principals 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 agreements with three subrecipients program, auditors noted IDOT did not include a suspension and debarment certification in four of the grant agreements.

In discussing these conditions with IDOT officials, they stated that the business area responsible for processing these agreements was not aware of these requirements prior to the fiscal year 2012 audit.

Response: The Department agrees with the recommendation. The Department confirmed that procedures were being followed to ensure that subrecipients are not suspended or debarred. In addition to the fiscal year 2012 revisions to the State Rail Agreements and the Phase III document, additional documentation of these procedures will be included in Phase II design and/or the Phase III construction documents.

Updated Response: Implemented.

13-63. The auditors recommend IDOT implement procedures to monitor each compliance requirement administered by its for-profit subrecipients of the TIGER program. (Repeated-2012)

Findings: IDOT did not monitor all applicable compliance requirements for subrecipients receiving funding under the TIGER program.

During testwork, auditors noted IDOT has implemented certain procedures to monitor its for-profit subrecipients, which include reviewing supporting documentation for 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.

In discussing these conditions with IDOT officials, they stated that the business area responsible for processing these agreements was not aware of these requirements prior to the FY12 audit.

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 review the procedures in place for federal grant compliance for TIGER projects and work with appropriate CREATE partners to improve procedures to ensure those federal compliance requirements are implemented.

Updated Response: Implemented.

13-64. 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. (Repeated-2012)

Findings: IDOT did not prepare accurate financial reports for the TIGER program.

IDOT is required to prepare financial status (SF-425) and ARRA 1512, reports on a quarterly basis for the 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.

Updated Response: Implemented. Multiple sources of reporting information are used for the three federal quarterly reports required for TIGER projects. The Department reviewed the process and procedures in place to prepare the financial reports, and developed and implemented additional quality assurance/quality control measures in September 2014.

13-65. The auditors recommend IDOT implement procedures to verify the High Speed Rail program vendor has complied with the Davis-Bacon Act and the Illinois Procurement Code.

Findings: IDOT did not perform procedures to determine whether a vendor receiving funding under the High Speed Rail program complied with the Davis-Bacon Act or the Illinois Procurement Code.

During testwork, auditors noted IDOT has implemented certain procedures to monitor its vendor, which include reviewing supporting documentation relative to time and material charges incurred by the for-profit organization or vendor 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 vendor and its subcontractors have complied with the Davis-Bacon Act prevailing wage rate requirements or procured services in accordance with the Illinois Procurement Code in carrying out their assigned duties.

In discussing these conditions with IDOT officials, they stated that monitoring procedures were put into place during FY13 to ensure compliance with the Davis-Bacon Act. As for monitoring the Illinois Procurement Code, the Department did not provide the auditors with current processes and documentation to support the monitoring activities by the Department.

Response: The Department agrees with the recommendation. The Department developed monitoring procedures for the Davis-Bacon Act requirements during fiscal year 2013 and written procedures were finalized in June 2013. The Department has been monitoring the Illinois Procurement Code requirements since inception of the agreement with the vendor in question; however, we acknowledge the need to revise our procedures to include those processes and ensure proper documentation is retained to support that monitoring requirements are being met.

Updated Response: Implemented.

13-66. 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.

IDOT is required to prepare financial status (SF-425) and ARRA 1512 reports on a quarterly basis for the High Speed Rail program. During testwork over two SF-425 reports and two ARRA 1512 reports, auditors noted the Expenditure Amount reported did not agree to the Federal Share of Expenditures reported on the SF-425 Federal Financial Report filed for the applicable quarter. Auditors noted the following differences:

Quarter End	Expenditure Amount (1512 Report)	Federal Share of Expenditures (SF-425 Report)	Difference
September 30, 2012	$249,566,163	$254,835,462	($5,269,299)
March 31, 2013	319,830,295	322,696,223	(2,865,928)

Upon further review of the supporting documentation, auditors noted that 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 that the business area responsible for the reporting was unaware of the need to revise the ARRA 1512 to match or reconcile to the SF-425 reports which are generated later in the reporting month.

Response: The Department agrees with the recommendation. The Department reviewed the ARRA 1512 and SF-425 reporting processes and requirements. Corrective action for all deficiencies identified by this review were implemented at the beginning of fiscal year 2014.

Updated Response: Implemented.

13-67. 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. (Repeated-2012)

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

The information technology applications that support the IDOT Integrated Transportation Project Management System include the following:

- The Electronic Contract Management System (ECM)
- The Electronic Letting Management System (ELM)

- The Illinois Construction Records System (ICORS)
- The Bureau of Contract Management System (BCM)
- The Fiscal Operations and Administration System (FOA)
- The Federal Payment Control System (FPC)

During testwork of IDOT's controls over user access to IDOT applications, auditors noted the following:

- Ten terminated employees (out of 25 tested) retained user access after their termination date for the FOA system.
- A shared ID is used by five IDOT employees to complete the federal billing process and access to the account is not logged.

Additionally, during testwork over changes made to IDOT's information systems, 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. Accordingly, auditors were unable to determine whether the list of changes provided by IDOT from the database during the audit was complete.

In discussing these conditions with IDOT officials, they stated that corrective measures were implemented to address the prior year finding in May 2013. The user access issues are due to oversight by the business area responsible for these functions.

Response: The Department agrees with the recommendation. In May 2013, the Department implemented procedures to address the tracking of changes to information systems. In addition, IDOT will review our current practices and communication protocols with the Bureau of Personnel Management to ensure that Information Processing is promptly notified when an employee separates from the agency so that their access permissions can be removed. Finally, the agency will issue a policy reminder to all system users that it is in violation of agency security policy to share user accounts and passwords.

Updated Response: Implemented.

RECOMMENDATIONS 68-70
Illinois Emergency Management Agency

13-68. The auditors recommend IEMA use its revised A-133 Audit Desk Review checklist and continue to evaluate the adequacy of the checklist as monitoring requirements continue to evolve. (Repeated-2010)

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

During testwork of five subrecipients of the Disaster Grants – Public Assistance (Presidentially Declared Disasters) (Public Assistance) program and eight subrecipients of the Homeland Security Grant program, auditors noted the following:

- IEMA did not obtain the OMB Circular A-133 audit reports for five subrecipients of the Public Assistance program, and did not perform follow up procedures to obtain the reports. Amounts passed through to these subrecipients totaled $4,134,000 during the year ended June 30, 2013.
- The standard checklist used by IEMA for A-133 desk reviews completed prior to May 2013 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. Of the subrecipients sampled for each program, auditors noted the deficient checklist was used for two Homeland Security subrecipients who expended $8,000, respectively, during the year ended June 30, 2013.
- IEMA did not reconcile the federal expenditures reported in the schedule of expenditures of federal awards included in subrecipient A-133 reports to IEMA's records for any subrecipients of the Public Assistance program selected for testwork.

Total awards passed through to subrecipients of the Public Assistance and Homeland Security Grant programs were approximately $4,975,000 and $110,517,000, during the year ended June 30, 2013.

In discussing these conditions with IEMA officials, they stated they have been working towards implementing new procedures for ensuring compliance. In addition, a new employee has been hired in the Public Assistance grant program to help perform these reviews.

Response: IEMA agrees with the finding and is currently implementing a new checklist to serve as the standard guidance for employees agency-wide working on any grant program. The agency is also exploring the possibility of hiring one employee to perform one consolidated review for all grant programs.

13-69. 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 15 expenditures (totaling $4,316,219) funded under the advanced basis related to Presidentially Declared Disasters program, auditors noted warrants were not issued for 8 expenditure vouchers (totaling $1,201,806) 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 4 to 11 business days. Total expenditures for the Disaster Grants – Public Assistance (Presidentially Declared Disasters) program administered by IEMA were $5,554,000 during the year ended June 30, 2013.

In discussing these conditions with IEMA personnel, they stated the agency is doing everything possible to minimize the amount of time between draws and expenditures but in some instances, unfortunately a three-day turnaround is just not possible.

Updated Response: Implemented.

13-70. The auditors recommend IEMA establish procedures to: (1) report required subaward information in accordance with FFATA on a timely basis and (2) obtain DUNS numbers from subrecipients prior to issuing final grant awards. (Repeated-2012)

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

As of the date of testwork (October 31, 2013), auditors noted IEMA had not reported the required FFATA information for all subawards made in State FY13 under the Homeland Security Grant program. Subaward information was required to be reported by November 30, 2012.

Additionally, during review of 25 subrecipient awards (19 of which required to be reported under FFATA), auditors noted IEMA had not obtained DUNS number for six subrecipients (with expenditures totaling $9,473,000 during the year ended June 30, 2013) prior to executing final grant award agreements. Total awards passed through to subrecipients of the Homeland Security Grant program during the year ended June 30, 2013 were approximately $110,517,000.

In discussing these conditions with IEMA personnel, they stated that subrecipients of federal preparedness funds are required to submit their DUNS number to IEMA at the time of application for funds. However, federal rules also require that IEMA obligates the local share of the Homeland Security Grant Program within 45 days of issuance of the federal award. This resulted in some of the DUNS numbers not being obtained. Additionally, the agency had problems uploading the FFATA reports into the federal system and tried a number of times.

Response: We agree with the finding and will improve our process to ensure the FFATA reports are uploaded timely, or in the instances that there are federal system issues, we will document our attempts to upload the reports and ensure we are repeatedly following up. The agency will also ensure we collect all DUNS numbers from grantees.

RECOMMENDATION 71
Illinois State Police

13-71. The auditors recommend State Police implement procedures to ensure all inventory items are appropriately tagged. Additionally, implement procedures to ensure supervisory reviews performed over monthly inventory reconciliations are documented. (Repeated-2012)

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

During physical observation of 40 pieces of equipment (totaling $2,537,825) purchased with Homeland Security Grant Funds, auditors noted one item selected from the equipment inventory listing (with a cost value of $48,279) was not tagged. The asset description included in the inventory records appear to be consistent with the asset tested; however, other identifying information (i.e. serial number) was not available or documented in the asset records to verify the asset.

In addition, auditors noted the State Police did not document supervisory review procedures performed over monthly inventory reconciliations completed for the months of July through December 2012.

As of June 30, 2013, the cumulative cost value of equipment purchased by the State Police with Homeland Security Cluster program funding was $13,344,863.

In discussing these conditions with State Police personnel, they stated that this piece of equipment must have been overlooked when a tag should have been applied. The officer in charge of this grant inventory stated that the tag number was hand written on the item. In regards to the reconciliations, the Public Safety Shared Service Center is responsible for the monthly inventory reconciliation process.

Updated Response: Implemented.

RECOMMENDATION 72
Illinois Criminal Justice Information Authority

13-72. The auditors recommend the 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. (Repeated-2012)

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

During review of 40 subrecipient monitoring files for the JAG Cluster program, auditors noted ICJIA did not perform a review of the A-133 reports for any of its subrecipients during fiscal year 2013. As a result, any management decisions were not issued within six months of receiving the OMB Circular A-133 audit report. ICJIA passed through approximately $11,329,000 to subrecipients of the JAG Cluster program during the year ended June 30, 2013.

In discussing these conditions with ICJIA officials, they stated that the timing of the implementation of the ICJIA procedural changes did not leave enough time to not repeat the original finding.

Updated Response: Implemented.

RECOMMENDATION 73
Governor's Office of Management and Budget

13-73. 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 audit, auditors noted the Community Development Block Grants/States Program and Non-Entitlement Grants in Hawaii, Airport Improvement Program, and High Speed Rail Corridors and Intercity Passenger Rail Service – Capital Assistance Grants programs were expected to exceed the $84,342,000 program expenditure threshold in FY13 based on amounts awarded; however, the TSA was not amended to include these programs during FY13.

In discussing these conditions with GOMB personnel, they stated they stated that their revised procedures were put in place toward the end of fiscal year 2013, and it is possible that oversight led to the failure to amend in a timely fashion.

Response: GOMB agrees with the auditors' recommendation. We believe that as our adopted procedures become routine for agencies, compliance will improve. The agency continues to be in close communication with the federal Bureau of the Fiscal Service to improve the State's performance under the CMIA.

RECOMMENDATION 74
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

13-74. The auditors recommend DCMS review its current process for maintaining procurement files and consider any changes necessary to ensure all required documentation is maintained in accordance with State and federal regulations.

Findings: DCMS did not properly retain documentation supporting procurements in accordance with the Illinois Procurement Code.

During testwork of 65 internal service fund expenditures (totaling approximately $12,797,000), auditors noted the bid and contract file supporting one expenditure (totaling approximately $505,700) could not be located for testwork.

In discussing these conditions with DCMS officials, they stated that the one requested file was unable to be located. Auditors believe the file was likely just misfiled or checked out to external parties and therefore not available for testing.

Updated Response: Implemented.