LEGISLATIVE AUDIT COMMISSION

Review of
Statewide Single Audit
Year Ended June 30, 2017

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REVIEW: 4499
STATEWIDE SINGLE AUDIT
YEAR ENDED JUNE 30, 2017

TOTAL FINDINGS/RECOMMENDATIONS – 72

TOTAL REPEATED RECOMMENDATIONS - 53

TOTAL PRIOR AUDIT FINDINGS/RECOMMENDATIONS - 73

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 FY17 Statewide Single Audit of federal funds. The Office of the Auditor General conducted a Statewide Single Audit of the FY17 federal grant programs in accordance with the federal Single Audit Act and Office of Management and Budget (OMB) Circular A-133. The auditors stated that the financial statements were fairly presented.

The Statewide Single Audit includes all State agencies that are a part of the primary government and expend federal awards. In total, 44 State agencies expended federal financial assistance in FY17. 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 $27.5 billion for the year ended June 30, 2017. This represents a $1.3 billion decrease from FY16, or about 4.5%. Overall, the State participated in 363 different federal programs; however, 13 of these programs or program clusters accounted for approximately 94% ($25.9 billion) of the total federal award expenditures as exhibited in the following table.

Federal Program Award	Total Expenditure	% of Total
Medicaid Cluster	$ 10,176,779,000	37.0%
Federal Family Education Loans	4,318,128,000	15.7%
Supplemental Nutrition (SNAP)	3,076,531,000	11.2%
Unemployment Insurance	2,011,738,000	7.3%
Highway Planning, Construction	1,526,095,000	5.5%
Child Nutrition Cluster	689,417,000	2.5%
Title 1 Part A Cluster	687,800,000	2.5%
Temporary Assistance (TANF)	572,345,000	2.1%
Special Education Cluster	522,222,000	1.9%
Children's Health Insurance (CHIP)	312,580,000	1.1%
All Others	3,612,004,000	13.2%
Total Federal Awards	$ 27,505,639,000	

The funding for the 363 programs was provided by 44 different federal agencies. The table below shows the five federal agencies that provided Illinois with the vast majority of federal funding in FY17.

Federal Funding Agency	Total Grant	% of Total
Health & Human Services	$ 12,325,800,000	44.8%
Education	5,984,000,000	21.8%
Agriculture	4,156,600,000	15.1%
Labor	2,197,100,000	8.0%
Transportation	2,181,700,000	7.9%
All Others	660,400,000	2.4%

A total of 30 federal programs were identified as major programs in FY17. The 30 major programs had combined expenditures of $25.8 billion, and 333 non-major programs had combined expenditures of $1.7 billion. Eleven State agencies accounted for approximately 98.8% of all federal dollars spent in FY17 as depicted in the table below.

State Agency	Federal Expenditures	% of Total
DHFS	$ 10,192,700,000	37.1%
Human Services	4,773,700,000	17.4%
Student Assistance	4,318,400,000	15.7%
Board of Education	2,337,100 ,000	8.5%
Transportation	2,177,700,000	7.9%
Employment Security	2,050,000 ,000	7.5%
DCEO	412,700,000	1.5%
DCFS	391,500,000	1.4%
Public Health	256,300,000	0.9%
EPA	166,800,000	0.6%
IEMA	105,800,000	0.3%
All Others	322,900,000	1.2%

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	15	14
Healthcare and Family Services	7	4
Children and Family Services	12	9
Public Health	4	4
Insurance	1	1

State Board of Education	6	4
ICCB	2	2
ISAC	3	2
Employment Security	6	5
Commerce & Economic Opportunity	1	1
Transportation	5	3
Environmental Protection Agency	3	N/A
Aging	6	3
TOTAL	72	53

RECOMMENDATION 1
Office of the Governor
Office of the State Comptroller

17-01. 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)

Finding: The State of Illinois' current financial reporting process does not allow the State to prepare a complete and accurate Schedule of Expenditures of Federal Awards (SEFA) in a timely manner. Reporting issues at various individual agencies caused delays in finalizing the Statewide SEFA.

Accurate financial reporting problems continue to exist even though the auditors have: (1) continuously reported numerous findings on the internal controls (material weaknesses and significant deficiencies), (2) commented on the inadequacy of the financial reporting process of the State, and (3) regularly proposed adjustments to the financial statements year after year. These findings have been directed primarily towards major State agencies under the organizational structure of the Office of the Governor and towards the Office of the State Comptroller (IOC).

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 even though the Illinois Office of the Auditor General has repeatedly informed State agency officials that the post-audit function **is not** a substitute for appropriate internal controls at State agencies.

The State of Illinois has a highly-decentralized financial reporting process. The system requires State agencies to prepare financial reporting packages designed by the IOC. These financial reporting packages are completed by accounting personnel within each State agency who have varying levels of knowledge, experience, and understanding of IOC accounting policies and procedures. Agency personnel involved with this process are not under the organizational control or jurisdiction of the IOC.

Although these financial reporting packages are subject to review by the IOC's financial reporting staff during the Comprehensive Annual Financial Report (CAFR) preparation process and there are minimum qualifications for all new GAAP Coordinators who oversee the preparation of financial reporting forms, the current process still lacks sufficient internal controls at State agencies. As a result, adjustments relative to the SEFA continue to occur.

Additionally, internal control deficiencies have been identified and reported relative to the SEFA financial reporting process in each of the past fifteen 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 included: (1) corrections to amounts reported or provided during the audit; (2) adjustments to accurately report loan balances; and (3) unreconciled amounts. These items have been reported in agency level findings for the DHS, DHFS, DCFS, IDPH, ISBE, ICCB, IDES, DCEO, IDOT and DoA. Additionally, other correcting entries were required in order to accurately state the financial information provided by various other State agencies.

Although the deficiencies relative to the 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 external financial reporting. Although there were improvements to the timing of receiving the SEFA, corrective action necessary to remediate these deficiencies **continues to be problematic**.

According to 2 CFR 200.510(b), a recipient of federal awards is required to prepare a schedule of expenditures of federal awards (SEFA) for the period covered by the entity's financial statements which must include the total federal awards expended as determined in accordance with 2 CFR 200.502 and must include the total amount provided to subrecipients for each federal program.

Additionally, 2 CFR 200.303 requires that non-Federal entities receiving federal awards establish and maintain internal control designed to reasonably ensure compliance with federal laws, regulations, and the terms and conditions of the federal award.

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. Without adequate financial and grants management systems, agency staff are required to perform highly manual calculations of SEFA amounts in a short time frame which results in increased errors. The lack of adequate financial and grants management personnel is due in part to a failure to establish the necessary job titles with specific qualifications to ensure agencies hire applicants who have the minimum required education and specialized skills. In 2014, the Financial Reporting Standards Board (jointly sponsored by the Governor and the Comptroller) issued new guidelines for internal audits and recommended minimum qualifications for GAAP coordinators at State agencies that should assist in addressing the lack of adequately trained personnel.

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 old and antiquated highly decentralized system of tracking, reporting and compiling federal spending information is inadequate to allow for the timely and accurate completion of the SEFA.

Failure to establish effective internal controls at all agencies regarding financial reporting for the preparation of the SEFA may prevent the State from completing an audit in accordance with timelines set forth by the Uniform Guidance and may result in the suspension of federal funding.

Office of the Governor's Response: The Office of the Governor concurs with the auditor's finding and recommendation. The Office of the Governor and the Office of the State Comptroller will continue to work together to address the core issues of the State's inability to produce timely and accurate GAAP basis financial information. Both offices are in the midst of a multi-year implementation of an Enterprise Resource Planning (ERP) system to develop an integrated

enterprise-wide application system for financials, which is an aspect of the Governor's Executive Order that created the Illinois Department of Innovation and Technology to transform Illinois' IT systems to be more responsive to state employees and taxpayers. An operational ERP system will improve the State's control environment and processes to produce accurate financial statements in a timely manner.

IOC's Response: The Office accepts the recommendation. While it is expected that the 2017 SEFA audit will be submitted prior to the March 31st deadline, the Office agrees that the existing financial reporting systems need to be upgraded with a cost-effective statewide grants management system that is designed to provide the information needed to complete the SEFA report and to improve the quality of the accounting information provided to the IOC.

RECOMMENDATION 2-16
Department of Human Services

17-02. The auditors recommend DHS implement adequate general information technology control procedures for the IES system. The auditors also recommend DHS evaluate the known IES system issues, implement monitoring procedures to identify potential noncompliance relative to its federal programs resulting from these items, and consider the changes necessary with respect to internal controls over eligibility determinations to ensure only eligible beneficiaries receive assistance under its federal programs. (Repeated-2015)

Finding: The Illinois Department of Human Services (DHS) and the Department of Healthcare and Family Services (DHFS) did not have appropriate controls over the Integrated Eligibility System (IES) used for eligibility determinations performed for the Supplemental Nutrition Assistance Program (SNAP) Cluster, Temporary Assistance for Needy Families (TANF) Cluster, Children's Health Insurance Program (CHIP), and Medicaid Cluster programs.

DHS administers the SNAP Cluster, the TANF Cluster, and certain Medicaid Cluster waiver programs and DHFS administers the CHIP and Medicaid Cluster programs. Effective October 1, 2013, the State implemented the Integrated Eligibility System (IES) to perform and document eligibility determinations for certain beneficiaries of its Medicaid Cluster program and later expanded to SNAP Cluster, TANF Cluster, and CHIP.

During testwork, the auditors were unable to perform adequate procedures to satisfy themselves that certain general information technology controls over the IES system were operating effectively. Specifically, they noted DHS and DHFS could not provide all information necessary to test system access security controls relative to the network on which IES resides. Additionally, a specific change management policy has not been developed for IES.

Accordingly, the auditors were not able to rely on IES with respect to the testing of the eligibility and related allowability compliance requirements for beneficiary payments made under the TANF Cluster, CHIP, and Medicaid Cluster programs. The auditors were also not able to rely on IES with respect to the special test and provision –- ADP System for SNAP related to the SNAP Cluster program.

In addition to the control deficiencies identified above, the auditors noted several instances of noncompliance during the review of system data obtained from IES. Specifically, the auditors noted cases were approved in IES despite beneficiaries not meeting eligibility requirements related to citizenship status or residency (immigration status). The auditors also noted cases were approved

in IES without valid social security numbers or submission of an application for a social security number. While DHS and DHFS were aware of certain system issues and have established manual workarounds for certain known errors, formal procedures were not established to monitor and evaluate noncompliance resulting from the known systems errors during the year ended June 30, 2017.

As a result of DHS' and DHFS' failure to have appropriate controls over the Integrated Eligibility System, the auditors qualified their opinion on the SNAP, TANF, CHIP, and Medicaid Cluster programs.

Details of the beneficiary payments paid by the State during the year ended June 30, 2017 for the SNAP Cluster, TANF Cluster, CHIP, and Medicaid Cluster programs are as follows:

Major Program	Total Beneficiary Payments in Fiscal Year 2017	Total Fiscal Year 2017 Program Expenditures	Percentage
SNAP Cluster	$2,964,118,000	$3,076,531,000	96.3%
TANF Cluster	42,009,000	572,345,000	7.3%
CHIP	280,375,000	312,580,000	89.7%
Medicaid Cluster	9,582,593,000	10,176,779,000	94.2%

In discussing these conditions with DHS officials, they stated the planned corrective action requires significant time and resources and they have prioritized corrective action of the findings noted based upon the risks involved. They also stated the non-financial eligibility issues identified were a combination of caseworker and system defects.

Response: The Departments accept the recommendation. The security issues were previously identified by the Department and a Plan of Action and Milestones (POA&M) was developed to track each issue, with the exception of two which are tracked in the weekly infrastructure technical meeting. In addition, Corrective Action Plans (CAPs) are in progress for each.

The Departments believe the errors found in the data researched for non-financial factors can be attributed to caseworker error due to the small percentage of cases affected. 496,154 cases were approved in IES and of those, 251 cases appeared to have a non-financial factor that would prevent eligibility, indicating less than .06% error rate. These are total cases representing Cash, SNAP and Medical for Health and Family Services and Department of Human Services combined. We are not stating that a system error is not possible, but at this point we do not have a known system error. However, the Departments did not investigate each case independently of the SQL run against the data to state emphatically that system error is not a possibility.

Updated Response: Partially Implemented.

Corrective Action Plan Completed:

- The IES SSP documents all security and privacy controls according to MARS-E and NIST requirements;

- IDHS has a change management policy/procedure that is being followed by Deloitte. As these are "standards", they apply across IDHS systems/applications. The only difference is for those items in development which are approved via email. Current policy/procedures:
    - 1 DoIT Change Management Policy, v1.2
    - 1 DoIT IT Governance Policy, v1.1
    - 2 DoIT General Security for Statewide IT Resources Policy
    - 3 IDHS III320-05 - Phases of SDLC

- DHS believes the errors found in the data researched for non-financial factors can be attributed to caseworker error due to the small percentage of cases affected. 496,154 cases were approved in IES and of those, 251 cases appeared to have a non-financial factor that would prevent eligibility, indicating less than .06% error rate. These are total cases representing Cash, SNAP and Medical for Health and Family Services and Department of Human Services combined. We are not stating that a system error is not possible, but at this point we do not have a known system error. However, the Departments did not investigate each case independently of the SQL run against the data to state emphatically that system error is not a possibility;

- The Integrated Eligibility System (IES) has formal procedures regarding system errors/weaknesses which is the IES Plan of Action and Milestones document. The document is reviewed and submitted quarterly to Federal CMS;

- For Hardware Inventory, MIS has ensured that all hardware (servers/components) are included on the Hardware Inventory and maintained in a location accessible by the Department's IES Security and Technical leads;

- For Infrastructure User Access: Current POA&M;

    1) All new users submit appropriate documentation for approval/access: Completed
    2) Existing user access listing and request documentation received and approved.

- Implemented Separation of Duties, Least Privilege, Security Functions.

Corrective Action in Progress:

- For Server End of Life (EOL):
    - Replacing with new appliances.
    - Extended Support Agreements and/or upgrade completed for EOL software (12 products).
    - 1) 2 products with Extended Support Agreements
      2) 9 products submitted purchase request to DoIT and currently in DoIT procurement process.
      3) 1 product not needed once DB2 is upgraded by DoIT. Task Order submission and planned submission and planned implementation of DB2 to be determined.

- For PII/PHI Exposure: Current POA&M
    - 1) Develop requirements of design: In process
    - 2) Application updated with requirements, tested and moved to Production

- For Incorrectly Configured Devices: Current POA&M

- 1) Decommission 2nd LDAP used in IES during infrastructure maintenance transition to DoIT: In progress
- 2) Risk mitigated through use of other controls

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

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

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

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

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

Expected Implementation Date: 10/01/2020

17-03. The auditors recommend DHS review its current process for maintaining and controlling beneficiary case records and consider the changes necessary to ensure case file documentation is maintained in accordance with federal regulations and the State Plans for each affected program. (Repeated-2007)

Finding: DHS 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 Medicaid Cluster programs.

DHS is the State agency responsible for performing eligibility determinations for the federal public welfare assistance programs. DHS has established a series of local offices throughout the State at which eligibility determinations and redeterminations are performed and documented. The eligibility intake processes for each of the programs identified above require case workers to obtain and review supporting documentation including signed benefits applications, copies of source documents reviewed in verifying information reported by applicants, and other information. Although most of this

information is entered into the electronic case record, DHS also maintains manual paper files which include the source documents required to determine eligibility for its federal programs.

During testwork, the auditors noted the procedures in place to maintain and control manual beneficiary case file records do not provide adequate safeguards against the potential for the loss of such records. Specifically, in the review of case files at five separate local offices, the auditors noted manual case files were generally available to all DHS personnel and that formal procedures have not been developed for checking hard-copy case files in and out of the file rooms or for tracking their locations. The auditors selected 10 TANF Cluster eligibility case records from each of the five separate local offices (50 total) and noted 13 case records could not be located for the testing. The auditors also selected 50 eligibility case records from two off-site storage facilities and noted 19 case records could not be located for the testing.

In addition, during the testwork over case files selected for the TANF Cluster, CHIP, and Medicaid Cluster programs, the 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 DHS.

In discussing these conditions with DHS officials, they stated the weakness can be attributed to the enormous caseload; difficulty in locating case records in the Family and Community Resource Centers (FCRCs); and in centralized storage facilities; and the current transition from paper records to a completely digital record system.

Response: The Department accepts the recommendation. In order to relieve some of the space limitations, offsite storage facilities were obtained and are being used. The Department is now utilizing a document management system that is capturing a portion of the information that was previously printed and stored in the paper case file, and now stored electronically. This is assisting in the reduction of the overwhelming size and amount of paper files in the offices. Additionally, we are in the midst of converting to a digital file system, which is accompanied by a learning curve in the utilization of scanning equipment and digital cataloguing processes.

Updated Response: Implemented.

Corrective Action Completed:

- As part of the phase two implementation of the new Integrated Eligibility System implemented in October 2017, all electronic documents produced are done so in electronic format, significantly reducing the need for paper-based files stored at the local offices;

- As part of the Illinois Medicaid Redetermination Project, implemented in 2014, copies of all medical only redetermination forms mailed to the customer, returned redetermination forms, electronic data matching results, request for missing information, and verifications provided by the client will be stored in content manager, reducing the need for error prone paper case filing;

- The new Integrated Eligibility System enhances the paperless case file concept. For new applicants, the caseworker now has the ability to upload client documents and associate those documents with the application on which they are working. Staff are able to view these documents in IES.

- The audit report states that case records are generally available to all DHS personnel and that formal procedures have not been developed for checking hard copy files in and out of the file rooms for tracking and location. Due to the volume of case records being maintained

by the Department, IDHS made the decision to move the vast majority of paper case files to three central storage facilities. As a result, IDHS eligibility files are not generally available to DHS staff. Additionally, given the progress made with the new Integrated Eligibility System (IES) as described above, hard copy case files are no longer being generated or created.

17-04. The auditors recommend DHS 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)

Finding: DHS could not locate case file documentation supporting eligibility determinations for beneficiaries of the TANF Cluster, CHIP, and the Medicaid Cluster programs.

During testwork, auditors selected eligibility files to review for compliance with eligibility requirements and for the allowability of the related benefits provided. Some items DHS could not locate or provide were as follows:

- the initial case application or redetermination completed and signed by the beneficiary;
- adequate documentation that citizenship verifications were performed to verify the beneficiaries were eligible;
- verification of the beneficiary's social security number;
- adequate documentation evidencing income and asset verification was performed;
- adequate documentation of residence verification of the beneficiary;
- adequate documentation that the beneficiary assigned their right to collect medical benefit payments to the State of Illinois;
- adequate documentation that cross match verifications were performed to verify the beneficiaries were eligible; and
- evidence that DHS verified these beneficiaries' participation in program work activities.

In discussing these conditions with DHS officials, they stated the cause of the finding can be attributed to misplaced, misfiled, or erroneously indexed documentation.

Response: The Department accepts the recommendation. The Department continues to ensure staff understands the importance of proper and accurate filing processes. The Department also continues to expand 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: Implemented.

Corrective Action Completed:

- As part of the phase two implementation of the new Integrated Eligibility System implemented in October 2017, all electronic documents produced are done so in electronic format, significantly reducing the need for paper-based files stored at the local offices;

- As part of the Illinois Medicaid Redetermination Project, implemented in 2014, copies of all medical only redetermination forms mailed to the customer, returned redetermination forms, electronic data matching results, request for missing information, and verifications provided by the client will be stored in content manager, reducing the need for error prone paper case filing;

- The new Integrated Eligibility System enhances the paperless case file concept. For new applicants, the caseworker now has the ability to upload client documents and associate with the application on which they are working. Staff are able to view these documents in IES;

- Due to the volume of case records being maintained by the Department, IDHS made the decision to move the vast majority of hard copy case eligibility files to three central storage facilities. As a result, IDHS eligibility files are not generally available to DHS staff. This has resulted in less missing or misplaced paper. Additionally, given the progress made with the new Integrated Eligibility System (IES) as described above, hard copy case files are no longer being generated or created. Once a document is scanned into the IES case, it remains indefinitely with no chance of the scanned document being misplaced or lost.

17-05. The auditors recommend DHS review its current process for performing eligibility redeterminations and consider changes necessary to ensure all redeterminations are performed within the timeframes prescribed within the State Plans for each affected program. (Repeated-2003)

Finding: DHS did not perform "eligibility redeterminations" for individuals receiving benefits under TANF Cluster, CHIP, and Medicaid Cluster programs in accordance with timeframes required by the respective State Plans.

Each of the State Plans for the TANF Cluster, CHIP, and Medicaid Cluster programs require the State to perform eligibility redeterminations on an annual basis. During the testwork over eligibility, the auditors noted the State was delinquent (overdue) in performing the eligibility redeterminations for individuals receiving benefits under the TANF Cluster, CHIP, and Medicaid Cluster programs. The delinquency statistics by program for June 2017 are as follows:

Program	Number of Overdue Redeterminations	Total Number of Cases	Percentage of Overdue Cases
TANF	4,759	26,828	17.74%
CHIP	196,286	1,334,735	14.7%
Medicaid	55,824	462,822	12.1%

In discussing these conditions with DHS officials, they stated the finding can be attributed to an increasing number of overdue redeterminations due to the absorption of cases that require staff action in completing the redetermination, rather than using the now obsolete Passive or Administrative Renewal process, which allowed eligible medical cases to be redetermined based on the absence of any known changes in the customer's household or financial situation. Additionally, the audit period was met with a substantial learning curve for staff becoming acclimated to the newly developed system and its functionality.

Response: The Department accepts the recommendation. The redetermination process will be enhanced with the implementation of the new updated processing system in IES Phase 2, which went live on October 24, 2017. The IES Phase 2 system will assist in tracking and auto initiating renewal notices to eligible customers using a three-step process. Online and classroom training venues are mandated and available for periodic, as needed reference to all staff using the new system.

Updated Response: Partially Implemented.

Corrective Action Completed:

- The Department completed the implementation of the Integrated Eligibility System (IES), which will provide enhancements to the redetermination process for many medical cases. This enhancement will utilize a 3-step process:

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

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

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

- For TANF cases, the EDG (Eligibility Determination Group) will be closed if the customer does not appear for the scheduled mandated face to face interview;

- For SNAP cases, the EDG (Eligibility Determination Group) is closed if the necessary redetermination application is not returned to the Department.

Corrective Action Plan in Progress:

- Each Regional Administrator will be required to submit a plan of action in order to improve our redetermination currency Due April 30th.

  Implementation Date: 06/30/2019

17-06. The auditors recommend DHS review its current process for calculating beneficiary payments and consider changes necessary to ensure payments are properly calculated and paid. (Repeated-2012)

Finding: DHS made improper payments to beneficiaries of the TANF Cluster program.

During testwork of 50 TANF Cluster program beneficiary payments, auditors noted 6 beneficiaries received payments that were improperly calculated. As a result of the calculation errors, the monthly payments for 4 beneficiaries were overstated in total by $307 and the monthly payments for 2 beneficiaries were understated in total by $47. Total payments made to these beneficiaries under the TANF Cluster were $17,068 for the year ended June 30, 2017. As of the date of the testing (January 30, 2018), the payment errors identified in the sample had not been corrected by DHS.

In discussing these conditions with DHS officials, they stated the cause of the finding can be attributed to human error in the calculation of the initial TANF payment that is issued to a family subsequent to a determination of eligibility. This initial payment results from a calculation that involves a percentage of the standard TANF monthly payment and the number of days remaining in the payment month after the eligibility determination.

Updated Response: Implemented.

Corrective Action Implemented:

- In order to have the improper payments corrected, DHS- Bureau of Collections (BOC) was notified of the specifics of the improper payments so that overpayments can be established.

On March 12, 2018, the cases in question were sent to the Bureau of Collection for review. On the same day, the Bureau of Collections submitted the overpayments to the Accounts Receivable System (ARS) for collection action;

- There was one case that had a $46 underpayment, however this customer has not been active on a TANF case since August 2017. The underpayment will be made when and if the customer returns to TANF;

- Phase 2 of IES was implemented in State Fiscal Year 2018 to eliminate the problem by performing automatic calculations.

17-07. The auditors recommend DHS 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)

Finding: DHS 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 DHS' controls over user access to DHS applications—Concurrent (eligibility system), Child Care Management System, Consolidated Accounting Record System, Cornerstone (data management)—auditors noted the following:

- DHS could not provide all information necessary to test that user access was appropriately removed from the various computer systems. Specifically, the auditors noted: (1) user access termination forms were not consistently completed or retained by DHS; (2) terminated users retained application access after their termination date; and (3) user IDs for terminated users were reassigned to new hires.
- User access reviews were not performed in accordance with established procedures by DHS to ensure user access rights were appropriate for the various applications.
- User access for users with administrative access at DHS local offices was not reviewed to ensure user access rights were appropriate for the applications.
- Network password settings did not conform to the State's policy for expiration and account lockout requirements.
- DHS' policies and procedures do not include specific procedures to review access rights for users at subrecipient organizations who have been contracted to assist DHS in carrying out compliance requirements for the Special Supplemental Nutrition Program for Women, Infants, and Children, Child Care Development Funds Cluster, and TANF Cluster programs.

Additionally, during testwork over changes made to DHS' information systems, the auditors noted DHS 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 DHS officials, they stated the exceptions are the result of DHS employees not following DHS policies and procedures and inadequate monitoring controls. Additionally, they stated two systems are over 30 years old and are not capable of producing system generated lists of program changes.

Response: The Department accepts the recommendation. The policies and procedures to review access rights for subrecipient organizations are the same access policies and procedures currently in place for internal users. RACF/LAN Coordinator training has been updated and are routinely held for new RACF/LAN Coordinators and used as a refresher to existing coordinators.

In regards to Cornerstone, review of access rights is included in the Cornerstone User Manual. Concurrent was replaced with Phase 2 of the IES application in October 2017. CARS is expected to be replaced with the Department of Innovation and Technology (DoIT) Enterprise Resource Planning (ERP) solution.

The current change management tracking system, Consolidated Accounting System (CATS) is utilized by all applications/programs for tracking of changes and bill-back and is deemed by DHS to provide adequate compensating controls with low risk. DHS, MIS has developed a new system, Information Technology Work Unit Reporting (ITWUR), which will replace CATS. In addition, Rational Team Concert (RTC) will be implemented which is in accordance with NIST guidance and recommendations regarding change management. This system will provide appropriate system requests and tracking for all changes to DHS systems and applications. This will provide a system generated listing of all changes, much like the Remedy System used by DoIT.

Updated Response: Partially Implemented.

Corrective Action Completed:

- The Bureau of Information security (BIS) has enhanced current monitoring of audit review responses to ensure timely completion of annual access reviews;
- The Bureau of Information Security has also provided quarterly/bi-annual refresher training for RACF/LAN Coordinators;
- BIS invited current RACF/LAN Coordinators to attend bi-monthly New Coordinator trainings;
- Developed specific refresher training curriculum.

Corrective Action in Progress:

- MIS Corrective Action - is working to develop and implement ITWUR (IT Request for Work Unit Reporting) and RTC (Rational Team Concert based application);
- Program (Cornerstone) Corrective Action – Working to ensure all subrecipient organizations complete an annual access review per Cornerstone policy;
- Program Corrective Action – Working to ensure RACF/LAN Coordinators attend refresher training;
- Program Corrective Action – Working to ensure RACF/LAN Coordinators complete/maintain appropriate On-boarding and Off-boarding documentation as well as any other MIS access requests.

Expected Implementation Date: 7/30/2019

17-08. The auditors recommend DHS review its process for monitoring compliance with the Substance Abuse Prevention and Treatment Maintenance of Effort (SAPT MOE) and for maintaining documentation for expenditures used to meet its SAPT MOE requirement. (Repeated-2014)

Finding: DHS did not maintain the required aggregate State expenditures for the maintenance of effort (MOE) requirements and was unable to provide adequate documentation to substantiate DHS

met the MOE requirements for the Block Grants for Prevention and Treatment of Substance Abuse (SAPT) program.

During the current fiscal year, the auditors noted DHS did not maintain the necessary aggregate expenditures to meet the SAPT MOE requirement. The following table illustrates the shortfall:

	DHS Actual Aggregate State Expenditures for State Fiscal Year June 30, 2017	**MOE Requirement**	**Amount of Shortfall**
MOE expenditures	$95,427,750	$120,725,801	($25,298,051)

Auditors noted DHS could not provide detailed supporting documentation for expenditures totaling $23,204,631. Accordingly, these expenditures are not allowable for purposes of meeting the maintenance of effort requirement.

In discussing these conditions with DHS officials, they stated the finding is a result of the inability of MIS to provide detailed supporting documentation for medical services provided by Managed Care Organizations (MCOs). Without access to supporting documentation for Medicaid services provided by MCOs, the State is unable to determine and to document if MOE was met.

Updated Response: Partially Implemented.

Corrective Action Completed:

- The Division of Substance Use Prevention and Recovery (SUPR) will work with DHS-MIS to develop a process to obtain detail for Medicaid payments used for MOE;

- SUPR will also discuss with the DHS Office of the Budget, the MOE shortfall and develop a plan to:
    - Explore the use of Managed Care Organization (MCO) billing information;
    - Ability to request and receive added state funds for treatment services and or prevention services.

- In addition, DASA will finalize MCO billing data and integrate it into the MOE reporting for the Center for Substance Abuse Treatment (CSAT) and audits.
    - Data Obtained from MCOs for SFY16 and SFY17:
    - Methodology set for adding MCO date to MOE calculations has been completed and submitted. This is pending SAMSHA approval at this point in time;
    - MCO expenditures need to be finalized;
    - General revenue Fund (GRF) need for meeting MOE has been discussed with DHS Budget staff.

Corrective Action in Progress:

- Await feedback from CSAT to modify MOE tables on the online application system (BGAS) for SABG reporting of expenditures.

Expected Implementation Date: 3/31/2019.

17-09. The auditors recommend DHS review its current process for identifying and reporting interagency expenditures and implement monitoring procedures to ensure that federal and state expenditures expended by other State agencies meet the applicable program regulations. (Repeated-2015)

Finding: DHS does not have an adequate process for monitoring interagency expenditures claimed under the SNAP Cluster, TANF Cluster, Child Care Cluster, Social Services Block Grant (Title XX), and Block Grants for the Prevention and Treatment of Substance Abuse (SAPT) programs.

Federal and State expenditures under the SNAP Cluster, TANF Cluster, Child Care Cluster, Title XX, and SAPT programs are comprised of programs operated by various State agencies. As the State agency responsible for administering these programs, DHS has executed interagency agreements with each of the State agencies expending federal and/or State program funds. The interagency agreements require periodic reporting of a summary of the agency's "allowable" expenditures to DHS for preparation of the financial reports required for each program. DHS is responsible for establishing procedures to ensure the expenditures reported by the expending State agencies meet the applicable federal requirements.

During the year ended June 30, 2017, DHS reported expenditures from other agencies that were claimed for reimbursement or used to meet maintenance of effort (MOE) requirements as follows:

Program	Expending State Agency	Expenditure Claimed	Total Expenditures
SNAP Cluster	Department of Healthcare and Family Services	$ 940,000	$ 3,076,531,000
TANF Cluster	Department of Children and Family Services	275,877,000	572,345,000
TANF Cluster	Department of Healthcare & Family Services	1,810,000	572,345,000
TANF Cluster	Illinois Department of Revenue	45,654,000	572,345,000
TANF Cluster	Illinois Student Assistance Commission	5,006,000	572,345,000
TANF MOE	Department of Healthcare & Family Services	5,524,000	537,722,000
TANF MOE	Illinois State Board of Education	51,452,000	537,722,000
Child Care Cluster	Department of Children and Family Services	34,000	188,076,000
Child Care MOE	Department of Children and Family Services	16,920,000	86,889,000
Title XX	Illinois Department of Public Health	2,810,000	50,943,000
Program	**Expending State Agency**	**Expenditure Claimed**	**Total Expenditures**
SAPT	Illinois Department of Revenue	29,000	70,277,000
SAPT	Illinois Department of Public Health	305,000	70,277,000

During testwork over the documentation of the monitoring procedures discussed above, the auditors noted the following deficiencies:

- Program questionnaires describing internal control procedures were not obtained by DHS from the Department of Healthcare and Family Services (SNAP Cluster).
- DHS did not perform a detailed review of costs claimed from expenditures reported by the Department of Children and Family Services (TANF Cluster) to ensure they met the specific program requirements.

- DHS did not reconcile the expenditures reported by IDPH at the end of State fiscal year 2017 to the amount reported and claimed under the Title XX program by DHS. The auditors noted IDPH incurred and paid $3,612,000 to subrecipients under the Title XX program; however, DHS only reported the $2,810,000 reimbursed to IDPH. As a result, amounts reported on the Statewide SEFA for the Title XX program and related amounts passed through to subrecipients were understated by $802,000.

In discussing these conditions with DHS officials, they stated the condition found was a result of late or incomplete responses from other Illinois' State human services agencies.

Updated Response: Implemented.

Corrective Action Completed:

- IDHS has stressed to the Department of Healthcare and Family Services the importance of returning the program questionnaire describing internal control in a timely accurate manner. A copy of the program questionnaire describing internal control has been received and filed;

- The Bureau of General Accounting has added a process to follow up with the Illinois Department of Public Health (IDPH) regarding expenditures. The amounts reported on the SCO567/568 were correct. They had expenditures that had not yet been reimbursed because DHS had not received notification of the expenditures by June 30. These additional expenditures were accounted for in the "due to amount";

- In regards to the SEFA not showing the correct amount, General Accounting uses the "Grantee" expenditure amounts on the SEFA. However, last year there was an issue with the download from IOC giving us, the "Grantor" expenditures rather than the "Grantee" expenditures. This caused the erroneous information in the SEFA. The SEFA was revised in January of 2018 using the correct "Grantee" amounts;

- The Office of Contract Administration (OCA) is continuing to monitor the interagency expenditures to ensure that federal and state expenditures expended by other State agencies meet the applicable program regulations.

17-10. The auditors recommend that DHS review its procedures for monitoring its service organizations and implement additional procedures to ensure appropriate follow up is performed relative to control deficiencies identified at its service organizations. Such procedures should include documentation of DHS' assessment of the impact of any control deficiencies and/or noncompliance identified in the service organization control report on the SNAP Cluster program.

Finding: DHS has not established adequate procedures to ensure controls are operating effectively at its third party service organization for the Supplemental Nutritional Assistance Program (SNAP) Cluster.

DHS issues SNAP benefits in the form of EBT (Electronic Benefits Transfer) cards to beneficiaries of the SNAP Cluster which are used to purchase food from retail stores. DHS contracts with a service organization to pay retailers that have accepted EBT cards for food purchases. Among other things, the service organization is responsible for drawing cash from the U.S. Treasury which is used to reimburse retailers. DHS is responsible for reconciling the payments made to retailers by its service organization with the amounts drawn from its EBT account with the U.S. Treasury on a monthly basis.

In order to ensure the service organization is properly performing its contracted duties relative to the EBT card settlement process, DHS requires the service organization to have a service organization control report. Auditors noted the auditors' report was modified for one control objective that was not achieved. Specifically, the control objective related to ensuring logical access to programs, data, and computer resources is restricted to authorized and appropriate users, and such users are restricted to performing authorized and appropriate actions was not achieved.

DHS personnel responsible for reviewing the service organization report did not identify the report modification as an exception or control deficiency on their internal review checklist and did not perform procedures to assess the impact of the control deficiencies with respect to the SNAP Cluster program until this item was identified during the audit.

In discussing these conditions with DHS officials, they stated a documented review of the SOC 1 report was not completed due to competing priorities in the current workflow.

Updated Response: Implemented.

Corrective Action Completed:

- The Division of Family and Community Services (FCS) has identified/created a review sheet to be used for documentation of the SOC1 Report (Service Organization Controls Report) review and follow-up.

17-11. The auditors recommend DHS establish procedures to accurately report federal expenditures (including subrecipient expenditures) used to prepare the SEFA to the IOC. (Repeated-2013)

Finding: DHS did not accurately report Federal expenditures under the SNAP Cluster, WIC, Vocational Rehabilitation (VR), TANF Cluster, Child Care Cluster, Social Services Block Grant (Title XX), CHIP, Medicaid Cluster, Block Grants for the Prevention and Treatment of Substance Abuse (SAPT), and Disability Insurance/SSI Cluster (SSDI) programs.

DHS inaccurately reported federal expenditures and amounts which were used to prepare the Schedule of Expenditures of Federal Awards (SEFA) to the Illinois Office of the Comptroller (IOC). Specifically, the auditors noted the following errors for DHS' major programs for the year ended June 30, 2017:

Program	Amounts per DHS' Records	Amounts Initially Reported to the IOC	Difference
VR	$108,687,000	$118,369,000	$ 9,682,000
Medicaid	23,909,000	65,963,000	42,054,000
SSDI	80,270,000	79,358,000	912,000

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

Program	Amounts per DHS' Records	Amounts Initially Reported to the IOC	Difference
WIC	$ 175,856,000	$ 175,873,000	$ 17,000

TANF Cluster	226,707,000	185,481,000	41,226,000

Also, upon further review, the auditors noted the cash basis expenditures provided by DHS for the audit procedures included accrued (not paid) expenditures. The auditors noted $11.4 million of $4.3 billion in expenditures were not paid as of June 30, 2017, but were erroneously reported as cash basis expenditures.

Although some of the differences identified are not quantitatively material to the SEFA as a whole, the State does not have a process in place to evaluate items of this nature outside of the audit process. Accordingly, an error which may be material to the SEFA (in either quantitative or qualitative terms) could occur and not be detected by the State.

In discussing these conditions with DHS officials, they stated the differences in the amount of federal expenditures and amount passed through to subrecipients was due to updated information submitted to DHS after the original submission date of the SEFA to the Illinois Office of the Comptroller.

Response: The Department accepts the recommendation. The Department will request detail source documentation from the Department of Healthcare and Family Services to ensure Medicaid program information provided for DHS funds is accurate. In addition, TANF subrecipient pass through amounts reported by other State agencies will be submitted to the Illinois Office of the Comptroller.

Updated Response: Implemented.

Corrective Action Completed:

- The Department has reviewed procedures to determine expenditure and subrecipient amounts reported on the SCO-563 for the major federal programs;
- The Bureau of General Accounting (BGA) and the Bureau of Federal Reporting (BFR) is now coordinating the completion of a reconciliation for any differences between expenditure patterns and amounts reported on SCO-563 forms;
- Contact staff responsible for preparing expenditure patterns is now determining if any revisions have been made prior to submitting fund GAAP packages;
- The Department is now verifying amounts reported by HFS as receivables at June 30th to ensure it have been received by August 31st;
- IDHS Office of Budget has drafted legislation (PA 100-0587), which became effective 6/4/18 to revise criteria for amount to be drawn into fund-142.

17-12. The auditors recommend DHS establish procedures to ensure: (1) subrecipient single audit reports are obtained and reviewed within established deadlines, (2) management decisions are issued for all findings affecting its federal programs in accordance with the Uniform Guidance, and (3) follow up procedures are performed to ensure subrecipients have taken timely and appropriate corrective action. (Repeated-2011)

Finding: DHS did not adequately review single audit reports received from its subrecipients for WIC, TANF, Child Care, Title XX, and SAPT programs.

Subrecipients who receive more than $750,000 in federal awards are required to submit a single audit report to DHS. The Office of Contract Administration is responsible for reviewing these reports and working with program personnel to issue management decisions on any findings applicable to DHS programs. A desk review checklist is used to document the review of the single audit reports.

During the review of a sample of 192 subrecipient single audit desk review files, the auditors noted DHS did not notify 33 subrecipients of the results of single audit desk reviews or issue management decisions on reported findings within six months of acceptance of the single audit report by the Federal Audit Clearinghouse (FAC) as required.

The auditors also noted the single audit desk reviews for FY16 and FY17 were still in process and had not been finalized as of the date of the testwork (January 30, 2018) for six subrecipients.

DHS' subrecipient expenditures under the federal programs exceeded $633 million in FY17.
In discussing these conditions with DHS officials, they stated that due to ongoing staffing shortages in the Office of Contract Administration (OCA) desk audit section and loss of one key staff member during fiscal year 2017 Single Audit cycle, the OCA was unable to make advances in resolving this repeated finding.

Updated Response: Partially Implemented.

Corrective Action Completed:

- The Office of Contract Administration's (OCA) desk audit review section has hired two new staff members to process desk audit reviews. This brings the staff assigned to review Single Audits from two to three staff assigned to the review of Single Audits.

Corrective Action in Progress:

- The Office of Contract Administration (OCA) is in the process of implementing changes in the desk audit review process to more closely align with the Grant Accountability & Transparency Act (GATA) consolidated desk review process which now also includes a reconciliation of a Consolidated Year End Financial Report (CYEFR);

- The Office of Contract Administration (OCA) has transitioned into the process of utilizing the GOMB-GATU Grant Accountability & Transparency Act Portal (GATA Portal) for consolidated desk audit reviews. This system is officially called the Audit Report Review Management System (ARRMS); all State of Illinois grantee-providers with a 12/31/17 fiscal year-end going forward are required to utilize this process. In addition, in October of 2018 OCA also hired a new Financial Reporting Administrator who is tasked with oversight of the GATA Portal consolidated desk review process. This finding is anticipated to repeat on IDHS's FY18 Single Audit due to not meeting the 180-day requirement for completion of our current audit cycles desk audit reviews. Once the GATA Audit Report Review Management System (ARRMS) has been fully implemented, this finding should be resolved.

  Expected Implementation Date: 09/30/2019

17-13. The auditors recommend DHS ensure programmatic on-site reviews are performed and documented for subrecipients in accordance with established policies and procedures. In addition, the auditors recommend DHS 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)

Finding: DHS did not follow its established policies and procedures for monitoring subrecipients of the WIC, TANF, Child Care, Title XX, and SAPT programs.

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

During testwork over on-site review procedures performed for 213 subrecipients of the WIC, TANF, Child Care, Title XX, and SAPT programs, the auditors noted DHS did not always follow its established monitoring procedures.

- DHS did not provide timely notification (within 60 days) of the results of the programmatic on-site reviews to 11 of 171 subrecipients.
- DHS did not receive corrective action plans (CAPs) on a timely basis (within 60 days) after communicating programmatic review findings or follow up with 2 of 88 subrecipients on delinquent CAPs.
- During testwork, auditors noted that DHS did not perform on-site monitoring reviews of 44 of 160 subrecipients in FY17 in accordance with DHS' planned monitoring schedule.
- During testwork, auditors noted that DHS did not provide evidence to support a payment of $560,079 to one SAPT subrecipient tested.

In discussing these conditions with DHS officials, they stated the cause can be attributed to untimely monitoring, no system of monitoring in place, and staff failure to follow procedures.

Updated Response: Implemented.

SUBSTANCE USE PREVENTION & RECOVERY (SUPR)

- Implemented system monitoring to ensure all documents are sent and received within required time frames. Employed a partial FTE for this function, placed in Chicago for system monitoring;

- Review policies and procedures with monitoring staff at least annually for correspondence and report due dates;

- The administration will review monthly and quarterly, any correspondence failing to be submitted within the due date and take appropriate action to remedy the deficiency.

DIVISION OF FAMILY AND COMMUNITY SERVICES (FCS)

- Meet with each program area in order to determine the cause of untimely monitoring visits, and make any necessary and reasonable adjustments;

- Program monitoring staff will be reminded of the monitoring protocol and the timeframe parameters of each monitoring task;

- All FCS monitoring staff have been retrained on both fiscal and program monitoring compliance.

17-14. The auditors recommend DHS ensure award information communicated to subrecipients is reviewed for completeness and accuracy. (Repeated-2013)

Finding: DHS did not follow its established policies and procedures for monitoring subrecipients of WIC, TANF, Child Care, Title XX, and SAPT programs.

During testwork of the award communications for the sample of subrecipients, the auditors noted the CFDA number was not communicated in the subrecipient award agreement for eight TANF Cluster, one Title XX, and four SAPT subrecipients tested. Upon further review, the auditors noted a general State appropriation code was communicated in the original award document for these 13 subrecipients as DHS had not determined under which federal program (if any) the expenditures would be claimed at the time they were awarded.

Additionally, the auditors noted the federal program name was not communicated in the subrecipient award agreement for two Title XX subrecipients tested.
In discussing these conditions with DHS officials, they stated program and division contracting staff did not properly review Exhibit A information of the Grant Agreements for proper accuracy prior to completing the agreements.

Response: The Department accepts the recommendation. The Office of Contract Administration (OCA) recommends that all program and division contracting staff be properly trained on the process of completing and reviewing Exhibit A of the Grant Agreements. The OCA, Bureau of Federal Reporting and the Division of Family and Community Services (FCS) have also met to discuss any needed modification to fiscal year 2018 Exhibit A information to ensure accuracy of the information.

Updated Response: Implemented.

DIVISION OF SUBSTANCE USE PREVENTION AND RECOVERY (SUPR)

- Community Service Agreement (CSA) will now allow copying of CFDA related DATA via exhibits;
- SUPR requested that a new Contract Service Agreement (CSA) report be developed for each contract providing a CSA contract number and related CFDA. DHS-DoIT staff modified the existing Business Objects report to provide needed information to DASA-SUPR staff;
- SUPR will review the report quarterly with contract development staff.

OFFICE OF CONTRACT ADMINISTRATION (OCA) and DIVISION OF FAMILY AND COMMUNITY SERVICES (FCS)

- OCA, Bureau of Federal Reporting staff and the Division of Family and Community Services (FCS) staff have met to discuss any needed modification to fiscal year 2018 Exhibit A information to ensure accuracy of the information.
- FCS created an electronic contract review tool to ensure all contracts have the correct federal award information to relay to sub recipients.

17-15. The auditors recommend DHS 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)

Finding: DHS did not determine the eligibility of beneficiaries under the Vocational Rehabilitation Grants to States (VR) program in accordance with federal regulations.

During testwork of Vocational Rehabilitation Grants to States program beneficiary payments, the auditors selected 80 eligibility files to review for compliance with eligibility requirements and for the allowability of the related benefits. The auditors noted the following exceptions in the testwork:

- For two cases, DHS did not perform a required review of the beneficiary's Individualized Plan for Employment (IPE).
- For 3 cases, DHS did not certify eligibility within 60 days of the application date as required.

DHS' procedures for determining eligibility for the VR program rely heavily on case workers understanding of policies and program requirements which can be inhibited by case load volume. DHS has not established appropriate monitoring procedures to ensure eligibility determinations are performed and documented in accordance with program requirements.

In discussing these conditions with DHS officials, they stated human error causes eligibility and Individualized Plan for Employment (IPE) timelines to be missed.

Updated Response: Implemented.

- The Division will notify those staff that had a case cited of the deficiency noted by the auditors.

- Timely completion of eligibility certification and IPE development is a key feature of VR training. Timeliness was one of the items on the Quick Reference Checklist developed in conjunction with the State Rehab Council and distributed to all offices fall 2018.

- All new VR counselors are trained in the timeliness requirements. Several reports in our WebCM case management system are available to local office supervisors to help them identify situations where an individual counselor is failing to meet timeliness requirements. These individuals can be referred for additional training or put under a plan of correction by the office supervisor. Annual quality assurance reviews at the office level provide feedback on the timeliness of meeting VR requirements for certification of eligibility and service plan development. DHS has sufficient information available to identify individual performance and provide remedial training as needed.

17-16. The auditors recommend DHS implement procedures to ensure fringe rates in the payroll system, which are subsequently allocated through the Public Assistance Cost Allocation Plan (PACAP), are consistent with those approved by DCMS. (Repeated-2016)

Finding: DHS did not identify that fringe benefit rates had not been updated prior to allocating costs to its federal programs.

Personal service (payroll and fringe benefits) expenditures represent the majority of expenditures allocated to federal programs. Personal service expenditures are approved on an annual basis (or more frequently if needed) through the completion of Department of Central Management Services employee information (CMS-2) forms which are filed within each employee's personnel file.

During the review of 140 employee payroll and fringe benefit charges (totaling $536,228) allocated to DHS' federal programs during the year ended June 30, 2017, the auditors noted DHS did not have adequate procedures in place to verify the fringe rates allocated through the PACAP were accurate

and consistent with the applicable rates approved by DCMS. Specifically, the auditors noted the DCMS approved dental rates were $41.27, $22.03 and $11.07; whereas, the dental rates allocated by DHS were $40.14, $21.57 and $10.88, respectively, which resulted in costs of $2.60 not being allocated for the six employees sampled. Upon further review, the auditors noted the benefit rates allocated by DHS were less than the approved rates established by DCMS for 1,089 transactions resulting in undercharges of $594.

While the costs charged to the program were understated by an immaterial amount, the control deficiencies identified in prior year audits have not been corrected by DHS. Specifically, the auditors noted DHS has not established controls to verify the accuracy of any of the fringe rates associated with benefit charges allocated through the PACAP.

In discussing these conditions with DHS officials, they stated the entry of this data into the Payroll System is performed by staff at the Department of Innovation and Technology (DoIT) and is not subject to review procedures at DHS.

Updated Response: Implemented.

- Staff in the Bureau of Payroll and Benefits is now reviewing data that is entered into the Payroll System by the Department of Innovation & Technology (DoIT) staff.

RECOMMENDATION 17-23
Department of Health and Family Services

17-17. The auditors recommend DHFS implement adequate general information technology control procedures for the Integrated Eligibility System (IES) system. The auditors also recommend DHFS evaluate the known IES system issues, implement monitoring procedures to identify potential noncompliance relative to its federal programs resulting from these items, and consider the changes necessary with respect to internal controls over eligibility determinations to ensure only eligible beneficiaries receive assistance under its federal programs. (Repeated-2015)

Finding: The Illinois Department of Human Services (DHS) and the Department of Healthcare and Family Services (DHFS) did not have appropriate controls over the Integrated Eligibility System (IES) used for eligibility determinations performed for the Supplemental Nutrition Assistance Program (SNAP) Cluster, Temporary Assistance for Needy Families (TANF) Cluster, Children's Health Insurance Program (CHIP), and Medicaid Cluster programs.

DHS administers the SNAP Cluster, the TANF Cluster, and certain Medicaid Cluster waiver programs and DHFS administers the CHIP and Medicaid Cluster programs. Effective October 1, 2013, the State implemented the Integrated Eligibility System (IES) to perform and document eligibility determinations for certain beneficiaries of its Medicaid Cluster program and later expanded to SNAP Cluster, TANF Cluster, and CHIP.

During testwork, the auditors were unable to perform adequate procedures to satisfy themselves that certain general information technology controls over the IES system were operating effectively. Specifically, they noted DHS and DHFS could not provide all information necessary to test system access security controls relative to the network on which IES resides. Additionally, a specific change management policy has not been developed for IES.

Accordingly, the auditors were not able to rely on IES with respect to the testing of the eligibility and related allowability compliance requirements for beneficiary payments made under the TANF Cluster, CHIP, and Medicaid Cluster programs. The auditors were also not able to rely on IES with

respect to the special test and provision – ADP System for SNAP related to the SNAP Cluster program.

In addition to the control deficiencies identified above, the auditors noted several instances of noncompliance during the review of system data obtained from IES. Specifically, the auditors noted cases were approved in IES despite beneficiaries not meeting eligibility requirements related to citizenship status or residency (immigration status). The auditors also noted cases were approved in IES without valid social security numbers or submission of an application for a social security number. While DHS and DHFS were aware of certain system issues and have established manual workarounds for certain known errors, formal procedures were not established to monitor and evaluate noncompliance resulting from the known systems errors during the year ended June 30, 2017.

As a result of DHS' and DHFS' failure to have appropriate controls over the Integrated Eligibility System, the auditors qualified their opinion on the SNAP, TANF, CHIP, and Medicaid Cluster programs.

Details of the beneficiary payments paid by the State during the year ended June 30, 2017 for the SNAP Cluster, TANF Cluster, CHIP, and Medicaid Cluster programs are as follows:

Major Program	Total Beneficiary Payments in Fiscal Year 2017	Total Fiscal Year 2017 Program Expenditures	Percentage
SNAP Cluster	$2,964,118,000	$3,076,531,000	96.3%
TANF Cluster	42,009,000	572,345,000	7.3%
CHIP	280,375,000	312,580,000	89.7%
Medicaid Cluster	9,582,593,000	10,176,779,000	94.2%

In discussing these conditions with DHS officials, they stated the planned corrective action requires significant time and resources and they have prioritized corrective action of the findings noted based upon the risks involved. They also stated the non-financial eligibility issues identified were a combination of caseworker and system defects.

Response: The Departments accept the recommendation and will work together to implement an approval process for changes made to the IES. The Departments will develop formal change control policies and procedures for IES and ensure that programmers do not have direct access to the production environment without proper approval. The security issues were previously identified by the Departments and a Plan of Action and Milestones were developed to track each issue, with the exception of two items which are tracked in the weekly infrastructure technical meeting. The current transition the Departments were undertaking from one system to another comes with an unfamiliarity of processing procedures and nuances that are still being learned and perfected. During the audit period, casework staff had been required to spend substantial time participating in training of the new system. The transition from paper case records to electronic case records required a massive change in the gathering and maintaining of documentation. Although the new system does allow for proper maintenance of documentation in an electronic format, the conversion to the new process is still being refined. It is expected that as the transition to the new system stabilizes, casework errors will be reduced.

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17-18. The auditors recommend DHFS implement procedures to verify with recipients whether services billed by providers were received. (Repeated-2010)

Finding: 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, the 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 less than 0.9% of total provider reimbursements. Additionally, the auditors noted DHFS obtains an annual summary of the results of recipient verification procedures performed by managed care organizations. DHFS does not perform any verification procedures for services billed by the following fee for service provider types:

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

Payments made to non-emergency transportation providers, optometric providers, and dental providers totaled $39,823,785 during the year ended June 30, 2017. Payments made to managed care organizations totaled $4,962,604,000 during the year ended June 30, 2017. Payments made to providers on behalf of all beneficiaries of the Medicaid Cluster totaled $9,582,593,000 during the year ended June 30, 2017.

In discussing these conditions with DHFS officials, they stated that prior to the roll out of managed care the Department used a risk based approach to send verifications so not all provider types were included in the verifications.

Response: The Department respectfully disagrees with this recommendation because it believes it is in compliance with the regulation. The Department has a method for verifying with recipients whether services were billed. Approximately 65% of the Medicaid recipients and 45% of the federal expenditures are within managed care. Managed Care Organizations, acting on the Department's behalf, send recipient verifications to recipients that have received services from various provider types. While the Department does not send verifications to recipients of services of the same provider types the managed care organizations send, the Department focuses its efforts on high risk fee for service providers. The Department believes the combined effort is in compliance with the federal regulation to have a method of verification. The Federal Medicaid Program Integrity auditors review compliance with this regulation every three years. While, the Federal auditors found the Department out of compliance in previous years, the Federal auditors did not find the Department out of compliance with this regulation in the most recent program integrity reviews issued in 2012 and 2015.

Auditors' Comment: As discussed in the finding above, the State must have a method for verifying with recipients whether services billed by providers were received. We do not believe the federal

regulations permit the State to exclude more than 50% of the Medicaid expenditures from these verification procedures.

Updated Response: Not Accepted. The Department has a method for verifying with recipients whether services were billed. Approximately 75% of the Medicaid recipients and 55% of the federal expenditures are within managed care. Managed Care Organizations conduct verifications as part of their contractual agreements. With the increase of recipients and federal expenditures related to Managed Care Organizations, the Department will increase its coverage of the services billed.

17-19. 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)

Finding: 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 another State agency. The federal Centers for Medicare and Medicaid Services (CMS) holds DHFS, as the Single State Medicaid agency, responsible for oversight and monitoring of the nine federally-approved home and community-based waiver programs operated by the State. To ensure compliance with these federal requirements, DHFS contracts with a Quality Improvement Organization (QIO) to independently perform onsite participant level review activities. In FY17, the QIO conducted 1,593 Record Reviews at 107 different site locations.

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. During the review of monitoring procedures performed by DHFS, the auditors noted DHFS selects a sample of on-site provider reviews with deficiencies to validate corrective action plans were implemented and that deficiencies were remediated. However, the auditors noted the on-site provider reviews performed by DHFS in FY17 were selected based upon the proximity of the providers location to available monitoring personnel and did not take into consideration the severity of the deficiencies identified.

In discussing these conditions with DHFS officials, they stated that they believe the current monitoring of agencies operating home and community-based waivers meets federal requirements.

Response: The Department accepts the recommendation but believes its current monitoring of agencies operating home and community-based waivers meets federal requirements. Federal CMS requires that DHFS retain administrative authority and responsibility for the operation of the waiver programs by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies and contracted entities. Federal requirements do not specify how the State Medicaid agency samples records chosen for individual remediation verification. Additionally, DHFS is conducting oversight of the operating agencies monitoring of deficiency remediation. As the operating agency is charged with ensuring that 100% of the deficiencies are remediated, the provider locations and severity of deficiency “sampled” by HFS becomes less significant.

Updated Response: Implemented.

17-20. The auditors recommend DHFS follow its established policies and procedures to ensure access to its information systems are adequately secured. (Repeated-2015)

Finding: DHFS does not have adequate program access controls over information systems used to pay medical benefits to beneficiaries and record program expenditures.

The information technology applications that support the DHFS major programs include the *Programmatic and Administrative Accounting System (PAAS)* – serves as the financial accounting database, *Medicaid Management Information System (MMIS)* – serves as the main system used to process the State's Medicaid activities, *Key Information Delivery System (KIDS)* – serves as the child support system that processes benefit claims for children's healthcare.

During testwork over user access to the State's network and DHFS' applications, the auditors noted the following:

- 22 terminated employees (out of 25 tested) did not have their user access removed timely.
- Three individuals (out of 25 tested) did not have evidence that annual user access reviews were performed during FY17.

During testwork over changes made to the Key Information Delivery System, the auditors also noted DHFS was not able to generate a list of changes made to the System.

In addition, the auditors noted the password settings for access to the PAAS server do not conform to the State's policy for minimum password length and the account lockout requirements.

In discussing these conditions with DHFS officials, they stated the access review process is still limited to the annual performance review process that were not always being performed timely.

Response: Accepted. Access control processes and procedures for DHFS currently in place, are being reviewed and revised to accommodate the changing IT structure in Illinois. Created under Executive Order 16-01, Illinois is currently in the process of modernizing technology by consolidating IT resources and IT services under a single agency, the Department of Innovation and Technology (DoIT). The Agency will continue to collaborate with DoIT in remediation efforts.

17-21. The auditors recommend DHFS establish procedures to ensure the results of single audit report reviews are communicated to its subrecipients on a timely basis.

Finding: DHFS did not communicate the results of its review of single audit reports received from its subrecipients for the Child Support Enforcement (CSE) program on a timely basis.

Subrecipients who receive more than $750,000 in federal awards are required to submit a single audit report to DHFS. DHFS is responsible for reviewing these reports and working with program personnel to issue management decisions on any findings applicable to DHFS programs.

During the review of a sample of single audit desk review files for 16 subrecipients (with expenditures over $5 million), the auditors noted DHFS did not notify four subrecipients (with expenditures totaling $3 million) of the results of single audit desk reviews within six months of acceptance of the single audit report. Delays ranged from 9 to 24 days after the required timeframe.

In discussing these conditions with DHFS officials, they stated Department practice has been to send management decision letters even when they are not required. The four subrecipient audits were reviewed timely; however, a delay in notification that the subrecipients did not have any DHFS specific findings was due to an oversight.

Response: The Department respectfully disagrees with this recommendation because it believes the Department is in compliance with Federal regulations. 2 CFR 200.331(d)(3) states that pass-through entity monitoring of the subrecipient must include "(3) Issuing a management decision for audit findings pertaining to the federal award provided to the subrecipient from the pass-through entity as required by 2 CFR 200.521 Management decision". 2 CFR 200.521(d) *Time Requirements* states that "The Federal awarding agency or pass-through entity responsible for issuing a management decision must do so within six months of acceptance of the audit report by the FAC" (Federal Audit Clearinghouse). Department practice has included sending management decision letters in instances that are not required; however, Federal regulations only require letters be issued according to Federal timelines when there are specific findings related to DHFS programs. Federal regulations require the cognizant agency to report on cross-cutting findings. All single audit reports are reviewed by the Department prior to the formal issuance of the management decision letter. The reports in question in this audit had been reviewed an average of 102 days prior to the due date. The reports are reviewed to determine whether any audit findings affect DHFS programs. In the case of the reports noted, there were no reports that had findings related to DHFS programs specifically. The management decision letters noted as untimely during this audit were related to cross-cutting findings where DHFS was not the cognizant agency and were not even required to be sent. DHFS will update its procedures to coincide with Federal requirements.

Auditors' Comment: As stated in the finding above, it is DHFS' practice to issue management decision letters to all subrecipient's with findings and the control exceptions reported in this finding are due to an oversight. We noted subrecipients identified as control exceptions in this finding did have findings attributable to the Child Support Enforcement program and it is DHFS' practice to issue management decisions in this instance. This finding has been classified as a control finding given the exception pertains to management's process which applies to all of its subrecipients.

Updated Response: Implemented.

17-22. The auditors recommend DHFS implement procedures to ensure quarterly expenditure reconciliations are performed and completed in a timely manner and adjustments identified in the reconciliation process are made in a timely manner.

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

Since cash draws are based on estimated expenditures for each quarter, the reconciliations identify the difference between the actual program expenditures and those estimates. The net cash position identified for each program in the quarterly reconciliation process is used to estimate the expenditures to be used for the next quarter's draws and to adjust future draws to ensure amounts drawn equal actual program expenditures.

During testwork, the auditors noted the first through third quarter reconciliations were not timely performed for all three programs and that draws for the CHIP, Medicaid Cluster, and CSE programs were not adjusted for the quarterly net cash position identified in the reconciliations in a timely manner. The auditors noted the following differences in the review of the quarterly reconciliations of the CSE, CHIP, and Medicaid Cluster programs:

	Medicaid		CHIP		CSE	
Quarter	Over/(Under) Drawn Position	Date Reconciliation Completed	Over/(Under) Drawn Position	Date Reconciliation Completed	Over/(Under) Drawn Position	Date Reconciliation Completed
9/30/16	($66,205,264)	7/17/17	($99,551,194)	7/17/17	($3,966,160)	7/17/17
12/31/16	($341,257,240)	7/17/17	($34,579,458)	7/17/17	$22,715	7/17/17
3/31/17	$90,700,446	7/17/17	($68,143,673)	7/17/17	$1,554,588	7/17/17
6/30/17	$299,714,945	8/23/17	($31,146,273)	8/23/17	$1,421,305	8/23/17

In discussing these conditions with DHFS officials, they stated reconciliations were performed quarterly, but the final supervisory review was late due to staff participation in new IT development for MMIS and accounting systems.

Response: Implemented.

17-23. The auditors recommend DHFS establish procedures to accurately report federal expenditures (including amounts passed through to subrecipients) used to prepare the SEFA to the IOC.

Finding: DHFS did not accurately report Federal expenditures under the Medicaid Cluster program.

	Amount per DHFS' Records	Amount Initially Reported to the IOC	Difference
Federal expenditures	$10,176,779,000	$10,218,833,000	($42,054,000)
Amounts passed through to subrecipients	52,440,000	52,454,000	14,000

Upon further review, the auditors noted the error in the reported federal expenditures was the result of the miscalculation of Medicaid Cluster expenditures made by the Illinois Department of Human Services (IDHS) which was detected during the IDHS departmental financial statement audit. Although the differences identified above are not quantitatively material to the SEFA as a whole, the State does not have a process in place to evaluate items of this nature outside of the audit process. Accordingly, an error which may be material to the SEFA (in either quantitative or qualitative terms) could occur and not be detected by the State.

In discussing these conditions with DHFS officials, they stated expenditures were reported consistent with prior years' methodology. An audit adjustment to the Illinois Department of Human Services departmental financial statements resulted in the expenditure difference. The difference in the amounts passed through to subrecipients was a human calculation error.

Response: The Department accepts the recommendation. Department officials notified both IOC and Office of the Auditor General (OAG) of these differences, but both entities passed on making further adjustments due to timeliness and materiality. As stated above, DHFS reported the Medicaid Cluster expenditures consistent with prior years' methodology and believes our process would not result in undetected material errors.

Auditors' Comment: The considerations made by DHFS and the IOC relative to the error identified in this finding were in relation to the State's financial statements, not the SEFA. The error identified was not evaluated by State management outside of the audit process related to the SEFA.

Updated Response: Implemented. As the state Medicaid agency, HFS assumes the responsibility for reporting the Medicaid cluster amounts on the SEFA, even though HFS is not the grantee or program agency for a majority of the programs in the Medicaid cluster. The amounts reported for the Medicaid program include expenditures from other state agencies. Sometimes adjustments are made by other state agencies very late in the process and therefore; HFS elects to not adjust the SEFA.

RECOMMENDATIONS 24-35
Department of Children & Family Services

17-24. The auditors recommend DCFS review its current process for reporting adjustments and implement procedures to ensure the adjustments claimed for the Foster Care and Adoption Assistance programs are properly determined and supported. DCFS should also consider implementing additional monitoring controls to ensure the adjustments are reported in accordance with program requirements. (Repeated-2016)

Finding: DCFS does not have an adequate process for supporting adjustments to the Title IV-E claiming report.

During testwork over adjustments to the Foster Care and Adoption Assistance programs reported on quarterly claiming reports filed during the year ended June 30, 2017, we noted DCFS did not properly report adjustments on a gross basis for 8 of 11 adjustments tested. Specifically, the auditors noted four increasing Foster Care adjustments (totaling $228,748), one decreasing Foster Care adjustment (totaling $242,479), and all three increasing Adoption Assistance adjustments (totaling $56,242) sampled in our testing included both debit and credit transactions. Accordingly, increasing and decreasing adjustments reported by DCFS are understated because they are reported net.

Additionally, in testing of 40 individual adjusting transactions (30 from Foster Care totaling $100,013 and 10 from Adoption Assistance totaling $8,324), auditors noted the following transactions were not properly supported as follows:

- DCFS could not provide the reason the adjustment was made or documentation supporting the adjustment for one decreasing transaction totaling $1,231 sampled from a decreasing adjustment (of $220,403) for the Foster Care program.
- DCFS could not provide the reason the adjustment was made or documentation supporting the adjustment for one decreasing transaction totaling $3,566 sampled from an increasing adjustment (of $34,342) for the Adoption Assistance program.

In evaluating DCFS' process for identifying and documenting adjustments made to its quarterly claims, we noted DCFS has not implemented adequate supervisory reviews or other monitoring controls to determine if the adjustments being made are complete, accurate, and properly supported.

In discussing these conditions with DCFS officials, they stated Agency oversight failed to ensure independent verification of the identified adjustments described above resulting with the Department not being able to supply required documentation as requested. The Department also stated that adjustments are reported net on the CB-496 due to limitations of the claiming system used to calculate adjustments.

Response: The Department agrees with the recommendations. Recent improvements to the claiming system will ensure that adjustments are presented in accordance with federal reporting requirements beginning with the quarter ending March 31, 2018. The Department will continue to review its monitoring controls to ensure that adjustments to quarterly financial reports are properly supported by adequate file documentation.

Updated Response: Repeated in FY18.

17-25. The auditors recommend DCFS implement procedures to ensure the provider licensing files are complete, including documentation that all required background checks have been performed and documentation that verifies safety considerations with respect to the staff of child-care institutions has been properly addressed. Additionally, DCFS should evaluate its process for ensuring providers are properly licensed and meet program requirements prior to placing Foster Care beneficiaries in their care and claiming payments to these providers for federal reimbursement. (Repeated-2016)

Finding: DCFS did not maintain complete provider licensing files, including documentation of required background checks for foster care service providers.

During testwork of 50 Foster Care maintenance assistance payments (totaling $92,235), the auditors reviewed the associated provider licensing files for compliance with licensing requirements and for the allowability of related benefits paid, the auditors noted the licensing files for 31 foster care beneficiary payments sampled (totaling $72,094) related to 24 child care institution service providers did not contain documentation that verified the safety considerations with respect to staff of the institution had been addressed. Specifically, required background clearances were not obtained for all staff members. DCFS claimed reimbursement for foster care maintenance payments made to these providers on behalf of these children totaling $566,602 during the year ended June 30, 2017.

As of the date of testing, DCFS has not evaluated whether additional errors exist or quantified the impact of these errors on the population.

In evaluating the controls in place relative to this compliance requirement, the auditors noted DCFS did not follow its established procedures for ensuring foster care providers were properly licensed prior to claiming Foster Care maintenance payments. Additionally, monitoring controls were not established to ensure licensing procedures were being followed.

Foster care maintenance payments during year ended June 30, 2017 totaled $74,604,000.

In discussing these conditions with DCFS officials, they stated the record keeping systems were not designed to adequately capture the information needed to document the completion of the background clearances.

Response: The Department agrees with and has implemented the auditor recommendations, including changes in both licensing and monitoring procedures, for provider background checks.

Updated Response: Repeated in FY18.

17-26. The auditors recommend DCFS implement procedures to ensure adoption assistance subsidy payments are consistent with the approved subsidy payment amount in the adoption assistance agreement and to obtain and include proper supporting documentation for subsidy payment changes in the adoption assistance case files. Additionally, DCFS should evaluate its process for ensuring subsidy payments are consistent with executed agreements or changes are adequately documented prior to paying adoption subsidies and claiming payments for federal reimbursement. (Repeated-2014)

Finding: DCFS made recurring payments of adoption assistance benefits that were not properly supported by adoption assistance agreements.

During testwork of adoption assistance beneficiary payments, we reviewed 50 case files and related benefit payments (totaling $30,364) for compliance with eligibility requirements and allowability of related benefits and noted the following:

- One beneficiary assistance subsidy payment sampled was greater than the subsidy amount documented in the approved adoption assistance agreement. The sampled payment was $1,270, whereas the payment amount in the approved adoption agreement was $1,019. The case records did not contain documentation supporting another amount had been agreed to by the State and adopting parents. Accordingly, the sampled payment was $251 more than the amount in the adoption agreement.
- One beneficiary assistance subsidy payment sampled was greater than the subsidy amount documented in the approved adoption assistance agreement. The sampled payment was $471, whereas the payment amount in the approved adoption agreement was $392. Upon further review, we noted the monthly payment actually paid at the time of the adoption was $409, which was consistent with the approved foster care rate at that time based upon the age of the child. The sampled payment is consistent with the approved foster care rate based upon the current age of the child; however, we noted neither the adoption assistance agreement nor the case file discuss using the foster care maintenance payment or any changes to the payment amount.

As of the date of testing, DCFS has not evaluated whether additional errors exist or quantified the impact of these errors on the population.

In evaluating the controls in place relative to this compliance requirement, we noted DCFS did not follow its established procedures for documenting changes to subsidy payments prior to claiming them under the Adoption Assistance program. Additionally, adequate monitoring controls were not established to ensure subsidy payments are consistent with executed agreements or changes are adequately documented in accordance with established procedures.

Adoption subsidies paid during the year ended June 30, 2017 totaled $61,270,000.

In discussing these conditions with DCFS officials, they stated the errors in payments were attributed to clerical errors and insufficient review procedures to ensure all documents relevant to the agreements were maintained.

Response: The Department agrees with the recommendations and has implemented procedures to assure that the subsidy rate amounts are in agreement with the approved subsidy amounts. The internal verification form (CFS 1800P) is used to ensure that the ongoing subsidy payment amount

is verified and approved. The review process, including a check of supporting documentation, is completed prior to the finalization of the Adoption by the Federal Participation Unit.

Updated Response: Not repeated in FY18.

17-27. The auditors recommend DCFS review its procedures for retaining and documenting how beneficiaries have met eligibility requirements and implement changes necessary to ensure supporting documentation for all eligibility requirements is maintained. Additionally, DCFS should evaluate its process for verifying eligibility requirements are met and adequately documented and implement additional procedures to ensure established procedures are followed. (Repeated-2016)

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

During testwork of 50 Adoption Assistance beneficiary payments (totaling $30,364), auditors noted the following:

- For one adoption assistance payment (totaling $1,147), DCFS could not locate documentation evidencing the child over 18 was participating in one of the prescribed eligible activities or that he was incapable of doing the activities due to a medical condition. DCFS claimed reimbursement for adoption assistance benefits made on behalf of this child totaling $15,240 during the year ended June 30, 2017.
- For four adoption assistance payments (totaling $1,773), DCFS could not locate the CANTS and/or SOR background checks for at least one adoptive parent or member of the household over the age of 13. DCFS claimed reimbursement for adoption assistance benefits made on behalf of these children totaling $21,276 during the year ended June 30, 2017.
- For one adoption assistance payment (totaling $471), the dispositional court order that sanctioned the child's removal from the home contained contradicting evidence as to whether or not the child's continuation in the home would be contrary to the health, welfare, and safety of the child. Additionally, the dispositional court transcript could not be obtained to clarify which contrary to the welfare determination applied. DCFS claimed reimbursement for adoption assistance benefits made on behalf of this child totaling $5,652 during the year ended June 30, 2017.
- For one adoption assistance payment (totaling $1,185), the termination hearing order used to evidence the child could not or should not be returned to the home of his parent(s) did not include documentation supporting the mother's parental rights were terminated. Additionally, the termination hearing order transcript could not be obtained to clarify if the mother's parental rights were in fact terminated. DCFS claimed reimbursement for adoption assistance benefits made on behalf of this child totaling $14,217 during the year ended June 30, 2017.
- For two adoption assistance payments (totaling $1,631), DCFS could not locate documentation evidencing the child was eligible, or would have been eligible, for the former AFDC program by meeting the State-established standard of need as of July 16, 1996 in the month he was removed from the home of his parents. Specifically, the income calculation for the household the child was removed from was inaccurate based on information documented in the files. DCFS claimed reimbursement for adoption assistance benefits made on behalf of these children totaling $33,474 during the year ended June 30, 2017.

As of the date of testing, DCFS has not evaluated whether additional errors exist or quantified the impact of these errors on the population.

In evaluating the controls in place relative to this compliance requirement, auditors noted case record documentation is maintained in several locations, including with third party contractors, and can be difficult for DCFS to locate. Additionally, adequate monitoring controls have not been established to ensure eligibility requirements were met and adequately documented in accordance with established procedures.

In discussing these conditions with DCFS officials, they stated documentation could not be located due to filing errors of employees. DCFS also stated that eligibility determinations are made based on the entirety of the information available when the determination is made.

Response: The Department agrees with the auditor's recommendation. The cases cited where documentation could not be located were from older case files (calendar years 2000 and 2012). The Department has made improvements in its review of case eligibility files to ensure documentation is adequate to support its eligibility determinations. The Department continues to routinely evaluate its processes and procedures to ensure that eligibility requirements are met and that documentation is maintained to support the federal reimbursement claim. The Department will continue to ensure staff determining eligibility is knowledgeable in the federal eligibility requirements.

Updated Response: Repeated in FY18.

17-28. 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. Additionally, DCFS should implement procedures to ensure case records and benefit payments are updated for any information reported on the recertification form that impacts eligibility. (Repeated-2016)

Finding: 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 $30,364), we noted the following exceptions:

- For two adoption assistance payments (totaling $3,499), DCFS could not locate a recertification form submitted by the adoptive parents within the most recent 12-month period. DCFS claimed reimbursement for adoption assistance benefits made on behalf of these children totaling $14,175 during the year ended June 30, 2017.
- For two adoption assistance payments (totaling $1,639), recertification forms submitted within the most recent 12-month period indicated the adoptive parents no longer remained legally and/or financially responsible for the child; however, DCFS continued to pay adoption assistance related to these cases. Payments made after the receipt of the certifications totaled $19,667 for these cases. DCFS claimed reimbursement for adoption assistance benefits made on behalf of these children totaling $19,395 during the year ended June 30, 2017.

Additionally, auditors noted DCFS has not established adequate control procedures to monitor whether required certifications are obtained and included in its case record files. DCFS also does not have adequate procedures to ensure case records are updated for eligibility changes reported in annual certifications by adoptive parents.

Adoption subsidies paid during the year ended June 30, 2017 totaled $61,270,000.

In discussing these conditions with DCFS officials, they stated responses are not always received from adoptive families when requested. The Department also stated that staff did not follow procedures to update the payment unit when the recertifications were received indicating the adoptive parent no longer remained legally responsible for the youth.

Response: The Department agrees with the auditor's recommendation. The Department will evaluate its procedures to ensure youth are still in care of the adoptive parents that receive post adoption subsidy payments. The Department will work to ensure procedures are followed so payments are not made to parents who are no longer eligible to receive them.

Updated Response: Not repeated in FY18.

17-29. The auditors recommend DCFS review its procedures to prepare financial reports required for the Foster Care and Adoption Assistance programs and continue to implement changes as necessary to ensure the reports agree or reconcile to its financial records.

Finding: DCFS did not prepare accurate financial reports for the Foster Care and Adoption Assistance programs.

During testwork over the 9/30/16 and 3/31/17 Foster Care and Adoption Assistance CB-496 reports submitted during the year ended June 30, 2017, auditors noted reported amounts in certain line items did not agree to supporting documentation provided by DCFS. Specifically, auditors noted the following differences in testing:

CB-496 Quarter Ended	Part 1 Report Line Item	Current Qtr Claims Fed Share Reported	Current Qtr Claims Fed Share Actual	Variance
3/31/2017	7. In-Placement Administrative Costs – Provider Management	$ 266,045	$ 275,295	$ 9,250
3/31/2017	8. In-Placement Administrative Costs – Agency Management	$ 976,639	$ 986,054	$ 9,415
3/31/2017	10b. Sex Trafficking Administrative Costs	$ 207,739	$ 395,717	$ 187,978
3/31/2017	17. Demonstration Project Costs – From Part 3	$ 29,788,429	$ 29,795,597	$ 7,168

In evaluating DCFS's reporting process for the CB-496 financial report, the auditors noted DCFS has not implemented adequate internal controls to ensure reports prepared by DCFS personnel are accurate. Specifically, DCFS does not perform analytical or other procedures during the report preparation process or supervisory reviews to ensure amounts reported are consistent with current program activities.

In discussing these conditions with DCFS officials, they stated the Department did not have time to make and test all system change requirements prior to the deadline for reporting for the quarter ending March 31, 2017 and as such were not able to identify and correct all issues until after the required report filing date.

Response: The Department agrees with this finding and has already implemented this recommendation. Due to changes from the IB3 Title IV-E Foster Care Demonstration Waiver to a Flex Funding Capped Allocation Waiver executed on January 17, 2017, the Department did not have time to make all required system changes prior to the filing deadline for the quarter ended March 31, 2017. The Department submitted that report with the best information available at the time of submission, knowing that there were defects included in that information. The Department tracked these defects and later corrected the data.

Updated Response: Not Repeated in FY18.

17-30. The auditors recommend DCFS establish procedures to accurately report federal expenditures used to prepare the SEFA to the IOC.

DCFS did not accurately report federal expenditures under its major programs.

Federal expenditures reported to the Illinois Office of the Comptroller (IOC) which were used to prepare the schedule of expenditure of federal awards (SEFA) did not agree to DCFS's financial records. Specifically, auditors noted the following difference for the year ended June 30, 2017:

Program	Federal Expenditures per DCFS's Records	Federal Expenditures Reported to the IOC	Difference
Adoption Assistance	$80,336,000	$80,581,000	$245,000

Upon further investigation, the auditors noted the differences identified in the table relate to prior period adjustments to receivables which should not be reflected in current year cash basis expenditures. Although the difference identified is not quantitatively material to the SEFA, as a whole, the State does not have a process in place to evaluate items of this nature outside the audit process, as discussed in finding 2017-001. Accordingly, any error which may be material to the SEFA (in quantitative or qualitative terms) could occur and not be detected by the State.

In discussing these conditions with DCFS officials, they stated the difference was a result of netting prior period adjustments against cash basis expenditures to correct federal receivables.

Response: The Department agrees with the recommendation. The Department will review procedures to ensure federal expenditures are accurately reported.

Updated Response: Repeated in FY18.

17-31. The auditors recommend DCFS implement procedures to ensure fringe benefit rates in the payroll system, which are subsequently allocated through the PACAP, are consistent with those approved by DCMS and SERS.

Finding: DCFS did not use the correct fringe benefit rates when allocating costs through the Public Assistance Cost Allocation Plan (PACAP).

During review of 25 employee payroll expenditures (totaling $94,260) and related fringe benefit charges (totaling $56,159) allocated to DCFS' federal programs during the year ended June 30, 2017, the auditors noted fringe benefits charged were not consistent with rates approved by DCMS and the State Employees Retirement Systems (SERS). Specifically, auditors noted the following errors:

- The dental insurance fringe benefit charge for one employee was less than the approved semi-monthly rate established by DCMS. Specifically, we noted the approved rate was $22.03 and the rate allocated was $11.07, which resulted in costs of $10.96 not being allocated for the employee sampled. Upon further review, we noted dental insurance fringe benefit rates were inaccurately used for a total of 10 transactions, resulting in undercharges of $109.60. Accordingly, the Foster Care – Title IV-E, Adoption Assistance, and TANF EA programs were undercharged by $25, $5, and $49, respectively, during the year ended June 30, 2017.

- The retirement fringe benefit charges for two employees during the lapse period (pay period June 16-30, 2016) were calculated using a lower percentage than the approved percentage established by SERS. Specifically, we noted the approved retirement percentage was 45.598% and the percentage utilized was 44.568%, which resulted in costs of $98.81 not being allocated for the two employees sampled. Upon further review, we noted the retirement fringe benefit rate was improperly used for 2,608 transactions resulting in undercharges of $141,254. Accordingly, the Foster Care – Title IV-E, Adoption Assistance, and TANF EA programs were undercharged by $32,522, $6,956, and $63,762, respectively, during the year ended June 30, 2017.

Additionally, auditors noted DCFS did not have adequate procedures in place to verify the rates allocated through the PACAP were accurate and consistent with the approved DCMS and SERS rates.

Total personal services (payroll and fringe benefits) costs allocated through the PACAP for the year ended June 30, 2017 for Foster Care, Adoption Assistance, and TANF EA were $53,998,000, $8,260,000, and $153,293,000, respectively.

In discussing these conditions with DCFS officials, they stated the errors were the result of a data input error. Additionally, the new retirement rates were entered before the lapse period payroll cycle was complete.

Response: The Department accepts this recommendation. The Department will review its procedures related to updating appropriate retirement rates to ensure rates are not changed in the system until lapse period payroll is completed. The Department will also review its procedures concerning accurate entry of fringe benefit rates of its employees.

Updated Response: Repeated in FY18.

17-32. The auditors recommend DCFS implement procedures to ensure: (1) access to its information systems is adequately secured; (2) terminated users are removed from applications in a timely manner and (3) system access rights are periodically reviewed for appropriateness. The auditors also recommend DCFS implement monitoring procedures to ensure reviews are performed and documented by data stewards in accordance with established procedures. (Repeated-2012)

Finding: DCFS does not have adequate access review controls over information systems used to document beneficiary eligibility determinations, to record program expenditures, and to identify amounts to be claimed under federal programs.

During testwork of DCFS' controls over user access to the federal claiming system applications, auditors noted the following exceptions:

- Five terminated users still appeared on the active user listing for Windows and four terminated users still appeared on the active user listing for the mainframe. There were 244 terminated users during the year ended June 30, 2017.

- One semi-annual review of user access rights out of five selected for testing was not reviewed by a data steward during the year ended June 30, 2017. Additionally, we noted DCFS has not established procedures to monitor whether data stewards complete access reviews in accordance with established procedures.

In discussing these conditions with DCFS officials, they stated the individuals performing this function did not understand the importance of the access reviews and failed to put the proper priority on completing this task.

Response: The Department agrees with the finding and has implemented procedures to address the auditor recommendations. Automated weekly separation reports will be used to verify that access rights for terminated employees have been removed on a timely basis. An automated monitoring process will be implemented to automatically send periodic access reviews to data stewards to ensure the reviews are performed timely and supported by adequate documentation.

Updated Response: Repeated in FY18.

17-33. The auditors recommend DCFS implement procedures to ensure cash draws are performed in accordance with the TSA or amend the TSA to reflect DCFS' cash draw request practices. (Repeated-2016)

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

During testwork over monthly cash draws performed for the Foster Care and Adoption Assistance programs during the year ended June 30, 2017, auditors noted 10 draws for each program in which funds were not drawn for receipt on the median business day of the month. These draws were performed on dates such that the Federal funds would be deposited between 14 days prior to and 2 days subsequent to the median business day of the month during the year ended June 30, 2017.

In discussing these conditions with DCFS officials, they stated the timing of available resources caused the target of the median business day of the month to be missed.

Response: The Department agrees with this finding and has updated procedures to request monthly federal draws in accordance with the negotiated Treasury-State Agreement.

Updated Response: Repeated in FY18.

17-34. The auditors recommend DCFS implement procedures to ensure cash reconciliations are performed on a monthly basis throughout the year. (Repeated-2014)

Finding: DCFS does not have an adequate process to reconcile its cash balances in a timely manner to the records of the Illinois Office of the Comptroller (IOC).

During testwork over the monthly cash reconciliation process, the auditors noted DCFS did not reconcile its cash balances to the IOC's records on a monthly basis during the year ended June 30, 2017. Specifically, auditors noted none of the monthly reconciliations were performed during the year. Upon further review, the auditors noted all 12 monthly reconciliations were performed subsequent to year-end.

In discussing these conditions with DCFS officials, they stated a combination of personnel vacancies, limitations of the accounting systems used and Department oversight allowed for this deficiency to occur.

Response: The Department agrees with the recommendation. The Department is reviewing its reconciliation procedures and is developing new procedures to ensure proper reconciliations are performed on a monthly basis. The Department will also ensure employees are properly trained to ensure reconciliations are done correctly.

Updated Response: Repeated in FY18.

17-35. The auditors recommend DCFS stress the importance of preparing and completing the initial service plans timely to all caseworkers to comply with Federal and State requirements. (Repeated-1999)

Finding: 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 three of the initial case plans were completed within a range of 10 to 31 days over the 60-day federal requirement, and seven of the initial case plans were completed within a range of 4 to 46 days over the 45-day State requirement.

In discussing these conditions with DCFS officials, they stated numerous outside factors can influence the timely completion of case plans. Staff changes and reductions, placement changes, and coordination with other internal agency procedures can cause delays in the completion of case plans.

Response: The Department agrees with the recommendation. The Department completed statewide training of policies and procedures related to permanency in late 2017. The same training components were added to the core training curriculum for new hire permanency caseworker staff. The training focuses on the state and federal requirements with an emphasis on the positive impact of timely service plan completion. Additionally, each region has devised regional plans to reinforce training with existing staff about the completion of timely service plans and identify any barriers to such.

Updated Response: Repeated in FY18.

RECOMMENDATIONS 36-39
Department of Public Health

17-36. The auditors recommend IDPH establish procedures to accurately report federal expenditures (including amounts passed through to subrecipients) used to prepare the SEFA to the IOC. (Repeated-2016)

Finding: IDPH did not accurately report Federal expenditure information under the Immunization Cooperative Agreements (Immunization) program.

Federal expenditures reported to the Illinois Office of the Comptroller (IOC) which were used to prepare the schedule of expenditures of federal awards (SEFA) did not agree to IDPH's financial records. Specifically, the auditors noted the following difference for the year ended June 30, 2017:

Program	Amounts per IDPH's Records	Amounts Reported to the IOC	Difference
Immunization (federal expenditures)	$95,502,000	$95,446,000	$56,000

Although the difference identified above is not quantitatively material to the SEFA as a whole, the State does not have a process in place to evaluate items of this nature outside of the audit process. Accordingly, an error which may be material to the SEFA (in either quantitative or qualitative terms) could occur and not be detected by the State.

In discussing these conditions with IDPH officials, they stated the error occurred with staff inadvertently omitting some expenditures. Due to the lack of staff, a timely review was not performed to ensure accuracy of the report.

Response: IDPH concurs with the finding and recommendation. IDPH is continuing to work on establishing procedures for the timely and complete reporting of federal expenditures including amounts passed through to subrecipients.

Updated Response: Not Repeated in FY18.

17-37. 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 time frames required by State law. (Repeated-2007)

Finding: IDPH did not investigate complaints received relative to providers of the Medicaid Cluster within required time frames.

The Office of Health Care Regulation within IDPH is responsible for receiving and investigating complaints received against providers of the Medicaid Cluster. State laws require the Office of Health Care Regulation to investigate complaints within 30 days of receipt unless the complaint alleges abuse or neglect. Complaints of abuse or neglect are required to be investigated within seven days of receipt. As the time frames for complaint investigations included in the State's laws are more stringent than those included in the federal Medicaid regulations, the State time frames are required to be followed.

During testwork of 40 complaints filed against Medicaid providers during the year ended June 30, 2017, the auditors identified 4 complaints that were not investigated within the time frames required by the State's law. The delays in investigating these complaints ranged from 1 to 17 days in excess of required time frames.

In discussing these conditions with IDPH officials, they stated the error cases were the result of staff turnover and shortage of experienced surveyors and supervisory staff.

Response: IDPH concurs with the finding and recommendation. Within the last eight months, 17 new Health Facilities Surveillance Nurse (HFSN) surveyor have been hired for this office; one resigned less than 90 days after being hired. However, until any HFSN has completed both State and Federal Surveyor training and successfully completed the federal Surveyor's Minimum Qualifications Test (SMQT), they are not allowed to conduct surveys independently. Federal CMS

has not conducted training or the SMQT since June or July, 2017. This is due to their focus on implementation nationwide of a new LTC survey process. While an online pilot training course is in the process of being developed, this Department has not received communication with approval to enroll new hires. As a result, having new employees may not result in a survey being conducted timely if an SMQT qualified surveyor is not available to accompany the new hire.

The Department will hire additional staff within budgetary guidelines to investigate complaints of abuse and neglect to meet the required state and federal timeframes.

Updated Response: Repeated in FY18.

17-38. 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)

Finding: 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 49 providers of the Medicaid Cluster program for the year ended June 30, 2017, auditors noted licenses were not on file for five providers sampled. Upon further review with IDPH personnel, these providers were end-stage renal disease facilities. The Centers for Medicare and Medicaid Services (CMS) State Operations Manual for End-Stage Renal Disease Facilities section 405.2135 requires these facilities to be licensed if State law provides for the licensure of such facilities. The Illinois End-Stage Renal Disease (ESRD) Facility Act (210 ILCS 62/10) states that no person shall open, manage, conduct, offer, maintain, or advertise an end-stage renal disease facility without a valid license issued by the State. Payments to these providers under the Medicaid Cluster totaled $3,111,097,740 during the year ended June 30, 2017. Payments to end-stage renal disease facilities under the Medicaid Cluster totaled $10,844,353 during the year ended June 30, 2017.

In discussing these conditions with IDPH officials, they stated the Advisory Committee has experienced difficulties meeting and the Division of Health Care Facilities and Programs has experienced turnover which have resulted in the delay in implementing licensing requirements.

Response: IDPH concurs with the finding and recommendation. The Department considered the value of continuing with rulemaking and proposes IDPH will seek repeal of the Act. Also Pursuant to P.A. 99-370 (HB 3887), the Department has reviewed the Act and proposed agency's rules, administrative regulations, and permitting processes for End Stage Renal Disease Facilities as they pertain to small businesses and has determined that the approval and implementation of these rules, regulations, and processes would be unreasonable, unduly burdensome, or duplicative, to small businesses. Proposed legislation HB5069 (attached) seeks to repeal the End Stage Renal Disease Facility Act.

Currently Medicare-certified ESRD providers are surveyed for compliance with federal regulations by the Department which serves as the State Survey Agency per contract with the Centers for Medicare and Medicaid Services (CMS). Further, for federal fiscal years 2016 and 2017 the Department has met the CMS State Performance Measures for completion of non-nursing home surveys which includes ESRD providers.

Actions will be taken based on outcome of proposed legislation**.**

Updated Response: Repeated in FY18.

17-39. The auditors recommend IDPH establish procedures to ensure all subrecipients expending federal awards have single audits as required. Additionally, reviews of single audit reports should be formally documented using a single audit review checklist which includes procedures to determine whether: (1) the audit reports meet the single audit requirements; (2) federal funds reported in the SEFA reconcile to IDPH records; and (3) Type A programs (as defined by the Uniform Guidance) are being audited at least every three years. (Repeated-2005)

Finding: IDPH did not obtain or review single audit reports for subrecipients of the Social Services Block Grant (Title XX) and HIV Care Formula Grants (HIV Care) programs.

During testwork, auditors noted IDPH passed through approximately $2.8 million and $8.4 million to subrecipients under the Title XX and HIV Care programs. Upon further review, the auditors determined that single audit reports had not been obtained or reviewed for any HIV Care subrecipients during the year ended June 30, 2017.

Subrecipient expenditures under the federal programs for the year ended June 30, 2017 were as follows:

Program	Total FY17 Subrecipient Expenditures	Total FY17 Program Expenditures	Percentage
Title XX	$2,810,000	$50,943,000	5.5%
HIV Care	$8,422,000	$35,552,000	23.7%

In discussing these conditions with IDPH officials, they stated IDPH had a shortage of qualified audit staff within the department and delay in the implementation of a statewide sub-recipient review process through the Grants Accountability and Transparency Act (GATA) has impeded the ability to fully meet these requirements.

Response: IDPH concurs with the finding and recommendation. IDPH, like other State agencies, lack qualified audit staff to review single audits. As a result, the State of Illinois' Grant Accountability and Transparency Unit is centralizing and outsourcing the submission and review of audit reports. IDPH will follow the central audit report review process to ensure audits meet single audit requirements when necessary, reconcile grant expenditures, and will issue management decisions where necessary.

Updated Response: Repeated in FY18.

RECOMMENDATIONS 40
Department of Insurance

17-40. The auditors recommend IDOI implement procedures to ensure cash drawn in advance is disbursed in accordance with program regulations. (Repeated-2014)

Finding: IDOI did not minimize 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 $1,052,892) funded under the advance basis related to the State Planning and Establishment Grants for the Affordable Care Act (ACA)'s Exchanges (ACA Exchanges) program, auditors noted warrants were not issued for 7 expenditure vouchers (totaling $670,839) within three business days of receiving federal funds to finance these expenditures. The number of days between the receipt of federal funds and the issuance of warrants ranged from 5 to

22 business days. Total contractual service expenditures for the ACA Exchanges program administered by IDOI were $4,832,158 during the year ended June 30, 2017.

In discussing these conditions with IDOI officials, they stated the excess days noted were the result of expenditure and receipt processing being segregated across the Department, the State Treasurer, and the Comptroller's Office. Additionally, other factors such as staffing turnover and holidays have also contributed to the delays in processing.

Response: The Department accepts this finding. All ACA Exchange grant expenditures are processed through the Department's Treasury Held Federal Trust Fund, which operates as a clearing account with a normal fund balance of $0. Because the fund balance is normally $0, the Department must draw down the federal grant funds before proceeding with processing expenditures, and due to the receipt and expenditure process being segregated across the Department, the State Treasurer, and the State Comptroller, delays between the drawdown and expenditure of funds occur. The Department has not incurred any interest liability to the federal government as a result of these delays and we will work to continue to make improvements in reducing the time between the drawdown and expenditure of federal funds. The Department is unable to take any additional steps to further mitigate these delays because the issuing of warrants is solely within the purview of the Comptroller's Office.

Updated Response: Not Repeated in FY18.

RECOMMENDATIONS 41-46
Department of State Board of Education

17-41. The auditors recommend ISBE review its monitoring procedures relative to individually significant subrecipients and implement additional procedures as necessary to ensure proper monitoring procedures are performed for all programs. Additionally, ISBE should review its risk assessment procedures to ensure compliance with the Uniform Guidance.

Finding: ISBE did not perform adequate on-site subrecipient monitoring procedures for the Title I – Grants to Local Educational Agencies (Title I), Special Education Cluster (IDEA) (Special Education), Twenty-First Century Community Learning Centers (21st Century), Supporting Effective Instruction State Grants (formerly Improving Teacher Quality State Grants) (Title II), and School Improvement Grants (SIG) programs.

During testing, auditors noted one subrecipient common across all Education programs which represented the single largest subrecipient for each program. As the auditors reviewed the monitoring procedures performed for this subrecipient, they noted the procedures performed were limited to on-site review of the central district office and reviews of individual schools which consisted of 15 on-site reviews, 6 desk reviews, and 397 analytical reviews. ISBE management was not able to provide documentation supporting the rationale for how they determined which schools to monitor and indicated there were limited resources to monitor this subrecipient. Given the significance of this individual subrecipient and the fact that it operates in excess of 600 individual schools, the auditors would expect ISBE to establish and formally document its approach for selecting locations for its monitoring procedures.

Expenditures to this subrecipient under the above referenced USDE programs were as follows:

Program Name	Expenditures for Individually Significant Subrecipient	Amounts Passed-Through to All Subrecipients	Percentage
Title I	$307,289,000	$671,891,000	45.7%
Special Education	$96,626,000	$511,587,000	18.9%
21st Century	$6,774,000	$42,139,000	16.1%
Title II	$43,452,000	$94,888,000	45.8%
SIG	$12,224,000	$35,127,000	34.8%

In addition, the auditors noted the on-site review procedures performed during fiscal year 2017 as a result of this risk assessment process included general fiscal and administrative requirements, specific programmatic requirements for the Title I, Title II, and Careers and Technical Education federal programs, and select requirements for certain state funded awards. Accordingly, requirements pertaining to the IDEA and 21st Century were not necessarily reviewed in connection with this risk assessment process. In reviewing procedures used for the IDEA and 21st Century, auditors noted the following:

- A risk assessment was not performed for the IDEA program and programmatic requirements were not reviewed for subrecipients during the year ended June 30, 2017.
- A separate risk assessment was performed for 21st Century; however, ISBE did not review any of the subrecipients identified as high risk during the year ended June 30, 2017.

ISBE's subrecipient expenditures under the federal programs for the year ended June 30, 2017 were as follows:

Program Name	Total FY17 Subrecipient Expenditures	Total FY17 Program Expenditures	Percentage
Title I	$671,891,000	$687,800,000	97.7%
Special Education	$511,587,000	$522,222,000	98.0%
21st Century	$ 42,139,000	$ 43,825,000	96.2%
Title II	$ 94,888,000	$ 96,759,000	98.1%
SIG	$ 35,127,000	$ 36,133,000	97.2%

In discussing these conditions with ISBE officials, they stated monitoring procedures have been impacted by staffing constraints and competing responsibilities.

Response: The Agency agrees with the finding.

Federal and State Monitoring: While a rationale was used for selecting which schools to include as part of the monitoring visit, the rationale was not adequately documented. ISBE will ensure adequate documentation of the selection rationale is included in the monitoring working papers going forward.

IDEA: Special Education Services is developing a risk assessment for special education programs to be implemented as part of programmatic monitoring during the 2018-2019 school year.

21st Century: The 21st Century Community Learning Centers (21st CCLC) program has recently transitioned to the division of Regulatory Support and Wellness. Staff are aware of monitoring

procedures and requirements within this program and the division has a process in place to ensure adequate monitoring of 21st CCLC sub-recipients for future program years.

Updated Response: Repeated in FY18.

17-42. The auditors recommend ISBE establish procedures to ensure subrecipient single audit reports are obtained and reviewed within established deadlines and management decisions are issued for all findings affecting its federal programs in accordance with required timeframes. (Repeated-2015)

Finding: ISBE did not obtain and adequately review single audit reports received from its subrecipients for the Child Nutrition Cluster (CNC), Child and Adult Care Food Program (CACFP), Title I – Grants to Local Educational Agencies (Title I), Special Education Cluster (IDEA) (Special Education), Career and Technical Education – Basic Grants to States (CTE), Twenty-First Century Community Learning Centers (21st Century), Supporting Effective Instruction State Grants (formerly Improving Teacher Quality State Grants) (Title II), and School Improvement Grants Cluster (SIG) programs on a timely basis. Additionally, ISBE does not have a formal process in place to ensure audit reports are received on a timely basis in order to issue a management decision within the required timeframe.

During review of a sample of 65 subrecipient single audit desk review files (sampled from each of ISBE's major programs and the CTE program), the auditors noted the following:

- ISBE did not obtain single audit reports in a timely manner for four subrecipients of the 21st Century, CNC, and CACFP programs. Specifically, we noted the reports were obtained from 198 to 288 days after they were filed with the Federal Audit Clearinghouse. Although none of these audit reports contained ISBE related program findings, ISBE does not have a process in place to ensure audit reports are received on a timely basis in order to issue a management decision within the required timeframe.
- ISBE did not obtain a single audit report for one subrecipient of the Title II and CTE programs. Upon further review, it was determined the subrecipient was not required to have a single audit; however, ISBE had not obtained a certification that an audit was not required from the subrecipient.
- ISBE did not issue a required management decision for one subrecipient.
- ISBE did not obtain a single audit report and issue a management decision within 6 months (180 days) for one subrecipient. The delay in obtaining the report and issuing a management decision was 64 days beyond the required timeframe. We also noted ISBE had only issued a management decision relative to one of the two findings reported for programs administered by ISBE.

ISBE's subrecipient expenditures under the federal programs for the year ended June 30, 2017 were as follows:

Program	Total FY17 Subrecipient Expenditures	Total FY17 Program Expenditures	Percentage
CNC	$688,285,000	$689,417,000	99.8%
CACFP	$145,359,000	$145,625,000	99.8%
Title I	$671,891,000	$687,800,000	97.7%
Special Education	$511,587,000	$522,222,000	98.0%

CTE	$38,961,000	$39,846,000	97.8%
21st Century	$42,139,000	$43,825,000	96.2%
Title II	$94,888,000	$96,759,000	98.1%
SIG	$35,127,000	$36,133,000	97.2%

In discussing these conditions with ISBE officials, they stated the delays in obtaining the reports and issuing management decisions were due to an oversight by staff.

Response: The Agency agrees with the finding. ISBE will evaluate and revise its process for processing single audit reports in accordance with statewide changes resulting from the Grant Accountability and Transparency Act. In addition, ISBE has modified the process for issuing management decision memos.

Updated Response: Repeated in FY18.

17-43. The auditors recommend ISBE personnel implement procedures to obtain certifications from LEAs and other educational institutions that child counts reported are unduplicated and accurate, in order to appropriately prepare the annual report of children served under the Special Education Cluster.

Finding: ISBE did not obtain certifications from local educational agencies (LEAs) or other educational institutions that their counts of children with disabilities receiving special education and related services were unduplicated and accurately reported for the Special Education Cluster program.

In preparing the annual report of children served under IDEA, ISBE collects special education student data from LEAs and educational institutions and aggregates the data from each district to determine the total State child count. During testing of the annual IDEA child count, the auditors noted ISBE had not obtained required certifications from the LEAs stating that the data submitted was accurate and unduplicated.

In discussing these conditions with ISBE officials, they stated the data collection process was not designed to include a certification at the LEA level.

Response: The Agency agrees with the finding. District level child count certifications will be developed, tested and integrated in the agency's special education data collection system, I-Star, for the 2018-19 school year.

Updated Response: Repeated in FY18.

17-44. The auditors recommend ISBE review its monitoring procedures and implement additional procedures as necessary to ensure proper monitoring procedures are performed for all programs. Additionally, ISBE should review its procedures for communicating monitoring results and closing out on-site monitoring files and implement additional procedures to ensure timely completion of these activities, including recoupment of overpayments identified in monitoring procedures performed. (Repeated-2016)

Finding: ISBE did not perform adequate on-site monitoring procedures in accordance with its established plan for subrecipients of the Child Nutrition Cluster (CNC) and the Child and Adult Care Food Program (CACFP) programs.

During review of the 66 CNC (25 from Summer Food Services and 41 from School Nutrition) and 41 CACFP subrecipients selected for testing, the auditors noted ISBE did not perform a required on-site review for 1 subrecipient of the CNC School Nutrition program. Reviews were last performed for this subrecipient in 2014.

The auditors also noted ISBE did not follow timeframes established in its on-site monitoring plan for communicating findings, collecting corrective action plans, and closing out monitoring files. Specifically, during testwork of the 66 CNC and 41 CACFP subrecipients referenced above, ISBE did not communicate findings for 25 reviews within 60 days of the completion of review procedures and did not close out 8 reviews within 60 days of receipt of the subrecipients' corrective action plan (CAP).

Additionally, for one CNC and three CACFP subrecipients, auditors noted the on-site review files were still open as of the conclusion of our testing (November 2, 2017) and ISBE had not received or obtained the corrective action plan for two of the three CACFP subrecipients.

The auditors also noted the Nutrition and Wellness Division responsible for the monitoring for CNC and CACFP subrecipients did not have a process for settling exceptions identified by its monitoring procedures. Accordingly, ISBE has not adjusted payments to subrecipients for overpayments and underpayments identified in monitoring procedures performed in fiscal years 2014, 2015, and 2016. Total overpayments for the CNC and CACFP programs were $99,659 and $126,143, respectively. Total underpayments for the CNC and CACFP programs were $384 and $4,810, respectively.

ISBE's subrecipient expenditures under the federal programs for the year ended June 30, 2017 were as follows:

Program Name	Total FY17 Subrecipient Expenditures	Total FY17 Program Expenditures	Percentage
CNC	$688,285,000	$689,417,000	99.8%
CACFP	$145,359,000	$145, 625,000	99.8%

In discussing these conditions with ISBE officials, they stated the Nutrition Division was understaffed due to competing responsibilities.

Response: The Agency agrees with the finding. Division hiring has improved from October 2017 through February 2018. The internal processing of reviews has been made more robust with the additional personnel hired during fiscal year 2018. Employees are now working with the system to follow up on reviews to meet program timelines. The National School Lunch Program monitoring program is scheduled to go-live during fiscal year 2018. The Web-based Illinois Nutrition System (WINS) continues to make performance improvements to process claims within the WINS system. The processing of claims within WINS is scheduled to go-live during fiscal year 2018.

Updated Response: Repeated in FY18.

17-45. The auditors recommend ISBE personnel appropriately account for USDA Donated Foods for the Child Nutrition Cluster program. Additionally, adequate controls should be implemented to ensure differences between inventory records of ISBE and its contractor are researched, resolved, and adequately documented. (Repeated-2016)

Finding: ISBE did not appropriately account for USDA Donated Foods related to the Child Nutrition Cluster program.

During testwork over the February 2017 and June 2017 reconciliations, auditors noted the reconciliations contained unreconciled differences between ISBE's records and the contractor's records. Upon further review, ISBE did not document reconciling items or the resolution of the differences for the remaining 10 reconciliations completed during the fiscal year. Unresolved differences between case counts identified on the monthly inventory reconciliations were as follows:

Month	ISBE Records	Contractor Records	Difference
July 2016	100,694	58,536	42,158
August 2016	124,141	106,469	17,672
September 2016	121,895	105,785	16,110
October 2016	133,402	123,384	10,018
November 2016	117,408	102,576	14,832
December 2016	121,326	109,233	12,093
January 2017	142,888	118,665	24,223
February 2017	145,893	133,856	12,037
March 2017	82,948	83,021	(73)
April 2017	12,435	12,508	(73)
May 2017	14,259	14,332	(73)
June 2017	62,037	63,008	(971)

The dollar values of the differences between ISBE's records and the contractor's records ranged from ($27,757) to $1,408,518.

Additionally, the monthly reconciliation completed for June 2017 did not agree to the annual physical inventory records as of June 30, 2017. Specifically, the auditors noted a difference between the physical inventory records and the monthly inventory reconciliation of 881 cases.

ISBE has not established adequate controls to ensure required reconciliations are completed in accordance with program requirements. Specifically, auditors noted there is not a supervisory review in place to ensure reconciliation data agrees to supporting documentation (physical inventory records) and that reconciling items are properly resolved and documented.

In discussing these conditions with ISBE officials, they stated unexpected turnover of key staff responsible for completing the reconciliation process led to spreadsheet errors and insufficient procedures to outline the reconciliation process.

Response: The Agency agrees with the finding. ISBE has written procedures and implemented controls to ensure differences between inventory records of ISBE and its contractor are researched, resolved, and adequately documented.

Updated Response: Not Repeated in FY18.

17-46. The auditors recommend ISBE establish procedures to accurately report federal expenditures, including amounts passed through to subrecipients, used to prepare the SEFA to the IOC. (Repeated-2016)

Finding: ISBE did not accurately report Federal expenditures, including amounts passed through to subrecipients, under the Child Nutrition Cluster (CNC), Child and Adult Care Food Program (CACFP), Title I – Grants to Local Educational Agencies (Title I), Special Education Cluster (Special Education), Twenty-First Century Community Learning Centers (21st Century), and Supporting Effective Instruction State Grants (formerly Improving Teacher Quality State Grants) (Title II) programs.

Federal expenditures reported to the Illinois Office of the Comptroller (IOC) which were used to prepare the Schedule of Expenditures of Federal Awards (SEFA) did not agree to ISBE's financial records. Specifically, auditors noted the following differences for the year ended June 30, 2017:

Program	Federal Expenditures Reported in ISBE's Records	Federal Expenditures Initially Reported to the IOC	Difference
CNC	$690,112,000	$687,544,000	$2,568,000
CACFP	$148,891,000	$145,512,000	$3,379,000
Title I	$685,763,000	$687,800,000	($2,037,000)
Special Education	$522,091,000	$522,202,000	($111,000)
21st Century	$43,909,000	$43,825,000	$84,000
Title II	$93,723,000	$93,759,000	($36,000)

In addition, auditors noted the following differences relative to amounts passed through to subrecipients for the ISBE's major programs, as follows:

Program	Amounts passed to Subrecipients Reported in ISBE's Records	Amounts passed to Subrecipients Initially Reported to the IOC	Difference
CNC	$688,727,000	$686,446,000	$2,281,000
CACFP	$146,526,000	$145,260,000	$1,266,000
Special Education	$508,026,000	$511,587,000	($3,561,000)
Title II	$91,911,000	$91,900,000	$11,000

Upon further investigation, the auditors noted the differences identified in the tables above primarily relate to prior period adjustments to receivables and deferred revenue which should not be reflected in current year cash basis expenditures and amounts passed through to component units of the State of Illinois reporting entity. Although most of the differences identified in the tables above are not quantitatively material to the SEFA as a whole, the State does not have a process in place to evaluate items of this nature outside of the audit process, as discussed in finding 2017-001. Accordingly, an error which may be material to the SEFA (in either quantitative or qualitative terms) could occur and not be detected by the State.

In discussing these conditions with ISBE officials, they stated the errors are a result of the procedures by which information is required to be reported to the IOC.

Response: The Agency agrees with the finding. The State of Illinois GAAP reporting process does not have a process in place to evaluate non-cash transactions that are required to be included in expenditure data submitted to the IOC as part of the GAAP reporting process. ISBE will continue to follow Generally Accepted Accounting Principles as well as procedures outlined by the State Comptroller when compiling data for the preparation of the Agency's financial statements. In addition, we will continue to work closely with the auditors to provide all information required to be reported in the Auditors' Federal Expenditures Questionnaires, as the information becomes available. Finally, a reconciliation will continue to be provided to the Auditors detailing the non-cash transactions which should be adjusted from the Form SCO-563 to prepare a cash basis SEFA.

Updated Response: Repeated in FY18.

RECOMMENDATIONS 47-48
Department of Illinois Community College Board

17-47. The auditors recommend ICCB review and revise their risk assessment procedures to ensure the risk criteria used will appropriately identify high risk subrecipients. Additionally, the risk assessment should be used to determine the appropriate level of monitoring to be performed for each subrecipient. (Repeated-2016)

Finding: ICCB does not perform an adequate risk assessment of subrecipients of the Career and Technical Education (CTE) program as required by Uniform Guidance.

ICCB passed through approximately $16,440,000 of federal funding under the CTE program to 39 community colleges and 2 state universities (subrecipients) during the year ended June 30, 2017.

Specifically, auditors noted ICCB's risk assessment was based on subrecipient responses to an internal control questionnaire submitted by each of its subrecipients to the Grant Accountability and Transparency Unit (GATU). This internal control questionnaire asks a variety of questions, including, among other things, the results of previous audits, levels of federal funding, and capabilities relative to administering federal funds. The results of these questionnaires were summarized by ICCB into six risk categories and were used to determine whether on-site monitoring or desk reviews would be performed.

During review of the risk assessments performed for 3 subrecipients of the CTE program (with expenditures totaling $4,967,000), the auditors noted the risk assessment procedures performed did not identify risks associated with these organizations. All three subrecipients sampled were determined to be low risk despite the fact two of the subrecipients have had recent publicity about matters suggesting noncompliance with administrative processes, as well as, significant leadership turnover. The auditors also noted ICCB's risk assessment procedures only require on-site visits for subrecipients identified as high risk and the only criteria which results in a high risk assessment is if the subrecipient acts as pass through entity for the program. Accordingly, ICCB determined that none of the 41 CTE subrecipients required an on-site monitoring visit as none were determined to be high risk based on the criteria.

However, in reviewing the monitoring actually conducted by ICCB during fiscal year 2017, auditors noted ICCB performed 22 on-site programmatic reviews and 6 fiscal desk reviews in fiscal year 2017 consistent with its previously established cyclical monitoring approach. Accordingly, while the risk assessment procedures were not adequate to identify higher risk subrecipients, it does not appear the risk assessment procedures performed were used to determine the monitoring to be performed.

Amounts passed thorough to subrecipients of the CTE program totaled $16,440,000 during the year ended June 30, 2017.

In discussing these conditions with ICCB officials, they stated risk assessment procedures were put in place as required under the Grant Accountability and Transparency Act (GATA). The Board was unaware that the risk assessment procedures implemented under GATA were insufficient to meet the federal guidelines.

Response: The Board is working to develop and implement a more robust risk assessment process than what was designed as part of the Grant Accountability and Transparency Act. Beginning in fiscal 2019, with the monitoring of fiscal 2018 grants, this new process will be in place.

Updated Response: Repeated in FY18.

17-48. The auditors recommend ICCB establish procedures to accurately report federal expenditures, including amounts passed through to subrecipients, used to prepare the SEFA to the IOC. (Repeated-2015)

Finding: ICCB did not accurately report expenditures under the Career and Technical Education – Basic Grants to States (CTE) program.

Federal expenditures reported to the Illinois Office of the Comptroller (IOC) which were used to prepare the schedule of expenditure of federal awards (SEFA) did not agree to ICCB's financial records. Specifically, the auditors noted the following differences for the year ended June 30, 2017:

SEFA Caption	Amount per ICCB's Records	Amounts Reported on the Initial SEFA	Difference
Federal expenditures	$16,810,000	$16,614,000	$196,000
Amounts passed through to subrecipients	$16,440,000	$16,619,000	$179,000

Upon further investigation, auditors noted the differences identified in the table relate to current period adjustments for overpayments made to subrecipients which should not have been reported in program expenditures. An adjustment was proposed and recorded by the IOC to correct the cash basis expenditure amount; however, an adjustment was not made to correct the amounts passed through to subrecipients. Although the difference identified is not quantitatively material to the SEFA, as a whole, the State does not have a process in place to evaluate items of this nature outside the audit process, as discussed in finding 2017-001. Accordingly, any error which may be material to the SEFA (in quantitative or qualitative terms) could occur and not be detected by the State.

In discussing these conditions with ICCB officials, they stated they receive their funding from another State agency and believe the differences to be immaterial.

Response: The Board incorrectly categorized payments made to other state agencies, acting in a sub-grantee capacity, as payments to subrecipients on the SCO-567. The Board agrees that this error is immaterial to the SEFA as a whole.

The Board will work to ensure correct identification of sub-recipients and sub-recipient expenditures for the purposes of accurate SEFA reporting.

Updated Response: Repeated in FY18.

RECOMMENDATIONS 49-51
Department of Illinois Student Assistance Commission

17-49. The auditors recommend ISAC review its process to ensure that loan information is properly verified and reported to the NSLDS. (Repeated-2008)

Finding: 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 (with loan balances totaling $520,878) to confirm the accuracy of the loan information with the lender and noted the following exceptions:

- Confirmations for 5 loans (with loan balances totaling $21,125) were returned as undeliverable. Upon further investigation, ISAC was unable to facilitate locating the respondent.
- Confirmations for 8 loans (with loan balances totaling $44,266) were returned identifying differences related to the status of the loan (e.g., loan holder, loan amount, etc.).

The outstanding principal balance on loans guaranteed by ISAC totaled $3,271,587,000 as of June 30, 2017.

In discussing these conditions with ISAC officials, they stated ISAC recognizes the importance of obtaining accurate and timely data from its lenders and supports standard reporting formats and schedules to ease the reporting process for 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 USDE to verify unreported loans.

Response: ISAC will continue to support the business processes that 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.

Updated Response: Repeated in FY18.

17-50. The auditors recommend ISAC implement procedures to ensure required collection efforts are performed in accordance with federal laws and regulations. (Repeated-2014)

Finding: ISAC does not have an adequate process to ensure collection efforts required by program regulations are performed for all loans

As the State Guaranty Agency for the Federal Family Education Loan program, ISAC is required to perform specific collection efforts for a loan on which it pays a default claim to a lender. Specifically, ISAC is required to send a written notice to the borrower within 45 days of paying a lender's default claim stating the actions that may be taken by ISAC to collect the debt.

During testwork over 25 defaulted loans, auditors noted 6 of 25 defaulted loan accounts tested where prescribed collection activities (e.g., phone calls, ODD-010 letters, etc.) were not performed.

Defaulted loans outstanding totaled $401,164,000 as of June 30, 2017. Lender claims for loans paid during the year ended June 30, 2017 totaled $101,443,141.

In discussing these conditions with ISAC officials, they stated corrective actions were not implemented for the 180 Day Due Diligence and Credit Bureau Notification letters in fiscal year 2018 due to oversight.

Response: We agree with the finding. We are currently revisiting this issue in order to make sure the above referenced letters are generated. Until the system fix is completed, we have a process in place to review and manually send letters that are not automatically generated by the system.

Updated Response: Not Repeated in FY18.

17-51. The auditors recommend ISAC review its process to ensure that bankruptcy claims are properly verified and submitted in a timely manner.

Finding: ISAC does not have an adequate process to verify bankruptcy claims are submitted in a timely manner.

During testwork over 40 death, disability, closed school, false certification, unpaid refund, bankruptcy, and teacher loan forgiveness claims, we noted that for 1 bankruptcy claim, the bankruptcy notice was received by ISAC 31 days after the date the condition occurred, which is 1 day after the required due date. As a result, ISAC should have rejected the claim and should not have reimbursed the lender for the loan amount ($7,708) nor requested reimbursement from ED.

In discussing these conditions with ISAC officials, they stated the ISAC system was set up to give five days grace period to bankruptcy claims to allow for mailing time of paper claims and has not been updated for e-claim requirements.

Response: We agree and have updated the system to ensure electronic claims do not allow a five day grace period, while paper claims will still allow for a mailing time grace period. The lender has repurchased the loans related to this claim.

Additionally, all bankruptcy claims are being scrutinized prior to processing to ensure they are received timely, and if not, are returned to the lender. We reviewed all bankruptcy claims for the audit period and this was the only claim that fell outside of the established guideline.

Updated Response: Not Repeated in FY18.

RECOMMENDATIONS 52-53
Department of Employment Security

17-52. The auditors recommend IDES implement procedures to ensure adequate supporting documentation is maintained for administrative cash draw requests, adjustments, and certain financial and special reporting applicable to its federal programs.

Finding: IDES could not provide appropriate supporting documentation for certain cash draws, adjustments, and financial and special reports for administrative grants of the Unemployment Insurance (UI) program.

Certain compliance requirements for the UI program are dependent on queries and other reports generated from data within the State's Enterprise Resource Planning (ERP) system. During the audit it was noted that monthly financial closing procedures were not performed and IDES was unable to generate reports necessary to support its administrative grants throughout the audit period. Specifically, auditors noted the following:

- IDES management was unable to provide supporting documentation which agreed to or could be reconciled to administrative cash draw requests made during the year ended June 30, 2017.
- IDES management was unable to demonstrate the population of UI administrative grant adjustments was complete and accurate due to ERP data integrity issues.
- Financial and special reports prepared by IDES were based upon queries of ERP data which could not be reperformed or tested for completeness and accuracy.

In addition, IDES was unable to provide a Service Organization Control (SOC) report covering ERP application or the general information technology controls relevant to the ERP. Accordingly, auditors were unable to obtain sufficient and appropriate audit evidence to conclude on the cash management, period of performance, and reporting (ETA 9130 – *Financial Status Report, UI Programs* and ETA 2208A – *UI Contingency Report)* compliance requirements applicable to the UI administrative grants.

IDES reported total UI administrative expenditures of approximately $153,100,000 in the SEFA as of and for the year ended June 30, 2017.

In discussing these conditions with IDES officials, they stated resources limitations have delayed the implementation of custom reports needed for UI administrative grants.

Response: IDES accepts this finding and will continue to pursue the development and deployment of the reports in question, which were preliminarily transported to the ERP system in November 2017, and which continue to be tested for compliance with Federal statutes, regulations, and the terms and conditions of the awards. We have fully validated the cash draw report. We should complete full validation of all other Federal reports by June 30, 2018.

Updated Response: Repeated in FY18.

17-53. The auditors recommend IDES develop and implement written procedures to improve UI program integrity and reduce overpayments that incorporate the required monetary penalty on fraud overpayments and prohibit providing relief to employers who fail to provide timely and adequate responses to information requests. (Repeated-2015)

Finding: IDES did not implement Federal requirements to improve program integrity and reduce overpayments.

The State is required to establish written procedures for: (1) identifying overpayments, (2) classifying overpayments into categories based on the reason the overpayment occurred (i.e. employer error, non-response from employers, beneficiary fraud, etc.), and (3) establishing appropriate methods for following up on each category of overpayment. In establishing these procedures, the State is required to enter into three agreements prior to commencing recoveries. The first agreement permits the State to offset State UI from Federal UI overpayments (Cross Program Offset and Recovery Agreement). The second agreement permits the State to recover overpayments from benefits being administered by another State (Interstate Reciprocal Overpayment Recovery Agreement). The third agreement permits the State to utilize the Treasury Offset Program to recover overpayments that remain uncollected one year after the debt was determined to be due. Additionally, the State is (1) required to impose a monetary penalty (not less than 15 percent) on claimants whose fraudulent acts resulted in overpayments, and (2) prohibited from providing relief from charges to employer's UI account when overpayments are the result of the employer's failure to respond timely or adequately to a request for information.

During testwork, the auditors noted that while IDES has developed the written procedures relative to overpayments and entered into the required agreements described in the previous paragraph, the written procedures did not address the requirement to impose a monetary penalty on fraud overpayments. Additionally, auditors noted the policies do not address the prohibition of providing employers relief resulting from an employer failing to provide timely or adequate information.

In discussing these conditions with IDES officials, they stated the procurement process for the IT services needed to implement the 15% penalty took longer than initially anticipated. IDES also had difficulty determining the best method for implementing the non-charging prohibition.

Response: IDES accepts the finding and is currently integrating our current overpayment tracking system into our benefit payment system. The 15% penalty on fraud overpayments is part of the scope of work and will be implemented as part of our systems integration, which is scheduled for completion by August of 2018. The department will also begin planning the implementation of the prohibition on non-charging due to employer fault per federal guidance and this is due to be completed by the end of April of 2019.

Updated Response: Repeated in FY18.

17-54. The auditors recommend IDES implement procedures to ensure all eligibility determinations are made within the prescribed timeframes. (Repeated-2013)

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

UI eligibility determinations are made during the initial intake of the claim and are monitored throughout the benefit payment period. If the claimant does not meet certain eligibility criteria either during the initial intake of the claim or throughout the benefit payment period, or if an employer disagrees with the initial eligibility determination, an issue is identified in the system and the claim requires further action prior to benefits determination. The claim is then assigned to a claims adjudicator for resolution through system workflow. The system monitors the number of days the claim has been outstanding since the initial detection date, which is the date on which IDES detected an issue on the claim which could affect past, present, or future benefit rights.

During review of the fiscal year 2018 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 fiscal year 2017, resolving only 70.5% of these determinations within 21 days of the detection date.

In discussing these conditions with IDES officials, they stated there are a number of factors that have contributed to the Department's failure to issue timely determinations, the most of which are the volatility of staffing resources and a backlog of adjudications resulting from an inefficient process.

Response: IDES accepts the finding and has focused on the reduction and elimination, where possible, of the posting and scheduling of adjudication assignments which are actually non-issues. Our attention has been directed to the Document Processing Unit and the Internet Claims Unit, which are in position to ensure that valid issues get posted. Staff in these units, by way of a continuous process improvement model, learn to properly identify documents, to properly index documents to the correct issue, and to prevent the posting of duplicate and unnecessary issues. Also, we have identified and focused in on localized causes of untimeliness and began pilot projects in those areas to fix the problems. For example, Southern Region began a project to shift majority focus on backlogged cases to completing cases which are timely—which also prevents such cases from becoming backlogged and untimely. Another pilot focused in on adjudication issues identified in regional offices and had staff post selected issues as they were identified instead of shifting the burden to the local office via a time-wasting referral. In addition, during the 3rd calendar year quarter of 2017, we implemented technical solutions in order to automatically prevent improper employer notification and also to prevent the posting of issues related to employers without party status. A critical aspect in correcting this finding is providing ongoing training opportunities for management and staff. Further, it should be noted that the performance level for the federal fiscal year under review is 8.6 percentage points greater than the prior year reviewed. Moreover, IDES completed the calendar year at a 76.9% performance level.

Updated Response: Repeated in FY18.

17-55. The auditors recommend IDES review its procedures for preparing financial reports required for the UI program and implement analytical and any other procedures considered necessary to ensure the reports are accurate prior to submission to the USDOL. (Repeated-2014)

Finding: IDES does not have an adequate process in place to ensure all financial reports prepared for the Unemployment Insurance (UI) program are accurate.

During testwork of two quarterly ETA 227 reports, auditors noted the amounts reported by IDES on several required line items did not agree to the supporting documentation provided by IDES during our audit. The errors identified related to the number of fraud and non-fraud overpayment cases established (Section B), the dollar amount recovery of the overpayments (Section C), and the aging of the benefit overpayment accounts (Section E). As of the date of testwork (December 4, 2017), IDES had not revised the report or reconciled any of the differences identified.

Additionally, in considering the reporting process for all required financial reports, the auditors noted adequate internal controls have not been established to ensure reports prepared by IDES personnel are accurate. Specifically, auditors noted IDES does not perform analytical or other procedures during the report preparation process or supervisory reviews to ensure amounts reported are reasonable in relation to previously reported information or expectations relative to

current program activities.

In discussing these conditions with IDES officials, they stated the errors were a result of a currently manual process to compile the reports with data from multiple systems that do not interact.

Response: IDES accepts this finding and is in the process of integrating the functionality of legacy benefit payment control systems into the Illinois Benefit Information System (IBIS). This integration will provide for a single data source for reporting financial activity related to benefit overpayments. The goal is to complete this integration and to reengineer the ETA 227 report in the 3rd quarter of calendar year 2018.

It should be noted that Section A of the report which records new overpayments established within the reporting quarter has passed data validation by the U.S. Department of Labor – ETA standards. This asserts that the reporting of new overpayments is accurate. IDES has also passed data validation for all collection activities that are reported within Section C of the report.

Further, the manager of the Benefit Payment Control Division is asked to review the compiled report for reasonableness prior to being submitted to the ETA.

Updated Response: Repeated in FY18.

17-56. The auditors recommend IDES implement procedures to ensure access to its information systems is adequately secured and user access reviews are performed. (Repeated-2011)

Finding: IDES does not have adequate controls over the information systems that support the Unemployment Insurance (UI) Program to remove terminated users in a timely manner.

During testwork over the access, program change and development, and computer operations controls of the mainframe system, auditors noted user access review procedures were not performed for five of the fifteen cost centers selected for testing.

In discussing these conditions with IDES officials, they stated Cost Center managers have not been held accountable for the timely review and sign off of the semi-annual Security Software review.

Response: IDES accepts this finding and will implement procedures to ensure the timely review and signoff of the semi-annual RACF Access review. IDES personnel will make one follow up attempt to the non-compliers and then it will be escalated to the appropriate Deputy Director or the Director.

Updated Response: Repeated in FY18.

17-57. The auditors recommend IDES establish procedures to accurately report federal expenditures used to prepare the SEFA to the IOC. (Repeated-2014)

Finding: IDES did not accurately report Federal expenditure information under the Unemployment Insurance (UI) program.

Federal expenditures reported to the Illinois Office of the Comptroller (IOC) which were used to prepare the schedule of expenditures of federal awards (SEFA) did not agree to IDES' financial records. Specifically, auditors noted the following differences for the year ended June 30, 2017:

Program	Amounts Reported per IDES' Records	Amounts Reported on the SEFA	Difference
Unemployment Insurance	$2,005,727,000	$2,011,738,000	($6,011,000)

Although the difference identified above is not quantitatively material to the SEFA as a whole, the State does not have a process in place to evaluate items of this nature outside of the audit process. Accordingly, an error which may be material to the SEFA (in either quantitative or qualitative terms) could occur and not be detected by the State.

In discussing these conditions with IDES officials, they stated the error was a result of human error, staff turnover, and the constraints of the State Comptroller Office (SCO) 563 form used to report this information.

Response: IDES accepts this finding and will establish new procedures on how to prepare the SEFA and ensure staff accurately reviews all expenditures before submitting the SEFA. The non-cash true-up entry for prior period estimates is an ongoing issue which we will work with the IOC to correct.

Updated Response: Repeated in FY18.

RECOMMENDATION 58
Department of Commerce & Economic Opportunity

17-58. The auditors recommend DCEO establish procedures to ensure loan balances reported to the IOC and used to prepare the SEFA are accurate. If DCEO believes these amounts are not required to be reported on the SEFA, the auditors recommend DCEO work with USHUD to obtain a formal management decision relative to this matter. (Repeated-2013)

Finding: DCEO did not properly report loan balances under the CDBG State Administered Small Cities Program (CDBG).

In the 1980's, DCEO established revolving loan funds with a number of municipalities (subrecipients) in order to provide CDBG loans to organizations within their respective communities. The subrecipients are required to collect and deposit loan repayments and interest into their revolving loan fund and issue new loans as funds become available. DCEO has not provided any new loans under the CDBG program in recent years; however, some organizations have returned loan fund balances to DCEO.

During audit procedures, auditors noted the federal expenditure information reported to the Illinois Office of the Comptroller (IOC) which was used to prepare the schedule of expenditures of federal awards (SEFA) did not agree to DCEO's financial records. Specifically, auditors noted DCEO did not include the beginning loan balances for the CDBG program of $50,385,000 in the information initially reported to the IOC. The auditors proposed and the State recorded an adjustment to include the beginning loan balances on the SEFA for the CDBG program to adopt the SEFA reporting requirements under the Uniform Guidance.

In discussing these conditions with DCEO officials, they stated they no longer believe the loans are required to be reported on the SEFA.

Response: The Department believes these amounts are not required to be reported on the SEFA and agrees with the auditor's recommendation to collaborate with USHUD to obtain a formal management decision relative to this matter. The Department will proceed in obtaining a management decision utilizing USHUD processes and protocols.

Updated Response: Not Repeated in FY18.

RECOMMENDATIONS 59-63
Department of Transportation

17-59. The auditors recommend IDOT review its current process and consider any changes necessary to ensure weekly payroll certifications are received and approved in accordance with federal requirements and IDOT's procedures. (Repeated-2011)

Finding: IDOT did not obtain certified payrolls in accordance with its established internal control procedures for the Highway Planning and Construction Cluster (Highway Planning) program.

During testwork of 50 Highway Planning contractor payments for regular construction projects (totaling approximately $35,169,000) and 15 Highway Planning contractor payments for advanced construction projects (totaling approximately $23,693,000), auditors noted the following:

- The certified payrolls for 17 Highway Planning contractor payments on regular construction projects (totaling approximately $5,799,000) and 1 Highway Planning contractor payment on advanced construction projects (totaling approximately $2,129,000) were not received in a timely manner. Delays in receiving the certified payrolls ranged from 13 to 114 days.
- The certified payrolls for 9 Highway Planning contractor payments on regular construction projects (totaling approximately $6,128,000) and 4 Highway Planning contractor payments on advanced construction projects (totaling approximately $2,094,000) were not date stamped. As a result, we were unable to determine whether they were received in compliance with federal requirements and IDOT's established procedures.
- The certified payrolls for 2 Highway Planning contractor payments on regular construction projects (totaling approximately $440,000) were not signed by either the Resident Engineer, documentation staff, or Equal Employment Opportunity (EEO) personnel. As a result, we were unable to determine whether the certified payroll was approved.

IDOT did not determine it necessary to suspend funding since the certified payroll had been received subsequent to notification by IDOT. Payments made for construction contracts under the Highway Planning program were approximately $1,216,587,000 during the year ended June 30, 2017.

In discussing these conditions with IDOT officials, they stated the condition noted is attributed to the lack of clear administrative procedures for collection of certified payrolls and actions for non-compliance.

Response: Documented progress has been made to correct the audit finding. The finding shows the vast preponderance of payrolls are received in accordance with the contract documents. Further consultation with district construction staff is necessary to attain full implementation. This will take place via each district's spring Project Implementation meeting and through field visits by the Project Review Engineers in the Bureau of Construction.

In addition, we have updated our process to address the finding but because of the extensive volume of documents required and the number of contractors involved, the Department believes an information technology solution is necessary to further strengthen the controls over this process.

IDOT has been diligently working to upgrade its systems critical to its processes. As part of the new Construction and Materials Management System, contractors will have the ability to scan and submit certified payroll files electronically. This information system development project is currently underway and we are hopeful it will assist in correcting the issue.

Updated Response: Repeated in FY18.

17-60. 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.

Finding: IDOT did not prepare an accurate financial report for the Airport Improvement Program (Airport Improvement).

IDOT is required to prepare an annual federal financial status report (SF-425) for the Airport Improvement program. During testwork of the SF-425 report submitted for the federal fiscal year ended September 30, 2016, auditors noted the following errors:

Report Line Items	Reported Amount	Actual Amount	Difference
Line 10.g – Total Federal share	$456,793,761	$456,793,948	$187
Line 10.h – Unobligated balance of Federal funds	$60,231,330	$0	$60,231,330

Additionally, auditors noted IDOT improperly identified the annual report as the final report (line item 6) and erroneously reported the grant period as 9/30/2013 to 10/1/2015 instead of 9/30/2003 to 9/30/2016.

The auditors further noted the supervisory review procedures performed for this report were not at an appropriate level of precision to identify the errors identified in our testing. Additionally, IDOT does not perform analytical procedures to identify potential errors or unusual fluctuations in reported amounts.

In discussing these conditions with IDOT officials, they stated the errors noted are attributed to a lack of written procedures guiding staff on the proper way to complete the reports accurately.

Response: Written procedures were developed on October 2, 2017 which address the issues noted in the finding. The written procedures outline the verification of the status of the grant and when the report should be marked as final or annual. They also include an additional quality assurance review by the Engineering Program Section. The procedures state the reported amount should be the actual amount expended. All funds assigned to active projects are obligated; therefore, funds should not be reported as uncommitted in future reports.

Updated Response: Repeated in FY18.

17-61. The auditors recommend IDOT implement procedures to ensure review of subrecipient single audit reports is documented and management decisions are issued for all findings affecting its federal program in accordance with required timeframes.

Finding: IDOT did not adequately review single audit reports received from its subrecipients for the Airport Improvement Program (Airport Improvement) and the Highway Planning and Construction Cluster (Highway Planning).

IDOT passed through approximately $37,247,000 and $268,868,000 to subrecipients of the Airport Improvement program and the Highway Planning program, respectively, during the year ended June 30, 2017. During testwork of 16 subrecipients of the Airport Improvement program (with total expenditures of $33,200,270) and 26 subrecipients of the Highway Planning program (with total expenditures of $129,057,222) the auditors noted the following regarding the desk review process:

- IDOT did not issue a management decision related to findings reported within 6 months after receipt of the subrecipient's audit report for 1 subrecipient of the Highway Planning program. The delay in issuing a management decision was 460 days after its required due date. Amounts passed through to this subrecipient during the year ended June 30, 2017 totaled $1,155,000.
- IDOT did not complete supervisory reviews of the desk review checklist for 2 subrecipients of the Highway Planning program and 3 subrecipients of the Airport Improvement program. The checklists provided at the date of our fieldwork (December 15, 2017), did not contain a signature or date to evidence completion of the supervisory reviews. Amounts passed through to these subrecipients during the year ended June 30, 2017 totaled $2,315,000 and $1,974,000, respectively.

Additionally, auditors noted IDOT has not established adequate monitoring controls to ensure management decision letters are issued in accordance with required timeframes.

Subrecipient expenditures under the federal programs for the year ended June 30, 2017 were as follows:

Program	Total Fiscal Year 2017 Subrecipient Expenditures	Total Fiscal Year 2017 Program Expenditures	Percentage
Airport Improvement	$ 37,247,000	$ 65,651,000	56.7%
Highway Planning	$ 268,868,000	$ 1,526,095,000	17.6%

In discussing these conditions with IDOT officials, they stated the section responsible for this requirement was understaffed due to turnover.

Response: Two staff were hired and began employment in the Unit on February 16, 2018. The goal is to have the Unit fully staffed and functional by the end of fiscal year 2018.

Updated Response: Repeated in FY18.

17-62. The auditors recommend IDOT establish procedures to accurately report federal expenditures (including subrecipient expenditures) used to prepare the SEFA to the IOC. (Repeated-2016)

Finding: IDOT did not accurately report Federal expenditure information under the Airport Improvement Program (AIP).

Federal expenditures reported to the Illinois Office of the Comptroller (IOC) which were used to prepare the schedule of expenditures of federal awards (SEFA) did not agree to IDOT's financial records. Specifically, auditors noted the following differences relative to amounts passed through to subrecipients for the year ended June 30, 2017:

Program	Amounts per IDOT's Records	Amounts Initially Reported to the IOC	Difference
AIP	$37,247,000	$35,267,000	$1,980,000

In discussing these conditions with IDOT officials, they stated IDOT's software systems do not have the ability to track federal expenditures by CFDA; therefore, the annual reconciliation of federal expenditures, including year-end expenditure cut-offs, for financial reporting purposes is highly manual.

Response: For future reporting periods, the procedures detailing the reconciliation of the federal expenditure reconciliation with be revised to include a detailed review of manual federal expenditure adjustments to ensure expenditures are properly categorized.

Updated Response: Repeated in FY18.

17-63. The auditors recommend IDOT implement procedures to ensure access to its information systems is adequately secured and changes identified in system access reviews are made on a timely basis. The auditors also recommend IDOT implement procedures to ensure all information systems can generate a list of program changes from the information systems and applications or implement other procedures to establish the completeness and accuracy of the listing of program changes. (Repeated-2012)

Finding: IDOT does not have adequate user access and program change management controls over the IDOT Integrated Transportation Project Management system.

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

In discussing these conditions with IDOT officials, they stated the systems are old and don't have the capability to produce a system generated list.

Response: IDOT believes all of these information technology systems need to be replaced to further strengthen controls. IDOT has been diligently working to upgrade its systems critical to its processes and has therefore identified these systems listed in this finding for replacement. All of these projects are currently under development or a request to replace the system is being sought for an outside vendor with the exception of the Fiscal Operations and Administration (FOA) system which will be replaced by the implementation of the new Statewide ERP System. The remaining systems will be addressed as stated below:

- The Electronic Contract Management System (ECM) – Vendor Contract and Letting Management System is currently in the Request for Proposal stage to seek a replacement System.
- The Electronic Letting Management System (ELM) – Vendor Contract and Letting Management System is currently in the Request for Proposal stage to seek a replacement System.
- The Illinois Construction Records Management System (ICORS) – Construction Materials Management System (CMMS) in development to replace this system.
- The Bureau of Contract Management System (BCM) – Construction Materials Management System (CMMS) in development to replace this system.
- The Federal Payment Control System (FPC) – Federal Project Management System in development to replace this system.

Updated Response: Repeated in FY18.

RECOMMENDATIONS 64-66
Department of Environmental Protection Agency

17-64. The auditors recommend IEPA establish procedures to ensure subrecipient single audit reports are obtained and reviewed within established deadlines and management decisions are issued for all findings affecting its federal programs in accordance with required timeframes.

Finding: IEPA did not obtain and adequately review single audit reports received from its subrecipients for the Capitalization Grants for Clean Water State Revolving Funds (CWSRF) and Capitalization Grants for Drinking Water State Revolving Funds (DWSRF) programs on a timely basis.

During review of a sample of 8 subrecipient single audit desk review files for each program, the auditors noted the following exceptions:

- Seven CWSRF subrecipient reports were not reviewed in a timely manner (within 60 days of receipt). Delays in reviewing these reports ranged from 146 to 429 days. Federal disbursements to the selected subrecipients totaled $14,997,033.
- Four DWSRF subrecipient reports were not reviewed in a timely manner (within 60 days of receipt). Delays in reviewing these reports ranged from 80 to 371 days. Federal disbursements to the selected subrecipients totaled $29,850,745.
- One DWSRF single audit report was not obtained by IEPA. Upon further review, IEPA determined the subrecipient did not have expenditures in excess of $750,000 and did not require an audit; however, IEPA had not obtained a certification that an audit was not required in accordance with their policy. The subrecipient had received $653,156 in Federal funding from IEPA for their fiscal year under audit.

IEPA's subrecipient expenditures under the federal programs for the year ended June 30, 2017 were as follows:

Program	Total FY17 Subrecipient Expenditures	Total FY17 Program Expenditures	Percentage
CWSRF	$60,333,000	$60,444,000	99.8%
DWSRF	$68,503,000	$70,056,000	97.8%

In discussing these conditions with IEPA officials, they stated they believe the files were obtained and reviewed in a timely manner, but could not locate documentation evidencing their timely completion due to an employee absence.

Response: Agree. The Agency has procedures in place to properly notify, track and monitor the recipients of federal funds and their requirements to have or not have a federal audit performed.

Updated Response: Repeated in FY18.

17-65. The auditors recommend IEPA perform procedures to verify vouchers have been received by the IOC for payment prior to requesting cash from the federal government.

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

During review of 25 payments (totaling $41,797,940) to subrecipients of the Capitalization Grants for Clean Water State Revolving Funds (CWSRF) program and 25 payments (totaling $21,237,271) to subrecipients of the Capitalization Grants for Drinking Water State Revolving Funds (DWSRF) program, auditors noted warrants were not issued on a timely basis by the Illinois Office of the Comptroller (IOC) due to difficulties encountered during the implementation of the State's Enterprise Resource Planning (ERP) system. Specifically, the auditors noted eleven CWSRF subrecipient payments (totaling ($24,421,783) and eight DWSRF subrecipient payments (totaling $3,974,054), were not received by the IOC for payment after the vouchers were approved by IEPA. As a result, IEPA received cash in advance of paying these expenditures. The number of days between the receipt of federal funds and the issuance of warrants ranged from 7 to 24 business days.

Total subrecipient payments for the CWSRF and DWSRF programs administered by IEPA were $60,333,000 and $68,503,000 during the year ended June 30, 2017, respectively.

In discussing these conditions with IEPA officials, they stated certain vouchers were not sent to the Illinois Office of the Comptroller for payment during the implementation of the Enterprise Resource Planning system.

Response: Agree. The Agency follows federal guidelines of minimizing the time between federal draws and the disbursement of funds for program purposes. The Agency now tracks approved vouchers to ensure payment by the IOC.

Updated Response: Not Repeated in FY18.

17-66. The auditors recommend IEPA review the process and procedures in place to prepare financial reports required for the CWSRF and DWSRF programs and implement the additional procedures necessary to ensure the reports agree or reconcile to its financial records prior to submission to the USEPA.

Finding: IEPA did not prepare accurate financial reports for the Capitalization Grants for Drinking Water State Revolving Funds (DWSRF) program.

IEPA is required to prepare financial status (SF-425) reports on an annual basis for the Capitalization Grants for Clean Water State Revolving Funds (CWSRF) and DWSRF programs. During testwork over two annual SF-425 reports submitted during State fiscal year 2017, auditors noted the following errors in the preparation of the reports as below:

Grant Award	Report Line Item	Amount Reported	Actual Amount	Variance Over/(Under)stated
FS98577715	10i. Total recipient share required	$ –	$7,333,600	($7,333,600)
FS98577715	10k. Remaining recipient share to be provided	$ –	$7,333,600	($7,333,600)
FS98577714	10i. Total recipient share required	$6,357,200	$7,382,200	($1,025,000)
FS98577714	10j. Recipient share of expenditures	$6,357,200	$7,382,200	($1,025,000)

Additionally, in considering the reporting process for these financial reports, auditors noted adequate internal controls have not been established to ensure reports prepared by IEPA are complete and accurate. Specifically, the auditors noted IEPA does not perform analytical or other procedures during the reporting preparation process or supervisory reviews to ensure amounts reported are reasonable in relation to previously reported information or expectations relative to current program activities.

In discussing these conditions with IEPA officials, they stated the errors identified were the result of the manual compilation process (human error).

Response: Agree. The Agency has a process in place to ensure amounts are for the correct amount using supporting documentation and a supervisory review is performed.

Updated Response: Repeated in FY18.

RECOMMENDATIONS 67-72
Department on Aging

17-67. The auditors recommend IDOA implement control procedures to ensure cash draws are performed in accordance with U.S. Treasury regulations and cash advances are reported and returned to USDHHS in a timely manner. The auditors also recommend IDOA prepare reconciliations of cash advances in a timely manner and require supervisory reviews to be performed at a level precise enough to identify noncompliance with cash management requirements.

Finding: IDOA did not properly draw and report cash advances made under the Aging Cluster program.

During testwork over 25 cash draws (totaling $40,548,437), auditors sampled one draw in the amount of $1,454,195 from federal fiscal year 2014 Aging Cluster grant awards (14AAILT3SS, 14AAILT3HD, and 14AAILT3FC). The auditors noted the draw related to the close out of the award and that the underlying expenditures supporting the sampled draw had been incurred and paid in 2014. They also noted IDOA had not established a grant receivable in its accounting records or otherwise identified the previous paid expenditures had not yet been claimed under this award prior to performing the draw to close out the award in February 2017.

Upon further discussion with IDOA management relative to this cash draw, IDOA management disclosed IDOA staff had performed cash draws against Federal fiscal 2012 Aging Cluster grant

awards in advance of anticipated expenditures expected to be reported by its subrecipients in Federal fiscal year 2015. It was later determined by IDOA personnel that these expenditures had not been incurred as expected which resulted in a cash advance relative to the Federal fiscal year 2012 Aging Cluster program grants and non-Aging Cluster Title III Part D and E programs.

Rather than reporting and returning the advance funding to the USDHHS, IDOA staff reduced draws on subsequent awards to reduce the overdrawn amounts throughout the period; however, additional advances resulted on subsequent awards for Federal fiscal years 2013, 2014, and 2015 which had not been reconciled by IDOA as of the date of our initial testing in January 2018.

In March 2018, IDOA management prepared reconciliations of cumulative cash draws compared to cumulative expenditures for each Title III grant administered for Federal fiscal years 2012 through 2017. As a result of those reconciliation procedures, IDOA management determined twelve Aging Cluster awards had cash draws in excess expenditures (overdrawn) totaling $4,678,964 as of June 30, 2017. Additionally, IDOA management identified non-Aging Cluster Title III Part D and E grants were overdrawn by $273,253 and $864,217, respectively.

The overdrawn Aging Cluster grants are as follows:

Federal Fiscal Year	CFDA Number	Award Name	Award Number	Cumulative Cash Draws	Cumulative Expenditures	Amount of Overdraw
2012	93.044	Title III B	12AAILT3SS	$15,903,620	$15,500,004	$403,616
2012	93.045	Title III C-1	12AAILT3CM	$15,541,500	$14,573,617	$967,883
2012	93.045	Title III C-2	12AAILT3HD	$8,644,477	$7,986,107	$658,370
2012	93.053	Nutrition Services Incentive Program (NSIP)	12AAILNSIP	$6,901,365	$6,897,403	$3,962
2013	93.044	Title III B	13AAILT3SS	$16,629,687	$15,239,705	$1,389,982
2013	93.045	Title III C-1	13AAILT3CM	$13,937,416	$13,736,237	$201,179
2013	93.045	Title III C-2	13AAILT3HD	$8,441,339	$8,172,185	$269,154
2014	93.044	Title III B	14AAILT3SS	$16,780,030	$16,329,614	$450,416
2014	93.053	NSIP	14AAILNSIP	$6,060,437	$5,764,680	$295,757
2015	93.044	Title III B	15AAILT3SS	$15,485,267	$15,460,194	$25,073
2015	93.045	Title III C-2	15AAILT3HD	$8,688,954	$8,680,571	$8,383
2016	93.045	Title III C-1	16AAILT3CM	$12,787,827	$12,782,638	$5,189

In addition, during testing of the data supporting the amounts identified in the reconciliations for each award year, auditors noted the cumulative expenditure amounts reported above include expenditures for carryover awards which may not have been obligated with the period of performance as discussed in finding 2017-068. The auditors identified two expenditures totaling $1,175,961 pertaining to awards for Federal fiscal year 2012 ($496,274) and 2013 ($679,687) which IDOA personnel stated were expenditure of carryover awards. Accordingly, the Amount of the Overdraw may be understated by any expenditures for carryover awards that were not obligated during the applicable Federal fiscal year.

As of the date of testing (April 13, 2018), auditors noted IDOA has not corrected its financial reports for the errors identified during its reconciliation of the awards for Federal fiscal years 2012 through 2017. Accordingly, the reports submitted by IDOA during State fiscal year 2017 are not accurate. In discussing these conditions with IDOA officials, they stated prior fiscal management had either not trained or incorrectly trained staff which led to issues with the accounting of the federal funds in previous fiscal years.

Response: IDOA had a change in fiscal management staff late in federal fiscal year 2016. Upon the change in IDOA management staff, it was recognized that there was a lack of internal controls. Management staff began revising procedures to create a segregation of duties between drawing of cash and processing vouchers. During this process it came to light that a reconciliation of federal fiscal year 2014 was necessary prior to closing out that year. Of the $4,678,964 potential overdraws mentioned above only $5,189 is attributable to federal fiscal year 2016, which is attributable to the change in mangement.

New management staff has implemented control procedures to facilitate that cash draws are performed in accordance with U.S. Treasury regulations and cash advances are reported and returned to USDHHS in a timely manner. IDOA has implemented control procedures that require supervisory reviews to be performed to identify noncompliance with cash management requirements.

The Department has trained staff on federal rules related to cash management as well as implemented procedures to track the timing of federal receipts and the release of vouchers to the Comptroller. This will facilitate that all cash management rules are adhered to. The Department will continue to improve procedures and training of staff. The Department has reviewed 45 CFR 75.305(b), grantees are required to implement methods and procedures for payment which minimize the time elapsing between the transfer of funds from the U.S. Treasury and disbursement of funds in accordance with the Treasury Regulations at 31 CFR part 205 (Treasury Regulations). The Department has updated the procedures and trained staff on this as well.

Updated Response: Repeated in FY18.

17-68. The auditors recommend IDOA implement procedures to ensure grant funding is obligated within required timeframes.

Finding: IDOA expended funds under the Aging Cluster program which were not obligated within required timeframes.

IDOA passed through $40,779,000 in Aging Cluster funds to 13 Area Agencies on Aging (AAA) to deliver services to the State's aged population during State fiscal year 2017.

Period of performance requirements for the Aging Cluster require IDOA to obligate funds during the Federal fiscal year for which they are awarded. During testing, the auditors noted the carryover awards issued by IDOA for the Federal fiscal year 2016 grant were not executed until November 2016. Additionally, auditors noted carryover awards were increased for several AAAs due to changes in spending estimates during fiscal year 2017. Increases to carryover awards for Federal fiscal year 2016 funding totaling $771,971 were made during Federal fiscal year 2017 after IDOA determined its subrecipients had not spent the entire amount obligated for the budget period ended September 30, 2016. Accordingly, carryover awards pertaining to Federal fiscal year 2016 totaling $1,502,761 were not obligated within the Federal fiscal year for which they were awarded.

In discussing these conditions with IDOA officials, they stated State of Illinois Budget Impasse directly created unavoidable delays in all processing of agreements in the State outside of the Department's historical timeframes.

Response: The Department concurs with this finding and the recommendation. The Department has implemented a multi-year grant agreement in State fiscal year 2018 to safeguard that grant funds are obligated in the year in which they are received. The Department will continue to work on updating procedures to facilitate that the handling of carryover is in compliance with federal regulations.

Updated Response: Repeated in FY18.

17-69. The auditors recommend IDOA review the process and procedures in place to prepare required financial reports and the certification of the maintenance of effort required for the Aging Cluster program and implement procedures necessary to ensure that actual expenditures incurred during the period are reported and certified. (Repeated-2016)

Finding: IDOA did not accurately certify its maintenance of effort (MOE) expenditures under the Aging Cluster program to USDHHS and meet MOE requirements.

During testing of the MOE requirement, auditors noted IDOA reported and certified it had paid MOE expenditures of $5,306,468 in Federal fiscal year 2016 which IDOA stated was an amount equal to the average of the previous three year's expenditures. However, IDOA did not determine the three year average based upon the actual State funded expenditures for each year in the three year period as IDOA passed through State funded Aging Cluster program funds of approximately $20 million annually. Accordingly, IDOA did not properly determined whether it has met, not met, or exceeded its MOE requirements.

The auditors also noted the amounts reported on the semi-annual Federal Financial Report (SF-425) as the total recipient share required exceeded $7.3 million annually. Additionally, the recipient share of expenditure reported in financial reports submitted in Federal fiscal year 2016 were revised as follows from the amounts previously reported:

Program Title	Federal Fiscal Year	Amount Reported 3/31/2016	Amount Reported 9/30/2016	Difference
Title III – Support Services	2014	$ 19,330,043	$ 3,399,918	$ 15,930,125
Title III – CM	2014	$ 7,403,860	$ 2,280,239	$ 5,123,621
Title III – HD	2014	$ 22,227,567	$ 1,649,132	$ 20,578,435
Title III – Support Services	2015	$ 18,428,329	$ 2,978,403	$ 15,449,926
Title III – CM	2015	$ 7,353,490	$ 2,626,832	$ 4,726,658
Title III – HD	2015	$ 21,668,414	$ 1,600,307	$ 20,068,107
Title III – Support Services	2016	$ 6,312,462	$ 2,177,068	$ 4,135,394
Title III – CM	2016	$ 4,136,127	$ 2,958,505	$ 1,177,622
Title III – HD	2016	$ 9,313,005	$ 1,616,190	$ 7,696,815

IDOA was unable to reconcile the differences in the amounts reported on the SF-425 reports, the schedule supporting the MOE certification, and IDOA records relative to State funded Aging Cluster expenditures provided for audit.

In discussing these conditions with IDOA officials, they stated they disagree with the finding.

Response: The Department disagrees with this finding as the MOE was accurately certified and accepted by Administration for Community Living (ACL). In 2017 the Department implemented a

new tracking methodology and modified their procedures which will create consistency regardless of staff turnover and availability of staff to train. This procedure also includes supervisor approval before reports are submitted.

The finding claims that the MOE is inaccurately reported and further claims that the Department did not properly determined whether it has met, not met, or exceeded its MOE requirements. The finding further indicates that internal controls do not exist to facilitate the accuracy of reporting.

Internal procedures were solidified and put in place, as well as used to generate the MOE, also the MOE certification is reviewed by ACL for accuracy before acceptance. Procedures and backup data were provided to the auditors electronically and by hard copy during the audit engagement which in the finding indicates they do not exist.

The guidance below provides further clarification regarding MOE.

AOA Fiscal Guide
(8) MAINTENANCE OF EFFORT FOR TITLE III
Sec. 309(c) and 45 CFR Part 1321.49 of the regulations. The maintenance of effort for Title III expenditures from state sources must not be less than the average of the three previous fiscal year certifications. Any amount of state resources included in the Title III maintenance of effort certification that exceeds the minimum amount mandated becomes part of the permanent maintenance of effort. Excess state match does not become part of the maintenance of effort unless the state certifies it as such.

MOE is based on General Revenue Spending in support of Older American Cluster programming. The portion of the 425 that has any impact on the MOE is in the 425 supplemental that calculates Match for the Area Agencies and the State. MOE must be at the minimum required match for the State of Illinois. The total for Sate Match (services and Admin) for FFY16 was $3.8 million which is the State required portion of the overall match for the cluster grant. Because the requirement for the MOE Certification is no less than the average of the previous 3 years reported, our MOE is higher than our required match for that year but equal to the average of the previous 3 years reported for MOE. Over Match reported on the 425 does not automatically become part of the MOE. The matter of reporting above the minimum required is at the States discretion. Since the Department did submit their MOE and did select meets the minimum requirement they are in compliance with Federal regulations.

Auditors' Comment:

As discussed in the finding above, IDOA is required to report the amount spent for both services and administration under the Title III program to USDHHS and to certify if the amount is less than, equal to, or more than the required level of MOE. IDOA could not provide authoritative guidance supporting its position that the State is only required to report and certify an amount equal to the average expenditures for the past three years. While a letter addressed to another State was provided to us by IDOA, we were unable to determine if the specific methodology used by the entity to which the letter was addressed is consistent with that used by Illinois.

Additionally, as discussed above, we were provided with documentation that was inconsistent with the information provided in the prior audit relative to the MOE and matching amounts reported by IDOA. IDOA's response relative to these inconsistencies was that a new methodology was implemented in 2017. A reconciliation was not provided for the differences noted.

Updated Response: Repeated in FY18.

17-70. The auditors recommend IDOA: (1) implement the risk assessment procedures required by the Uniform Guidance; (2) review its current policies and procedures for monitoring Aging Cluster program subrecipients and implement changes necessary to implement any changes required by the Uniform Guidance; and (3) implement procedures to ensure on-site reviews are appropriately performed and completed as planned. (Repeated-2016)

Finding: IDOA did not perform a risk assessment of subrecipients of the Aging Cluster program as required by the Uniform Guidance. Additionally, IDOA did not perform any on-site programmatic reviews during the fiscal year for Aging Cluster subrecipients and further did not perform fiscal on-site reviews in accordance with its established monitoring procedures.

IDOA passed through approximately $40,779,000 of federal funding under the Aging Cluster program to 13 area agencies on Aging (subrecipients) during the year ended June 30, 2017.

Additionally, during review of on-site monitoring reviews performed by IDOA for the Aging Cluster program during the year ended June 30, 2017, auditors noted the following deficiencies in the monitoring procedures performed by IDOA for four subrecipients sampled (with expenditures of $19,426,000):

- Programmatic on-site reviews were not performed for any of the subrecipients sampled during the year ended June 30, 2017. On-site reviews were last performed for these subrecipients in fiscal year 2014. Upon further review, we noted on-site reviews have not been performed for any of the 13 subrecipients since fiscal year 2014.
- Corrective action plans (CAPs) were not obtained for two subrecipients in our testing over fiscal on-site reviews. As of the date of our testwork (February 9, 2018), IDOA has not followed up with the subrecipient to obtain the CAPs. Amounts passed through to these two subrecipients during the year ended June 30, 2017 were $15,793,000.
- For one subrecipient fiscal on-site reviews, the review file did not contain evidence that the CAP was reviewed and approved and the file was closed out. Amounts passed through to this subrecipient during the year ended June 30, 2017 was $2,185,000.

In discussing these conditions with IDOA officials, they stated corrective action was planned for 2018.

Response: The Department concurs with the finding and recommendation and has implemented risk assessment procedures required by the Uniform Guidance for fiscal year 2018 and going forward both for Fiscal and Program. The Department will continue to review its current policies and procedures for monitoring the Aging Cluster program subrecipients and implement changes necessary to carry out the requirements of the Uniform Guidance. The Department is revising its procedures on on-site reviews so that all reviews are planned and performed appropriately.

In section 1000 of the Department's AAA policy and Procedures Manual, it outlines that on-site visits and reviews of the Area Agencies on Aging will be conducted a minimum of once during the Area Plan cycle which has been defined by Department on Aging policy to be a three-year time period. Office of Older American Services agrees that we need to implement a risk assessment process for conducting on-site reviews. Some Area Agencies on Aging may need on-site reviews more often than once during the Area Plan cycle.

Updated Response: Repeated in FY18.

17-71. The auditors recommend IDOA establish procedures to ensure subrecipient single audit reports are obtained and reviews are completed and documented in a timely manner.

Finding: IDOA did not adequately review single audit reports received from its subrecipients for the Aging Cluster program on a timely basis.

During testing of a sample of single audit desk review files for 6 subrecipients (with expenditures of $28,582,000), auditors noted IDOA did not prepare a single audit desk review checklist to evidence the review of the single audit report for one subrecipient (with expenditures of $8,270,000).

IDOA's subrecipient expenditures under the Aging Cluster program for the year ended June 30, 2017 were $40,779,000.

In discussing these conditions with IDOA officials, they stated a lack of oversight of the personnel performing single audit desk reviews resulted in the undocumented review.

Response: The Department concurs with this finding and accepts the recommendation. We will revise the procedures to facilitate that subrecipient single audit reports are obtained and reviews are completed and documented in a timely manner. We will add a procedure that all reviews are done and verified by an independent staff person as well. Procedures will also be updated to include communication with subrecipients regarding findings and corrective action plans are well documented and followed up on.

Updated Response: Repeated in FY18.

17-72. The auditors recommend IDOA establish procedures to accurately report federal expenditures, including amounts passed through to subrecipients, used to prepare the SEFA. (Repeated-2016)

Finding: IDOA did not accurately report Federal expenditures, including amounts passed through to subrecipients, under the Aging Cluster.

Federal expenditures reported to the Illinois Office of the Comptroller (IOC) which were used to prepare the schedule of expenditures of federal awards (SEFA) did not agree to IDOA's financial records. Specifically, the auditors noted the following differences between amounts provided for audit and the SEFA expenditures initially reported to the IOC for the Aging Cluster for the year ended June 30, 2017:

SEFA Caption	Amounts Reported on the Final Expenditure Pattern	Amounts Initially Reported on the SEFA	Difference
Expenditures	$41,973,000	$43,032,000	$1,059,000
Amounts passed through to subrecipients	$40,779,000	$40,762,000	($17,000)

Upon further testing, auditors noted the difference in the expenditure amounts reported to the IOC was due to an adjustment recorded to eliminate excess revenue over expenditures in one of the accounting funds used by IDOA. However, this entry did not represent valid federal expenditures for

the Aging Cluster and should not have been reported as such. Accordingly, the auditors proposed an entry to reduce Aging Cluster expenditures which was reflected in the final SEFA.

In discussing these conditions with IDOA officials, they stated the error identified above was a result of an adjustment made by the IOC.

Response: The Department concurs that the adjustment should not have been made to the Aging Cluster. The Department has established procedures to accurately report federal expenditures, including amounts passed through to subrecipients, and used to prepare the SEFA. The Department will continue to strengthen and enhance the procedures over expenditures and the reporting of them. The Department has trained and will continue to enhance the training given to staff on federal rules related to cash management as well as implementing procedures to track the timing of federal receipts and the release of vouchers to the Comptroller. This will facilitate that all cash management rules are adhered to.

Updated Response: Repeated in FY18.