LEGISLATIVE AUDIT COMMISSION

Review of
Statewide Single Audit
Year Ended June 30, 2016

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REVIEW: 4476
STATEWIDE SINGLE AUDIT
YEAR ENDED JUNE 30, 2016

TOTAL FINDINGS/RECOMMENDATIONS - 73

TOTAL REPEATED RECOMMENDATIONS - 49

TOTAL PRIOR AUDIT FINDINGS/RECOMMENDATIONS - 75

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 FY16 Statewide Single Audit of federal funds. The Office of the Auditor General conducted a Statewide Single Audit of the FY16 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, 43 State agencies expended federal financial assistance in FY16. 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 $28.8 billion for the year ended June 30, 2016. This represents a $0.7 billion decrease from FY15, or about 2.4%. Overall, the State participated in 366 different federal programs; however, 10 of these programs or program clusters accounted for approximately 88% ($25.3 billion) of the total federal award expenditures as exhibited in the following table.

Federal Program Award	Total Expenditure	% of Total
Medicaid Cluster	$ 11,001,600,000	38.2%
Federal Family Education Loans	4,804,700,000	16.7%
Supplemental Nutrition (SNAP)	3,207,800,000	11.1%
Unemployment Insurance	2,018,600,000	7.0%
Highway Planning, Construction	1,480,100,000	5.1%
Child Nutrition Cluster	680,100,000	2.4%
Title 1 Part A Cluster	678,900,000	2.4%
Temporary Assistance (TANF)	548,500,000	1.9%
Special Education Cluster	512,400,000	1.8%
Children's Health Insurance (CHIP)	395,300,000	1.4%
All Others	3,437,500,000	12.0%
Total Federal Awards	$ 28,765,500,000	

The funding for the 366 programs was provided by 23 different federal agencies. The table below shows the five federal agencies that provided Illinois with the vast majority of federal funding in FY16.

Federal Funding Agency	Total Grant	% of Total
Health & Human Services	$ 13,238,300,000	46.0%
Education	6,448,200,000	22.4%
Agriculture	4,303,000,000	15.0%
Labor	2,209,300,000	7.7%
Transportation	1,846,100,000	6.4%
All Others	720,600,000	2.5%

A total of 28 federal programs were identified as major programs in FY16. The 28 major programs had combined expenditures of over $27.1 billion, and 338 non-major programs had combined expenditures of approximately $1.6 billion. Eleven State agencies accounted for approximately 98.8% of all federal dollars spent in FY16 as depicted in the table below.

State Agency	Federal Expenditures	% of Total
DHFS	$ 11,017,000,000	38.3%
Human Services	4,952,700,000	17.2%
Student Assistance	4,804,900,000	16.7%
Board of Education	2,314,100,000	8.0%
Employment Security	2,053,400,000	7.1%
Transportation	1,839,700,000	6.4%
DCEO	421,500,000	1.5%
DCFS	399,800,000	1.4%
Public Health	310,000,000	1.1%
EPA	202,500,000	0.7%
IEMA	118,300,000	0.4%
All Others	331,600,000	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	18	15
Healthcare and Family Services	7	6
DCFS	10	4
Public Health	4	3
Insurance	2	2
Aging	5	0

State Board of Education	7	4
Illinois Community College Board	3	2
SAC	3	3
Employment Security	9	6
Commerce & Economic Opportunity	1	1
Transportation	3	2
TOTAL	73	49

RECOMMENDATION 1
Office of the Governor
Office of the State Comptroller

01. The auditors recommend the Office of the Governor and the Illinois Office of the Comptroller (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 OC 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 Illinois 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 fourteen 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, IDPH, DoA, ISBE, ICCB, IDES, DCEO, and DOT. Additionally, other correcting entries were required in order to accurately state the financial information provided by various other 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.

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 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.

Office of the Governor's Response: The Office concurs with the auditor's finding and recommendation. In August 2015, the Office of the Governor jointly with the Illinois Office of the State Comptroller (OC) kicked off the implementation of the multi-year implementation of an Enterprise Resource Planning (ERP) system to develop an integrated enterprise-wide application system for financials. The statewide blueprint for all financial processes, led by the ERP Program team which is part of the Department of Innovation & Technology, was developed jointly with a representation of Governor's agencies and the IOC. On October 1, 2016, three pilot agencies as well as the constitutional office of the IOC went live on the new ERP system. The current implementation schedule for the remaining approximately 50 state agencies has various implementations dates thru January 1, 2019. This operational ERP system will improve the State's control environment and processes to enable the State and agencies to prepare a complete and accurate Schedule of Expenditures of Federal Awards in a timely manner.

Updated Response: Repeated FY17

Office of the State Comptroller's Response: The Office accepts the recommendation. While it is expected that the 2016 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.

Updated Response: Repeated FY17

RECOMMENDATIONS 2-19
Department of Human Services

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. The Affordable Care Act of 2010 required the State to consolidate and modernize its eligibility determination functions into a single system which is known as the Integrated Eligibility System (IES). Effective October 1, 2013, the State implemented IES and began performing and documenting eligibility determinations for certain beneficiaries of its Medicaid Cluster program and later expanded the use of IES to eligibility determinations for beneficiaries of the SNAP Cluster, TANF Cluster, and CHIP programs. IES was developed through a partnership between DHS and DHFS with each agency providing system requirements specific to their respective federal programs.

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, the auditors noted DHS and DHFS could not provide all information necessary to test system access security controls and several system changes did not follow the established change management policies of either DHS or DHFS.

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, 2016.

Details of the beneficiary payments paid by the State during the year ended June 30, 2016 for the SNAP Cluster, TANF Cluster, CHIP, and Medicaid Cluster programs are as follows:

Major Program	Total Beneficiary Payments in FY16	Total FY16 Program Expenditures	Percentage
SNAP Cluster	$3,096,832,000	$3,207,808,000	96.5%
TANF Cluster	$54,806,000	$548,472,000	10.0%
CHIP	$372,052,000	$395,328,000	94.1%
Medicaid Cluster	$10,445,896,000	$11,001,626,000	95.0%

In discussing these conditions with DHS officials, they stated the exceptions noted can be attributed to the complexity of the federal laws governing each program's eligibility rules. Additionally, the eligibility rules for medical programs were changing while IES was being designed and built because the Federal Centers for Medicare and Medicaid Services continued issuing guidance and promulgating regulations.

DHS Response: The Department accepts the recommendation. Upon receiving the fiscal year 2015 eligibility related audit findings, DHFS and DHS staff worked to resolve the system errors. The dataset exceptions were identified and the system errors with respect to social security numbers, citizenship, and residence were corrected late in fiscal year 2016. Errors identified in this audit about eligibility determinations related to social security numbers, citizenship, and residence occurred in the earlier months of fiscal year 2016 before the resolutions were in place. The Departments will also continue ongoing training of caseworkers to ensure they are properly trained to obtain and retain documentation in support of case eligibility determinations. The exceptions identified during testing of the sixty cases were attributable solely to caseworker error and were not the result of any type of errors or calculations attributable to IES.

Updated Response: Repeated in FY17.

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 SNAP Cluster, TANF Cluster, CHIP, and Medicaid Cluster programs. DHS is the State agency responsible for performing eligibility determinations for the federal public welfare assistance programs.

Effective October 1, 2013, the State implemented the Integrated Eligibility System (IES) to perform and document eligibility determinations for certain beneficiaries of the SNAP Cluster, TANF Cluster, CHIP, and Medicaid Cluster programs. Since its initial implementation, the use of IES has continued to expand. Documentation related to eligibility determinations performed using IES generally resides solely within the information system.

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 three case records could not be located for the testing. The auditors also selected 25 eligibility case records from an off-site storage facility and noted eight case records could not be located for the testing

In addition, during 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. The auditors also noted three CHIP and eight Medicaid case files (with medical payments sampled of $275 and $1,235, respectively) for which DHS could not locate any case file documentation supporting the eligibility determinations performed on or prior to the service date sampled. Medical payments made on behalf of these beneficiaries of the CHIP and Medicaid Program were $6,072 and $237,081 during the year ended June 30, 2016.

Details of the beneficiary payments selected in the eligibility samples for the TANF Cluster, CHIP, and Medicaid Cluster programs are as follows:

Major Program	Number of Cases Sampled	Total Amount of Payments for Cases Sampled	Total Beneficiary Payments in FY16	Total FY16 Program Expenditures
TANF Cluster	50	$22,189	$54,806,000	$548,472,000
CHIP	65	$16,443	$372,052,000	$395,328,000
Medicaid Cluster	125	$30,334	$10,445,896,000	$11,001,626,000

In discussing these conditions with DHS officials, they stated case files could not be provided due 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.

DHS Response: The Department accepts the recommendation. In order to relieve some of the space limitations, off-site 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: Repeated in FY17.

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.

Details of the beneficiary payments selected in the samples for the TANF Cluster, CHIP, and Medicaid Cluster programs are as follows:

Case Type	Number of Cases Tested	Total Amount of Payments for Cases Tested	Total Amount of Payments Made on Behalf of Beneficiaries for FY16	Total FY16 Program Expenditures
TANF Cluster	50	$22,189	$54,806,000	$548,472,000
CHIP	65	$16,443	$372,052,000	$395,328,000
Medicaid Cluster	125	$30,334	$10,445,896,000	$11,001,626,000

During test work or 50 TANF, 65 CHIP, and 125 Medicaid beneficiary payment for compliance with eligibility requirements and for the allowability of the related benefits provided, auditors noted numerous exceptions. DHS could either not locate items needed for test, could not provide adequate support of items tested, or could not provide evidence that various items had been performed or completed. We also noted HFS could not locate documentation supporting the completion of the initial eligibility determination or subsequent redetermination procedures.

As discussed in findings 2016-002 and 2016-020, several errors were identified in IES which resulted in noncompliance with eligibility requirements and affected the reliability of source documentation maintained in IES for certain eligibility determinations performed for the SNAP Cluster, TANF Cluster, CHIP and Medicaid Cluster programs.

In discussing these conditions with DHS officials, they stated the missing documentation was misplaced, misfiled, or erroneously indexed.

DHS Response: The Department agrees with the recommendation. The Department continues to ensure staff understands the importance of proper and accurate filing processes. The Department also continues 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: Repeated in FY17.

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 the TANF Cluster, CHIP, and Medicaid Cluster programs in accordance with timeframes required by the respective State Plans.

Program/Month	Number of Overdue Redeterminations	Total Number of Cases	Percentage of Overdue Cases
TANF Cluster			
June	3,650	32,849	11.11%
CHIP			
June	133,612	1,343,607	9.94%
Medicaid Cluster			
June	59,654	470,952	12.67%

During test work 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 2016 are as follows:

During testwork the auditors noted redeterminations were not completed within required time frames for 7 TANF cluster cases, 29 CHIP cases, and 10 Medicaid cases (with payments sampled of $2,409, $5,292, and $7,472, respectively). Delays in performing redeterminations ranged from 1 to 21 months after the required timeframe.

In discussing these conditions with DHS officials, they stated the increasing number of overdue redeterminations was due to the absorption of cases that would have previously been eligible for administrative renewal; start up issues and time spent on process development with their vendor; and the amount of time spent on staff development for new hires. The audit period was met with a learning curve and staff becoming acclimated to the newly developed system and its functionality.

DHS Response: The Department agrees with the recommendation. DHS will continue to work with the Department of Healthcare and Family Services to review current processes for performing eligibility redeterminations and consider changes necessary to ensure all redeterminations are performed within prescribed timeframes.

Updated Response: Repeated in FY17.

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 Temporary Assistance for Needy Families (TANF) Cluster program.

During testwork of 50 TANF Cluster program beneficiary payments, the auditors noted 11 beneficiaries received payments that were improperly calculated. As a result of the calculation errors, the monthly payments for 6 beneficiaries (with payments of $2,480) were overstated in total by $1,252 and the monthly payments for 5 beneficiaries (with payments of $3,066) were understated in total by $113. Total payments made to these beneficiaries under the TANF Cluster were $27,856 for the year ended June 30, 2016. As of the date of the testing (January 20, 2017), the payment errors identified in the sample had not been corrected by DHS.

In discussing these conditions with DHS officials, they stated errors were made in the manual calculation of the initial prorated entitlement TANF payment and supportive services.

DHS Response: The Department accepts the recommendation. The implementation of Phase 2 of the Integrated Eligibility System will reduce or eliminate the need for manual calculations of initial prorated entitlements.

Updated Response: Repeated in FY17.

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, the auditors noted the following:

- DHS could not provide all information necessary to test that user access was appropriately removed from the Concurrent, Child Care Management System (CCMS), Consolidated Accounting Record System (CARS), and Cornerstone applications. 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 during the fiscal year to ensure user access rights were appropriate for the Concurrent, CCMS, CARS, and Cornerstone applications.
- 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 WIC, Child Care Cluster, and TANF Cluster programs.

Additionally, during the 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. DHS' current procedures include tracking changes made to its information systems in a database; however, the information input into the database is based on manual change request forms.—Accordingly, the auditors were unable to determine whether the list of changes provided by DHS from the database during the audit was complete.

In discussing these conditions with DHS officials, they stated CARS and Concurrent legacy systems are over 30 years old and are incapable of producing system generated change reports. RACF account reviews were untimely due to difficulties with the automated system report generation and response tracking system.

DHS Response: The Department accepts the recommendation. The policies and procedures to review access rights for sub-recipient organization are the same RACF policies and procedures currently in place for internal users. This includes an annual review of user accounts. In addition, RACF/LAN Coordinator training has been updated and MIS Security personnel attend the training to provide additional instruction. RACF/LAN Coordinators will also be required to take annual refresher training. The current change management process, CAT tracking system, has been utilized in both Concurrent and CCTS and was deemed as an adequate compensating control with low risk. Concurrent is expected to be replaced with Phase 2 of the IES application. In addition, CARS is expected to be replaced with the Enterprise ERP solution. The CARS system will be replaced with newer technology once the ERP system has the functionality required.

Updated Response: Repeated in FY17.

08. The auditors recommend I DHS review its process for monitoring compliance with the 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 supporting 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 was short $58,207,406 of the aggregate expenditures needed to meet the SAPT MOE requirement. Additionally, during test work over 25 expenditures used by the State to meet the SAPT MOE requirements (totaling $5,074,083), the auditors noted DHS could not provide detailed supporting documentation for 16 expenditures sampled (totaling $2,664,147). Accordingly, these expenditures are not allowable for purposes of meeting the maintenance of effort. Upon further review, the auditors noted an additional $41,307,973 for which detailed supporting documentation was not readily available.
In discussing these conditions with DHS officials, they stated Darts system was not designed to archive detail payment information and adjustments.

DHS Response: The Department accepts the recommendation. Effective July 1, 2016 (State fiscal year 2017), detail extracts are reconciled with Darts system billing summary reports on a monthly basis. Effective February 1, 2017, these detail reports are being reconciled monthly with DARTS Mobius year-to-date service reports.

Updated Response: Repeated in FY17.

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 Temporary Assistance for Needy Families (TANF) Cluster, Child Care Development Funds (Child Care) Cluster, Social Services Block Grant (Title XX), and Block Grants for the Prevention and Treatment of Substance Abuse (SAPT) programs.

During the year ended June 30, 2016, 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	Expenditures Claimed	Total Expenditures
TANF	DCFS	$278,314,000	$548,472,000
TANF	DHFS	$2,134,000	$548,472,000
TANF	IDOR	$53,090,000	$548,472,000
TANF	ISAC	$5,385,000	$548,472,000
TANF (ARRA)	DHFS	$1,047,000	$548,472,000
TANF MOE	DHFS	$7,163,000	$640,783,000
TANF MOE	ISBE	$44,354,000	$640,783,000
Child Care	DCFS	$333,536	$171,305,000
Child Care MOE	DCFS	$17,744,136	$120,089,000
Title XX	IDPH	$4,717,000	$64,899,000
SAPT	IDOR	$21,000	$72,422,000
SAPT	IDPH	$108,000	$72,422,000

DHS' procedures to monitor other State agencies expending program funds reported by DHS include the following:

- Interagency agreements were reviewed and updated (where necessary) to ensure all State programs claimed under the TANF Cluster, Child Care Cluster, Title XX, and SAPT programs were subject to an interagency agreement.

- Program questionnaires were developed and distributed to each of the State agencies to assist in documenting the nature of the expenditures provided to DHS and the internal controls established to ensure compliance with the applicable federal regulations.
- Quarterly certification reports were collected from each of the State agencies to support amounts reported in the federal reports required for each federal program.
- Expenditure details were obtained from each of the State agencies and were reconciled to the quarterly certifications.

However, 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 or had not been updated recently by DHS from the Department of Children and Family Services (Child Care and Child Care MOE), Illinois Department of Public Heath (Title XX), or the Illinois Department of Revenue (SAPT).
- Quarterly certification reports were not collected from the Illinois Department of Public Health (SAPT) during the audit period.

In discussing these conditions with DHS officials, they stated the condition found was a result of inadequate monitoring procedures over interagency expenditures.

DHS Response: The Department accepts the recommendation. The current process for identifying and reporting interagency expenditures will be reviewed and DHS will implement additional monitoring procedures to ensure that federal and state expenditures by other state agencies meet the applicable program regulations.

Updated Response: Repeated in FY17.

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

Finding: DHS did not accurately report Federal expenditures under SNAP Cluster, WIC, Vocational Rehabilitation Grants to States (VR), TANF Cluster, Child Care Development Funds (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 which were used to prepare the Schedule of Expenditures of Federal Awards (SEFA) to the Illinois Office of the Comptroller (OC). Specifically, the auditors noted the following errors for DHS' major programs for the year ended June 30, 2016:

Program	Amounts per DHS' Records	Amounts Initially Reported to the OC	Difference
SNAP Cluster	$3,207,655,000	$3,207,808,000	($153,000)
WIC	$200,989,000	$201,023,000	($34,000)
SAPT	$72,551,000	$72,422,000	$129,000
SSDI	$82,066,000	$82,055,000	$11,000

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 OC	Difference
SNAP Cluster	$15,407,000	$15,412,000	($5,000)
WIC	$192,241,000	$111,718,000	$80,523,000
Child Care Cluster	$166,180,000	$165,832,000	$348,000
Title XX	$37,738,000	$34,431,000	$3,307,000

The auditors also noted several errors and unsupported amounts identified in DHS' financial statement audit that impacted the statewide SEFA as follows:

- DHS could not provide supporting documentation for expenditures of approximately $1,976,000 identified as an adjustment to agree to the expenditure pattern related to the WIC program.
- DHS could not provide supporting documentation for expenditures of approximately $2,181,000 related to the SNAP Cluster program.
- DHS could not provide supporting documentation for expenditures of approximately $25,882,000 related to the Title XX program.
- DHS does not maintain supporting documentation for certain amounts reported relative to the CHIP and Medicaid Cluster programs. Amounts reported by DHS which were provided by the Illinois Department of Healthcare and Family Services totaled $10.7 million and $426.3 million for the CHIP and Medicaid Cluster programs, respectively.
- The auditors also noted several errors in expenditure and subrecipient pass through amounts reported to the OC for DHS' non-major programs.

In discussing these conditions with DHS officials, they stated the federal expenditure differences noted were a result of adjustments necessary to ensure the correct federal receivable amounts were reported as of year-end.

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

Updated Response: Repeated in FY17.

11. 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 OMB Circular A-133 or 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 the WIC, TANF Cluster, Child Care Cluster, Social Services Block Grant (Title XX), and Block Grants for Prevention and Treatment of Substance Abuse (SAPT) programs on a timely basis.

During review of a sample of 183 subrecipient single audit desk review files, the auditors noted DHS did not notify 31 subrecipients of the results of single audit desk reviews or issue management decisions on reported findings within six months of receiving the audit reports as required

The auditors also noted the single audit desk reviews for the two most recent fiscal years are still in process and have not been finalized as of the date of the testwork (January 20, 2017) for 11 subrecipients.

In discussing these conditions with DHS officials, they stated the change to a new Desk Review Vendor at the beginning of fiscal year 2016 and the need to add additional staff to the Office of

Contract Administration (OCA) Desk Review Section resulted in significant delays in reviewing Single Audit Reports.

DHS Response: The Department agrees with the recommendation. DHS OCA will continue to review and revise the Single Audit Desk Review process to provide additional assurance that reports are obtained and reviewed within established deadlines and management decisions are issued for all findings and corrective action taken is timely and appropriate.

Updated Response: Repeated in FY17.

12. 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 Cluster, Child Care Cluster, Social Services Block Grant (Title XX), and Block Grants for Prevention and Treatment of Substance Abuse (SAPT) programs.

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

- DHS did not provide timely notification (within 60 days) of the results of the programmatic on-site reviews. The auditors noted the following exceptions:

Federal Program	Number of Late Communications	Number of Subrecipients Tested	Number of Days Late (Range)
TANF Cluster	18	41	1-89
WIC	1	44	17
SAPT	3	44	24-71
Child Care	1	42	10

- DHS did not receive corrective action plans (CAPs) on a timely basis (within 60 days) after communicating programmatic review findings or follow up with subrecipients on delinquent CAPs. The auditors noted the following exceptions:

Federal Program	Number of Late CAPs	Number of Subrecipients Tested	Number of Days Late (Range)
TANF Cluster	8	41	1-279
WIC	2	44	3-35
Title XX	3	42	18-40
Child Care	1	42	2
SAPT	1	44	3

- During testwork performed, the auditors noted that DHS did not perform on-site monitoring reviews of subrecipients in fiscal year 2016 in accordance with DHS' planned monitoring schedule. Specifically, the auditors noted the following exceptions:

Federal Program	Number of Reviews Not Performed	Number of Subrecipients Tested
Child Care	8	42
Title XX	1	42
TANF Cluster	6	41

- During testwork performed, the auditors noted that DHS did not provide evidence that a notification letter was sent to the subrecipient to communicate the results of the programmatic review. Specifically, the auditors noted the following exceptions:

Federal Program	Number of Missing Notification Letters	Number of Subrecipients Tested
TANF Cluster	1	41

DHS' subrecipient expenditures under the federal programs for the year ended June 30, 2016 were as follows:

Program	Total FY16 Subrecipient Expenditures	Total FY16 Program Expenditures	%
WIC	$192,241,000	$201,023,000	95.6%
TANF Cluster	135,050,000	548,472,000	24.6%
Child Care Cluster	165,832,000	171,305,000	96.8%
Title XX	37,738,000	64,899,000	58.1%
SAPT	69,927,000	72,422,000	96.6%

In discussing these conditions with DHS officials, they stated delays in programmatic monitoring and documentation weaknesses were due to oversight.

DHS Response: The Department agrees with the recommendation. The Department will review its process to ensure all programmatic on-site and expenditure reviews are performed and documented for subrecipients in accordance with established policies and procedures. In addition, DHS will review i*ts process for reporting* and following up on findings relative to subrecipient on-site reviews to ensure timely corrective action is taken.

Updated Response: Repeated in FY17.

13. 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 Cluster, Child Cluster, Social Services Block Grant (Title XX), and Block Grants for Prevention and Treatment of Substance Abuse (SAPT) programs.

During testwork of the award communications for the sample of subrecipients, the auditors selected the fiscal year contracts awarded to each subrecipient in 2016 to review for compliance with federal award communication requirements. During review of the award communication files for the sample of awards, the auditors noted the CFDA number was not communicated in the subrecipient award agreement for five TANF Cluster and one SAPT subrecipients tested. Upon further review, the auditors noted a general State appropriation code was communicated in the original award document for these six subrecipients as DHS had not determined under which federal program (if any) the expenditures would be claimed at the time they were awarded.

In discussing these conditions with DHS officials, they stated staff did not have a complete understanding of the procedures used to complete the award communications.

DHS Response: The Department agrees with the recommendation. The Department will continue to review and enhance its process to ensure award information is accurately communicated to subrecipients.

Updated Response: Repeated in FY17.

14. The auditors recommend DHS implement procedures to ensure ARRA information and requirements are properly communicated in writing to its subrecipients. (Repeated-2015)

Finding: DHS did not communicate American Recovery and Reinvestment Act (ARRA) information and requirements to subrecipients of the Temporary Assistance for Needy Families (TANF) Cluster program.

In discussing these conditions with DHS officials, they stated the award information was not properly communicated due to oversight.

DHS Response: The Department agrees with the recommendation. The Department will review and implement procedures to ensure that all award information and requirements are properly communicated in writing to its subrecipients.

Updated Response: Not Repeated in FY17.

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 test work:

- For four cases, DHS did not perform a required annual review of the beneficiary's Individualized Plan for Employment (IPE). Payments made on the behalf of these beneficiaries during the year ended June 30, 2016 were $20,064. The payments selected in the sample for these beneficiaries were $3,980.
- For three cases, DHS did not complete the IPE within 90 days after eligibility was determined. Payments made on behalf of these beneficiaries during the year ended June 30, 2016 were $1,070. The payments selected in the sample for these beneficiaries were $440.

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. Payments made to beneficiaries of the Vocational Rehabilitation Grants to States program totaled $31,475,000 during the year ended June 30, 2016.

DHS Response: The Department agrees with the recommendation. We will continue to review our processes to identify any additional improvements that can be made to ensure eligibility determinations are made and documented in accordance with program regulations.

Updated Response: Repeated in FY17.

16. The auditors recommend DHS implement procedures to ensure fringe rates in the payroll system, which are subsequently allocated through the PACAP, are consistent with those approved by DCMS.

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

During review of 137 employee payroll and fringe benefit charges (totaling $453,728) allocated to DHS' federal programs during the year ended June 30, 2016, the auditors noted fringe benefits charged were not consistent with rates approved by DCMS.

In discussing these conditions with DHS officials, they stated a programming error resulted in the discrepancies noted.

DHS Response: The Department accepts the recommendation. DHS Bureau of Payroll will work with DHS Management Information Services (MIS) to put controls in place to ensure the accuracy of data entered on the tables.

Updated Response: Repeated in FY17.

17. The auditors recommend DHS review its process for maintaining documentation for beneficiary payments.

Finding: DHS does not have appropriate controls over case records for beneficiaries of the Social Services Block Grant (Title XX) program.

During testwork of 25 Title XX program beneficiary payments (totaling $22,406), DHS was initially unable to provide supporting case records for three beneficiaries with sampled payments totaling

$270. At the time the sample was selected and documentation was provided by DHS for audit (October 2016), these three case records were identified by DHS as having been lost. In January 2017, DHS located the files and provided them for audit; however, the auditors noted DHS does not have a formal system in place for controlling and maintaining Title XX beneficiary case records and could not explain how the files had been misplaced and subsequently located.

Payments made on behalf of beneficiaries of the Title XX program totaled $20,483,000 during the year ended June 30, 2016.

In discussing these conditions with DHS officials, they stated the missing vouchers were associated with older cases that had been closed.

DHS Response: The Department agrees with the recommendation. The Division of Rehabilitation Services (DRS) will review how cases and the documentation associated with them are stored.

Updated Response: Not Repeated in FY17.

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

Finding: DHS did not perform monitoring reviews of health and safety requirements for providers of the Child Care Cluster program.

DHS has not established monitoring or other control activities to ensure health and safety monitoring reviews are performed for all child care providers as required by State and Federal law. Additionally, as of the date of the testing (January 20, 2017), DHS has not evaluated the population of providers to determine if there are other providers for which reviews were not performed.

In discussing these conditions with DHS officials, they stated staffing changes at the Illinois Department of Children and Family Services (DCFS) and untimely reassignment of monitoring tasks contributed to the weakness.

DHS Response: The Department accepts the recommendation. Administrative Code, Title 89, Chapter III, Subchapter D, Part 383, states that monitoring visits for child care institutions shall be conducted annually by a DCFS licensing representative. Although DHS, as the Child Care lead agency, is not responsible for executing monitoring visits to licensed child care centers, the Department does assume responsibility for ensuring child care providers are monitored for compliance with health and safety requirements. We tested DHS for the proper health and safety monitoring of 25 child care facilities. Seven of the tested facilities were license exempt facilities, for which DHS is responsible for obtaining the self-certification form from the provider, which covers the health and safety issue. DHS was able to obtain all 7 self-certification forms. The remaining 18 selections were state licensed providers, for which DCFS is responsible for the health and safety monitoring. We obtained the proper health and safety monitoring documents from DCFS for 17 of the 18 selections. According to DCFS, the required health and safety review was not performed timely for one of the selections, although it was subsequently done.

Updated Response: Not Repeated in FY17.

19. The auditors recommend DHS review the process and procedures in place to prepare financial reports required for the Supplemental Nutrition Assistance Program Cluster

and implement procedures necessary to ensure the reports are accurate. (**Repeated-2015)**

Finding: DHS did not prepare an accurate financial report for the SNAP Program Cluster program.

During test work over the SF-425 report for the federal fiscal year ended September 30, 2015, the auditors noted the report first submitted on December 29, 2015 was provided to us for audit and contained several errors. Upon further review and discussion with DHS personnel, the auditors noted the report was revised and resubmitted five separate times with updated amounts for certain line items on the report. These resubmissions were necessary due to errors that were not detected by DHS' internal control procedures prior to submission to USDA. The final report corrections were submitted on July 13, 2016.

Additionally, in considering the reporting process for the SF-425 report, the auditors noted DHS did not perform analytical or other procedures during the report preparation process to ensure amounts reported were reasonable in relation to previously reported information or expectations relative to current program activities.

In discussing these conditions with DHS officials, they stated some expenditures were reflected incorrectly when the final expenditure report was filed.

DHS Response: The Department accepts the recommendation. The process and procedures to prepare financial reports required for the Supplemental Nutrition Assistance Program cluster will be reviewed and necessary steps will be added to ensure the financial reports are accurate. The federal grant manager was aware of and approved the requested revisions prior to submission of financial reports. Federal Regulations allow financial reports to be changed up to two years after the close of a grant.

Updated Response: Not Repeated in FY17.

RECOMMENDATIONS 20-26
Department of Healthcare and Family Services

20. The auditors recommend DHFS implement adequate general information technology control procedures for the 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 DHS and the DHFS did not have appropriate controls over the Integrated Eligibility System (IES) used for eligibility determinations performed for the SNAP Cluster, TANF Cluster, CHIP, and Medicaid Cluster programs.

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, the auditors noted DHS and DHFS could not provide all information necessary to test system access security controls and several system changes did not follow the established change management policies of either DHS or DHFS.

Accordingly, the auditors were not able to rely on IES with respect to 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, 2016.

In discussing these conditions with DHFS officials, they stated the exceptions noted can be attributed to the complexity of the federal laws governing each program's eligibility rules. Additionally, the eligibility rules for medical programs were changing while IES was being designed and built because the Federal Centers for Medicare and Medicaid Services continued issuing guidance and promulgating regulations.

DHFS Response: The Department accepts the recommendation. Upon receiving the fiscal year 2015 eligibility related audit findings, DHFS and DHS staff worked to resolve the system errors. The dataset exceptions were identified and the system errors with respect to social security numbers, citizenship, and residence were corrected late in fiscal year 2016. Errors identified in this audit concerning eligibility determinations related to social security numbers, citizenship, and residence occurred in the earlier months of fiscal year 2016 before the resolutions were in place. The Departments will continue ongoing training of caseworkers to ensure they are properly trained to obtain and retain documentation in support of case eligibility determinations. The exceptions identified during testing of the sixty cases were attributable solely to caseworker error and were not the result of any type of errors or calculations attributable to IES.

Updated Response: Repeated in FY17.

21. The auditors recommend DHFS review its current process for maintaining documentation supporting eligibility determinations and consider changes necessary to ensure all eligibility determination documentation is properly maintained. (Repeated-2014)

Finding: DHFS could not locate case file documentation supporting eligibility determination for beneficiaries of the CHIP and the Medicaid Cluster Programs.

During test work, the auditors selected eligibility files to review for compliance with eligibility requirements and for the allowability of the related benefits provided. The auditors noted for one CHIP case file (with a medical payment sampled of $98), DHFS could not locate documentation supporting the completion of the initial eligibility determination or subsequent redetermination procedures.

Additionally, the auditors noted the State implemented the Integrated Eligibility System (IES) on October 1, 2013 and has continued expanding the use of IES to additional groups of beneficiaries of the SNAP Cluster, TANF Cluster, CHIP, and Medicaid Cluster. As discussed in findings 2016-002 and 2016-020, several errors were identified in IES which resulted in noncompliance with eligibility requirements and affected the reliability of source documentation maintained in IES for certain

eligibility determinations performed for the SNAP Cluster, TANF Cluster, CHIP and Medicaid Cluster programs.

In discussing these conditions with DHFS officials, they stated the case was transferred to another State agency and cannot be located for testing.

DHFS Response: The Department accepts the recommendation. The Department is working with DHS to incorporate all initial eligibility and redeterminations of eligibility into the new Integrated Eligibility System which will significantly improve record retention. As noted in the finding, the sample was not intended to be and was not statistically valid. While the Department will work with DHS to ensure all eligibility determination documentation is properly maintained it believes that the majority of case files do include proper documentation.

Updated Response: Not repeated in FY17.

22. 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 certain beneficiaries such as non-emergency transportation providers, optometric providers, and dental providers which only account for less than 1% 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 $52,408,000 during the year ended June 30, 2016. Payments made to managed care organizations totaled $4,841,439,000 during FY16.

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

DHFS Response: The Department respectfully disagrees with this recommendation because it believes the Department 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: Repeated in FY17.

23. 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.

During review of monitoring procedures performed by DHFS and its service providers for 5 provider reviews sampled, the auditors noted DHFS does not have a formalized process to follow up on deficiencies identified during on-site reviews for the Brain Injury, HIV and AIDS, and Persons with Disabilities waiver programs. Following each on-site review, DHFS sends the other state agencies a letter notifying them of the deficiencies identified, with a request to respond within 60 days with plans for individual and systemic correction. However, no formal follow-up procedures are performed to ensure the corrective action plans were implemented or whether the deficiencies may still exist.

In discussing these conditions with DHFS officials, they stated the Department's procedures were not established by the Bureau of Quality Management until September 2015. In addition, full implementation of the remediation process of monitoring agencies was prevented due to travel budget restrictions and staff shortages.

DHFS Response: The Department accepts the recommendation. The Department established procedures for monitoring the performance of operating agencies for Home and Community Based Waivers in September 2015. Remediation verifications are conducted while providing oversight of vendor performance of on-site and comprehensive provider reviews at an operating agency to maximize staff productivity and travel dollars.

Updated Response: Repeated in FY17.

24. The auditors recommend DHFS evaluate their procedures to ensure provider audits are fully complete prior to issuing a final audit determination.

Finding: DHFS did not document Medicaid provider audits performed as part of the Medicaid Integrity Program on a timely basis.

During testwork over 40 Medicaid provider audits completed during the year ended June 30, 2016, the auditors noted four audits in which the audit program guide was not completed and signed-off on until after the final audit determination letter had been issued to the provider. The audit program guide documents the objectives of the audit, the audit procedures planned to be performed, and the results/conclusions reached.

In discussing these conditions with DHFS officials, they stated the exceptions noted were due to staff oversight.

DHFS Response: The Department accepts the recommendation. The Department will implement audit protocols within the Audit Compliance Plan to ensure all work-papers are completed and signed-off prior to audit issuance. While the Department agrees that it is extremely important to ensure that provider audits are fully complete prior to issuing a final audit determination it believes that the majority of provider audits are complete before it issues a final audit determination.

Updated Response: Not Repeated in FY17.

25. 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.

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

- One newly hired employee (out of 25 tested) did not obtain proper approval prior to being granted access to information systems.
- Seventeen terminated users still appeared in the active user listing for KIDS, eleven terminated users still appeared in the active user listing for MMIS, and one terminated user still appeared in the active user listing for PAAS. There were 245 terminated users during the year ended June 30, 2016.
- Thirteen terminated employees (out of 25 tested) did not have their user access removed timely. DHFS policy requires user access to be removed from information systems by the 25th day of the month following the employee's termination date.
- Eight individuals (out of 25 tested) did not have evidence that annual user access reviews were performed during the year ended June 30, 2016. DHFS requires an annual certification to be completed for each user granted access. The annual certification requires each user's immediate supervisor to view the user's access permissions and certify those permissions continue to be appropriate.

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 Key Information Delivery 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 Department relied on the annual employee evaluation process to review appropriate staff system access; however, annual reviews are not always performed timely.

DHFS Response: The Department accepts the recommendation. The access control process and procedures currently in place for DHFS are being reviewed and revised to accommodate the changing information technology structure in Illinois.

Updated Response: Repeated in FY17.

26. The auditors recommend DHFS establish procedures to ensure that vendors contracting with DHFS are not suspended or debarred or otherwise excluded from participation in Federal assistance programs. The auditors also recommend DHFS work with agencies contracting with vendors on the behalf of DHFS to ensure the suspension and debarment certifications are included or the SAM is checked. (Repeated-2009)

Finding: DHFS did not obtain required certifications that vendors or medical providers were not suspended or debarred from participation in Federal assistance programs for the Child Support Enforcement (Child Support); CHIP; and Medicaid Cluster programs.

In discussing these conditions with DHFS officials, they stated the required language regarding suspension and debarment is not included in State master contracts. The Department did not have a process in place to review vendors prior to making purchases using a master contract.

DHFS Response: The Department accepts this recommendation. The Department has implemented a process to ensure the vendors are reviewed on the Federal SAMS website.

Updated Response: Not Repeated in FY17.

RECOMMENDATIONS 27-36
Department of Children and Family Services

27. The auditors recommend DCFS review its current process for identifying and documenting adjustments and implement procedures to ensure the adjustments claimed for the foster care and adoption assistance programs are properly determined and supported. Also, consider implementing additional monitoring controls to ensure the adjustments reported are complete, accurate, and properly supported.

Findings: DCFS does not have an adequate process for supporting adjustments to the Title IV-E claiming report for the foster care and adoption assistance programs.

During testwork of over 25 adjustments to the foster care and adoption assistance programs reported on quarterly claiming reports filed during FY16, auditors experienced significant delays in receiving detailed documentation supporting the adjustments sampled. DCFS personnel stated that the original files supporting the adjustments had not been maintained and had to be recreated over a period of several weeks for testing.

Auditors also noted the following errors during testwork of documentation supporting the sampled adjustments:

- One decreasing adjustment (totaling $45,148) selected from the March 31, 2016 foster care quarterly claiming report was improperly reported. In reviewing this adjustment with DCFS personnel, auditors noted the adjustment should have been made to the adoption assistance program, not the foster care program.
- One decreasing adjustment (totaling $65,080) selected from the December 31, 2015 foster care quarterly claiming report was improper. Upon further review, DCFS determined this adjustment had been made in error.
- One increasing adjustment (totaling $27,779 and pertaining to the quarter ended June 30, 2015) selected from the June 30, 2016 foster care quarterly claiming report and one increasing adjustment (totaling $2,353 and pertaining to the quarter ended September 30, 2014) from the March 31, 2016 adoption assistance quarterly claiming report were not supported by eligibility determinations.

In evaluating DCFS' process for identifying and documenting adjustments made to its quarterly claims, auditors 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 system limitations which do not allow for the retention of detailed transactional information required the Department to recreate the data for audit purposes. Additionally, the Department noted that summary level reports used to support certain adjustments and the timing of the reporting deadlines resulted in adjustments being made to the wrong program.

Response: Accepted. Improvements in design of our system will ensure detailed transaction information will be maintained on a permanent basis to ensure adjustments are better supported. The Department will also make changes to the manual process of reviewing adoption assistance and foster care adjustments to ensure they are properly categorized. The Department will continue to review its procedures to ensure claiming on all judicial determinations is appropriate and that documentation of eligibility files are complete.

Updated Response: Status 03/29/18: Partially Implemented—Repeated in FY17. This audit finding was repeated in the FY17 Single Audit due to two different issues: reporting issues related to presentation of adjustments to prior periods and lack of documentation to support adjustments to claiming. The Department accepted the auditor recommendations and will institute corrective action.

28. 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, evaluate 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.

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

During testwork of 65 foster care maintenance assistance payments (totaling $134,980), auditors reviewed the associated provider licensing files for compliance with licensing requirements and for the allowability of related benefits paid, and noted the following exceptions in testwork:

- For one foster care beneficiary payment sampled (totaling $295) with an unlicensed relative service provider, DCFS could not locate documentation evidencing the provider had undergone the proper criminal background checks and child abuse and neglect registry check.
- For 33 foster care beneficiary payments sampled (totaling $119,218) with child-care institution service providers, the licensing files 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.

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 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.

In discussing these conditions with DCFS officials, they stated record keeping systems were not designed to adequately capture the information needed to document the completion of background clearances. As a result, the Department was not able to demonstrate how this requirement had been monitored for all employees at its service providers.

Response: Accepted. The Department received similar recommendations from a Title IV-E foster care Eligibility Review conducted in June 2016. As a result, the Department made significant changes in both licensing and monitoring procedures to ensure that all required background clearances for provider employees are completed timely and that supervisory oversight is documented for provider staff who have not completed the clearance process.

Updated Response: Status 03/29/18: Partially Implemented—Repeated in FY17. This audit finding was repeated during the FY17 Single Audit. Weaknesses noted during a Title IV-E Foster Care Eligibility Review in June 2016 were addressed in a Program Improvement Plan that was implemented in the following months. In internal discussions, auditors noted marked improvement in documentation provided by the Licensing Unit compared to the previous year.

29. 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 obtain and include proper supporting documentation for subsidy payment changes in the adoption assistance case files. Additionally, evaluate 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)

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

During testwork of adoption assistance beneficiary payments, auditors reviewed 50 case files and related benefit payments (totaling $33,092) for compliance with eligibility requirements and allowability of related benefits and noted the following:

- Two beneficiary assistance subsidy payments sampled were greater than the subsidy amounts documented in the approved adoption assistance agreements. The sampled payments were $1,577.10 and $948.06; whereas, the payment amounts in the approved adoption agreements were $1,550 and $948, respectively. The case records did not contain documentation supporting another amount had been agreed to by the State and adopting parents.
- Two beneficiary assistance subsidy payments sampled were greater than the subsidy amounts documented in the approved adoption assistance agreements. The sampled payments were $471 and $458; whereas, the payment amounts in the approved adoption agreements were $384.38 and $369.01, respectively. Upon further review, auditors noted the monthly payments actually paid at the time of the adoption were $435 and $380, respectively, which were consistent with the approved foster care rates at that time based upon the ages of the children. The sampled payments are consistent with the approved foster care rates based upon the current ages of the children; however, auditors noted neither the adoption assistance agreement, nor the case file, discuss using the foster care maintenance payments or any changes to the payment amounts.

Total assistance subsidy payments made on behalf of program beneficiaries were $61,798,000 during the year ended June 30, 2016.

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 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.

In discussing these conditions with DCFS officials, they stated the exceptions noted were from older cases (2005 to 2010). The errors in payments were attributed to clerical errors and insufficient review procedures to ensure all documents relevant to the agreements were maintained.

Response: Implemented. The Department has implemented a procedure to assure that all subsidy rate amounts listed in the adoption agreement is in line with the approved subsidy amount listed on the internal verification form (CFS 1800 P). The review process is completed prior to the finalization of the adoption by the Federal Participation Unit. This review process also includes the review of supporting documentation. The Department has also implemented a quality assurance review completed by the data entry supervisor to assure that the amount entered for payment matches the approved amounts listed in the approved subsidy agreement.

Updated Response: Repeated in FY17.

30. The auditors recommend DCFS review its procedures for retaining and documenting how beneficiaries have met eligibility requirements and implement changes necessary to ensure all judicial determinations and adequate documentation of special needs exists for all children for whom adoption subsidy payments and nonrecurring expenditures are claimed. Additionally, evaluate process for ensuring eligibility requirements are met and adequately documented prior to paying adoption subsidies and claiming payment for federal reimbursement.

Findings: 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 $33,092), auditors noted the following exceptions at the conclusion of testwork:

- For five adoption assistance payments (totaling $2,464), DCFS could not locate documentation evidencing the child has special needs. Specifically, DCFS could not locate documentation that the State made reasonable, but unsuccessful, efforts to place the children with appropriate adoptive parents without providing adoption assistance.
- For two adoption assistance payments (totaling $761), DCFS could not locate the petition to terminate, order to terminate, or surrender of parental rights, evidencing that the child could not or should not be returned to the home of his parent(s). Additionally, for one of these payments, DCFS also could not locate the initial judicial determination effecting that the child's continuation in the residence would be contrary to the welfare of the child. This amount is also included in the first bullet above.
- For one adoption assistance payment (totaling $104), DCFS could not locate the initial judicial determination effecting that the child's continuation in the residence would be contrary to the welfare of the child. This amount is also included in the first bullet above.

In mid-February, subsequent to reviewing these exceptions, DCFS provided documentation to clear all but one exception in the second bullet (for an adoption assistance payment totaling $316). In evaluating the controls in place relative to this compliance requirement, auditors noted DCFS did not

follow its established procedures for maintaining documentation prior to claiming adoption assistance payments as several attempts needed to be made to obtain support for the sample of adoption assistance payments and related beneficiary case files sampled on November 14, 2016. Additionally, adequate monitoring controls were not established to ensure eligibility requirements were met and adequately documented in accordance with established procedures.

The Department stated case files are maintained in field offices rather than in the centralized eligibility unit, resulting in long lead times to retrieve file documents.

Updated Response: Accepted—Repeated in FY17. Status 03/29/18: This audit finding was repeated during the FY17 Single Audit. 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.

31. 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.

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

During testwork of 50 adoption assistance beneficiary payments (totaling $33,092), auditors noted three case files (with sampled payments of $1,360) in which 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 $8,304 during the year ended June 30, 2016.

Additionally, auditors noted DCFS has not established adequate control procedures to monitor whether required certifications are obtained and included in its case record files.

In discussing these conditions with DCFS officials, they stated multiple attempts are made to contact adoptive families to complete the recertification process; however, responses are not always received.

Updated Response: Status 03/29/18: Accepted—Repeated in FY17. This audit finding was repeated during the FY17 Single Audit. 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.

32. The auditors recommend DCFS review its procedures for obtaining and documenting whether judicial determinations have been made for all beneficiaries. Such procedures should include identifying children who are not eligible for assistance under the foster care program as a result of the required judicial determinations not being made.

Findings: DCFS did not ensure that required judicial determinations were made in applicable court rulings, including those pertaining to "reasonable efforts to prevent removal" and "contrary to the welfare".

During testwork of 65 foster care maintenance assistance payments (totaling $134,980), auditors reviewed case files for compliance with eligibility requirements and for the allowability of related benefits paid. Auditors noted in one case (with a maintenance payment of $511), the temporary custody court order contained contradicting evidence as to whether or not the reasonable efforts performed by DCFS eliminated the immediate and urgent necessity to remove the child from the home. Additionally, the temporary custody court transcript could not be obtained to clarify which reasonable efforts determination was properly marked. DCFS claimed reimbursement for foster care maintenance payments made on behalf of this child totaling $3,389 during the year ended June 30, 2016.

Total maintenance assistance payments made on behalf of program beneficiaries were $79,947,000 during the year ended June 30, 2016.

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 discussing these conditions with DCFS officials, the Department stated the contradiction identified in the court documents was a clerical error in the judicial determination.

Response: Not Accepted. The Department respectfully disagrees with the recommendation. The Department complied with the judicial determination that "there is immediate and urgent necessity to remove the minor from the home and leaving the minor in the home is contrary to the health, welfare and safety of the minor." The Department was granted temporary custody of the minor in the judicial determination as well. The Department believes the minor was eligible for assistance under the foster care program guidelines as a result of the judicial determination.

Auditors' Comments: As noted in the finding above, the documentation supporting the beneficiary payment sampled in testwork contained contradicting information as to whether or not the reasonable efforts performed by DCFS eliminated the immediate and urgent necessity to remove the child from the home. DCFS has stated the error was the result of a clerical error on the temporary custody order; however, this error was not identified by DCFS personnel and court transcripts could not be provided to substantiate which determination was accurate. As a result, auditors do not believe the documentation in this case supports the allowability of the beneficiary payments and we have questioned the costs relative to this case.

Updated Response: Status 03/29/18: This finding did not repeat in FY17 Single Audit.

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.

Findings: 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, 2016, auditors noted 10 draws for each program in which funds were not drawn for receipt on the median day of the month. These draws were performed on dates that resulted in Federal funds being received between 12 days prior to and 13 days subsequent to the median business day of the month during the year ended June 30, 2016.

In discussing these conditions with DCFS officials, they stated the Department performed cash draws on other than the median day of the month to more closely align with the payment schedules for foster care and adoption assistance payments.

Response: The Department agrees with the recommendation. The Department is reviewing the TSA and will work with GOMB to negotiate a draw down date to align more with the cash needs of the program.

Updated Response: Implemented. Status 03/29/18: This audit finding repeated in the FY17 Single Audit due to mid-year implementation of corrective action.

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

Findings: DCFS does not have an adequate process to reconcile its cash balances to the records of the Illinois Office of the Comptroller (OC).

During testwork over the monthly cash reconciliation process, auditors noted DCFS did not reconcile its cash balances to the OC's records on a monthly basis during the year ended June 30, 2016. Specifically, auditors noted none of the monthly cash reconciliations for State FY16 were performed.

In discussing these conditions with DCFS officials, they stated personnel vacancies have affected the timeliness of certain procedures during the audit period.

Response: Accepted. Receipts and expenditure reconciliations are currently being performed. The Department is also working towards implementation of a statewide Enterprise Resource Project (ERP) which will provide a more modern general ledger system to enhance reconciliation capabilities. The current timeline calls for an implementation date of ERP of January 1, 2018.

Updated Response: Status 03/29/18: Accepted—Repeated in FY17. This audit finding was repeated in the FY17 Single Audit. 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.

35. The auditors recommend DCFS implement procedures to ensure access to its information systems is adequately secured and system access rights are periodically reviewed for appropriateness. Also, implement monitoring procedures to ensure reviews are performed and documented by data stewards in accordance with established procedures. (Repeated-2012)

Findings: 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 two semi-annual reviews of user access rights out of five selected for testing were not reviewed by data stewards during FY16. Additionally, auditors noted DCFS has not established procedures to monitor whether data stewards complete access reviews in accordance with established procedures.

Department officials stated that the individual who performed that function retired. Upon his retirement responsibility for this function was transferred to another department. The individuals responsible for this function were not properly trained.

Response: The Department agrees with the recommendation and has completed the employee training to ensure that proper procedure is followed in order to ensure that detailed transaction information and adequate support for adjustments is maintained.

Updated Response: Implemented, but repeated in FY17. Status 03/29/18: This audit finding was repeated in the FY17 Single Audit due to mid-year implementation of corrective action. The Department took further steps to automate parts of the monitoring process to ensure compliance.

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

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

During a review of 40 case files selected for testwork, auditors noted six of the initial case plans were completed within a range of 24 to 120 days over the 60-day federal requirement.
In discussing these conditions with DCFS officials, they stated that numerous outside factors can influence the timely completion of case plans and coordination. Of the six initial case plans completed after the 60-day federal requirement, it appears that the majority of the cases reviewed show a delay in the completion of the Integrated Assessment (IA) which subsequently caused a delay in the initial service plan being completed within the required timeframe. Services are put in place regardless of whether there is a completed service plan.

Response: Accepted and partially implemented. The Department has updated its policies and procedures related to permanency. Statewide permanency practice training began in January of 2017 and will continue with Permanency staff until all DCFS/POS staff is trained. The timely development and completion of service planning is emphasized in the updated procedures. The training also provides the federal and state requirements to complete service plans for youth who are in substitute care. Additionally, the training will demonstrate how timely service plans positively impact children and families which can lead to better outcomes and timely permanency achievement.

Updated Response: Repeated in FY17.

RECOMMENDATIONS 37-40
Department of Public Health

37. The auditors recommend DPH 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 DPH records; and (3) Type A programs (as defined by OMB Circular A-133 or the Uniform Guidance) are being audited at least every three years. (Repeated-2005)

Finding: DPH did not obtain or review single audit reports for subrecipients of the State Planning and Establishment Grants for the Affordable Care Act (ACA)'s Exchanges (ACA Exchanges), Social Services Block Grant (Title XX), and HIV Care Formula Grants (HIV Care) programs.

During test work over eight subrecipients of the ACA Exchanges program (with expenditures of $4,385,657), the auditors noted DPH had not obtained or reviewed single audit reports for any of the subrecipients selected for testing. Amounts passed through to subrecipients under the ACA program totaled $11,682,000.

The auditors also noted DPH passed through approximately $4.7 million and $8.7 million to subrecipients under the Title XX and HIV Care programs, respectively. Upon further review, the auditors determined that single audit reports had not been obtained or reviewed for any ACA Exchanges, Title XX, or HIV Care subrecipients during the year ended June 30, 2016.

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

DPH Response: DPH concurs with the finding and recommendation. DPH is in the final stages of submitting its proposed directive regarding the review and follow up activities required. The procedures will include the development of an annual listing of subrecipients; distribution of a 30-day advanced reminder of the due date of said reports with directions for formal requests for extension, non-compliance notifications, report receipt and review procedures to identify findings; and instructions to the awarding DPH program regarding the receipt of subrecipient corrective action plans and the program's management decision letter responsibilities.

Updated Response: Repeated in FY17.

38. The auditors recommend DPH 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: DPH did not investigate complaints received relative to providers of the Medicaid Cluster within required time frames.

During test work of 40 complaints filed against Medicaid providers during the year ended June 30, 2016, the auditors identified seven 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 41 days in excess of required time frames.

In discussing these conditions with DPH officials, they stated due to hiring delays and the necessary mandated training of newly hired staff, some complaints are not being investigated within the necessary time frames.

DPH Response: DPH concurs with the finding and recommendation. The Office of Health Care Regulation continues to maximize available resources (surveyors) to ensure timely completion of all complaints. Surveyors are shared between regions to assist, when necessary, to meet required time frames. Regional supervisors are accessing complaint reports on a daily basis to stay ahead of the due date for complaint investigations. DPH has significantly reduced the backlog of complaints.

Updated Response: Repeated in FY17.

39. The auditors recommend DPH 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: DPH does not have adequate procedures to verify medical providers are properly licensed in accordance with applicable State laws.

During testwork over the licensing of 44 providers of the Medicaid Cluster program for the year ended June 30, 2016, the auditors noted licenses were not on file for five providers sampled. Upon further review with DPH personnel, the auditors noted these providers were end-stage renal disease facilities and DPH stated this provider type was not required to be licensed. 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.

In discussing these conditions with DPH officials, they stated due to delays in convening the ESRD advisory board and the complexity of writing rules for ESRD facilities, rules are not yet completed.

DPH Response: The Department concurs with the finding and recommendation. The ESRD Advisory Board met on April 14, 2015 and approved the final rules and regulations. The ESRD rules are now under the Department legal review and will be sent to the Governor's office for their legal review. When the legal review is completed, they will be submitted to the State Board of Health and then published for first public comment.

Updated Response: Repeated in FY17.

40. The auditors recommend DPH establish procedures to accurately report federal expenditures, including amounts passed through to subrecipients, used to prepare the SEFA to the OC.

Finding: DPH did not accurately report amounts passed through to subrecipients under the State Planning and Establishment Grants for the Affordable Care Act (ACA)'s Exchanges (ACA Exchanges) and Social Services Block Grant (Title XX) programs. The difference exceeded $5 million.

In discussing these conditions with DPH officials, they stated a $323,000 voucher was inadvertently overlooked during the preparation of the subrecipient report due to the voucher being an in-transit item.

DPH Response: DPH concurs with the finding and recommendation. DPH has established procedures for the timely and complete reporting of federal expenditures. However, the $323,000 voucher and Title XX funds were inadvertently overlooked during the preparation of the subrecipient report. DPH will implement a control to validate accurate reporting of amounts passed through to subrecipients.

Updated Response: Repeated in FY17.

RECOMMENDATIONS 41-42
Department of Insurance

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

Finding: DOI 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 40 expenditures (totaling $1,916,425) funded under the advance basis related to the State Planning and Establishment Grants for the Affordable Care Act (ACA)'s Exchanges (ACA Exchanges) program, the auditors noted warrants were not issued for 34 expenditure vouchers (totaling $1,476,013) 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 4 to 74 business days.

In discussing these conditions with DOI 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.

DOI 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: Repeated in FY17.

42. The auditors recommend DOI review the process and procedures in place to prepare financial reports required for the ACA Exchanges program and implement the additional procedures necessary to ensure the reports agree or reconcile to its financial records. (Repeated-2014)

Finding: DOI did not prepare accurate financial reports for the State Planning and Establishment Grants for the Affordable Care Act (ACA)'s Exchanges (ACA Exchanges) program.

DOI is required to prepare financial status (SF-425) reports on a quarterly basis for the ACA Exchanges program. During testwork over two quarterly SF-425 reports, the auditors noted DOI reported that the cash basis of accounting was being used; however the amounts reported included accrued (not paid) expenditures. As a result, the auditors noted several errors in the preparation of the reports.

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 DOI personnel are accurate. Specifically, the auditors noted DOI 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 DOI officials, they stated the differences noted were partially related to the usage of incorrect information (voucher date instead of warrant date) to identify the timing of cash disbursements consistent with the prior year and cumulative errors made in reporting for closed grants in previous quarterly reports which they are unable to manually correct.

DOI Response: The Department accepts this finding. The SF-425 quarterly report is completed electronically through the federal government's Grant Solutions website. The cash receipts are pre-populated based on the dollar amount that has been drawn down for the quarter and the Department manually enters current cumulative disbursement amounts per grant, as required by the online report. The rest of the report is auto-calculated based on previously reported data and current quarter data. The variances noted are due to errors made in previous quarterly SF-425 reports, for which the federal government does not have a process in place for us to correct. As a result, previous errors have continued to roll forward and result in the variances noted.

Further, as an additional control, the Department has implemented additional quality assurance procedures, such as analytical procedures and supervisory review of the reports to ensure amounts that are manually entered in the online report are accurate and reconcile with underlying financial records.

Updated Response: Not Repeated in FY17.

RECOMMENDATIONS 43-47
Department on Aging

43. The auditors recommend the Department on Aging (DOA) review the process and procedures in place to prepare the certification of the maintenance of effort and its financial reports required for the Aging Cluster program and implement procedures necessary to ensure that actual expenditures incurred during the period are reported and certified. The auditors also recommend DOA implement procedures to ensure financial reports are subject to documented supervisory reviews prior submission.

Finding: DOA did not accurately certify its maintenance of effort (MOE) expenditures under the Aging Cluster program to the U.S. Department of Health and Human Services (USDHHS).

DOA is required to spend for both services and administration under the Title III program within the Aging Cluster program at least the average amount of State funds it spent under the State plan for these activities for the past three previous fiscal years. DOA is also required to report the MOE expenditures on its semi-annual SF-425 report.

During testwork of the MOE requirement, auditors noted DOA passed through a total of $20,380,075 to Area Agencies on Aging (subrecipients) for both services and administration under the Title III program during the federal fiscal year ended September 30, 2015, but only reported and certified that $5,305,727 was spent for MOE expenditures. The amount reported for MOE expenditures was equal to the amount certified to USDHHS as the average expenditures for the past three years. Upon further discussion with DOA management, auditors noted the MOE expenditures reported for the past four federal fiscal years have been determined in a similar manner. As a result, the average expenditures in the three year period have been consistent and does not properly reflect the actual expenditures incurred for the respective periods which would have resulted in a higher MOE requirement.

Auditors also noted that DOA could not support the amount reported with expenditures from the period covered by the report as the MOE expenditures for fiscal year 2016 had not been identified at the date of testing (February 23, 2017).

Additionally, in considering the reporting process for the semi-annual SF-425 report and the supplemental form, auditors noted five reports (out of 11 sampled) did not contain evidence of a supervisory review to ensure amounts and information reported were complete, accurate, and consistent with current program activities.

In discussing these conditions with DOA officials, they stated staff turnover, inadequate training, and lack of proper procedures has led to this finding.

Response: The Department disagrees with the portion of the finding referring to MOE not accurately being certified. The Department will implement a new tracking methodology and also create a procedure for the Fiscal Procedure Manual which will ensure consistency regardless of staff turnover and availability of staff to train. This procedure will include supervisor approval before reports are submitted.

Auditors' Comment: As discussed in the finding above, DOA 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. DOA 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.

Updated Response: Implemented, but Repeated in FY17. We have discussed and implemented a team approach creating a mini-work group of budget and business services staff. We have created a new work book/tool that accounts for both the match and the Maintenance of Effort and allows for more stringent tracking of the different categories.

44. The auditors recommend DOA: (1) implement the risk assessment procedures required by the Uniform Guidance; (2) review 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.

Finding: DOA did not perform a risk assessment of subrecipients of the Aging Cluster program as required by the Uniform Guidance. Additionally, DOA 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 as required by its established monitoring procedures.

DOA passed through approximately $45,005,000 of federal funding under the Aging Cluster program to 13 area agencies on Aging (subrecipients) during the year ended June 30, 2016. Beginning for all new federal awards (as well as any amendments to existing awards as identified by the federal agency) with effective dates on or after December 26, 2014, DOA was required to perform a risk assessment to establish appropriate monitoring procedures based upon the risks inherent at each subrecipient. Auditors noted DOA had not amended its existing approach to monitoring its subrecipients.

Additionally, auditors noted the following deficiencies in the monitoring procedures performed by DOA:

- Programmatic on-site reviews were not performed for any of the program's 13 subrecipients during the year ended June 30, 2016. On-site reviews were last performed for these subrecipients in FY14.
- Fiscal on-site reviews were not performed for two subrecipients out of six sampled. Amounts passed through to these two subrecipients during FY16 totaled $10,105,705.
- Corrective action plans (CAPs) were not obtained for two subrecipients out of six sampled. As of the date of testwork (February 16, 2017), DOA has not followed up with the subrecipient to obtain the CAPs. Amounts passed through to these two subrecipients during FY16 totaled $19.6 million.

In discussing these conditions with DOA officials, they stated the risk assessment is a component of Uniform Guidance and that a statewide approach to implementing Uniform Guidance was being developed in connection with the implementation of the State's Grants Accountability Transparency Act (GATA) in FY17.

Response: The Department concurs with the finding and recommendation. The Agency is working with GATA to make sure that we are in compliance with all of the requirements of the Uniform Guidance.

Section 1000 of the Department's AAA policy and Procedures Manual 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: Accepted. This has not yet been corrected, but is expected to be implemented during the FY18 Monitoring Cycle (beginning October 1, 2017).

45. The auditors recommend DOA review its current process for obtaining DUNS numbers and preparing subrecipient funding notifications to ensure all required information is obtained and properly communicated to subrecipients. The auditors also recommend DOA implement internal control procedures to monitor whether required information is obtained and communicated in accordance with federal regulations.

Finding: DOA did not obtain DUNS numbers prior to making subawards or communicate required federal program information at the time of award to subrecipients of the Aging Cluster program.
During test work over six subrecipients of the Aging Cluster program (with expenditures of $34,581,000), auditors noted DOA did not obtain the subrecipient's DUNS numbers or communicate the FAIN, Federal Award Date or whether the award is research and development (R&D) in the subaward agreement. Auditors also noted DOA has not established control activities or monitoring procedures to ensure DUNS numbers are obtained and award communications include all required information.

In discussing these conditions with DOA officials, they stated the Agency had a shortage of staff and a statewide approach to implementing Uniform Guidance was being developed in connection with the implementation of the State's Grants Accountability Transparency Act (GATA) in fiscal year 2017.

Response: The Department concurs with the finding and recommendation. The Department has put in place under the guidance of GATA a process for obtaining DUNS numbers and preparing

subrecipient funding notifications to ensure all required information is obtained and properly communicated to our subrecipients.

Updated Response: Implemented and not repeated in FY17**.**

46. The auditors recommend DOA implement procedures to ensure cash drawn in advance is disbursed in accordance with program regulations.

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

During a review of 55 subrecipient expenditures (totaling $3,439,344), auditors noted warrants were not issued for two expenditure vouchers (totaling $167,669) 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 was six business days.

In discussing these conditions with DOA officials, they stated this was an error and oversight that the vouchers did not reach the Comptroller's office in a timely manner.

Response: The Department concurs with the finding and recommendation. 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 ensure that all cash management rules are adhered to.

Updated Response: Implemented and not repeated in FY17.

47. The auditors recommend DOA establish procedures to accurately report federal expenditures, including amounts passed through to subrecipients, used to prepare the SEFA.

Finding: DOA 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 (OC) which were used to prepare the schedule of expenditures of federal awards (SEFA) did not agree to DOA's financial records. Specifically, auditors noted the following differences between amounts provided for audit and the SEFA expenditures initially reported to the OC for the Aging Cluster for the year ended June 30, 2016:

SEFA Caption	Amounts Reported on the Final Expenditure Pattern	Amounts Initially Reported to the OC	Difference
Expenditures	$46,607,000	$49,275,000	($2,668,000)
Amounts passed through to subrecipients	45,005,000	47,910,000	(2,905,000)

In discussing these conditions with DOA officials, they stated they believe that the prior year and current year lapse period expenditures were inadvertently included in the preparation of the SEFA.

Response: The Department concurs with the finding and recommendation. The Department will implement procedures to have work completed by staff and adequately reviewed for accuracy. This

will ensure amounts passed to sub-recipients and the reporting of federal expenditures will be represented accurately.

Updated Response: Implemented, but Repeated in FY17.

RECOMMENDATIONS 48-54
Illinois State Board of Education

48. 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, the auditors recommend ISBE review its procedures for communicating monitoring results and closing out audit files and implement additional procedures to ensure timely completion of these activities. (Repeated-2015)

Finding: IISBE did not perform adequate on-site subrecipient monitoring procedures in accordance with its established monitoring plan 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), and Supporting Effective Instruction State Grant (formerly Improving Teacher Quality State Grants) (Title II) programs.

During review of the subrecipients selected for review, the 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, the auditors noted the procedures performed were limited to on-site reviews of nine schools and analytical expenditure reviews at additional schools for the purpose of determining whether further on-site reviews were deemed necessary. The auditors also noted no on-site monitoring procedures were performed for the 21st Century program at this subrecipient. Given the significance of this individual subrecipient and the fact that it operates in excess of 600 individual schools, the auditors do not believe the on-site monitoring procedures performed by ISBE during the year ended June 30, 2016 were adequate.

The auditors also noted ISBE did not follow timeframes established in its on-site monitoring plan for communicating findings and closing out monitoring files

In discussing these conditions with ISBE officials, they stated there was a critical shortage of staff during the period tested. In addition to meeting Federal on-site monitoring, report issuance, and file closure obligations, the Division must also address competing agency priorities.

ISBE Response: The Agency agrees with the finding. The Division of Federal and State monitoring has modified the risk scoring process to ensure individually significant subrecipients are adequately monitored. The Division has also worked to establish procedures related to communicating monitoring results and closing out audit files to ensure timely completion of these activities.

Updated Response: Not Repeated in FY17.

49. 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, the auditors recommend ISBE 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.

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

During review of the 65 CNC (25 from Summer Food Services and 40 from School Nutrition) and 40 CACFP subrecipients selected for testing, the auditors noted ISBE did not perform required on-site reviews for 5 subrecipients of the CNC School Nutrition program. Reviews were last performed for these subrecipients in 2012.

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 the testwork of the 65 CNC and 40 CACFP subrecipients referenced above, the auditors noted ISBE did not communicate findings for 33 reviews within 60 days of the completion of review procedures and did not close out 11 reviews within 60 days of receipt of the subrecipients' corrective action plan (CAP).

Additionally, for five CNC subrecipients, the auditors noted on-site review files were still open at the conclusion of the testwork (January 27, 2017) and ISBE had not received or obtained corrective action plans for these subrecipients.

In discussing these conditions with ISBE officials, they stated the Division of Nutrition and Wellness was critically understaffed and, in addition to meeting Federal on-site monitoring, report issuance, and file closure obligations, the Division must also address other competing agency priorities.

ISBE Response: The Agency agrees with the finding. ISBE will review and implement monitoring procedures to ensure proper monitoring is performed and results are communicated for all nutrition programs. Beginning in fiscal year 2017, ISBE contracted with a firm to assist with the School Nutrition Program (SNP) review process. ISBE has also implemented the use of a data system for the fiscal year 2017 CACFP reviews, which automates the issuance of reports and makes the corrective action and closure phases more efficient. The data system for SNP will be implemented in fiscal year 2018.

Updated Response: Repeated in FY17.

50. 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 Grant (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 communicate management decisions to its subrecipients.

During review of a sample of 54 subrecipient single audit desk review files, the auditors noted ISBE did not complete 41 of the 54 reviews in a timely manner (within 60 days of receipt).

The auditors also noted there was not a single audit report on file for one of the 54 subrecipients sampled. Upon further review by ISBE, 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 prior to the audit procedures.

Additionally, the auditors noted ISBE has not established adequate monitoring controls to ensure subrecipient single audit reports are obtained and reviewed in a timely manner. As a result, management decision letters are not issued in accordance with required timeframes. Specifically, the auditors noted ISBE was required to issue 20 management decisions related to the 54 subrecipient single audit desk review files tested. Of the 20 management decisions required in the sample, 15 were not completed within six months (180 days) of ISBE receiving the audit report. Delays in issuing these management decisions ranged from 8 to 138 days beyond the required timeframe.

In discussing these conditions with ISBE officials, they stated completing and closing the review of single audits from the 2015 cycle overlapped the time in which audits for the 2016 cycle should have started. Competing staff priorities, correcting inefficiencies with the Annual Financial Report Finance System and creation of the Single Audit Certification System took more time away from performing audits than anticipated.

ISBE Response: The Agency agrees with the finding. ISBE management continues to improve oversight over the single audit process, which includes implementation of bi-weekly communication with single audit staff to assess progress, discuss potential obstacles and review allocation of staff resources to comply with the new federal circular requirement in 2 CFR 200.521(d) of issuing a management decision within 6 months from the acceptance of the audit with the federal audit clearinghouse. ISBE has also implemented a new process to create and distribute a Management Decision letter per 2 CFR 200.521(a). ISBE is part of the statewide workgroup that is coordinating changes and transitions of the single audit process in accordance with the Grant Accountability and Transparency Act (GATA), which will see many of the statewide single audit functions contracted out starting in fiscal year 2018.

Updated Response: Repeated in FY17.

51. The auditors recommend ISBE personnel appropriately account for USDA Donated Foods for the Child Nutrition Cluster program.

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

During review of monthly reconciliation procedures and the annual physical inventory, the auditors noted the inventory records did not agree to the monthly reconciliation completed for June 30 2016. Specifically, the auditors noted a difference between IISBE's inventory records and the monthly inventory reconciliation of 29 cases. Additionally, the auditors noted the ending inventory value reported in IISBE's financial statements as of the year ended June 30, 2016 did not agree to the physical inventory count records. The inventory value reported in the financial statements was approximately $1,827,000 as compared to $1,868,000 identified in the physical inventory records (a difference of $41,000).

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

IISBE Response: The Agency agrees with the finding. IISBE corrected the data input errors and has implemented a reconciliation process for USDA Donated Foods.

Updated Response: Repeated in FY17.

52. The auditors recommend IISBE implement the necessary procedures to comply with program requirements. (Repeated-2015)

Finding: ISBE did not comply with the requirements of the Elementary and Secondary Education Act (ESEA) Flexibility waiver applicable to its Title I – Grants to Local Educational Agencies (Title I) program.

ISBE applied for an ESEA flexibility waiver which was granted by USDE in a letter dated April 18, 2014. Under the conditions of its ESEA flexibility waiver, ISBE is required to identify and report on three categories of schools to USDE and the public. The categories of schools are: (1) reward schools; (2) priority schools; and (3) focus schools. The ESEA flexibility waiver eliminates the requirements for ISBE to identify Local Education Agencies (LEAs) in need of improvement, identify the necessary corrective action to be taken by the LEAs, and report the LEAs' improvement status in its report card.

In May 2014, ISBE received a letter from USDE encouraging the State to continuously evaluate the effectiveness of the plans and other elements of its ESEA flexibility request as it proceeded with the implementation and to make necessary changes to address any challenges identified. The letter stated that ISBE would need to follow established procedures for amending its ESEA flexibility request and that ISBE could not implement any changes until they had been approved by USDE. Further, the letter specified that ISBE was required to submit its final lists of priority, focus, and reward schools to USDE by September 1, 2014 and that amendments resulting in the State not meeting the required timelines for implementation of ESEA flexibility would generally not be approved.

During the year ended June 30, 2016, the auditors noted ISBE reported a listing of focus schools in July 2015; however, ISBE has not reported a listing of reward schools as of the date of the testing (January 27, 2017). Accordingly, ISBE did not comply with the waiver reporting requirements or establish adequate controls to comply with the reporting requirements of the ESEA Flexibility waiver.

In discussing these conditions with ISBE officials, they stated they did not have the data available necessary to identify the reward schools and legislative changes effective December 2015 modified this reporting requirement.

ISBE Response: ISBE agrees with the finding. ESEA legislation ended August 1, 2016. ISBE is in the final stages of developing a state plan to ensure compliance with the implementation of the new Every Student Succeeds Act (ESSA).

Updated Response: Not Repeated in FY17.

53. The auditors recommend ISBE establish procedures to accurately report federal expenditures, including amounts passed through to subrecipients, used to prepare the SEFA to the OC. (Repeated-2014)

Finding: ISBE did not accurately report Federal expenditures, including amounts passed through to subrecipients.

Federal expenditures reported to the Illinois Office of the Comptroller (OC) which were used to prepare the Schedule of Expenditures of Federal Awards (SEFA) did not agree to ISBE's financial records. Specifically, the auditors noted the following differences for the year ended June 30, 2016:

Program	Federal Expenditures Reported in ISBE's Records	Federal Expenditures Initially Reported to the OC	Difference
CNC	$678,926,000	$680,086,000	($1,160,000)
CACFP	$151,353,000	$150,941,000	$412,000
Title I	$680,175,000	$678,927,000	$1,248,000
Special Education	$512,085,000	$512,376,000	($291,000)
CTE	$37,112,000	$37,311,000	($199,000)
21st Century	$52,158,000	$52,083,000	$75,000
Title II	$89,669,000	$91,967,000	($2,298,000)

In addition, the 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 OC	Difference
CNC	$676,927,000	$678,381,000	($1,454,000)
CACFP	$148,551,000	$149,617,000	($1,066,000)
Title I	$661,945,000	$662,109,000	($164,000)
Special Education	$499,246,000	$500,188,000	($942,000)
CTE	$20,968,000	$21,878,000	($910,000)
21st Century	$49,268,000	$50,593,000	($1,325,000)
Title II	$87,506,000	$89,830,000	($2,324,000)

In discussing these conditions with ISBE officials, they stated that the issues noted in this finding are primarily attributable to the statewide financial reporting process using the same form, Form SCO-563, for determining modified accrual and cash basis expenditures to report in the Agency's financial statements and SEFA, respectively.

ISBE 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 OC 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 FY17.

54. The auditors recommend ISBE personnel formally document the review and approval of the annual State Per Pupil Expenditure Data report for the Title I program.

Finding: ISBE has not implemented formal review and approval procedures for the annual State Per Pupil Expenditure Data special report filed for the Title I – Grants to Local Educations Agencies (Title I) program.

During testwork of the State Per Pupil Expenditure Data report prepared and submitted by ISBE during the fiscal year under audit, the auditors noted no evidence that an independent supervisory review was performed prior to submission.

In discussing these conditions with ISBE officials, they stated documentation of the review was not retained.

ISBE Response: The Agency agrees with the finding. Agency personnel formally documented the review of the current year's State Per Pupil Expenditures Data report for the Title I program.

Updated Response: Not Repeated in FY17.

RECOMMENDATIONS 55-57
Illinois Community College Board

55. The auditors recommend ICCB:(1) implement the risk assessment procedures required by the Uniform Guidance; (2) review its current policies and procedures for monitoring CTE 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.

Finding: ICCB did not perform a risk assessment of subrecipients of the Career and Technical Education (CTE) program as required by the Uniform Guidance. Additionally, ICCB did not perform any on-site fiscal reviews of CTE subrecipients as required by its established monitoring procedures.

For all new federal awards, ICCB was required to perform a risk assessment to establish appropriate monitoring procedures based upon the risks. Auditors noted ICCB had not amended its existing approach to monitoring its subrecipients.

ICCB passed through approximately $13,925,000 of federal funding under the CTE program to 39 community colleges (subrecipients) during the year ended June 30, 2016

The auditors noted ICCB did not perform any on-site fiscal reviews of CTE subrecipients as identified and planned within ICCB's monitoring policies and procedures. During fiscal year 2016, ICCB had planned to visit nine subrecipients; however, none of these on-site reviews were performed.

In discussing these conditions with ICCB officials, they stated desk reviews were completed in place of on-site reviews in fiscal year 2016 and that the Board was unaware of the risk assessment procedures.

ICCB Response: The Board did not conduct on-site fiscal monitoring for CTE program subrecipients. In fiscal year 2016, the Board did perform fiscal monitoring for the 9 subrecipients identified as part of the 5-year cycle. These were completed as desk-reviews.

The Board implemented risk assessment procedures, as required by the Uniform Guidance, in fiscal year 2017. The Board will perform on-site fiscal monitoring for all grantees designated as high-risk each fiscal year.

Updated Responses: Repeated in FY17.

56. The auditors recommend ICCB establish procedures to obtain subrecipient DUNS numbers at the time of the subaward in accordance with federal requirements. (Repeated-2015)

Finding: ICCB did not obtain Dun and Bradstreet Universal Numbering System (DUNS) numbers as part of its subaward application process or prior to granting subawards to subrecipients of the Career and Technical Education (CTE) program.

In discussing these conditions with ICCB officials, they stated that the Board was unaware of this requirement until the completion of the fiscal year 2015 single audit. By the time the fiscal year 2015 single audit had concluded, the Board had issued all fiscal year 2016 grants without verifying subrecipient DUNS numbers. .

CCB Response: The Board concurs with this finding. In fiscal year 2017, DUNS numbers for all subrecipients have been obtained and verified.

Updated Response: Not Repeated in FY17.

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

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

Specifically, the auditors noted that ICCB did not report $13.9 million in funds passed through to subrecipients to the IOC for the year ended June 30, 2016.

In discussing these conditions with ICCB officials, they stated key staff were unaware of the option to report subrecipient expenditures on the SCO 567 GAAP form.

CCB Response: Beginning with the fiscal year 2017 GAAP process, the Board will report subrecipient expenditures on the SCO 567, ensuring accurate federal expenditure reporting.

Updated Response: Repeated in FY17.

RECOMMENDATIONS 58-60
Illinois Student Assistance Commission

58. 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, the auditors selected a sample of 100 student loans (with loan balances totaling $1,185,011) to confirm the accuracy of the loan information with the lender and noted the following exceptions:

- Confirmations for two loans (with loan balances totaling $6,625) were returned as undeliverable. Upon further investigation, ISAC was unable to facilitate locating the respondent.
- Confirmations for seven loans (with loan balances totaling $24,650) 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 $3,695,996,000 as of June 30, 2016.

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.

ISAC 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 FY17.

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

Finding: The Illinois Student Assistance Commission (SAC) does not have an adequate process to ensure collection efforts required by program regulations are performed for all loans.

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 the during the current

year audit, the auditors noted 2 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 $461,795,664 as of June 30, 2016. Lender claims for loans paid during the year ended June 30, 2016 totaled $129,271,705.

In discussing these conditions with ISAC officials, they stated it appears the system fails to move certain re-defaulted loans into the proper category in their system to generate the required due diligence letters. ISAC has a manual process in place to identify borrowers where the above letters are not generated automatically; however, this process did not identify the loans identified in this finding.

ISAC Response: A system fix was done to correct the assignment rules for re-defaults in order to generate the required due diligence letters systematically and an exception report if not corrected automatically. This system redesign was implemented on December 5, 2016.

Updated Response: Repeated in FY17.

60. The auditors recommend ISAC assign all defaulted loans to the USDE that meet the criteria contained in 34 CFR 682.409 by the required December 1st deadline. (Repeated-2015)

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

In discussing these conditions with ISAC officials, they stated the large number of loans still eligible for assignment prevented ISAC from meeting the deadline of December 1, 2015.

ISAC Response: During the audit review period, ISAC had a total of 8,145 loans that were eligible for assignment. ISAC assigned 500 loans per file. ISAC also had loans that were rejected which required them to be reassigned, due to an issue with electronic signatures on promissory notes. These loans were assigned and after being rejected were manually marked as being electronically signed so they could be accepted on a future subrogation file.

As of February 2017, there are approximately 4,500 loans that are currently eligible for subrogation. This number is half of the population that was eligible last audit period. ISAC has taken steps to identify the current eligible population that have loans under an electronically signed promissory note. These loans are being marked as electronically signed so they will not be rejected when they are initially assigned to USDE. This will eliminate the need to reassign loans which caused ISAC to not be able to assign eligible loans by the December1st deadline during the period audit period.

Updated Response: Not Repeated in FY17.

RECOMMENDATIONS 61-69
Department of Employment Security

61. The auditors recommend DES 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: DES did not implement Federal requirements to improve program integrity and reduce overpayments.

During test work, the auditors noted that while DES 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, the 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 DES officials, they stated the procurement process for the IT services needed to implement the 15% penalty took longer than initially anticipated. The Department also had difficulty determining the best method for implementing the non-charging prohibition.

DES Response: DES accepts this 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 December 2017. The department will also begin planning the implementation of the prohibition on non-charging due to employer fault per federal guidance.

Updated Response: Repeated in FY17.

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

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

During review of the fiscal year 2017 State Quality Service Plan (Plan) submitted by DES to the USDOL, the auditors noted DES 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 2016, resolving only 61.9% of these determinations within 21 days of the detection date.

In discussing these conditions with DES officials, they stated the posting and scheduling of unnecessary adjudication assignments has generated a backlog of cases, resulting in untimely eligibility determinations.

DES Response: DES accepts this finding and is focusing on the reduction and possible elimination of the posting and scheduling of adjudication assignments which are actually non-issues. Our attention is directed to the Document Processing Unit and the Internet Claims Unit, which are in positions to ensure that valid issues get posted. Staff in these units will learn to properly identify documents, to properly index documents to the correct issue, and to prevent the posting of duplicate and unnecessary issues.

Updated Response: Repeated in FY17.

63. The auditors recommend DES review its current process for calculating the dependent child allowance supplemental benefit and consider changes necessary to ensure the supplemental benefit is calculated in accordance with program requirements.

Finding: DES did not accurately calculate the supplemental benefit amount for the dependent child allowance paid to certain claimants (beneficiaries) of the Unemployment Insurance (UI) program.

During test work, DES disclosed they had not used the most recent DCAR in calculating the supplemental benefit amounts for a portion of calendar year 2016. As a result, DES underpaid claimants eligible to receive the supplemental benefit by $1 each week. As a result, the total supplemental benefits underpaid to claimants during calendar year 2016 totaled $700,806 of which $327,996 pertained to the State fiscal year ended June 30, 2016.

DES has not established adequate controls to ensure supplemental benefits are accurately calculated in accordance with program regulations. Specifically, the auditors noted DES has not implemented review procedures relative to the calculation of this type of supplemental benefits to identify inaccurate payment amounts.

In discussing these conditions with DES officials, they attributed the problem to a lack of training for staff assigned to calculate the DCAR and a lack of clear procedures regarding the calculation.

DES Response: DES accepts the finding. Prior to calculating the 2017 DCAR, DES developed a step-by-step work sheet for calculating the DCAR for each year, as well as certain unemployment tax parameters. The work sheet is completed by the Department's budget and legal offices.

Updated Response: Not Repeated in FY17.

64. The auditors recommend DES review its procedures for preparing and submitting the annual FUTA certification data and implement procedures to ensure submissions are made within required timeframes.

Finding: DES did not perform the match to support its certification of Federal Unemployment Tax Act (FUTA) tax credits for the Unemployment Insurance (UI) program within required timeframes.

During testwork over DES' annual FUTA match certification, the auditors noted the FUTA data match and certification were not completed and submitted to the IRS until March 29, 2016 (58 days after the due date). DES has not established adequate controls to ensure the required match was performed and that the data and certification were submitted within the required timeframe.

In discussing these conditions with DES officials, they stated that the problem was the reduction and the overall redistribution of staff.

Response: DES accepts this finding. However, DES worked in conjunction with the IRS to submit the data without any detrimental effect to the employer. Procedures have been developed to ensure that the annual FUTA Certification Guidelines will be followed and implemented timely. This was successfully tested this year and the FUTA Certification was submitted timely.

Updated Response: Not Repeated in FY17.

65. The auditors recommend DES 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: DES 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, the auditors noted the amounts reported by DES on nearly all required line items did not agree to the supporting documentation provided by DES during the audit. As of the date of the testwork (December 16, 2016), DES 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 DES personnel are accurate.

In discussing these conditions with DES officials, they stated the problem stems from the data being compiled from multiple systems that do not interact and therefore the data needs to be manually collected.

DES Response: DES accepts this finding and is in the process of integrating the functionality of benefit legacy systems into IBIS throughout Federal fiscal year 2017 and Federal fiscal year 2018.

Updated Response: Repeated in FY17.

66. The auditors recommend DES review its process to prepare the UI Contingency report to ensure the report is complete and accurate prior to submission to the USDOL.

Finding: DES did not accurately prepare the UI Contingency report for the Unemployment Insurance (UI) program.

During testwork of two quarterly ETA 2208A reports, the auditors noted certain line items reported by DES did not agree to supporting documentation.

Additionally, in considering the reporting process for this special report, the auditors noted adequate internal controls have not been established to ensure reports prepared by DES personnel are accurate.

In discussing these conditions with DES officials, they stated because of the redistribution of staff, the Manager responsible for the report was new to the process.

DES Response: DES accepts this finding and has recently hired a staff member for the Office of the Budget who will be responsible for this report and will have the manager review all reports before they are submitted.

Updated Response: Not Repeated in FY17.

67. The auditors recommend DES implement procedures to ensure cash draws are performed in accordance with U.S. Treasury Regulations. (Repeated-FY15)

Finding: DES does not have formal procedures to ensure cash draws are performed in accordance with the Treasury –State Agreement.

During the test work, the auditors noted draw requests were not calculated in accordance with the TSA requirements and did not occur on the first business day following the end of the payroll period. Specifically, the auditors noted the following exceptions:

- One draw request (totaling $7,269,000) occurred prior to the end of the payroll period. This draw was performed 2 days prior to the first business day following the end of the payroll period.
- Four draw requests (totaling $30,787,000) occurred after the first business day following the end of the payroll period. These draws were performed between 1 and 5 days subsequent to the first business day following the end of the payroll period.

In discussing these conditions with DES officials, they stated information is not always posted to the accounting records in time to calculate an accurate administrative draw for deposit on the first business day following the end of the pay period as specified by the Treasury-State Agreement (TSA).

DES Response: DES accepts this finding. We will document a procedure for semi-monthly administrative draws in conformity with the implementation of the State's ERP system. We have also requested a change in the TSA which will give us more time, if needed, to request the draw.

Updated Response: Not Repeated in FY17.

68. The auditors recommend DES implement procedures to ensure terminated users are removed from its information systems in a timely manner. (Repeated-2011)

Finding: DES 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 25 terminated users, the auditors noted access rights were terminated more than 15 days after the payroll termination date for 20 users sampled. Delays in terminating access ranged from 1 to 15 days.

In discussing these conditions with DES officials, they stated the cost center managers are not timely in submitting the TSS-001 form when one of their staff is terminated.

DES Response: DES accepts this finding and is in the process of reviewing the procedures to ensure that terminated users are removed from its information systems in a timely manner.

Updated Response: Repeated in FY17.

69. The auditors recommend DES establish procedures to accurately report federal expenditures used to prepare the SEFA to the OC. (Repeated-2013)

Finding: IDES did not accurately report Federal expenditures under the Unemployment Insurance program.

Federal expenditures reported to the Illinois Office of the Comptroller (OC) which were used to prepare the schedule of expenditures of federal awards (SEFA) did not agree to DES' financial records. Specifically, the auditors noted a difference of $555 thousand for the year ended June 30, 2016.
In discussing these conditions with DES officials, they stated the variance was because of human error.

DES Response: IDES accepts this finding and will establish new procedures to ensure staff accurately reviews the expenditures before they are submitted. This error was corrected and communicated to the Illinois Comptroller before the GAAP package was approved.

Updated Response: Repeated in FY17.

RECOMMENDATIONS 70
Department of Commerce and Economic Opportunity

70. The auditors recommend DCEO establish procedures to ensure loan balances reported to the OC and used to prepare the SEFA are accurate. (Repeated-2013)

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

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.

During audit procedures, the auditors noted the CDBG loan balances reported to the Illinois Office of the Comptroller (OC) which were used to prepare the SEFA did not agree to DCEO's financial records.

In discussing these conditions with DCEO officials, they stated the error was caused by inaccurately including loan activity at the subrecipient level in the amount reported on the prescribed Grant/Contract Analysis form (SCO-563C).

DCEO Response: Accepted. The Department of Commerce and Economic Opportunity agrees with this recommendation. The Department will establish procedures to ensure that the revolving loan balance is accurately reported to the OC and on the SEFA.

Updated Response: Repeated in FY17.

RECOMMENDATIONS 71-73
Department of Transportation

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

Finding: DOT 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 45 Highway Planning contractor payments for regular construction projects (totaling approximately $40,862,000) and 20 Highway Planning contractor payments for advanced construction projects (totaling approximately $5,988,000), auditors noted the following:

- The certified payrolls for 14 Highway Planning contractor payments on regular construction projects ($16,873,000) and 4 Highway Planning contractor payments on advanced construction projects ($1,328,000) were not received in a timely manner. Delays in receiving the certified payrolls ranged from 4 to 28 days.

- The certified payrolls for 17 Highway Planning contractor payments on regular construction projects ($14,568,000) and 8 Highway Planning contractor payments on advanced construction projects ($1,879,000) were not date stamped. Auditors were unable to determine whether they were received as required.
- The certified payrolls for 8 Highway Planning contractor payments on regular construction projects ($7,826,000) and 4 Highway Planning contractor payments on advanced construction projects ($2,470,00) were not signed by either the Resident Engineer, documentation staff, or Equal Employment Opportunity (EEO) personnel. Auditors were unable to determine whether the certified payroll was approved.
- The certified payrolls for 4 Highway Planning contractor payments on regular construction projects ($3,077,000) and 1 Highway Planning contractor payment on advanced construction projects ($21,600) were not provided by DOT as of date of testing (February 2, 2017). Auditors were unable to determine whether the certified payroll was approved in compliance with federal requirements and DOT's procedures.

In discussing these conditions with DOT officials, they stated the Bureau of Construction published Construction Memorandum 14 in April 2016, but has not fully implemented it yet.

Response: The Department agrees with the finding. Documented progress has been made to correct the audit finding. Further consultation with district construction staff is necessary to attain full implementation. This will happen via each district's spring Project Implementation meeting and through field visits by the Project Review Engineers in the Bureau of Construction.

Updated Response: Implemented, but repeated in FY17.

72. The auditors recommend DOT establish procedures to accurately report federal expenditures provided for audit and to ensure they are consistent with those used to prepare the SEFA.

Finding: DOT did not accurately report Federal expenditure information under the Highway Planning and Construction Cluster (Highway Planning) and the ARRA Surface Transportation Discretionary Grants for Capital Investment (TIGER) program.

Federal expenditures reported to the Illinois Office of the Comptroller (OC) which were used to prepare the schedule of expenditures of federal awards (SEFA) did not agree to information provided by DOT for audit procedures. Auditors noted the following differences for the year ended June 30, 2016:

Program	Amounts Reported to the OC	Amounts Initially Provided for Audit	Difference
Highway Planning	$1,480,121,000	$1,479,871,000	$250,000
TIGER	4,408,000	3,515,000	893,000

In discussing these conditions with DOT officials, they stated that DOT staff preparing the Final Major Program Expenditure Questionnaires did not verify total expenditures to the Schedule of Expenditures of Federal Awards (SEFA) reported expenditure amounts. As differences were discovered by the auditors, staff investigated and revised the Questionnaire to resolve differences.

Response: The Department agrees with the finding. The procedures have been revised to include assurance that expenditure totals provided in the Final Major Program Expenditure Questionnaires agree to the Schedule of Expenditures of Federal Awards (SEFA) expenditure amounts prior to submission to the auditors. Any differences noted are to be resolved prior to the submission of the Questionnaires.

Updated Response: Implemented, but repeated in FY17.

73. The auditors recommend DOT 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 DOT 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: DOT does not have adequate user access and program change management controls over the DOT Integrated Transportation Project Management system.

During testwork of DOT's controls over user access to the applications identified above, auditors noted seven individuals who were identified to be removed from the Fiscal Operations and Administration System (FOA) system during the annual access review (performed in late June 2016) who had not been removed from the FOA application as of September 26, 2016.

Additionally, during testwork over changes made to DOT's information systems, auditors noted DOT was not able to generate a list of changes made to its information systems from each respective information system or application.

In discussing these conditions with DOT officials, they stated the user IDs were retained to be used in the future and the mainframe environment does not provide the capability to log or track changes made to production programs.

Response: The Department agrees with the finding. Starting March 1, 2017, the RACF Coordinator or other authorized BIP staff are attaching an e-mail from DoIT (which confirms that the requested change from DOT has been completed and put into production) to the SharePoint list item. This enables DOT to have a complete record of the RACF requests and completion of the request from DoIT. This also allows the SharePoint site to generate a report containing a complete list of changes made to its information systems from each respective information system or application.

When RACF accounts are requested to be removed, the DOT RACF Coordinator takes over those accounts and disables the individual from using the account for RACF access. The RACF ID is kept for up to 90 days for subsequent reassignment.

Updated Response: Implemented, but repeated in FY17.