

# LEGISLATIVE AUDIT COMMISSION



Review of  
Department of Human Services  
Two Years Ended June 30, 2011

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**REVIEW: 4391**  
**DEPARTMENT OF HUMAN SERVICES**  
**TWO YEARS ENDED JUNE 30, 2011**

**FINDINGS/RECOMMENDATIONS - 43**

**ACCEPTED – 28**  
**IMPLEMENTED - 15**

**REPEATED FINDINGS - 29**  
**PRIOR RECOMMENDATIONS - 29**

This review summarizes the reports on the Department of Human Services, which includes the facilities operated by the Department—seven Developmental Centers, eight Mental Health Centers, two combined Mental Health and Developmental Centers and three Rehabilitation Services Facilities—for the two years ended June 30, 2011, filed with the Legislative Audit Commission on July 19, 2012. The auditors performed a financial audit and compliance examination in accordance with *Government Auditing Standards* and the Illinois State Auditing Act. The auditors stated that the financial statements were fairly presented.

The Illinois Department of Human Services was created in 1997 and consolidated the Departments of Alcoholism and Substance Abuse, Mental Health and Developmental Disabilities, and Rehabilitation Services, along with the client-centered services provided through the Department of Children and Family Services, Public Aid and Public Health. Its primary mission is to assist Illinois residents to achieve self-sufficiency, independence and health, to the maximum extent possible, by providing integrated family-oriented service, promoting prevention and establishing measurable outcomes, in partnerships with communities. The Secretary of the Department during the first four months audit period was Dr. Carol L. Adams. Dr. Adams resigned from the Department effective October 31, 2009. Michelle Saddler served as Secretary of DHS from October 11, 2009 until August 24, 2010. Thereafter, Grace Hong Duffin served as Acting Secretary from August 26, 2010 to December 13, 2010. Then Michelle Saddler was again appointed Secretary, and is still currently serving in that position.

The number of employees by division at June 30 was:

<b>Division</b>	<b>FY11</b>	<b>FY10</b>	<b>FY09</b>
Administrative Services	702	710	740
Community Health and Prevention	163	172	181
Human Capital Development	0	0	9
Disability & Behavioral Health Services	9,640	8,896	10,981
Community Operations	3,132	3,155	1,877
<b>TOTAL</b>	<b>13,637</b>	<b>12,933</b>	<b>13,788</b>

## **Service Efforts and Accomplishments**

Appendix A provides a summary of the Department's service efforts and accomplishments for the years ended June 30, 2011 and 2010, in all major divisions: Assistance Programs; Developmental Disabilities; Mental Health Services; Reproductive and Early Childhood Services; Home Services; Addiction Treatment Services; Youth Services; Vocational Rehab Services; and the Sexually Violent Person Program.

## **Expenditures From Appropriations**

The General Assembly appropriated \$6,395,064,000 to the Department in FY11, a decrease of about \$102.5 million, or almost 1.5%, compared to FY10. The Department received the third largest appropriation in the State budget for the FY11 budget year, behind the Department of Healthcare and Family Services and the State Board of Education. Total expenditures (including expenditures from non-appropriated funds) were \$5,902,757,000 in FY11 compared to \$5,560,905,000 in FY10, an increase of \$341.5 million, or 6.1%. Appendix B presents a summary of appropriations and expenditures by fund for FY11 and FY10.

Some of the more significant changes in expenditures were as follows:

- \$103 million decrease in GRF from the Governor's Discretionary Appropriation,
- \$207 million increase in the Employment and Training Funds due to ARRA funds (federal stimulus), and
- \$194.3 million increase in the Healthcare Provider Relief Fund.

Appendix C presents a summary of expenditures by major object code for FY11-FY09. According to the audit report, expenditures for awards and grants increased about \$270 million from FY10 to FY11. Interfund Cash Transfers increased by \$38 million as a result of cash flow shortages experienced by the Department requiring additional interfund cash transfers. Appendix D presents a summary of expenditures by facility. Total facility expenditures were \$625 million in FY11. Only two facilities (Kiley and Ludeman) had greater expenditures in FY11 than in FY09. Lapse period expenditures for the Department were almost \$407 million, or 6.9%, in FY11.

## **Cash Receipts**

Appendix E provides a summary of the Department's cash receipts, which totaled \$2.2 billion in FY11. Cash receipts increased by \$208 million, or about 10.5%, from \$1.99 billion in FY10. Most of the increase was due to federal stimulus funds (ARRA) for TANF, Child Care and Development and Medical Assistance.

### **Property and Equipment**

Appendix F provides a summary of property and equipment for which the Department's Central Office was accountable during FY11 and FY10. The value of the Department's property and equipment, which includes the facilities, was \$954,656,477 at June 30, 2011.

### **Accounts Receivable**

Appendix G provides a summary of accounts receivable for FY11 and FY10. The Department's net accounts receivable totaled \$337,044,000 as of June 30, 2011. Almost \$238 million in receivables is due from the Federal Departments of Health and Human Services, Agriculture, Education and the Social Security Administration. Other receivables, net, included an allowance for uncollectibles of \$456 million for FY11 and \$463 million for FY10.

### **Accountants' Findings and Recommendations**

Condensed below are the 43 findings and recommendations included in the audit report. There are 29 findings repeated from past reports. The following recommendations are classified on the basis of updated information provided by the Department of Human Services, in a memo received via email on March 28, 2013.

#### **Accepted or Implemented**

- 1. Implement procedures and cross-training measures to ensure GAAP Reporting Packages are prepared in a timely, accurate and complete manner. Also, allocate sufficient staff resources and implement formal procedures to ensure GAAP financial information is prepared and submitted to the Office of the Comptroller in a timely and accurate manner, and that all supporting documentation is maintained in a contemporaneous manner. (Repeated-2009)**

**Finding:** The Department of Human Services' (Department's) year-end financial reporting in accordance with generally accepted accounting principles (GAAP) to the Illinois Office of the Comptroller contained numerous inaccuracies and errors which resulted in changes being made to originally submitted information.

During the audit of the June 30, 2011 Department financial statements, some of the exceptions noted were as follows:

- GAAP reporting packages contained numerous inaccuracies and required corrections which delayed audit testing of the financial statements and the Schedule of Federal Awards prepared by the Department. Auditors did not receive a complete draft of the financial statements and footnotes from the Department until February 24, 2012, approximately five months late.

## REVIEW: 4391

### Accepted or Implemented – continued

- In the prior year, auditors posted an adjustment to record the correct amount for the WIC rebates receivable, but the adjustment was not posted by the Illinois Office of the Comptroller. When preparing the expenditure reconciliation utilized to determine current year expenditures, the corrected amount was not considered. As a result, current year revenues and expenditures were understated by \$11.889 million.
- The Department had not properly accounted for prior or current year liabilities related to the Children's Health Insurance Program and two Medical Assistance Programs. As a result, the current year expenditures were misstated on a cash basis. This resulted in a total understatement of \$14.467 million. The Grant/Contract Analysis Form (SCO-563) and Schedule of Expenditures of Federal Awards were revised to correct the misstatement.
- Auditors noted the Department had not timely posted payroll expenditure amounts to their accounting system. The reports which support financial reporting data had to be adjusted to include expenditures for the April 2011 payroll that were not posted until August, or four months late. This occurred in sixteen fund reporting packages for a total of \$1.448 million in payroll expenditures.

Department officials cited numerous issues with the functionality of the Comptroller's WEDGE reporting system as the reason for the delays in the ability of the Department to enter financial data into the GAAP reporting packages. Additionally, Department officials stated the errors contained in the GAAP packages were due to the lack of a complete general ledger and grants management system as well as lack of a sufficient number of staff and corresponding titles to hire staff with adequate qualifications, education, and experience to prepare GAAP packages and financial statements in accordance with GAAP.

**Response:** Accepted. DHS will implement procedures to cross-train employees to help ensure GAAP packages are prepared timely and accurately. Additionally, DHS is in the process of hiring staff to be utilized in the GAAP reporting process.

**Updated Response:** Partially Implemented.

#### **Corrective Action Implemented:**

- Contracted with GAAP vendor to provide the Illinois Office of the Comptroller (IOC) follow-up and review comment assistance.
- Once the contract was awarded, a planning meeting was held with the GAAP vendor to review expectations pertaining to GAAP preparation process and audit findings.
- SPSA, Assistant Bureau Chief has been hired.

**REVIEW: 4391**

**Corrective Action to be completed:**

- Two PSA Option 8 C positions have been posted and awaiting to be hired
- Recruit and hire Bureau Chief - General Accounting

These positions have been posted several times in the last year but we have not been able to recruit qualified candidates.

**% of CORRECTIVE ACTION COMPLETED = 40%**

**Estimated Date of Completion: 6/30/2013**

**2. Continue strengthening oversight function related to commodities to allow for improved internal controls. (Repeated-1999)**

**Finding:** The Department does not maintain an adequate oversight function over commodities, resulting in inadequate controls at individual facilities, multiple warehouses, and Central Office locations.

Audit testing performed at various locations, including warehouses, facilities, schools, and centers, identified several exceptions and weaknesses over commodities inventories. Some of the inventory problems noted during testing were as follows:

- Weaknesses in segregation of duties for annual inventory counting were noted at four of twenty-two locations (20 facilities and 2 warehouses).
- Auditors noted five of twenty facilities did not distribute written inventory procedures to the personnel conducting the count.
- The Department's Warehouse Control System (WCS) does not allow the system user to readily review the purchase history of items to ensure the commodities are accurately priced under the average cost method. Under the average cost method, inventory is valued based on the average purchase price (cost) of the items in stock. Auditors noted the average cost method is not being utilized to record the cost of commodities inventories at the two warehouses.
- Inventory counts that could not be reconciled to perpetual inventory records at six of twenty facilities and two warehouses.
- Pharmaceutical inventories for six facilities were misstated at June 30, 2011 by the value of the pharmaceuticals disbursed to patients June 27 - 30 but not posted to the Commodity Control System (CCS) until July 1 - 3. Due to the end of the fiscal year occurring midweek and the limited reporting capabilities of the CCS, a custom report was created to capture the pharmaceuticals that were disbursed from July 1<sup>st</sup> through July 3<sup>rd</sup>. However, the report which was provided to auditors for the pharmacies contained a programming error and did

**Accepted or Implemented – continued**

## REVIEW: 4391

not accurately reflect the pharmaceuticals that were disbursed June 27 - 30 to allow for the proper statement of the year end balance. Pharmacy personnel attempted to utilize the standard weekly report and custom report to arrive at the correct year end balance. However, auditors were unable to verify test counts with the final inventory balances.

- Four of twenty facilities had inventory items that were overstocked or in excess of a twelve-month supply. In addition, auditors noted expired items at two facilities.

Similar exceptions were noted at the Department in previous reports. The Department stated they have established a centralized oversight for commodities; however, staffing shortages and the outdated system continue to contribute to the weaknesses noted for commodity inventories.

**Response:** Accepted. The Department is investigating ways to strengthen and develop a more centralized oversight function related to commodities to allow for improved internal controls.

**Updated Response:** Partially Implemented.

### **Corrective Action Implemented:**

#### **Office of Business Services (OBS)**

- The Office of Business Services (OBS) has issued instructions to DHS facilities regarding the importance of conducting an accurate inventory. The instructions included detailing examples of past finding.
- Facility has confirmed to the Office of Business Services (OBS) that all staff involved in the inventory has read the instruction.
- Training needs are being identified, and training has been conducted.
- Timeline to complete FY 12 annual inventory was provided.

#### **Office of Clinical Administrative and Program Support**

- The Office of Clinical Administrative and Program Support (OCAPS) worked with MIS Clinical to change 06/30/12 weekend cycle.
- The Office of Clinical Administrative and Program Support (OCAPS) worked with MIS Clinical to develop Excel version of Inventory Worksheet. Due to difficulties in recruiting staff needed for inventory processing and to improve accuracy, OCAPS created an Excel Spreadsheet on 5/11/12 to automatically calculate adjustments, place adjustments in correct column and calculate the overage adjustment value. The only manual entry required was the transfer of counts.
- OCAPS completed testing of the spreadsheet on 6/25/12 to ensure there were no errors in any formulas and that all columns were protected so no one could alter the formulas.
- The creation of spreadsheet eliminated the need for additional staff because it eliminated manual calculations and the double checking.

**REVIEW: 4391**

- DHS MIS has modified the interface between the Unit Dose System and the Commodity Control System to allow daily usage to hit the Commodity Control System.

**Corrective Action to be Completed:**

- Develop a Request for Proposal (RFP) and implement a new inventory control system to improve centralized oversight for commodities.

**% of CORRECTIVE ACTION COMPLETED = 91%**

**Estimated Date of Completion: 4/30/2013**

- 3. Upgrade the Commodity Control System (CCS) or implement a new system that includes real-time capabilities. This would allow the Department to access current inventory levels so all inventory unit costs are properly recorded. (Repeated-2005)**

**Finding:** The Department's Commodity Control System (CCS) is a batch entry system developed over 30 years ago that does not allow users real time inventory controls regarding inventory management and purchasing. The CCS is utilized for inventory at all mental health and developmental centers and for the Bureau of Pharmacy and Clinical Support Services pharmaceutical warehouse.

The CCS does not allow the system user to readily review the purchase history of items to ensure the commodities are accurately priced under the average cost method. Under the average cost method, inventory is valued based on the average purchase price (cost) of the items in stock. The Department counted their annual inventory for all stores from June 27th to June 30th as opposed to June 30th which is the fiscal year end. As a result of the year end count, the records for eighteen locations required adjustments.

Auditors also noted pharmaceutical inventories for six facilities were misstated at June 30, 2011 by the value of the pharmaceuticals disbursed to patients June 27 - 30 but not posted to the CCS until July 1 - 3. A custom report was created to capture the pharmaceuticals that were disbursed from July 1<sup>st</sup> through July 3<sup>rd</sup>. However, the report which was provided to auditors for the pharmacies contained a programming error and did not accurately reflect the pharmaceuticals that were disbursed June 27 - 30. The lack of an accurate transaction register caused either overstatements or understatements in the ending inventory balances of the pharmaceuticals distributed the last week of June. Pharmacy personnel stated it was not cost-effective to allocate resources to determine the differences in ending inventory values.

**Updated Response:** Accepted.

**Corrective Action to be Implemented:**

- The Department has completed a Request for Proposal (RFP) for the purchase of a new asset management system.

## REVIEW: 4391

### Accepted or Implemented – continued

- The RFP has been sent to the Office of Clinical Administrative and Program Support (OCAPS), DHS Management Information Services (MIS) and Central Management Services (CMS) for review numerous times.
- Two members of the workgroup met on 3/14/13 to discuss final comments made by CMS on the latest RFP. Once the RFP is reviewed and revised, the RFP will be attached to the PBC.
- New PBC without RFP was released to the Agency Purchasing Officer (APO) on 3/11/13. Once the RFP is finalized by workgroup, the RFP will be attached to the PBC and ready for review by APO.

**% of CORRECTIVE ACTION COMPLETED = 25%**

**Estimated Date of Completion: 10/31/2013**

**4. Review and revise, as necessary, the current system of gathering capital asset information to improve the accuracy and timeliness of capital asset records and devote necessary personnel to these tasks. (Repeated-2007)**

**Finding:** The Department's capital asset GAAP Package Forms contain several accounts that are not supported by the Department's capital asset accounting records.

During testing of the capital asset reporting system, several accounts on the GAAP Package Form *Capital Asset Summary* (SCO-538) could not be traced to supporting records. The Department records the entire difference between beginning of year and end of year accumulated depreciation as an addition to accumulated depreciation, when in fact there are probably deletions and transfers. Although the differences between "netted" and "gross" totals are not significant, additions, deletions and transfers during the year should be supported.

The original SCO-538 was submitted to the Office of the Comptroller on October 27, 2011 or approximately two months late. However, after the initial submission the Department made significant revisions to the SCO-538 which was then resubmitted on January 26, 2012 or approximately five months late. The Department originally reported \$4.641 million of construction in progress while no amount was reported for internally generated intangible assets in development. The revised amount for internally generated intangible assets in development was \$3.223 million. Additionally, the liabilities associated with capital assets at June 30, 2011 as originally reported were \$1.046 million while the revised amount was \$1.888 million. Auditors also noted several other accounts which were adjusted by several hundred thousand dollars.

Auditors also noted differences from amounts reported on the SCO-538 when compared to the fund reporting packages. The Office of the Comptroller made adjustments to reclassify amounts reported as capital assets to intangible assets.

**REVIEW: 4391**

Department officials stated if additions, deletions, or net transfers are unknown, then the overall net change is used to get to an ending balance that agrees to the Department's capital asset records. Department records do not always readily reflect the components of additions, deletions, and net transfers.

**Response:** Accepted. The Department is considering alternatives to enhance the overall reporting capabilities of the Department's tracking systems.

**Updated Response:** Partially Implemented.

**Corrective Action Implemented:**

- Capital Asset system purchased in FY2012. DHS purchased a subscription to software as a service. Therefore, DHS does not own the software.
- Trained staff on Capital Assets procedures.

**Corrective Action to be Completed:**

**Long Term:**

- Fiscal Services will work with DHS Management Information Services (MIS) to complete reconciliation to implement a new system.
- Develop Form C-15 (Agency Report of State Property), C-37 (SAMS to GAAP Reconciliation)/C-38 (Capital Assets Summary) Forms for submission to the Illinois Office of the Comptroller (IOC).

**% of CORRECTIVE ACTION COMPLETED = 33%**

**Estimated Date of Completion: 8/30/2013**

**5. Implement a Department-wide accounts receivable system, working with the appropriate parties regarding any possible state-wide consolidated accounting system initiatives. (Repeated-2007)**

**Finding:** The Department's accounts receivable reporting system is cumbersome, relies on numerous subsystems, and requires manual entries.

During testing of the quarterly receivable forms, auditors noted the reports were manually compiled from multiple accounts receivable systems in order to issue a single report. The compilation is complex and cumbersome and, as a result, there is a potential for errors in reporting. The current process takes approximately 15-20 hours to complete over a period of several weeks.

Auditors noted the quarterly Form C-98 submitted to the Comptroller contained differences that could not be reconciled with the Department's supporting documentation. Auditors reviewed the supporting documentation for these receivables but were unable to reconcile the amounts to the totals reported for the quarter end. For FY11, differences ranged from \$13 million to \$23 million at the end of each quarter.

**REVIEW: 4391**

**Accepted or Implemented – continued**

Auditors also noted there were quarterly accounts receivable reports generated for funds that do not report receivables. According to Department personnel, these amounts are populated in error and must be zeroed out manually.

In response to this prior finding, the Department has developed formal written policies and procedures to document its existing system and cross-trained other workers on preparing the required reports. However, limitations in current systems make it cumbersome and difficult to support. The balance of accounts receivable was approximately \$509 million.

**Updated Response:** Partially Implemented.

**SHORT TERM**

- Based on the Department's review of the Accounts Receivable System Agency wide, the Department will establish and implement an interim Department wide solution until a statewide system is implemented.
- The Department has an interim solution in place for establishing, reporting, aging and collection of debt owed to DHS.
- Procedures have been developed and back-up staff has been trained to complete the Quarterly SCAAR Reporting process.
- Fiscal Services staff met with DHS-MIS to review and improve the systems that DHS currently maintains
- Office of Fiscal Services (OFS), Bureau of System Support developed an MIS Request requesting DHS –Management Information Services (MIS) to review and analyze the Accounts Receivable Systems to address the audit finding.

**Corrective Action to be Completed:**

**LONG TERM:**

- MIS to review and analyze the Accounts Receivable Systems to address the audit finding.
- MIS will not only review the process but will flowchart the process and fix it if necessary.

**% of CORRECTIVE ACTION COMPLETED = 50%**

**Estimated Date of Completion: 12/15/2013**

- 6. Ensure that children for which the State is assisting with child care costs are not placed in arrangements in which the provider or other members of the household are listed on the Illinois Sex Offender Registry. Specifically, implement systems to allow the Department to periodically match the addresses of child care providers with those addresses listed in the Illinois Sex Offender Registry. (Repeated-2009)**

## REVIEW: 4391

**Finding:** The Department's Child Care Assistance Program (CCAP) provides low-income, working families with access to quality, affordable child care that allows them to continue working. Participants choose the child care provider who best fits their individual needs, and care is available on a full-time or part-time basis including care before and after school. According to the Department's Annual Child Care Report, in FY10 the CCAP supported an average of 168,000 children from 89,900 families each month. The Department expended \$794 million related to child care assistance in fiscal year 2010.

The Department's Child Care Manual bars anyone from "*residing in a family home in which a child care facility operates*" who has been included in the Illinois Sex Offender Registry or convicted of committing or attempting to commit a variety of serious criminal offenses.

In FY09, auditors noted 90 instances where a child care provider's address matched an address of a registered sex offender. Of those ninety providers, the Department determined 59 were no longer providing services and 6 providers had incorrect addresses listed. One provider was a registered sex offender; however, he is no longer providing child care services. For the remaining 24 providers, the Department sent letters to the parents of the children involved notifying them that a sex offender is listed at the same address.

In order to follow up on the prior year finding, auditors requested a listing of the current addresses of the child care providers who were noted to have a sex offender registered at their address. Auditors noted 16 providers who listed addresses that still matched the address of a registered sex offender. Of the 16 providers, the Department indicated 11 of them are no longer providing child care services. In 5 cases, the provider's address still matches the address of a sex offender.

Department officials stated a lack of staff and resources contributed to the discrepancies noted.

**Response:** Accepted. Currently, DHS has entered into an IGA with DCFS to perform the background checks for license-exempt providers. The background check performed is the same background check that DCFS performs for child care providers under licensure. The Sex Offender Registry System (SORS) check is currently done by name, not by address. Since DCFS does not currently check addresses for those individuals seeking a license, it is an additional burden to add the address check to this process. Given that DCFS is unable to conduct background checks for licensed providers in a timely manner, it is unlikely that we can add to their work with this request and expect timely results. We will explore enhancing our technology system to determine if we can perform the address match through our own database.

We wish to stipulate that the Sex Offender Registry is not maintained or monitored by the ISP. An address match is not definitive and will require additional research by staff to determine if the match is accurate. It is unlikely that there will be additional resources available in the coming fiscal year to devote to this project.

**Accepted or Implemented – continued**

**REVIEW: 4391**

**Updated Response:** Implemented.

**Corrective Action Implemented:**

- On 10/20/12, the Department of Human Services (DHS) Management Information Services (MIS) began performing monthly checks of current child care providers on record against the State of Illinois sex offender's website.
- The resulting reports are shared with the Child Care Resource and Referral (CCR&R) staff to update or close out providers.

**% of CORRECTIVE ACTION COMPLETED = 100%**

**Date Completed: 12/11/2012**

**7. Strengthen internal controls over the payment of child care funds for school aged children. Specifically:**

- **Ask parents and guardians to disclose whether school age children attending private or parochial schools for care are attending classes with the provider.**
- **Verify for providers receiving full-time reimbursement that the hours in care do not include the school day.**
- **Ensure that providers, including private providers, keep appropriate documentation to show the hours in care.**
- **Implement controls to monitor actual hours provided when multiple child care providers are utilized. (Repeated-2009)**

**Finding:** In July 2009, the Office of the Auditor General released a Management Audit of the \$1 Million Grant to Loop Lab School. The audit contained a recommendation to DHS regarding the use of child care assistance funds for tuition payments. As part of the compliance examination of the Department, testing was conducted to determine if other providers were also using child care funds to cover the cost of tuition.

The Department provided a download of school age children who received full-time child care assistance during FY10 and FY11 for certified providers. The download provided by the Department contained 731,201 payments for a total of \$181,459,423 for FY10, and 753,568 payments for a total of \$220,738,195 in FY11.

A sample of 26 payments to providers for school aged clients receiving full-time reimbursement was selected for testing. Auditors did not note instances of tuition payments being made with child care assistance monies; however, other exceptions were noted as a result of testing procedures performed:

- Two of 13 cases tested at Bloomington noted providers were paid for days for which they were not eligible. The overpayments totaled \$215.

During the review of case files, auditors also noted there was no system in place to substantiate the actual hours of child care provided when more than one child care

## REVIEW: 4391

provider was being utilized.

Although no situations were noted, the Department has not implemented the recommendations presented in the original finding.

**Updated Response:** Partially Implemented.

### **Corrective Action Implemented:**

- Ask parents and guardians to disclose whether school age children attending private or parochial schools for care are attending classes with the provider:
  - This question has been added to the Child Care Application.
- Verify for providers receiving full-time reimbursement that the hours in care do not include the school day:
  - Certification statement has been added to the Child Care Application.
  - Certification statement has been added to the Site Administered Monthly Enrollment Report.
- Ensure that providers, including private providers, keep appropriate documentation to show the hours in care:
  - Certification statement has been added to the Child Care Application.
  - Certification statement has been added to the Site Administered Monthly Enrollment Report
  - Certification statement has been added to the Child Care Certificate.
  - Attendance records and sign in/out sheets are reviewed to ensure hours of work and hours of care coincide.

### **Corrective Action to be Completed:**

- An MIS Request has been submitted to include language on the Child Care Certificate, however MIS has not completed this task
- Implement controls to monitor actual hours provided when multiple child care providers are utilized:
  - The Child Care Arrangement screen in the Child Care Management System (CCMS) allows for the data entry of the actual start and end dates of care, as well as the daily (Monday through Sunday) start and end times for each known provider.
  - In addition, the DHS - Bureau of Child Care and Development (BCCD) has recommended that DCFS require licensed providers to include the times when a child is dropped off or picked up from the provider (currently only a signature in and out are required). These forms will then be collected from the providers during monitoring or if there is a billing conflict.
  - BCCD will determine other monitoring protocol when we revise our monitoring based on the desk audits we will be able to do with CCMS.
  - CCMS will not be deployed until July, 2013.

**% of CORRECTIVE ACTION COMPLETED = 80%**

**Estimated Date of Completion: 6/30/2013**

**Accepted or Implemented – continued**

**8. Strengthen controls and review all contract expenditure reports and performance measures to ensure all payments are in accordance with the contract and any overpayments have been properly offset or recouped. (Repeated-2009)**

**Finding:** The Department's Division of Mental Health has been in the process of converting from grant based payments to fee-for-service payments to providers of mental health services with the aid of an Administrative Service Organization (ASO). During testing, auditors noted overpayments to the ASO were not resolved in a timely manner.

The final contract payments for FY08, FY09, and FY10 were processed prior to final review of performance measurements and overpayments. The Department subsequently noted it overpaid the ASO \$1,785,185 during FY08. The Department notified the ASO of the overpayment on September 25, 2008 and that the overpayment would be applied toward FY09 contract payments. However, only part of the overpayment was recovered in 2009 and 2010. Efforts were made in FY11 to recoup the overpayments; however, since the ASO did not incur actual costs equivalent to the original contract amount plus change orders, an overpayment remains.

Based on an analysis of over/under payments and contract adjustments over the previous four fiscal years, the ASO has received net overpayments from the Department totaling \$1,366,259 as of June 30, 2011. As a result, the ASO remains prepaid for services.

As noted in a finding in the previous compliance report, the Department made errors when deducting performance penalty amounts from subsequent year payments. Auditors noted the Department made additional errors in calculations for FY11.

Department officials stated the failure to properly monitor the ASO contract was due to the lack of trained personnel.

**Response:** Accepted. The Department will strengthen its controls and review all contract expenditure reports and performance measures to ensure all payments are made in accordance with the contract and recoup any overpayments.

**Updated Response:** Partially Implemented.

**Corrective Action Implemented:**

- Reviews are being conducted to ensure all payments are made in accordance with the contract, and recoupment of overpayments is made.
- The Division of Mental Health (DMH) did, in fact, apply multiple payment offsets for prior year overpayments against FY2011 reimbursements to the Administrative Service Organization (ASO).
- Prospectively, the DMH grants manager for the ASO contract routinely monitors expenditures and deliverables.

**Corrective Action to be Completed:**

## REVIEW: 4391

- All overpayments from prior years shall be recouped as credit offsets against FY13 contract expenditures.

**% of CORRECTIVE ACTION COMPLETED = 99%**

**Estimated Date of Completion: 6/30/2013.**

**9. Make payments to providers in accordance with contract terms and Department policies and procedures. Also, hold providers accountable when they fail to submit complete financial information.**

**Finding:** The Department made preferential payments to a mental health provider which the provider could not support in a timely manner. Such payments included advances, a \$1.2 million safety-net payment, and catch-up payments.

The Medicaid Reimbursable costs (MRO) contract with the provider for FY09 was \$6.7 million. Under the old reimbursement system, this amount would have been paid out in equal monthly payments and reconciled with approved billings at the end of the fiscal year. However, during FY09, the Department converted the MRO program to fee-for-service which would pay the provider based on their approved billings. Consequently, the provider's monthly payments dropped significantly from \$562,572 to \$329,544 per month. The provider informed the Department they were experiencing financial difficulties. In September of 2008, the Director of Mental Health approved issuance of \$692,573 in 'catch-up' payments and advanced to the provider their \$562,572 June 2009 payment. After the Director's involvement, the provider received regular monthly payments as though they operated under the old reimbursement system instead of the fee-for-service system. By May 6, 2009, the provider had received 100% of their contracted MRO amount.

In May 2009, the provider requested additional funding due to financial hardship. Their independent audit report later revealed a liability for \$1 million in back payroll taxes, penalties and interest. The Department agreed to give the provider additional funds and issued them a \$1.2 million safety net payment on June 10, 2009 through a contract amendment. A safety net payment as set forth in the executed contract between the Department and the provider is an expenditure to the provider in order to sustain consumer access levels.

When the provider submitted its grant report with its FY09 financial reporting package in December of 2009, it failed to include expenditures for 9 programs, including those related to the safety net funding. After months of correspondence from the Department, the provider submitted a revised grant report on June 21, 2011, approximately 18 months after the original report was submitted. The provider's revised grant report included expenditures for all the previous missing programs. The expenditures related to the safety net funding were lumped together with other special projects rather than accounted for separately. The revised grant report noted unspent funds totaling \$192,750 of which

**Accepted or Implemented – continued**

## REVIEW: 4391

\$50,980 related to special projects. On August 31, 2011, an Administrative Law Judge ordered the repayment of these unspent grant funds over a four month period ending November 30, 2011. As of January 31, 2012, only \$50,000 had been recovered. An overall weakness by the Department to recover unspent funds is also addressed in finding 11-18. As a result, the provider did not account for safety net payments of \$1.2 million received in July 2009 for more than two years.

Department officials stated the unintentional lack of oversight and staffing changes contributed to discrepancies noted.

**Updated Response:** Implemented.

### **Corrective Action Implemented:**

- The Department finally severed all Community Service Agreements (CSA) with the provider by the end of FY12, and the Division of Mental Health (DMH) withheld final FY12 grant payments of approximately \$2M at the direction of the DHS Office of the General Counsel and the DHS Secretary.
- DMH has implemented an internal approval process for issuance of "Safety Net" advances under the terms of the CSA Attachment B. Each request for an advance payment to a community provider must be reviewed and approved by a minimum of three senior DMH staff, including the DMH Director, DMH Chief Fiscal Officer, and DMH Community Services Chief or designee.
- Once a Safety Net advance payment is approved, the accepted terms of the advance and the recovery schedule are detailed in a two-party agreement that must be signed by the Provider and the DMH Chief Fiscal Officer prior to issuance of any advance.
- Upon preparation of the voucher for a safety net payment advance, DMH issues e-mail instructions to the Department of Healthcare and Family Services (HFS) staff to post a corresponding mass credit that will be applied against fee-for-service claims in a manner consistent with the agreed recovery terms.
- DMH receives bi-monthly updates from the Department of Health Care and Family Services (HFS) on the progress of the applied credits to ensure that recoveries occur as specified.

### **NOTE:**

- Attachment B of the Community Service Agreements contained a payment provision that allowed DHS – division of Mental Health (DMH) to issue safety net advance payments to providers to ensure consumer access. As specified in the contract attachment, "Funds advanced will be offset against fee for service claims or reconciled at the end of the contract period. The Department will recover any safety net funds not supported by eligible costs or services."
- In FY09 and FY10 DMH issued payment advances consistent with these provisions of Attachment B in order to maintain critical access to care for a large number of Mental Health (MH) clients. Unfortunately, each time DMH attempted to recover the advances via reimbursement offsets, the provider indicated they could not meet their operational needs due to inadequate cash flow. The provider repeatedly

**REVIEW: 4391**

requested payment deferrals in order to stay in business, and DMH approved the deferrals due to the critical role that the provider filled within the MH community provider network.

- **However, the Department finally severed all community service agreements with the provider by the end of FY12, and DMH withheld final FY12 grant payments of approximately \$2M at the direction of the DHS Office of the General Counsel and the DHS Secretary.**

**% of CORRECTIVE ACTION COMPLETED = 100%**

**Date Completed: 2/28/2013**

- 10. Ensure confidential information is adequately protected. Also, effectively communicate and enforce procedures for safeguarding, retention, and subsequent disposal of all confidential information to all personnel, including facilities. (Repeated-2005)**

**Finding:** The Department has not ensured its compliance with procedures for disposal of documents containing confidential and sensitive information.

The Department regularly collects and maintains various types of documents, including confidential and personal identifiable information, necessary for fulfilling its mission. Although the Department has established several administrative directives regarding the disposal of confidential information, procedures for properly disposing of confidential information were not always being followed by Department employees. Some examples of issues noted were as follows:

- During walkthroughs at the Department's Central Office, auditors found unlocked shred bins in open areas that were clearly marked as shred. Auditors also found multiple boxes of documents that contained confidential information in the Fiscal Operations area.
- Several documents containing confidential information were found in trash or recycle bins while performing testing at certain Department facilities.
- Some facilities were not maintaining confidential information in secured areas. Confidential information was found in various rooms not adequately secured from unauthorized individuals.

Department personnel stated the lack of employee oversight contributed to noncompliance with Department policy.

**Updated Response:** Partially Implemented.  
**Accepted or Implemented – continued**

## REVIEW: 4391

### **Corrective Action Implemented:**

#### Office of General Counsel (DHS - LEGAL):

- The HIPAA training Administrative Directive has been revised, and is undergoing the normal review process prior to publication. The form will be distributed with the Employee Handbook when the handbook is provided to new employees, or periodically updated.
- The HIPAA Training Administrative Directive was issued on February 15, 2013. Section II.A.5 denotes the requirement to include a HIPAA training goal as part of the annual Performance Evaluation system.
- Developed and placed HIPAA and privacy training modules on Net Learning.

#### Division of Mental Health (DMH):

- Follow up is being conducted to ensure each Mental Health Center (MHC) is working on a corrective action plan that resolve the issues mentioned in the finding:

##### Choate MHC:

- Identify tray tickets by only using first name and last initial. Supporting documentation consists of meal tickets indicating only the patient's first name and last initial.
- Collect all meal tickets after use and store in a secure area until they can be destroyed.
- Dietary staff reminded of HIPAA protocols and was retrained. Supporting documentation includes a sign-off sheet for Dietary staff and a record of training regarding the protection and disposal of confidential documents.
- Trash dumpsters will be monitored for six months to ensure compliance.

##### Elgin MHC:

- The facility will further isolate the records wing of the storage building with a door and a new lock. Only authorized personnel will have access to the patient record area.
- Facility will purge records before storage and only required paperwork will be maintained.
- Facility will make every effort to microfilm older records based on availability of funds.
- Facility microfilmed \$10,000 worth of thinned records and provided a copy of the invoice for service.

##### Treatment and Detention Facility:

- The records room will be secured from the hours of 4:00 p.m. to 7:00 a.m., Monday – Friday and on weekends and holidays. Staff that needs to access the room during these times must be on the approved list and shall only be granted approval by the (AOD) Administrator on Duty. Supporting documentation consists of a memo from the Program Director indicating the hours that the Record Room will be secured and a list of individuals who will be granted access.
- A sign will be posted which indicates, "Authorized Staff Only".
- An updated list shall be posted in the records room which indicates who is "Authorized Staff".

**REVIEW: 4391**

**Corrective Action to be Completed:**

Division of Developmental Disabilities (DDD):

- Corrective Action Plans (CAP) for DDD facilities that had this issue are to be monitored for six months.

**% of CORRECTIVE ACTION COMPLETED = 90%**

**Estimated Date of Completion: 6/30/2013**

- 11. Follow procedures to include all State Board of Elections Certifications; ensure all contracts have the required components; include all Illinois Use Tax Certifications; file all contracts with the Office of the Comptroller in a timely manner; and strengthen the Contract Agreement Approval Form (CAAF) approval process to ensure all required signatures are obtained in a timely manner on the original CAAF, or consider amending the Administrative Directive to include teleconferencing. (Repeated-2009)**

**Finding:** The Department failed to ensure proper controls were established in the administration of its contracts during the examination period. During testing of 60 contractual agreements, weaknesses were identified in contract administration:

- 2 agreements did not include the State Board of Elections Certification.
- 2 agreements were executed before the Contract/Agreement Approval Form (CAAF) was fully signed.
- 1 contract agreement totaling \$2,918,520 failed to list the addresses of the subcontractors.
- 1 of 60 contract agreements totaling \$30,000 failed to include the Illinois Use Tax Certification.
- 5 administrative contracts totaling \$606,693 were not filed timely with the Comptroller's Office.
- 6 contractual agreements contained multiple CAAF forms to illustrate approvals. Department policy requires a Contract/Agreement Approval Form (CAAF) be completed for each contract or any amendment which increases the dollar amount contracted. Department personnel stated the final approval process is performed at weekly roundtable group meetings where the CAAF is to be signed. They indicated it has become increasingly difficult to get all of the people required to sign the CAAF at the meetings at the same time. The roundtable meetings have transitioned to teleconferences and CAAF forms are signed and faxed in at various times. Consequently, more than one copy of the CAAF appears in some contract files.

**Accepted or Implemented – continued**

## REVIEW: 4391

Department officials stated the contracts did not include the required components and were not filed in a timely manner due to the number of contracts processed by the Department and the time it requires to process and approve contracts after receipt.

**Updated Response:** Partially Implemented.

**Corrective Action Implemented:**

**Office of Contract Administration (OCA):**

- For quarter ending 9/30/2012, OCA reminded all division staff to verify that State Board of Elections' Certifications are included in their FY13 contract agreements.
- For quarter ending 9/30/2012, OCA reminded all division staff to verify that all required information is included in their FY13 contract agreements.
- For quarter ending 9/30/2012, OCA ensured that all non grant contracts used the CMS boilerplate, which contains all required certifications effective for FY13 contract agreements.

**Office of General Counsel (DHS – LEGAL):**

- DHS LEGAL has reviewed the contract agreement templates for Procurement Code covered and non-Procurement Code covered purchases and services, and for grant agreements to ensure the appropriate terms and conditions are included.

**Corrective Action to be Completed:**

- The Office of Contract Administration (OCA) will attempt to file contracts in a timely manner, subject to time and personnel limitations.
- DHS management will consider amending the Administrative Directive to address the weakness in the Contract/ Agreement Approval Form (CAAF) approval process.

**% of CORRECTIVE ACTION COMPLETED = 70%**

**Estimated Date of Completion: 12/31/2013**

**12. Implement procedures to strengthen internal controls over the Home Services Program as follows:**

- **Implement controls to monitor and ensure accuracy in the timekeeping process for personal assistants.**
- **Continue to show improvement in its caseload per counselor through the allocation of resources or alternative controls. (Repeated-2005)**

**Finding:** During testing, numerous internal control weaknesses were identified in the Department's Home Services Program (HSP) managed by the Department's Division of Rehabilitation Services (DRS).

During FY10 and FY11, the Home Services Program maintained 41 offices and, over the course of those two years, on behalf of the customers, paid 40,934 personal assistants at a cost of \$383,286,341 and paid 40,787 personal assistants at a cost of \$412,200,102, respectively. Personal assistants are hired, supervised, and fired by the customer. The

## REVIEW: 4391

customer may hire a relative or other acquaintance as a personal assistant. Because the customer approves timesheets, and Department reviews are not adequate, personal assistants may be paid for excessive hours. The HSP also has a fraud division that was established to identify and address fraudulent activities in this area.

The auditors noted through testing and discussions with HSP and fraud division personnel that the following weaknesses were still prevalent during the current engagement period:

- There were inconsistencies throughout the local offices in the supervisor's monitoring of the counselors' activities. Several supervisors utilize GroupWise calendars, scheduling boards, and frequent interaction with the counselors to ensure they are performing their job duties.
- There was insufficient monitoring of case files to ensure program objectives were being met. There is only one supervisor at each of the 41 local offices to monitor Home Services Program activities. On average, each supervisor was responsible for approximately 890 case files during FY10 and FY11. During the previous audit report period, management indicated the average responsibility per supervisor was approximately 680 case files. Average statewide caseload per counselor is 222 cases.
- During testing at four local offices, auditors noted there were many cases that did not contain a timely redetermination of need. Of the 40 files tested, auditors noted 17 (43%) did not contain a timely redetermination.
- Auditors noted insufficient controls in the payroll system used for processing personal assistants' payroll. These weaknesses are addressed in findings 11-15.

Department officials stated the discrepancies noted were due to lack of oversight and continuing staff shortages.

**Updated Response:** Partially implemented.

### **Corrective Action Implemented:**

- The Home Services Program (HSP) has completed its pilot testing of a timesheet that includes in & out times. Statewide mailing during October for full implementation in November.
- Twelve (12) submissions received for Request for Information (RFI) regarding electronic means of timekeeping for both individual providers (Personal Assistants) & Homemakers.
- The Request for Proposal (RFP) is in process. All interested parties were required to submit their proposals by 2/14. Current review deadline is March 8, with the system implemented by January 2014.

### **Corrective Action Plan to be Implemented:**

- As HSP moves forward with its technological solution to timesheets, it will clearly document the procedure for review and input of the timesheet.

### **Accepted or Implemented – continued**

**REVIEW: 4391**

- HSP will continue to work to fill vacancies and shift caseloads to bring caseload ratios closer to desired levels.
- Staffing levels continue at a similar stage as managed care rollouts have been delayed and are still ongoing. The final effect of the Managed Care initiative has not yet been determined

**% of CORRECTIVE ACTION COMPLETED = 30%**

**Estimated Date of Completion: 01/31/2014**

**13. Strengthen oversight function related to the union agreements and maintain accountability when they fail to submit required reports on a timely basis.**

**Finding:** The Department did not adequately monitor its two contracts with the union which provides health insurance for personal assistants and home day care providers.

One agreement requires the State to pay \$62 million over the course of 4 years to provide healthcare benefits to eligible personal assistants who work for customers receiving services in the Department's Division of Rehabilitation Services Home Services Program. The following problems were noted during testing of this agreement:

- Under the terms of the agreement, the provider was required to submit an independent audit report of its insurance fund by August 15 of each fiscal year. In FY10 and FY11, the Department received the audit reports 43 and 119 days late, respectively, and did not seek recourse during the period of noncompliance.
- Under the terms of the agreement, the provider was required to submit a copy of the Fund's annual financial report by March 15, 2011. The Department did not receive this report until January 10, 2012, or 301 days late. The Department did not seek recourse during the period of noncompliance.

The other agreement requires the State pay \$82 million over the course of 3 years to provide healthcare benefits to eligible home day care providers. The auditors noted the home day care provider renewal agreement omits requirements the provider submit reports of financial accountability. The original contract required the submission of an independent audit report with supplemental revenue and expense data to enable the State to perform fiscal monitoring and to account for the usage of funds paid to the union. The renewal agreement requires the provider submit only a report of how many individuals are enrolled in the provider health care fund to receive benefits for the upcoming quarter.

Department officials stated the failure to adequately monitor the contracts was due to a lack of oversight.

**Updated Response:** Partially Implemented.

**REVIEW: 4391**

Office of Contract Administration (OCA):

- OCA has worked to ensure that all FY11 Financial Reporting information is submitted in a timely manner.
- SEIU was not required to file and FY10 DHS Financial reporting packet with OCA for the fiscal year FY10 contracting period (they did not meet Financial Reporting selection criteria). SEIU voluntarily submitted their FY10 Audit to OCA on 12/12/11.
- SEIU was selected for FY11 and FY12 DHS Financial Reporting requirements. The FY11 packet was submitted to OCA on 9/28/12 (due to the Providers April fiscal year-end) The FY11 packet is currently under review.
- SEIU's FY12 Financial Reporting packet is currently due to OCA on 8/28/13.

Division of Rehabilitation Services (DRS):

- For the SEIU Training Fund, the Home Services Program (HSP) receives detailed quarterly expenditure information, including individual detail on participants.
- In addition there are regular workgroup meetings on the progress of the training program.
- For the Healthcare Funding negotiations have agreed to change the payment method for FY13 going forward to tie specifically to service provided, meaning enrolled members.
- The latest contract has been developed. The contract should have clearer goals, and more clarity in realigning of responsibilities among the state agencies affected.

Family and Community Services (FCS):

- Contract Amendment form has been completed and has been sent to DHS Legal for review. Once approved the amendment will be sent to SEIU for signature.

**Corrective Action to be Implemented:**

Division of Rehabilitation Services (DRS)

- Contracts with the union will be evaluated to determine the reporting requirements for the contractor and identify the area of the department that has primary responsibility for the monitoring of each specific reporting requirement.

**% of CORRECTIVE ACTION COMPLETED = 90%**

Family and Community Services(FCS)– Bureau of Child Care:

- Attempt to amend the FY13 agreement to include submission of an annual audit report.

**% of CORRECTIVE ACTION COMPLETED = 50%**

Legal and OCA (Grants Recovery)

- Will work with SEIU/appropriate staff to recoup any outstanding amount.

**% CORRECTIVE ACTION COMPLETED = 0%**

**Estimated Date of Completion: 6/30/2013**

**Accepted or Implemented – continued**

**14. Strengthen controls over monitoring unemployment insurance benefits claims to Personal Assistants (PA). The controls should ensure timely review and completion of the BIS-032 forms and the BEN-118R reports and maintenance of adequate supporting files for each claimant. (Repeated-2009)**

**Finding:** The Department's Home Services Program (Program) did not have adequate controls over monitoring unemployment insurance benefits paid by IDES to Personal Assistants (PA) employed by customers of the Program.

Auditors tested a sample of 25 unemployment claimants of the Program during the audit period and noted the following weaknesses:

- Fourteen (56%) claims, for which benefits were paid, did not have the required benefit claim documentation on file at the Department.
- One claim was not protested by the Department although they were aware the claimant was still working as a PA at the time of the claim.

Department personnel are responsible for reviewing the BEN-118R quarterly reports to ensure all claimants reported on the report were entitled to unemployment benefits paid by IDES on behalf of the Department.

Department officials stated a large increase in the work needed by Agency staff to monitor this issue, both from a rise in the number of claims and the requirement to complete work formerly performed by another agency, created a situation where the workload was impossible for the current staffing to manage.

**Updated Response:** Partially Implemented.

**Corrective Action Implemented:**

- A proposal for an electronic tracking system has been drafted.
- Additional support has been shifted to assist with the unemployment claims; the Home Services Program (HSP) Worker's Compensation Coordinator now assists with Unemployment Insurance.
- The independent electronic tracking concept is being retooled to look more into communication with other agency data systems allowing more access to useful information and less time performing clerical re-entry of data.
- The HSP Worker's comp staff continues to receive assistance from the Unemployment Insurance staff.

**Corrective Action to be Implemented:**

- DRS Home Services Program (HSP) is working on creating a system of electronically tracking these claims to allow for more efficient use of staff time.
- A proposal for an electronic tracking system has been drafted. The next step is to review what has been proposed to determine if it is practical to implement and to what extent performance improvement will exceed the effort required to building and maintaining the database.

**% of CORRECTIVE ACTION COMPLETED = 30%**

**Estimated Date of Completion: 12/31/2013**

- 15. Establish formal Department-wide procedures for processing the Personal Assistants (PA) payroll, including procedures for reviewing the accuracy of timesheets prior to entry into the system. Procedures should address monitoring of the payroll process to ensure timesheets are completed properly and a PA is not paid more than permitted. Require supervisory approval to override system warnings associated with service plan overages or more than one timesheet per pay period. Maintain and review the record of override approvals. Perform a reconciliation of PA timesheets to the payroll warrants.**

**Finding:** The Department did not ensure adequate internal controls existed for processing its Rehabilitation Services' Personal Assistants (PA) timesheets within the STARS payroll system. Specifically, auditors noted the following:

- Although procedures existed for entering the PA timesheets into the system, auditors found no formal Department-wide procedures for reviewing the accuracy of timesheets prior to entry into the system existed. Department staff stated each field office used its own review process. However, during testing at four field offices auditors found no formal procedures existed.
- No supervisory approval was required for overriding system warnings associated with service plan overages or more than one timesheet per pay period. Auditors found no record these overrides were maintained or reviewed.
- No reconciliation was performed of the PA warrants to the timesheets. Auditors found no formal procedures existed to ensure a Personal Assistant was not paid more than permitted.

During testing of a sample of 50 PA timesheets to payroll, auditors identified the following exceptions:

- In 1 file tested, it was noted the hours paid to a personal assistant varied from the hours recorded on the timesheet. This resulted in an overpayment of \$728.
- In 13 files tested, auditors noted personal assistant timesheets lacked Department approval prior to payment. Of those, 12 occurred in the Galesburg office.
- In 1 file tested, the Department could not provide timesheets for the personal assistant. Therefore, auditors were unable to test whether the file complied with the Department's policies and procedures.

Department officials stated the growth of the program to its current level, coupled with staff changes have left controls, which were designed for the program when it was much smaller, to be less adequate at its current size.

**Accepted or Implemented – continued**

**Updated Response:** Partially Implemented.

**Corrective Action Implemented:**

- Process for the new timesheet was worked out in the pilot, which covered 5 offices & 15% of the caseload. Full state implementation has begun and should be in place by the middle of November.
- Analysis of timesheets that appeared to exceed cost maximums find that the great majority fall within the rules but are not accounted for by the data system. They are temporary increases as approved by the data system. They are temporary increases as approved by rule within the annual SCM & respite cases.
- The new PA timesheet has been implemented and all staffs have been re-trained in its use.
- The Request for Proposal (RFP) is in process. All interested parties were required to submit their proposals by 2/14. Current review deadline is March 8, with the system implemented by January 2014.

**Corrective Action to be Implemented:**

- Formalize the process of reviewing and entering a PA Timesheet for the new timesheet as well as the original version.
- Trainings for field staff will accompany implementation. Process for the new timesheet was worked out in the pilot, which covered 5 offices & 15% of the caseload. Full state implementation has begun and should be in place by the middle of November. Trainings for field staff will accompany implementation.
- Work on a system to address the concerns regarding reconciliation of the timesheet past the entry of the authorization to the gross payroll amount.
- Fully addressing the issue will take place with the planned electronic timekeeping system.

**% of CORRECTIVE ACTION COMPLETED = 50%**

**Estimated Date of Completion: 12/31/2013**

**16. Comply with laws and provisions regarding Medicare and Medicaid certification at the Tinley Park Mental Health Center. (Repeated-2007)**

**Finding:** One of the Department's facilities, Tinley Park Mental Health Center (Tinley), continued to remain decertified during FY11 due to failure to comply with requirements to be certified as an eligible Medicare or Medicaid service provider.

Department personnel stated a new application had been prepared to begin the certification process. Before the application process was complete, it was announced Tinley would close with a tentative closure date of July 2012. After the closure was announced, the Department did not move forward with the application for certification.

## REVIEW: 4391

As of June 30, 2011, Tinley did not maintain housing for any Medicare/Medicaid patients. Therefore, the Department stated there was no revenue lost as a result of the decertification during fiscal year 2011.

**Updated Response:** Implemented. Tinley Park closed. The Facility will not pursue re-certification due to scheduled closure on 7/3/2012.

### 17. Comply with various statutory requirements as follows:

- ensure all employees authorized to employ restraints receive the required annual training;
- file notifications of death with the Department of Public Health in a timely manner;
- document the resident's evaluation at the facilities by properly completing all forms and recording all evaluations;
- assess residents' subsistence needs before releasing them from the facility;
- complete a Notice of Admissions Form for each new resident and notify the designated person of the resident's admission to the facility;
- establish a rate structure for services provided at the Rushville Treatment and Detention Facility;
- maintain documentation of the female residents' menstrual cycle and their consent or denial to pregnancy tests;
- ask residents whether they would like anyone to be notified of their admittance;
- ensure written reports on evaluations are prepared timely; notify victims at least 60 days prior to the release of sexually violent residents; and,
- perform a comprehensive social investigation within 72 hours of a resident's admittance.

**Finding:** The Department's facilities did not comply with various statutory requirements. During testing, auditors noted the following:

- At 3 of 21 facilities, auditors noted instances in which employees did not receive annual training in the safe and humane application of restraints to prevent a recipient from causing physical harm to himself or others.

Facility personnel stated the failure to ensure personnel received required training was due to oversight. Facility personnel also stated the inability to resolve scheduling conflicts contributed to the noted deficiencies. Personnel at another facility stated the training deficiency is caused by a lack of staffing since the facility is required to maintain a certain level of staff on the units at all times.

- At Ann M. Kiley Developmental Center, auditors noted the following:

**Accepted or Implemented – continued**

- In all 25 restraint applications tested, the facility director did not review the restraint orders and inquire the reasons for the use of restraint.
- In 3 of 25 restraint applications tested, the application was not submitted in writing to the facility director, or designee, within 24 hours of application.

Facility personnel stated the Department's policy allows the facility director to designate a designee to perform the facility director's statutorily mandated duties. Facility personnel stated the facility director did review restraint orders on a daily basis although the assistant facility director completed the review documentation. Auditors noted the Code does not state the facility director may subordinate these duties.

- The facility did not properly prepare the Notice Regarding Restriction of Rights of an Individual. Auditors noted 12 of 25 notices sent from the facility to the resident's guardian were not accurate with regards to the time the individual was initially restrained.
- At 3 of 21 facilities, auditors noted the facilities either submitted late or submitted incomplete resident death notifications to the Department of Public Health. Facility personnel stated human error contributed to the noted deficiencies.
- At 4 of 21 facilities, auditors noted weaknesses in the documentation of a resident's evaluation.

Facility management stated the monthly reviews were completed as required, but the forms could not be located. Management at another facility stated the failure to properly complete the forms was due to oversight. Management at another facility stated the lack of evaluations was due to a misinterpretation of the Code, or more specifically, which conditions constituted mental retardation.

- At the Clyde L. Choate Mental Health and Developmental Center, auditors noted the Center does not consistently and expressly document the results of its pre-discharge assessments for the subsistent needs for residents. The following weaknesses were noted:
  - 4 of 5 recipient files tested did not specifically address all of the elements specified in the Mental Health and Developmental Disabilities Act (Act) in the pre-discharge notes.
  - 5 of 5 recipient files tested did not include documentation the Social Security Administration had been notified of the recipient's discharge and new address. Additionally, the recipient files in these cases did not include a copy of communication between the Center and Medicaid to notify Medicaid of the recipient's discharge.

## REVIEW: 4391

- 5 of 5 recipient files tested did not contain any documentation of conclusions made by the Center's chief administrative officer or any resultant actions taken as a result of the pre-discharge assessments.

Management at the Center stated these problems were caused by staffing shortages, which led to oversights in this area. The information is often contained within the files of the Resource Unit, but retrieving this data is difficult because the Unit has lost half of its staffing in the past year.

- At Tinley Park Mental Health Center, auditors noted 17 of 25 (68%) of resident files tested did not contain evidence the facility notified a designated person of the resident's admission. Fourteen of those files did not contain a Notice of Admission form, while the other three did not list the name of the person contacted or the means by which they were notified.

Center management stated the facility has been training staff on the proper completion of resident files for over a year; however, some staff members have struggled to ensure proper completion of all aspects of resident files. As a result, the facility has begun to perform internal self reviews in this area.

- At Rushville Treatment and Detention Facility, auditors noted the facility has not formally documented a policy on charging residents for services and a corresponding rate structure. Under the existing conditions, a resident may have access to assets to pay for services the facility provides, but the resident would not be required to pay without a documented policy in place.
- At 3 of 21 facilities tested, auditors noted facilities were not maintaining adequate records of the female residents' menstrual record. Additionally, 2 of 21 facilities tested, the facilities did not maintain adequate documentation regarding the consent or denial of the recipient to a pregnancy test.
- At Andrew McFarland Mental Health Center, auditors noted 4 of 25 notices of restricted communication reviewed did not indicate whether the recipient wished anyone to be notified of the restricted communication.

Center management stated the majority of the instances occurred prior to the updated form being implemented which has increased compliance with the requirement to almost 100%.

- At Rushville Treatment and Detention Facility, auditors noted 4 of 25 Medical Condition Reports tested were not completed within 30 days of their examination date. The reports ranged from 2 to 30 days late.

Facility personnel stated reports were not completed in a timely manner due to staffing shortages.

**Accepted or Implemented – continued**

## REVIEW: 4391

- At Rushville Treatment and Detention Facility, auditors noted the facility did not notify 4 of 4 victims of residents being released at least 60 days prior to the resident's release.
- At Clyde L. Choate Mental Health and Developmental Center, auditors noted 2 of 5 residents tested did not have a comprehensive social investigation performed within 72 hours of admittance. The investigations were performed 1 and 2 days late.
- At Clyde L. Choate Mental Health and Developmental Center, 2 of 5 resident treatment plans tested were not updated every 30 days. The plans were updated 5 and 6 days late.

Facility management stated this oversight was due to staff shortages in the social work and case management departments.

**Updated Response:** Partially Implemented.

### Alton MHC:

- Facility supervisors will be reminded to ensure that all employees authorized to employ restraints receive annual training. Supporting documentation includes an annual training roster revealing that all direct care staff have been trained. 100% compliance as of 10/4/12.

### Chester MHC:

- The facility has incorporated two additional accountability check points to monitor and ensure that these reports are completed and filed in a timely manner.
  - A monthly check off is completed by the Qualified Mental Retardation Professional (QMRP) Secretary. Supporting document consists of the QMRP secretary check off list. 100% compliance as of 5/7/12.
  - The Hospital Administrator will conduct a check off to ensure compliance. Supporting documentation consists of the Hospital Administrator check off list. 100% compliance as of 5/7/12.

### Singer MHC:

- This Mental Health Center is no longer in operation.

### Tinley Park MHC:

- This Mental Health Center is no longer in operation.

### Choate MHC:

- The Discharge Summary policy has been revised to include the completion of the Life Management Assessment/Post Plan document by the Social Worker/Case Manager which will be provided to the patient at the time of discharge. Supporting documentation includes the revised Post Discharge Plan. 100% compliance as of 2/10/12.
- A policy relating to funding assessment and procedures

## REVIEW: 4391

to provide guidance and details of the required assessment and application steps, as well as time frames, documentation, and tracking requirements will be developed. 100% compliance as of 2/10/12.

- All Social Workers/Case Managers will be retrained. Supporting documentation includes a completed training program attendance form. 100% compliance as of 2/10/12
- The facility did not timely complete the social investigations as required by the Mental Health and Disabilities Code.
- Update facility policy to match State Statute's timeline of completion of social investigation within 72 hours of admission. Supporting documentation includes the updated policy. 100% compliance as of 9/14/11.
- Social Work staff will be trained on the updated Social Investigation policy. 100% compliance as of 12/2/11.
- The facility did not timely update recipients' treatment plans.
- Team leader (SW III) will develop a monthly calendar of review dates to be shared with all team members. 100% compliance as of 12/1/11.
- Implement a formal plan for covering staff on days off and/or absence of physicians in order to ensure reviews are timely. Supporting documentation includes a memo from the Medical Director regarding the coverage plan. 100% compliance as of 5/15/12.

### Elgin MHC:

- The Hospital developed and implemented a policy, Reporting Patients with Mental Retardation (MR) diagnosis, to ensure immediate involvement of the Qualified Mental Retardation Professional (QMRP) in the assessment and care of any patient with suspected MR diagnosis and that all reporting requirements are met. Supporting documentation includes a copy of the policy and a completed MI/MR report. 100% compliance as of 10/14/11.
- The policy change summary was sent to all staff to alert them of the change along with a copy of the Follow-Up Audit Response. 100% compliance as of 11/7/11.
- Reporting to Central Office began 11/9/11. 100% compliance as of 11/9/11.
- A section was added to the Quality Council monthly report on 5/8/12 to ensure that the system is functioning correctly. 100% compliance as of 11/9/11.

### McFarland MHC:

- The facility did not properly complete the notice regarding restricted rights of individuals.
- Record review audits of the Notice Regarding Restriction of Rights form were conducted on 9/11, 1/12, and 2/12 with the final audit producing a result of 100% compliance. 100% compliance as of 3/1/12.
- Clinical Nurse Managers were retrained on proper form completion and continue to monitor the form to ensure accuracy. 100% compliance as of 10/31/11.
- The facility did not properly complete the habilitation/service determination form.
- The Quality Manager will audit MI/MR assessments to ensure the AMcF/CR-34A is completed correctly. 100% compliance as of 1/10/12.

### **Accepted or Implemented – continued**

## REVIEW: 4391

- The facility did not maintain adequate documentation of the menstruation cycle of female patients.
- A memo will be issued by the director of nursing to remind staff to document menstrual cycles for female with a stay of 60 days or longer. Memo not completed, but message was relayed verbally. 100% compliance.
- Monthly random medical record audits will be conducted to ensure documentation compliance. 100% compliance as of 3/30/12.

### Treatment and Detention Facility:

- The facility did not ensure residents were examined timely as required by the Sexually Violent Persons Commitment Act.
- TDF will request that an additional SVP Evaluator position be added in FY13. An SVP Evaluator was approved for 7/1/12 and started on 8/1/12. Supporting documentation consists of the Contract Approval Request form, Personal Service Contract PAR entry form, and Personal Services Contract Classification Review form. 100% compliance as of 8/1/12.
- TDF will establish a monitoring process to ensure compliance. Supporting documentation consists of the Facility Review Report. 100% compliance as of 5/12/12.

### **Corrective Action to be Implemented:**

#### Division of Developmental Disabilities (DDD):

Meetings have been held with the State Operated Developmental Centers (SODCs) to:

- Review findings in depth and enforce strict compliance with all applicable procedures and requirements;
- Develop strategies to fill vacant positions necessary to ensure consistent compliance.

**% of CORRECTIVE ACTION COMPLETED = 80%**

#### Division of Mental Health (DMH):

Follow up will be conducted to ensure each Mental Health Center (MHC) is working on a corrective action plan that will resolve the issues mentioned in the finding:

- The DMH Director will review each DMH hospital/facilities Corrective Action Plan (CAP) for resolving the issue(s), making sure the CAP(s) are appropriate.
- The DMH Director will monitor CAP(s) to ensure progress is being made through completion and successful in correcting the issue(s) identified. 61% complete, 11 out of 18 completed.

**% of CORRECTIVE ACTION COMPLETED = 75%**

## REVIEW: 4391

Treatment and Detention Facility: The facility did not have a policy and rate structure in place for charging services to residents:

- The Department has prepared preliminary language to be added to the SVP Administrative Rule which is currently being reviewed by the Office of Legal Council. A second draft of the reimbursement language has been completed and is pending review by DHS Fiscal and Reimbursement Departments. **80%** complete with an estimated date of completion is 4/1/13.
- The rate structure has been established and is pending review by DHS Fiscal and Reimbursement Departments. **60%** complete with an estimated date of completion of 5/1/13.
- TDF modified the Program Directive to reflect the change in the Sexually Violent Persons Act to ensure victim notification. The Program Directive is being further modified to reflect a newly implemented automated victim notification program. **75%** complete with an estimated date of completion of 5/1/13.
- Finalize the language to the Administrative Rule concerning charging residents for services including the addition of the rate structure. **0%** compliance with an estimated completion date of 6/1/13.
- Begin the process of promulgating an Administrative Rule through the Joint Commission on Administrative Rules. **0%** compliance with an estimated completion date of 6/1/13.
- Upon adoption of the Rule, begin the process of seeking reimbursement. Notify the residents of the change via memo. **0%** compliance with an estimated completion date of 7/1/13.

**% of CORRECTIVE ACTION COMPLETED = 80%**

**Estimated Date of Completion: 7/01/2013**

**18. Review and revise, as necessary, the current system of reconciling grant payments to program expenditures to improve the timeliness of reconciliations and to devote necessary personnel to these tasks. Also, establish specific deadlines in which the Office of Contract Administration (OCA) is required to notify providers to return unspent funds.**

**Finding:** The Department's Office of Contract Administration (OCA) failed to reconcile grant funds and to seek recovery of unspent funds in a timely manner.

Auditors tested a sample of 120 providers that received State grants in either FY09 or FY10 and noted for 18 of 120 (15%) providers tested, OCA did not seek timely recovery of funds totaling \$4.1 million that were not expended or legally obligated during the grant period. Auditors noted all of these providers had their audit reports submitted to OCA during the Department's current audit period, but OCA had yet to seek recovery of lapse funds.

**REVIEW: 4391**

**Accepted or Implemented – continued**

In 2 of 120 providers tested, auditors noted the Department had not begun the reconciliation process for the provider's grants. The provider had submitted their grant report to OCA on a timely basis, but several months had elapsed since their submission and OCA had not yet entered the expenditure data into the software that performs the reconciliation.

Department officials stated the reconciliation and recovery of grant funds were not done in a timely manner due to lack of staff in that area.

**Updated Response:** Partially Implemented.

**Corrective Action Plan Implemented:**

- Additional staffing request for the Office of Contract Administration (OCA) Grants Recovery Section have been sent to the DHS-Budget Office and are awaiting approval to begin the process.

**Corrective Action to be Implemented:**

- The Office of Contract Administration (OCA) started the EPAR process on April 30, 2012 to hire three additional staff in the OCA Grants Recovery Section. The additional staff will ensure timely reconciliation and recovery of grant funds.

**% of CORRECTIVE ACTION COMPLETED = 10%**

**Estimated Date of Completion: 12/31/2013**

**19. Determine the availability of funds for expenditure or return the funds after proper consultation with the respective grantor. (Repeated-2007)**

**Finding:** During testing of the Department FY11 annual Office of the Comptroller financial reporting (GAAP) forms for various funds, 13 concluded programs were identified with unspent grant funds of which the Department had not determined the final disposition. Several programs were noted that had concluded in previous years with balances in the deferred revenue and unearned deferred revenue accounts that would indicate unspent balances due to grantor agencies. Some of the specific programs with unspent grant funds noted were as follows:

- The Policy Research and Evaluation Grants reported deferred revenue totaling \$360,000. The grant period ended in fiscal year 2002, with the last receipt coming in June 2002.
- Social Services Research and Demonstration reported deferred revenue totaling \$142,000. The grant period ended in fiscal year 2005, with the last receipt coming in July 2005.
- AmeriCorps program reported deferred revenue totaling \$79,000. The grant period ended in fiscal year 2005, with the last receipt coming in February 2003.

## REVIEW: 4391

- The Ten State Performance Indicator Pilot Project Program (reported deferred revenue totaling \$72,000). The grant period ended in fiscal year 2005, with the last receipt coming in May 2005.
- The Cooperative Agreements for State-Based Diabetes Control Program and Evaluation of Surveillance Systems Program reported deferred revenue totaling \$153,000. The grant period began in fiscal year 1999 and is currently still active, but had no activity during the audit period.
- The Abstinence Education Program reported deferred revenue totaling \$1,033,000. The grant period ended in fiscal year 2004 with the last receipt coming in fiscal year 2010.
- The Enforcing Underage Drinking Laws Program (CFDA No. 16.727) reported deferred revenue totaling \$146,000. The grant period ended in fiscal year 2008, with the last receipt coming in January 2006.

Department officials stated the final disposition was not determined timely due to staffing shortages; however, the Department is continuing to review and reconcile the funds.

**Updated Response:** Partially Implemented.

### **Corrective Action to be Implemented:**

- Fiscal Services has started reviewing for expenditures misapplied to wrong grant.

### **Corrective Action to be Implemented:**

- An extensive analysis was completed in order to determine the correct accounting treatment required to properly reclassify these balances. However, many of the deferred revenue balances were existent prior to the formation of DHS and accounting record no longer exists.
- The balances pre-DHS, or where there are no records existent should be written-off to fund balance as there are no other options.

**% of CORRECTIVE ACTION COMPLETED = 20%**

**Estimated Date of Completion: 10/30/2013**

**20. Ensure all interagency agreements are approved by all parties prior to the effective date of the agreement. Also, update the agreement for the use of Lincoln Developmental Center and seek reimbursement of \$682 for work for another agency.**

**Finding:** Weaknesses were identified in the Department's process of monitoring interagency agreements. During testing of the interagency agreements between the Department and multiple other State departments, the following deficiencies were noted:

- 4 of 12 interagency agreements tested were not signed by all necessary parties before the effective date. The agreements were signed 34 to 293 days late.

**Accepted or Implemented – continued**

- Auditors noted an interagency agreement pertaining to the utilization of Lincoln Developmental Center between the Department of Human Services and the Illinois State Police expired May 13, 2010. As of January 13, 2012, the Illinois State Police was still utilizing the space at the Lincoln Developmental Center with no updated agreement between ISP, DHS or CMS, which is currently responsible for the upkeep of the Lincoln Developmental Center.
- The Department entered into an agreement with another agency in which an employee would split his work hours between the two agencies, and the Department would request reimbursement for the hours the employee worked at the other Agency. The Department did not seek reimbursement for two days that the employee worked for the other agency, totaling \$682.

Department officials stated the discrepancies were caused by lack of staff oversight and an interagency agreement pertaining to the utilization of Lincoln Developmental Center between the Department of Human Services and the Illinois State Police which expired May 13, 2010.

**Updated Response:** Accepted.

**Corrective Action Plan to be implemented:**

- DHS Office of General Counsel (DHS LEGAL) will develop an Administrative Directive and Template to ensure all Department programs follow a uniform process when developing and executing an IGA.
- DHS is working with the Central Management Services (CMS) Legal on the Quit Claim Deed.

**% of CORRECTIVE ACTION COMPLETED = 60%**

**Estimated Date of Completion: 6/30/2013**

**21. Strengthen controls over the processing of receipts and include the timely deposit of receipts as well as timely entry to CARS. Add controls to ensure timely completion and submission of reconciliations as well as the clearance of reconciling items. (Repeated-2001)**

**Finding:** The Department lacked an adequate receipt reconciliation process and did not timely deposit all receipts. The following exceptions were identified related to the Department's receipts reconciliation process:

- During receipt reconciliation testing, four funds were found to have reconciling items which were not resolved within 60 days after identification. Clearance of the reconciling items ranged from 78 to 428 days.

## REVIEW: 4391

- The Department did not reconcile its receipt records to Comptroller records on a monthly basis. In 41 of 156 revenue source codes tested, the reconciliation was not completed until 35 to 191 days following the end of the month. In 4 of the 156 revenue source codes tested, the reconciliation report was not completed during the fiscal year.

The following exceptions were identified related to the Department's receipts process:

- Seventeen of 60 nonfederal receipts tested totaling \$26,839, were not deposited timely ranging between 1 to 67 days late.
- In 54 of 235 resident receipts tested, auditors noted the receipts were not entered into the Department's primary accounting system in a timely manner, ranging from 1 and 67 days late.
- In 16 of 60 nonfederal receipts totaling \$25,305, drafts received from the Treasurer's clearing account were not submitted to the Comptroller within 5 days. The drafts were submitted between 6 and 151 business days beyond this time frame.

The following exceptions were identified related to the Department's refunds process:

- In 12 of 60 refunds requested for testing totaling \$16,631, the files were not provided.
- In 35 of 60 refunds tested totaling \$16,908, the refund was not deposited as required, ranging between 2 to 187 days late.

Similar weaknesses were noted at Clyde L. Choate Mental Health and Developmental Center. As a result of testing the Center's receipts records for FY11, auditors concluded the Center did not timely deposit receipts and refund transactions. Auditors noted the following specific problems:

- No receipts were recorded in the Center's ledger between October 28, 2010 and February 28, 2011. On March 1, 2011, the facility recorded 19 receipts totaling \$9,174. Some of those transactions were for rents dating as far back as November and December 2010, which were received from lessees on the Center campus.
- No receipts were recorded in the Center's ledger between the dates of April 13, 2011 and June 19, 2011. On June 20, 2011, the facility recorded 20 receipts totaling \$4,244. Some of those transactions were for rents dating as far back as September and October 2010 and January 2011, which were received from a lessee on the Center campus.

Department management stated the problems are the result of being understaffed; therefore, they are unable to prepare reconciliations and process receipts in a timely manner.

**Accepted or Implemented – continued**

**Updated Response:** Accepted and partially implemented.

**Corrective Action Implemented:**

- A new deposit extension of time required to deposit checks has been increased from 15 days to 30 days as a result of staffing shortages.
- Fiscal Services has hired an additional staff to complete monthly receipt reconciliation. As of 3/22/13, receipt reconciliations are partially completed. By 6/30/13, DHS will be current on performing reconciliations.

**Corrective Action to be Completed:**

- Clearly assign responsibility of reconciling the receipt accounts and the posting of adjusting entries to newly hired staff in Agency Accounting by using a newly hired, PSA 8C.

**% of CORRECTIVE ACTION COMPLETED = 60%**

**Estimated Date of Completion: 6/30/2013**

**22. Comply with established policies and procedures to ensure accounts receivable are reported in accordance with Department directives. Additionally, maintain detailed records of all billings and the corresponding collections to facilitate proper reporting of accounts receivable activity. Consider writing off delinquent or uncollectible accounts to reflect only realizable amounts. Finally, allocate sufficient staff and fill pertinent positions in order to ensure job duties are performed as required so that accounts receivable transactions are processed and accounts are properly maintained. (Repeated-2007)**

**Finding:** The Department's mental health and developmental disability centers (facilities) failed to exercise adequate controls over accounts receivable. The facilities did not make timely determinations of residents' ability to pay non-Medicare and non-Medicaid charges and did not follow-up on outstanding accounts receivable in a timely manner.

During the audit period, four facilities did not timely complete the "Notice of Determination" (Form DHS-612) which is used to notify residents or their responsible parties of charges. Resident financial case records supporting receivables in the billing system were noted as being incomplete. Complete case records are required to investigate every individual or entity that may have an obligation or responsibility for the payment of services rendered to a resident. In addition, facility resource staff did not follow Department procedures to monitor and report delinquent accounts receivable.

- Facility staff failed to complete a Notice of Determination as required for 32 of 105 files tested at seven facilities. There were many instances where the form was not completed at all.

## REVIEW: 4391

- Resident financial case records did not have documentation to support the determination of the resident's ability to pay for 59 of 141 files tested at seven facilities.
- Four facilities did not have "Delinquency Notice" forms on file supporting the facilities' follow-up on accounts receivable for 20 of 60 files tested. These receivables totaled \$494,206.
- At four facilities, 35 of 75 accounts receivables tested, totaling \$661,406, were outstanding for over 180 days and were not submitted timely to the Central Office for collection. In addition, for 15 of 60 accounts tested, totaling \$467,781, the facilities did not coordinate collection efforts with the Department's Central Office in order to ensure outstanding account balances are pursued in accordance with Department policies and procedures.
- Tinley Park Mental Health Center admitted and treated Medicare eligible patients while decertified and unable to seek payment for services under the Medicare program. Auditors identified 9 patients, with accounts totaling \$63,443 on the facility's accounts receivable reports that were admitted during the decertification period and incurred charges reimbursable by Medicare.
- The Illinois School for the Deaf did not complete and submit a Form C-97, the Quarterly Summary of Accounts Receivable, to the Illinois Office of the Comptroller for the Hansen-Therkelsen Memorial Deaf Student College Fund. Accounts receivable balances totaled \$97,841 and \$95,034 at June 30, 2010 and June 30, 2011, respectively.

Auditors noted multiple instances of inadequate supporting documentation for account balances for facility residents.

- At Clyde L. Choate Mental Health and Developmental Center, auditors noted 6 of 15 resident files tested had account balances that did not agree with supporting documentation and 2 of 15 files did not contain supporting documentation.
- At H. Douglas Singer Mental Health Center, 13 of 15 resident files tested, with a total receivable balance of \$766,652, did not contain documentation detailing financial background was properly investigated.
- At Elgin Mental Health Center, 14 of 15 accounts tested lacked accurate supporting documentation; therefore, auditors were not able to determine the accuracy of account balances.

Auditors noted for certain facilities the Resident Resource Unit (RRU) was unable to provide procedures used in order to determine admitted resident's ability to pay for services, identify responsible parties such as parents or guardians, and properly determine whether the patient has private insurance or is eligible for Medicare and Medicaid.

## REVIEW: 4391

### Accepted or Implemented – continued

- The Reimbursement Officer Position at the Jack Mabley Developmental Center was vacant effective July 9, 2010. As a result, the daily duties required to properly update and maintain the resident accounts receivable were not performed as required. Due to the Facility not properly maintaining the accounts receivable system, auditors were unable to determine whether amounts detailed on the accounts receivable aging report are correct and whether accounts over 180 days delinquent are properly pursued. In addition, auditors noted mail correspondence containing time sensitive patient account information is not opened in a timely manner and patient accounts are not updated accordingly.
- At two (Mabley and Ludeman) of 21 facilities, auditors noted errors on aged analysis of accounts receivable reports.

Issues were also identified with the processing of Medicare claims at two Centers. Mabley Developmental Center did not bill Medicare as required. According to Department officials, no Medicare slips have been processed since July 2010. Additionally, one of 15 accounts tested at Elgin Mental Health Center was billed to a resident that was eligible for Medicare. The Facility was unable to provide documentation that Medicare was properly billed.

Issues with receivables were also noted in testing at the Central Office:

- In 2 of 120 files tested, auditors noted a significant lapse in time since the Department attempted to contact the indebted party for collection of an aged receivable.
- In 2 of 120 files tested, the bankruptcy filing was not recorded in a timely manner. For one account tested, the Central Office did not ensure the outstanding account balance was pursued in accordance with Department policies and procedures.

The Department reported gross resident accounts receivable (excluding Medicare and Medicaid) at facilities totaling \$21.477 million and \$18.977 million for the years ending June 30, 2011 and 2010, respectively. The related uncollectible allowances were \$18.255 million and \$16.130 million, respectively. Also, the total revenue from hospitalization insurance covering individuals for 2011 and 2010 totaled \$16.574 million and \$16.911 million, respectively.

Ludeman personnel stated the inaccurate accounts receivable balance noted was due to a computer error which is now being corrected. Mabley personnel stated the deficiencies noted were due to the fact that the facility has been unable to fill the Reimbursement Officer position since July 9, 2010. Illinois School for the Deaf personnel stated they were not aware loans receivable should be included in the C-97 reporting forms. Kiley personnel stated the reason for their accounts receivable deficiencies were due to not timely following-up on the adjustments. Choate, Elgin, Singer, Chicago Read, Madden and Tinley personnel stated the deficiencies resulted from staffing shortages and oversight.

**Updated Response:** Partially Implemented.

## REVIEW: 4391

### **Corrective Action Implemented:**

#### Bureau of Collections:

- The accounts were put in administrative suspension and closed due to bankruptcy.

#### Elgin MHC:

- Elgin Mental Health Center has made patient financial interviews a part of the process. Supporting documentation consists of three copies of processed patient interviews indicating same day completion and meeting notes indicating patient financial interviews are part of the intake process. 100% compliance as of 7/1/12

#### Mabley DD:

- The Facility coordinated with Central Office to provide support and training to correct accounts receivables.
- The Facility is now monitoring accounts receivables to ensure all actions are completed timely. 100% compliance as of 10/9/12

### **Corrective Action to be Completed:**

- The Division of Developmental Disabilities Centers and DHS Schools have enhanced its procedures to ensure accounts receivable are reported in accordance with Department directives. Additionally, the Department will maintain detailed records of all billings and the corresponding collections to facilitate proper reporting of accounts receivable activity. The Center will also review its accounts for delinquent or uncollectible accounts.

#### Elgin MHC:

- The facility will refine current processing to improve outcomes on Notice of Determination completions. Nursing and Social Workers are completing the patient financial interview to free up PRU staff time to help with the overall processing. Supporting documentation consists of copies of Form 681 (Proceed with Collections) and Form 682 (Write Offs). 80% compliance with a 6/30/13 estimated date of completion.
- After 90 days the facility will follow up on uncollectable receivables. The facility continues to process all patient billing within the proper timeframes and collection problem forms are completed in a timely manner. Supporting documentation consists of a copy of an e-mail to Central Office indicating follow up with facility uncollectable amounts and Comptroller involuntary withholding system for RE2 and copies of Form 628 (Uncollectable) and Form 681 (Collection Problems). 75% compliance with a 6/30/13 estimated date of completion.
- PCG is being included in the processing and documentation of patient billing files. Supporting documentation consists of notification to PCG regarding the status of medical patients as well as correspondence with PCG on the billing information of patient accounts. 50% compliance.

**% of CORRECTIVE ACTION COMPLETED = 60%**

**Estimated Date of Completion: 6/30/2013**

**Accepted or Implemented – continued**

**23. Remind facility staff of the requirements set forth in law, the SAMS Manual and Department policies and procedures related to the operation and maintenance of the locally held funds. (Repeated-2009)**

**Finding:** The Department's Central Office and mental health and developmental disability facilities inadequately administered locally held funds (bank accounts) during the audit period. Auditors noted exceptions regarding the administration, accounting, reconciliation, reporting, receipt and disbursement of these funds at the Central Office and the facilities. Some of the weaknesses noted were as follows:

- Six of 21 facilities tested did not properly perform monthly reconciliations of their locally held funds. Exceptions included: reconciliations not being performed timely or at all, reconciliations not signed off as being reviewed, lack of segregation in preparation of reconciliations and mathematical inaccuracies.
- Exceptions were identified in testing locally held fund disbursements at 4 of 21 facilities. Auditors noted a variety of errors at these facilities, including: posting the wrong check number, incorrectly fixing an error, and not posting disbursement timely. In addition, disbursements did not always trace from the bank statement to the system ledger and from the system ledger to the bank statement.
- Five of 21 (24%) facilities did not properly record locally held fund receipts. Exceptions included: receipts did not trace from the bank statement to the system ledger, receipts lacked supporting documentation, the dates recorded on the general ledger did not agree with the computerized accounting system dates and cash receipts were not deposited timely.

Department officials stated a lack of oversight by the fund reconciliation staff and late receipt of a bank statement contributed to the discrepancies noted.

**Updated Response:** Accepted.

**Corrective Action Implemented:**

- Fiscal Services has distributed the Illinois Office of the Comptroller (IOC) requirements to Locally Held Fund custodians.
- Division of Developmental Disabilities (DD) staff at Central Office has followed up with each facility regarding the status of corrective actions. DD held meetings with State Operated Developmental Centers (SODCs) to review findings in depth enforce strict compliance with all applicable procedures and requirements; and develop strategies to fill vacant positions necessary to ensure consistent compliance.

**Chicago-Read DC:**

- Facility ensures separation of duties by rotating staff to perform the duties of receiving, recording and depositing locally held Funds. Supporting documentation consists of form 4144 for Access to the Trust Fund System.
- Business Administrator signs all monthly reconciliations. Monthly audits will be performed until 100% compliance is reached for three consecutive months.

## REVIEW: 4391

- Receipts and disbursements must be entered into Moby's within one week. Audits will be performed until 100% compliance is reached for three consecutive months. 100% compliance as of 8/1/12.
- Excel tracking system for all locally held funds will be developed and used to balance receipts and disbursements for reconciling C-17's for all locally held funds. 100% compliance as of 8/1/12.
- C-17's will be audited to accuracy against the general ledger using Excel tracking logs and Moby's reports. Audits will be performed until 100% compliance is reached for three consecutive months. 100% compliance as of 8/1/12.
- All cash drawers will be audited for accuracy. Audits will be performed until 100% compliance is reached for three consecutive months. 100% compliance as of 7/31/12.

### Elgin MHC:

- Monthly audits are conducted to ensure the accuracy of the number of petty cash fund transactions and the actual disbursed funds. Supporting documentation consists of copies of recent audits for the General Revenue Petty Cash Fund, the Trust Fund Imprest Cash Box and the Rehabilitation Workshop Program Imprest Fund Audit. 100% compliance as of 10/1/12.
- Develop a spreadsheet that will simplify the oversight process. Supporting documentation consists of a copy of calendar year 2012 Annual Petty Cash Fund Usage Report. 100% compliance as of 2/25/13.
- Train all staff to ensure consistency of the process. 100% compliance as of 7/1/12.

### McFarland MHC:

- Bank checks to reimburse the cash box will be made out to the custodian, not the designee. Supporting documentation consists of copies of checks made out to the custodian. 100% compliance as of 10/6/11.

### **Corrective Action to be Completed:**

#### Chicago-Read MHC:

- Funds will not be co-mingled. Expedited payment requests will be made more frequently to the Comptroller's office requesting Trust Fund monies. Receipt of checks from Central Office for deposit into locally held funds will be monitored until 100% compliance is reached.

**% of CORRECTIVE ACTION COMPLETED = 90%**

**Estimated Date of Completion: 6/30/2013**

**24. Devote adequate resources and follow established policies to ensure invoice vouchers are processed, approved and paid in a timely manner to limit interest penalties.**

**Finding:** The Department did not maintain adequate controls over the processing, approval and payment of vouchers as required by the Illinois Administrative Code and Department policy. As a result of testing random samples of invoice vouchers processed

## REVIEW: 4391

### Accepted or Implemented – continued

at the Central Office during the engagement period, some of the exceptions auditors noted were as follows:

- Thirty-two of 328 invoice vouchers totaling \$4,415,328 did not include adequate supporting documentation. For thirty-one of the vouchers, auditors were not provided supporting vendor invoices. For one voucher, auditors were provided an email and screenprints from the accounting system. However, a vendor invoice was not provided.
- Four of 180 invoice vouchers totaling \$180,080 were not approved within 30 days after receipt of the vendor invoice. The vouchers were approved for payment from 19 to 92 days late.
- Two of 120 invoice vouchers totaling \$103,120 contained errors during processing. One invoice voucher showed an approval date in the accounting system three months before the vendor invoice was received. The other invoice voucher was supported by a vendor invoice marked as paid the day before the invoice voucher was marked as approved for payment.

In addition to testing invoice vouchers processed at the Central Office, auditors also tested invoice vouchers processed at Department facilities during the engagement period noting the following exceptions:

- Eight of 123 contractual services invoice vouchers tested totaling \$145,419 did not remit required prompt payment interest to vendors which totaled \$3,272.
- Thirteen of 123 contractual services invoice vouchers totaling \$230,204 were not approved within 30 days after receipt of the vendor invoice. The vouchers were approved for payment from 2 to 180 days late. Additionally, seven of 123 invoice vouchers totaling \$69,080 did not contain a date stamp indicating the date the invoice was received. Auditors were unable to determine if these vouchers were approved timely.

Department officials stated a lack of staff oversight, staff shortages and staffing changes in the payroll division at Chester Mental Health Center contributed to the deficiencies noted.

**Updated Response:** Implemented.

#### **Corrective Action Implemented:**

- The interest penalty calculation has been automated which will eliminate the manual process and the potential for errors that caused the interest to be overlooked.
- Receivables have been established and are currently recouping the overpayments.
- The receivables have also been recorded in the Consolidated Accounting and Reporting System (CARS).
- Reminders will be sent and training will be enhanced to all Fiscal employees that they are not to accept e-mails or screen prints and not to process any vouchers that do not contain the proper documentation.
- Reminders will be sent and training will be enhanced to all Fiscal employees that they are to take extra care to process documents as soon as possible after receipt.

**REVIEW: 4391**

All items returned incomplete should be documented for the date and why it is being returned. Payments not processed within 30 days should contain documentation as to why they were not processed timely.

- Reminders will be sent and training will be enhanced to all Fiscal employees that they should not enter any item unless they have the invoice. No document should ever be marked as paid when it is entered or approved in our system since it is not paid by DHS but by the IOC

Chester MHC:

- The Business Office has implemented a process to complete the vouchering process for bills within 30 days after receipt of a correct bill from vendors.
- The interest not paid was corrected by the facility sending a court of claims form to the vendor in order for application of payment of the interest.

**% of CORRECTIVE ACTION COMPLETED = 100%**

**Date Completed: 2/28/2013**

**25. Implement procedures to perform expenditure reconciliations in a timely manner.**

**Finding:** The Department did not reconcile its expenditure balances with Illinois Office of Comptroller (Comptroller) records in a timely manner. In all 5 monthly expenditure reconciliations tested, auditors noted the reconciliation was not performed timely. The reconciliations were completed between 6 to 11 months after the period being reconciled.

Department officials stated the exceptions were related to a decrease in staff available to prepare expenditure reconciliations.

**Updated Response:** Partially Implemented.

**Corrective Action Implemented:**

- Expenditure Reconciliations have been completed through 3/22/13.

**Corrective Action to be Completed:**

- The remaining months of Expenditure Reconciliations will be completed timely by 6/30/13.
- Ensure the responsibility of reconciling the expenditure accounts and the posting of adjusting entries to newly hired staff in Agency Accounting are clearly understood.

**% of CORRECTIVE ACTION COMPLETED = 30%**

**Estimated Date of Completion: 6/30/2013**

**Accepted or Implemented – continued**

**26. Maintain the necessary required documentation in employee files including payroll deduction authorizations and leaves of absence. (Repeated-2007)**

## REVIEW: 4391

**Finding:** The Department did not maintain all necessary and required supporting documentation in employee payroll and personnel files. During testing of employee payroll and personnel files at the Central Office and Department facilities, some of the exceptions noted by the auditors were as follows:

- In 71 of 120 (59%) payroll files tested, voluntary withholding payroll deduction authorization requests were not maintained in the files.
- In 20 of 120 (17%) payroll files tested, the employee's W-4 was not maintained on file, but the employee's payroll tax exemptions were greater than zero.
- In 1 of 120 payroll files tested, union dues were withheld in excess of the correct rate.
- In 1 of 120 payroll files tested, the deferred compensation withholding did not agree with the amount on the Deferred Compensation Plan Request (IL 444-4295).
- In 1 of 120 (1%) payroll files tested, the personnel file was not provided.
- In 3 of 120 (3%) personnel files tested, the employee's original application was not on file.
- In 5 of 120 personnel files tested, the pay rate per the CMS-2 on file does not match the employee's actual pay amount. The CMS-2 documents the employee's rate of pay. The most current CMS-2 was not in the employee's file.

During testing of employees on leave of absence, auditors noted the following exceptions:

- In 3 of 50 leave of absences tested, auditors noted the Department was unable to provide the Physician's Statement Form or additional verification of recovery while on leave for employees claiming non-service connected disability leave.

During testing of terminated employees, the following exceptions were noted:

- In 2 of 50 terminated employees tested, auditors noted the CMS-2 report was not completed properly. As a result, auditors were unable to verify the employee's final paycheck was correct.

Department personnel stated the Department's Payroll Office had been formed in 1998 and the payroll files were obtained from five legacy agencies. Logistically, this caused problems with obtaining complete payroll files. In addition, staffing shortages have contributed to incomplete payroll files as well.

**Updated Response:** Implemented.  
**Corrective Action Plan to be completed:**

**REVIEW: 4391**

- The Director of the Office of Human Resources has issued instructions to Central Office and Facility/School Human Resources staff regarding the required contents of a personnel file and a payroll file.
- The Director of the Office of Human Resources has issued instructions to Central Office and Facility/School Human Resources staff regarding the need for timely and accurate physician statements for leaves of absence.

**% of CORRECTIVE ACTION COMPLETED = 100%**

**Date Completed: 2/26/2013**

**27. Follow the Personnel Rules and hold management accountable for completing employee performance evaluations timely. (Repeated-2005)**

**Finding:** The Department did not conduct employee performance evaluations on a timely basis. During testing of personnel expenditures, auditors noted 6 of 32 Central Office employees sampled did not receive a performance evaluation on a timely basis. Many of these employees had not had evaluations for several years. Additionally, the Department could not provide documentation that an employee performance evaluation had been performed during the engagement period for 17 of 32 (53%) employees.

Auditors also noted 91 of 306 (30%) facility employees at thirteen of the twenty-one facilities did not receive a performance evaluation on a timely basis. Additionally, seven of the twenty-one facilities could not provide documentation that an employee performance evaluation had been performed during the engagement period for 43 of 217 (20%) employees.

During testing of the timeliness of performance evaluations, other exceptions were noted related to performance evaluations such as unsigned evaluations and missing files.

Department personnel stated personnel managers sent out reports of upcoming evaluations and managers did not always comply. Furthermore, Department personnel stated performance evaluations were not always completed timely because supervisors and staff were busy performing additional duties resulting from a shortage of staff. In addition, Department personnel stated evaluations for merit compensation employees were not prioritized appropriately as the evaluations would not impact compensation increases for those employees. Department officials stated the lack of an electronic tracking system contributed to the discrepancies noted.

**Updated Response:** Implemented.

**Accepted or Implemented – continued**

**REVIEW: 4391**

**Corrective Action Implemented:**

- The Bureau of Employee Services will implement and fully populate a data tracking system for late/overdue evaluations.
- The Director of the Office of Human Resources will distribute to Executive Staff (for distribution to managers) and Facility/School personnel offices regarding the necessity of completion of timely performance evaluations.

**% of CORRECTIVE ACTION COMPLETED = 100**

**28. Maintain required documentation to substantiate all temporary employee assignments. (Repeated-2007)**

**Finding:** The Department failed to follow their own administrative directives as well as State administrative rules for administering temporary employee assignments.

During testing of temporary employee assignments, the Department was unable to provide documentation for 16 of 50 (32%) employees tested who currently work in temporary assignment positions. Because there was no documentation, auditors were unable to determine how long the employees had been functioning in these positions. The exceptions were noted in 8 of 15 locations tested.

Department officials stated the exceptions were a result of lack of staff oversight due to temporary assignment that occurs on a daily basis at DHS' 24/7 operations when an employee takes unscheduled benefit time and the shift needs to be covered. Often, the fast pace of covering the shift results in the proper forms not being completed.

**Updated Response:** Implemented.

**Corrective Action Implemented:**

- The Director of Human Resources sent a memo to Executive Staff via e-mail on December 10, 2012, instructing the Executive staff to share with their management staff the process for approving and documenting temporary assignment situations.

**% of CORRECTIVE ACTION COMPLETED = 100%**

**Date Completed: 12/10/2013**

**29. Remind supervisors and employees of the requirements of the Administrative Directive to timely sign and maintain the Monthly Attendance Records. (Repeated-2009)**

**Finding:** The Department did not maintain time records in compliance with the State Officials and Employees Ethics Act. Auditors noted the following exceptions at Department facilities:

## REVIEW: 4391

- 209 of 883 employee Monthly Attendance Records, which document that employee time was spent on official State business, were not retained at 12 of 21 facilities.
- 96 of 769 employee Monthly Attendance Records were not signed and dated by the employee, supervisor, and/or timekeeper within five working days of the employee's submission at 14 of 21 facilities tested. The supervisor or timekeeper signed the Monthly Attendance Records between 1 and 460 days late.
- 52 of 771 employee Monthly Attendance Records were missing required signatures at 12 of 21 facilities tested. As a result, the auditors could not determine whether the Monthly Attendance Record was signed and approved within the required time period.
- 1 of 21 facilities tested (Jack Mabley Development Center) did not maintain proper segregation of duties over its timekeeping function. The facility failed to designate an employee to record the time and attendance for the usual timekeeper.

Department officials stated the unintentional lack of oversight, staff shortages and employees on vacation or leave of absence contributed to the discrepancies noted.

**Updated Response:** Implemented.

Corrective Action Implemented:

- The Department issued revisions to Administrative Directive 01.02.02.170 on 12130111 which reaffirms the requirements surrounding the Monthly Activity Record. In addition, a presentation of the requirements for timekeeping (including the Monthly Activity Record) was provided to DHS Executive Staff in March, 2012.
- The Department of Human Resources sent a memo to Executive staff and timekeepers regarding instructions for handling the Monthly Activity Record.
- To address concerns raised by residential facilities about the current 5-day processing time, Administrative Directive 01.02.02.170 has been amended to change the processing time to ten (10) working days.

**% of CORRECTIVE ACTION COMPLETED = 100%**

**Date Completed: 10/10/2012**

**30. Comply with the State Property Control Act and Department policies and procedures for State property control. Specifically, place inventory decals on all State property, document and control property movements, submit documents to the Property Control Unit timely for updates to the property list, physically inspect State property periodically, and transfer unused State property items to the Department warehouse. Also, adequately maintain buildings and facilities to prevent further deterioration. (Repeated-2005)**

**Finding:** The Department did not have adequate physical control over recordkeeping for State property. As of June 30, 2011, the Department valued its State property at **Accepted or Implemented – continued**

## REVIEW: 4391

\$220,826,000. During testing of property and equipment at the Central Office and Department facilities, some of the discrepancies noted were as follows:

- Six of the 21 facilities tested, the property records did not agree with the observed physical location or description of the equipment, totaling \$10,078.
- Five of the 21 facilities tested, items physically observed were not recorded on the respective location property listings, and the Department was not able to provide support verifying the items were recently transferred or loaned to the location.
- Four of 21 facilities tested, inventory items were identified that did not have inventory identification tags properly affixed.
- Two of 21 facilities tested, auditors noted equipment transaction errors resulting in overstatements of property and equipment totaling \$270,450.
- Four of 21 facilities tested contained equipment items, totaling \$90,210, which appeared to be obsolete at the time of observation.
- At Clyde L. Choate Mental Health Center, auditors noted deterioration of property and equipment, including peeling paint, missing floor and ceiling tiles, and outdated windows. In addition, auditors noted 459 old unused items consisting of typewriters, desks, chairs, printers, computers, etc. totaling \$241,474.
- At Jacksonville Mental Health and Developmental Center, auditors noted the facility did not adequately maintain its buildings and grounds. Auditors noted a significant amount of mold. Additionally, auditors noted much of the ceiling, walls, and carpeting had water damage due to a leaky roof.
- At Elgin and Tinley Park Mental Health Centers, auditors noted severe deterioration of buildings and grounds.
- At the Central Office, auditors were unable to locate a printer valued at \$533,835. The auditors subsequently received documentation from the Department verifying the item was transferred to CMS as surplus.
- At Tinley Park Mental Health Center, auditors noted the facility incorrectly recorded two permanent improvements to buildings, totaling \$690,000, as repair and maintenance expense when those costs should have been capitalized.
- At Elisabeth Ludeman Developmental Center, auditors noted the building in which equipment property items are stored is not properly secure from possible theft.

Exceptions were identified related to the Department's process of deletions to property records.

Department officials stated the deficiencies noted were as a result of human error, lack of oversight, changes of personnel and untimely submission of corresponding paperwork.

**Updated Response:** Partially Implemented.

**Corrective Action Plan Implemented:**

## REVIEW: 4391

### Business Services:

- Update One Net Property Control Unit Guide
  - The DHS One Net Property Control Unit Guide has been updated and is available for all Property Control Coordinators (PCC) use.
- Update Property Control Manual
  - Property Control Manual has also been updated

### Chester MHC:

- Discussions with Central Office regarding the utilization of this equipment will continue:
- Discussions at the Hospital Administrators' meetings were held on February 23, 2012; March 8, 2012; March 22, 2012; May 3, 2013. (100% COMPLETE)
- The paperwork to surplus this equipment to Springfield was faxed on May 8, 2012. (100 % COMPLETE)
- All equipments were transported out. (100% COMPLETE).

### Elgin MHC:

- The facility did not exercise adequate control over the protection, maintenance, disposal and record keeping of State property.
  - Roof on the condemned medical building will be rechecked for leaks. Facility engineering staff patched the roof and will continue to follow up with periodic reviews for leaks. The phone/server system was relocated from this building. A capital project was requested to repair the roof. Supporting documentation consists of the FY14 and Capital Project request. 100% compliance as of 10/1/12.
  - Mowing plan will be reviewed and updated to ensure all facility areas are on a standard schedule. To be reviewed monthly by the Chief Engineer. Supporting documentation consists of a copy of the mowing plan and schedule. 100% compliance as of 6/30/12.
  - Regular rounds of unused areas of the facility will be conducted on a monthly basis to ensure they are maintained and no animal infestations are present. 100% compliance as of 6/30/12.
  - A review of all unused or obsolete equipment is completed. The items identified were offered to CMS and other facilities and/or condemned according to CMS guidelines. Supporting documentation consists of Request for Deletion from Inventory form. 100% compliance as of 2/15/12.
  - Two x-ray machines will be condemned and transferred out. Supporting documentation consists of a copy of the WCS transfer to CMS. 100% compliance as of 2/17/12.
  - The value of two lawn mowers will be determined and documented. In the property control system. Supporting documentation consists of a copy of WCS indicating items tagged. 100% compliance as of 2/17/12.

### **Corrective Action Plan to be completed:**

#### Business Services:

- Department to conduct FY12/13 PCC Training Sessions.
  - FY 12/13 PCC Training Sessions (part 1 of 3 has been completed)

### **Accepted or Implemented – continued**

## REVIEW: 4391

The first and second segment training sessions has been completed on June 21, and 22, 2012 respectively.

**% of Corrective Action Completed = 80%**  
**Estimated Date of Completion: 6/01/2013**

### **31. Transfer Lincoln Developmental Center to DCMS to comply with the Rules regarding acquisition, management and disposal of real property.**

**Finding:** The Department did not follow the required procedures for surplus real property. The Department failed to transfer the Lincoln Developmental Center (LDC) to the Department of Central Management Services (DCMS).

The Department ceased housing residents at LDC in August 2002. Although there was no formal agreement, DCMS became responsible for LDC effective July 1, 2010. However, the property is still recorded on the property records and in the financial statements of the Department.

Auditors noted the following responses to inquiries and observations during a site visit at LDC on January 13, 2012:

- The Department has not used the property since August 2002.
- The property includes 104 acres.
- Twenty-four buildings were built prior to the 1980's and 5 buildings were built during 2006.
- Nineteen of the 24 buildings (79%) are not being used by any State agency.
- Buildings are used by the Department of Corrections, Illinois State Police, DCMS, and Illinois Correctional Industries.
- Several older buildings had water damage and evidence of mold.
- Three of the older buildings have substantial asbestos issues.
- Most of the older buildings were empty except for permanent fixtures related to kitchen and restroom amenities.
- All first floor windows of the older buildings were boarded up to deter break-ins.
- Copper gutters had been stolen from the exterior of one building.

The Department was to retain custody of the property until the future use of the site was determined. However, LDC is being used by several State agencies excluding the Department. The Department incurred maintenance costs totaling \$744 thousand and \$503 thousand during fiscal years 2009 and 2010, respectively. The Department did not have an appropriation and did not spend anything during fiscal year 2011. DCMS is managing the property and incurring the maintenance costs effective fiscal year 2011. The net value of the property recorded in the Department's financial statements is \$9.665 million which is net of \$36.681 million of accumulated depreciation.

**REVIEW: 4391**

Department officials stated this effort was initiated with DCMS. The Department will continue to work with DCMS to initiate the Quit Deed from DHS to DCMS for the Lincoln Developmental Center.

**Updated Response:** Partially Implemented.

**Corrective Action Implemented:**

**BUSINESS SERVICES:**

- The DHS Office of Business Services has contacted CMS Legal to start the process of the Quick Claim.
- They (CMS Legal) are working on the legal description.
- That is the last step to be done prior to effectuating the Quit Claim

**Corrective Action to be Completed:**

**BUSINESS SERVICES NOTE:**

- CMS Legal and the Logan County Assessment Office can only find deed documentation for 3 out of 4 parcels of property which make up Lincoln Developmental Center (LDC). When the fourth parcel is resolved the Quick Claim Process can be completed.

**% of CORRECTIVE ACTION COMPLETED = 80 %**

**Estimated Date of Completion: 6/30/2013**

**32. Enforce procedures to ensure monitoring of telecommunications charges and services as well as adherence to Department guidelines and policies.**

**Finding:** The Department did not maintain adequate controls over telecommunication services and expenditures. During testing of detail billings for telephone and cell phone charges the Department did not always perform a timely review of the vendor invoices and monitored charges for services and expenditures at the Central Office or the facilities.

Department officials stated the lack of staff oversight and outdated telephone system which makes it difficult to track phone usage contributed to the deficiencies noted.

**Updated Response:** Partially Implemented.

**Corrective Action Implemented:**

**Division of Alcohol and Substance Abuse (DASA):**

- Applicable staff at the Division of Alcohol and Substance Abuse (DASA) were reminded /notified by e-mail to date stamp all telecommunication bills/vouchers for date of receipt of the telecommunication voucher.
- DHS DASA procedures for review and signoff of all telecommunications billing was revisited by staff. Assigned staffs were reminded to review telecom bills for any unusual monthly billing, and to notify the appropriate site supervisor for documentation and/or resolution.

**REVIEW: 4391**

**Accepted or Implemented – continued**

Jacksonville DC:

- Jacksonville Development Center is transitioning to closure with a target date of October 31, 2012. It was decided to not provide funding for any improvements at the center including a new telephone system.

**Corrective Action to be Completed:**

Mabley DC:

- The facilities will re-in-service all Mental Health Technicians regarding the use of telephone logs.
- The facility will coordinate with Central Office to modify the telephone bill to display the phone number associated with each phone.

**% of CORRECTIVE ACTION COMPLETED = 75%**

**Estimated Date of Completion: 4/30/2013**

**33. Remind employees to follow procedures and submit all telephone calling card cancellation requests to the Property Control Coordinator immediately upon notification of a situation that necessitates cancellation, along with a reason for the cancellation, to ensure adequate documentation and timely compliance. In addition, maintain accurate and up-to-date records of telecommunications devices in instances where devices have been transferred to other employees. (Repeated-2009)**

**Finding:** The Department is not canceling telephone calling cards and cell phones on a timely basis when an employee retires, transfers, or otherwise leaves the Department.

Thirteen of 25 items were not cancelled in a timely manner ranging from 9 to 270 days after the employee left the Department. Telecommunications records were also noted as not being updated for changes in assignments of equipment, such as cell phones and calling cards.

Department personnel stated the employees' supervisors are not forwarding the proper information to DHS MIS staff in a timely manner, resulting in delays in submitting cancellation requests to CMS.

**Updated Response:** Accepted.

**Corrective action plan to be implemented:**

HUMAN RESOURCES:

- After additional research, we have determined that the program areas are reassigning cell phones and telephone calling cards after an employee retires, transfers, or otherwise leaves the Department.

**REVIEW: 4391**

- We believe that adequate internal controls exist and are in place to ensure the correctness of charges associated with cell phones and telephone calling cards in that the program areas' management are required to sign-off and approve cell phone and telephone calling card bills monthly.
- As a result, no more than a month will pass before management would be aware that the paperwork to reassign a cell phone or calling card had not been completed.
- We believe it is the program areas' management responsibility for monitoring these bills and ensuring their accuracy and that they are responsible for ensuring that the records are updated.

**Estimated Date of Completion: 6/30/2013**

**34. Maintain adequate records for Department owned vehicles. Further, monitor the assignment of vehicles and ensure all required forms are obtained timely. (Repeated-2003)**

**Finding:** The Department did not maintain adequate records for Department owned vehicles. Records for all 15 personally assigned vehicles were tested during the engagement period. Auditors identified instances of failure to file required reports, inadequate vehicle maintenance, and incomplete records.

Department officials stated the unintentional lack of oversight by staff and failure to file required reports contributed to deficiencies noted.

**Updated Response:** Implemented.

**Corrective Action Plan Implemented:**

- The Department has sent reminders and due notices to all Regular Maintenance and required reports
- Report functions have been updated so delinquent reports can be ran and then notices for past due maintenance on all vehicles will be sent out.

**% of CORRECTIVE ACTION COMPLETED = 100 %**

**Date Completed: 2/26/2013**

**35. Establish and document guidelines that outline both DHS and DCMS responsibilities for recovery of critical computer systems. Specifically:**

- **Work with DCMS to ensure recovery of critical computer systems within the required 24-hour timeframe;**
- **Perform and document tests of recovery capabilities at least once a year. Due to the critical nature of the recovery requirements, ensure tests demonstrate the ability to meet the 24-hour timeframe.**

## REVIEW: 4391

### Accepted or Implemented – continued

- **Continually review and update contingency plan to reflect the current operating environment and ensure all facilities have an adequately developed and tested contingency plan. (Repeated-2005)**

**Finding:** The Department had not ensured adequate planning for the recovery of its applications and data. In particular, acceptable disaster recovery capabilities did not exist to ensure that critical computer systems (integral to ensuring the safety and well-being of its clients) could be recovered within the required timeframe.

The Department updated its contingency plan in April 2011; however, the plan did not adequately address all facilities. In addition, the Department participated in the annual comprehensive Disaster Recovery exercise in September 2011. Although the Department was able to recover its critical systems and considered the test a success, the Department was not able to recover its critical systems within the required 24-hour timeframe.

Many of the Department's IT functions were consolidated into the Department of Central Management Services (DCMS). As a result, the Department and DCMS have a shared responsibility over disaster contingency planning. Although the Department shares some responsibility with DCMS, the Department has the ultimate responsibility to ensure it has the capability to recover its applications and data.

Department officials stated a recovery site capable of being configured within the recovery time frame did not exist.

**Updated Response:** Implemented.

#### **Corrective Action Implemented:**

- DHS participated in the DR test concluded on May 17th, 2012).
- DHS, DR Plan last update was FY12. Next scheduled update is end of first quarter 2013).
- 2012 Disaster Recovery (DR) test was conducted and it was successful because it allowed DHS to recover requirements within 24 hours.
- DHS participated in the annual CMS Disaster Recovery (DR) test.
- The Department will continue to Update DHS Disaster Recovery (DR) Plan.

**% of CORRECTIVE ACTION COMPLETED = 100%**

### **36. Periodically review and assess access to production data and limit access only to required individuals. (Repeated-2009)**

**Finding:** The Department did not adequately restrict access to its production data. In some cases, all users of an application also had access rights to the actual production data. Although many of these users were unaware they possessed this access, access to production data should be restricted.

## REVIEW: 4391

In addition, weaknesses were found in the use of the Department's User ID Action Request form used to assign access rights. Twenty-five employees were selected for testing from a list of new Department employees for FY10 and FY11. Of the 25 forms requested, the Department was unable to provide 3 of the forms and 11 forms did not contain the appropriate signatures.

Department officials stated a shortage of staff contributed to deficiencies noted.

**Updated Response:** Implemented.

**Corrective Action Implemented:**

- Reviewed the two COPY LIBRARY reports and removed excess access rights.
- Both reports were forwarded to the Application Manager for review on 9/26/2012. Appropriate actions will be taken based on the review.
- Remind Security Coordinators of proper procedures.
- Notification will be sent to all RACF coordinators reminding them of the requirement to obtain a properly completed 4055 form prior to issuing a user ID and to keep the form on file for audit purposes.

**% of CORRECTIVE ACTION COMPLETED = 100%**

**Date Completed: 6/12/2012**

**37. Submit all reports on or before the due date specified in State law and remind management at facilities of reporting requirements to the Central Office. (Repeated-2009)**

**Finding:** The Department did not submit required reports to the Governor and the General Assembly in a timely manner as required by State law. Facilities also did not submit required reports to the Central Office.

During the engagement period, the Department was required to submit various reports to the Governor and the General Assembly. These reports related to children with developmental disabilities, the Work Opportunity Tax Credit, the Agency Workforce Reports, the streamlining of auditing and accreditation systems with other human service departments, and the Commission on Children and Youth. None of these reports were filed in a timely manner.

Department officials stated the reports were not submitted due to the lack of staff oversight.

**Updated Response:** Implemented.

**Corrective Action Implemented:**

- A process has been set up to ensure all reports are submitted before the due date.
- The Division will compile and submit the next required bi-annual report by March 1, 2014.
- Agency Workforce Reports will be filed to the Governor's office timely.

**REVIEW: 4391**

**Accepted or Implemented – continued**

- Agency Workforce Reports will be filed to the Secretary of State's office timely.

**% of CORRECTIVE ACTION COMPLETED = 100%**

**Date Completed: 2/28/2013**

**38. Comply with the requirements of the Mental Health and Developmental Disabilities Administrative Act or seek a legislative change to be more in line with the Division of Mental Health's current mission and focus.**

**Appoint appropriate personnel to boards and commissions and evaluate the process to ensure appointments are made in a timely manner. (Repeated-2009)**

**Finding:** The Department did not make appointments to State boards and commissions or did not make timely appointments as follows:

- The Secretary of the Department did not appoint five physicians to a medical advisory panel as required by the Mental Health and Developmental Disabilities Administrative Act. In response to the previous finding, Department officials stated the statute should be revised or eliminated.
- The Department did not appoint a representative as an ex-officio member of the Illinois Health Information Exchange Authority.
- The Department appointed a representative for only one of its six Divisions to the Employment and Economic Opportunity for Persons with Disabilities Task Force.
- The Department did not appoint a representative to the Task Force on Inventorying Employment Restrictions.
- The Department did not appoint a designee to be an ex-officio, nonvoting member to a commission created by the Governor to review funding methodologies, identify gaps in funding, identify revenue, and prioritize use of that revenue.

Department officials stated they were in the process of designating staff to serve on the aforementioned boards or commissions.

**Updated Response:** Partially Implemented.

**Corrective Action Implemented:**

- The names of five (5) physicians were forwarded to Office of the Secretary on 3/28/2012 by the Division of Mental Health (DMH).

**Corrective to be Completed:**

**REVIEW: 4391**

- DMH is awaiting final action by the office of the Secretary to finalize the panel and convene the first meeting (e-mail attached).
- The Division of Developmental Disabilities (DDD) will name a staff to the task force.

**% of CORRECTIVE ACTION COMPLETED = 30%**

**Estimated Date of Completion: 7/1/2013**

**39. Continue working with the CDB to rectify the conditions noted by the State Fire Marshal to ensure the safety of residents at the Illinois School for the Deaf.**

**Finding:** The Department failed to fully comply with fire safety standards. The Illinois School for the Deaf has not fully corrected fire safety conditions which were noted in a December 2006 State Fire Marshall inspection report. The School has three dormitories and two classrooms that lack automatic or self-closing doors.

School personnel stated funding has been approved through the Capital Development Board (CDB); however, work on safety improvements is scheduled to begin December 2011.

**Updated Response:** Accepted.

**Corrective Action Implemented:**

- The Illinois School for the Deaf (School) - First dormitory of the four, work will start on the installation of the sprinklers on 12/01/2011.
- The four units to be done are Horner, Officer, Wait and then Elementary Unit 5.
- Work has begun on Elementary and Horner Hall. Horner Hall will be 100% completion 8/17/2012. Elementary is still pending completion.
- The first two of four dorms to receive sprinkler work are Horner Hall and Elementary. Horner Hall is 95% complete. The contractor is doing final cleaning. We have substantial completion.
- We anticipate being able to move back into the building in early November 2012. The fire system has been tested and is ready to go on line.
- We have been waiting on CDB approval of a change order that would install a Simplex Monitor on the dry portion of the attic work.
- The approval to proceed actually came through this morning, 10-4-12. That change order will complete the sprinkler system at Horner Hall.
- Elementary building, all sprinkler piping has been installed and tested. Project is about 80% complete. Work remaining includes ceiling installation in lower level dorm areas.
- The ceiling is a sheet rock ceiling, the frame is all done. The project has been on hold approximately 6 weeks waiting approval from the State Procurement Office on numerous change orders caused by unforeseen issues found above the old ceiling.
- Two of 4 dormitories are completed and students have moved back into them. They are Horner Hall and Elementary Unit 5.
- The contractors have now moved to Officer Hall on 12/3/12. Currently they are at 80% complete on sprinkler work and have started the work on bathrooms.

**Accepted or Implemented – continued**

**REVIEW: 4391**

- That part is also moving faster than it did in Horner Hall. When complete, we will move to Wait Hall. Status of Horner Hall 100% complete, Elementary 100% complete, Officer Hall 65% complete, and Wait 5% complete. See Administrative Council Report for 1-22-13 from Chief Engineer showing progress on CDB projects.

**Corrective Action Plan to be implemented**

- Work on Officer Hall will start in September 2012 and after the completion of Officer Hall they will begin work on Wait.
- Wait and Officer Halls, the project will continue next with the completion of Horner Hall as we move construction into Officer Hall.
- New sprinklers will be added there. Once that work is finished we will move into Wait Hall and add new sprinklers there.
- The only work begun in Wait or Officer is the contractual bidding, no physical work as begun.
- We anticipate work at Officer Hall to begin Nov. 15, 2012 with completion in March 2013. We anticipate work to begin at Wait Hall in March of 2013 with completion in June 2013.

**% of CORRECTIVE ACTION COMPLETED = 60%**  
**Estimated Date of Completion: 8/01/2013**

**40. Emphasize to Department and facilities employees the importance of wearing proper identification, and establish controls that will enforce identification policies.**

**Finding:** The Department's facilities did not ensure all employees wore the proper State identification while on the facility grounds. At 7 of 21 facilities, auditors noted employees were not wearing proper identification cards.

Department officials stated the lack of staff oversight contributed to deficiencies noted.

**Updated Response:** Implemented.

**Corrective Action Plan Implemented:**

**MURRAY DDC:**

- All staffs are now required to wear their name tags.
  - Memo was disseminated to all staff.

**JDC:**

- Facility has closed.

**MADDEN MHC:**

- E-mail was sent to all staff at Madden, reminding them of the policy regarding the displaying of identification badges.

**REVIEW: 4391**

- The facility will continue to spot check visually to ensure employees at Madden are wearing proper identification cards (ID).
- Security Officers and Hospital Leadership will continue to make visual spot checks for employees in Madden. (THIS IS ON GOING).

**DDD:**

- The Division of Developmental Disabilities has also met with the State Operated developmental Centers to review findings and to stress strict adherence.

**% of CORRECTIVE ACTION COMPLETED = 100%**

**Date Completed: 5/30/2012**

**41. Re-establish and administer the Rapid Reintegration Pilot Program. Additionally, the document initial assessments and post-admission assessments utilized to determine individual participant placement needs. Perform additional assessments of eligibility for enhanced Community Home Maintenance Allowance for individuals as necessary.**

**Finding:** The Department failed to administer the Rapid Reintegration Pilot Program as required by the Disabilities Services Act of 2003.

During testing, auditors noted the Department was not operating the Rapid Reintegration Pilot Program during fiscal year 2011 as required by the Act. In addition, the Department was unable to demonstrate that individual participant's needs for placement and eligibility for enhanced Community Home Maintenance Allowance were assessed.

Department personnel stated staffing issues caused the program to become unsustainable from a programmatic perspective. In addition, Department officials stated the current status of the Rapid Reintegration Pilot Program is not clear as the program's goals have been transitioned into the Department's regular reintegration project.

**Updated Response:** Implemented.

**Corrective Action Plan Implemented:**

- Though the stand alone pilot was discontinued, the core goals of the pilot were continued as an integrated expansion of the Home Services Reintegration program.
- The transition allowed more individuals in the targeted population (in the nursing home less than 6 months) to participate in the project than would have been possible in the limited geographic areas of the original pilot program.
- This increased population allows Division of Rehabilitation Services (DRS) to better evaluate the specific needs of the targeted population and document how successful serving this population can be.
- In the future, DRS will work to comply with all statutory requirements of a pilot program.

**NOTE:**

- 1) The core goals of the pilot were continued as an integrated expansion of the Home Services Reintegration program.

**Accepted or Implemented – continued**

- 2) The transition allowed more individuals in the targeted population (in the nursing home less than 6 months) to participate in the project than would have been possible in the limited geographic areas of the original pilot program.
- 3) DRS evaluated the specific needs of the targeted population and documented how successful serving this population can be.

**% of CORRECTIVE ACTION COMPLETED = 100**

**42. Conspicuously display notices of State employee protection under the Whistle Blower Protection Article of the State Officials and Employees Ethics Act.**

**Finding:** The Department did not conspicuously display notices of State employee protection under the Whistle Blower Protection Article of the State Officials and Employees Ethics Act (Act).

During testing, auditors observed several Central Office locations in which the Department did not conspicuously display notices of State employee protection under the Act. Auditors also noted two facilities in which conspicuous notices of the Act were not present.

Department officials stated notice posters had been ordered but were not received or posted at the time of testing.

**Updated Response:** Implemented.

**Corrective Action Plan Implemented:**

- The Ethics Officer worked with the Office of the Secretary to distribute electronic copies of the poster to all Executive Staff members.
- Accompanying the poster was a memo that instructed the Executive Staff member to ensure the poster was prominently displayed in all office locations under their charge.
- The Ethics Officer will work with applicable staff throughout DHS to ensure that all DHS Offices are supplied with notices of Whistle Blower Protection and are aware of the requirement to prominently display the notice:
  - The poster has been updated and reflects the name of the current Ethics Officer and a copy has been submitted to Ethics Officer.

**% of CORRECTIVE ACTION COMPLETED = 100%**

**Date Completed: 10/15/2012**

**43. Implement an active eligibility redetermination process and require that eligibility redeterminations be completed on an annual basis as required for ALL KIDS. (Repeated-2005)**

## REVIEW: 4391

**Finding:** The Department failed to make annual redeterminations of eligibility for KidCare (now known as ALL KIDS) services in compliance with the Children's Health Insurance Program Act. During testing of 30 ALL KIDS case files, auditors identified 5 case files where an annual redetermination was not performed as required. Auditors also noted the Department was using a passive redetermination process to redetermine eligibility.

Department personnel stated the passive redetermination was implemented in response to the federal Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111-3) effective April 1, 2009.

**Updated Response:** Partially Implemented

**Corrective action plan implemented:**

- The Contractor (Maximus) has begun sending recommendations to the Department of Health Care and Family Services (HFS) and the Department of Human Services (DHS) as to the continuation, cancelation, or modification of medical cases that had been overdue for redetermination.
- **HFS will submit request to eliminate PASSIVE REDETERMINATION process.**
  - An active electronic renewal process has been implemented. Currently, HFS All Kids Unit staff is reviewing medical cases that would have formerly been selected for administrative (passive) renewal.
  - The review includes electronic checks and clearances in order to verify earned income, unearned income, child support receipt, and Illinois residence.
  - This new process has been set up using the guidance of the Federal Center for Medicare and Medicaid Services (CMS).
  - Supporting documentation includes a Head's Up to all staff dated 7/3/12, describing the change in redetermination procedure.
- **MIS will complete required system changes to eliminate PASSIVE REDETERMINATION coding:**
  - Prior to the SMART Act, passed and signed into law in June 2012, HFS and DHS implemented an enhanced residency verification process as part of the eligibility determination process.
  - This process, beginning in March 2012, allows staff to verify Illinois residence via an automated Illinois Secretary of State clearance.
- **HFS will submit an Request for proposal(RFP) and secure a vendor to perform automated enhanced eligibility checks during REDETERMINATION process:**
  - HFS and DHS worked to contract with an outside vendor (Maximus) to perform eligibility redeterminations.
  - The vendor will perform each of the aforementioned eligibility factor verifications.
  - Discussion continues with the selected vendor regarding the process and system requirements for implementation.

**Accepted or Implemented – concluded**

**Corrective action to be Completed:**

- HFS will submit an Request for proposal(RFP) and secure a vendor to perform automated enhanced eligibility checks during REDETERMINATION process:
  - HFS and DHS worked to contract with an outside vendor (Maximus) to perform eligibility redeterminations.
  - The vendor will perform each of the aforementioned eligibility factor verifications.
  - Discussion continues with the selected vendor regarding the process and system requirements for implementation.

**% of CORRECTIVE ACTION COMPLETED = 90%**

**Estimated Date of Completion: 12/30/2012**

**Emergency Purchases**

The Illinois Procurement Code (30 ILCS 500/) states, “It is declared to be the policy of the State that the principles of competitive bidding and economical procurement practices shall be applicable to all purchases and contracts....” The law also recognizes that there will be emergency situations when it will be impossible to conduct bidding. It provides a general exemption when there exists a threat to public health or public safety, or when immediate expenditure is necessary for repairs to State property in order to protect against further loss of or damage to State Property, to prevent or minimize serious disruption in critical State services that affect health, safety, or collection of substantial State revenues, or to ensure the integrity of State records; provided, however that the term of the emergency purchase shall not exceed 90 days. A contract may be extended beyond 90 days if the chief procurement officer determines additional time is necessary and that the contract scope and duration are limited to the emergency. Prior to the execution of the extension, the chief procurement officer must hold a public hearing and provide written justification for all emergency contracts. Members of the public may present testimony.

Notice of all emergency procurement shall be provided to the Procurement Policy Board and published in the online electronic Bulletin no later than 3 business days after the contract is awarded. Notice of intent to extend an emergency contract shall be provided to the Procurement Policy Board and published in the online electronic Bulletin at least 14 days before the public hearing.

A chief procurement officer making such emergency purchases is required to file an affidavit with the Procurement Policy Board and the Auditor General. The affidavit is to set forth the circumstance requiring the emergency purchase. The Legislative Audit Commission receives quarterly reports of all emergency purchases from the Office of the Auditor General. The Legislative Audit Commission is directed to review the purchases and to comment on abuses of the exemption.

The Department filed nine affidavits for emergency purchases in FY10 totaling \$1,639,288 as follows:

## REVIEW: 4391

- \$ 1,254,872.00 for equipment;
- 219,290.00 for repairs;
- 105,315.00 for delivery services; and
- 59,811 for a service contract.

During FY11 the Department filed 24 affidavits for emergency purchases totaling \$2,861,303.41, as follows:

- \$ 744,571.59 for repairs;
- 500,404.00 for claims processing;
- 432,963.60 for psychiatric services;
- 328,126.50 for computer services;
- 248,893.00 for training services;
- 200,000.00 for medical care;
- 125,505.00 for equipment;
- 110,835.72 for food services;
- 104,454.00 for youth follow-up services;
- 49,300.00 for monitoring services; and
- 16,250.00 for scientific analysis.

### Headquarters Designations

The State Finance Act requires all State agencies to make semiannual headquarters reports to the Legislative Audit Commission. Each State Agency is required to file reports of all its officers and employees for whom official headquarters have been designated at any location other than that at which official duties require them to spend the largest part of their working time.

The Department filed a headquarters report in July 2011 indicating it had 468 employees assigned to locations other than official headquarters.