LEGISLATIVE AUDIT COMMISSION

Review of
Department of Human Services
Two Years Ended June 30, 2015

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REVIEW: 4457
DEPARTMENT OF HUMAN SERVICES
TWO YEARS ENDED JUNE 30, 2015

FINDINGS/RECOMMENDATIONS - 33

ACCEPTED - 18
IMPLEMENTED - 15

REPEATED FINDINGS - 25
PRIOR RECOMMENDATIONS - 38

This review summarizes the reports on the Department of Human Services, which includes the facilities operated by the Department—six Developmental Centers, six Mental Health Centers, one combined Mental Health and Developmental Centers, one Treatment and Detention Facility, and three Rehabilitation Services Facilities—for the two years ended June 30, 2015, filed with the Legislative Audit Commission on June 2, 2016. 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 Departments of Children and Family Services, Healthcare and Family Services, 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 services, promoting prevention and establishing measurable outcomes, in partnerships with communities.

The Secretary of the Department during the audit period was Michelle Saddler who served as Secretary from October 11, 2009 until Melissa A. Wright was appointed Acting Secretary effective January 20, 2015. In mid-February 2015, Gregory M. Bassi, the Department's General Counsel, was appointed Interim Secretary. Mr. James T. Dimas was appointed Secretary in May 2015. Mr. Dimas was a primary architect in the consolidation of the current Agency, and he previously worked in a number of roles at IDHS, including Acting Director of Community Operations.

The number of employees by division at June 30 appears on the following page.

Division	FY15	FY14	FY13
Administrative Services	787	774	759
Alcohol and Substance Abuse	44	46	49
Rehabilitative Services	1,513	1,479	1,516
Developmental Disabilities	3,896	3,729	3,756
Mental Health Services	2,545	2,355	2,252
Family & Community Services	4,140	3,572	2,956
TOTAL	**12,925**	**11,956**	**11,287**

Service Efforts and Accomplishments

Appendix A provides a summary of the Department's service efforts and accomplishments for the years ended June 30, 2015 and 2014, in all major divisions: Addiction Treatment and Related Services; Developmental Disabilities; Family and Community Services; Home Services; Mental Health Services; Reproductive and Early Childhood Services; Sexually Violent Persons Program; Vocational Rehabilitation; and Youth Services and Adult Services.

Expenditures From Appropriations

The General Assembly appropriated $6,428,793,000 to the Department in FY15, an increase of about $252.2 million, or 4.1%, compared to FY14. The Department received the third largest appropriation in the State budget for the FY15 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 $6,107,862,000 in FY15 compared to $5,836,683,000 in FY14, an increase of $271.2 million, or 4.6%. Appendix B presents a summary of appropriations and expenditures by fund for FY15 and FY14.

Appendix C presents a summary of expenditures by major object code for FY15-FY13. According to the audit report, the most significant change in expenditures was an increase of about $248 million for Awards and Grants from FY14 to FY15 which included a $189 million increase for Developmental Disabilities Grants-in-aid and Purchase of Care and approximately $23.3 million increase in Personal Services attributed to increased staffing levels from FY14 to FY15. Lapse period expenditures for the Department were almost $474 million, or 8.0%, in FY15.

Appendix D presents a summary of expenditures by facility. Total facility expenditures were almost $517.2 million in FY15 compared to $520.3 million in FY14. The Department had an average total population of 3,757 residents/students at centers in FY15 compared to 3,811 in FY14. Cost of care ranged from a high of $426,278 per resident/student at Madden Mental Health Center to a low of $61,194 at the Treatment and Detention Center. The average number of employees at the facilities was 6,618 in FY15.

Cash Receipts

Appendix E provides a summary of the Department's cash receipts, which totaled over $2 billion in FY15. Cash receipts increased by $41.1 million, or about 2.1%, from FY14. An increase of $16 million in the Early Intervention Services Revolving Fund was due to an FY14 appropriation that was not received until FY15. An increase of $10.6 million in the DHS Special Purpose Trust Fund was due to FY15 being the first full year of collections for the Race to the Top grant. An increase of $9.7 million in the General Revenue Fund was due to an increase in the federal Food Stamp program in FY15.

Property and Equipment

Appendix F provides a summary of property and equipment for which the Department's Central Office was accountable during FY15 and FY14. The value of the Department's property and equipment, which includes the facilities, was $757,416,605 at June 30, 2015. The increase in property and equipment in FY15 is due to increased spending for buildings and building improvements.

Accounts Receivable

Appendix G provides a summary of accounts receivable for FY15 and FY14. The Department's net accounts receivable totaled $473,693,000 as of June 30, 2015. About $188 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 increase of $64 million in amounts due from other State funds for FY15.

Accountants' Findings and Recommendations

Condensed below are the 33 findings and recommendations included in the audit report. Twenty-five findings repeat from previous reports. The following recommendations are classified on the basis of updated information provided by Jane Hewitt, Chief Internal Auditor, Department of Human Services, in a memo received via email on September 29, 2016 and in a subsequent memo dated November 9, 2016.

Accepted or Implemented

1. **Implement a process for ensuring amounts reported for all grants are accurate and that controls are in place to ensure knowledgeable individuals in the Bureau of Federal Reporting validate the amounts calculated by the Bureau of General Accounting and reported for receipts, expenditures and accruals for these**

Accepted or Implemented – continued

grants, giving proper consideration to both the federal award year and the State fiscal year. Further, enter into a new updated agreement with DCFS which contains all the key elements pertaining to the agreement between the two State agencies and which complies with the statute. (Repeated-2014)

Finding: The Department of Human Services (Department) does not have adequate controls over the reconciliation of amounts reported at year-end related to its various federal grant programs resulting in errors in the prior year financial statements.

In testing amounts reported in the GAAP packages and Comptroller accounting forms (SCO 563 Forms) for federal grant receivables, payables and unearned revenue, auditors found that the process for reporting grants and related accruals for financial reporting is inadequate.

In its analysis of the June 30, 2014 receivable for the SNAP program, the Department did not accurately reconcile receipts during the fiscal year to the appropriate federal award year. Amounts received during SFY 2014 were compared to the FFY 2014 award year when much of the receipts related back to the FFY 2013 award. As such, the receivable at year end June 30, 2014 in the General Revenue Fund and governmental activities was understated by approximately $40 million.

Additionally, as a result of this circumstance, in the General Revenue Fund, deferred inflows of resources were understated by approximately $40 million and in governmental activities, revenues and net position were understated by $40 million.

Also, in the prior year, accounts receivable of approximately $12 million for the Women, Infants, and Children (WIC) program was overstated because the impact of rebates receivable was not considered in determining the federal receivable amount. This amount was corrected in the current period.

Auditors also noted the Department draws $17.2 million every third month and remits it to the Department of Children and Family Services (DCFS), totaling $68.8 million for the year. The agreement provided to the auditors in support of this amount did not contain any information on the amount of the payments under the agreement, or the frequency of the payments.

The Department stated a new process was implemented during FY15 to ensure accruals at June 30th were materially correct based on the information available at the time the GAAP packages were required to be submitted. This process resulted in no adjustments to the FY15 financial statements for the current fiscal year activity. However, the 2015 financial statements were adjusted for three funds which had incorrectly reported a fund balance in the FY14 financial statements.

Updated Response: Implemented. The Bureau of General Accounting GAAP staff is to develop a process for verification of receipt, expenditure, and accrual amounts. The Bureau of Federal Reporting staff is to validate amounts determined by the General Accounting GAAP staff for the major programs. DHS Office of Budget will draft a proposed legislation revision for 305 ILCS 5/12-5. The Department of Human Services (DHS) will draft an interagency agreement with the Department of Children and Family Services (DCFS).

2. Analyze all available collection data annually through year-end and up through the report issuance date and adjust the methodology for calculating the allowance for doubtful accounts as necessary. Use the information gathered for accurately reporting the allowance for doubtful accounts in the financial statements. (Repeated-2014)

Finding: The Department did not sufficiently review the completeness of the information utilized when establishing the allowance for doubtful accounts in the June 30, 2015 financial statements.

The DHS Recoveries Trust Fund accounts for approximately $463.5 million in gross receivables for overpayments to program recipients for things such as food stamps and grants. The Department recorded an allowance for doubtful accounts for these receivables of approximately $318.7 million, resulting in a net receivable of $144.9 million. Beginning in FY15, for financial reporting purposes, the Department calculated the allowance amount using historical collection data through June 30, 2014 in accordance with their new methodology. For the purpose of reporting to the State Comptroller in FY16, the Department updated its collection history through June 30, 2015. The updated analysis, had it been applied to the June 30, 2015 receivable balance reported, would have resulted in an allowance of $309.4 million, a difference of $9.3 million. This difference was not deemed material to the financial statements.

The Department stated that a new methodology for calculating the allowance for doubtful accounts was implemented during FY15. The new uncollectible percentage was reported on the Quarterly Summary of Accounts Receivable report submitted to the State Comptroller. The Department did not consider the receivable amount used in the financial statements to be incorrect because it agreed to the Quarterly Summary of Accounts Receivable report for the quarter ended June 30, 2015.

Updated Response: Implemented. The Bureau of Collections has developed a process for communicating the most current uncollectible percentage to General Accounting. The Bureau of Collections provided the uncollectible percentage rate based on historical collection data, including the FY16 data, to the Bureau of General Accounting. The Bureau of General Accounting recalculates the allowance for doubtful accounts for applicable DHS funds based on the most current uncollectible percentage provided by the Bureau of Collections.

Accepted or Implemented – continued

3. **Perform a thorough assessment of the year-end financial reporting process and determine the significant liability estimates that need to be re-evaluated. Also, work with management of DHFS to gain a better understanding of the amounts reported in the Department's financial statements. Establish a control whereby financial information pertaining to activities and balances at HFS, the Department of Revenue and elsewhere are reviewed. Reconcile the accounting system CARS to the Comptroller's Statewide Accounting Management System (SAMS) each month in a timely manner. Maintain support for all transactions and balances reported in its financial statements. Also, review the policy for requiring the collateralization of deposits with financial institutions. (Repeated-2009)**

Finding: The Department's year-end financial reporting in accordance with generally accepted accounting principles (GAAP) contained inaccurate information.

The Department does not have a complete general ledger or adequate controls over the completeness and accuracy of monthly and year-end annual financial reporting which resulted in errors in the GAAP basis financial statements, GAAP schedules prepared for the State Comptroller's Office, and additional supporting schedules and analysis.

The Department did not timely record all expenditures and receipts into its Consolidated Accounting and Reporting System (CARS).

- This included payroll transactions in approximately 20 funds totaling $84.2 million through June 30 and $8.6 million as of August 31, 2015. The Department generally relied on inquiries from the Comptroller's Statewide Accounting Management System (SAMS) for payroll expenditure data. The Department determined they could not efficiently rely on their own internal accounting records for payroll information.

Auditors also noted the following issues with the year-end financial reporting process:

- The Department does not have a robust documented process for estimating liabilities payable from future year's appropriations (IBNR) for certain programs. Most significant programs administered by the Department allow service providers to claim reimbursement from the Department for services within 120 days of the service date; however, a few programs allow up to two years. Adding to the complexity is that much of the detailed data on these provider claims is maintained by the Department of Health and Family Services, a separate State agency. As a result of a separate analysis performed by auditors over these liability estimates, auditors concluded the following liabilities were misstated:
    - Developmental Disabilities was understated approximately $5.8 million;
    - DASA was overstated approximately $500,000;
    - Mental Health was overstated approximately $2.6 million; and
    - Early Intervention was overstated approximately $12.9 million.

- Pension amounts (pension expenditures and the related revenues) pertaining to pension contributions made for DHS employees paid from the General Revenue Fund were not recorded. The omission was not originally detected and the initial drafts of the financial statements did not include these amounts.
- The Department could not provide expenditure reconciliations for federal Medical Assistance Program (MAP) funds.
- When reviewing the expenditure reconciliations from the Department's accounting system, CARS, to the Comptroller's accounting system at June 30, 2015, auditors noted as of December 2015, the June reconciliation (as well as lapse) was incomplete.
- Unexpended appropriations (an asset account) was misstated in the draft financial statements in the General Revenue Fund. This error was later corrected.
- At June 30, 2015, the Department held deposits at financial institutions that exceeded federal deposit insurance coverage in the amount of $1.3 million.
- The Department does not maintain a detailed accounts receivable subsidiary ledger to support the ending Mental Health Fund (0050) quarterly balances.
- The Department does not perform a supervisory review of all amounts recorded in its GAAP packages and financial statements.
- During the testing of federal grant expenditures, auditors determined that the Department is not reviewing the payments submitted by HFS. When HFS submits a request for payment to the Comptroller, a summary file is also sent to the Department which goes through an interface and is recorded into CARS. An employee in Fiscal Services reconciles the payments between CARS and the Comptroller's office before accepting them into CARS. However, nobody within the Department is reviewing the detailed reports that the providers submit to HFS requesting payment, which are the support for the transactions recorded in CARS.
- In FY15 the Department began reporting a new fund "Commitment to Human Services Fund" (0644) which reports income tax receipts from the Illinois Department of Revenue and expenditures from the Department of Aging which were recorded on the Department's financial statements. During testing of receipts and expenditures, auditors found that no documentation was maintained or reviewed by Department personnel to support the amounts recorded in the financial statements. The auditors were able to obtain and review information from those other State agencies.

A key contributor to the number of errors, system inefficiencies and lack of adequate system reports is the Department's accounting system CARS. CARS is not used as a complete general ledger and not all transactions and balances are reported in CARS. Certain receivables, payables and capital assets are not reported in CARS. Certain payroll expenditures are added to CARS using manual entries. Additionally, the chart of accounts for all programs is not consistently utilized by all programs and departments. This makes extracting specific data from the system complex and time consuming.

Accepted or Implemented – continued

The Department indicated the financial reporting issues noted during the audit period were due to staff vacancies. In addition, approximately 60 GAAP reporting packages were required to be submitted within a short time frame with the limited (human) resources. In order to meet the State Comptroller's due dates for the GAAP reporting packages, DHS has to rely on information submitted by other agencies to the State Comptroller. DHS reviewed the other agencies' information for reasonableness, but did not review the information at a detailed level.

Updated Response: Implemented. The Department will review the GAAP process and revise procedures as necessary. Monthly reconciliations will be completed on a timely basis. Management will follow up with DHS legal staff on collateralization requirements.

4. Enforce use of the Child Care Management System (CCMS) audit screen for all entries/documents added to the system. Additionally, improve system controls to prevent further child care payments for children no longer eligible under the program due to their age. Also, perform regular reconciliations between the approved payments per the CCMS and actual payments per the Consolidated Accounting and Reporting System (CARS), and investigate any differences. (Repeated-2014)

Finding: The Department implemented the Child Care Management System (CCMS) in January 2014, despite known glitches and system issues and without executive management team approval, resulting in several implementation issues including service disruptions.

The rollout of the program resulted in casework processing delays which also delayed payment to the childcare providers in the program. To increase the speed of payments to providers, the Department instituted automatic renewals for program participants in order to alleviate the backlog of eligibility determinations and the resulting payment backlog. In effect, case information from the previous eligibility period carried over into the new eligibility period. Cases that were redetermined through this processing shortcut were not reviewed. This process has continued at some level through December 2015. Management stated that the federal government was aware of this process change.

As a result of the known system issues, the auditors again requested a reconciliation from the Department's Child Care Tracking System (CCTS) which uses eligibility and other information from CCMS to authorize payments to providers, to the Department's CARS system, which is the accounting record (general ledger) for provider and other payments for FY15. The Department was able to reconcile the two systems within a reasonable amount; however, the following additional issues were discovered:

- The CCMS system did not indicate the individual who completed each action in the CCMS "audit screen".
- The identifying information is also missing in the CCMS "documents tab" which shows who uploaded the documents into CCMS.
- The Department should have controls in place to ensure only authorized personnel make entries in CCMS. In order to monitor the activity in CCMS, there should be an audit trail showing who entered data into CCMS, who made changes to data in CCMS, and who reviewed the data in CCMS.

Department management stated that the CCMS application has a defect causing the audit screen to not display the individual who completed actions in some scenarios. The individual audit information is captured and stored in the CCMS database; however, the individual name is not being displayed in all cases. The CCMS application needs to be fixed to properly display the individual audit information.

Child Care payments were made for children that were deemed ineligible according to the CCMS System. Upon further investigation the Department reported that 812 children who became ineligible due to their age, received childcare payments they were no longer eligible to receive totaling $1.7 million. A system error can be attributed to the other weaknesses noted.

Updated Response: Accepted. The process previously used for auto-extension resulted in children no longer being eligible due to their age and will no longer be run. All eligibility and redetermination will now be performed within the Child Care Management System (CCMS) application.

The CCMS application will correct the defect, resulting in CCMS audit screens to not display the user who performed the displayed action. The State will run a quarterly CCMS/CARS reconciliation process.

5. Develop a process whereby detail support for all adjustments is maintained and reviewed and approved by supervisory personnel within the DASA division.

Finding: The Department does not maintain sufficient detailed records in support of approved DASA (Department of Alcohol and Substance Abuse) adjustments and payments.

During testing of expenditures for DASA, auditors noted the detailed DARTS report (Division of Alcohol and Substance Abuse Automated Reporting and Tracking System) that was provided in support of service providers' payments, did not have a total. As a result, auditors tried to add the MOBIUS service reporting (payments) from the service providers and compare it to the payment that was recorded into CARS. The two amounts did not agree because the Department's Office of Management Information Services (MIS) adjusted the monthly payments drawn from the provider's DARTS payment information. The Department does not

Accepted or Implemented – continued

retain detailed monthly adjustment information supporting the MIS adjustments (difference between what was entered into DARTS versus what was approved to be paid).

The Department stated that the DHS MIS extract report used for monthly reports, when developed, was designed to give aggregate amounts consistent with DHS CARS accounting cost centers/obligations. It was not designed to archive detail payment information and adjustments that impacted the monthly aggregate amounts. Once identified, DHS MIS has had to retrace the DHS MIS processes in creating the Monthly Extract report and engage the one MIS staff who understood how it was developed (who has since retired and came back temporarily on contract). In addition, DHS MIS is unable to go back to prior dates to regenerate the history since no archive of the adjustments to the monthly earnings was developed and implemented. MIS has been working on this to develop and remedy this issue.

Updated Response: Implemented. The Division of Alcohol and Substance Abuse (DASA) worked with DHS-MIS to implement the process of obtaining a monthly report of Adjustments, and the Monthly Payments Detail report. DASA has also developed a DHS DASA monthly process to reconcile the reports with the MonthCate reports received.

6. Establish controls over project management and due diligence, such as improving vendor relationships, monitoring, testing, etc. for major projects, such as the Integrated Eligibility System (IES).

Finding: The Department of Healthcare and Family Services and the Department of Human Services (Departments) did not establish controls to conduct due diligence or ensure project management over the State of Illinois' Integrated Eligibility System (IES) development project.

In order to meet the requirements of the Affordable Care Act of 2010, the Departments undertook a project to consolidate and modernize eligibility functions for several human service programs by October 1, 2013. Three contracts totaling $167.8 million were executed for the development, oversight, and independent verification and validation of IES.

The Departments had to rely on the vendors to provide the required documentation to respond to the auditors' requests. Additionally, during this timeframe, the vendors did not provide complete and accurate information responsive to the requests.

Given the severity of issues noted and the potential impact to the Departments' and the State's financial statements, the auditors met with the Departments' management in December 2015 to discuss the lack of due diligence, lack of complete documentation

provided, and the delays associated with responding to requests. From December 2015 through February 2016, the Departments worked with the vendors to provide the auditors with information regarding identified risks and the associated corrective actions.
Based on the information provided by the Departments, Phase One of IES went live on October 1, 2013 even though it had known problems, required manual workarounds, and encountered data integrity and downtime issues. The auditors' review of documentation identified a significant number of critical deficiencies:

- The Departments did not conduct due diligence or assess the risks over the known problems at October 1, 2013.
- Over-reliance was placed on the vendors.
- System testing was inadequate and did not comply with development requirements.
- The Departments did not thoroughly review or assess testing completed by one of the vendors.
- Project management was lacking. For example, during the auditor's testing of compliance with contractual requirements, the Departments were unable to provide the information and had to request deliverables from the vendors. In addition, it was noted the vendors routinely reviewed and approved the deliverables, rather than the Departments.

As a result of the lack of project management, IES did not accurately determine individuals' eligibility for various social service programs. See Finding 2015-002. In addition, the Departments did not implement adequate security controls over IES. See Finding 2015-003.

The Departments' management stated the weaknesses identified were the result of an inadequate process for collection and retrieval of supporting documentation of management's review and approval of contract deliverables and executive decision-making related to the planning, development, testing, assessment of risk, and implementation of the system.

Updated Response: Accepted. The following are some of the steps that have been taken since June, 2015, to establish improved due diligence and control over project management. The Departments have appointed a senior state employee, who is a certified Project Manager, as IES Phase 2 Project Director to refocus project management principles. Two additional project managers have also been added to maintain focus on these principles. They have instituted joint management of a comprehensive project schedule encompassing state and vendor efforts and implemented observation sessions to validate results of System Test stage before moving into User Acceptance Test stage. We have extended the timeline for Phase 2 to increase the User Acceptance Test stage from 12 to 43 weeks. We have also created a detailed requirements traceability matrix to enable thorough due diligence of defects and workarounds, refocusing on quality by requiring vendor quality reviews and joint quality review meetings with the vendor. We are redefining project deliverables jointly with the vendor to focus on quality and acceptable defect levels for deployment.

Accepted or Implemented – continued

We are still in the process of revamping change management, decision management and documentation of deliverable approvals. We also will be restructuring the SharePoint library to assure all documentation is filed in it appropriately and is accessible. The Departments will continue to work proactively to implement sound project management principles in order to prevent project management weaknesses in the future.

7. Implement controls over the review of the design and operations of the Integrated Eligibility System (EIS) and future development projects. Also, take corrective actions over all defects.

Finding: The Department of Healthcare and Family Services and the Department of Human Services (Departments) lacked internal controls to review the design and operation of the State of Illinois' Integrated Eligibility System (IES) to sufficiently prevent or detect defects that could cause inaccurate determinations of eligibility. As a result, the auditors noted IES did not accurately determine eligibility for human service programs.

In order to meet the requirements of the Affordable Care Act of 2010, the Departments undertook a project to consolidate and modernize eligibility functions for over 100 human service programs funded by the federal government and the State of Illinois. On October 1, 2013, the Departments implemented IES and utilized it for the intake of applications and the determination of eligibility for human service programs.

From October 1, 2013 through June 30, 2015, the Departments had:

	FY14	FY15
Applications submitted via IES	625,672	1,116,179
Applications approved via IES	514,499	894,680
Expenditures associated with applications approved via IES	$861,730,573	$3,307,145,211

In order to obtain social services, individuals are evaluated on hundreds of financial and non-financial criteria. To test the efficacy of IES' determination of eligibility for benefits, the auditors selected a sample of a subset of non-financial eligibility criteria, including residency, citizenship, and social security information.

The auditors tested all individuals who were approved within IES from October 1, 2013 to June 30, 2015, to ensure they were properly approved based on the eligibility criteria selected for testing. The testing identified multiple defects which resulted in individuals being improperly approved for certain programs. As a result of the defects identified, inappropriate expenditures were made to or on-behalf of individuals, totaling:

Fiscal Year	Individuals Inappropriately Approved	Department of Human Services Expenditures in Error	Department of Healthcare and Family Services Expenditures in Error
2014	751	$138,940	$1,294,177
2015	2,469	$338,931	$6,508,701

The more significant defects, which caused 3,220 individuals to be inappropriately approved, resulted in individuals being approved:

- Without meeting immigration requirements.
- Without verifications of citizenship.
- Without verification of residencies.
- Without valid SSNs or documentation of submitted SSN applications.
- For non-expedited Supplemental Nutrition Assistance Program (SNAP) benefits even though required citizenship information was not provided by a due date.
- For individuals who were not citizens and who did not provide other acceptable alternate information (i.e.; legal permanent residents, refugees, etc.).

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

Response: Accepted. The Departments will ensure that controls over the review of the design and operations of IES are complete and fully documented. A sophisticated system is already in place for documenting, tracking and prioritizing correction of all identified defects. Because of the size and complexity of the benefit programs IES controls, the Departments will review IES on an ongoing basis to assure accuracy of all eligibility determinations, both approvals and denials.

As stated in the finding above, the Departments did not view the erroneous expenditures as material and therefore did not make adjustments to their respective financial statements. The incorrect expenditures referenced for FY15 represent approximately two tenths of one percent of all expenditures associated with applications approved via IES. As was the case for the cost of the errors found in this audit, the Departments expect any additional errors that may be found will not affect more than a small percentage of enrollees or expenditures and that a substantial majority of eligibility decisions made by IES are correct.

The Departments will not attempt to recover payments deemed as incorrect because Medicaid providers performed services for clients in good faith under those eligibility determinations. A small percentage of DHS clients also received benefits based upon the determination of eligibility at the time.

Accepted or Implemented – continued

Updated Response: Accepted. The Department will implement a quality control process to identify and correct the types of non-compliance issues uncovered by the audit and then integrate this process with the existing Illinois Department of Human Services' (IDHS) operations to monitor and control the potential non-compliance of the Department's programs.

The State will work with the Illinois Integrated Eligibility System (IES) Contractor to establish ongoing procedures for Contractor to document and maintain the information necessary to test user access and follow established State change control procedures, including established audit trails.

For cases approved in IES (despite beneficiaries not meeting eligibility requirements related to Citizenship, Residency or social security reasons) the State has documented IES system defects that will be corrected and tested for deployment to IES. The policy and operational teams are aware of these defects and have been provided with workaround procedures to follow in the interim.

8. Establish controls that ensure the Integrated Eligibility System (IES) security is safeguarded, including monitoring the vendor's compliance with the security requirements outlined in the contract. Additionally, work with the vendors to promote the use of best practices and ensure:

- **IES security controls be adequately documented and comply with the required federal and State security standards.**
- **Access rights are appropriate, based on job duties, approved and documented, and periodically reviewed.**
- **All changes comply with approved change management procedures and are properly documented.**
- **An adequately developed and tested disaster contingency plan exists.**
- **State employees have access to the IES environment.**
- **Device incompatibility issues are resolved.**
- **An acceptable means for users to recover their User Identifications is implemented.**

Finding: The Department of Healthcare and Family Services and the Department of Human Services (Departments) had not implemented adequate security, change management, or recovery controls over the Integrated Eligibility System (IES).

IES was developed to consolidate and modernize eligibility functions and to comply with the Affordable Care Act of 2010. As such, IES was required to comply with specific federal and State security standards.

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The auditors requested from both of the Departments specific information related to the security, change management, and recovery controls over IES. During the review of information provided, the auditors identified a significant number of critical deficiencies:

- Neither of the Departments or vendor provided complete and detailed information necessary to support the implementation of security controls, including compliance with the federal and State security standards.
- The auditors identified three individuals with Global Security Administration rights for whom evidence to support the need for such powerful access rights was not provided.
- Contrary to accepted security practices, users were required to provide their dates of birth and social security numbers in order to recover their User Identifications.
- Changes were made by vendor to the infrastructure that did not comply with approved change management procedures.
- An adequately developed and tested disaster contingency plan had not been completed.

In addition, during the Departments' own review of security controls, they noted:

- IES and its servers could be accessed without authentication.
- The Departments had not ensured the vendor was able to provide a listing of users who had powerful privileges, accounts, or passwords.
- The Departments had not ensured the vendor maintained documentation to verify the approval of access rights.
- The Departments had not ensured the vendor maintained a complete listing of users on the infrastructure devices.
- Devices were not properly configured resulting in incompatibilities between devices.
- The Departments had not ensured the vendor implemented only approved changes to the infrastructure.
- The Departments had not ensured State personnel had access to the infrastructure.

The Departments acknowledge these matters are the Departments' responsibility and this responsibility cannot be outsourced.

The Departments' management stated the primary focus was on gaining approval from federal CMS to connect IES to the Federal Data Services Hub by October 1, 2013.

Updated Response: Accepted. For the Illinois Integrated Eligibility System (IES) Phase 1, known system issues were thoroughly documented and resolved through subsequent Go Live rollouts of the missing functionality, approximately once per month. The process followed was documented and presented to auditors in early 2016. For IES Phase 2, known system issues and risk assessments are being tracked according to new procedures already under development. Development of these procedures involves several tools such as Requirements Traceability, Operational Readiness Dashboard and Jira/Jama defect definitions.

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The Illinois Department of Human Services (IDHS), working in conjunction with the Illinois Department of Healthcare and Family Services (IHFS), will develop a plan to resolve defects remaining after Go Live in IES Phase2 and monitor the system for potential non-compliance occurrences. The components of the plan include: track all active defects at Phase 2 Go-Live, document the operational and compliance impact of the known defects, advise staff of the issue and appropriate workarounds, assign time frames for the individual defects to be fixed, conduct ongoing regression testing to ensure that the fixes for the defects are functioning correctly, and collaborate with the Department of Healthcare and Family Services on a regular basis on known issues to determine ongoing compliance and operational impact, and updating staff as appropriate.

9. Execute all interagency agreements required by law and have all parties sign the agreements prior to the effective date. Also, enter into interagency agreements with the Department of Healthcare and Family Services, Department of Children and Family Services and the sheriffs' offices of every Illinois County (other than Peoria and Sangamon which have signed agreements).

Finding: The Department failed to adequately execute interagency agreements. During the examination period, auditors noted the following:

- The Department did not have an interagency agreement with the Department of Healthcare and Family Services to govern the administration of the Home Services Medicaid Trust (Fund 0120). Total revenues and expenditures included in the Department's financial statements for the year ended June 30, 2015 were $263,207,000 and $243,925,000, respectively.

- During testing of interagency agreements between the Department and multiple other State agencies, two out of 40 interagency agreements sampled were not signed before the effective date. These agreements were signed between 55 and 168 days after the effective date.

- The Department did not enter into intergovernmental agreements (IGA) with all sheriff offices, in order to collect incarceration data to compare if those individuals were still eligible for benefits administered by the Department.

- The Department did not execute a signed interagency agreement for the purpose of preventing children and youth who are not otherwise abused or neglected from entering the custody or guardianship of the Department of Children and Family Services solely for the purpose of receiving mental health services. The Department has drafted an interagency agreement but has not completed the execution of an interagency agreement with the Department of Children and Family Services for the purpose of

preventing children and youth from entering custody or guardianship of the Department of Children and Family Services. Further, the interagency agreement was to have been provided to the Illinois Attorney General, within 180 days after the effective date of the Act, January 1, 2015.

Department management stated that generally DHS does a very good job executing IGAs in a timely manner. However, DHS cannot control the internal processes by which other governmental agencies decide when and if to sign IGAs. The finding (pertaining to IGAs with all sheriff offices) exists due to the non-cooperation or unwillingness of county sheriff's departments in agreeing to share data with IDHS.

Response: Accepted. The IGA with DCFS have been signed by DHS. DHS will continue its efforts to encourage its governmental partners to negotiate and sign IGAs as required by law.

The Department is mandated by state statute to enter into intergovernmental agreements with county sheriffs' departments in order to conduct monthly exchanges of information to determine whether incarcerated individuals are also included in SNAP, TANF, and/or Medical assistance units. There is no known mandate for county sheriff offices to cooperate or enter into the same intergovernmental agreements with IDHS.

IDHS staff, in order to achieve compliance with the statute, sent written requests for intergovernmental agreement cooperation to each Illinois County Sheriff in December, 2015, accompanied by a draft of the agreement. Those requests were met with only limited success. Only 10 county sheriffs agreed to send the monthly data. Additionally, the Illinois Sheriff's Association has indicated that they have discouraged the county sheriffs from entering into the agreements, as they believe negative action to an individual's SNAP and/or TANF case may result in a higher county jail recidivism rate.

Updated Response: Accepted. The Department continues to encourage governmental partners to negotiate and sign IGAs as required. The Department has decided to propose legislation that would no longer make it mandatory that DHS enter into data share agreements with county sheriff's departments. In practice, the Department will continue to match with all sheriff's departments that are willing to share the information, however, due to the current non-cooperation of the sheriff's departments in the legislated sharing of this information, the proposal will change language from "DHS shall enter into agreements with all sheriff's departments" to "DHS may enter into agreements with all sheriff's departments…".

10. Establish comprehensive Department-wide internal controls over compliance with State mandates regarding the use of restraints that is applicable to all Centers. Also, include requirements for training personnel on compliance requirements and outline management oversight over compliance requirements. (Repeated-2011)

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Finding: The Department's facilities did not comply with statutory requirements regarding the use of restraints. During testing, the following exceptions were noted with regard to the use of restraints at nine of the Department's facilities:

Chicago Read Mental Health Center

- Sixty-seven out of 159 (42%) employees authorized to apply restraints did not receive their required annual training at the end of FY15.
- Two out of six (33%) residents placed in restraints were not reported to the Center Director in writing within 24 hours of the use of the restraint.
- One out of six residents placed in restraints was not reviewed by the Center Director within 24 hours of use.
- One out of six residents placed in restraints did not have an order for Physical Hold to support the use of the restraint.

Elgin Mental Health Center

- Two out of five employees authorized to apply restraints during FY14 did not receive their required annual training.
- For one out of six residents placed in restraints, it could not be determined if the person who applied the restraint was appropriately trained in the use of restraints.
- One out of six residents placed in restraints, was restrained twice in a 48-hour period without the prior written authorization of the Center Director.

John J. Madden Mental Health Center

- Fourteen out of 222 (6%) authorized to apply restraints did not receive their required annual training at the end of FY15.
- For three out of six restraint instances tested, it could not be determined that the Center Director was informed in writing of the use of restraint within 24 hours. Also it could not be determined if the Center Director reviewed the restraint and inquired into the reason for the order of the restraint by the person who ordered it.

Andrew McFarland Mental Health Center

- For one out of six residents tested, the restraint report noted the restraint was applied for one hour while the resident's file noted the restraint was applied for two hours and 55 minutes.
- For one out of six residents tested, a manual hold noted in the file did not appear on the report.

Clyde L. Choate Mental Health and Developmental Center

- One out of five employees tested did not receive the required annual training during FY15.
- Twenty-eight out of 486 (6%) employees authorized to apply restraints during FY15 did not receive the required annual training.

Ann M. Kiley Developmental Center

- Four out of six (67%) employees tested did not have the most recent training date listed on the Center's records for at least one type of restraint testing.
- Five out of six (83%) employees tested were not re-trained within 12 months of their previous training date. The employees were between 41 and 598 days late.

Ludeman Developmental Center

- Two out of five (40%) employees tested did not receive the required annual training. The employees' annual training was 59 and 268 days overdue.

Mabley Developmental Center

- One out of five employees authorized to apply restraints during FY15 did not receive their required annual training.
- One out of five residents placed in restraints was restrained twice in a 48-hour period without the prior written authorization of the Center Director.
- One out of five residents placed in restraints did not have the use or application of the restraint reviewed by the Center Director or Administrator on Duty (AOD).

Department management stated that the finding was due to staff oversight and changes in the statewide tracking system for trainings.

Updated Response: Implemented. The Division of Developmental Disabilities (DDD) had all appropriate staff at the DD Centers retrained on Administrative Directive 02.02.060.030 for training staff on the statutory requirements regarding the use of restraint. The Division of Developmental Disabilities (DDD) plans to develop and implement a tracking system at each DD Center to monitor and identify training due dates. The Division of Developmental Disabilities (DDD) Regional Management of State-Operated Developmental Center (SODC) Operations will develop a periodic quality assurance report requiring all Centers to verify compliance in this area. Also, SODC Regional Management will require periodic reports from all DD Centers to ensure compliance is achieved and maintained.

The Division of Mental Health (DMH) had all applicable staff retrained on the Restraint Program Directive 02.02.06.030 and all related documentation (Alton 100%, Chester N/A, Read 100%, Elgin N/A, McFarland N/A, Madden 100%, and TDF N/A). They also conduct monthly audits to measure compliance and the results are submitted quarterly to Quality Control to ensure compliance is achieved and maintained (Alton 100%, Chester N/A, Read 100%, Elgin N/A, McFarland N/A, Madden 100%, and TDF N/A). The Division of Mental Health (DMH) will develop and implement a tracking system to monitor timely completion of restraint documentation (Alton 100%, Chester N/A, Read 60%, Elgin N/A, McFarland N/A, Madden 100%, and TDF N/A).

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11. Establish comprehensive Department-wide internal controls over compliance with State mandates applicable to all Centers. Include requirements for training personnel on compliance requirements and outline management oversight over compliance requirements. (Repeated-2011)

Finding: The Department did not comply with various mandates applicable to its facilities for administering pregnancy tests, monitoring facility visitors, resident admission, resident discharge, reporting resident deaths, providing dental examinations, and charging residents for services as follow:

- During resident file testing, it was noted that two facilities failed to obtain a signed consent form prior to administering pregnancy tests to residents:
    - At McFarland, 11 out of 60 (18%) files did not include documentation of consent by the resident or her guardian.
    - At Kiley, two out of 60 residents received a pregnancy test before their guardian signed a consent form. The forms were signed 28 and 260 days after the pregnancy test was administered.
- At Kiley, that two out of five visitors sampled did not sign in at the individual homes as required.
- The Read, Madden, and Murray facilities failed to follow proper procedures relating to admissions of residents.
- Chester, McFarland, Madden, Read, and Elgin—had instances in which admission procedures, forms, and required reporting of disabled residents were not properly performed or completed.
- Resident discharge was not properly administered at Murray, Madden, and McFarland.
- Patient deaths were not properly reported at the Elgin Mental Health Center. There was an instance in which written notice of death was provided to the court 31 days late.
- Three of five residents at McFarland did not have a dental examination performed at least once every 18 months as required.
- The Rushville Treatment and Detention Facility did not implement a policy and rate structure for charging residents for services. The Department has drafted but not implemented policies and procedures on charging residents for services and a

corresponding rate structure at the Facility. Currently, 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. As of June 30, 2015, the Facility had approximately 550 residents. The Facility expenditures for FY15 and FY14 were approximately $26 million and $30 million, respectively.

Department management stated that the discrepancies noted were due to staff oversight. The Rushville Treatment and Detention Facility (Facility) has developed a rate structure and drafted language that directs the rate structure, but it is currently being held up in the review and approval process with the Joint Committee on Administrative Rules (JCAR) and is not anticipated to be established until the end of FY16.

Updated Response: Implemented. The Division of Developmental Disabilities (DDD) has had the appropriate staff at the DD Centers re-trained on the compliance requirements of the statutory requirements identified in this finding. The Division of Developmental Disabilities (DDD) states that SODC Regional Management will develop a quality assurance monitoring document to be implemented at all DD Centers. SODC Regional Management will require periodic reports from all DD Centers to ensure compliance is met in this area.

The Division of Mental Health (DMH) has had the State hospital policy and procedure reviewed and revised to include required consent prior to the administration of pregnancy testing. Patient/guardian consent for pregnancy testing has been developed and implemented. The Notice of Admission (IL462-2018) is completed by the psychiatrist at the time of admission to ensure 100% completion (JJMMHC). All Nursing staff has been retrained on the Admission Notification (CRMHC). Recommendations were made to revise the Illinois Notification of Admission form IL462-2018. These recommendations were accepted and revisions were applied as of August 2015.

All MI/ID staff have been retrained on the requirements of completing the assessment to certify and re-certify MI/ID individuals, the modification of the Master Treatment Plan to include MI/ID when applicable, the timely completion of the MI/ID notification, and have established a tracking system for MI/ID individuals (Alton 100%, Chester N/A, Read N/A, Elgin N/A, McFarland N/A, Madden 100%, and TDF N/A).

All of the social work staff has been retrained on the requirement/procedure to provide notice of discharge 7 days prior to the actual discharge date. A corrective procedural change includes placing a copy of the Notice of Determination (NOD) in the patient record (JJMMHC). There is also a quarterly audit of the discharge packet to ensure timely completion of the Notice of Determination (AMMHC) (Alton N/A, Chester N/A, Read N/A, Elgin N/A, McFarland N/A, Madden 100%, and TDF N/A).

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Health Information Management staff and court services have been retrained on the requirement for timely notification in the event of a patient death (within10 days) and a tracking system has been established (EMHC). Medical staff has been retrained on the statutory requirement that all patients receive a dental consultation at least once every 18 months, have developed a computerized tickler system to prompt the dental consult order, and conduct quarterly audits to ensure compliance (AMMHC) (Alton N/A, Chester N/A, Read 100%, Elgin 100%, McFarland N/A, Madden 100%, and TDF N/A).

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

- **Perform customer redeterminations in accordance with Administrative Rules governing the Home Services Program.**
- **Improve monitoring by assigning additional staff resources or by enacting alternative means for monitoring program activities. (Repeated-2005)**

Finding: During testing, numerous internal control weaknesses were identified in the Department's Home Services Program managed by the Department's Division of Rehabilitation Services. These weaknesses were first noted in a review of the Home Services Program that Department management had performed in FY05.

Through testing and discussions with Home Services Program personnel, it was determined the following weaknesses were still prevalent during the current examination period:

- There was insufficient monitoring of case files to ensure program objectives were being met. There were an average of 38 supervisors at 44 field offices to monitor Home Services Program activities. On average, each supervisor was responsible for approximately 797 case files during FY15 and FY14. During the previous examination period, the statewide average responsibility per supervisor was approximately 803 case files. There were an average of 148 counselors with an average caseload of approximately 202 case files during FY15 and FY14. During the previous examination period, the statewide average per counselor was approximately 216 case files.
- The customer receiving services is to be visited by the Case Counselor once annually and the counselor is to perform a redetermination of need. In circumstances of a traumatic brain injury, the customer is to be visited twice annually. Testing noted seven out of 20 personal assistants (35%) had payments approved without a current service plan. The services performed ranged from 25 to 519 days after the next redetermination period as indicated on the customer's service plan. Therefore, redeterminations are not being performed timely.
- In seven out of 20 (35%) tested, the service plan was not up to date. The annual (or semiannual for traumatic brain injury) reassessments had not been performed for 25 to 519 days. This allowed the Personal Assistant hours to be limited and the pay

calculated based upon out of date service plans, regardless of the current care need of the customer. The hours paid during testing were 570.70 hours totaling $7,082.

Department management stated that staffing levels and the overall scale of the program contribute to the issues identified.

Updated Response: Accepted. New staffing positions have been created that will allow for the Division of Rehabilitation Services (DRS) to hire counselors from additional degrees than they had formerly been able to. Staffing is continuing to be monitored in terms of caseload as the Electronic Visit Verification (EVV).

13. Establish formal Department-wide procedures for processing Personal Assistant 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 Personal Assistant is not paid more than permitted;**
- **Requiring supervisory approval to override system warnings associated with service plan overages or more than one timesheet per pay period. A record of these override approvals should be maintained and reviewed;**
- **Performing a reconciliation of Personal Assistant timesheets to the payroll warrants; and**
- **Performing eligibility redeterminations in accordance with the requirements outlined in the Department's Administrative Rules governing the Home Services Program. (Repeated-2011)**

Finding: The Department did not have adequate internal controls for processing its Rehabilitation Services' Personal Assistants timesheets within the Statistical Tracking and Retrieval System (STARS) payroll system or within the new Electronic Visit Verification (EVV) system.

During testing, auditors noted the following:

- No supervisory approval was required for overriding system warnings associated with service plan overages or more than one timesheet per pay period.
- No formal Central Office review procedures existed to ensure a Personal Assistant was not paid more than permitted.

The Department implemented the EVV system during the examination period, in which Personal Assistants call in when they arrive and when they leave each customer. The EVV Phone System was activated in January 2014 and was available for use in May 2014. Mandatory use was initiated in January 2015, while EVV did not "drive" the payments until July 1, 2015. In July 2015 the system interfaced directly into the Payroll system. During the transition to the new system, and current situations in which a phone cannot be used, manual processes were still involved with the STARS system. Also, manual adjustments

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are often made to fix any errors of the system, such as calling in upon arrival but forgetting to call in before leaving the customer. There are no Department-wide policies and procedures in place regarding manual adjustments made to the system, including if supervisory approval is needed to make these types of changes or the manner and frequency in which exceptions reports are created and reviewed.

During testing of Personal Assistants' timesheets to payroll, auditors identified the following exceptions:

- In five out of 20 (25%) tested, it was noted that hours paid to the Personal Assistant varied from the hours recorded on the timesheet. This resulted in an overpayment of 19.08 hours for a total of $248.
- In four out of 20 (20 %) tested, the Personal Assistant was paid for more hours than allowed by the service plan. This resulted in 33.70 hours totaling $400 of unallowable payroll.

Department management stated that the period of review was the transition period from a process of paper timesheets to the full roll out of the EVV system.

Updated Response: Implemented. Implementation of the Electronic Visit Verification (EVV) system addresses the concerns identified in this finding.

14. Allocate sufficient resources to improve compliance with the Administrative Rules for monitoring provider agencies who were Division of Rehabilitation Services grant/award recipients. (Repeated-2013)

Finding: The Department did not adequately monitor provider agencies who were Division of Rehabilitation Services grant/award recipients.

Programs administered through the Department's Division of Rehabilitation Services accounted for $63 million of the $5.24 billion (1%) of the Department's grants/awards expended in FY15 and $62 million of $5,097 million (1%) of its grants/awards expended in FY14. The Independent Living Program accounted for $1 million during FY15 and $678,000 during FY14. During testing, auditors noted the Independent Living Unit implemented an internal paper review process, where information was received from all 22 providers during FY15 and combined for Federal Reporting purposes. However, no formal processes and procedures had been developed in order to report back to the providers any issues noted in a timely and systematic manner.

Testing of the Department's monitoring of the Division of Rehabilitation Services' grant/award agreements with its independent living program provider agencies also revealed the following:

- No on-site monitoring for any of the providers in the Independent Living Program had occurred during FY14 and FY15. According to the Community Rehabilitation Program (CRP) Manual, the DHS/DRS Program Advisor is to perform on-site reviews of all contracted CRPs no less than every three years.
- For one of the three providers tested, monitoring of FY15 was conducted on December 8, 2015 with a report issued January 14, 2016 and a corrective action plan received February 29, 2016. Both the report issued and corrective action plan were after the 30 day requirement per statute. Additionally, the other two providers tested did not have an on-site monitoring visit since 2009 and 2006.

Department management stated staffing vacancies and a lack of a smooth transition led to instances where on-site reports were not completed timely.

Updated Response: Accepted. Staff will continue scheduling and completing on-site reviews in accordance with program guidelines. All report monitoring and expenditure monitoring will continue as it has. Additional program staff positions will be hired to help complete on-site monitoring of providers.

15. Allocate additional resources to the ALL KIDS eligibility redetermination process and establish an internal control whereby benefits are not provided until such redeterminations are complete. (Repeated-2005)

Finding: The Department does not have adequate controls over eligibility redeterminations and, as a result, 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.

The ALL KIDS program provides health benefits to children of the State whose family income was greater than 133% of the federal poverty level and at or below 200% of the federal poverty level. The Department is responsible for eligibility determinations or redeterminations of the ALL KIDS program. The Department of Healthcare and Family Services (HFS) is responsible for overall program administration.

Based on the Office of the Auditor General's February 2016 Program Audit of the Covering ALL KIDS Health Insurance Act, of the 28,695 EXPANDED ALL KIDS recipients that required an annual redetermination of eligibility in FY14, 6,625 (23%) were not redetermined annually as required. Testing for FY15 found that of the 29,881 EXPANDED ALL KIDS recipients that required an annual redetermination of eligibility, 3,715 (12%) were not redetermined annually as required.

Department management stated that an increasing number of overdue redeterminations exist due to the absorption of cases that would have previously been eligible for administrative renewal; start-up issues and time spent on process development with Maximus; and the amount of time spent on staff development for new hires. The audit period

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was met with a learning curve as staff became acclimated to the newly developed system and its functionality.

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

DHS and HFS have allocated additional resources by setting up 4 specialized central redetermination units across the state to handle most medical only redeterminations. Staff in these units specialize in working in the new Max-IL system, developed by Maximus, that records and stores redetermination information, forms, and verifications.

As the Illinois Department of Healthcare and Family Services is the single state Medicaid agency, any policy changes related to stopping medical benefits until the redetermination is made would need to be implemented by them.

Updated Response: Accepted. A modified Illinois Medicaid Redetermination Project began in February, 2014, in order to assist with medical only cases due for a redetermination. Beginning April, 2014, the central redetermination units began receiving and acting upon automated eligibility recommendations from the Max-IL system.

When Phase 2 of IES rolls out, additional efficiencies will be realized in many different areas, including redeterminations. IES will allow for automatic redetermination for many medical cases that can have all eligibility factors verified electronically. The Department will complete the implementation of the Illinois Integrated Eligibility System (IES), which will provide enhancements to the redetermination process for many medical cases. This enhancement will utilize a 3 step process which includes the following:

1. Selection/Exclusion – The system selects cases eligible for the enhanced, more automated, redetermination process.
2. Medical Redetermination Clearances – prior to the redetermination due date, the system automatically runs eligibility clearances for the selected cases.
3. Processing the Redetermination – using the information gathered from the client and from the automated clearance runs, eligibility is determined.

16. Implement the recommendations as reported in the Program Audit of the Office of the Inspector General that was released in December 2010.

Finding: The Office of the Inspector General (OIG) has not fulfilled recommendations made in the program audit of the OIG.

In December 2010, the Office of the Auditor General released its report of the Program Audit of the Office of the Inspector General, Department of Human Services. During the current compliance examination, the auditors followed up on the implementation of the outstanding recommendations, as follows:

> "The Office of the Inspector General should update its interagency agreements with other State agencies that have investigatory powers." (Recommendation 2)

The Department has an expired agreement with the Illinois Department of Public Health and no interagency agreement with the Department of Children and Family Services.

> "The Office of the Inspector General should continue to work to improve the timeliness of investigations of abuse and neglect. The OIG should also work to improve the timeliness of investigations conducted by Clinical Coordinators, especially death investigations." (Recommendation 3)

The recommendation had been partially implemented. During FY15, the average time of completion for all Department OIG investigations increased from 78.6 days in FY14 to 95.5 days in FY15, which omitted time for delays necessitated by pending Illinois State Police or local law enforcement investigations. The average does not fall within the required 60 days and the timeliness of investigations has not improved. The average time for Clinical Coordinators, however, improved from 112.9 average days in calendar year 2014 to 74.2 days in calendar year 2015. Steps taken by the OIG to improve timeliness include relocating staff, requesting additional staff, and the creation of a Clinical Coordinator Department with all Clinical Coordinators reporting to the same Bureau Chief.

> "The Office of the Inspector General should assign all allegations to an investigator within one working day and complete all investigative plans within three working days as is required by OIG directives." (Recommendation 4)

The recommendation had not been implemented. Although the Office of the Inspector General indicated that they assign investigations within one working day when possible, delays occur due to backlog of intakes, absence of supervisors, and an initial law enforcement referral. The database has been programmed to send an email to an investigator when the Bureau Chief assigns him/her a case. Additionally, Bureau Chiefs are responsible for ensuring that investigative plans are completed within three working days.

> "The Office of the Inspector General should continue to work with State facilities and community agencies to ensure that allegations of abuse or neglect are reported within the time frame specified in the Department of Human Services Act and OIG's administrative rules." (Recommendation 5)

The recommendation had been partially implemented. During FY15, 8.29% of allegations reported to the OIG by staff of the community agency or facility where the alleged abuse or

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neglect occurred were reported late, an increase of 0.25% from FY14. If an allegation is reported late, the database will flag the allegation and the field investigator will investigate as to why it was late. The final investigative report will cite the agency or facility for late reporting and the written response will indicate corrective action required. Additional efforts to improve timeliness include a review of all community agency internal policies on reporting to ensure each one contains accurate reporting timeframes, as well as providing training sessions to facility and agency staff each year that covers timely reporting.

> "The Office of the Inspector General should use the annual site visit process to target and examine areas at individual facilities where other investigations and/or reports have identified systemic resident safety concerns, such as the underreporting of abuse and neglect. Furthermore, if State facilities repeatedly fail to take corrective action on matters raised by OIG site visits or arising out of other investigations, the Inspector General should also consider making recommendations, up to and including sanctions, to ensure the safety of State-operated facility residents." (Recommendation 8)

During the current compliance examination, auditors noted that the OIG has continued to fail to impose sanctions on facilities. The Department stated the OIG considers issues raised in investigations during the site visit issue selection process. Each year, repeat recommendations exist and they are reviewed during the site survey process. If the facility has a realistic and appropriate plan in place the OIG notifies the program division of the finding and plan and continues to monitor progress. During FY14 and FY15, the Department made seven second-year recommendations and three third-year recommendations. No sanctions were involved, however, the OIG requested the assistance of the Division of Developmental Disabilities to explore ways to resolve the issue that occurred for a third consecutive year. The Department still appears to have an issue with addressing site visit recommendations not implemented for multiple years.

> "The Secretary of the Department of Human Services and the Inspector General should continue to work with the Governor's Office to get members appointed to the Board as promptly as possible, in order to fulfill statutory membership requirements (20 ILCS 1305/1-17(u)). Staggering the terms of members should be used in order to ensure membership." (Recommendation 9)

The recommendation has not been implemented. Although a quorum met for each quarterly meeting during both FY14 and FY15, the Board was unable to maintain seven members as required.

Response: The OIG accepts the recommendation. The OIG will update its IGA with DCFS, will continue to streamline our processes to improve in the assignment of cases and investigative plan completion, work with agencies and facilities to reduce the number of late reports, revise our Sanctions directive to memorialize OIG's referral process of issues to the divisions, and will continue to work with the Quality Care Board, the DHS Secretary and the Governor's Office to fill the vacant seats on the QCB.

Updated Response: Implemented. The Division of Developmental Disabilities (DDD) had all appropriate staff retrained on the Department of Human Services Act and OIG's Administrative Rules specifically related to timely submission of allegations. Also, the State Operated Developmental Centers (SODC) Regional Management ensured compliance with training.

The DHS Office of the Inspector General (OIG) will update its Intergovernmental Agreement (IGA) with the Department of Children and Family Services (DCFS); streamline DHS-OIG processes to improve in the assignment of cases and investigative plan completion; work with agencies and facilities to reduce the number of late reports; revise the DHS-OIG Sanctions Directive to memorialize OIG's referral process of issues to the Divisions; and work with DHS Secretary and the Governor's Office to fill the vacant seats on the Quality Care Board (QCB). DHS-OIG is currently proofing a draft of the DHS-OIG Sanctions Directive, which should be finalized by October 31, 2016. Since DHS-OIG is in the process of revising most of its Directives at this time, this took longer than planned.

17. Increase the level of supervisory review of the voucher process. Direct supervisors to allocate adequate resources to the area and direct staff to follow established policies so that invoice vouchers are processed and paid in a timely manner to limit interest penalties. Provide interest amounts determined to be owed to the IOC prior to the deadline. Also, develop and document Agency wide policies and procedures for small purchases that are consistent for all Business Offices and Centers. (Repeated-2011)

Finding: The Department did not perform an adequate level of supervisory review over the processing, approval and payment of vouchers as required by the Illinois Administrative Code and Department policy.

Voucher Processing and Payment Testing

Testing of 660 vouchers was performed across several areas and it was noted that in 81 instances the Department did not review each vendor's invoice and either deny the bill in whole or in part, ask for more information necessary to review the bill, or approve the voucher in whole or in part, within 30 days after the receipt of the bill.

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Also, five out of the 60 (8%) EDP vouchers types tested did not provide a requisition or other obligating document with the voucher support.

During testing of the 660 vouchers, there were 12 instances wherein the Department's required interest penalty payments, which were incurred due to late payment of invoices from various vendors, were not submitted to the Illinois Office of the Comptroller (IOC).

Upon further testing of the population of all interest penalty payment vouchers, approximately 964 interest penalty payment vouchers were processed to some extent during FY15, totaling $359,550. Of that total, approximately 681 interest penalty payment vouchers (71%), which totaled $304,474, were not fully processed with the IOC nor paid to vendors as required.

Purchasing Policies

Although the Department has policies and procedures governing purchases greater than $10,000, the Department does not have agency specific purchasing policies in place for amounts under $10,000.

Approvals

The Office of Fiscal Services Division, Bureau of Expenditure Control, has the responsibility for the third and final agency approval function for all Department expenditures. Auditors noted one third-level approver who was not included on the original listing of third-level approvers provided during voucher testing. The Department could not provide authorization support for why this individual was given third-level approval.

Department management stated untimely approval of vendor invoices is attributable to staff oversight and/or competing priorities.

Response: Accepted. The Department currently requires three levels of approvals and will ensure controls are followed. A reminder will be sent to appropriate staff to process vouchers timely. The Department will ensure the interest amounts owed are submitted to the IOC prior to the deadline. In addition, the Department will develop agency-wide procedures to address the small purchase issue.

Updated Response: Implemented. The Division of Developmental Disabilities (DDD) retrained all appropriate staff on Administrative Code - 74 Ill. Adm. Code 900.70 and Administrative Directive 01.09.02.020 - Payment Voucher Approvals. The Division of Developmental Disabilities (DDD) SODC Operations Regional Management will draft a procedure for Center level operations for the voucher process. All appropriate DD Center

staff will be trained on this procedure. SODC Regional Management will require periodic reports from DD Centers to ensure compliance is achieved in the processing of vouchers.

The Office of Fiscal Services will send an agency reminder to ensure staff follows the Directives for timely processing of vouchers and remind the System Support unit to submit interest due on vouchers by the IOC deadline.

The Office of Budget will develop and disseminate policies regarding small purchases.

18. Improve processes and implement controls necessary to reduce the instances of missing documentation in employee files which includes the forms necessary for payroll deduction authorizations, leaves of absence, and employee overtime. Have a Supervisor review the Agency Workforce Report and make any corrections before it is filed. Also, provide training to employees who are required to file economic interest statements. (Repeated-2007)

Finding: The Department did not maintain all necessary and required supporting documentation in employee payroll and personnel files. In addition, the Department did not file accurate Agency Workforce Reports or enforce Economic Interest Statement requirements per statute.

Employee File Testing

During testing of employee payroll and personnel files at the Central Office, auditors noted the following exceptions:

- In 16 of 60 payroll files tested, voluntary withholding payroll deduction authorization requests were not maintained in the files.
- In one of 60 personnel files tested, the pay rate per the CMS-2 on file did not match the employee's actual pay.
- During testing of employees who incurred overtime, two of 20 employees tested had overtime amounts included in the calculation of lump sum pay when prohibited, based on their status. Total overtime paid was $2,025 and this amount has not been recouped and both employees have since terminated their employment.
- During testing of employee vacation, one of 22 sampled did not have supporting documentation for the vacation request.
- During testing of employees on leave of absence, one out of nine employees had a leave of absence term past the date in which the employee returned to work. This timekeeping error resulted in the employee not being paid for those days they returned early. A supplemental payment was made to these employees in the month following their return.

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Fringe Benefit Testing

During testing of fringe benefits of employees with personally-assigned vehicles, auditors noted the following exceptions:

- Two out of 17 Quarterly Reporting of Commuting Reports could not be located.
- Three out of nine selections from the Employee Assigned Vehicle Listing were not updated accordingly.
- One out of nine amounts denoted on payroll vouchers as paid for fringe benefit amounts did not agree to the amount reported on the W-2 confirmed with the Comptroller's Office by $120 ($213 reported on the W-2 and $93 on the payroll voucher).

Agency Workforce Report Testing

During the examination, auditors determined that the Department's FY13 and FY14 Agency Workforce Reports contained variances between the numbers and percentages in the report versus the numbers and percentages contained in the Department's supporting records.

Economic Interest Statement Testing

During testing of the Statements of Economic Interest, auditors noted the following exceptions:

- Five out of 60 Statement of Economic Interest forms did not have all sections properly completed by the Department's employees.

Department management stated that withholding documents were not received from legacy agencies in the merger of DHS, not received by the former employing agency upon employee transfer or misfiled.

Review was not complete for the Economic Interest Statement forms due to employees submitting the forms directly to the Secretary of State (SOS). One employee was not removed from the list due to management oversight.

An employee input error resulted in an inaccurate Agency Workforce Report.

Updated Response: Accepted. DHS-Office of Human Resources (HR) will send a reminder to all staff involved in maintaining and accessing Payroll and Personnel Files to ensure that documents are filed timely and appropriately.

DHS-Office of Civil Affairs will coordinate the completion of the Agency Workforce report and review the numbers for accuracy, and submit the report to the Bureau Chief for review and approval prior to submitting the report to the Secretary of State and the Governor's Office.

DHS-Legal (Statement of Economic Interest) will implement a review process to ensure all sections of the Statement of Economic Interest forms are properly completed by the Department employees prior to submission to the Secretary of State's Office. A process will be implemented to ensure Department records are properly updated to reflect the change in employment status when a Statement of Economic Interest form is not filed when an individual is no longer employed by the Department.

19. Submit all reports on or before the due date specified in State Law. (Repeated-2013)

Finding: The Department did not submit required reports to the Governor and the General Assembly in a timely manner as required by State Law.

During the examination period, the Department was required to submit various reports to the Governor and the General Assembly. None of these reports were filed in a timely manner.

- The Department did not prepare a report for the General Assembly regarding the Work Opportunity Tax Credit during the two-year period ended June 30, 2015. Department management stated this report is duplicative of a report currently provided to the Generally Assembly by the Illinois Department of Employment Security. As such, the Section of the Act requiring the report was repealed effective June 30, 2015.

- The Mental Health and Developmental Disabilities Administrative Act requires the Department to annually report to the Governor and the General Assembly, by September 1, on both the total revenue deposited in the Community Developmental Disability Services Medicaid Trust Fund (Trust Fund) and the total expenditures made from the Trust Fund for the previous fiscal year. The Department did not submit the FY13 report to the Governor's Office as required by the statute and did not submit the FY14 report timely.

- The Mental Health and Developmental Disabilities Administrative Act requires that on December 31st (2011 through 2014) the Department shall prepare and submit an annual report to the General Assembly concerning the implementation of the Williams v. Quinn consent decree and other efforts to move persons with mental illnesses from institutional settings to community-based settings. Except for the Legislative Research Unit, the Department was unable to provide support showing the reports were filed with and received by the other required parties.

- The Department of Human Services Act requires that within 30 calendar days from receipt of a substantiated investigative report or an investigative report which contains recommendations, the Center or agency shall file a written response. During examination, auditors noted that the Center or agency did not file a written response

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within 30 calendar days for 21 out of 25 files selected. Also, the Secretary did not determine the appropriate corrective action to be taken as required. Three out of the 21 exceptions noted pertained to Department facilities, the remaining 18 were not Department facilities. Department management stated employee error and oversight contributed to the deficiencies identified above.

Updated Response: Implemented. DHS-Office of Legislation has shared a master document of all reports and due dates with the Divisions. The Office of Legislation sends a memo to Division Directors to remind them of their responsibility to complete the reports on time.

20. Develop and implement procedures to perform expenditure reconciliations in a timely manner. Require the timely posting of expenditure transactions to CARS prior to the performance of reconciliations. Also, address the unexpended budget authority. (Repeated-2011)

Finding: The Department did not reconcile its expenditure balances with the Illinois Office of the Comptroller (Comptroller) records in a timely manner.

For all four monthly expenditure reconciliations tested, it was noted that the reconciliation was not performed timely. The reconciliations were completed between three and four months after the period being reconciled.

During the testing of payroll during FY15, it was noted that the payroll amounts recorded at the Comptroller's Office were not recorded by August 31, 2015, the end of the lapse period. As of August 31, 2015, $8.6 million of payroll at the Comptroller's Office was not recorded in the Consolidated Accounting and Reporting System (CARS) in a timely manner.

In addition, during review of the monthly reconciliations, it was noted that the reconciliations primarily focused on expenditures incurred by the Department. Per inquiry with Department personnel, the Department does not conduct a reconciliation to determine the unexpended budget authority as prescribed in the SAMS Manual. Instead, the Department only reconciles the expenditures incurred on a monthly basis.

Department management stated that staffing vacancies and the lack of an integrated accounting system led to the delays.

Updated Response: Implemented. The Department completes expenditure reconciliations in a timely manner and forwards a list of the reconciling items applicable to the Bureau of Expenditure Accounting for resolution on a monthly basis. Expenditure reconciliations have been revised to include unexpended budget authority as required by the SAMS Manual. The

Department has developed a process to ensure payroll journal vouchers are posted in a timely manner to the Consolidated Accounting Reporting System (CARS) and has implemented the new process. The Department has posted prior payroll journal vouchers and continues to post payroll journal vouchers in a timely manner.

21. Develop a methodology to calculate prompt payment interest that results from late medical payments to vendors processed through MMIS. Include the creation of an interagency agreement with HFS to obtain the necessary detailed documentation to ensure prompt payment interest is calculated as outlined in SAMS. Also, estimate a liability for such contingency when preparing financial statements, where applicable. (Repeated-2013)

Finding: The Department failed to calculate and pay prompt payment interest that resulted from late medical assistance payments to vendors.

During testing, it was determined that the Department does not have a methodology to calculate prompt payment interest that results from late medical payments to vendors processed through MMIS and, therefore, the Department did not pay these amounts going back to the year ended June 30, 2010. The Department determined it had failed to pay prompt payment interest in the amount of $20,475,749 to 270 vendors during FY10 through FY13.

In addition, the Department is unable to provide supporting documentation for the medical assistance payments recorded against its appropriations. The Department does not have a process to track, and has not determined the amount of prompt payment interest for FY14 and FY15. The Department provided support for the payment of $207,124 for MMIS Prompt Payment Interest. However, compared to the amounts calculated for prior years as indicated above, auditors were unable to determine the entire population of MMIS prompt pay interest due to vendors in order to determine if all amounts were paid. Department management stated the Department only receives summary transactions data for entry into their Consolidated Accounting and Reporting System (CARS).

No liability is necessary for unpaid claims because any demanded amounts would be paid outside of the Department, from the Court of Claims.

Department management stated a verbal agreement to pay and process MMIS interest payments was initiated back in FY10 between the Department and HFS. However, no written interagency agreement has ever been in place to handle processing MMIS payments or paying interest. The Department also noted that because their access to MMIS data is limited, they felt it was impossible to calculate the full amount of eligible prompt payment interest.

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Updated Response: Accepted. The Department of Human Services will draft an interagency agreement with the Department of Healthcare and Family Services (HFS) that will include a methodology to calculate the Prompt Payment Interest (PPI), the calculation of the Prompt Payment Interest (PPI) on Medical Assistance through the HFS Medical Management Information System (MMIS), and access to view the MMIS and the Enterprise Data Warehouse (EDW) to verify the accuracy of the PPI calculation.

The Department will perform a legal review of the interagency agreement and obtain signatures. We will draft procedures for the review of the PPI methodology and calculation, documentation process, and estimation of the liability for financial reporting. We will review the PPI methodology and calculation and obtain sufficient documentation for audit purposes. We will calculate the estimated liability for PPI and document the calculation for audit purposes.

22. Either comply with the law by serving as the lead agency to establish joint rules for the pre-qualification process, or obtain a statutory change in the law to transfer the responsibility to another State agency or office.

Finding: The Department did not comply with a law requiring it to serve as the lead agency to establish a cross-agency prequalification process for contracting with human service providers.

The Department in its role as "lead agency" did not work with each State human services agency to establish joint rules for the pre-qualification process for contracting with human service providers and did not establish cross-agency master service agreements of standard terms and conditions for contracting with human service providers. The statute was not amended to reflect a change in lead agencies nor is there a formal agreement to transfer the responsibilities of this mandate.

Department management stated that the responsibility of the initiative to establish joint rules for the prequalification process and cross-agency master service contracts with human service providers was transferred from DHS to the Illinois Office of Management and Budget (GOMB) under the Grant Accountability and Transparency Act.

Updated Response: Implemented. Legislation requested the change be made to the Statute.

23. Comply with current policies and procedures regarding employee evaluations and follow the control system in place. (Repeated-2005)

Finding: The Department did not perform sufficient supervisory reviews over employee performance evaluations and, as a result, did not comply with Department of Central Management Services' (DCMS) rules for the conduct of employee performance evaluations. During testing, it was noted 38 of 76 (50%) Department employee evaluations sampled did not receive a performance evaluation on a timely basis. The date of completion ranged from six to 534 days late. Additionally, the Department could not provide documentation that employee performance evaluations had been performed during the examination period for two of 60 employees.

During the examination, additional testing was performed at certain facilities where issues with employee evaluations were noted: Chicago Read Mental Health Center, John J. Madden Mental Health Center, and Illinois School for the Deaf.

Department management stated that supervisors are not completing the evaluations timely due to competing priorities.

Updated Response: Accepted. The Bureau of Employee Services (BES) has made the task of addressing delinquent evaluations a priority. A reminder memo will be sent to all Executive Staff to share with their supervisors. Notice is received from CMS regarding evaluation due dates. These notices are shared with Facility and Division Liaisons timely upon receipt. In addition, the Director of Human Resources has made compliance a priority with Division Administration and is an ongoing task. BES is also attempting to obtain a database for easier tracking of evaluation due dates.

24. Comply with current policies and procedures regarding property and equipment, and follow the control system in place. Additionally, adequately maintain buildings and facilities to prevent further deterioration. (Repeated-2005)

Finding: The Department did not have adequate control over State property inventories and recordkeeping.

As of June 30, 2015, the Department valued its State property at $226,971,000. During testing of property and equipment at the Central Office and Department facilities, some of the discrepancies noted by the auditors were as follows:

Central Office:

- In two out of 40 equipment additions tested, the Department did not include freight and installation charges as indicated on the invoice when recording the assets' value within their inventory records. This resulted in the assets being understated by $1,033.
- While testing lease and installment purchase agreements, auditors noted the Department did not provide complete information within the Accounting for Leases – Lessee Forms (SCO-560).

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- The Annual Real Property Utilization Report for FY14, which is due to the Department of Central Management Services by July 31st of each year, was submitted on November 3, 2014.

Alton Mental Health Center:

- Thirteen out of 20 (65%) buildings observed were deteriorating or susceptible to deterioration due to nonuse.

Chicago Read Mental Health Center:

- The Center Space Utilization Report was incomplete.

Elgin Mental Health Center:

- Three out of ten equipment items, totaling $1,672, appeared to be obsolete or not in use by the Center when physically observed.

Ann M. Kiley Developmental Center:

- During the examination period, the Center was using seven homes for storage/warehouse purposes. The homes appeared to have water damage and deterioration issues with the floors and ceilings. The homes contained several items that were in oversupply or appeared to be obsolete. Also, six of 28 items tested at these homes did not trace to the inventory listing and six of 28 items tested traced to incorrect locations on the inventory listing.
- During testing of equipment transactions, auditors noted three out of 10 (30%) items tested, totaling $141,060, were added to the property listing between 54 and 123 days late.

Ludeman Developmental Center:

- One out of five (20%) equipment items tested and physically observed at the Center could not be located on the Center's Property Listing.

Andrew McFarland Mental Health Center:

- Two of 15 equipment items tested, totaling $3,303, were not located in the same location as reported on the property listing.
- One of 10 large equipment transactions tested, totaling $28,199, was not entered into the inventory system within 30 days. The item was entered seven days late.

Warren G. Murray Developmental Center:

- One building contained property items totaling $192,715 that appeared to be obsolete.

Illinois School for the Deaf:

- Three out of 20 equipment items tested, totaling $16,997, were not located in the proper location as reported on the School's inventory listing.

Illinois School for the Visually Impaired:

- Three out of 10 equipment items tested, totaling $11,124, were not located in the proper location as reported on the School's inventory listing.

Department management stated that insufficient headcount and an outdated and insufficient inventory system contributed to the discrepancies noted.

Updated Response: Accepted. The Division of Developmental Disabilities (DDD) had all DD Center's Property Control Coordinators and their designated back-up received training in Property Control Procedures. The Office of Business Services (OBS) will increase Property Control headcount, develop and implement a quarterly inventory schedule for all IDHS locations, and implement an ERP system for IDHS. The Business Administrator or designee at the Division of Developmental Disabilities (DDD) Center will monitor property control at the Center to ensure compliance with all procedures, codes and applicable acts. Also, the Regional Management of SODC Operations will develop and implement a periodic quality assurance report requiring all Centers to verify compliance in this area.

25. Comply with current policies and procedures regarding accounts receivable and follow the control system in place. Maintain detailed records of all billings and the corresponding collections to facilitate proper reporting of accounts receivable activity. Write off delinquent or uncollectible accounts to reflect only realizable amounts. Finally, allocate sufficient staff 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 is in violation of its own policies and procedures as well as statutory requirements regarding the administration of accounts receivable. During testing, some of the deficiencies noted by the auditors were as follows:

Alton Mental Health Center:

- Three out of five recipient files tested, with receivables totaling $2,630, included receivables aged over 180 days that were not submitted to Central Office timely.
- Medicare Part B billings are not being processed because of a key employee being on a leave of absence.

Chicago Read Mental Health Center:

- For 221 out of 279 (79%) accounts receivable on the Center's records, ranging from 13 months old to 318 months old, there was a total past due balance of $745,791. The Center and the Central Office did not analyze the related financial history of

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respective accounts receivable in order to determine the adequacy of a potential write-off.

Clyde L. Choate Mental Health and Developmental Center:

- For six of 12 recipient accounts tested, totaling $9,131, the Center did not provide support to show the accounts had been properly billed.
- Two accounts titled "Settlements" had large negative balances totaling ($664,092) and ($98,685). The settlement accounts are payments that have been made to the Center for contractor billings, but they have not been applied to the individual recipient's accounts.

Elgin Mental Health Center**:**

- One out of six (17%) recipient files tested, with receivables totaling $171,171, was aged over 180 days and not submitted to Central Office for collection.

Ann M. Kiley Developmental Center:

- During testing, auditors noted the Aged Recipient Accounts Receivable Report was not accurate for one of five accounts tested. Part of a former resident's past due balance was being reported as a current receivable while the other portion was being classified as "aging of amount owed over one year." It took the Center 420 days to record an accurate receivable for the State.

John J. Madden Mental Health Center:

- Four of five recipient files, with receivables totaling $16,698 were aged over 180 days. Three were not submitted to the Department of Human Services (DHS) - Central Office for collection and one was not submitted timely.
    - Two recipient files, with receivables totaling $12,658, had no documentation to determine the validity of the receivable amount.
    - One recipient with receivables totaling $10,580, was sent the Notice of Determination 1,088 days after the start of services.
- In addition, when reviewing the aged accounts receivable balances at June 30, 2015, auditors noted:
    - A majority of the accounts receivable (97%), totaling $711,605, are aged over one year, ranging from 13 months to 362 months old.

Illinois School for the Deaf:

- The School is responsible for the Hansen-Therkelsen Scholarship Fund; however, auditors noted two of eight (25%) Reports tested contained adjustments, totaling $7,000, which the School was unable to explain.

Department management stated that the cause of this finding was staff oversight at the Center level.

Updated Response: Implemented. The Division of Developmental Disabilities (DDD) had all appropriate staff retrained on Administrative Directive 02.08.01.040 State Operated Mental Health/Developmental Disabilities (MH/DD) Facilities - Accounts Receivable Collection Procedure, other applicable procedures and proper monitoring of system reports. The Division of Developmental Disabilities (DDD) Business Administrator or designee at the DD Center will monitor compliance of the monthly monitoring of system reports to ensure the processing of accounts receivables is completed timely. The Regional Management of SODC Operations will develop and implement a periodic quality assurance report requiring all Centers to verify compliance. The Regional Management of SODC Operations will develop and implement a periodic quality assurance report requiring all Centers to verify compliance in this area.

The Division of Mental Health (DMH) had all Reimbursement Officers retrained on Administrative Directive 01.09.02.030 "Accounts receivable Collection Procedures" to ensure correct and timely completion of the billing cycle for each admission (Alton 100%, Chester N/A, Read 100%, Elgin 100%, McFarland N/A, Madden 0% due to no RRU staff – therefore, N/A, and TDF N/A). The Division of Mental Health (DMH) will review all financial records on the Aging report and Transaction Register for potential write-off or referred to the Bureau of Collections (Alton 80%, Chester N/A, Read 100%, Elgin 100%, McFarland N/A, Madden 0%, and TDF N/A).

26. Comply with current policies and procedures regarding commodities and follow the control system in place. (Repeated-2013)

Finding: The Department does not maintain an adequate oversight function over commodities, resulting in inadequate controls. Inventory control includes responsibilities 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 at Choate Mental Health and Developmental Center, Fox Developmental Center, Ludeman Developmental Center, and Madden Mental Health Center:

Department management stated that insufficient headcount and an outdated and insufficient inventory system contributed to the discrepancies noted.

Updated Response: Accepted. DHS-Office of Clinical, Administration, and Program Support (OCAPS) has developed an RxWorks report showing all meds with $0.00 value. RxWorks has been implemented at Madden Mental Health Center Hub Pharmacy. OCAPS has also developed an RxWorks report showing all meds with a negative quantity on-hand.

The Division of Developmental Disabilities (DDD) had all appropriate staff retrained on Administrative Directive 01.05.07.010 Annual Inventory Procedures, Administrative Directive 01.05.07.020 Periodic Commodity Physical Inventory Counts and procedures for

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excessive and/or obsolete inventory. The Business Administrator or designee at the DD Center will monitor compliance of the weekly reconciliation of commodities and ensure proper adjustments are completed if needed. Also, the Regional Management of SODC Operations will develop a periodic quality assurance report requiring all Centers to verify compliance in this area.

The Office of Business Services (OBS) will increase Property Control headcount, specific to management of IDHS Statewide Inventories; develop and implement a rolling quarterly inventory schedule, beginning with the State Operated Facilities and Schools, and implement the ERP system as the primary inventory system for IDHS.

27. Comply with current policies and procedures regarding petty cash and locally held funds, and follow the control system in place. In addition, reconcile locally held fund accounts monthly using an individual with no other responsibilities for the fund. (Repeated-2009)

Finding: The Department inadequately administered locally held funds (bank accounts) during the examination period. Exceptions were noted regarding the administration, accounting, reconciliation, reporting, receipt and disbursement of these funds.

Weaknesses were noted during the testing of the Department's petty cash funds and quarterly reporting of receipts and disbursements of locally held funds at Chicago Read Mental Health Center, Ludeman Developmental Center, Madden Mental Health Center, Kiley Developmental Canter, and Choate Mental Health and Developmental Center.

Department management stated that the cause of this finding was staff oversight.

Updated Response: Accepted. The Division of Developmental Disabilities (DDD) created and implemented a standardized bank reconciliation form for locally held funds. DDD implemented SODC Operations Regional Management oversight of the timely and accurate submission of bank reconciliations. DDD has also retrained all appropriate staff on Administrative Directives 02.08.01.010 Locally Held Funds - Mental Health and Developmental Centers/Programs - Overview and 01.09.01.020 Petty Cash Fund Management and applicable sections of the SAMS Manual. The Division of Developmental Disabilities (DDD), SODC Operations Regional Management will draft a procedure for the proper administration and establishment of adequate and effective controls for locally held funds. All appropriate DD Center staff will be trained on this procedure. SODC Regional Management will require periodic reports from DD Centers to ensure compliance is achieved in this area.

The Division of Mental Health (DMH) will require all staff involved in the handling of petty cash be retrained on the Administrative Directive 02.08.01.010 Locally Held Funds and 01.09.01.020 Petty Cash Funds (Alton 100%, Chester N/A, Read N/A, Elgin N/A, McFarland N/A, Madden 50%, TDF N/A). Reconciliations of the Petty Cash Fund to avoid court of claims processing (Alton 100%, Chester N/A, Read N/A, Elgin N/A, McFarland N/A, Madden 50%, and TDF N/A) will be implemented.

28. Comply with the requirements of the Code in effect at the time or obtain a formal Attorney General opinion as to the retrospective application of P.A. 98-0024. (Repeated-2013)

Finding: The Department failed to transfer the remaining balance in the DHS Recoveries Trust Fund (Fund 0921) to the General Revenue Fund as required by the Illinois Public Aid Code (Code) (305 ILCS 5/12-9.1).

The Department initially recorded this amount as a liability, but then later reversed it by recording a transfer. An actual transfer of funds, however, was not made. A statutory change to the Code was effective June 19, 2013 and no longer requires the transfer (P.A. 98-0024). However, the statutory change should have been implemented on a prospective basis beginning with the effective date. The physical transfer of the funds prior to this legislative change has still not been made.

Department management stated that when PA 98-0024 was enacted, it was DHS' belief that deleting the former transfer language meant that past transfers would no longer be required.

Updated Response: Accepted. The Department will introduce legislative remedy in spring 2017.

29. Comply with existing controls for reporting NSF checks to the Bureau of Collections timely for the establishment of receivables. (Repeated-2013)

Finding: The Department did not maintain adequate internal controls over checks returned for non-sufficient funds.

During testing of non-sufficient funds (NSF) or stop payment checks, 19 out of 60 (32%) NSF checks tested were not sufficiently supported to determine if collection attempts were made. The returned checks totaled $9,984. The returned checks were entered into the Department's accounting system but no collection related support was provided from either the Cash Management Unit (CMU) or the Bureau of Collections (BOC) to indicate establishment of receivables.

Department management stated the issues were a result of staffing turnover and vacancies.

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Updated Response: Implemented. The Bureau of General Accounting updated policies and procedures for processing NFS checks. CMU submits NFS checks to the Bureau of Collections (BOC) on a timely basis as specified in the procedures. CMU maintains a list of NSF checks sent to the Bureau of Collections (BOC) and monitors to ensure a receivable is established. A weekly status report is submitted to the Cash Management Unit (CMU) manager.

30. Strengthen controls over the processing of refunds, including the timely deposit of refunds.

Finding: The Department lacked controls over the Department's refund process and did not deposit the refunds timely.

In 17 of 60 refunds tested in the amount of $129,826, the refunds were not deposited in compliance with the State Officers and Employees Money Disposition Act (Act). The deposits ranged between 13 to 1,006 days late.

Department management attributed the exceptions to staffing vacancies and the lack of an integrated accounting system.

Updated Response: Implemented. A weekly status report is submitted to the Cash Management Unit (CMU) manager and refunds not processed timely are addressed. The Bureau of General Accounting has also drafted policies and procedures for refund processing.

31. Continually review and update the disaster contingency plan to reflect the current operating environment and ensure all facilities have an adequately developed contingency plan. Continue participation in disaster recovery exercises and strive to recover critical systems within the 24-hour timeframe. Ensure facilities perform and document tests of their recovery capabilities at least once a year. (Repeated-2005)

Finding: Although progress had been made and the Department's Disaster Recovery Plan (Plan) had been updated since the prior examination, auditors found the Plan still needed updating to reflect its current operational environment, and had not assured adequate recovery planning and testing had been performed at its facilities.

Auditors reviewed the Department's Plan and noted the Plan:

- Made reference to an off-site storage location in St. Louis, MO, which is no longer in use.

- Discussed the use of physical "carts" in the back-up storage section. However, physical carts were replaced by virtual backup system.
- Did not include recovery or business continuity information for the Department's facilities.

The Department participated in the annual comprehensive Disaster Recovery exercise on October 14 and 21, 2015. The Department considered the test to be successful; however, critical systems were recovered in approximately 39 hours rather than within the required 24-hour timeframe. Additionally, not all of the Department's facilities performed adequate recovery planning and testing during the review period.

Department management stated that due to competing priorities and limited personnel the disaster recovery plan has not been completely updated. The Department needs to develop a recovery methodology that includes realistic and accurate recovery stage and recovery times which reflect current operations and requirements, as well as includes additional guidance for facility DR planning.

Updated Response: Accepted. MIS has revised policies and procedures regarding Access Management with Recovery Methodology. MIS will coordinate with program areas for system categorization and Recovery Time Objectives (RTO). MIS will coordinate with Divisions for facility Disaster Recovery (DR) development, exercise, and submission of exercise reports.

32. Comply with the Directive and ensure confidential information is adequately protected. Review existing policies regarding the security and control of confidential information, and assure Department-wide procedures exist for ensuring confidential and personal information is adequately secured in both electronic and hardcopy format. Secure confidential and personal information in hardcopy format is adequately secured at all times prior to shredding. 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 had not ensured compliance with procedures for disposal of documents containing confidential information.

Although the Department has established several administrative directives regarding the disposal of confidential information, procedures for properly disposing and securing of confidential information were not always being followed by Department employees.

During walkthroughs at the Department's Central Office, auditors found confidential information, including social security numbers, names, and dates of birth, in recycle bins. Additionally, auditors noted that the Department had performed a review of physical security

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and reported a similar finding relating to confidential and protected information found in unsecured areas.

Additionally, documents containing confidential information were found in trash or recycle bins while performing visits at the Department's Ann M. Kiley Developmental Center and Illinois School for the Deaf.

Department management stated that employees need more robust training regarding the secure retention and destruction of protected information.

Updated Response: Accepted. HIPAA training with emphasis on proper disposal of confidential information has been developed. The IDHS HIPAA training was completed on 9/15/16 with 93% of the DHS workforce taking the training which included an emphasis on proper disposal of PHI (slides were developed as part of the training).

The Local Privacy Officers duties will include both unannounced and announced periodic inspections of facilities to make sure that confidential information is disposed of properly. As of September 15, 2016, 50% of the facilities have been inspected by the Local Privacy Officer.

The Office of Business Services (OBS) will identify locations requiring locking shred bins and approximate monthly volume of current sensitive documents requiring disposal. Develop and implement a monthly delivery/retrieval schedule for all IDHS locations Statewide.

33. Comply with the statutes and ensure confidential information is adequately protected. Effectively communicate and enforce procedures for safeguarding, retaining, and communicating confidential information to all Department personnel, including facilities. Provide staff with training and information on available encryption resources such as those available from the Department of Central Management Services.

Finding: The Department regularly collects and maintains various types of documents, including confidential and personal identifiable information, necessary for fulfilling its mission. The Department is required to comply with the Personal Information Protection Act, the Identity Protection Act, and the Health Insurance Portability and Accountability Act.

Although required to protect personal and confidential information, the Department put such information at the risk of disclosure during the examination. In addition, at the entrance and at subsequent meetings, auditing staff informed Department staff about the importance of protecting such information, provided information on encryption resources, and specifically

requested that personal information not be sent to auditing staff in unencrypted emails over the Internet.

Although the Department made improvements since the prior examination and notified employees of confidentiality policies and procedures, Department staff sent multiple unprotected emails to auditing staff from July to September that contained confidential, sensitive, or personally identifiable information.

In each case, auditing staff informed the sender of the infraction, asked the sender to refrain from sending such information in an email, and provided information on the availability of State's encryption resources.

Department management stated that some IDHS personnel are unfamiliar with using the Entrust software to encrypt data, when and how to send secure (Transport Layer Security) and/or encrypted emails.

Response: Accepted. IDHS Office of Information Technology (OIT) agrees with this finding and recognizes the need to protect confidential information while in transit or encrypted if it is protected information. It is the intent of OIT to push the state approved encryption resource, Entrust with the Outlook plug-in, to all IDHS workstations. This will allow users to more easily encrypt email as the software will be installed. Once this is completed, with the concurrence of the IDHS Privacy and HIPAA Officer, the intent is to change the policy so that ALL email that includes Social Security Numbers and protected health information must be encrypted. Information that would not be made available to the public and therefore classified as confidential must be sent via a secure transmission. The IDHS OIT's Bureau of Information Security and Audit Compliance (BIS-AC) has updated OneNet with additional instructions on how to send encrypted emails, and get an Illinois Digital Certificate. Additional information needs to be included regarding secure transmission utilizing the Secure Web Gateway and the Illinois FTP Transfer Site when sharing confidential information with those external to the state network. In addition, DHS MIS Information Security needs to educate and inform DHS users about security awareness and handling of confidential and protected data.

BIS-AC has also updated the Security Awareness Training to include additional information regarding the transmission of confidential and protected information. Security Awareness Training will become mandatory for all new employees and is part of mandatory annual training in October. The IDHS Privacy Office will reemphasize in the HIPAA training material that unsecured protected health information should not be transmitted over the internet without the necessary safeguards in place. The training will focus on the practical solutions that employees can use to make sure that confidential information is safeguarded, retained, and communicated both within the Department's email system and with external parties. The HIPAA training will take place from August through September 2016.

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Accepted or Implemented – concluded

Updated Response: Accepted. The Office of Information Technology (OIT) will coordinate with CMS to push Entrust client with Outlook plug-in to all IDHS workstations. OIT will update policy to state that all Protected Information, i.e. Protected Health Information, Social Security Numbers, Individually Identifying Health Information, Federal Tax Information, must always be encrypted and Personally Identifying Information must always be sent via secure transmission. OIT, BIS-AC will update IDHS OneNet with additional information/directions regarding sending secure transmission and encrypted email. OIT will coordinate with IDHS HR to incorporate Security Awareness training in New Employee Orientation. OIT will also coordinate with CMS to create Outlook message when new employees first login to Outlook that directs user to take Security Awareness Training. IDHS Privacy Officer updated HIPAA Training to cover transmission of Confidential and Protected Information.

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 three 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 10 affidavits for emergency purchases in FY14 totaling $4,058,121.06 as follows:

- $2,246,542.74 for compliance monitoring of the Early Intervention System;
- $1,273,770.00 to develop software for the FOID System;
- 464,895.30 for repairs or equipment replacement at the various centers;
- 42,328.61 for linen and towel services; and
- 30,584.41 for food service for students.

During FY15 the Department filed 14 affidavits for emergency purchases totaling $2,009,945.13 as follows:

- $1,436,157.00 for repairs or equipment replacement at the various centers;
- 347,974.88 for implementation of Statewide Conditional Release Program;
- 121,600.00 for IT services;
- 49,891.00 for a fire certification survey;
- 38,375.00 for asbestos abatement; and
- 15,947.25 for educational services.

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 2015 indicating 461 employees were assigned to locations other than official headquarters.

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DEPARTMENT OF HUMAN SERVICES
TWO YEARS ENDED JUNE 30, 2015

APPENDIX A

Service Efforts and Annual Cost Statistics

	FY15	FY14
Addiction Treatment and Related Services		
Total expenditures - all sources	$ 187,188,600	$ 193,749,700
Number of unduplicated patients served (patient services data)	63,231	68,829
Developmental Disabilities - Community & Facility Services		
Total Expenditures - all sources	$ 1,542,293,300	$ 1,502,549,700
Number of Individuals served in waiver settings	22,592	21,510
Number of individuals served in private Intermediate Care Facilities and Mental Retardation facilities (ICF/MR), including Skilled Nursing Facility/Pediatrics	5,078	5,608
Number of individuals served in SODC's (State Operated Developmental Centers)	1,685	1,752
Persons receiving developmental disability services as a percent of the estimated number of persons with a diagnosis of a developmental disability	18%	17.5%
State to resident ratio	2.1	2.1
Family and Community Services - Basic Family Supports		
Total expenditures - all sources	$ 1,793,543,700	$ 1,572,295,200
Total Number of Medical Assistance No Grant (Mang) Aid to the Aged, Blind and Disabled (AABD) applications approved	98,501	88,135
Average number of TANF families engaged each month (Fed. Participation rate)	5,272	5,108
Number of children served through the Child Care program - avg. month	179,315	163,000
Total number of Refugees and Immigrants receiving citizenship assistance	7,138	8,821
Total number of children served through the Crisis Nursery program	1,068	1,292
Total number of Seniors accessing services through the Donated Funds Initiative program	7,496	11,123
Percent of TANF clients working and/or engaged in the required number of average countable activities per week	68.8%	68.8%
Family and Community Services - Family Wellness and Early Intervention		
Total expenditures - all sources	$ 616,465,300	$ 619,868,700
Number of pregnant women and infants enrolled in Family Case Management (FCM)	202,804	233,694
Number of 0-2 year olds immunized	298,406	288,550
Number of WIC participant births	67,219	57,835
Number of children who have Early Intervention - Individualized Family Service Plan	21,387	21,055
Family and Community Services - Community and Positive Youth Development		
Total expenditures - all sources	$ 74,879,300	$ 66,842,400
Number of Teen REACH participants (a)	13,158	14,903
Number of CCBYS recipients	6,962	6,997
Proportion of 10th grade children reporting use of marijuana in the past month	16.6%	16.6%
Proportion of 10th grade children reporting use of alcohol in the past month	27.4%	33.2%
Proportion of CCBYS recipients that are referred by law enforcement organizations	46.5%	44.6%
Percent of live births to 15-17 year olds as a percent of births to women under the age of 20	13.3%	16.6%
National proportion of 10th grade children reporting use of marijuana in the past month	18.0%	17.0%
National proportion of 10th grade children reporting use of alcohol in the past month	25.7%	26.0%
National birth rate of teen-aged women (15-17 years of age)	15.0%	15.0%

Appendix A - continued

	FY15	FY14
Home Services		
Total expenditures - all sources	$ 603,285,700	$ 568,143,300
Persons with disabilities receiving in-home services to prevent institutionalization	29,595	30,357
Persons moved out of nursing homes	129	118
Average monthly cost of in-home services per client	$ 1,502	$ 1,391
Mental Health - Community & Facility Services		
Total Expenditures - all sources	$ 586,397,000	$ 599,433,300
Number of Individuals served in DHS/DMH Assertive Community Treatment Program	1,075	1,206
Number of juveniles found eligible for mental health juvenile justice services	311	252
Percent of re-admissions to state hospitals within 30 days of discharge	14.0%	13.0%
Staff to patient ratio in state hospitals	1.9	1.8
Mental Health - Sexually Violent Persons Program		
Total expenditures - all sources	$ 31,745,900	$ 30,658,500
Number of detainees/sexually violent persons in the Treatment/Detention Facility	546	546
Annual cost per detainee/sexually violent person in the TDF (in dollars)	$ 56,702	$ 54,804
Vocational Rehabilitation		
Total expenditures - all sources	$ 123,874,000	$ 126,014,500
Persons in supported employment	1,168	1,576
Person competitively employed	5,442	5,155
Rehabilitation rate (success rate)	52.1%	51.5%
Average hourly wage earned by Vocational Rehabilitation customers	$ 10.34	$ 10.42
Average lifetime cost per rehabilitation (in dollars)	$ 4,904	$ 4,485

(a) The Teen reach program was eliminated in both fiscal year 2016 Proposed Budgets (Govenors and Legislature). At this time, they are curren waiting for the final budget to see if the program is reinstated. No contracts have been issued although they are completed and awaiting final budget decision.

APPENDIX B

Summary of Appropriations and Expenditures

	FY15	FY14
TOTAL APPROPRIATIONS	**$ 6,428,793,000**	**$ 6,176,552,000**
EXPENDITURES, BY FUND		
General Revenue Fund	$ 3,363,377,000	$ 3,217,321,000
Prevention and Treatment of Alcohol and Substance Abuse Block Grant Fund	63,740,000	67,145,000
Group Home Loan Revolving Fund	30,000	40,000
Illinois Veterans' Rehabilitation Fund	5,072,000	5,116,000
Mental Health Fund	36,263,000	26,913,000
Vocational Rehabilitation Fund	126,174,000	126,536,000
Assistance to the Homeless Fund	-	258,000
Home Services Medicaid Trust Fund	243,442,000	221,824,000
Youth Alcoholism and Substance Abuse Prevention Fund	832,000	741,000
State Gaming Fund	767,000	846,000
Community DD Services Medicaid Trust Fund	49,244,000	22,317,000
Drunk and Drugged Driving Prevention Fund	1,835,000	1,894,000
Mental Health Reporting Fund	296,000	496,000
Sexual Assault Services & Prevention Fund	500,000	100,000
DHS Technology Initiative Fund	5,809,000	6,026,000
Autism Research Checkoff Fund	12,000	48,000
Illinois Affordable Housing Trust Fund	12,864,000	12,897,000
Federal National Community Services Fund	-	7,073,000
Care Provider for Persons with Developmental Disabilities Fund	35,260,000	33,178,000
Employment and Training Fund	481,435,000	483,730,000
Health and Human Services Medicaid Trust Fund	32,012,000	34,986,000
Drug Treatment Fund	3,613,000	3,418,000
Gaining Early Awareness and Readiness for Undergraduate Programs Fund	1,634,000	1,920,000
DHS Special Purposes Trust Fund	262,638,000	252,308,000
Old Age Survivors Insurance Fund	79,444,000	73,589,000
Early Intervention Services Revolving Fund	155,791,000	157,733,000
DHS Community Services Fund	6,325,000	15,048,000
Domestic Violence Abuser Services Fund	100,000	-
Juvenile Accountability Incentive Block Grant Fund	1,677,000	802,000
DHS Federal Projects Fund	16,078,000	14,466,000
DHS State Projects Fund	-	945,000
Special Olympics Illinois Fund	20,000	16,000
Commitment to Human Services Fund	98,641,000	-
Alcoholism and Substance Abuse Fund	6,927,000	6,859,000
DHS Private Resources Fund	66,000	117,000
U.S.D.A Women, Infants and Children Fund	281,064,000	288,392,000
Hunger Relief Fund	-	68,000
Community Mental Health Medicaid Trust Fund	82,962,000	105,901,000
Tobacco Settlement Recovery Fund	907,000	1,389,000
Local Initiative Fund	19,568,000	19,604,000
Healthcare Provider Relief Fund	378,931,000	370,137,000
Rehabilitation Services Elementary and Secondary Education Act Fund	574,000	684,000
Farmer's Market Technology Improvement Fund	13,000	10,000
Domestic Violence Shelter and Service Fund	728,000	577,000
Maternal and Child Health Services Block Grant Fund	6,106,000	5,784,000
Community Mental Health Services Block Grant Fund	15,076,000	14,430,000
Habitat for Humanity Fund	-	-
Youth Drug Abuse Prevention Fund	106,000	239,000
Juvenile Justice Trust Fund	2,462,000	2,364,000
DHS Recoveries Trust Fund	10,832,000	9,770,000
Total Expenditures, Appropriated Funds	**$ 5,891,247,000**	**$ 5,616,055,000**

Appendix B - continued

EXPENDITURES, NON-APPROPRIATED FUNDS

	FY15	FY14
Hansen-Therkelsen Memorial Fund	$ 4,000	$ 7,000
Electronic Benefits Transfer Fund	204,400,000	206,364,000
DHS Federal Projects Fund	878,000	649,000
DHS State Projects Fund	6,604,000	8,733,000
DHS Private Resources Fund	64,000	154,000
DHS Recoveries Trust Fund	4,665,000	4,721,000
Total Expenditures, Non-Appropriated Funds	**$ 216,615,000**	**$ 220,628,000**
TOTAL EXPENDITURES, ALL FUNDS	**$ 6,107,862,000**	**$ 5,836,683,000**

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DEPARTMENT OF HUMAN SERVICES
TWO YEARS ENDED JUNE 30, 2015

APPENDIX C

Expenditures By Major Object Code

Expenditures	FY15	FY14	FY13
Personal Services	$ 893,356,000	$ 860,059,000	$ 826,848,000
Retirement	39,688,000	36,526,000	42,418,000
Social Security	64,175,000	61,658,000	59,894,000
Group Insurance	23,485,000	24,162,000	28,826,000
Contractual Services	213,291,000	215,836,000	200,293,000
Travel	2,356,000	2,993,000	3,062,000
Commodities	32,967,000	30,431,000	27,298,000
Printing	2,084,000	1,835,000	1,831,000
Equipment	2,371,000	4,404,000	2,899,000
Telecommunications	12,655,000	15,425,000	11,086,000
Automotive Equipment	1,076,000	1,459,000	1,085,000
Lump Sums and Other Purposes	271,000	169,000	2,090,000
Interfund Cash Transfers	291,295,000	293,470,000	295,297,000
Awards and Grants	4,264,980,000	4,016,963,000	4,049,588,000
Tort, Settlements and Similar Payments	27,000	648,000	27,000
Medical Preparation & Food Supplies for Free Distribution	225,160,000	233,649,000	239,299,000
Awards and Grants to Students	1,968,000	2,241,000	2,651,000
Grants to Other State Agencies	32,082,000	24,095,000	29,336,000
Permanent Improvements, Lump Sums & Other Purposes	375,000	6,314,000	295,000
Other Refunds	3,499,000	3,621,000	3,016,000
Refunds, Not Elsewhere Classified	701,000	725,000	357,000
TOTAL	**$ 6,107,862,000**	**$ 5,836,683,000**	**$ 5,827,496,000**

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DEPARTMENT OF HUMAN SERVICES
TWO YEARS ENDED JUNE 30, 2015

APPENDIX D

Expenditures By Facility

Expenditures	FY15	FY14	FY13
Alton Mental Health Center	$ 23,510,558	$ 23,295,501	$ 22,235,713
Illinois School for the Visually Impaired	8,309,301	8,823,547	8,155,987
Illinois School for the Deaf	17,239,632	17,513,217	16,562,856
Andrew McFarland Mental Health Center	23,354,250	22,441,499	19,845,440
Chester Mental Health Center	39,297,087	37,806,008	35,636,130
Gov. Samuel H. Shapiro Developmental Center	77,172,494	76,042,188	69,326,496
Elgin Mental Health Center	67,412,719	67,238,407	60,430,257
John J. Madden Mental Health Center	31,969,821	32,888,398	30,979,294
H. Douglas Singer Mental Health Center	-	-	5,153,523
Chicago-Read Mental Health Center	27,859,851	28,338,332	25,163,008
Tinley Park Mental Health Center	-	-	2,435,099
Elisabeth Ludeman Developmental Center	59,320,936	60,903,752	50,689,980
William W. Fox Developmental Center	18,482,958	17,715,618	16,113,989
Jacksonville Development Centr	-	-	10,744,224
Warren G. Murray Developmental Center	27,924,610	32,827,437	35,725,424
Ann M. Kiley Developmental Center	33,765,632	35,017,638	27,220,543
Clyde L. Choate Mental Health and Developmental Center	42,461,941	40,852,590	35,512,284
Jack Mabley Developmental Center	14,341,779	13,365,718	10,110,959
Other Not Identified in Department Records	4,768,200	5,265,084	5,031,623
TOTAL	**$ 517,191,769**	**$ 520,334,934**	**$ 487,072,829**

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TWO YEARS ENDED JUNE 30, 2015

APPENDIX E

Summary of Cash Receipts -- By Fund

	FY15	FY14
General Revenue Fund	$ 109,451,000	$ 99,763,000
Prevention & Treatment of Alcoholism & Substance Abuse Block Grant Fund	66,072,000	65,479,000
Group Home Loan Revolving Fund	26,000	19,000
Mental Health Fund	27,883,000	30,077,000
Vocational Rehabilitation Fund	134,715,000	138,415,000
Hansen-Therkelsen Memorial Deaf Student College Fund	2,000	1,000
DHS Technology Initiative Fund	8,031,000	5,134,000
DCFS Children's Services Fund	68,800,000	68,800,000
Income Tax Refund Fund	42,661,000	42,752,000
Federal National Community Services Fund	767,000	7,118,000
Employment & Training Fund	477,653,000	471,812,000
DHS Special Purposes Trust Fund	265,444,000	254,807,000
Old Age Survivors Insurance Fund	79,000,000	76,312,000
Early Intervention Services Revolving Fund	116,998,000	100,928,000
DHS Community Services Fund	2,568,000	-
Electronic Benefits Transfer Fund	204,400,000	206,364,000
Juvenile Accountability Incentive Block Grant Fund	20,000	3,719,000
DHS Federal Projects Fund	15,452,000	15,658,000
DHS State Projects Fund	6,500,000	7,152,000
Alcoholism & Substance Abuse Fund	6,842,000	6,454,000
DHS Private Resources Fund	145,000	371,000
USDA Women, Infants & Children Fund	288,806,000	276,908,000
Rehabilitation Services Elementary & Secondary Education Act Fund	674,000	703,000
Farmer's Market Technology Improvement Fund	2,000	25,000
Maternal & Child Health Services Block Grant Fund	5,729,000	9,020,000
Community Mental Health Services Block Grant Fund	15,092,000	17,599,000
Youth Drug Abuse Prevention Fund	387,000	404,000
Juvenile Justice Trust Fund	2,464,000	2,071,000
DHS Recoveries Trust Fund	15,673,000	13,336,000
Social Services Block Grant Fund	65,180,000	65,133,000
TOTAL CASH RECEIPTS	**$ 2,027,437,000**	**$ 1,986,334,000**

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APPENDIX F

Property and Equipment

	FY15		FY14	
Balance, July 1	**$ 750,148,946**		**$ 778,676,858**	
Additions	10,384,984		5,357,735	
Deductions	(3,744,521)		(43,483,284)	
Net Transfers	627,196		9,597,637	
Ending Balance June 30	**$ 757,416,605**	*	**$ 750,148,946**	*
* Represented by:				
Equipment	96,758,237		97,541,259	
Land & land improvements	3,415,140		3,415,140	
Building & building improvements	574,221,589		566,014,243	
Site Improvements	82,196,184		82,195,349	
Capital lease equipment	825,455		982,955	
TOTAL	**$ 757,416,605**		**$ 750,148,946**	

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DEPARTMENT OF HUMAN SERVICES
TWO YEARS ENDED JUNE 30, 2015

APPENDIX G

Accounts Receivable

	FY15	FY14
Taxes receivable, net	$ 52,120,000	$ 198,000
Due from other governments - federal	188,074,000	189,923,000
Due from other governments - local	415,000	351,000
Other receivables, net	163,090,000	161,580,000
Due from other State funds	69,391,000	5,383,000
Due from component units	225,000	298,000
Loans and notes receivable, net	378,000	390,000
Total Receivables	**$ 473,693,000**	**$ 358,123,000**