LEGISLATIVE AUDIT COMMISSION

Review of
Department of Corrections
Two Years Ended June 30, 2020
& One Year Ended June 30, 2020

622 Stratton Office Building
Springfield, Illinois 62706

REVIEW: 4542
DEPARTMENT OF CORRECTIONS
TWO YEARS ENDED JUNE 30, 2020 (COMPLIANCE EXAM)
& ONE YEAR ENDED JUNE 30, 2020 (FINANCIAL AUDIT)

FINDINGS/RECOMMENDATIONS - 60

IMPLEMENTED - 26
ACCEPTED AND PARTIALLY IMPLEMENTED – 32
ACCEPTED - 2

REPEATED RECOMMENDATIONS - 34

PRIOR AUDIT FINDINGS/RECOMMENDATIONS - 46

This review summarizes the auditors' report on the compliance examination of the Department of Corrections for the two years ended June 30, 2020, filed with the Legislative Audit Commission on October 13, 2021, and the financial audit for the year ended June 30, 2020, filed with the Audit Commission on June 23, 2021. The reports were conducted in accordance with *Government Auditing Standards* and State law. The auditors stated the Department's financial statements presented fairly.

The Department of Corrections was established in 1970 and operates under the powers and duties established by the Unified Code of Corrections Effective June 1, 2006, Public Act 94-0696 established the Department of Juvenile Justice. This Act transferred certain rights, powers, duties and functions that were exercised by the Juvenile Division of the Department. Effective July 1, 2006, the Department's school district was transferred to the Department of Juvenile Justice. The Department retained the Adult Education and Vocational Services area which provides services to the adult population.

Mission Statement To serve justice in Illinois and increase public safety by promoting positive change in behavior, operating successful re-entry programs, and reducing victimization.

Program Goals and Objectives

- To operate safe, secure, and humane correctional facilities.
- Reduce recidivism, or the number of individuals who return to correctional facilities within three years of release.
- Continually improve the safety and security of staff and individuals in custody.
- To provide quality services to those who require medical and mental health treatment.
- To evaluate each individual in custody and develop an appropriate course of action based on individual needs.
- To reduce recidivism by offering seamless, efficient services that are geared toward rehabilitation of individuals in custody.

- Staff is the Department's greatest asset and the Department will ensure that all staff is trained to the highest professional level.
- It is a team-based environment in which open communication and sharing new ideas are encouraged.
- To the well-being of IDOC staff and individuals in custody and serve the people of Illinois with compassion and fairness.

KEY PERFORMANCE METRICS

	FY19 Actual	FY20 Actual	FY21 Actual	FY22 Target
Individuals on parole returned monthly as % of the avg daily parole pop.	2.4%	2.2%	1.4%	1.4%
Avg contrabands confiscations per month	50	35	36	23
Avg assaults per month of individuals in custody on staff	65	65	58	61
Avg assaults per month between individuals in custody	190	184	104	113
Ind in custody eligible for Adult Basic Ed/Secondary	5,000	5,250	5,469	5,500
Serious assaults of individuals in custody	350	310	349	350
Participants in Adult Basic Ed/Secondary	11,070	10,900	7,733	11,000
Individuals on GPS monitoring	625	650	1,200	1,300
Individuals in custody receiving mental health treatment	12,710	13,079	11,448	12,110
Individuals in custody completing vocational program	4,000	3,500	576	1,500
Avg of parolee monitors in use	2,280	2,300	1,548	1,600
Avg monthly full-time headcount	12,450	12,680	12,311	12,019
Avg parolees assigned per agent	80	77	68	66
Adults reincarcerated within 3 years of release	42%	40%	38.5%	38%

Source: Comptroller Public Accountability Report

OFFICE OF ADULT EDUCATION AND VOCATIONAL SERVICES (OAEVS)

The mission of OAEVS is to enhance the quality and scope of education for individuals in custody within the Illinois Department of Corrections (IDOC) consistent with age, commitments and sentence by ensuring that the state and federal resources are appropriately used in aiding committed persons to restore themselves to constructive and law-abiding lives in the community.

Since January 1, 1987, all individuals committed to IDOC for two or more years, except those serving life sentences, take the Test of Adult Basic Education (TABE) to determine their academic level**. In FY20, 8,115 individuals in custody were tested at intake with 5,140 individuals scoring below the sixth-grade level.** Individuals are also eligible for Earned Program Service Credit (EPSC).

Adult Basic Education (ABE) is a critical component in the education programming of OAEVS. ABE is mandatory for all individuals scoring below 6.0 on the TABE test. Mandatory ABE students must attend a minimum of 90 days of instruction. The ABE

core curriculum provides instruction in basic reading, writing, mathematics, and life skills. The program is designed to provide students with a base of skills and knowledge that will prepare them for additional academic/vocational instruction and subsequent employment.

DEPARTMENT TEAMS & DIVISIONS

General Office: The function of the General Office is to provide support services to all the Department's facilities and divisions. This includes establishing and monitoring budget activities, capital planning, accounting services, and data processing. The General Office performs other functions as necessary to meet the provisions of the Code; as well as provides administrative and services to the Department of Juvenile Justice, Prisoner Review Board, Illinois State Police, Office of the State Fire Marshal and Illinois Criminal Justice Information Authority as detailed in various interagency agreements that make-up Public Safety Shared Services.

Adult Institutions/Adult Transition Centers: The institutions, which include the Adult Transition Centers are the backbone of IDOC and include all locations that house the incarcerated population. They seek to reduce recidivism by supporting the efforts of people with criminal records to become employed, law-abiding members of the community.

Bureau of Operations: Operations handles the Department's security, safety, maintenance and sanitation, management and movement of individuals in custody, classification, transfers, reception and orientation, special issues and field operations.

Parole: The Parole Division addresses public safety through the appropriate application and management of community supervision.

Program and Support Services: The Programs team is responsible for providing a continuum of services for those committed, from the point of incarceration to discharge from parole, by providing consistent and effective programs for them to become productive members of society upon release.

Office of Health Services: The Office of Health Services is responsible for managing the physical and mental health of the incarcerated population. In 2020, OHS has been central in guiding IDOC's response to the COVID-19 pandemic. This office now also oversees and include all positions relative to healthcare.

Legal Services: The mission of Legal Services is to provide department administrators with legal advice and counsel on an array of issues, coordinate legal representation with the Office of the Attorney General, review proposed legislation, assist assistant attorneys general with discovery and case management, train staff on legal issues, respond to correspondence, handle Human Rights matters and a host of other various assignments.

Women and Family Services Division: the Women's Division is responsible for ensuring that the unique needs of incarcerated women are treated with the same attentiveness and professionalism as the needs of the male population.

During the audit period, John R. Baldwin was Acting Director serving from August 14, 2015 to May 19, 2019. Gladyse Taylor served as Acting Director from May 20, 2019 to May 31, 2019. Rob Jeffreys began serving as Acting Director effective June 1, 2019. Mr. Jeffreys is a nationally-recognized criminal justice expert with correctional experience spanning more than two decades. He spent 21 years in corrections management at the Ohio Department of Rehabilitation and Corrections.

The average number of employees at the years indicated was as follows:

	2018	2019	2020
General Office	252	263	256
Education Services	180	191	184
Statewide and Field Services	544	560	580
Correctional Centers	11,009	11,327	11,567
Total	**11,985**	**12,341**	**12,587**

Note: The table above, prepared from Department of Corrections records, presents the average number of employees by the divisions and the Correctional Centers (excluding Illinois Correctional Industries) for the fiscal years ended June 30, 2018, 2019, and 2020.

Assaults on staff for all facilities totaled 781 in FY20, 777 in FY19 and 759 in FY18. Pontiac Correctional Center had the most assaults on staff in FY20 at 224 followed by 164 assaults at Dixon Correctional Center. More recent numbers provided by the Department indicate that assaults on staff have dropped in recent fiscal years. There were 701 assaults on staff in FY21 and 712 assaults on staff in FY22. The year-to-date total as of July 2022 for FY23 is 79 assaults on staff. See Appendix A for a list of reporting definitions used when reporting assaults on staff at the Department.

Population and Average Cost Per Resident

According to statistics provided by the Department, the average daily population of adult institutions (maximum, medium, minimum security, and multi-security) decreased from 39,931 in FY19 to 36,909 in FY20. The rated capacity of adult institutions at June 30, 2020 was 44,088, or 7,197 under capacity.

The Department also maintains work camps and impact incarceration camps (boot camps) at the following locations:

Work Camps	Structured Impact Programs
Clayton	Dixon Springs
Greene County	DuQuoin

Pittsfield Logan
Southwestern Illinois

According to the Department's Financial Impact Statement for FY20, the annual cost of incarcerating an individual in a DOC facility during FY20 was $34,362. The Department did not have a Financial Impact Statement for FY21 or FY22 listed on their website. Please see the link below for more information:

https://www2.illinois.gov/idoc/reportsandstatistics/Pages/FinancialImpactStatements.aspx

Expenditures from Appropriation

	Fiscal Year		
	2020	2019	2018
EXPENDITURE STATISTICS			
All State Treasury Funds			
Total Operations Expenditures:	$1,523,497,000	$1,566,414,000	$1,931,581,000
Percentage of Total Expenditures:	99.0%	99.0%	99.1%
Personal Services	971,547,000	1,013,315,000	897,224,000
Other Payroll Costs	77,150,000	80,350,000	71,610,000
All Other Operating Expenditures	474,800,000	472,749,000	962,747,000
Total Awards and Grants Expenditures:	$14,719,000	$15,151,000	$17,090,000
Percentage of Total Expenditures:	1.0%	1.0%	0.9%
Total Permanent Improvements Expenditures:	$235,000	$1,284,000	$354,000
Percentage of Total Expenditures:	0.0%	0.1%	0.0%
Total Refund Expenditures:	$9,000	$43,000	$187,000
Percentage of Total Expenditures:	0.0%	0.0%	0.0%
GRAND TOTAL - ALL EXPENDITURES:	$ 1,538,460	$ 1,582,892	$ 1,949,212

Source: OAG FY19/20 Compliance Exam on the Department of Corrections

Ramp up to FY23

	FY21	FY22	FY23 Requested
General Funds	$1,550,231,300	$1,544,134,400	$1,642,236,300
Other State Funds	198,629,600	152,100,000	142,100,000
Federal Funds	0	70,000,000	50,000,000
Total All Funds	**1,748,860,900**	**1,766,234,400**	**1,834,336,300**
Funded Headcount	12,192.5	12,649.0	12,649.0

Source: GOMB Budget Book

DOC had appropriation authority from the following funds in FY22:

- General Revenue Fund – 87.43%;
- Working Capital Revolving Fund – 0%;
- State Coronavirus Urgent Remediation Emergency Fund – 3.95%
- DOC Reimbursement and Education Fund – 8.61%;
- Sex Offender Management Board Fund – 0.01%

Cash Receipts

Cash receipts totaled $56.4 million in FY20, $46.8 million in FY19 and $74.5 million in FY18. A comprehensive table of cash receipts from its various sources is on pg. 173 of the FY19/20 compliance exam.

State Property

	Beginning Balance	Additions	Deletions	Net Transfers	Ending Balance
FISCAL YEAR 2020					
Property					
Land and Land Improvements	$ 60,853	$ -	$ -	$ (3,601)	$ 57,252
Site Improvements	92,549	165	36,914	(3,598)	52,202
Buildings and Building Improvements	1,575,346	36,923	7,201	(24,367)	1,580,701
Equipment	145,400	11,079	1,156	(1,772)	153,551
Total	$ 1,874,148	$ 48,167	$ 45,271	$ (33,338)	$ 1,843,706
Capital Leases					
Buildings and Building Improvements	$ -	$ -	$ -	$ -	$ -
Equipment	704	910	310	-	1,304
Total	$ 704	$ 910	$ 310	$ -	$ 1,304

(Expressed in thousands)
Source: OAG FY19/20 Compliance Exam on the Department of Corrections

	Beginning Balance	Additions	Deletions	Net Transfers	Ending Balance
FISCAL YEAR 2019					
Property					
Land and Land Improvements	$ 60,853	$ -	$ -	$ -	$ 60,853
Site Improvements	92,530	19	-	-	92,549
Buildings and Building Improvements	1,557,154	89	-	18,103	1,575,346
Equipment	148,630	2,579	3,972	(1,837)	145,400
Total	$ 1,859,167	$ 2,687	$ 3,972	$ 16,266	$ 1,874,148
Capital Leases					
Buildings and Building Improvements	$ -	$ -	$ -	$ -	$ -
Equipment	4,167	330	3,793	-	704
Total	$ 4,167	$ 330	$ 3,793	$ -	$ 704

(Expressed in thousands)
Source: OAG FY19/20 Compliance Exam on the Department of Corrections

Correctional Industries

Due to declining sales and increased cost, beginning in FY20, the Department started the process to make ICI a wholly funded and operated program exclusively for DOC and its facilities. Shortfalls in sales over prior fiscal years forced the Department to re-evaluate the ICI program funding and purpose. The Department's new model focuses on vocational training that meets the demands of today's labor force while also addressing ICI's future financial stability. Department officials stated that this transition is "budget neutral" given that the Department purchased 90% of ICI products, that in some cases were overvalued due to obsolete product lines being left in operation by the program.

The Department is assessing ICI's product lines to implement efficiencies and improve operations while also paying special attention to programmatic outcomes for the offenders participating in the program. The Department believes that bringing ICI under the Department's operations will allow for the Department to produce better outcomes for program participants while also giving the Department the ability to tailor ICI products to more efficiently serve the Department's needs. The Department's goal is to finalize this change statutorily during the FY22 legislative session.

Operating loss was $2.7 million in FY20 and was $2.3 million in FY19.

Emergency Purchases

A chief procurement officer making such emergency purchases is required to file affidavits or statements with the Procurement Policy Board and the Auditor General setting forth the amount expended (or an estimate of the total cost), the name of the contractor involved, and the conditions and circumstances requiring the emergency purchase. The Code also allows for quick purchases. 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.

There were nine emergency purchase statements filed by the Department during FY19 totaling $1,795,541 as follows:

- FY19 Q1 Actual cost of $129,136 to purchase white and wheat flower for the production of various bakery items at the Illinois Correctional Industries, Illinois River facility located in Canton;
- FY19 Q3 Actual cost of $418,320 to Quick Purchase a limited supply of grilled chicken breasts for a reduced price;
- FY19 Q3 Actual cost of $120,000 to purchase parts and repair services for two boiler systems at Stateville Correctional Center;
- FY19 Q3 Actual cost of $203,085 to ensure continued access to law libraries to meet with the constitutional mandate of the Department;
- FY19 Q3 Actual cost of $120,000 to repair a leak to a sewer line to prevent further flooding at Stateville Correctional Center located in Crest Hill;
- FY19 Q3 Actual cost of $150,000 to cover the purchase of the parts and repair of two water heaters and two variable drives to ensure continued heated water at Vienna and Shawnee Correctional Centers;
- FY19 Q3 Actual cost of $426,000 to purchase white and wheat flour for production for ICI – IL River located in Canton;
- FY19 Q4 Actual cost of $120,000 to repair a water main break and replace a water pump that feeds the water tower at East Moline Correctional Center; and,
- FY19 Q4 Actual cost of $110,000 to cover the repair of the failed Computerized Locking Control System at the Logan Correctional Center.

There were 14 emergency purchase statements filed during FY20 totaling $7,747,202 as follows:

- FY20 Q1 Actual cost of $318,000 to purchase pancakes and waffles for Illinois Correctional Industries at the Illinois River Facility located in Canton;
- FY20 Q2 Actual cost of $6,000,000 covering the purchase of IT infrastructure and application of the Offender 360 Tracking System;
- FY20 Q2 Actual cost of $50,000 to repair severe storm damage at the Sheridan Correctional Center;
- FY20 Q2 Actual cost of $50,000 to repair the hot water heater and Boiler at Stateville Correctional Center located in Crest Hill;
- FY20 Q3 Actual cost of $145,000 to procure food services at the Peoria and Fox Valley Adult Transition Centers;
- FY20 Q3 Actual cost of $50,000 to repair a damaged sewer line at the Taylorville Correctional Center;
- FY20 Q3 Actual cost of $55,202 to procure an emergency lease to ensure continued housing for DOC records while a new contract was negotiated;
- FY20 Q3 Actual cost of $125,000 to repair a failed hot water heater at the Pontiac Correctional Center;
- FY20 Q3 Actual cost of $22,000 to cover cable tv services for Hill Correctional Center;

- FY20 Q4 Actual cost of $45,000 for repairs due to electrical failures and for generator rental to ensure continued electricity at the Vienna Correctional Center;
- FY20 Q4 Actual cost of $55,000 to rent four generators to provide electrical power for Logan Correctional Center located near Lincoln;
- FY20 Q4 Actual cost of $102,000 to repair the electrical system for dietary and the dietary warehouse at the Centralia Correctional Center;
- FY20 Q4 Actual cost of $570,000 to procure court mandated sensory tactile notification capability for deaf offenders; and,
- FY20 Q4 Actual cost of $160,0000 to replace a dish machine at the Logan Correctional Center located near Lincoln.

There were 16 emergency procurements totaling over $14.5 million in FY21 and 13 emergency procurements totaling approximately $12.4 million in FY22. The largest procurements in FY21 were $6.8 million for IT infrastructure, $1 million to purchase milk and juice due to closure of ICI as the result of the Covid-19 pandemic, $1.6 million to procure commissary items and $2 million for continued monitoring services for committed felons and/or parolees. The largest procurements in FY22 were $6.2 million to procure commissary items, $3.5 million to provide multiple skill levels of nursing staff for placement statewide to correctional facilities and $1.2 million to provide milk distribution to the correctional facilities.

Other notable emergency procurements in FY22 that were no cost contracts to the state, but were procured via emergency purchase—outside of the procurement process—were the following:

Estimated Cost - $6,000,000.00 to provide commissary items for individuals in custody to purchase. (E Ford Commissary Inc). This is a zero-dollar contract. The State does not fund the expense; however, the vendor who receives the revenue was not procured under competitive solicitation.

Estimated Cost - $6,000,000.00 to provide commissary items for individuals in custody to purchase. (Performance Group dba Vistar). This is a zero-dollar contract. The State does not fund the expense; however, the vendor who receives the revenue was not procured under competitive solicitation.

Estimated Cost - $6,000,000.00 to provide commissary items for individuals in custody to purchase. (Keefe Group). This is a zero-dollar contract. The State does not fund the expense; however, the vendor who receives the revenue was not procured under competitive solicitation.

Estimated Cost - $6,000,000.00 to provide commissary items for individuals in custody to purchase. (Walkenhorst's). This is a zero-dollar contract. The State does not fund the expense; however, the vendor who receives the revenue was not procured under competitive solicitation.

Estimated Cost - $6,000,000.00 to provide commissary items for individuals in custody to purchase. (Union Supply Group). This is a zero-dollar contract. The State does not fund the expense; however, the vendor who receives the revenue was not procured under competitive solicitation.

Note: DOC issued a solicitation for statewide commissary in March 2021. In July 2021, DOC was set to make an award resulting from the solicitation. However, there were subsequent protests filed prohibiting the issuance of the award. All vendors except E Ford Commissary Inc. have worked with DOC before. The vendors who were selected all operate in the niche market segment of providing items in a secure environment such as corrections. Please note that due to security issues the vendors' products and packaging require special consideration in terms of packaging (clear, no metal, etc.) and product ingredients (no alcohol, internal parts like a stick within a tube of deodorant, etc.).

A notice of award was issued on April 11th, 2022 for milk and juice products via competitive solicitation to Advanced Commodities, Inc.

See Appendix B for details related to **emergency procurements during FY20 that fell under the Gubernatorial Disaster Proclamations** from March 12, 2020 through June 30, 2020.

Significant Operational Challenges

The most significant challenges for the Department as they closed out Fiscal Year 2020 were related to new fiscal processes and the Department's COVID-19 response. In December 2019, the Department went live with Enterprise Resource Planning System for all fiscal operations, i.e. Accounts Payable/Receivable, Property Control (Assets), Contract Management, Budget and Commodity Inventory. While staff were learning a new fiscal system, the Department was involved in a statewide COVID-19 response. The Department experienced lengthy staff absences as well as staff being pulled to perform duties critical to the ongoing operations of the Department's facilities.

Accountants' Findings and Recommendations

Condensed below are the 60 findings and recommendations included in the audit report. Of these, 34 are repeated from the previous report. **Findings one through eight reflect the same findings from both the FY19/20 compliance exam and the FY20 financial audit.** The following recommendations are classified on the basis of updated information provided by the Department of Corrections, in a memo received via electronic mail on October 13, 2021.

Accepted or Implemented

1. **The auditors recommend the Department outline, document, and implement procedures to ensure GAAP Reporting Packages and financial statements and schedules are prepared accurately. They also recommend the Department maintain documentation of the calculation and basis of liability estimates. In addition, they recommend the Department identify the appropriate reports from the ERP systems and determine the proper timing of generating reports for complete and accurate recording of payables. Lastly, they recommend proper yearend cutoff procedures and internal reviews be included in those procedures as a method to identify and correct errors prior to the submission of financial information to the Office of Comptroller and other external parties.**

Finding: *(Weaknesses in preparation of GAAP reporting forms submitted to the Office of Comptroller and preparation of year-end Department financial statements and schedules) - First reported 2008, last reported 2018*

The following were noted during the audit of the Department's June 30, 2020 financial statements:

- In the review of beginning balances, auditors identified three errors in recording back pay liabilities and accounts payable as of June 30, 2019.

  DOC erroneously reversed a back pay liability accrual of $79.1 million when these liabilities were still unpaid as of June 30, 2019.

  Additional back pay liabilities of $11.3 million and accounts payable of $2.8 million were not accrued as of June 30, 2019.

  These errors resulted in a $93.2 million overstatement of the FY20 beginning fund balance for governmental funds and beginning net position for governmental activities.

- During the current examination, auditors continued to identify weaknesses regarding DOC's process for year-end accruals and noted management did not take all reasonable steps to implement appropriate and reasonable corrective action to address delays in receipt and processing of vendor invoices and ensure all payables are reasonably estimated and accrued. Similar issues have been reported since 2008.

- DOC did not have adequate accounting and review procedures to ensure all liabilities at June 30, 2020 were recorded promptly and accurately. Auditors noted the following in the review of DOC liabilities:

- DOC did not accrue liabilities totaling $36 million in the originally submitted GAAP Package to the Comptroller. These additional liabilities were identified as part of the review process by the Comptroller.

- The search for unrecorded liabilities identified accounts payable totaling $5.6 million that were not included in accounts payable accruals as of June 30, 2020.

- DOC's financial reporting of federal funds expenditures in the GAAP forms submitted to the Office of Comptroller did not agree with the Schedule of Expenditures of Federal Awards (SEFA) submitted to the auditors for the years ended June 30, 2019 and 2020. Auditors noted expenditures for the Catalog of Federal Domestic Assistance (CFDA) No. 16.606 – State Criminal Alien Assistance Program amounting to $6.201 million and $7.566 million in FY19 and 20, respectively were not accurately reported in the originally submitted SEFA.

The Department subsequently adjusted the financial statements to correct these errors, included the required disclosures in the notes to financial statements, and revised the SEFA.

Department management stated the errors in the prior year liabilities and SEFA were due to oversight and lack of a review process due to staff turnover. Management stated the additional liabilities in the current fiscal year were not identified due to delays in receipt and processing of vendor invoices and an error in generating the reports from the new Enterprise Resource Planning (ERP) system as the basis of the accrual estimates.

Department Response:
Recommendation accepted. The Department will strengthen its controls and documentation related to liability estimates used in the financial statements. However, the Department does want to make mention that during FY18 lapse period it was determined that the state owed certain bargaining unit employees for step increases that had not been awarded since July 1, 2015. This resulted in the Department being given the daunting task of estimating a total dollar impact for associated personnel moves of over 7,000 employees.

Updated Response:
Partially Implemented. The Department has staffed the Accounting Compliance Unit, which includes a designated GAAP Coordinator. With the assistance of an outside firm, staff are working to capture accurate information as it relates to liabilities and capital assets.

2. The auditors recommend the Department:

- **Identify and assign sufficient resources to perform the required tasks related to property record keeping and capital assets reporting.**

- **Strengthen its procedures over property and equipment to ensure accurate and timely recording in the ERP property system.**

- **Develop and document procedures for tracking, monitoring and proper accounting of construction in progress from inception to completion.**

- **Incorporate internal review procedures within its property reporting function to ensure capital asset information is complete, properly recorded, and accounted for to permit the preparation of reliable financial information and reports to the Office of Comptroller.**

Finding: *(Weaknesses in the financial accounting for, and inaccurate and inadequate recordkeeping of capital assets) – First reported 2008, last reported 2018*

During the current examination, auditors continued to identify weaknesses regarding DOC's process for accounting for and reporting capital asses and noted management did not take all reasonable steps to implement appropriate and reasonable corrective action to provide sufficient resources, prevent errors and oversight and ensure capital asset information was properly and accurately recorded and maintained. Similar issues have been reported since 2008.

The Enterprise Resource Planning (ERP) asset module used for property records was not updated timely and accurately for several assets capitalized by the Department. Therefore, DOC used manually compiled capital asset summaries and depreciation calculations to prepare financial reporting forms related to capital assets for submission to the Comptroller and in determining the amounts reported in the financial statements. The auditors identified the following errors and inadequacies in DOC's property recordkeeping process and financial reporting:

- DOC did not update its property records accurately and timely. Auditors noted additions totaling $1,339,194 and Capital Development Board (CDB) capitalized transfers totaling $13,164,675 dating back to FY13 were reflected in the capital asset amounts in the financial statements but not entered in the ERP records and also noted duplicate entries in the ERP system amounting to $58,252.

- DOC did not record in the ERP system capital assets transferred in Fiscal Year 2018, totaling $47,010,985, and related accumulated depreciation, totaling $21,773,805, for the Joliet Treatment Center transferred from the Department of Juvenile Justice. These capital assets were included in the manual capital asset schedule for capital assets reporting, but DOC did not manually calculate annual depreciation of $953,658 for these assets in FY19 and FY20. Accordingly,

depreciation expense totaling $1,907,316 related to these unrecorded capital transfers was not reported in the financial statements.

- DOC did not consistently apply its capitalization policy and did not accurately maintain its manual capital asset schedules supporting the financial statements. Auditors noted the following errors:

    - DOC incorrectly calculated depreciation on capitalized CDB projects based on each quarterly transfer date and amounts instead of the project completion date for the total cumulative completed project costs as required.
    - CDB projects not yet completed with cumulative costs totaling $4,686,289 were inaccurately reported as Capital Assets – Building Improvements instead of Construction in Progress.
    - Depreciation totaling $463,503 was prematurely calculated for construction projects which were still in progress.
    - Depreciation of $15,132 was improperly calculated on CDB projects for demolition and repair which were not subject to capitalization and depreciation.
    - Depreciation totaling $273,875 was still manually calculated and reported for items already entered in the ERP system causing duplicate depreciation amounts.
    - Property disposals below the capitalization threshold totaling $799,635 that were not included in beginning capital asset balances were erroneously deducted in the manual capital asset schedules, thereby understating the ending capital asset balances.

- DOC assessed a closed facility (Tamms) as temporarily impaired, subject to continued assessment in future reporting periods. However, the Department did not disclose the carrying values of the assets located in this idle facility totaling $40,840,843 as required.

The Department subsequently adjusted the financial statements to correct these errors and included the required disclosures in the notes to the financial statements.

Department management attributed the exceptions relating to capital assets and financial reporting classification errors to staff turnover, staff limitations, competing priorities, human error, and employee oversight. Department management stated staff interpreted amounts listed as non-Construction-in-Progress on reports received from CDB as completed projects. In addition, management indicated staff time was also spent on the transition to the ERP system and staff was still navigating the new system for property updates and reporting.

The Department had capitalized property and equipment throughout the state totaling approximately $1.8 billion as of June 30, 2020. Failure to maintain complete and accurate property records and inaccurate reporting of capital assets increases the risk

of equipment theft or loss occurring without detection and resulted in financial misstatements.

Department Response:
Recommendation accepted. The Department continues devoting the resources necessary to ensure Capital Asset Reporting is prepared in an accurate manner. The Department will strive to increase timeliness of recordkeeping and reduce the number of manual calculations.

Updated Response:
Partially Implemented. The Department is in the process of adding the items that were previously manually tracked into the ERP system. The property control manager position has been filled effective 2/1/22. The property control accountant position has become vacant since the original finding response was provided. The Department plans to post the position to maintain staffing to support the property control area.

3. The auditors recommend the Department implement and document the controls over its computing environment and ensure the controls provide sufficient protection.

Finding: *(Lack of controls over computer systems) – First reported 2012, last 2018*

In order to meet its mission of "serving justice in Illinois and increase public safety," the Department utilizes computer systems such as Offender 360 and Fund Accounting and Commissary Trading Systems. The Department utilizes these systems to track offender's location, information, and maintain accounting of offender's finances and the Department's finances.

Since 2016, auditors have determined the Department had not implemented adequate controls over its computing environment. During the current audit, the Department still had not taken appropriate actions to document and implement the necessary controls.

During testing, auditors noted:

- The Department had not developed a disaster recovery plan or conducted testing.
- The Department had not performed a review of user access to its applications.
- The Department had not implemented a formal change management process to control changes to its environment and applications. In addition, it was noted programmers had access to the production environment.

Department management stated the exceptions were due to the understaffing of support personnel to monitor and document the controls for the computer systems.

Due to the severity of the deficiencies noted, the auditors were unable to rely upon the IT environment controls. The auditors consider the weakness to be a material weakness in the Department's internal control over financial and fiscal operations.

Department Response:
Recommendation accepted. In February 2020, work started to address the issues noted in this finding with respect to disaster recovery planning. Target completion date has been pushed out to late summer of 2021 due to the impact of COVID-19 remote working conditions. The Department of Innovation and Technology's Business Impact Analysis Team is working with the Department of Corrections for planning and scheduling.

Updated Response:
Partially Implemented. The disaster recovery planning and testing has been postponed due to lack of resources within the Department's Information Services Unit and DoIT. In addition, there has been a turnover of the Chief Information Officer role.

The formal change management committee has not been established yet, however, changes are approved by individuals within the chain of command via Electronic Service Request forms. Adequate workflow processes have been in place to mitigate any risks and to ensure data is not compromised and is protected. No data breaches have been reported.

4. **The auditors recommend the Department implement controls to ensure expenditures are made in accordance with State statute, terms of the contract, and are properly documented and reported in financial statements. The Department should also assign responsible staff and implement internal controls to ensure the costs related to future internally developed software are adequately tracked by development stage and project and analyzed for accurate calculation of costs to be capitalized. Specifically, policies, procedures and records should be developed in a timely manner to identify, track, and report capitalizable software projects and new costs incurred. In addition, they also recommend the Department establish a central repository of information related to the project, track and monitor deliverables and performance. The Department should adequately review vendor billings for accuracy of payments and any prepayments to ensure they are properly applied to completed deliverables.**

Finding: *(Lack of fiscal controls and proper financial reporting over Offender 360 project) – New finding*

In June 2010, the Department embarked on the development of the Offender 360 system in order to meet the statutory requirements of Public Act 097-0697 to manage the awarding of sentence credits to eligible offenders. Over the last ten years, the Department has added additional functionality to Offender 360 in the areas of offender

tracking, offense information, security levels, offender personal, and medical information.

Since the FY14 engagement, auditors have reported the Department had not implemented controls over the fiscal requirements and vendor payments related to Offender 360 and failed to determine the capitalizable costs for the development of Offender 360. During the current engagement, auditors continued to identify weaknesses regarding monitoring, tracking and financial reporting of software application development costs and noted management did not take all reasonable steps to implement appropriate and sufficient corrective action.

During testing, auditors requested the Department provide documentation supporting the cost of the Offender 360 project through FY20. In response, the Department provided spreadsheets which documented the Department had paid $88,520,691 for vendor services since FY10. The spreadsheets did not include the total cost of Department staff and some additional hardware and software purchases. The Department provided a summary of staffing costs totaling $1,440,607 from FY10 to FY19. The Department stated these vendors and staffing costs included costs of the Youth 360 system for the Department of Juvenile Justice, but the Department did not have adequate information to determine the amount that should have been excluded from the Offender 360 costs. Auditors also noted the spreadsheets were the same spreadsheets provided in the prior audit and had not been updated with all FY19 and any FY20 additional vendor and staff costs. The Department subsequently provided vendor invoices incurred through FY20.

In addition, auditors noted:

- In response to the prior finding, the Department reviewed vendor payments and determined the Department had paid the vendor in full for services not yet rendered as of June 30, 2020 totaling $7,359,021. The Department subsequently entered into a spend-down agreement with the vendor to apply the credit balance to future infrastructure stabilization and maintenance services and noted the Department did not recognize this prepaid expense in the Generally Accepted Accounting Procedures Package and financial statements for FY20. The Department subsequently adjusted its financial statements to report the prepaid expense.

- The Department had not capitalized the costs for the development of Offender 360. Furthermore, it was determined the Department had not maintained sufficient records to determine the development costs related to the Offender 360 project and the modules which the Department subsequently discontinued development, to properly exclude in the capitalizable costs.

  The amount to be capitalized is to include all vendor and Department staff development costs since June 2010 for software projects expected to be completed. The Department was not able to obtain sufficient details from internal

records or the vendor to be able to separate the costs between capitalizable amounts and expenses. The Department also did not maintain detailed time records for staff involvement in development tasks to properly compute capitalizable staffing costs.

- The Department still had not developed adequate policies and procedures to identify projects that are capitalizable, determine what costs should be included in the capitalization, and track and maintain support for the costs to be capitalized.

- Since the prior audit, the Department had not taken adequate corrective action as of June 30, 2020 to strengthen internal controls over development, fully complete a central repository of information, or track and monitor deliverables and performance for internally generated software, in order to accurately identify capitalizable assets.

Total cumulative costs incurred, including both vendor payments as well as software licenses and subscriptions, through FY20 amounted to $103,775,797 based on the Department's listing of invoices and staffing cost estimates that had not been analyzed to identify properly capitalizable amounts related to the application development phase or to determine costs incurred related to the Youth 360 system.

Department management stated staffing changes contributed to the lapse in monitoring and controlling expenditures for this project. Department management further stated a substantial number of hours had been spent trying to determine whether the development costs could be identified and Department management concluded there was no benefit in spending more time evaluating invoices and determining an unreliable estimate of capitalizable costs. Department management stated they did not initially recognize a prepaid expense for the overpayment as of June 30, 2020 due to oversight. In addition, Department management stated policies, procedures and records had not been developed to identify, track, and report capitalizable software projects and new costs incurred since the prior audit due to turnover of staff intricately involved in the project and conflicting staff priorities.

Department Response:

Recommendation accepted. The Department will work to strengthen its internal controls over the development and support of its IT environment. A central repository of application documentation has been established, deliverables and performance will be tracked and monitored, and an exhaustive review of all IT expenditures will be completed with appropriate action being taken for billing irregularities.

The Department would like to point out that the $103,775,797 listed in the finding represents both internal development staffing costs and the total amount paid to the outside vendor over the time periods of fiscal years 2011-2020. Included in this amount are costs for items such as storage, maintenance support, and software licensing, in

addition to the development costs for modules that were later determined to be inoperable and contracted deliverables that were never provided by the vendor.

Through negotiations with the vendor, the Department was able to recoup $7,359,021 to offset storage and maintenance costs of the application, which was fully utilized in early 2021.

Furthermore, in March of 2021, the Department switched vendors for the maintenance of the application.

Updated Response:
Partially Implemented. The new vendor for the Offender 360 system (system) started working on stabilizing and maintaining the system in March of 2021. There have been no new developments or enhancements within the system since the new vendor took over management of the system. Weekly timesheets, monthly invoices, and monthly cumulative burned down costs are being tracked appropriately and records are being kept in a central location within the Department's Accounts Payable Division. In addition, quarterly meetings are being conducted with the outside vendors who handle management of the system and the preparation of the financial statements, as well as the Department's Fiscal Accounting and Compliance Division and Information Services Unit to discuss whether any development costs have been incurred.

5. The auditors recommend the Department implement controls to ensure reportable events are timely and accurately transmitted to CMS.

Further, they recommend the Department work with SERS and CMS to develop an annual reconciliation process of its active members' census data from its underlying records to a report from each plan of census data submitted to the plan's actuary. After completing an initial full reconciliation, the Department may limit the annual reconciliations to focus on the incremental changes to the census data file from the prior actuarial valuation, provided no risks are identified that incomplete or inaccurate reporting of census data may have occurred during prior periods.

Finding: *(Inadequate Internal Controls over Census Data) – New finding*

Auditors noted the Department's employees are members of both the State Employees' Retirement System of Illinois (SERS) for their pensions and the State Employees Group Insurance Program sponsored by the State of Illinois, CMS for their OPEB. In addition, it is noted these plans have characteristics of different types of pensions and OPEB plans, including single employer plans and cost-sharing multiple-employer plans.

During testing, auditors noted the following:

1) The Department had not performed an initial complete reconciliation of its census data recorded by SERS and CMS to its internal records to establish a base year of complete and accurate census data.

2) After establishing a base year, the Department had not developed a process to annually obtain from SERS and CMS the incremental changes recorded by SERS and CMS in their census data records and reconcile these changes back to the Department's internal supporting records.

3) Six of 120 (5%) employees tested had an event occur impacting CMS' census data records that was not reported until a subsequent fiscal year. In addition, auditors noted it took between 35 and 152 days from the occurrence of the event and when this information was entered into CMS' records. Auditors worked with CMS' actuary to project the impact of these errors on CMS' valuation and determined these exceptions did not materially impact the Department's financial statements.

4) One of 120 (1%) employees tested had a discrepancy between the change date recorded within CMS' records and the Department's records. Auditors noted the reported date within CMS' census data records was 202 days after the event purportedly occurred according to the Department's records. Auditors considered the impact of this discrepancy and determined this amount did not materially impact the Department's financial statements.

Department management indicated they were unaware of the need to perform a reconciliation of the census data information recorded by SERS and CMS to the Department's records. Department management indicated delays in reporting and data input occurred due to submission of manual forms and a need for additional supporting documents and approval.

Department Response:
Recommendation accepted. The Department will use its scarce public resources to work with SERS to develop and implement a process to reconcile the census data for the pension plan to the Department's underlying records for active members.

Updated Response:
Partially Implemented. The Department began in August of this year working with the State Employees Retirement System (SERS) to complete a reconciliation of the census data information. This work is ongoing with plans to finalize the reconciliation within the first quarter of 2022. In addition, once paperwork is received in the Central Office for leaves of absence and other changes, the staff date stamp or include an email to substantiate the date these items were received. The information is entered into the CMS system usually within a few days to two weeks.

6. **The auditors recommend the Department remind Center staff of the requirements set forth within the Administrative Directives and statutes related to the operation and maintenance of the locally held funds. They further recommend the Department devote adequate resources, provide sufficient training on locally held funds, ensure sufficient oversight, and implement sufficient internal controls to ensure adequate administration of locally held funds. The Department should also ensure records are timely updated and printed, perform reconciliations of financial reports with the general ledger balances and resolve differences to ensure accuracy of reports used in operational procedures and analysis. In addition, adequate supporting documentation for any forms or reports completed should be maintained on file to resolve differences that may be identified.**

Finding: *(Inadequate administration of and controls over locally held funds) – First reported 2008, last 2018*

These issues were first reported during the examination for the period ended June 30, 1994.

Auditors identified several exceptions and weaknesses related to the controls over the Department's locally held funds as follows:

- Auditors tested all 27 correctional centers and noted the following exceptions related to the recording of financial transactions:

    - Three (11%) correctional centers (Graham, Lincoln and Stateville) were not able to provide a complete listing of outstanding invoices comprising DOC Commissary Funds accounts payable balance of $204,048 and $445,719, for FY19 and 20, respectively. As a result, auditors were unable to conclude the correctional centers' population records were sufficiently precise and detailed under the Attestation Standards promulgated by the American Institute of Certified Public Accountants (AT-C § 205.35) to test the DOC Commissary Funds accounts payable. Also, the auditors were not able to determine if accounts payables for the DOC Commissary Funds were properly reported for Fiscal Years 2019 and 2020 for these correctional centers.

    - Four (15%) correctional centers (Decatur, Lincoln, Jacksonville, and Taylorville) were not able to provide supporting documents for 6 of 270 (2%) DOC Commissary Funds accounts payable samples selected for FY19 and 20, totaling $8,108 and $3,390, respectively.

    - Three (11%) correctional centers (Joliet, Logan, and Shawnee) did not correct errors in DOC Commissary Funds accounts payable during FY19 and 20, totaling $12,882 and $19,808, respectively.

- One (4%) correctional center (Lincoln) did not properly record FY20 transactions, resulting in a negative balance of $31,555 in the Inmate Trust Fund cash on hand.

- Four (15%) correctional centers (Decatur, Hill, Lincoln, and Taylorville) understated DOC Commissary Fund accounts payable by a total of $2,162 and $729, during FY19 and 20, respectively.

- Financial reports of ATCs did not agree to supporting documents. Auditors noted the following unexplained differences:

	Financial Reports Over (Under)		
	Cash / Fund Balances	Revenues / Additions	Expenditures / Deletions
Fiscal Year 2020			
Crossroads	$ 13,759	$ 17,037	$ 658
North Lawndale	(19)	(20,152)	5,960
Fox Valley	3,197	-	-
	$ 16,937	$ (3,115)	$ 6,618
Fiscal Year 2019			
Crossroads	$ 5,152	$ (44,080)	$ 14,662
North Lawndale	26,158	16,006	5,385
Fox Valley	1,338	-	-
	$ 32,648	$ (28,074)	$ 20,047

- The auditors tested 560 receipts at 27 correctional centers, 80 receipts at the ATCs, and 120 receipts at Central Office and noted the following exceptions:

  - Thirty of 760 (4%) locally held funds receipts tested, totaling $372,377, were deposited between 1 and 89 days late during FY19 and 20. This condition was noted at Centralia, Decatur, Dixon, Hill, Jacksonville, Lawrence, Lincoln, Pinckneyville, Robinson, Sheridan, Southwestern, and Vandalia Correctional Centers and at Fox Valley, North Lawndale, and Peoria ATCs.

    The Department's A.D. (02.40.110) states that cash accumulated in the amount of $1,000 or more on any business office working day shall be deposited no later than 12:00 a.m. the next working day.

- Seven of 760 (1%) locally held funds receipts tested, totaling $120,814, did not have complete supporting documents. This condition was noted at Lincoln and Sheridan.

- Twenty-seven (4%) receipts tested were deposit transfers from the Inmate Trust Fund to the Inmate Commissary Fund, which were made one to three months late for purchases during FY19 and 20 totaling $1,094,197 and $1,246,981, respectively. This condition was noted at Decatur, Dixon and Stateville Correctional Centers.

  Department management stated untimely deposits from the Trust Fund to the Inmate Commissary Fund were due to untimely receipt of reimbursements for Offender's payroll. In addition, Center personnel indicated they have been directed to maintain a sufficient cash balance in the Trust Fund account to cover the due to inmates' amount in the event of a Center closure.

The auditors tested 560 disbursements at 27 correctional centers, 80 disbursements at the ATCs and 78 disbursements at Central Office and noted the following exceptions:

- For 55 of 718 (8%) locally held fund disbursements tested, totaling $131,083, adequate supporting documents were not provided, such as invoices, receiving reports, and committee member meeting minutes. This condition was noted at Centralia, Danville, Dixon, Graham, Illinois River, Jacksonville, Lawrence, Lincoln, Menard, Pinckneyville, Pontiac, Sheridan, Stateville, Taylorville, Vandalia, and Western Illinois Correctional Centers, Joliet Treatment Center, and at Central Office. A.D. (02.43.102) and A.D. (02.45.102) establish written requirements for Benefit Fund expenditures, including documentation of committee decisions at each facility for review and approval of purchase requests. A.D. (02.95.105) requires records be properly identified for ready access, stored, and safeguarded at the facility.

- Eight of 718 (1%) locally held fund disbursements tested, totaling $30,871, did not contain all the required signatures for approval or had improper approval signatures. These conditions were noted at Centralia, Dixon, and Sheridan Correctional Centers and at Central Office. The Department's A.D. (02.40.102) requires two signatures on all checks and specifies positions with signature authority.

- Auditors tested bank reconciliations at 27 correctional centers, 4 ATCs and Central Office and noted the following:

  - Lincoln Correctional Center was unable to provide documentation supporting $71,846 of outstanding checks in the Resident's Commissary Fund's bank reconciliation for June 30, 2020.

- The Department could not provide explanations for the differences noted between the cash balances reported in the bank reconciliation and the general ledger for 7 of 60 (12%) Resident's Trust Fund bank reconciliations tested totaling $15,148, and for 1 of 60 (2%) Travel and Allowance Fund bank reconciliations tested, amounting to $1,608. These conditions were noted at Danville, Decatur, Lincoln, and Sheridan Correctional Centers and at North Lawndale, Fox Valley and Crossroads ATCs.

- The auditors noted 63 of 450 (14%) bank reconciliations tested did not have all the required signatures of the preparer and/or the individuals responsible for approval and the dates of preparation and approval were not always indicated. These 63 bank reconciliations were missing 82 of 189 (43%) required signatures. These conditions were noted at Big Muddy, Centralia, Danville, Decatur, Dixon, Lincoln, Logan, Taylorville, Vandalia, and Vienna Correctional Centers; Crossroads, Fox Valley, and North Lawndale ATCs; and at Central Office.

- Logan Correctional Center failed to timely void a $689 check that had been outstanding for more than three months for the Employee's Commissary Fund during Fiscal Year 2020. The check was voided 482 days late. In addition, at three ATCs, there were 7 instances in which stop-payments were not issued for Resident Trust Fund checks that were outstanding for more than three months. The exceptions occurred at North Lawndale (two instances, totaling $21,785), Peoria (three instances, totaling $506), and Fox Valley (two instances, totaling $300).

- Auditors reviewed segregation of duties at 27 correctional centers and the 4 ATCs. Auditors noted 4 (13%) facilities lacked sufficient segregation of duties over all commissary fund duties at Danville and Vienna Correctional Centers and over the trust fund duties at Sheridan Correctional Center and Fox Valley ATC. The Centers and the ATC did not have the required statement in writing by the Chief Administrative Officer, approved by the Chief Financial Officer, for the exceptions to specified segregation of duties.

- Auditors tested signature authority at 27 correctional centers and the 4 ATCs and noted exceptions at 3 (10%) correctional centers as follows:

  - Logan and Sheridan Correctional Centers failed to provide DOC Commissary Funds and Resident's Trust Fund signature cards from the bank for 7 months and 21 months of the examination period, respectively.

  - At Stateville Correctional Center, one of five (20%) individuals included on the Resident's Commissary and Resident's Trust Fund's signature cards was a former employee who left the Center two months prior to the inquiry. In addition, the Warden did not have signature authority for over six months after

his appointment. Center personnel indicated the Fund's signature cards were not updated timely due to limitations brought on by COVID-19.

- During analysis of the Employee's Commissary Fund, auditors noted 19 of 21 (90%) Centers with an Employee's Commissary Fund reported negative gross margins in their Inventory Sales Gross Margin reports reviewed during the examination period.

Department management indicated these negative gross margins reflected in the reports were mainly due to timing differences in updating sales transactions and errors on cost of sales calculations. Management stated other less significant negative gross margins were due to inventory adjustments made and lower sales due to COVID.

- The Department did not adequately perform formal monitoring procedures of its locally held funds to ensure that cash balances maintained at various financial institutions were fully secured and collateralized. The Department had bank accounts with 44 financial institutions with bank balances totaling $42 million. Of this total, the cash balance as of June 30, 2020 held with one financial institution was $484,300 over the Federal Deposit Insurance Coverage (FDIC) of $250,000 and no additional collateral pledged by the financial institution was obtained to cover the remaining uninsured amount. Department management stated the exception was due to turnover of the staff responsible for maintaining the monitoring spreadsheets and oversight.

Department management stated the exceptions related to controls over locally held funds were due to lack of employee oversight, insufficient training and staffing, failure to follow established policies and procedures, human error, and competing priorities at the correctional center level. At the Central Office level, Department management stated a lack of staff to monitor correctional center issues, as well as competing priorities, compounded the problems.

Department Response:
Recommendation accepted.

Updated Response:
Partially Implemented. The Department has staffed the Accounting Compliance Unit. These staff are resources for facility staff and monitor bank account levels to ensure proper collateral levels. The Department has also updated Administrative Directives and related forms. Staff are involved with monthly fiscal calls with facility administrative staff.

7. The auditors recommend the Department:

- **Develop a process for identifying service providers and assessing the effect on internal controls of these services on an annual basis.**
- **Obtain SOC reports or perform independent reviews of internal controls associated with service providers at least annually.**

- **Analyze the SOC reports obtained to determine the impact of the report's opinion or noted deviations.**
- **Monitor and document the operation of the CUECs relevant to the Department's operations.**
- **Document its review of the SOC reports and review all significant issues with subservice organizations to ascertain if a corrective action plan exists and when it will be implemented, any impacts to the Department, and any compensating controls.**
- **Review contracts with service providers to ensure applicable requirements over the independent review of internal controls are included.**

Finding: *(Lack of adequate controls over the review of internal control over service providers*) -First and last reported 2018

Auditors requested the Department provide its population of service providers utilized by the Department in order to determine if they had reviewed the internal controls over the service providers; however, the Department was unable to provide a listing of service providers utilized. During testing, auditors worked with the Department to identify their service providers to determine the services delivered.

Due to these conditions, auditors were unable to conclude whether the Department's population records were sufficiently precise and detailed under the Professional Standards promulgated by the American Institute of Certified Public Accountants (AU-C § 330, AU-C § 530, AT-C § 205).

Even given the population limitations noted above, auditors performed testing of eight service providers identified.

The Department utilized various service providers for hosting the Department's Offender 360 application, maintaining residents' trust funds and medical records, as well as for the preparation of financial reports and statements.

During testing, auditors noted the Department had not:

- Developed a process for identifying service providers and assessing the effect on internal controls of these services on an annual basis.

- Obtained System and Organization Control (SOC) reports or conducted independent internal control reviews for five of the eight (63%) service providers tested.
- Conducted an analysis of the three (60%) SOC reports obtained to determine the impact of the modified opinion(s) or the noted deviations.

- Conducted an analysis of the Complementary User Entity Controls (CUECs) documented in the SOC reports.

- Obtained and reviewed SOC reports for subservice organizations or performed alternative procedures to determine the impact on its internal control environment.

Additionally, auditors noted 5 of 7 (71%) contracts between the Department and the service providers did not contain a requirement for an independent review to be completed.

Department management stated the exceptions were due to staff turnover, competing staff priorities, and contract managers new to the Department who were unaware of the need for SOC reports from certain types of service providers.

Department Response:
Recommendation accepted.

Updated Response:
Partially Implemented. The Department has compiled a list of the external service providers. SOC reports and full background checks are a requirement for existing and new vendors and providers of technical services for the Department. The Department has hired a new contracts manager to oversee the contracts with external service providers. This individual is very knowledgeable with regards to reviewing SOC reports from these providers. The Department will obtain and review SOC reports for internal control deficiencies at the vendor.

8. The auditors recommend the Department improve its centralized oversight function related to inventory to allow for adequate controls, compliance with procedures and rules, as well as provision of guidance, reminders, and assistance to the Center's staff. They also recommend the Department ensure staff are adequately trained on inventory policies and procedures.

Finding: *(Inadequate controls over commodity and commissary inventory) – First reported 2008, last 2018*

The inventory balance reported by the Department at June 30, 2020 totaled $13.8 million, excluding the inventory balance of the Department's Correctional Industries. Each correctional center (center) maintained at least a portion of that inventory balance with commodity and/or commissary inventory.

As part of performing the financial audit of the Department, auditors performed tests of commodity and/or commissary inventory at a sample of the Department's 27 centers. The determination of which centers to test by sampling for each step was made based upon an analysis of the centers' inventory, locally held fund balances, and other factors.

During the current examination, auditors continued to identify weaknesses regarding the Department's internal controls over commodity and commissary inventory and

noted management did not take all reasonable steps to implement appropriate and reasonable corrective action to provide sufficient resources and to prevent errors and oversight to ensure commodity and commissary inventory were adequately maintained and accurately reported.

Auditors noted the following weaknesses in controls over commodity and commissary inventory:

- The Department did not adjust inventory balances for advance sales orders at centers totaling $227,818. As a result, inventory and unearned revenues reported in the financial statements were understated by $227,818. These conditions were noted at Big Muddy River, Centralia, Danville, Dixon, East Moline, Graham, Jacksonville, Kewanee, Lawrence, Lincoln, Pinckneyville, Pontiac, Robinson, Shawnee, Stateville, Southwestern, Vandalia, Vienna, and Western Correctional Centers.

- At 7 of 27 (26%) centers tested, the inventory counts and/or balances did not agree with physical count and inventory records, and errors were noted in the total final inventory list resulting in a net inventory overstatement of $47,679 and a net understatement of $1,642 at June 30, 2020 and 2019, respectively. These conditions were noted at Big Muddy River, Dixon, Lawrence, Lincoln, Menard, Pinckneyville, and Vienna Correctional Centers.

- Dixon Correctional Center's inventory procedures did not identify and direct staff how to handle obsolete or damaged items and third-party owned inventory, and the Employee Commissary was not organized in an orderly manner to facilitate an accurate count.

- Lincoln Correctional Center was unable to provide the June 30, 2020 physical inventory count documents for the Inmate Commissary and Employee Commissary inventory totaling $92,005.

- Auditors tested 66 inventory items with inventory balances exceeding $5,000 as of June 30, 2020 at six centers for overstocking and noted Lincoln Correctional Center was holding more than one year's supply of inventory for one (2%) item, amounting to an excess amount of $7,912.

- The complete selling price lists for FY19 for 5 of 27 (19%) inmate commissaries (Joliet Treatment Center, Lincoln, Pontiac, Shawnee, and Sheridan) and 1 of 21 (5%) employee commissaries (Danville) were not provided. The complete selling price lists for FY20 for 1 of 27 (4%) inmate commissaries (Sheridan) and 2 of 21 (10%) employee commissaries (Danville and Western) were not provided. As a result, auditors were not able to test these Centers' compliance with statutory requirements on mark-ups of commissary items.

- Auditors tested 210 Employee Commissary inventory items and noted 49 (23%) were priced 0.3% to 414.24% over the allowed mark-up at Big Muddy River, Hill, Illinois River, Lincoln, Logan, Pinckneyville, Shawnee, Vienna, and Western Correctional Centers and tested 280 inmate commissary items and noted one (.36%) item tested was priced 24.81% over the allowed markup at Hill Correctional Center.

- Four of 210 (2%) Employee Commissary items tested at centers were priced between 3.35% and 43.92% below the actual cost of the item at Danville and Logan Correctional Centers during FY20. One of 280 (.36%) Inmate Commissary items tested at centers was priced 1.98% under the actual cost of the item at Western Correctional Center.

- Sheridan Correctional Center did not maintain adequate segregation of duties by having two employees, individually order, receive, record, and price the goods in the inmate commissary.

Department management indicated the conditions noted were caused by lack of knowledge of requirements and training, staff shortages, incomplete documentation of costs of employee commissary items, calculation errors in inventory spreadsheets, human error, and employee oversight.

Department Response:
Recommendation accepted. The Department will strive to improve its centralized oversight on inventory controls and continue working with Center staff regarding maintaining and accounting for inventory in the Fund Accounting and Commissary Trading System (FACTS).

Updated Response:
Partially Implemented. The Department has increased communication with facility staff by sending policy and processing guidance and reminders by email and hosting monthly fiscal calls with facility administrative staff.

9. The auditors recommend the Department allocate the necessary resources and take all reasonable and appropriate measures in order to meet court-mandated staffing and reporting requirements.

Finding: *(Failure to meet court-ordered mental health service requirements) – New finding*

In April of 2019, the United States District Court issued a permanent injunction after finding the Department was "not in substantial compliance" with the settlement agreement entered by the parties in December 2015. The permanent injunction issued by the District Court, *Rasho v. Walker,* 376 F.Supp.3d 888 (C.D. Ill. 2019) ("the court order"), ordered the Department to provide mental health treatment to prisoners, as well

as to provide medication management, mental health evaluations, and necessary mental health staff throughout the correctional system. The Department filed an appeal the following month with the U.S. Appellate Court, Seventh Circuit. On April 23, 2021, the District Court extended the permanent injunction to continue during the pendency of the appeal. The appeal was pending as of August 31, 2021.

Within 90 days of the court order, the Department was required to employ a certain number of additional staff necessary to meet system-wide staffing levels for mental health staff positions as follows: 7 Site Mental Health Service Directors, 12 Mental Health Unit Directors, 16 Staff Psychologists, 142.5 Qualified Mental Health Professionals, 102 Behavioral Health Technicians, 54.5 Registered Nurses – Mental Health, 24 Staff Assistants, 85.5 Psychiatric Providers, 1 Director of Nursing – Psychiatric, and 5 Recreational Therapists.

Based on the auditor's review of staffing levels reported by the Department, the Department failed to meet hiring requirements from the effective date of the permanent injunction through FY20. Positions that were understaffed included Mental Health Unit Directors, Site Mental Health Service Director, Behavioral Health Technicians, and Psychiatric Providers. Specifically, auditors examined the Department's reporting of compliance with mental health staff requirements and noted the following exceptions from the court order:

Understaffing of Mental Health Positions

Fiscal Year	Quarter	Mental Health Position Titles with Vacancies	Number of Unfilled Mental Health Service Positions (Full Time Equivalent Staff)
2019	4th	3 of 10 (30%)	6 Mental Health Unit Directors, 6 Behavioral Health Technicians, 16.787 Psychiatric Providers
2020	1st	3 of 10 (30%)	3 Mental Health Unit Directors, 5 Behavioral Health Technicians, 18.712 Psychiatric Providers
2020	2nd	3 of 10 (30%)	6 Mental Health Unit Director, 8 Behavioral Health Technicians, 18.637 Psychiatric Providers
2020	3rd	4 of 10 (40%)	1 Site Mental Health Service Director, 2 Mental Health Unit Directors, 11 Behavioral Health Technician, 18.987 Psychiatric Providers
2020	4th	3 of 10 (30%)	3 Mental Health Unit Directors, 4 Behavioral Health Technicians, 13.962 Psychiatric Providers

Source: Department Quarterly Reports on Compliance with Rasho V. Baldwin

The court order also required the Department to meet and certify that its facilities comply with certain requirements to provide mental health services relating to the following areas: class members who are placed on mental health crisis watch, class members who are placed in segregation, class members who are prescribed psychotropic medication, and treatment plans, including mental health evaluations. The court order also required the Department to provide results of their own quality assurance audit and certification of whether compliance has been reached with the Department's quality assurance audit requirements. Within each of the mental health service areas, the court issued up to twelve specific directives requiring Department compliance. Auditors tested the report created by the Department to certify each facility's compliance with the above court-ordered requirements and noted the Department reported numerous facilities did not meet all court-ordered requirements for some of these mental health service areas. Specifically, the Department's quarterly reports noted the following facilities reported some noncompliance with at least one directive:

Noncompliance with Mental Health Service Requirements

Fiscal Year	Quarter	Number of Facilities Not in Compliance with Directive(s) in One or More Service Areas	Facilities Reporting Noncompliance (Number of Mental Health Service Areas with Noncompliance)
2019	4th	13 of 28 (46%)	Centralia (2), Danville (2), Dixon (3), Graham (1), Hill (3), Illinois River (5), Lawrence (5), Logan (1), Pinckneyville (1), Pontiac (5), Stateville (1), Stateville Northern Reception Center (3), Western Illinois (3)
2020	1st	14 of 28 (50%)	Danville (3), Decatur (1), Dixon (3), Elgin Treatment Center (1), Graham (1), Hill (3), Illinois River (5), Lawrence (2), Pinckneyville (3), Pontiac (4), Stateville (4), Stateville Northern Reception Center (3), Taylorville (1), Western Illinois (4)
2020	2nd	15 of 28 (54%)	Danville (3), Decatur (1), Dixon (3), Graham (1), Hill (3), Illinois River (5), Joliet Treatment Center (3), Lawrence (4), Pinckneyville (3), Pontiac (3), Southwestern Illinois (2), Stateville (5), Stateville Northern Reception Center (3), Taylorville (1), Western Illinois (5)

2020	3rd	14 of 28 (50%)	Danville (1), Dixon (3), Graham (2), Hill (4), Illinois River (5), Lawrence (3), Logan (1), Menard (2), Pinckneyville (1), Pontiac (3), Stateville (2), Stateville Northern Reception Center (3), Taylorville (1), Western Illinois (5)
2020	4th	15 of 28 (54%)	Danville (2), Dixon (3), Graham (1), Hill (1), Illinois River (5), Joliet Treatment Center (2), Lawrence (3), Logan (3),Menard (2), Pinckneyville (1), Pontiac (3), Stateville (4), Stateville Northern Reception Center (3), Taylorville (1), Western Illinois (5)
Source: Department Quarterly Reports on Compliance with Rasho V. Baldwin			

Department management stated the exceptions were due to a shortage of qualified individuals who applied to fill the necessary positions. In addition, Department management stated the centers that did not comply with all court ordered requirements resulted from a lack of staff, capacity issues, timing issues, untimely review by medical personnel, and a lack of documentation. Subsequent to testing and the Department's agreement with exceptions noted, Department management stated they disagree with the finding and contended that although the facts presented are technically accurate based on facility certifications, noncompliance would be better measured based on the number of the court's 29 directives facilities had not complied with rather than the 5 mental health service areas those directives related to. Failure to provide appropriate and reasonable treatment to seriously mentally ill inmates coupled with deliberate indifference to those health needs violates inmates' Eighth Amendment rights. The Department agreed to litigate certain portions of the settlement agreement if compliance did not occur, which resulted in the court order currently on appeal. Failure to comply with court-ordered requirements increases the risk of legal liability of the Department.

Department Response:

Recommendation accepted. The Department agrees that the audit accurately reflects the publicly available data within facility certifications that self-identify compliance with the permanent injunction in *Rasho*. The facility certifications provide no more than an opinion of those at the facility level regarding their compliance with the order. The Department's quarterly reports fully explain how and why it has complied with the 29 data points set forth in the injunction.

The Department further responds by stating it has, at all times, during the effective date of the permanent injunction provided appropriate and constitutionally required mental health care to its population. The Department's compliance with the 29 requirements within the Rasho permanent injunction throughout the entire system (28 facilities),

based solely on facility certifications, indicates it has averaged 91.28% (In this calculation, a facility is considered compliant with a mandate within the Rasho permanent injunction if it rates its compliance 85% or more, consistent with National Commission on Correctional Heath Care standards) compliance over the span of the audit cycle. The Department will continue to dedicate resources to ensuring we provide constitutionally required mental health care to individuals in custody. The most recent quarterly report for July 2021 indicates a compliance rate system wide of 96.3%.

Accountant's comment:

The Department's response contradicts evidence examined, as follows:

- The Department contends its "…quarterly reports fully explain how and why it has complied with the 29 data points set forth in the injunction." However, when other quarterly report components documenting compliance by each facility are considered, the quarterly reports still disclose noncompliance with court-ordered requirements.

- The April 2019 court order found "that despite the good efforts of the [Department], constitutionally deficient care [was] still being provided" and that "finding [was] based generally on the fact that there [was] insufficient mental health staffing at the [Department]." The court order set requirements for mental health care which are currently in effect, pending the Department's appeal. The documentation provided to the auditors does not provide sufficiently appropriate audit evidence to establish the Department's compliance with the staffing requirements of the court order.

- The Department's response states "The facility certifications provide no more than an opinion of those at the facility level regarding their compliance with the order." However, the court order's first compliance requirement is "A quarterly report created by IDOC shall certify each facility's compliance with the above requirements." (emphasis added) The Department's reports to the Court state the quarterly reports and attachments certify whether each facility complies with the court order. The Department cannot both certify to the Court that the Department's submissions certify each facility's compliance as required by the court order, while also indicating to the auditors that those certifications are not the Department's opinion.

- The compliance rates cited by the Department are misleading and incorrectly imply the Department has exceeded court-ordered compliance requirements. Each of the facilities did not meet at least 85% compliance with each of the 29 directives based on facility certifications, as reported by the Department to the Court.

Updated Response:

Implemented, Injunction Reversed. On January 12, 2022, the United States Court of Appeals for the Seventh Circuit reversed the district court's order and vacated the permanent injunction in its entirety. The permanent injunction was the criteria listed in

the finding. While the plaintiffs may challenge this opinion through rehearing or a cert petition to the US Supreme Court, the Department does not expect this finding to be repeated.

10. The auditors recommend the Department strengthen its internal controls over acquisition, custody, recording, and reporting of State property.

Finding: *(Inadequate controls over State property) – New finding*

Recording and reporting weaknesses were identified during the detailed testing of the Department's State property as follows:

- For 6 of 18 (33%) equipment vouchers tested, totaling $254,578, equipment acquired was not found on the Department's property control records as of yearend and was not included in the Department's annual report submitted to the CMS.
- Twelve of 60 (20%) equipment additions tested, totaling $131,205, were not added to property records timely, ranging from 1 to 185 days late.
- For two of 60 (3%) additions tested, totaling $26,258, property records were overstated by $10,159 based on supporting documentation.
- One of 60 (2%) additions tested, amounting to $1,200, incorrectly omitted the freight charge of $16 from the equipment value in property records.
- A State Property Surplus – New Furniture Affidavit was not filed with CMS for 1 of 1 (100%) vouchers tested for the purchase of new furniture, amounting to $2,828.

- During equipment inventory testing, auditors noted the following exceptions:
  - 16 of 60 (27%) equipment inventory items tested, totaling $47,973, could not be located, including a lawn tractor, office furniture and equipment, and information technology equipment.
  - Six of 60 (10%) equipment inventory items tested, totaling $40,651, were deemed obsolete but remained on the inventory listing and approval had not been requested to dispose of them.

- During property observation, auditors noted the following exceptions:
  - Five of 60 (8%) selected equipment items of undetermined value were not properly tagged.
  - Two of 60 (3%) equipment items of undetermined value, which were physically observed, were not included in the Department's inventory listing.

- During deletions testing, auditors noted the following exceptions:
  - 20 of 60 (33%) deletions tested, totaling $325,950, were missing the date and evidence of approval on Request for Change of Status of Equipment (Form DOC 0013).
  - 20 of 60 (33%) asset deletions tested, amounting to $275,454, were removed from property records 1 to 496 days late.

- Three of 60 (5%) deletions tested, totaling $11,774, were not properly classified on Form DOC 0013.
- Support was not provided for 2 of 60 (3%) deletions tested, totaling $28,881; therefore, auditors were unable to test compliance.

- During testing of internal controls over asset dispositions, auditors noted the following exceptions:
  - Eleven of 30 (37%) deletions tested, totaling $32,778 were deleted from property records 4 to 108 days late.
  - Three of 30 (10%) deletions tested, totaling $108,764, were missing the date and evidence of approval on Form DOC 0013.
  - For two of 30 (7%) deletions tested, totaling $6,161, the Form DOC 0013 was not provided; therefore, auditors were unable to test compliance.
  - For one of 30 (3%) deletions tested, amounting to $2,389, the CMS Surplus Property Form was not provided; therefore, auditors were unable to test compliance.

- During testing of the C-15 report reconciliation, auditors noted additions reported in FY19 and 20 were not adequately reconciled with state property expenditures. The unreconciled difference totaled $6,564,475 in FY19 and $3,925,162 in FY20.

- During testing of 36 inventory certifications submitted to CMS, auditors noted the following reporting discrepancies:
  - For 8 (22%) FY20 facility equipment inventory certifications reviewed, the amount of discrepancies reported on facility certifications did not agree with the Certification of Inventory reported to CMS, resulting in a net understatement of $704,699.
  - For 6 (17%) FY20 facility certifications reviewed, the total count of discrepancies per the facility certification discrepancies did not agree with the Certification of Inventory reported to CMS, resulting in a net understatement of 122 items.
  - For 4 (11%) FY20 facility certifications reviewed, the amount of discrepancies per the facility certification discrepancies did not agree with the Annual Report discrepancies, resulting in a net understatement of $173,818.
  - For 2 (6%) FY20 facility certifications reviewed, the net total count of capital items per facility certification discrepancies did not agree with the Certification of Inventory reported to CMS, resulting in an overstatement of 56 items.
  - For 2 (6%) FY20 facility certifications reviewed, the total count of inventory items per facility certifications did not match with the Certification of Inventory reported to CMS, resulting in a net overstatement of 45 items.
  - For 1 (3%) FY20 facility certifications reviewed, the amount of FY20 Total Inventory per Facility Certification does not agree with the Certification of Inventory reported to CMS, resulting in an understatement of $430,597.
  - For 1 (3%) FY20 facility certifications reviewed, the amount of FY20 net capital items per facility certifications did not agree with the Certification of Inventory reported to CMS, resulting in an understatement of $276,344.

- The FY19 total inventory per facility certifications and the Certification of Inventory reported to CMS did not agree with the asset listing certified and reported to CMS, resulting in an understatement of $950.
- The FY19 total amount of capital items per facility certifications did not agree with the Certification of Inventory reported to CMS, resulting in a difference of $2,000,000.

Department management stated exceptions were due to staff turnover, staff limitations, competing priorities, human error, and employee oversight.

Department Response:
Recommendation accepted. The Department is updating property control administrative directives and working on putting together a property control training manual for staff.

Updated Response:
Implemented. The updating of the administrative directives has been implemented including the higher tagging threshold of $500. Partially Implemented - The training manual is in the draft stages of completion.

11. The auditors recommend:

- **The Department ensure a full-time internal audit program is in place and headed by a chief internal auditor appointed by the Director in accordance with the Act.**
- **If another agency is to be relied upon to supplement internal audit functions at the Department, the Department should obtain written approval of the Governor for these services and ensure such services are provided in accordance with the Act's requirements.**
- **The Department implement policies and procedures to track internal audit costs, maintain documentation which adequately documents the costs of the Department's internal audit function, and ensure other agencies providing services to the Department are only reimbursed for allowable costs.**
- **The Department should not grant another agency authority to charge the Department's appropriations for payroll costs unnecessarily or without implementing and documenting proper controls over charges.**

Finding: *(Inadequate internal audit function) – First reported 2012, last 2018*

During testing, auditors noted the following:

- During the engagement period, the Department's Director did not appoint an individual to fill the Department's chief internal auditor position. This position was vacant from January 1, 2017 through July 16, 2020 (1,292 days).

- The Department and CMS did not obtain the Governor's approval for CMS to provide professional internal auditing services to the Department. Department management stated Governor's approval was not obtained due to competing priorities.

- The Department was unable to provide sufficient and appropriate audit evidence related to costs of the Department's internal audit function from July 1, 2018 through the end of the examination period June 30, 2020. Specifically, auditors noted the following:

    - Department management indicated CMS does not bill the Department for its internal audit services and related assistance. As opposed to direct billing for services performed, CMS charges costs for various statewide services – such as labor relations, personnel, mail and messenger, procurement, and internal audit – to the Professional Services Fund. Given this process, it does not appear the Department is monitoring the current costs of its internal audit function. As a result, auditors were unable to audit the cost of the Department's internal audit function to ensure the Department is accurately reimbursing CMS.

    - Also, the Department granted CMS authorization through its intergovernmental agreement to charge the Department's appropriations for payroll costs associated with CMS' rendering of professional internal audit services to the Department; however, as indicated by the Department in its response to the auditors' requests, it is not the Department's nor CMS' intent to process any vouchers against the Department's appropriations. As a result, auditors believe there is a significant internal control risk with potentially delegating a state's appropriation authority unnecessarily.

  Department management stated CMS had not billed the Department for internal audit services due to billing complexities of invoicing for an individuals' services across multiple agencies and payroll systems.

Department Response:
Recommendation accepted.

Updated Response:
- Implemented. The Department has hired a Chief Internal Auditor who began the duties of the role on July 16, 2020. There is currently a full-time internal audit program headed by a chief internal auditor appointed by the Director.
- No Change. – The Department would like to point out that 20 ILCS 405/405-293(a) applies to CMS not the Department of Corrections.
- No change. – The Department would like to point out that since CMS has not billed the Department for any internal audit services, the Department has not reimbursed any unallowable costs. Furthermore, during the examination period

covered by the audit, the Department employed one to three full-time auditors. The payroll expenses and other administrative expenses of the Office of Internal Audit were readily available, although not requested.

- Partially Implemented. The Department is working towards posting two supervisory (Public Service Administrator Option2) positions and two Internal Auditor 1 positions. Once these individuals are in place, the Department should have enough staffing to eliminate the Intergovernmental Agreement with CMS. Therefore, the Department's appropriations authority will not be used by another agency from that time forward.

12. The auditors recommend the Department implement controls to ensure reportable events are timely and accurately transmitted to CMS and records are properly completed and maintained to support transactions reported.

Finding: *(Untimely and inaccurate reporting of census data events) – New finding*

During testing, auditors noted the following problems:

1) 53 of 120 (44%) employees tested had 69 events occur impacting CMS' census data records where auditors noted it took between 15 and 152 days from the occurrence of the event to when this information was entered into CMS' records. Six of these noted incidents were also reported in Finding 2020-005.

2) One of 120 (1%) employees tested had a discrepancy between the change date recorded within CMS' records and the Department's records. This exception was also reported in Finding 2020-005.

3) Five of 120 (4%) employees tested had transactions reported to CMS where the Department's underlying records lacked support for when Department personnel actually reported the transaction to CMS.

Department management indicated delays in reporting and data input occurred due to submission of manual forms and a need for additional supporting documents and approval. Department management also indicated the missing information on when personnel changes were reported to CMS was due to employees' failure to document the date of transmittal to CMS.

Department Response:
Recommendation accepted.

Accountant's Comment:
Department officials contradict themselves by accepting our recommendation that they should implement controls to ensure reportable events, including leaves of absences, are reported timely to CMS, while simultaneously rejecting this recommendation by stating an unspecified CMS policy – which had not previously been disclosed to us

during this examination – allows employees an indefinite amount of time to submit the paperwork for reporting leaves of absences or other changes. We continue to believe the Department should implement controls to ensure all reportable events are timely and accurately transmitted to CMS.

Updated Response:
Partially Implemented. Leaves of absence are date stamped on the back when they are received by the Central Office of the Department for entry into the CMS system. In addition, other transactions are sent via email and a copy of the email is being saved to substantiate when the Central Office has received these changes. The Central Office enters the changes into the CMS system within a few days to two weeks for those items that can be directly entered by the Department.

Furthermore, the Department officials do not believe they were rejecting the auditor's recommendation but rather providing clarity of the situation both internally and when interacting with another state agency.

13. The auditors recommend the Department strengthen internal controls to maintain documentation of educational records as required by statute and A.D. and comply with the requirements to timely submit reports.

Finding: *(Failure to comply with Administrative Directives regarding submission and maintenance of required reports and educational records) – First reported 2016, last 2018*

During testing at correctional centers, auditors noted the following:

- Two of 12 (17%) offenders selected from the population of vocational students provided by Lincoln Correctional Center were not students in the Career Tech program and were not invited nor attended any of the classes. As a result, auditors were unable to conclude whether the Center's population records were sufficiently precise and detailed under the Attestation Standards promulgated by the American Institute of Certified Public Accountants (AT-C § 205.35). Nonetheless, auditors selected a sample of files and noted the following instances of noncompliance:

- Eight of 48 (17%) educational files tested for vocational students did not contain adequate documentation of the Vocational Program Waiver of Liability and Hold Harmless Agreement (Form DOC 0359) at Dixon, Lawrence, Lincoln, and Pinckneyville Correctional Centers.

- Nine of 36 (25%) offenders files selected for testing did not contain adequate documentation of the Educational Release of Information (DOC 0362) form at Lawrence, Lincoln, and Pinckneyville Correctional Centers. Additionally, 2 of the 12 (17%) offenders selected for testing at Pinckneyville Correctional Center did

not fully complete the Educational Release of Information (Form DOC 0362) form.

- Lawrence Correctional Center was unable to provide support for when the FY18 or the FY19 annual evaluation of programs due each October 1st were submitted by the Educational Facility Administrator (EFA) in the Center to the Administrator and Chief of Program and Support Services.

Department management indicated these issues were caused by human error, oversight, staff shortages, employee turnover, lack of training, and differing interpretations of when educational files could be purged.

Department Response:
Recommendation accepted.

Updated Response:
Partially Implemented. The Office of Adult Education and Vocation Services (OAEVS) management has reminded vocational staff of the importance of ensuring the proper forms are signed by the individual in custody student upon entry into the class and kept in the student's file.

14. The auditors recommend the Department fully implement an evidence-based programming system, including policies, procedures, and regulations for risk assessment; employee training; a system to evaluate effectiveness; and annual reporting, to fulfill its mandated duties.

Finding: *(Noncompliance with Evidence-Based Programming Requirements of the Illinois Crime Reduction Act of 2009) – First reported 2018, last 2018*

During the testing of statutory mandates, auditors noted the following:

- The Department did not adopt policies, rules, and regulations regarding the adoption, validation, and utilization of a statewide standardized risk assessment tool for supervised and incarcerated individuals during the engagement period. The Department ended its existing development of the Risk, Assets, & Needs Tool Assessment during FY19, and began the process to implement the Ohio Risk Assessment System in FY20, but had not implemented the system as of June 30, 2020. As of June 30, 2020, 23,140 paroled individuals were subject to supervision by the Department.

- The Department, in conjunction with the Prisoner Review Board (Board), had not provided all of its Parole Division employees with intensive and ongoing training and professional development services to support the implementation of evidence-based practices on all required topics during the examination period.

- The Department, in conjunction with the Board, did not design, implement, or make public a system to evaluate the effectiveness of evidence-based practices.

- The Department did not annually submit to the Sentencing Policy Advisory Council a comprehensive report on the success of implementing evidence-based practices.

Department management stated the exceptions were due to the decision in November 2019 to transition to a new risk assessment system and time required for negotiation of contract terms with an outside vendor during the examination period.

Department Response:
Recommendation accepted.

Updated Response:
Implemented. The Department has fully implemented the Ohio Risk Assessment System (system) to provide evidence-based programming to the individuals in the Department's custody as well as those on parole. This system indicates the risk to recidivate and the programmatic needs to address this risk. All staff within the Department who are required to use the system have been trained and training continues as new staff are hired. The COVID-19 restrictions during 2020 hindered the completion of the training since a portion of the assessment (face to face interviewing) could only be conducted in person.

In addition, the Department developed an Administrative Directive to detail the process that is to be followed with regards to a risk and needs assessment. The Department began completing these assessments in January of 2021. The COVID-19 restrictions greatly hindered the completion of the assessments within the facilities.

15. The auditors recommend the Department clarify statutory requirements to staff and implement internal controls to ensure compliance with the requirements of the Code for medical consent waivers or seek legislative remedy.

Finding: *(Failure to document compliance with statutory medical consent waivers) – First reported 2016, last 2018*

Since 2016, auditors have reported the Department had not ensured completion of all required Offender Medical Emergency Consent Waiver forms (DOC 0095) for medical emergencies in which an offender was incapable of giving consent for medical treatment or medication. During FY19 and 20, auditors continued to identify internal control weaknesses and noted sufficient corrective action had not been taken to ensure identification of all instances requiring DOC 0095 forms and completion of such waivers. During testing of waiver compliance by five correctional centers, auditors noted the following:

- Big Muddy River and Centralia Correctional Centers did not maintain sufficient internal controls to ensure the completion of waiver forms for medical emergencies in which an offender was incapable of giving consent for medical treatment or medication. Auditors noted personnel lacked a sufficient understanding of instances in which a DOC 0095 would be required. Further, due to the absence of a listing or other such records to identify instances of medical emergencies requiring a DOC 0095, auditors were unable to determine the completeness, accuracy, and reliability of the Centers' population of identified instances requiring completion of a DOC 0095 form under Attestation Standards promulgated by the American Institute of Certified Public Accountants (AT-C 205.35). Consequently, the auditors were unable to obtain assurance whether required DOC 0095 forms were properly prepared and maintained on file as required to substantiate the consent from the Center's Chief Administrative Office or Duty Administrative Officer.

- Despite the population limitations noted above which hindered the ability to conclude whether a sample selected could be representative of the population, the auditors performed testing where possible. Auditors of Centralia Correctional Center performed tests on all five of the medical emergencies recalled by Center staff for the audit period. For four of five (80%) instances of medical emergencies, the Center did not complete and maintain a DOC 0095 in the offender's medical file. In the fifth instance, Centralia determined that completion and filing of the DOC 0095 was not necessary due to a Do Not Resuscitate order.

Centralia Correctional Center management indicated these issues were caused by oversight and differing interpretations of the statute's applicability. Big Muddy River personnel indicated the Center followed guidance in the Health Care Surrogate Act rather than the Code and contacted a family member to provide consent whenever possible; as a result, use of the form DOC 0095 was infrequent.

Department Response:
Recommendation accepted.

Updated Response:
Partially Implemented. The Department is working on revising the Administrative Directive regarding the instances when a medical consent waiver is required.

16. The auditors recommend the Department review and update its policies and procedures as needed to ensure a consistent and accurate transfer of commissary profits occurs and maintain sufficient supporting documentation for measures taken. They also recommend the Department develop and implement a plan of action to decrease the liability with the Commissary Funds. Further, if the Department determines the current statutory language is not sufficient to accommodate operations of the Commissary Funds, it should seek legislative changes.

Finding: *(Noncompliance with the required transfers of profits from DOC Commissary Funds) – First reported 2016, last 2018*

Amounts due to other Departmental funds from the DOC Commissary Funds totaled $11.6 million as of June 30, 2020. The amount due to other Department funds within the Commissary Funds totaled $14.1 million, $9.7 million, and $7.8 million in FYs 18, 16 and 14, respectively. As a result, the Department did not comply with the requirement to expend forty percent of Inmate and Employee Commissary profits for the special benefit of committed persons and employees and the advancement or reimbursement of employee travel, respectively.

This finding was first reported for the Fiscal Year 2015-2016 examination period. The Department did not take sufficient measures to comply with the statute, to modify their Administrative Directives (A.D.) to meet the requirement, to eliminate the liability to the benefit funds, or to seek legislative remedy.

Department management indicated the A.D. limits transfers of profits to the benefit funds to ensure sufficient cash flow for commissary operations, but does not ensure compliance with the Code's requirement for 40% of commissary profits to be paid to the benefit fund.

Department Response:
Recommendation accepted. The Department made a concerted effort to pay down the liability as evidenced by the fact that it decreased by $2.5 million (18%) during the period from 2018 to 2020. The Department will continue to try to pay down on the liability. The Department is in the process of revising Administrative Directive 02.44.110 and internal form DOC 0075 to help ensure compliance with 730 ILCS 5/3-4-3c.

Updated Response:
Implemented. The Department has updated its internal Administrative Directives to more closely reflect the related statute. Direction has been provided to the facility staff.

17. The auditors recommend the Department comply with the requirements of the Act. Specifically, the Department should ensure timely notification, proper completion, and maintenance of the Murderer and Violent Offender Against Youth Registration Notification Form and review records in Offender 360 to ensure accuracy.

Finding: *(Noncompliance with the Murderer and Violent Offender Against Youth Registration Act) – First reported 2016, last 2018*

The auditors tested 60 notification forms at five correctional centers and noted the following:

- At Pinckneyville Correctional Center, notification forms for 4 (7%) applicable offenders tested were incomplete or contained the incorrect registration date. Furthermore, the Center was unable to provide documentation of the required notification form for 1 (2%) offender selected for testing.

- One (2%) offender selected for testing at Dixon Correctional Center was incorrectly classified in the Offender 360 system as to their status as a Violence against Youth Offender.

This finding was first reported for 2016. The Department has not taken sufficient measures to implement all appropriate and reasonable corrective actions, as exceptions continue to persist on noncompliance with the Act.

Department management indicated these issues were caused by oversight.

Department Response:
Recommendation accepted.

Updated Response:
Implemented. Management in the Field Services area have stressed during quarterly meetings with staff in this area the need to notify the applicable individuals in custody of the requirement to register as a Murderer and Violent Offender Against Youth in person within five days of release. The Field Services Management will continue to stress the need for this registry at future quarterly meetings.

18. The auditors recommend the Department transfer dormant accounts to the GRF timely and properly without offsetting or netting Inmate Trust Fund accounts with positive cash balances against accounts with negative cash balances. They further recommend the Department transfer inmate's account balances to the receiving centers. They also recommend the Department ensure all Centers have sufficient internal controls in place to identify, monitor and when required, transfer dormant account balances.

Finding: *(Failure to properly transfer unclaimed inmate cash account balances) First reported 2010, last 2018*

During testing of inmate balance transfers at five correctional centers, auditors noted exceptions at 60% of facilities tested:

- Lawrence and Menard Correctional Centers transferred $1,010 in total Inmate Trust Fund dormant accounts that should have totaled $2,803. The differences were due to offsetting or netting the total amount required to be transferred from unclaimed dormant accounts with positive cash balances against other inmates' accounts which had negative balances.

- At Lawrence Correctional Center, an Inmate Trust Fund dormant negative account balance of $466 was not transferred to the inmate's current facility.

- Lincoln Correctional Center was unable to provide an accurate listing of dormant Inmate Trust Fund accounts for the examination period. Due to this condition, the auditors were unable to conclude whether the Center's population records were sufficiently precise and complete under the Attestation Standards promulgated by the American Institute of Certified Public Accountants (AT-C 205.35) to test the Center's dormant account balances. The Center indicated that it did not perform any Inmate Trust Fund dormant account transfers during the examination period.

Noncompliance with inmate balance transfer requirements has been reported since the 2010 examination. The Department has not taken sufficient, substantial corrective actions to address the underlying causes of their noncompliance.

Management indicated negative dormant accounts were netted against positive dormant accounts due to approval from the Department's Central Office. Management stated Lincoln's failure to provide an accurate listing and to perform required balance transfers for dormant inmate accounts was due to staff shortages and lack of training.

Offsetting negative account balances against other accounts in the Inmate Trust Fund effectively requires other inmates' accounts to temporarily bear the costs of those deficits in violation of the Department's fiduciary responsibility and the Code. Failure to ensure dormant cash balances are transferred to receiving centers results in unavailability of funds to intended recipients in violation of State law. Failure to maintain adequate documentation identifying dormant Inmate Trust Fund accounts hinders the Center's ability to ensure compliance with the Code and with the Department's Administrative Directive.

Department Response:
Recommendation accepted.

Updated Response:
Implemented. Staff in the Accounting Compliance Unit are working with facilities on dormant accounts.

19. The auditors recommend the Department:

- **Review current practices to determine if enhancements can be implemented to prevent the theft or loss of computers.**
- **Perform and document an evaluation of data maintained on computers and ensure those containing confidential information are adequately tracked and protected with methods such as encryption.**

Further, they recommend the Department immediately assess if missing computers contained confidential information and take the necessary actions per the Department's policies and the Personal Information Protection Act notification requirements.

Finding: *(Inadequate controls over computer inventory) – First reported 2012, last 2018*

The Department conducted an annual physical inventory of all equipment with an acquisition cost of $500 or more and annually reported its results to CMS. Per review of the Annual Reports of Physical Inventory Discrepancies, auditors noted 92 computer inventory items not located in FY19, totaling $79,726, and 142 computer inventory items not located in FY20, totaling $118,772. The missing computer equipment ranged from 1 to 32 years old.

The Department had not protected all its laptop computers with encryption software, thus increasing the risk that confidential or personal information would be exposed. Therefore, the auditors could not determine if the computers had confidential information exposed.

DOC did significantly reduce the amount of missing computer equipment from the prior examination period.

Department management stated the exceptions were due to staff oversight and lack of resources.

Department Response:
Recommendation accepted.

Updated Response:
Partially Implemented. DoIT has taken over the responsibility for purchasing, delivering, deploying, and decommissioning (surplus) the DOC's computer equipment. This is done in collaboration with the DOC Local Area Network (LAN) administrator. DoIT has implemented using a new software program called ServiceNow in which all assets are recorded. Moving forward it is anticipated that accurate records will be tracked and maintained by DoIT and DOC.

20. The auditors recommend the Department strengthen its internal controls to ensure filing and proof of timely submission of their annual reports to the Governor is maintained.

Finding: *(Failure to submit Annual Reports to the Governor) – New finding*

At the time of testing after the end of the examination period, the Department had failed to file and maintain documentation for the submission of their annual reports to the Governor for FY18 and FY19. Therefore, auditors were unable to test the timeliness of

submission during the examination period. The FY18 report was due on December 31, 2018, as the General Assembly convened on January 9, 2019. The FY19 report was due on January 19, 2020, as the General Assembly convened on January 28, 2020. As of June 30, 2020, the reports were 547 and 154 days overdue, respectively.

Department management stated their annual reports had been filed, but staff did not maintain proof of submission when their annual reports were mailed to the Governor's Office.

Department Response:
Recommendation accepted. The Department was timely in mailing the annual reports for the years in question to the Governor's Office via regular United States Postal Service.

Updated Response:
Implemented. The Department has implemented filing the annual report with the Governor's Office via certified mail with return receipt. The Department will retain the receipt as proof of timely filing.

21. The auditors recommend the Department strengthen internal controls to ensure timely and accurate submission of required reports.

Finding: *(Inadequate controls over the submission of required employment reports) – First and last in 2018*

During testing of the State Hispanic, Asian American, and African American Employment Plans for both FY19-20, and the Native American Employment Plan for FY20, auditors noted the following exceptions:

- 16 of 81 (20%) total survey questions tested in the FY19 Plans reported 52 less total staff as compared to supporting documentation.

- 21 of 108 (19%) total survey questions tested in the FY20 Plans reported 570 more total staff as compared to supporting documentation.

During testing of the Agency Workforce Reports, auditors noted:
- The FY18 Agency Workforce Report due in FY19 was submitted 13 and 20 days late to the Secretary of State and the Governor, respectively.
- The Department reported information on the FY18 Agency Workforce Report which did not agree to supporting documentation. Discrepancies were noted in the data presented for 10 employee categories.

Department management stated the exceptions were due to miscalculations and human error when inputting data. In addition, management stated there were data

compilation errors in the system generated reports used for completion of employment plans.

Department Response:
Recommendation accepted.

Updated Response:
Partially Implemented. The Department has implemented a job aid and workflow to help keep track of the deadlines for filing of the reports, so that going forward they will be filed timely. The Department is hopeful the Human Capital Management (HCM) module will help with the preparation of the reports to ensure accurate information is being reported. However, a go live date has not been set by DoIT, who is responsible for the implementation of HCM.

22. The auditors recommend the Department allocate sufficient staff and continue its efforts to review and update its A.D.s to ensure they represent the most current, standardized practices of the Department.

Finding: *(Failure to update administrative directives) – First reported 2008, last 2018*

During testing, auditors noted the Department had not updated all its A.D.s when changes occurred in its operation, including the following examples:

- A.D. 02.42.106 regarding the transfer or closing of accounts had not been updated to reflect the use of the most updated form for the request of payment.
- Some of the Department's A.D.s related to inventory were not properly updated to reflect the change in inventory systems.
- The Department's A.D.s related to fixed assets were not updated to show the change in the inventory system.

305 of 503 (61%) A.D.s had not been reviewed within FY19 or FY20.

Department management stated the exceptions were due to competing priorities, staff shortages, and the introduction, training, and familiarization with a new review and revision process for A.D.s.

Department Response:
Recommendation accepted.

Updated Response:
Implemented. The Department began implementing a change to the administrative directive review process starting towards the end of 2019 and continuing throughout 2020. Every administrative directive is assigned a policy owner. Each quarter, approximately one fourth of the Department's administrative directives are targeted for review by policy owners such that on an annual basis every administrative directive has

received at least one review. Currently, every administrative directive has been through this process including those noted as issues in this finding.

In addition, the Department would like to point out that often during the review process an administrative directive does not require a revision because the process has not changed since the last review. Therefore, the effective date is not changed on the administrative directive, however, documentation is retained evidencing a review was conducted by the policy owner with the indication no change was necessary.

23. The auditors recommend the Department implement and enforce internal controls to ensure parolees receive a copy of the conditions of parole or mandatory supervised release and maintain adequate supporting documentation thereof.

Finding: *(Failure to provide conditions of parole or mandatory supervised release) - New*

Auditors tested 60 parolees and noted for 28 (47%) parolees tested, the Department was missing a copy of the conditions of parole or mandatory supervised release. Therefore, auditors were unable to test whether the parolee received a copy of the conditions of parole or mandatory supervised release.

Department management indicated the exceptions were due to a failure to retain documents and employee oversight.

Department Response:
Recommendation accepted.

Updated Response:
Implemented. All individuals in custody are given a copy of their Parole Board Orders (orders), which details the conditions of their parole, within four months prior to their release date. This copy is not required to be signed. At release, all individuals are given another copy of their orders, which is required to be signed by the release. A copy of the orders is kept in section 2 of the individual's master file.

24. The auditors recommend the Department timely notify the appropriate parties of parolee residency.

Finding: *(Failure to provide offender resident information to appropriate parties) – New*

During FY19-20, five offenders became residents of Department of Human Services (DHS) facilities. Auditors tested notification requirements for all five offenders and noted the following:

- All 5 (100%) offender files tested were missing support of the submitting name and contact information for the assigned parole agent and parole supervisor to the DHS facility.
- Four of 5 (80%) offender files tested were missing support the Prisoner Review Board was notified within 3 days of offenders becoming residents of a DHS facility.
- Four of 5 (80%) offender files tested were missing support of the chief of police and sheriff being notified within 3 days of the offenders becoming residents of a DHS facility.
- For one of 5 (20%) offenders tested, the Department provided information to the DHS facility more than three days after the offender became a resident. The facility was informed 142 days late.

Department management stated the exceptions were due to competing priorities and employee oversight.

Department Response:
Recommendation accepted.

Updated Response:
Implemented. The Department would like to point out that none of the individuals noted in the finding ever left the Department's custody. Four of the individuals were severely mentally ill individuals who suffered a mental health crisis that was beyond the capability of the Department staff to handle within the confines of a department facility. They were transferred to mental health hospital operated by DHS for stabilization services. Once they were stabilized, the individuals were transferred back to a department facility. The fifth individual was classified as a Sexually Dangerous Person and was therefore transferred to a DHS facility to serve out the remainder of the individual's sentence. None of these individuals were considered to be on parole and therefore the reporting requirements listed in the finding were not required.

25. The auditors recommend the Department implement a food donation policy to comply with the requirements of the Code, including identification of non-profit recipients, notification of all Department employees, and annual policy submission to CMS. Auditors further recommend the Department implement internal controls to identify and ensure compliance with generally applicable laws.

Finding: *(Failure to adopt a food donation policy) – New finding*

The Department had not adopted a leftover food donation policy addressing daily food operations run by the Department, including one-time events, as well as a listing of nearby soup kitchens, food pantries, and other organizations where leftover food can be donated. The Department spent $86,680,617 for purchases of food supplies during FY19 and 20.

Department management stated the lack of a food donation policy was due to management oversight.

Department Response:
Recommendation accepted. The Department will seek legislative remedy.

Updated Response:
No Change. The Department is working to draft a food donation policy.

26. The auditors recommend the Department timely appoint members and provide administrative support to task forces, boards, and commissions as required by state law, and actively participate in mandated committees to help ensure the purpose of such entities is achieved.

Finding: *(Tamms Minimum Security Task Force) – New finding*

The Department of Corrections (Department) failed to comply with the Unified Code of Corrections regarding the Tamms Minimum Security Task Force (Task Force).

The Task Force was dissolved by the Code on January 1, 2021.

Department management disagreed with the finding and indicated they took no actions related to this mandate because they believed another agency was responsible for ensuring the Task Force was formed.

Department Response:
The Department agrees the Tamms Minimum Security Unit Task Force (task force) was not formed during the one year the task force was statutorily required to be active.

Updated Response:
Implemented. The Department makes every effort to ensure that required appointments to task forces, boards, and commissions is completed in compliance with state law. To that end, the Director or his designee has been appointed to over 30 such task forces, boards, or committees throughout state government.

27. The auditors recommend the Department allocate sufficient resources to timely approve and process vouchers for payment and retain supporting documentation and also recommend the Department ensure employees timely submit travel reimbursement requests and adequate supporting documentation, accurately report their headquarters, and timely obtain preapprovals for out-of-State and out-of-country travel.

Finding: *(Inadequate Controls over Voucher Processing) – First reported 2014, last 2018*

The Department of Corrections (Department) did not maintain adequate controls over voucher processing.

During sample testing of 469 vouchers, auditors noted the following exceptions:

- For 93 (20%) vouchers tested, totaling $13,771,680, payments were approved by the agency head more than 30 days after receipt by Fiscal Operations, ranging from 4 to 227 days late.

- For 25 (5%) vouchers tested, totaling $2,185,344, bills did not have a date received stamp; therefore, auditors were not able to test timeliness of receipt of the vendor invoice and payment to the vendor.

- One (0.2%) voucher tested for $61,875, had a date received stamp later than the approval date.

- One (0.2%) voucher tested, amounting to $44,058, was paid 22 days late, and late payment interest was not paid as required.

- One (0.2%) voucher selected for testing, totaling $15,932, was not provided by the Department.

During sample testing of 152 travel vouchers, auditors noted the following exceptions:

- For six (4%) vouchers tested, totaling $1,904, reimbursement requests were received by Fiscal Operations later than the 30th of the next month after the trip took place, ranging from 21 to 111 days late.

- For two (1%) vouchers tested totaling $426, the employee's headquarters did not agree with the official headquarters on file with the Legislative Audit Commission.

An additional sample of 60 out-of-State travel vouchers and noted 11 (18%) vouchers tested, totaling $7,928, did not have DOC Form 0277 (Out-of-State or Out-of-Country Travel Request form) documenting Department approval.

Department management stated the exceptions noted were due to conflicting priorities and lack of resources.

Department Response:
Recommendation accepted.

Updated Response:
Partially Implemented. The Department's Central Office has sent numerous reminder emails to voucher processing staff regarding the timely approval of vouchers. In addition, monthly fiscal calls with the administrative staff at the facilities is occurring to remind them to process vouchers timely and to address any issues arising.

28. The auditors recommend the Department work with the Centers to identify staff shortages and take corrective actions to ensure an adequate separation of duties is maintained.

Finding: *(Inadequate separation of duties for handling cash boxes at Correctional Centers) – First reported 2008, last 2018*

Auditors tested segregation of duties over cash at five facilities and noted the following:

- Lincoln Correctional Center (Center) did not maintain an adequate separation of duties over the cash box. Auditors noted the Center employee responsible for performing counts of the cash box was also the individual assigned custody of the cash box.

- The Center was unable to provide documentation to substantiate periodic counts of the cash box were performed by someone independent of the person assigned custody of the cash box.

Department management indicated these issues were caused by a staff shortage in the business office.

Department Response:
Recommendation accepted. The COVID-19 pandemic contributed to short-staffing in the facility Business Offices.

Updated Response:
Partially Implemented. The Department is working to fill vacancies and has increased the authorized headcount in our facility Business Offices.

29. The auditors recommend the Department establish a written fraud prevention, deterrence, and detection program. This program should include evaluating whether appropriate internal controls have been implemented in any areas identified as posing a higher risk of fraudulent activity, as well as controls over the financial reporting process.

Finding: *(Failure to develop a formal fraud risk assessment program) – First reported 2012, last 2018*

Department management stated the failure to develop a formal fraud risk assessment program was due to competing priorities.

Department Response:
Recommendation accepted.

Updated Response:

Partially Implemented. The Department has started the process of developing a fraud risk policy and assessment process.

30. The auditors recommend the Department assign sufficient staff to ensure all reporting requirements are adhered to and ensure required quarterly visits are conducted to ensure appropriate training and support of Peer Educators.

Finding: *(Noncompliance with grant agreements) – First and last reported 2018*

Auditors tested 7 grant agreements for grants awarded to the Department, and noted the following exceptions:

- For 1 of 7 (14%) grant agreements tested, required quarterly visits were not conducted for 3 of 4 (75%) quarters tested.

- For 1 of 7 (14%) grant agreements tested, noted 2 of 4 (50%) required quarterly reports were submitted 70 and 180 days late.

- For 1 of 7 (14%) grant agreements tested, the annual audit report was submitted 109 days after the extended due date granted in an extension.

Department management stated the exceptions noted were due to timing constraints, staff shortages, and turnover.

Department Response:
Recommendation accepted.

Updated Response:
Partially Implemented. The quarterly visits were not occurring due to lack of staff and the COVID-19 lockdown restrictions. The Department has hired more staff to conduct the required quarterly visits. Starting with the quarter ending September 30, 2021, the Department's Central Office Grant Accounting Supervisor has begun coordinating the filing of the quarterly reports. The due date for the annual report is before the State-wide Single Audit is completed each year.

31. The auditors recommend the Department implement controls and maintain adequate supporting documentation to ensure cash receipts and refunds are deposited in a timely manner in accordance with state law.

Finding: *(Cash receipts and refunds not paid into the State Treasury on a timely basis as required by State law) – First and last 2018*

Auditors noted the following exceptions:

- 10 of 43 (23%) refunds, totaling $19,434, were not deposited timely, ranging from 2 to 96 days late.

- For five of 43 (12%) refunds tested, totaling $2,130, the Expenditure Adjustment Transmittal Forms were missing the date.

- Three of 43 (7%) refunds tested, totaling $1,465, lacked adequate supporting documentation and were not able to determine the timeliness of deposit.

- For three of 43 (7%) refunds tested, totaling $1,380, the Expenditure Adjustment Transmittal Forms' date noted did not align with the proper fiscal year period.

- Three of 60 (5%) receipts, totaling $90, were not deposited within the 15-day extended due date, ranging from 6 to 66 days late.

Department management stated the exceptions noted were due to a lack of staff, conflicting priorities, human error, and employee oversight.

Department Response:
Recommendation accepted.

Updated Response:
Implemented. The Department ensures that guidance and reminders are sent to staff as it relates to the timely processing of money received for the State Treasury.

32. The auditors recommend the Department implement an automated timekeeping system.

Finding: *(Payroll timekeeping system not automated) – First reported 1998, last 2018*

The Department of Corrections (Department) payroll timekeeping system was not automated.

The Department continued to maintain a manual timekeeping system for 12,509 employees as of June 30, 2019 and 12,642 employees as of June 30, 2020. Correctional center employees signed in and out, and these sheets were sent to the correctional center's timekeeping clerk. Other information, including notification of absences and call-in reports, were also forwarded to center timekeepers. Within the General Office, unit timekeepers from each division maintained daily attendance records, which were reviewed and approved at the end of the pay period by the supervisor and then submitted to the General Office Timekeeping Supervisor. However, the Department had not implemented an automated timekeeping system during the examination period. As a result, testing of compensatory time noted significant exceptions. See finding 2020-037 for details. This finding has been repeated since the Fiscal Year 1998 examination.

Department management indicated there was a lack of resources to procure its own automated timekeeping system, or to develop and maintain a homegrown system to meet the needs of the Department.

Department Response:
Recommendation accepted. The State of Illinois is in the process of implementing the Human Capital Management (HCM) system for all agencies under the Governor, which includes a timekeeping component. The Department is hopeful this finding can be addressed during the implementation of this system.

Updated Response:
No Change. The Department has been conducting user acceptance testing of the Human Capital Management System however a go live date has not been set by DoIT, who is responsible for the implementation of HCM.

33. The auditors recommend the Department improve controls over leave of absence requests to ensure forms are properly completed, timely approved, and maintained in the Department's files and ensure employees are properly compensated and further recommend the Department remind facilities and enforce the requirement to timely submit support for leaves of absence.

Finding: *(Inadequate controls over request for leaves of absence) – First reported 2016, last 2018*

During testing of employees' requests for leave of absence (LOA), auditors noted the following exceptions:

- 50 of 60 (83%) employees on LOA tested were approved by the Director after the LOA effective date, ranging from 1 to 447 days late.

- Four of 60 (7%) return LOA forms tested were approved more than 90 days after the LOA effective return date, ranging from 101 to 305 days late.

- Three of 60 (5%) employees on LOA tested were missing the initial Personnel Action Form for LOA approval.

- One of 60 (2%) employee on LOA tested was missing the employee signature on the return LOA form.

- One of 60 (2%) employee on paid Military Leave was not properly compensated, resulting in an underpayment of $15,952. The Department completed the necessary forms to claim for back wages due to the employee, subsequent to the notification of this exception.

Department management stated the exceptions were due to late submission of approvals and forms from the correctional centers, and the under compensation for military leave was an error.

Department Response:
Recommendation accepted.

Updated Response:
Implemented. The Department's Central Office sent out an email requiring leaves of absences to be filed with the Central Office within 14 days of the occurrence of the leave. If this is not possible, then the facility staff is required to provide an explanation of the reason for the delay. This process has drastically reduced the number of late filings.

34. The auditors recommend the Department allocate resources, implement internal controls for identification of needed evaluations, follow up on needed evaluations, and hold management accountable for completing and documenting employee performance evaluations on a timely basis.

Finding: *(Employee performance evaluations not performed) – First reported 2006, last 2018*

During testing of personnel files for 60 employees, auditors noted the following:

- 21 (35%) employees' annual performance evaluations for FY20 were not performed timely, ranging from 2 to 283 days after the last day of the employee's performance review period.

- 20 (33%) employees' annual performance evaluations for FY19 were not performed timely, ranging from 9 to 649 days after the last day of the employee's performance review period.

- Two (3%) employees did not have an annual performance evaluation in FY20.

- One (2%) employee did not have an annual performance evaluation in FY19.

Department management stated the performance evaluations were not conducted in a timely manner due to staffing constraints, vacancies, retirements, oversight, and lack of adequate follow-up. Further, Department management indicated due to the COVID pandemic, staff were working remotely and this also contributed to untimely completion of performance evaluations.

Department Response:
Recommendation accepted.

Updated Response:
Partially Implemented. The Department's Central Office sent an email to executive staff to remind them of the importance of completing performance evaluations timely. HCM is in the user acceptance testing phase. Final go live date has not been set by the Department of Innovation and Technology.

35. The auditors recommend the Department allocate sufficient resources to document and monitor training and follow up to ensure employees receive the required training to enable them to perform their specific job duties and to reduce risks to the Department.

Finding: *(Inadequate documentation of employee training) – First reported 2000, last 2018*

During testing of personnel training records, auditors noted the following:

- Nine of 60 (15%) employees tested did not meet the FY20 required minimum in-service training hours.
- Eight of 60 (13%) employees tested did not meet the FY19 required minimum in-service training hours.
- Five of 60 (8%) employees tested were missing support for FY20 minimum in-service training hours completed.
- Six of 60 (10%) employees tested were missing support for FY19 minimum in-service training hours completed.
- Five of 10 (50%) newly hired employees tested did not complete the minimum requirement for orientation training hours.
- Four of 10 (40%) newly hired employees tested did not complete ethics training within 30 days of hiring date, ranging from 12 to 16 days late.
- One of 60 (2%) employees tested was missing the 2020 ethics training, sexual harassment training, and cybersecurity awareness training.

Department management stated exceptions were due to competing priorities and employee oversight.

Department Response:
Recommendation accepted.

Updated Response:
Implemented. In January of 2020, the Department created new positions at the facility level. A new Training Academy Manager was also hired during that same timeframe. In April of 2020, the Department implemented these newly created positions as Staff Development Specialists (SDS). The Department currently has one SDS stationed at each facility with an additional nine at the training academy. The duties of the SDS includes conducting Pre-Service Orientation Training (PSOT) at each facility rather than regionally, which was the practice prior to the implementation of the SDS position. All security staff spend the first week of employment at the facility completing facility orientation and all computer related training prior to attending the academy at Concordia Court. All other facility staff complete PSOT at the facility. In addition, the SDS personnel plan any required in-service training sessions for the facility staff at each facility. This process has reduced the backlog of staff in need of PSOT training as well as travel costs for the Department since staff are no longer required to travel to another location, sometimes overnight, to attend this type of training.

The COVID-19 lockdowns did hinder progress on these improvements to a certain degree since the training academy as well as facility training sessions were halted for several months during the pandemic. The next audit cycle will reflect some of this situation.

36. The auditors recommend the Department monitor the use of leave time being used on the same day as overtime is worked and comply with its training manual by not allowing employees to work overtime on the same day that a full day of leave time is also used.

Finding: *(Taking paid leave time and working overtime on the same day) – First reported 2014, last 2018*

The Department of Corrections (Department) allowed employees to use leave time (i.e., sick, vacation, personal leave, and accumulated holiday time) for their regular shift and then work another shift at an overtime rate on the same day. While there may be instances where this would be a needed solution to a difficult staff coverage scenario, it could be a sign of abuse of overtime and may be against Department policy.

According to the Department, for FY20, there was a total of 1,107,596 hours of overtime paid at a cost of $53,497,160. Stateville Correctional Center reported 204,903 hours of overtime at a cost of $10,120,852, the highest amount of overtime of any correctional facility. The facility with the next highest amount of overtime was the Logan Correctional Center with 99,960 hours of overtime at a cost of $4,660,997.

Auditors reviewed FY20 overtime payments for 20 employees and selected 10 employees at the Stateville Correctional Center and 10 employees at the Logan Correctional Center who had the highest amount of overtime paid. As part of review, auditors obtained employee annual timesheets and payroll reports.

In the review of these 20 employee timesheets for FY20, 12 employees (60%) had used a full day of leave time at least once during the fiscal year on the same day they had worked an overtime shift. For these 12 employees, auditors identified a total of 29 instances during FY20 in which employees used a full day of leave time (7.5 hours) the same day that they also worked overtime. One employee at Stateville Correctional Center used leave time the same day in which they worked an overtime shift on 13 different occasions during FY20.

Auditors requested any union agreements that allow overtime pay on the same day that leave time is taken; however, the Department could not provide any.

The Department's Overtime Equalization Training Manual requires the Department to not consider employees on benefit time for Master Overtime Equalization if the overtime is occurring during the time of the employee's absence.

Department management stated generally the reason for employees taking paid leave time and working overtime on the same day is due to competing priorities, lack of staff, and employee oversight.

The financial effect on the state, however, is that not only does the state pay the employee at the overtime rate for the shift worked in addition to the regular rate for the leave time taken, but the state may need to pay another employee overtime to cover the shift for which the leave time was used. This type of abuse of leave time may be an example of "shift swapping" in which employees knowingly use leave time and swap shifts in order to gain a financial advantage.

Department Response:
Recommendation accepted. The Department will strive to limit the number of occasions in which a staff member uses leave time on the same day that overtime is worked.

The Department would like to point out the following information regarding the exceptions noted in this finding:

- The Department operates and staffs' correctional facilities on a 24-hour basis for 365 days a year.
- Due to staff shortages in these correctional facilities, overtime is inevitable.
- The majority of the instances involved staff members who had requested and received approval for leave time in advance of working the overtime. In some cases, the approval was obtained several months in advance.
- These individuals in most cases had reached the maximum amount of leave time accrual allowed. Therefore, they needed to reduce the balance by taking some leave time.

Updated Response:
Partially Implemented. The Department Central Office Payroll Division has designed a program to review all timesheets and provide a report detailing these types of

occurrences. The report has been tested for accuracy and began production monthly starting with September 2021.

37. The auditors recommend the Department:

- **Comply with the federal Fair Labor Standards Act of 1938 by not allowing employees to accrue more than 480 hours of compensatory time.**

- **Comply with the union master agreement and track and pay compensatory time at the rate it was earned/accrued.**

Finding: *(Compensatory time accrual in violation of federal law) – First reported 2014, last 2018*

According to the Department, for FY20 there was a total of 828,502 hours of compensatory time used/reimbursed at a cost of $27,938,573. Stateville Correctional Center reported 87,751 hours of overtime compensatory time paid at a cost of $3,125,422, the highest amount of compensatory time of any correctional facility. The facility with the next highest amount of compensatory time was Dixon Correctional Center with 75,770 hours of compensatory time at a cost of $2,515,883.

Auditors reviewed FY20 compensatory time for 20 employees and selected 10 employees at Stateville Correctional Center and 10 employees at Dixon Correctional Center, which had the highest amount of compensatory time paid. As part of the review, auditors obtained employee annual timesheets and payroll information for each pay period.

For 5 of 20 (25%) employees sampled, timesheets showed they were allowed to accrue more than 480 hours of compensatory time during at least one month and up to six months of FY19 and/or FY20, ranging from 1 to 362 hours in excess of allowable accrued time.

The Department did not have a centralized timekeeping system to track the hours of compensatory time that employees have accrued. The Department used a manual timekeeping system and was not able to appropriately track the rate at which compensatory time was accrued/earned for each employee.

This finding was first noted during the examination of the two years ended June 30, 2014. The Department had not taken sufficient, substantive steps to implement all appropriate and reasonable corrective action, as excessive compensatory time accruals continue to persist.

Department management stated the excessive compensatory time accruals were due to employee oversight.

Allowing employees to accrue excessive compensatory time and failing to track the rate at which compensatory time was accrued/earned may result in a loss of funds for the State. Further, compensatory time liquidated at the end of the fiscal year may be paid at a higher rate than it was earned earlier in the year. This is because employees who wait until all cost-of-living raises, merit raises, and promotions are received prior to liquidating the time for cash receive a higher rate of pay for the accrued compensatory time. Because the Department did not have a centralized electronic timekeeping system during the examination period, it was difficult to quantify how prevalent the accrual of compensatory time was or the financial impact.

Department Response:
Recommendation accepted. The new Human Capital Management (HCM) will notify supervisors when the comp time earned has reached the maximum number of hours.

Updated Response:
Partially Implemented. The Department Central Office Payroll Division has designed a program to review all timesheets and provide a report listing the comp time balance for each employee. For any employee approaching the 480-hour Federal maximum, the facility is notified so that a payout can be arranged.

38. The auditors recommend the Department ensure that quarterly reports for locally held funds are properly reviewed for accuracy prior to submission to the Office of Comptroller.

Finding: *(Inadequate Controls over Locally Held Fund Reporting) – New finding*

During testing of the Reports of Receipts and Disbursements for Locally-Held Funds (Form C-17), auditors noted the following:

FY19:

- For three of 27 (11%) Center Inmate Commissary Funds tested, the first quarter sales amount per the Statement of Operations was not reflected in the Form C-17 worksheet, resulting in a total Form C-17 understatement of $1,447,413.

- For one of 27 (4%) Center Inmate Commissary Funds tested, the third quarter sales amount per the Statement of Operations did not agree with the amount in the Form C-17 worksheet, resulting in a Form C-17 understatement of $366,424.

- For one of 30 (3%) Center Employee Benefit Funds tested, the second quarter vending income amount per the Statement of Operations was not reflected in the Form C-17 worksheet, resulting in a Form C-17 understatement of $2,611.

FY20:

- For one of 30 (3%) Center Employee Benefit Funds tested, the first quarter rental income amount in the Form C-17 worksheet was not reflected in the Statement of Operations, resulting in a difference of $3,835.

- For one of 21 (5%) Center Employee Commissary Funds tested, the second quarter checking account amount per the General Ledger Trial Balance did not agree with the amount in the Form C-17 worksheet, resulting in a Form C-17 understatement of $20.

- For one of 21 (5%) Center Employee Commissary Funds tested, the Vending Commissions Income amount per the Statement of Operations did not agree with the amount in the Form C-17 worksheet, resulting in a Form C-17 understatement of $29.

Department management stated the exceptions were due to staff oversight.

Department Response:
Recommendation accepted. The Department will work towards ensuring that the quarterly Report of Receipts and Disbursements for Locally Held Funds (Form C-17) is properly reviewed for accuracy prior to submission to the Office of the Comptroller.

Updated Response:
Implemented. The Department has staffed the Accounting Compliance Unit that provides the reviews of Form C-17.

39. The auditors recommend the Department ensure external assessments of its internal audit function are timely conducted as required by professional standards.

Finding: *(Lack of external assessment of the internal audit function) – New finding*

During testing, auditors noted the Department failed to have an external assessment of its internal audit function performed prior to the end of the examination period. The last external assessment was conducted in FY15.

Department management stated an external assessment was not conducted or scheduled during the examination period due to the Department's decision to delay an external assessment until after a Chief Internal Auditor was hired.

Department Response:
Recommendation accepted.

Updated Response:
Partially Implemented. The Department believes the external QAR will be completed by the end of Fy22 as planned.

40. The auditors recommend the Department develop and issue formal change management procedures to control all changes made (including emergency changes) to computer systems. The procedures should include at a minimum:

- **The Department's process for requesting a change,**
- **The Department's approval process of the requested change,**
- **Monitoring of change requests,**
- **Testing and documentation requirements,**
- **User acceptance and documentation, and**
- **Post implementation reviews requirements.**

In addition, the Department should restrict programmer access to all production programs and data. If the Department determines that programmer access is necessary in some situations, the Department should establish and enforce compensating controls to ensure appropriate management oversight and approval of changes.

Finding: *(Weaknesses in change control management) – First reported 2012, last 2018*

During testing of changes to Offender 360 and Correctional Intelligence (INTEL), auditors noted:

- 12 of 17 (71%) changes were not properly approved
- 9 of 17 (53%) changes were not logged properly, and
- 1 of 17 (6%) changes had no testing details

Also, one (6%) change was tested months after deployment or completion date.

Furthermore, auditors reviewed the access rights of the developers, noting they have access to the production environment, resulting in a segregation of duties weakness.

Department management indicated the exceptions were due to the understaffing of support personnel to monitor and document request for changes to computer systems.

Department Response:
Recommendation accepted.

Updated Response:
Partially Implemented. All change requests are tracked via the Department's Electronic Service Request form and/or in the Offender 360 Ticketing System. Change requests

screening, approval, development, testing, deploying, etc. steps have been thoroughly documented in the appropriate systems. Collaboration with appropriate staff as part of the change committee has been introduced.

41. The auditors recommend the Department:

- **Develop a formal, comprehensive, adequate, and communicated security program (policies, procedures, and processes) to manage and monitor the regulatory, legal, environmental, and operational requirements.**
- **Address the results of the risk assessment and/or document the corrective actions included in the mitigation plan.**
- **Develop a data classification policy.**
- **Develop a policy or procedure regarding the method and responsibilities for data wiping.**
- **Ensure all Department employees participate in cybersecurity awareness training.**
- **Ensure cybersecurity roles and responsibilities are documented and communicated.**

Finding: *(Weaknesses in Cybersecurity Programs and Practices) – First reported 2016, last 2018*

During examination of the Department's cybersecurity program, practices, and control of confidential information, auditors noted the Department:

- Had not developed a formal, comprehensive, adequate, and communicated security program (policies, procedures, and processes) to manage and monitor the regulatory, legal, environmental and operational requirements.
- Had not addressed the results of the risk assessment and/or documented the corrective actions included in the mitigation plan.
- Had not developed a data classification policy.
- Had not developed a policy or procedure related to data wiping.
- Had not ensured cybersecurity awareness training was completed for 808 of 13,958 (6%) registered employees.
- Had not ensured cybersecurity roles and responsibilities were documented and communicated.

The Department management indicated work overload and understaffing caused the delay of completion of these activities.

Department Response:
Recommendation accepted.

Updated Response:
Partially Implemented. The Department is working to ensure recommendations in safeguarding all aspects of IT are established and provided for awareness and compliance. The Department will adopt and implement established policies and procedures provided by DoIT. These policies include Security Guidelines and Requirements regarding Securing Data (At-Rest & In-Transit), Protecting Mobile Device Data, Protection of Personally Identifiable Information and procedures regarding "Breach or Data Loss" – These Policies also include the proper procedures for disposal & destruction of State of Illinois Devices and the Data contained within – The Department's Staff are currently active in participation of the State's required "Cyber-Security Awareness Training" – A Risk Assessment was completed by DoIT in October of 2021. The Department is working to address the issues found. However, progress has been hindered by turnover of the CIO role. – Cyber Security Roles and Responsibilities are currently being established by the Department with the assistance of DoIT – The Department has identified a Privacy Officer, who is responsible for reviewing IT contracts and internal policies to ensure compliance with established guidelines, policies and procedures.

42. The auditors recommend the Department:

- **Develop and implement a disaster recovery plan. At a minimum, the plan should reflect the current environment, identify a prioritized list of critical applications and minimum recovery times, outline the recovery team responsibilities and contact information, alternative recovery locations, and off-site storage facilities.**

- **Annually test the plan across all environments and update, where necessary, based on the test results.**

Finding: *(Lack of disaster contingency planning or testing to ensure recovery of computer systems) – First reported 2012, last 2018*

Since 2012, auditors have noted the Department had not developed a disaster recovery plan to ensure the recovery of its systems and data and again noted in the current examination, the Department had not developed a disaster recovery plan.

In addition, the Department had not conducted disaster recovery testing of its systems and data during the examination period.

Department management indicated the delay of completion of the activities were due to work overload and understaffing.

Department Response:
Recommendation accepted. In February 2020, work started to address the issues noted in this finding with respect to disaster recovery planning. This process was interrupted

due to considerations of the COVID-19 Pandemic. Efforts with DoIT have resumed for disaster & contingency planning as part of the Business Impact Analysis process. These efforts will provide insight into each Business Area within the Department of Corrections and provide guidance to remediation in the event of interruption of regular business operations. A target completion date for these efforts has not yet been established. DoIT's Business Impact Analysis Team is working with the Department of Corrections for planning and process review.

Updated Response:
Partially Implemented. The disaster recovery planning and testing has been postponed due to lack of resources within the Department's Information Services Unit and DoIT. In addition, there has been a turnover of the Chief Information Officer role.

43. To enhance computing resource controls, the auditors recommend the Department:

- **Develop and implement policies and procedures regarding the provisioning of access rights to all applications and environments.**
- **Ensure documentation is obtained in approving access to applications and required access rights are documented.**
- **Ensure access rights are disabled upon an individual's separation from the Department or upon determination access is no longer required.**
- **Periodically review user access rights to ensure user accounts are appropriate based upon job responsibilities.**

Finding: *(Computer security weakness) – First reported 2016, last 2018*

Since 2016, auditors noted the Department had not developed access provisioning policies to document the controls over requesting, changing, and terminating of access rights to computer systems and again noted in the current examination, the Department had not developed access provisioning policies to document controls over requesting, changing, and terminating of access rights to computer systems.

In addition, auditors tested a sample of new hires and terminated employees, noting:

- 6 of 33 (18%) new hires' access was not approved.
- 4 of 33 (12%) new hires' requested access was not documented. Therefore, auditors were unable to determine if proper access was established.
- 7 of 17 (41%) terminated employees still had access to the Department's computing environment (61 to 700 days post termination).

Furthermore, the Department had not conducted a review of access rights to its computer systems.

Department management indicated the weaknesses were the result of filing and monitoring delinquency and lack of notification from the employee's immediate superior regarding the employee's termination.

Department Response:
Recommendation accepted.

Updated Response:
Implemented. In-place security governance has been implemented to address the issues noted in this finding with respect to user access controls. Staff are on-board to monitor, control, and govern application security concerns. An Application User Access request process is in place for anyone requiring access to any of the Department of Corrections server and client systems. The Department is proactive in maintaining the proper security controls. Formal documented data and security governance policies & guidelines are in place under the DoIT umbrella.

44. The auditors recommend the Department allocate resources to ensure compliance with administrative directives regarding weekly safety and sanitation inspections, and monthly inspections of all housing units and dietary areas. Further, the Department should remind staff to timely prepare and adequately maintain supporting documents for inspections.

Finding: *(Noncompliance with standards for safety and sanitation inspections and enforcement) – New finding*

Auditors tested 60 Medical Inspectors' monthly reports at five correctional centers and noted the following exceptions:

- All twelve-monthly inspection reports tested at Dixon Correctional Center, which comprised 20% of all Centers' reports tested, lacked recommendations for corrective actions for safety and sanitation deficiencies noted during inspections.

- Six (10%) monthly inspection reports for all housing units and dietary areas were not submitted by the 25th day of the month. The report was submitted between 1 to 3 days late at Dixon, Lincoln, Menard, and Pinckneyville Correctional Centers.

- Ten (17%) monthly inspection reports sampled lacked the dates of submission to the Safety and Sanitation Coordinator. Therefore, auditors could not determine if these reports for Lawrence Correctional Center were completed timely.

- Three (5%) monthly inspection reports sampled were not provided. Therefore, auditors could not determine if these reports for Lincoln Correctional Center were completed timely or whether they properly cited safety and sanitation

deficiencies noted during the inspections and included recommendations for corrective action.

Auditors tested 90 Safety and Sanitation Officers' weekly inspection reports at 5 correctional centers and noted the following exceptions:

- For eighteen (20%) weekly safety and sanitation inspection reports tested, Pinckneyville Correctional Center was unable to provide documentation to support the initiation of work orders or direct action for deficiencies noted. As a result, the auditors were unable to determine whether the Center initiated work orders or direct actions to correct violations of minor safety and sanitation standards reported in the inspections.

- For fourteen (16%) weekly safety and sanitation inspections which indicated deficiencies existed, work orders or direct actions were not initiated by Dixon Correctional Center. In addition, deficiencies were not properly documented for eight of those inspections.

- One (1%) weekly safety and sanitation inspection report was not fully completed by Dixon Correctional Center.

- Two (2%) weekly safety and sanitation reports selected for testing were not provided. Therefore, auditors could not determine if these reports for Lawrence Correctional Center were completed timely or at all.

Department management indicated these issues were caused by security staff shortages, employee turnover, oversight, and competing priorities. Management also stated untimely submissions were due to changes in Medical Inspectors, and the due dates for monthly reports were not effectively communicated.

Department Response:
Recommendation accepted.

Updated Response:
Partially Implemented. Department management has sent reminders regarding the importance of completing the weekly safety and sanitation inspections as well as monthly inspections of all housing units and dietary areas. In addition, Deputy Directors are following up during the monthly facility audits to ensure these inspections are being completed.

45. The auditors recommend the Department implement internal controls and allocate sufficient resources to ensure that emergency purchase procurements are published and notices are filed in a timely manner in accordance with the Code.

Finding: *(Noncompliance with the Procurement Code for emergency purchases) – New*

During review of eight emergency purchases, auditors noted the following exceptions:

- Two (25%) emergency purchases tested, which had estimated costs of $1,442,398, were published 2 to 154 days late in the Illinois Procurement Bulletin.
- One (13%) emergency purchase tested, which had an estimated cost of $614,262, was filed 48 days late with the Auditor General.
- One (13%) emergency purchase tested, which had an estimated cost of $150,000, was filed 48 days late with the Procurement Policy Board.

Department management indicated the exceptions were due to employee oversight, conflicting priorities, and backlogs.

Failure to timely publish and file notices of emergency purchases reduces the transparency and accountability of the State.

Department Response:
Recommendation accepted.

Updated Response:
Implemented. The Department has made an effort to reduce the need for emergency purchases. In particular, the Department has clarified with staff the difference between a true emergency purchase and a small purchase with emergency intent. This clarification has been accomplished through training sessions with Department procurement staff as well as staff from the Chief Procurement Office (CPO). In addition, all emergency purchases must be reviewed and approved by the Department's Procurement Officer and Chief Administrative Officer prior to entry into the Bidbuy system.

46. The auditors recommend the Department implement internal controls and sufficient oversight to timely report vehicle accidents, properly maintain State vehicles, and ensure forms are fully completed, dated, submitted, and retained for those employees who are personally assigned state vehicles. The Department should also track and monitor personally assigned vehicles.

Finding: *(Policies and procedures regarding operation of State vehicles not followed) – First reported 2000, last 2018*

During testing of vehicle accident reports, auditors noted the following:

- 26 of 49 (53%) Motorist's Report of Illinois Motor Vehicle Accident Forms (SR-1) and Uniform Cover Letters tested were submitted more than 7 days from the day of the accident.

An analysis of this issue from the last six examinations is summarized in the following table:

Two Years Ending	Number of Exceptions	Sample Size	% of Exceptions	Range of Days Late
June 30, 2010	35	60	58%	1 to 593
June 30, 2012	11	60	18%	1 to 70
June 30, 2014	20	60	33%	1 to 41
June 30, 2016	25	60	42%	1 to 59
June 30, 2018	23	38	61%	7 to 383
June 30, 2020	26	49	53%	1 to 87

- 23 of 49 (47%) Uniform Cover Letters tested were not properly completed. These forms were missing information on the State driver ticketed, ownership of the vehicle, agency/division code related to the employee, license plate number, time period of the accident, claimant, or description of the accident.

- Seven of 49 (14%) Forms SR-1 tested were not properly completed. These forms were missing information on the claimant or the description of the accident.

- One of 49 (2%) Forms SR-1 was not submitted to CMS.

During testing of vehicle maintenance, auditors noted the following exceptions:

- 24 of 60 (40%) vehicles tested did not receive oil changes timely within the allotted mileage requirement ranging from 54 to 12,577 miles overdue.

- 11 of 60 (18%) vehicles tested did not have tire rotations performed for every other oil change.

- Seven of 60 (12%) vehicles tested were missing information on oil changes and tire rotations, and therefore auditors were unable to test compliance with maintenance requirements.

- Three of 60 (5%) vehicles tested did not undergo annual inspections in FY19 and FY20

- Four of 15 (27%) vehicles used to transport offenders tested did not undergo the required six-month safety inspections.

During testing of 16 employees for personal use of state vehicles, auditors noted the following exceptions:

- The following required documents were missing from employee files:
  - 12 (75%) Annual Certification of License and Vehicle Liability Coverage forms.
  - 12 (75%) Annual Commute Mileage Certification forms.
  - 10 (63%) Determination of Value for Individual Use of a State Vehicle forms.
  - Seven (44%) Annual Individually Assigned Vehicles Tax Exemption Certification forms.

- Auditors were unable to test timeliness of submission of the following documents due to lack of a date received stamp:
  - Nine (56%) Annual Individually Assigned Vehicles Tax Exemption Certifications.
  - Six (38%) Determination of Value for Individual Use of a State Vehicle forms.
  - Three (19%) Annual Certifications of License and Vehicle Liability Coverage.
  - One (6%) Annual Commute Mileage Certifications.

- Two (13%) employees tested were missing a supervisor signature on the Annual Individually Assigned Vehicle Tax Exemption Certification form.

Auditors also tested 23 auto certifications and noted the following exceptions:

- 16 (70%) Annual Certifications of License and Vehicle Liability Coverage were missing a date received stamp; therefore, were unable to test timeliness of submission.
- Seven (30%) Annual Certification of License and Vehicle Liability Coverage forms were missing.

Department management stated the exceptions were due to conflicting priorities and employee oversight.

Department Response:
Recommendation accepted.

Updated Response:
Implemented - The Department has implemented the date stamping of all vehicle forms.
Partially Implemented - The Department has sent reminder emails to facility vehicle coordinators and those individuals with assigned vehicles regarding vehicle maintenance requirements and completion of required forms timely.

47. The auditors recommend the Department implement monitoring procedures to track the annual percentage of local farm and food products purchased on an annual basis in compliance with the Act or seek legislative remedy.

Finding: *(Noncompliance with the Local Food, Farms, and Jobs Act) – New finding*

During testing, auditors noted the Department failed to track the annual percentage of local farm or food products purchased during FY19 and FY20. Further, the Department did not provide evidence of any measures taken during the examination period to identify their statutory responsibilities under the Act, to contact or work with the Local Food, Farms, and Jobs Council (Council), to develop procedures, or to take steps to comply. During Fiscal Years 19-20, the Department expended $86,680,617 for food and food products purchases.

Department management indicated they disagree with the finding. Department management indicated that when this exception was brought to their attention after the end of the examination period, they reached out to the Council for further guidance, and found out the Council was not active at that time. Therefore, Department management indicated they believe their noncompliance with the Act should not be cited as a finding. Auditors noted the Department's noncompliance appears to be due to a lack of adequate internal controls to identify, assign responsibility for, and ensure compliance with this statutory mandate.

Department Response:
Recommendation accepted. The Local Food, Farms and Jobs council was completely disbanded several years prior to the examination period. The Illinois Procurement Code requires the Department to purchase the bulk of its food and supplies from master contracts negotiated by the Department of Central Management Services. Therefore, the Department has very little control over or insight into the amount of food purchased from local farms. For small purchases, the Department solicits bids from registered small businesses. Therefore, the Department will seek legislative remedy.

Updated Response:
Partially Implemented. The Department is working through the Budgeting for Results Mandate Group to have this language rescinded.

48. The auditors recommend the Department implement controls to ensure timely submission of Reports to the Comptroller.

Finding: *(Untimely submission of Agency Fee Imposition Report) – New finding*

The Department submitted its FY19 Report 13 days past the August 1 due date.

Department management stated the late report submission was due to a clerical error by the contractor who prepared the report.

Department Response:
Recommendation accepted. The Department would like to point out that the issue noted in this finding has already been corrected.

Updated Response:
Implemented. The Department is filing the fee imposition reports timely with the Office of Comptroller.

49. The auditors recommend the Department allocate sufficient resources and implement procedures to timely offer and provide assistance with applications for health care coverage for offenders prior to release as defined by the Code.

Finding: *(Failure to provide health care coverage application assistance to offenders prior to release) – New finding*

The Department did not have procedures in place to provide assistance with the timely completion of applications for health care coverage to offenders prior to release. Therefore, auditors were unable to test the timeliness of health care coverage assistance to offenders. During the examination period, 7,684 offenders were discharged from the Department's custody.

Department management stated the exceptions were due to lack of staff.

Department Response:
Recommendation accepted.

Updated Response:
Partially Implemented. During the examination time period, specific staff were not identified for this responsibility or trained on how to enroll men and women in our custody for health care coverage prior to their release. The Department also determined that staff needed access to the Integrated Eligibility System (IES) through the Department of Healthcare and Family Services (HFS) to determine if the individual in custody already had an active Medicaid application. The Re-Entry Unit has conducted statewide training with clinical staff on the enrollment procedures, entered the process and deadline for enrollment into an Administrative Directive and placed all forms and instructions on the Department's intranet for staff to use as a resource.

50. The auditors recommend the Department allocate sufficient resources to timely perform, review, and approve monthly reconciliations with Comptroller's reports. They also recommend the Department promptly notify the Comptroller and resolve all differences noted during the reconciliation process.

Finding: *(Inadequate controls over monthly reconciliations) – New finding*

Auditors noted the monthly reconciliations between Department and Comptroller records were not properly performed and timely completed as follows:

- Monthly Appropriation Status Report (SB01) reconciliations were not properly performed during FY19 and 20. 15 of 24 (63%) SB01 monthly reconciliations tested were not completed timely, ranging from 25 to 297 days late. In addition, 5 of 24 (21%) SB01 monthly reconciliations tested did not include reviewer signoffs; therefore, unable to test the timeliness of reconciliations.

- Monthly Revenue Status Report (SB04) reconciliations were not properly performed during FY19 and 20. 18 of 48 (38%) SB04 monthly reconciliations were not completed timely, ranging from 3 to 258 days late. In addition, 21 of 48 (44%) SB04 monthly reconciliations did not include reviewer signoffs; therefore, unable to test the timeliness of reconciliations.

- Monthly Obligations Activity Report (SC15) reconciliations were not completed properly during FY19 and 20. 9 of 24 (38%) SC15 monthly reconciliations were not completed timely, ranging from 47 to 184 days late. In addition, 9 of 24 (38%) SC15 monthly reconciliations did not include reviewer signoffs; therefore, unable to test the timeliness of reconciliations.

- The Department did not perform the Monthly Appropriation Transfer Report (SB03) reconciliations for each month during FY19 and 20.

- The Department failed to provide support of supervisory review of any monthly reconciliations performed for the Cash Report (SB05) during FY19 and 20.

Department management stated the exceptions were due to staff shortages, vacancies, and high employee turnover.

Department Response:
Recommendation accepted.

Updated Response:
Implemented. The Department has staffed the Accounting Compliance Unit that provides timely reconciliations of Office of the Comptroller reports.

51. The auditors recommend the Department ensure violence and public safety data is reviewed on a quarterly basis in order to identify trends and develop action plans to reduce violence and the root causes of violence.

Finding: *(Failure to review reports of violence and public safety data) – New finding*

For 2 of 9 (22%) correctional centers tested, the Department failed to review all reports on violence and public safety data on a quarterly basis. East Moline Correctional Center failed to review reports for 4 of 6 (67%) quarters tested and Stateville Correctional Center failed to review reports for 5 of 6 (83%) quarters tested.

Department management stated the exceptions were due to management oversight.

Department Response:
Recommendation accepted.

Updated Response:
Partially Implemented. Department management has provided guidance to the executive team at the facilities regarding the importance of reviewing violence data and developing a corrective action plan to address the root causes of the violence. The guidance included a requirement to conduct a trend analysis of the restrictive housing placements. In addition, the executive team of each facility conducts a monthly meeting where this data is discussed. The Central Office Operations team and Regional Deputy Directors review the monthly meeting minutes to ensure the discussion is taking place.

52. The auditors recommend the Department comply with mandated reporting requirements or seek legislative remedy.

Finding: *(Noncompliance with special education data reporting required by the School Code) – New finding*

Auditors noted that the Department failed to report a census of individuals under 22 years of age with disabilities receiving special education services during FY19-20

Department management indicated a lack of awareness and understanding of the specific provisions of this mandate as it relates to the Department.

Department Response:
Recommendation accepted. In addition, the school district was removed from the Department's adult facilities in 2006. The removal of the school district eliminated the school psychologist who conducted the screening for special education services. The Department will seek legislative remedy.

Updated Response:
Partially Implemented. The Department is in the process of seeking legislative remedy to remove the requirement to report the number of individuals enrolled in special education classes to the Illinois State Board of Education.

53. The auditors recommend the Department allocate necessary resources for high school equivalency programs and remind staff to accurately report information on such.

Finding: *(Under enrollment and misreported participation in the high school equivalency testing program) – New finding*

During testing, auditors noted the Department failed to increase the number of committed persons enrolled in programs for high school equivalency testing. Since the effective date of January 1, 2015, the number of committed persons enrolled reported in FY20 decreased by 1,358 or 63%.

Further, the Department inaccurately reported the number of committed persons in the Adult Division who were enrolled in adult education programs in FY20. In the Department's FY20 annual report for adult education, enrollments were overstated a total of 4,043 (52%) for adult basic education and high school equivalency enrollment.

Department management stated the exceptions were due to lack of staff and employee error.

Department Response:
Recommendation accepted. The Department would like to mention the following information regarding to this finding:

- Since January 1, 1987, all individuals in custody committed to the Department for two or more years, except those serving life sentences, take the Test of Adult Basic Education (TABE) to determine their academic level.
- During FY19 and 20, 12,685 and 8,115, respectively, individuals in custody were tested at intake with 6,549 (51.62%) and 5,140 (63.34%), respectively, scoring below the 6th grade level.
- High School Equivalency (HSE) program is available to but not required for all individuals in custody who score at an 8th grade level or above on the TABE. Less than half of the individuals in custody fall into this category.
- The number of individuals in custody who took advantage of the opportunity and completed the HSE program during FY19 and 20 was 735 and 604, respectively.
- Due to COVID-19, the TABE and the GED test stopped in March of 2020. The number of GEDs earned decreased as a result.

Updated Response:
Implemented. The reporting errors have been corrected. Partially Implemented. The Department has been able to increase testing due to COVID-19 restrictions being lifted at some but not all facilities.

54. The auditors recommend the Department ensure mandated financial impact information is submitted.

Finding: *(Incomplete reporting in financial impact statements) – New finding*

The Department did not report on the monthly cost of incarcerating an individual and estimated construction cost per bed for financial impact statements due in Fy19 and 20.

Department management stated the exception was due to employee oversight.
Failure to properly report incarceration and construction cost information to the clerk of the circuit court and the public reduces accountability.

Department Response:
Recommendation accepted.

Updated Response:
Implemented. The Department is including the monthly cost of incarcerating an individual and the estimated construction cost per bed in the Department's financial impact statements.

55. The auditors recommend the Department implement internal controls to ensure compliance with notification provisions of the Code.

Finding: *(Untimely notification of settlement) – New finding*

The Department of Corrections (Department) did not notify the State's Attorney within fourteen days of award of damages incurred while the recipient was committed.

For two of 3 (66%) settlements tested, the Department notified the State's Attorney of the county from which the person was committed 59 and 524 days late.

Department management stated the untimely notification of damages awarded was due to administrative oversight.

Department Response:
Recommendation accepted. The Department will work to ensure compliance with the notification's requirement of the Code of Civil Procedure with regard to settlements.

Updated Response: Implemented. The Department has reminded staff of the statutory mandate.

56. The auditors recommend the Department allocate necessary resources in order to properly report all required violence and public safety data to the General Assembly on a timely basis. They further recommend facilities designate staff to review violence data for trends and develop action items to address and reduce violence.

Finding: *(Incomplete quarterly reporting of violence and public safety data) – New finding*

Beginning January 1, 2019, the Department was required to report on violence in institutions and facilities and public safety. Since the effective date, the Department failed to report on all required data on violence and public safety each quarter through June 30, 2020. The missing information includes the following, which represents 10 of 23 (43%) required statistics:

Information Missing	Fiscal Year (FY) / Quarters (Q)
Multi-committed person on a single committed person fights.	FY19 Q3 and Q4
Sexual assault committed by a committed person against another committed person, correctional staff, or visitor.	FY19 Q3 and Q4
Sexual assault committed by correctional staff against another correctional staff, committed person, or visitor.	FY19 Q3 and Q4
Correctional staff use physical force.	FY19 Q3 and Q4
Requests and placements in protective custody.	FY19 Q3 and Q4
Data on average length of stay in segregation, secured housing, and restrictive housing.	FY19 Q3 and Q4 FY20 Q1 thru Q4
The types of housing facilities, whether private residences, transitional housing, homeless shelters, or other, to which committed persons are released from Department correctional institutions and facilities.	FY19 Q3 and Q4 FY20 Q1 thru Q4
Committed persons who are being held in custody past their mandatory statutory release date and the reasons for their continued confinement.	FY19 Q3 and Q4 FY20 Q1 thru Q4
Parole and mandatory supervised release revocation rate by county and reasons for revocation.	FY19 Q3 and Q4 FY20 Q1 thru Q4
Committed persons on parole or mandatory supervised release who have completed evidence-based programs, including educational, vocational, chemical dependency, sex offender or cognitive behavioral.	FY19 Q3 and Q4 FY20 Q1 thru Q4

Public Act 100-0907, which required reporting of this data, was signed into law on August 17, 2018. Department management stated the Department was unable to collect and report the data required due to conflicting priorities. Failure to gather and properly report required violence and public safety data to the General Assembly reduces accountability and the effectiveness of governmental oversight. Failure to analyze all violence and public safety data and develop corrective action hinders the Department's ability to reduce and mitigate the root causes of violence.

Department Response:
Recommendation accepted. The Department would like to mention the following information regarding the exceptions listed in the finding:

- The first five measures listed in the finding did not exist prior to the mandate. Therefore, the Department included them in the quarterly reports as soon as administratively possible as evidenced by the fact that none of the exceptions listed are related to FY20 quarterly reporting.

- The Department data on the average length of stay in segregation, secured housing, and restrictive housing measure did not exist prior to the mandate either.
  - This measure requires a manual calculation since the tracking system of record does not capture the information in the proper form to calculate the average.

- In June of 2021, the Department began reporting the types of housing facilities, whether private residences, transitional housing, homeless shelters, or other, to which committed persons are released from Department correctional institutions and facilities. However, the Department has difficulty gathering validated data for this measure for the following reasons:
  - The tracking system of record the Department uses to track the residence of the paroled or released population only displays the individual's current residence and does not allow the Department staff to target and capture residences upon release.
  - The Department has submitted a programming ticket to resolve the issue.

- In June of 2020, the Department began reporting the total number and ratio of committed persons who are held in custody past their mandatory statutory release date.
  - However, the reasons for the continued confinement portion of the measure has never been part of the tracking system.
  - The Department has submitted a complicated programming ticket to resolve this issue requiring new procedures, directives, and staff training in addition to coordination with other state agencies.

- The Department is unable to provide information regarding the parole and mandatory supervised release revocation rate by county and reasons for revocation for the following reasons:
  - Individuals who are on parole or mandatory supervised release can and do commit parole violations, resulting in a return to prison, in counties, or in some instances other states, than the one in which they reside.
  - In addition, the county has no operational function or jurisdiction when attempting to identify and isolate the reasons for return.

- The legislative intent is unclear as to whether the Department is to identify the county in which the violation occurs, the county in which the parolee resides, or other non-specified parameters in the report.
- The Department has submitted a mandate statute change to the Governor's Office to rescind this mandate.

- The Department is unable to provide information regarding the committed persons on parole or mandatory supervised release who have completed evidence-based programs, including educational, vocational, chemical dependency, sex offender or cognitive behavioral for the following reasons.
  - Reporting capabilities of the current computer tracking system are not available to isolate programs completed during the current parole term versus those completed during a previous parole term for those individuals who serve multiple parole terms.
  - Parolees do not accurately report program compliance or noncompliance to their parole agents on a consistent basis.
  - Parolees are free to live where they chose so long as they do not violate certain conditions such as near schools, etc.
    - The necessary program services may not be available in the parolee's chosen community.
    - The parolee may not access to transportation.
    - The Department cannot force parolees to reside in communities that offer the necessary program services.
    - Many of the community-based program utilized by parolees have not undergone studies to establish whether or not they are evidence based.
  - The Department has submitted a mandate statute change to the Governor's Office to rescind this mandate.

Updated Response:
Partially Implemented. The Department is in the process of seeking legislative remedy for several of these items.

57. The auditors recommend the Department allocate the necessary resources in order to provide requested information to auditors in a timely manner.

Finding: *(Failure to provide requested engagement documentation in a timely manner)*

As is necessary in a financial audit and compliance examination, auditors made numerous requests of the Department during fieldwork. One thousand fifty-one (1,051) written requests for information were made to the Department's Central Office for documentation required to perform testing. Requests were routed through two employees, as requested by the Department. These employees were designated as the liaisons for the financial audit and compliance examination, and ensured all requests were sent to the appropriate personnel, and conducted follow-up on requested information. During the engagement, outstanding request listings were sent up to four

times a month to the Department. Further, four letters were sent from the Office of the Auditor General to the Department during the audit documenting the delays encountered and requesting assistance necessary to complete the financial audit and State compliance examination of the Department and the financial audit of the Statewide financial statements.

As of May 11, 2021, documents related to 491 (47%) requests were provided after the time frame for responses agreed upon with the Department as noted below:

Days received after the due date of request	Compliance Requests	Financial Requests	Exception Listing Response Requests	Potential Audit Finding Response Requests	**Total Number of Items Past Due**
1 to 14	177	43	26	21	**267**
15 to 30	49	14	18	21	**102**
31 to 60	44	7	18	10	**79**
61 to 90	21	4	4	-	**29**
90 to 120	7	-	1	-	**8**
Over 120	4	1	1	-	**6**
Total	302	69	68	52	**491**

Further, some requests for documentation from correctional facilities were never provided to the facility auditors and therefore were considered as exceptions during testing. Those instances have been reported as part of other findings in this report.

Department management agreed to provide requested documents within three weeks of receipt of requests at the beginning of the pandemic, then within two weeks of requests effective August, 2020. Beginning in mid-November 2020, the Department agreed to return to prior audits' practice of providing documents and responses to exceptions and potential audit findings within one week of receipt.

Department management stated they were unable to provide the requested information timely due to the coordination needed between the General Office and the correctional centers, time constraints, and competing priorities. Further, management stated the COVID pandemic contributed to additional time needed to fulfill the engagement requests, as some staff were working remotely. Management indicated documents not provided by facilities were due to inexperienced fiscal staff, conflicting priorities and improper preparation and maintenance of records.

Department Response:
Recommendation accepted. The Department of Corrections' Financial Audit was released on 6/23/21. Four other major state agency financial audit reports were released after this date. The Statewide Annual Comprehensive Financial Report

(ACFR) was issued on 8/19/21. The Department takes great comfort in knowing that none of the delays mentioned in this finding caused the delay in completing the Statewide ACFR.

In addition, the Department would like to point out the following with regards to the delays noted in this finding:

- The Department was very clear that reducing the timeframe for a response from 3 weeks down to 2 and then 1 would be extremely difficult to achieve given the constraints of the COVID 19 restrictions and other issues experienced by the Department. However, the auditors still insisted on these reductions. The Department made every effort possible to comply, however, the information listed below were contributing factors.
- For 43 of 371 (12%) Requests, 19 of 68 (28%) Exception Listing Requests, and 24 of 52 (46%) Potential Audit Finding Requests, the Department reached out to the auditors, sometimes multiple times, for clarification of the items being requested to enable staff to provide the right documentation. These requests took in some cases months to receive a response.
- For 4 of 371 (1%) Requests and 2 of 68 (3%) Exception Listing Requests, the same information was requested again even though the Department had already provided the information on a previous request.
- For 14 of 371 (4%) Requests and 6 of 68 (9%) Exception Listing Requests, the auditors requested additional information or indicated the information provided was not what they needed to perform testing many months after the original request had been fulfilled by the Department. Rather than start the time for response over again, the auditors tracked the Department's response time from the original request due date.
- For 4 of 371 (1%) of Requests, the auditors requested to look at the same documentation again requiring staff time to retrieve information that had already been filed away.
- For 30 of 371 (8%) Requests and 4 of 68 (6%) of Exception Listing Requests, requested document files were too large to send via electronic means. This information either had to be viewed on site or delivered via a USB drive. The auditors were not always available when the information or files were ready.
- The COVID-19 pandemic affected the Department greatly in the following ways:
  - Many staff in the facilities were required to quarantine either because they were positive for the COVID-19 virus or exposed to a positive individual. These staff members in most cases did not have access to the requested documentation.
  - On several occasions, the Central office buildings were either completely inaccessible to staff or staffing were only allowed access for 50 percent of the work week. This situation hindered staff in responding to requests for documents.
- The Department experienced an extreme shortage in the Information Technology area during the audit cycle due to the retirement of key individuals.

Several requests had to wait for additional personnel to be hired to fill the vacancy.

- In some cases, the Department was completely dependent on decisions and information to be provided from outside entities including other state agencies.
- New this year, the auditors tested the accuracy of the census data upon which the actuarial calculation of the Department's contribution, assets and liabilities for the pension plans and other post-employment benefits is based. Requests for information to complete this testing was not sent to the Department until late January 2021.

Accountant's Comment:

The Department is not in a position to evaluate the effect the Department's delays may impose on the Statewide Annual Comprehensive Financial Report, the Department's financial audit, or the Department's State compliance examination. The auditors concluded the Department did not provide timely information to the auditors, which is noncompliance with the Illinois State Auditing Act. The facts in the finding clearly demonstrate this noncompliance. The timelines established for providing audit requests were reasonable for a routine post audit.

Audit document requests were clearly communicated in writing to enable the Department to provide the requested information. The auditors routinely followed up with the Department on outstanding, incomplete, and unresponsive documents, and as detailed in the finding, the Department at times took months to provide complete, responsive documents. A total of 224, or 21% of all requests made, were provided over 2 weeks late (3 to 5 weeks after the date requested). Follow up requests to examine documents are a routine part of audits and did not impact the number of days late.

The auditors made repeated requests for the Department to notify the auditors if they believed any facts were in error. For this particular issue, the auditors sent a potential audit finding and support on April 16, 2021, to which the Department stated it was reserving comment until the finding was received. On August 13, 2021, the Department received this draft finding. The Department did not raise any concerns with the facts until it submitted its finding response September 8, 2021, which it further revised after the close of business on the September 10, 2021 examination completion date.

Both the finding and the Department's response demonstrate the difficulty the auditors experienced in obtaining timely information and cooperation during this post audit.

Updated Response:

Implemented. The Department plans to establish realistic timelines for response to auditor requests for information during the initial stages of the next audit engagement. These timelines will continue throughout the duration of the engagement. In addition, the Department plans to make changes to the handling of these requests to cut down on the time required to provide responses. Throughout the next audit engagement, the Department will track the timeliness of auditor responses to Department requests for

additional or clarifying information to ensure guidance is provided in time for the Department to meet the response deadline set by the auditors.

58. The auditors recommend the Department ensure county boards and sheriffs are notified of any noncompliance of county jails with jail standards.

Finding: *(Failure to notify county boards and sheriffs of noncompliance of county jails) – New finding*

The Department conducted annual inspections of county jails for compliance with standards and procedures established for the physical condition of such institutions and for the treatment of offenders with respect to their health and safety and the security of the community.

During testing of 25 annual county jail inspections, auditors noted the Department failed to give notice to the county board and the sheriff for all 11 (100%) 2018 inspections and 9 of 12 (75%) 2019 inspections of county jails cited for noncompliance.

Department management stated the exceptions were due to management oversight.

Department Response:
Recommendation accepted. In the past, the Department would provide verbal notification of the deficiencies at the time of the inspections. In November of 2019, the Department began sending letters from the Director to county boards and sheriffs outlining any noncompliance with the jail standards and procedures noted during the inspections of local county jails.

Updated Response:
Implemented. Once the inspection of a local county jail is completed, the Department sends a letter to the Sheriff and County Clerk of the affected county indicating that an inspection was completed, listing the section of the code that applies, and requesting that they share the information with the members of their community. Along with the letter, the Department sends the checklists used to conduct the inspection noting any findings of noncompliance. Also included with the letter is an addendum, which details improvements the county has made in the conditions of the jail since the last inspection and another listing of the findings of noncompliance. In addition, those counties with findings are sent a letter signed by the Director of the Department of Corrections stating this fact.

59. The auditors recommend the Department take measures to ensure timely compliance with the extended supervision of sex offender progress report requirements of the Code.

Finding: *(Noncompliance with extended supervision of sex offender requirements of the Unified Code of Corrections) – New finding*

For the one released sex offender tested, the required progress report was prepared 205 days late. Further, the Department did not submit the progress report to the Chief of Police and Sheriff as required.

Department management stated the sex offender progress report was not timely prepared and reported to all required parties due to employee oversight.

Failure to timely prepare and report required information for a sex offender on mandatory supervised release to the local Chief of Police and Sheriff may reduce the effectiveness of governmental monitoring and oversight to identify and manage risks posed to public safety.

Department Response:
Recommendation accepted. The Department will work to ensure timely compliance with the extended supervision of sex offender progress report requirements of the Unified Code of Corrections. In addition, the Department would like to point out that in the past when the reports have been sent to the local chiefs of police and sheriffs, the Department has been met with resistance. The Department will seek legislative remedy for this requirement.

Updated Response:
Partially Implemented. The Department is in the process of submitting a mandate revision request to change the following language in the mandate from "The progress report shall be submitted to the Prisoner Review Board and copies provided to the chief and police and sheriff in the municipality and county in which the offender resides and is registered" to "A copy of the progress report shall be made available to the Prisoner Review Board and the chief of police or sheriff in the municipality and county in which the offender resides and is registered upon request."

60. Auditors recommend the Department implement effective internal controls to ensure timely completion and maintenance of required forms and prompt reporting of required information to the Illinois State Police for released convicted arsonists.

Finding: *(Noncompliance with applicable portions of the Arsonist Registration Act) – First 2006, last 2018*

For 10 of 14 (71%) released convicted arsonists tested, the Department was unable to provide records to support the reporting of required information to the Illinois State Police (ISP) regarding convicted arsonists expecting to reside, work, or attend school upon discharge, parole, or release within the City of Chicago. In all 10 instances, the Department failed to require the offenders to sign the Arsonist Registration Act

Notification to Register Form (Form) prior to release. In addition, for 2 of 14 (14%) released convicted arsonists tested, the Form was signed more than 10 days prior to release, ranging from 423 to 610 days early.

This finding was first reported for 2006. The Department has not taken sufficient measures to implement all appropriate and reasonable corrective actions, as exceptions continue to persist on noncompliance with the Act.

Department management stated since the registry is only completed for released offenders whose intended place of residence, employment, or school is within the city limits of Chicago, employees tend to forget to check for the need to register while processing released offenders.

Timely notification of convicted arsonists of their reporting responsibilities and completion of required notification forms within 10 days of release increases the likelihood released offenders will subsequently register their location as required. Timely informing ISP of convicted arsonists upon their discharge, parole, or release provides information to assist law enforcement in the identification or location of released arsonists.

Department Response:
Recommendation accepted. The Department will work to ensure timely completion and maintenance of required forms and prompt reporting of required information to the Illinois State Police for released convicted arsonists.

Updated Response:
Implemented. The Field Services Management have conducted extensive training of field services staff on the need to notify the applicable individuals of the need to register with the Illinois State Police, if the individual plans to live, work, or attend school within the limits of the City of Chicago. In addition, the need for this registry has been emphasized in quarterly meetings with field services staff. This has been a problem area in the past because it applies to a very small percentage of the entire released population.

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 of Corrections indicated as of July 15, 2022, the Department had 475 employees assigned to locations other than official headquarters.

Appendix A

ASSAULTS

Assaults – Note: Assaults are defined as causing a person, substance or object to come into contact with a staff member, contractual employee, official visitor, visitor, volunteer or any other Individual In Custody in an offensive, provocative or injurious manner.

INDIVIDUAL IN CUSTODY ON EMPLOYEE

> **Note:** The assaults tracked in this category are those in which an Individual In Custody causes a person, substance or object to come into contact with any staff member, any contractual employee, or any volunteer in an offensive, provocative or injurious manner. The collection of this assault data will be by general area (general population, segregation, PC, and minimum/farm). Additional data by location may be kept by the institution.

Total Incidents: Total number of Incidents is defined as the number of events involving an assault, regardless of the number of Individual In Custody/staff involved. An incident is defined as an event which has a defined start/stop period. Any subsequent events which follow an incident shall be counted as a separate incident.

Total Assaults: Total number of Assaults include a person or an object to come into contact with another person in an offensive, provocative, injurious manner or fighting with a weapon. This may be spontaneous or a planned incident involving one or more Individual In Custody. Includes fighting, pushing, shoving, intentionally bumping or tripping, kicking, intentionally striking with an object, hand or other body part, spitting on, throwing food, liquids, or other material. NOTE: Total assaults include “Serious Assaults” (the sum of Sexual Assaults, Throwing of Feces or Urine, Assaults with a Weapon, and Other Serious Assaults) and Other Assaults (those that are not considered serious).

> **Note:** These definitions should allow the Division to track Total Assaults and Serious Assaults and depending on the particular institution, focus on the most appropriate statistic. The collection of this assault data will be by general area (general population, segregation, PC, and minimum/farm). Additional data by location may be kept by the institution.

Other Assaults: Other Assaults are defined as ALL assaults that do NOT fall under the definition of “Serious Assault” or “Assaults with Feces” or “Assault with a Weapon” or “Other Serious Assault.” Examples of Other Assaults include “brushing, bumping, spitting on, throwing food, liquids (not feces or urine) or other material.”

Total Serious Assaults: Serious Assaults. This includes causing a person, substance or object (e.g., broom handle, knife, chair, stool, pipe, tools, scalding liquid and/or chemical, etc.) to come into contact with, and resulting in serious bodily injury to, a staff member, contractual employee, official visitor, visitor or volunteer and any sexual assaults. This does not include brushing, bumping, spitting on, and throwing food, liquids, or other material.

Other Serious Assaults: All Other Serious Assaults which result in bodily injury (other than those reported as throwing of Feces or Urine, or Assaults with a Weapon) should be inserted in Other Serious Assaults.

Assaults w/feces, urine, etc.: Throwing of Feces or Urine is considered a serious assault and will also be collected as a separate item under Serious Assaults.

Assaults w/a weapon: Individual In Custody on Staff Assaults with a weapon are the number of serious assaults (defined in Individual In Custody on Staff Assaults) committed against an employee involving a weapon as defined in the following subcategories:

Gun: Gun is any company-manufactured or store-bought weapon that fires bullets.

Projectile device: Projectile device is any handmade weapon that is forcibly thrown or projected at a target(s) that may fire bullets but is not self-propelled.

Knife: Knife is any cutting or stabbing instrument with a sharp blade, single-edged or double-edged, set in a handle manufactured or store bought.

Shank/Sharpened Object: Shank/Sharpened Object is any cutting or stabbing instrument (may be crude) that has been fashioned from any material into a sharpened blade or ice pick by Individual In Custody.

Explosive/Chemical/Combustible: Explosive/Chemical/Combustible is any chemical, explosive, or gasoline.

Other: Other is any other item determined to be a weapon not listed above. This includes a blunt object, soap or a battery in a sock, and scalding liquid. This does not include feces, urine, a body part (teeth, fist), or tattoo gun.

Appendix B

The Governor, in response to the COVID-19 pandemic, issued sequential Gubernatorial Disaster Proclamations from March 12, 2020, through June 30, 2020. These proclamations allowed the Department of Corrections (Department) to waive the requirements of the Illinois Procurement Code to the extent the requirement (1) would have, in any way, prevented, hindered, or delayed necessary action to cope with the COVID-19 pandemic and (2) was not required by federal law. The following procurements were all processed under this waiver granted by the Governor.

Fiscal Year 2020

Personal Protective Equipment

The Department identified a need for personal protective equipment to mitigate the spread of COVID-19, as well as meet the anticipated surge of offenders and staff testing positive during the COVID-19 pandemic. The Department ultimately paid its vendors $97,029.92 as follows:

• Key Surgical	face shields	$820.00
• Charm-Tex	shoe covers	$33,330.80
• Cascade Health Solutions	gowns	$64.32
• BHL	gowns	$2,699.00
• Sterling Medical	face masks	$22,000.00
• Occup Training & Supply	face masks	$780.00
• Charm-Tex	gloves	$17,475.00
• Cusumano & Sons	gloves	$551.00
• Charm-Tex	hairnet	$19,309.80

Thermometers

The Department identified a need for thermometers to mitigate the spread of COVID-19. The Department ultimately paid its vendors $11,104.75 as follows:

- Medco $1,355.40
- GALCO Ind. Electronics $9,749.35

Trash Bags & Cans

The Department identified a need for trash bags and cans due to the increased disposal of personal protective equipment used to mitigate the spread of COVID-19. The Department ultimately paid its vendors $90,604.36 as follows:

- Industrial Supply Consultants $19,140.00
- Extra Package $16,130.00
- Charm-Tex $28,170.00
- Shelby County $55,305.

Bread & Cookies
The Department identified a need for loaves of bread due to the shutdown of the Illinois Correctional Industries at Illinois River CC due to COVID-19. The Department ultimately paid MJ Kellner $991,298.00.

Sanitizing Wipes
The Department identified a need for sanitizing wipes to mitigate the spread of COVID-19. The Department ultimately paid its vendors $78,774.75 as follows:

- Charm-Tex $78,705.00
- Cusumano & Sons $69.75

Hand Sanitizer
The Department identified a need for hand sanitizer to mitigate the spread of COVID-19. The Department ultimately paid its vendors $18,238.50 as follows:

- ZEP$17,846.50
- Cusumano & Sons $392.00

Paper Towels
The Department identified a need for paper towels to mitigate the spread of COVID-19. The Department ultimately paid Shelby County $20,600.00.

Body Bags
The Department identified a need for body bags due to the spread of the COVID-19 pandemic. The Department ultimately paid Body Bag Store $6,467.00.

Hand Soap
The Department identified a need for hand soap to mitigate the spread of COVID-19. The Department ultimately paid its vendors $68,670.00 as follows:

- Charm-Tex $56,900.00
- IN Corr Industries $11,770.00

Styrofoam Trays
The Department identified a need for Styrofoam trays to mitigate the spread of COVID-19. The Department ultimately paid its vendors $103,391.20.

- MJ Kellner $26,163.20
- Shelby County $77,228

Serving Trays & Lids
The Department identified a need for serving trays and lids to mitigate the spread of COVID-

19. The Department ultimately paid its vendors $106,932.07 as follows:

- Design Specialties $24,624.00
- Cooks Correctional $31,316.80
- MJ Kellner $50,991.27

Tissue

The Department identified a need for facial tissue to mitigate the spread of COVID-19. The Department ultimately paid Chicago Green Office Company $3,450.00.

Tents

The Department identified a need for 12x12 tents to be placed outside of doorways for proper areas for staff donning and doffing of personal protection equipment. The Department ultimately paid Menards $30,799.30.

Bleach, Cleaners & Disinfectants

The Department identified a need for bleach, various cleaners and disinfectants to mitigate the spread of COVID-19. The Department ultimately paid its vendors $99,225.05 as follows:

- Charm-Tex $44,511.80
- Zep $54,713.25

Radios & related Equipment

The Department identified a need to replace handheld radios so that clear communication would be possible across entire facilities. The Department ultimately paid Motorola, $3,665,424.75.

Food Service Film

The Department identified a need for food service film/plastic wrap for proper transporting of food during the COVID-19 pandemic. The Department ultimately paid its vendor $16,025.50 as follows:

- Cooks Correctional $11,268.00
- Shelby County $4,757.50

Polycarbonate

The Department identified a need for polycarbonate to mitigate the spread of COVID-19. The Department ultimately paid Liard Plastics $28,300.00.

Pens

The Department identified a need for getting pens to offenders so they could write letters home during the COVID-19 pandemic. The Department ultimately paid its vendor, Bob Barker, $644.76.